ombudsman news

essential reading for people interested in financial complaints – and how to prevent or settle them

Financial Ombudsman Service

got it covered?

Caroline Wayman
chief ombudsman

As the winter months roll on, it's not surprising that it's a busy time of year for planning and booking our next holidays. As I speak, there will be many people trawling through websites and going through hotel listings with a fine-tooth comb.

For many people, choosing the right hotel and imagining themselves relaxing by the pool may all be part of the fun. But the same level of attention may not be paid to travel insurance. When planning things to look forward to, we understandably might not want to worry about what might go wrong.

In general, holidays go to plan – and for most people, the types of problems insurance is there to cover won't be brought to life. However, each year people contact us when they've had trouble on holiday – and haven't had the help from their travel insurer that they expected.

And most of the time, these disputes centre on what's covered and what's not. With this in mind, in this *ombudsman news*, we look at issues ranging from winter sports injuries and medical emergencies, to age limits and official advice not to travel.

We've also included examples of complaints involving alcohol – specifically, whether someone's claim relates to how much they've drunk. Insurers may choose not to pay out if they believe someone's been drinking excessively – although, as we've highlighted, this doesn't necessarily mean holidays should be totally alcohol-free. In each case, we'll need to carefully weigh up all the evidence to decide, on balance, whether the insurer has made the right call.

Encouragingly, compared with recent years, we're generally upholding fewer travel insurance complaints. This suggests – while there's still clearly work to do – that many insurers are increasingly treating their customers in a fair and reasonable way.

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in this issue

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Let's hope that continues into the new year – as the holidays being booked right now become a reality. If holidaymakers put the right protection in place – and insurers continue to focus on getting things right – then, even if a trip doesn't go to plan, making a claim won't be any more stressful than it needs to be.

Caroline

… we're generally upholding fewer travel insurance complaints …

third quarter 2017/2018 statistics

a snapshot of our complaint figures for the third quarter of the 2017/2018 financial year

Each quarter we publish updates about the financial products and services people have contacted us about. This data includes the number of enquiries we've received, the number of complaints passed to an ombudsman for a final decision, and the proportion of complaints resolved in favour of consumers.

In this issue we focus on data for the third quarter of the financial year 2017/2018, showing the new complaints received during October, November and December 2017.

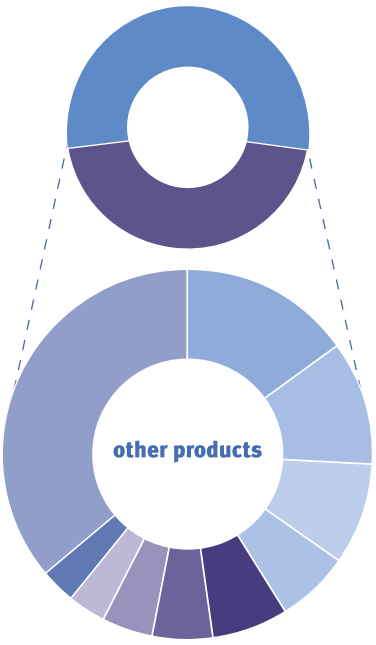
Between October and December:

- We handled 147,775 enquiries from consumers, taking on 81,647 new cases – with 9,326 complaints passed to an ombudsman as the final stage of our complaints handling process.
- PPI remained the most complained about financial product, with 43,394 new cases. Current accounts were the second most complained about product, with 4,976 new cases.
- We started to resolve PPI complaints affected by the judgment in *Plevin v Paragon Personal Finance Ltd*. As we set out in our feedback statement on complaints data publication, we won't be reporting the *outcome* of complaints affected by *Plevin* that we received up to 29 August 2017, which is when the FCA's final PPI rules and guidance came into effect. However, we'll report the volumes of complaints affected by *Plevin* that we resolve – which was 47,782 in the third quarter 2017/2018 cases.

the financial products that consumers complained about most to the ombudsman service in October, November and December 2017.*

