

complaint

Mrs K has made a complaint that Inter Partner Assistance SA ('IPA') declined a claim she and her late husband, Mr O, made on their travel insurance policy. Mrs K is also the representative of the estate of the late Mr O.

background

Mr O became very unwell whilst on holiday and was admitted to intensive care. Mrs K contacted IPA for assistance. IPA contacted Mr O's doctor in the UK to access his medical records. They declined to cover the claim as they said Mr O hadn't declared pre-existing medical conditions. Mr O was repatriated to the UK and sadly passed away shortly after his return.

Mrs K and Mr O made a complaint. IPA sent a final response letter in November 2017 saying there was no cover for pre-existing medical conditions that hadn't been declared or accepted by the insurer. They explained that Mr O had received treatment within the last two years and was taking medication. So they stood by their decision to decline the claim.

Our adjudicator looked into what happened. Initially she upheld the complaint on the basis that IPA hadn't been able to demonstrate what question Mr O and Mrs K were asked as part of the sales process. She also explained that Mr O hadn't been diagnosed with a condition. IPA provided more information and pointed out that Mr O and Mrs K had obtained quotes for policies including the medical conditions before deciding to take out this policy which excluded them.

The adjudicator changed her thoughts about the complaint on the basis of the further information, which included a telephone sales script containing the question which would have also appeared as part of the online sales process. She also considered the relevant legislation and decided that Mrs K's failure to declare her condition had been reckless. So she thought it was fair for IPA to decline the claim.

Mrs K, via her representatives, didn't agree and asked for an ombudsman to review her complaint. In summary she said that Mr O had been given a clean bill of health to travel and hadn't been diagnosed with any condition. She said IPA hadn't shown that a clear question was asked and that it was for IPA to show that they wouldn't have offered the policy had it not been for the misrepresentation.

I asked IPA to clarify how they had treated the misrepresentation under the relevant legislation. They replied to say they thought this was a deliberate act but were prepared to refund the premiums. I asked an investigator to contact Mrs K's representatives to explain this and invite their comments on the post-sale documentation.

They said that the questions at the point of sale weren't clear which is why Mrs K accepted a quote with no medical declarations and there's no evidence that what happened to Mr O was due to a pre-existing condition. The representative also said that Mrs K felt IPA had been aggressive and unsympathetic towards her.

So I need to make a decision.

my findings

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

the relevant law, industry rules and guidelines

Under the Consumer Insurance (Representations and Disclosure) Act 2012 "CIDRA" before entering into a contract of insurance the consumer has a duty to take reasonable care not to make a misrepresentation to the insurer.

Whether or not a consumer has taken reasonable care not to make a misrepresentation is to be determined in the light of the all relevant circumstances. CIDRA gives examples of things which may need to be taken into account in making a determination about whether a consumer took reasonable care. If the consumer fails to take reasonable care in accordance with the provisions of CIDRA and the insurer has a remedy, this is deemed to be a qualifying misrepresentation.

Under CIDRA a qualifying misrepresentation can be either deliberate or reckless, or careless. If a qualifying misrepresentation is not deliberate or reckless, it is classified as careless.

The categorisation of reckless or careless is important because, as far as is relevant here, it entitles the insurer to reach a different outcome in the event of a claim. It is for the insurer to show that a qualifying misrepresentation was reckless or deliberate.

The relevant rules and industry guidelines say that where the sale is non-advised, as it is in this case, it isn't IPA's responsibility to make sure the policy was right for Mrs K and Mr O. However, they do need to be provided with enough information to decide if the policy was right for her.

the medical questions asked

This particular policy has been discontinued and so IPA can't provide the screen shots from the sales process. In their final response letter IPA said Mrs K would have been asked:

"Do you require cover for any pre-existing medical conditions?"

IPA says Mrs K would have been presented with the options 'yes' and 'no'. Selecting 'yes' would take her to the medical screening questions. Selecting 'no' would let her carry on with the purchasing process.

Where the evidence isn't clear I need to decide what is most likely to have happened. Based on the evidence I've seen in this case I'm satisfied it is most likely that a clear question was asked.

I think it is most likely that as part of the online sales process Mrs K would've been asked to confirm whether or not she wanted to cover any pre-existing medical conditions. I think that's supported by the data captured during the sales process which differs significantly depending on whether 'yes' or 'no' is answered to the question about pre-existing conditions.

