DRN-6075116

The complaint

Mr and Mrs G complain because Liverpool Victoria Insurance Company Limited ('LV') hasn't paid a claim under their travel insurance policy. Mr and Mrs G are also unhappy with LV's delays in telling them the claim wasn't covered.

All references to LV include the agents appointed to handle claims and complaints on its behalf. Mr and Mrs G's complaint has been brought to us by a representative and all references to Mr and Mrs G's submissions include those of their representative, where relevant.

What happened

Mr and Mrs G held a travel insurance policy, provided by LV, which covered a number of declared pre-existing medical conditions for them both. The policy cost £2,425.92.

Unfortunately, while on holiday abroad, Mrs G became ill and was admitted to hospital. LV was notified about the claim and, after around eleven days, said it wasn't covered. LV said this was because Mrs G hadn't told it about certain other medical conditions when she bought the policy.

Unhappy, Mr and Mrs G complained to LV, who offered to pay £150 compensation for its delays in making a decision about the claim. Mr and Mrs G didn't accept LV's position about the claim, or its offer of compensation, so they brought the matter to the attention of our Service.

One of our Investigators looked into what had happened. He said he didn't think LV had acted unfairly or unreasonably by declining Mr and Mrs G's claim but recommended that LV should pay a total of £300 compensation for its delays. LV accepted our Investigator's opinion, but Mr and Mrs G didn't, so the complaint was referred to me to make a decision as the final stage in our process.

After reviewing the file, I queried information which LV had provided to our Service about the medical questions it said Mr and Mrs G were asked when the policy was purchased. LV provided additional evidence about this, which I addressed in the provisional decision I made earlier this month. My provisional decision said:

'I'm very sorry to hear about the circumstances which led to this complaint, and I hope Mrs G is now in better health. I understand the total claim costs in this case are significant, and this has had a serious effect on Mr and Mrs G and their family, but I must reach an independent and impartial outcome which is fair and reasonable to both parties in the circumstances. While I've taken into account all the evidence which both parties have provided in relation to this complaint, I haven't commented on every point raised, and I'm not obliged to do so. This isn't intended as any discourtesy to Mr and Mrs G but, as we're an informal alternative to the civil courts, I've addressed only what I think are the key issues.

Industry rules set out by the regulator say insurers must handle claims promptly and fairly and shouldn't unreasonably reject a claim. The rules also say insurers must provide

reasonable guidance to help a policyholder make a claim, as well as appropriate information on its progress. I've taken these rules, alongside other relevant considerations such as Consumer Duty principles and the applicable law, into account when making this provisional decision.

As Mr and Mrs G were asked to answer questions about their health when taking out this policy, the relevant law is The Consumer Insurance (Disclosure and Representations) Act 2012 ('CIDRA').

CIDRA requires consumers to take reasonable care not to make a misrepresentation when taking out an insurance policy. The standard of care required is that of a reasonable consumer. If a consumer fails to do this, the insurer has certain remedies available to it provided the misrepresentation is - what CIDRA describes as – a 'qualifying misrepresentation'. For a misrepresentation to be a qualifying one, the insurer must show it would have offered the policy on different terms, or not at all, if the consumer hadn't made the misrepresentation. The remedy available to the insurer under CIDRA depends on whether the qualifying misrepresentation was deliberate or reckless, or careless.

CIDRA sets out a number of considerations for deciding whether a consumer failed to take reasonable care – including how clear and specific the insurer's questions were.

LV has now provided screenshots to show the questions Mr and Mrs G were asked when the policy was sold. These say:

> *'In the last 12 months, has anyone on the policy had, or been advised to have, any of the following for a diagnosed condition?*
>
> *• medical investigations or tests*
> *• treatment or surgery*
> *• prescribed medication (including repeat prescriptions)'*
>
> *and*
>
> *'In the last 5 years, has anyone on the policy been diagnosed, treated, or had medication for any of the following?*
>
> *…*
>
> *• COPD, asthma or any other breathing condition.'*

I'm satisfied these questions are clear and specific. LV says Mr and Mrs G failed to take reasonable care not to make a misrepresentation because they didn't tell it about Mrs G's interstitial lung disease and hypertension when they bought the policy.