- payment protection insurance (PPI) 54%
- complaints about other products 46%

- current accounts 13%
- payday loans 9%
- car and motorcycle insurance 8%
- packaged bank account 8%
- credit card accounts 7%
- house mortgages 6%
- overdrafts and loans 5%
- hire purchase 4%
- buildings insurance 3%
- other products 38%



*Please note: the figures above have been rounded up/down to the nearest percent

third quarter 2017/2018

	... in Q3 October - December 2017				... in Q2 July - September 2017				... so far this year April 2017 - December 2017				... in the whole of 2016/17 April 2016 - March 2017			
	enquiries received	new cases	ombudsman	% of cases upheld	enquiries received	new cases	ombudsman	% of cases upheld	enquiries received	new cases	ombudsman	% of cases upheld	enquiries received	new cases	ombudsman	% of cases upheld
payment protection insurance	67,197	43,394	3,595	35%	69,103	50,639	1,863	39%	197,162	135,364	7,136	*38%	213,418	168,769	16,443	52%
current accounts	7,475	4,976	636	26%	7,260	4,497	705	27%	23,292	14,631	2,026	26%	31,128	17,434	2,188	27%
payday loans	6,332	3,972	448	56%	5,565	3,593	562	60%	16,495	10,402	1,561	61%	15,007	10,529	2,225	59%
car and motorcycle insurance	5,557	2,867	412	27%	6,345	2,971	496	30%	18,723	8,925	1,440	29%	29,154	11,844	1,871	30%
credit card accounts	3,748	2,781	396	28%	3,738	2,276	401	28%	11,809	7,707	1,184	28%	15,253	9,104	1,371	29%
packaged bank accounts	5,207	2,410	268	12%	5,442	3,082	216	10%	16,235	8,553	702	12%	29,310	20,284	1,641	19%
house mortgages	3,003	2,261	453	22%	2,998	1,901	505	25%	9,503	6,475	1,545	24%	14,830	10,411	1,935	31%
overdrafts and loans	2,692	1,802	247	27%	2,512	1,523	265	28%	7,845	4,921	783	29%	10,015	6,425	1,085	26%
hire purchase	2,068	1,494	278	33%	2,124	1,335	296	34%	6,328	4,146	831	34%	9,035	5,029	911	34%
buildings insurance	1,609	1,176	245	36%	1,739	1,049	305	34%	5,332	3,480	847	34%	7,831	4,815	1,134	35%
“point of sale” loans	1,356	1,010	68	33%	940	682	81	35%	3,812	2,721	246	33%	4,706	2,556	441	32%
travel insurance	1,239	896	149	37%	1,305	731	183	37%	3,757	2,392	482	38%	5,047	3,191	656	38%
self-invested personal pensions (SIPPs)	546	546	97	54%	767	498	193	49%	2,138	1,575	472	51%	1,959	1,493	495	56%
term assurance	542	514	73	9%	599	414	85	15%	1,972	1,458	256	14%	3,028	2,295	341	18%
catalogue shopping	817	499	49	43%	796	465	44	44%	2,658	1,516	155	47%	3,432	1,640	180	45%
hiring / leasing / renting	634	466	66	35%	608	379	56	26%	1,857	1,154	166	30%	1,819	920	131	32%
contents insurance	623	457	97	27%	668	426	99	25%	1,994	1,326	283	26%	2,440	1,555	353	26%
home emergency cover	713	457	75	43%	549	319	102	44%	2,040	1,345	292	45%	3,163	2,117	396	47%
debit and cash cards	657	436	74	23%	710	445	103	26%	2,210	1,401	248	25%	2,442	1,435	196	30%
deposit and savings accounts	569	426	61	29%	605	382	95	29%	1,955	1,270	224	30%	2,644	1,740	306	29%