The sales script from the telephone sales process asked the consumer to confirm that no insured person has symptoms for which they are awaiting investigation/consultation or are awaiting results of investigations, where the underlying cause has not been established. Where pre-existing conditions are declared the consumer is then asked:

Do you, or any other insured person to be covered under this policy have any past medical condition that occurred during the last two years:

- *Has resulted in symptoms*

Or for which:

- *Prescribed medication*
- *Any form of treatment*
- *Medical consultation*
- *Investigation or follow-up/check up*

Has been required or received?

As these issues were central to Mr O's eligibility for the policy, and the type of cover IPA could offer, it seems unlikely to me that there would be a significant difference between the online questions and the telephone process, particularly bearing in mind the information I've seen from the quotations.

I'm satisfied it is most likely that Mrs K was asked if she wanted cover for pre-existing conditions and that if she had answered 'yes' she was then asked a similar more detailed question in relation to past medical conditions within the last two years. If she answered 'no' then I don't think she was required to complete the medical screening questions.

was there a qualifying mis-representation?

I've gone on to consider whether Mrs K took reasonable care when saying that Mr O didn't need cover for pre-existing medical conditions.

The policy was taken out in March 2017 for a long haul trip in May 2017. Mr O was admitted to hospital in late 2016 and in February 2017 with a working diagnosis of aspergillosis (a condition which can affect the lungs and can cause breathing difficulties). He was prescribed three medications following his discharge from hospital according to his medical records. All of this happened within two years of the policy start date and very shortly before the policy was bought.

I think given that Mr O had been admitted to hospital twice within a short space of time and didn't have a firm diagnosis for his symptoms it would have been reasonable for Mrs K to answer the question about pre-existing medical conditions 'yes'.

Two of the quotes she obtained disclosed previous conditions, including aspergillosis. This prompted her to provide a lot of more detail about conditions. Mrs K says that she followed the questioning pathway but she says, on realising none of the medical conditions applied, she decided on the policy that didn't include cover for pre-existing conditions.

I don't find this argument very persuasive in the circumstances of this case. The three quotes were taken out in very short space of time, minutes apart. And, for the reasons I've already explained, I think Mrs K was most likely to have been asked about conditions where Mr O had been prescribed medication, experienced treatment, had a consultation or been investigated as part of that process. It seems likely to me that's what led her to generate the two quotes which she didn't proceed with. And, if she wasn't sure, it was her responsibility to contact the insurer to clarify what she should say. All of this leads me to the conclusion it isn't unreasonable for IPA to say Mrs K didn't take reasonable care and she acted deliberately or recklessly when answering the question/s she was asked.

In any event, I've also taken into account the post-sale documentation which has a section entitled, 'important requirement applying to your policy'. In that section it sets out the significant and unusual exclusions or limitations. It says:

- *There is no cover for any claims arising directly or indirectly as a result of any pre-existing medical conditions unless you have declared ALL pre-existing medical conditions to us (and any subsequent changes in health or medication) and we have written to you accepted them for insurance*
- *There is no cover provided by this policy, if on the commencement of cover under this policy or when booking a trip, you are having or waiting to have any medical tests or investigation, or are waiting for the results of any test or investigations, into any undiagnosed medical condition or symptoms for which the underlying cause has not been diagnosed. This is regardless of how significant the issue for which you have been referred for further investigation was considered to be by the medical practitioner consulted*

Mrs K was obviously concerned about her husband's state of health at the time she took out the policy as she generated quotes about various conditions. And it was up to her to decide if the policy was right for them. So, even if this information wasn't drawn to her attention during the sales process, I think she was provided with enough information in the policy documents and that it would have been clear to her that her husband's recent medical history ought to be discussed further with the insurer. She would have been entitled to cancel the policy within the 'cooling off' period and receive a full refund of the premium she'd paid.

Finally, I'm not persuaded by the argument that there's no medical evidence connecting the pre-existing conditions to Mr O's death. He had a working diagnosis of aspergillosis and died of bronchopneumonia and adult respiratory distress syndrome. So I don't think it's unreasonable for IPA to conclude there's a connection between the two, particularly given Mr O's recent medical history. The policy excludes claims relating to directly or indirectly to pre-existing medical conditions unless they'd been declared and accepted by the insurer.

IPA has agreed to refund the premiums which I think is reasonable in the circumstances. But I don't think they need to pay the claim. I appreciate that Mrs K felt IPA were aggressive and didn't want to pay the claim. But I think they had legitimate concerns about how the policy was taken out and they were entitled to ask reasonable questions of her. I understand that this came at an already very difficult time for Mrs K but I don't think IPA treated her unfairly.

my final decision

I'm not upholding this complaint. Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs K to accept or reject my decision before 12 December 2019.

Anna Wilshaw
ombudsman