This policy was taken out in July 2024. Mrs G's medical records say she was diagnosed with interstitial lung disease (which I think it's reasonable to consider as 'a breathing condition') in the five years before the policy was taken out. Mrs G's medical records also show she was prescribed medication for hypertension in the 12 months before the policy was purchased. I understand Mrs G declared asthma to LV, and Mr and Mrs G have carried out extensive research into the relationship between asthma, interstitial lung disease and hypertension, quoting from medical studies about the categorisation of and links between these conditions. It's not my role to reach my own medical conclusions about Mrs G's health, or about links between medical conditions more generally. I'm not medically qualified so it wouldn't be appropriate for me to do this. Instead, I've weighed up the available medical evidence to decide whether I think LV acted fairly and reasonably in the circumstances based on the

information available to it.

The available medical information clearly shows a diagnosis of interstitial lung disease, separate to a diagnosis of asthma, so I don't think it was unfair or unreasonable for LV to conclude that Mrs G had both of these, separate, medical conditions. Hypertension was also noted as a distinct, diagnosed medical condition on Mrs G's medical records and she was prescribed medication for this. So, I think it would have been reasonable for Mrs G to have told LV about these medical conditions in response to the questions asked.

It wasn't up to Mrs G to decide what information she thought LV wanted to know about the risk it was agreeing to insure. There was a duty on Mrs G to take reasonable care to accurately answer the questions asked. I'm satisfied a reasonable person would have realised from the questions above that LV wanted to know about interstitial lung disease and hypertension, in addition to the other medical conditions which Mr and Mrs G declared. So, I don't think Mrs G took reasonable care not to make a misrepresentation when she failed to tell LV about these issues.

LV has mentioned another medical condition (aortic regurgitation) in some of its correspondence, but it hasn't consistently mentioned this when turning down Mrs G's claim and/or when carrying out retrospective medical screenings. So, I don't think it's fair or reasonable for LV to now seek to include this medical condition within its assessment under CIDRA. Based on the underwriting information which LV has provided, I don't think the inclusion of aortic regurgitation makes a difference here anyway.

LV has provided retrospective medical screenings and underwriting evidence to our Service which I'm satisfied demonstrates that it wouldn't have offered cover for any of Mrs G's pre-existing medical conditions if it had known about interstitial lung disease and hypertension in addition to the medical conditions which Mrs G did tell it about. This is commercially sensitive, confidential information which means I can't share it with Mr and Mrs G, but I want to assure them I've carefully considered it, and I'm satisfied it evidences what LV says, and that LV would have treated anyone in the same circumstances as Mr and Mrs G in the same way. This means I think LV has demonstrated that Mrs G made a 'qualifying misrepresentation' under CIDRA. So, it is entitled to apply the relevant remedy set out under the legislation.

LV has classified Mrs G's misrepresentation as 'careless', so it can treat the contract as if it had been entered into on the terms it would have offered had it been aware of all the medical conditions which I think Mrs G should reasonably have declared. This means an exclusion for any claims that are in any way related to Mrs G's pre-existing medical conditions applies to the policy, and Mr and Mrs G are due a refund of £1,219.10 as they would have been charged a lower premium overall.

Based on the medical information I've seen, I don't think it was unfair or unreasonable for LV to conclude that Mrs G's claim related to her pre-existing medical conditions, which are now retrospectively excluded from cover under the policy. And, as Mr G's claim arose from Mrs G's pre-existing medical conditions then this wouldn't be covered either. This means I don't think Mr and Mrs G's claim is payable, but I think LV should refund them the premium mentioned.
I've gone on to consider LV's handling of Mr and Mrs G's claim and whether I think this was in line with industry rules.

Firstly, I should say that its common practice for travel insurers to appoint third party medical assistance companies to deal with emergency medical insurance claims, and this isn't unfair or unreasonable.

I've taken into account the timeline of events from when LV was first notified of the claim, until the date the claim was declined around eleven days later. LV was entitled to carry out reasonable investigations before confirming cover, and this included asking for GP records. I'm satisfied the GP records were requested promptly, and LV also reviewed these promptly when they were received. However, I think there were some unreasonable delays by LV in progressing the claim after this point.