pet and livestock insurance	540	422	63	26%	615	347	93	30%	1,820	1,182	238	27%	2,487	1,508	289	30%
personal pensions	673	408	75	27%	885	337	110	29%	2,362	1,174	312	27%	3,393	1,881	416	30%
whole-of-life policies	497	366	55	14%	481	270	61	15%	1,504	982	201	17%	2,374	1,580	326	20%
mortgage endowments	514	325	51	15%	459	220	50	18%	1,541	804	152	16%	2,973	1,511	236	15%
ISA - Individual Savings Accounts (Not Cash)	378	316	46	32%	305	199	67	31%	1,046	779	178	32%	1,634	1,261	253	31%
debt collecting	753	305	42	28%	760	231	60	31%	2,317	771	140	29%	3,057	1,027	113	32%
electronic money	823	296	25	36%	772	253	54	28%	2,621	838	118	32%	3,909	1,183	163	30%
private medical and dental insurance	338	280	49	26%	334	247	81	25%	1,095	818	195	25%	1,596	1,147	283	31%
credit reference agency	478	279	23	32%	485	219	23	34%	1,459	706	60	33%	1,461	579	82	35%
inter-bank transfers	450	270	39	28%	495	300	54	27%	1,496	898	140	27%	2,820	1,645	231	26%
warranties	437	252	29	46%	456	196	55	44%	1,391	707	140	45%	2,716	1,327	215	39%
portfolio management	230	243	64	42%	198	172	113	34%	787	650	269	39%	1,702	1,216	348	41%
critical illness insurance	297	236	37	15%	290	202	50	24%	892	628	138	20%	1,185	849	150	18%
share dealings	325	234	40	34%	321	189	46	27%	986	568	147	31%	1,324	746	178	34%
mobile phone insurance	387	227	29	37%	477	241	23	40%	1,353	741	83	38%	1,952	904	97	35%
specialist insurance	335	224	36	29%	365	227	56	36%	1,181	841	129	32%	1,493	729	93	39%
income protection	260	220	38	22%	262	186	52	24%	875	627	137	21%	1,413	1,075	258	26%
home credit	230	219	14	34%	203	105	25	37%	633	429	55	32%	490	328	94	30%
roadside assistance	290	215	31	34%	246	160	29	31%	829	542	89	33%	1,346	795	130	37%
occupational pension transfers and opt**outs	152	181	52	37%	165	114	67	25%	559	418	182	29%	673	496	143	27%
annuities	172	179	42	17%	214	181	47	15%	714	588	135	15%	993	743	111	19%
secured loans	216	178	28	24%	208	155	50	30%	820	582	134	25%	1,694	1,147	190	24%
legal expenses insurance	212	175	58	28%	196	142	55	27%	678	497	179	29%	1,005	692	289	26%
Instalment Loans	167	146	91	63%	206	197	125	54%	816	680	289	56%	978	883	246	39%
cash ISA - Individual Savings Account	166	134	19	36%	152	99	21	33%	554	362	59	30%	1,007	716	107	36%
store cards	209	130	14	42%	185	112	12	34%	604	352	47	37%	847	440	53	34%
merchant acquiring	206	124	13	40%	162	106	20	36%	613	350	49	33%	979	515	82	35%
commercial vehicle insurance	198	123	18	33%	208	115	31	33%	674	363	79	31%	1,447	620	127	32%
direct debits and standing orders	270	118	17	27%	269	111	14	37%	796	355	60	33%	937	581	84	30%
personal accident insurance	146	115	18	17%	154	98	21	39%	489	318	51	25%	729	579	131	23%
conditional sale	122	104	20	39%	127	113	38	37%	470	362	90	36%	587	550	208	36%
cheques and drafts	142	98	19	35%	174	123	32	35%	532	346	65	36%	813	491	70	37%
card protection insurance	157	93	3	29%	184	79	7	14%	555	268	17	26%	978	493	38	20%
money remittance	135	80	12	32%	148	66	15	26%	466	236	35	28%	608	255	26	38%
commercial property insurance	80	75	24	27%	82	59	26	31%	281	213	85	31%	676	473	154	35%
endowment savings plans	77	74	12	28%	87	60	24	27%	274	202	58	25%	525	411	95	18%
unit-linked investment bonds	59	71	22	24%	61	53	28	28%	240	207	83	34%	587	484	148	39%
building warranties	95	66	29	33%	100	59	17	35%	336	219	75	34%	598	487	200	30%
Guarantor Loans	81	65	11	30%	77	39	11	18%	240	140	33	24%	290	172	34	21%
Investment Trusts	83	60	13	30%	66	46	18	53%	278	163	37	42%	231	130	34	28%
business protection insurance	70	57	14	32%	58	31	13	15%	224	149	39	23%	489	241	60	26%
“with-profits” bonds	41	52	17	19%	48	36	19	24%	187	143	57	20%	379	256	61	29%
guaranteed asset protection (“gap” insurance)	75	50	7	24%	92	44	9	11%	283	155	22	18%	438	210	31	27%
unit trusts	42	46	4	24%	-	-	-	-	129	103	28	33%	189	139	34	33%
foreign currency	65	45	7	18%	86	35	6	17%	226	102	15	21%	252	118	26	36%
caravan insurance	61	37	8	20%	-	-	-	-	171	90	23	28%	249	125	27	27%
credit broking	80	36	6	19%	90	47	11	21%	294	139	31	25%	665	228	81	32%
spread betting	43	36	11	28%	42	32	21	26%	168	121	72	22%	320	202	87	21%
derivatives	39	33	9	18%	37	35	30	18%	155	121	78	21%	379	268	114	21%
income drawdowns	-	-	-	-	37	38	15	30%	136	126	39	34%	200	172	59	37%
debt adjusting	-	-	-	-	73	33	7	41%	239	109	19	29%	886	560	248	23%
capital protected structured products	-	-	-	-	-	-	-	-	107	105	38	27%	150	140	25	36%
FSAVC – free standing additional voluntary contributions	-	-	-	-	-	-	-	-	109	90	23	24%	187	127	40	27%
premium bonds	-	-	-	-	-	-	-	-	153	84	7	23%	159	82	15	24%
OEICs (open-ended investment companies)	-	-	-	-	-	-	-	-	96	83	34	33%	221	243	42	32%
safe custody	-	-	-	-	-	-	-	-	94	75	14	41%	89	66	17	39%
Logbook Loans	-	-	-	-	-	-	-	-	118	69	23	44%	172	103	16	32%
Savings Certificates/Bonds	-	-	-	-	-	-	-	-	140	69	12	19%	115	67	7	16%
debt counselling	-	-	-	-	-	-	-	-	134	67	13	22%	512	342	121	16%
state earnings-related pension (SERPs)	-	-	-	-	-	-	-	-	99	66	8	6%	163	112	18	9%
Banker's Reference	-	-	-	-	-	-	-	-	83	41	6	30%	-	-	-	-
interest rate hedge	-	-	-	-	-	-	-	-	35	32	38	19%	273	250	147	35%
PEP - Personal Equity Plans	-	-	-	-	-	-	-	-	-	-	-	-	97	85	22	37%
Non-Structured Periodically Guaranteed Fund	-	-	-	-	-	-	-	-	-	-	-	-	70	73	29	42%
Crowdfunding (loan-based)	-	-	-	-	-	-	-	-	-	-	-	-	69	46	8	30%
Children's Savings Plans	-	-	-	-	-	-	-	-	-	-	-	-	58	45	1	18%
Pawnbroking	-	-	-	-	-	-	-	-	-	-	-	-	97	44	12	30%
EPP - Executive Pension Plans	-	-	-	-	-	-	-	-	-	-	-	-	39	39	13	42%
Structured Deposits	-	-	-	-	-	-	-	-	-	-	-	-	47	33	6	41%
sub total	124,480	80,958	9,191	33%	126,570	84,366	8,567	35%	377,674	244,807	26,281	34%	469,132	320,651	42,191	43%
other products and services	23,295	689	135	26%	24,542	479	157	29%	56,992	757	180	31%	74,321	632	126	35%
total	147,775	81,647	9,326	33%	151,112	84,845	8,724	35%	434,666	245,564	26,461	34%	543,453	321,283	42,317	42%