LV asked for further information from Mrs G's GP around four days after receiving its response to the initial request. So, while I don't necessarily think LV gave Mr and Mrs G inaccurate information when it said it was still waiting for medical records, it's not entirely clear why a further request needed to be made to the GP and LV's own internal notes say Mr and Mrs G's expectations could have been managed that the claim was likely not going to be covered.

Overall, I think LV was in a position to tell Mr and Mrs G some days earlier than it did that the claim wasn't covered. And I don't think LV kept Mr G updated as regularly as I'd have expected it to. Given the vulnerable position Mr and Mrs G were in, and the clear urgency of the situation, I'd expect LV to have acted more proactively than it did.

I've carefully thought about whether I think it's likely, on the balance of probabilities, that Mr and Mrs G would have acted differently (thereby incurring less costs) if LV had told them sooner that their claim wasn't covered. Based on the information available to me and the situation Mrs G was in, I don't think this is likely. I understand Mr and Mrs G have queried why LV authorised a scan when the claim wasn't covered but, if investigations or treatment was medically necessary while a claim decision was being made, I don't think it would be fair or reasonable for LV to have refused to authorise this.

I appreciate Mr and Mrs G had to make their own repatriation arrangements after cover was declined but I don't think LV can fairly be held responsible for this. LV offered to help with assistance as a private arrangement, which I think was reasonable in the circumstances.

Overall, I think it would be fair and reasonable in the circumstances for LV to pay compensation for the impact of its delays on Mr and Mrs G. Only Mr and Mrs G are insured under this policy, so they are the only eligible complainants I can award compensation to – I don't have the power to award compensation to their representative and/or other family members for any impact on those individuals. And, I can't seek to punish LV for its actions through an award of compensation.

Taking into account what I think LV's failings were here, as well as our published guidance on the payment of compensation for distress and inconvenience, I think a total payment of £300 compensation would be fair and reasonable in the circumstances. For the avoidance of doubt, this includes the £150 which LV previously offered.

I understand LV already sent a cheque to Mr and Mrs G for £150, which they didn't cash. Mr and Mrs G say a payment for this amount was then credited to their bank account by LV on 16 October 2025. In response to my provisional decision, LV should confirm whether this payment relates to the compensation previously offered.'

LV accepted my provisional decision and confirmed it had previously paid £150 compensation into the bank account mentioned. Mr and Mrs G responded to my provisional decision with additional comments.

What I've decided – and why

I've considered all the available evidence and arguments to decide what's fair and reasonable

in the circumstances of this complaint.

I've carefully thought about everything Mr and Mrs G have said in response to my provisional decision.

I accept there have been developments in the understanding of asthma comorbidities in the last few decades, and that the term 'interstitial lung disease' can be used to describe over 200 medical conditions. I've also taken into account what Mrs G has said about her belief about her lungs and her hypertension, as well as her comments about an expectation for LV to keep up-to-date with medical research.

While I understand Mr and Mrs G's strength of feeling about the matter, my decision remains that it wasn't unfair or unreasonable for LV to rely on the content of Mrs G's medical records when taking the action it did. I'm sorry to disappoint Mr and Mrs G, and I wish them well for the future, but I won't be changing my provisional findings.

Putting things right

Liverpool Victoria Insurance Company Limited needs to put things right and do the following:

- refund Mr and Mrs G £1,219.10 of the premium they paid, together with interest at 8% simple per annum from the date Mr and Mrs G paid for the policy until the date of settlement:
- pay Mr and Mrs G a total of £300 compensation for the distress and inconvenience they experienced. This includes any amount already paid.

Liverpool Victoria Insurance Company Limited must pay the compensation within 28 days of the date on which we tell it Mr and Mrs G accept my final decision. If it pays later than this it must also pay interest on the compensation from the deadline date for settlement to the date of payment at 8% a year simple[1].

My final decision

I'm upholding Mr and Mrs G's complaint about Liverpool Victoria Insurance Company Limited in part, and I direct it to put things right in the way I've outlined above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr and Mrs G to accept or reject my decision before 24 February 2026.

Leah Nagle
Ombudsman

[1] If Liverpool Victoria Insurance Company Limited considers that it's required by HM Revenue & Customs to deduct income tax from that interest, it should tell Mr and Mrs G how much it has taken off. It should also give Mr and Mrs G a tax deduction certificate if they ask for one, so they can reclaim the tax from HM Revenue & Customs if appropriate.