*PPI uphold rate does not include complaints affected by the Plevin judgment.

travel insurance

Official figures show that more than 21.9 million UK residents went on summer holidays abroad last year. By comparison, we dealt with around 3,000 complaints about travel insurance in 2017 – deciding in nearly four in ten cases that the insurer in question hadn't treated their customer fairly. This suggests that things go to plan most of the time – or at least, that holidaymakers can resolve any problems directly with their insurers.

However, trips away don't always go smoothly. The case studies in this issue illustrate the wide range of problems that can lead to travel insurance claims – ranging from political unrest to serious accidents. While people can spend a lot of time planning a holiday, travel insurance might not always be a priority. But if something goes wrong, having chosen the right cover can prove to be much more important than deciding what outfits to pack.

Likewise, if insurers treat their customers fairly – looking at all the individual circumstances when considering a claim – it can make a significant difference to the people involved, in what may be very upsetting situations.

what types of complaints do you see?

We sometimes see travel insurance complaints involving advice, sales and administration. But, unsurprisingly, most of the complaints we see centre on claims.

In some cases, the claim in question has been made before the holiday has even begun – when someone cancels their planned trip.

As our case studies show, whatever the reason for the cancellation, our job is to decide whether the insurer has applied the terms of the policy fairly.

We also see travel insurance complaints relating to specific types of holiday activities, such as winter sports or cruise breaks. The high risk of serious injury, sometimes in remote locations, can lead to claims being complex and expensive – so insurers are likely to be specific about what they'll cover.

If we think a policy term is unclear – or if the insurer has applied it in an unfair and unreasonable way – we may say a claim should be paid, even if the circumstances aren't strictly covered.

Insurers sometimes tell us they believe their customer's excessive drinking led to a claim – and because of this, they won't pay out. But if someone's been honest about the fact they'd had a drink, we wouldn't just assume they'd been drinking to excess – or that their drinking was necessarily the reason for their claim.

We sometimes need to remind insurers that it's for them to show that any exclusion applies, rather than for their customer to show that it doesn't. And we'll expect to see the evidence – which is often medical evidence – that the insurer has relied on to reach the decision they have.

how do you put things right?

Unpicking these complaints can be challenging. There may not be as much evidence available if something's happened abroad, compared with claims in the UK. We'll reach our conclusions on the balance of probabilities – deciding, in all the circumstances and given everything we've seen, what we think is most likely to have happened.

If we decide a claim has been unfairly rejected, we may tell insurers to add 8% simple interest when they pay it – for example, if someone had to pay their medical expenses themselves, so were wrongly left out of pocket.

Mr P complains that insurer won't refund holiday medical fees on grounds he was drunk

Mr P, in his twenties, phoned us after his insurer had turned down his claim for hospital fees following an accident on holiday. His insurer was saying he'd been drinking excessively when the accident happened, so his travel insurance policy didn't cover him.

Mr P explained he'd been on a beach holiday with his friends when he'd slipped over in the toilets of a nightclub and hit his head. He said that he'd gone back to his table after the fall and told his friends what had happened – but that they hadn't been worried at the time, as he'd seemed fine. However, he'd woken up with a headache and dizziness the next day – and had felt worse as the day went on.

Mr P said he hadn't been sure what to do, so he'd contacted his insurer. They'd advised him to go to hospital, where he'd had some tests and been given some medication. But when he'd made a claim for his medical costs, the insurer wouldn't pay out because he'd told them he'd been drinking.

Mr P remembered telling the insurer when he'd phoned them that he'd had some alcohol before the accident – but insisted he hadn't been drunk at the time. He said he'd had some food and a couple of drinks, but nothing excessive like the insurer was saying. He thought the insurer was acting unfairly, and asked for our help to sort things out.

putting things right

We looked at the terms and conditions of Mr P's travel insurance policy. These said the insurer didn't expect policyholders to avoid alcohol on holiday – but said claims wouldn't be covered where the policyholder was so drunk their judgement was affected. The policy said one example of this would be where, in the treating doctor's opinion, "excessive alcohol" had caused or contributed to the injury.

We asked the insurer to point us to any evidence they had to show excessive alcohol was likely to have been the cause of Mr P's claim. We pointed out that the medical reports from the hospital abroad said Mr P had a head injury – and the scan and blood test results were normal. Once he was back home, his GP had told him he'd probably been concussed. We reminded the insurer that it was for *them* to show the exclusion applied, rather than for Mr P to show that it didn't.

The insurer said that because Mr P didn't go to hospital until the following morning, the alcohol might not have still been in his system – so it wouldn't have shown up in any tests. They also pointed out that Mr P had told them he'd been drinking.

We considered what Mr P had told us – and the insurer – about how much he'd had to drink. We also took into account all the medical evidence.

We acknowledged that Mr P had drunk some alcohol. He wasn't disputing that. But, on balance, we didn't think the evidence showed it was more likely than not that excessive alcohol consumption had caused his accident.

Because of this, we didn't think it was fair or reasonable for the insurer to turn down Mr P's claim. So we told them to pay the costs Mr P had paid out for his medical treatment, plus interest at 8%.

case study 143/1

Mr N complains that insurer has turned down claim for medical fees, saying alcohol caused the claim

Mr N contacted us after his claim on his travel insurance policy was turned down. He said he'd fallen and hit his head while on holiday – but his insurer had rejected his claim, saying he'd had too much to drink when it happened.

The insurer had told Mr N that his policy didn't cover claims arising from excessive alcohol consumption. But Mr N argued that the policy didn't define "excessive". He also said he'd tripped over in his room – which could have happened to anyone, regardless of whether they'd been drinking. He felt the insurer was being unfair and asked us to sort things out.

putting things right

We asked the insurer what evidence they'd relied on when turning down Mr N's claim.

They sent us medical records showing the emergency doctor diagnosed Mr N with "acute alcohol intoxication" – alcohol poisoning. These records also said Mr N hadn't been able to sign a form when he arrived at the hospital – with the reason given that he was "under the influence of an intoxicant". Other records made during his trip in the ambulance suggested he'd said he'd been drinking all night.

Mr N said the hospital didn't carry out any tests – and that his friends would back up the fact he hadn't drunk that much.

However, we thought there was enough medical evidence to decide, on balance, that his accident was likely to have been caused by excessive alcohol – and that the accident wouldn't have happened otherwise. When we explained this to Mr N, he accepted our view.

case study 143/2

Miss R complains that travel insurer won't pay whole claim – saying she fell over because she'd been drinking

Miss R wanted to dispute her insurer's decision about her travel insurance claim. She explained that her knee had come out of its joint while she was on holiday. Following a number of scans in a foreign hospital, she'd ended up with her leg in a cast – and ended her trip early. But the insurer refused to pay her claim, saying the problem related to alcohol.

Miss R disagreed with this. She accepted she'd had something to drink that night, but didn't think alcohol was to blame for what had happened. She said she'd recently been told she had a joint condition. However, the insurer was refusing to change their mind – and Miss R wanted our help.

putting things right

We asked the insurer for their records about the claim. We saw Miss R had said on her claim form that she'd had something to drink on the night her knee came out of joint. And the insurer was saying the injury wouldn't have happened if Miss R hadn't been drinking.

We asked Miss R for more information about what had happened. She explained she'd been walking back to her hotel following a night out on holiday, when her knee had come out of joint and she'd fallen over. She said she'd got a taxi back to her hotel – but had ended up going to hospital.
Miss R said that, since getting home, she'd been told she had a condition that meant her joints were prone to dislocation. She sent us a letter from her GP confirming this.

We then considered the evidence from the time of the injury. The hospital report said there was no sign of an impact to Miss R's knee – which we thought suggested it had dislocated before she fell, rather than doing so because she'd fallen on it. And there wasn't anything in the hospital report to suggest alcohol was to blame.

We told the insurer that, based on the information we'd seen, we thought it was more likely than not that the injury would have happened regardless of whether Miss R had drunk any alcohol. We asked them to send us any evidence they had that showed Miss R's drinking alcohol was likely to have led to her injury.

The insurer didn't provide any evidence. In view of our investigation, they accepted what we'd said and agreed to pay Miss R's claim.

case study 143/3

Mr and Mrs L complain that insurer won't cover hospital fees following holiday illness

Mrs N contacted us on behalf of her elderly neighbours, Mr and Mrs L, who were having trouble with their travel insurance claim. She said Mr L had become seriously ill while on holiday. He'd ended up in a private hospital – and the insurer was refusing to pay the fees.

Mrs N said that Mrs L had been given misleading information by the insurer – and was still very distressed about the whole thing. She asked if we could look into what had happened and tell them what to do.

putting things right

We asked the insurer for all their records – and asked Mrs N for more detail about what had happened to Mr and Mrs L.

Looking at this evidence, we began to get a clearer picture. Mr L had been told he needed urgent hospital treatment, and had been taken away in an ambulance. Mrs L had phoned the insurer the following day to let them know he was receiving private care. At this stage, the insurer hadn't mentioned the fact they wouldn't pay for private care costs. Two days later, the insurer called back to say Mr L would need to be moved when he left intensive care, as private care wasn't covered by the couple's policy.

Mr L had needed a further week in intensive care before his treating doctor confirmed he was fit to be moved– and was then taken to a public hospital. It seemed Mrs L had also had trouble getting the information she needed from the insurer about hotel arrangements near the hospital.

We carefully reviewed Mr L's policy documents. Like most travel insurance policies, these said private medical treatment wasn't covered. And we thought this term was clearly set out in the policy.

However, we saw that the doctor who first examined Mr L had said his condition was life-threatening – and he needed urgent treatment. The medical advice was that Mr L needed to be taken to the nearest hospital with an intensive care unit. And it turned out that the closest hospital to where Mr L was staying was a private one.

We accepted that, applying the policy terms strictly, Mr L's claim for private medical treatment wasn't covered. And Mr and Mrs L should have called the insurer before Mr L received any treatment.

But in the circumstances, we could see why the couple had acted on the medial advice they received. And we understood why, because of the situation they were in, they hadn't had the opportunity to phone their insurer until the next day. We also concluded, looking at the evidence, that Mr L had been moved to a public hospital at the first available opportunity.

We recommended that the insurer pay the private medical costs Mr and Mrs L had already paid for, as well as the accommodation expenses Mrs L had run up as a result of Mr L being in hospital – adding interest.

We also recommended that the insurer compensate the couple for the trouble and upset they'd experienced as a result of the way their claim had been handled. The insurer agreed this was a fair way forward. In all circumstances, we judged the compensation should fall within the moderate range – as explained on our website.

case study 143/4

Mrs G complains that travel insurer won't pay back cost of skiing holiday when she isn't fit to ski

Mrs G contacted us after cancelling her skiing holiday. She'd provided her travel insurer with a medical certificate showing she had tendonitis – and her doctor's opinion that she couldn't ski.

However, the insurer had said even though Mrs G couldn't ski, she'd still have been able to travel and enjoy her holiday. So they wouldn't cover the cost of the cancelled trip. Mrs G thought this was unfair, and asked for our help to sort things out.

putting things right

We contacted the insurer to ask for their side of the story. They repeated Mrs G wasn't covered under her policy. The policy said cancellation was covered if the policyholder became seriously ill or injured – and that a medical certificate was needed to support the reason why the policyholder couldn't travel. The insurer said Mrs G's doctor hadn't specifically said she couldn't travel – only that she was unfit to ski.

We could see that Mrs G's doctor had completed the questions on the insurer's form. The doctor hadn't specifically been asked to distinguish between Mrs G being fit to ski and being fit to travel. However, the doctor *had* said they'd certify that Mrs G was compelled to cancel her trip.

We considered the medical evidence Mrs G had provided. And, importantly, we took into account that the whole purpose of Mrs G's holiday was to ski. Now she wasn't able to do that, we didn't think it was fair or reasonable for the insurer to strictly apply the policy terms and conditions to the circumstances of her claim.

In light of this, we told the insurer to pay Mrs G's cancellation claim, adding interest.

case study 143/5

Mrs V complains that travel insurer won't pay her claim – disputing the definition of a toboggan

Mrs V got in touch after she injured herself on a ride at an alpine resort. She said her travel insurer wouldn't pay her claim for medical fees and ruined clothes, saying she wasn't covered under her policy for either tobogganing or for dangerous activities.

Mrs V said the ride was more like a rollercoaster than a toboggan. But the insurer didn't agree – and Mrs V wanted our help to sort things out.

putting things right

We looked carefully at the policy terms and conditions – and the evidence we had about how Mrs V had hurt herself.

The resort's website explained how the ride had been converted from an existing toboggan run. However, it now operated as a small cart fixed to a rail – something that was clear from the website's photos. The website also said the ride was suitable for children aged three or over, provided they were accompanied by an adult. There was no mention that any protective clothing or equipment was required.

We acknowledged that the insurer's policy clearly listed tobogganing as a winter sport – and Mrs V didn't have cover for it. However, we agreed with Mrs V that going on this particular ride wasn't the same as "tobogganing". And, based on the evidence we'd seen, we didn't think it was fair to classify the ride as a "dangerous activity" either.

When we explained this to the insurer, they said they'd pay Mrs V's claim for her medical expenses and damaged clothing, adding 8% interest.

case study 143/6

Mrs P complains after insurer turns down travel insurance claim following husband's serious skiing injury

Mr and Mrs P complained to us when their insurer rejected their travel insurance claim. They explained Mr P and a friend had been skiing off-piste – when Mr P had had a serious accident. He'd severely injured his back and had a long stay in hospital in the country he'd been skiing in.

Mr and Mrs P explained they'd contacted their travel insurer to claim back the medical expenses under their policy. But the insurer had said skiing off-piste without a guide was a "hazardous activity", so it wasn't covered.

The couple had already complained to the insurer – but the outcome hadn't changed. Increasingly distressed, they asked us to step in to sort things out.

putting things right

We asked the insurer for their side of the story – and for all the information they had, including the policy terms and conditions. The insurer told us that they knew their policy terms didn't specifically mention off-piste skiing as an "excluded" or "hazardous" activity – but that the list in the policy documents wasn't exhaustive. They said that if Mr P was going to go off-piste, he should have checked beforehand that he was covered.

Mr and Mrs P insisted Mr P hadn't been carrying out a hazardous activity when he'd had his accident. They sent us information showing Mr P and his friend had been visiting and skiing in that area for decades, and also regularly went mountaineering there.

We considered whether the policy was clear enough. The policy said participation in any specifically excluded or hazardous activities would be excluded from cover, unless the insurer had confirmed otherwise. It also said the policyholder should contact the insurer if they had any plans to take part in any listed activity.

We acknowledged what the insurer had said about the list of excluded or hazardous activities not being exhaustive. However, we didn't think it was fair for the insurer to put the burden on their customers of deciding what exactly an excluded or hazardous activity might be. So, in our view, the insurer couldn't rely on the list to turn down Mr P's claim.

On the other hand, the policy did say that off-piste skiing should only be done with an instructor. There was also a term saying policyholders should take reasonable steps to avoid accidents and avoid deliberately exposing themselves to danger.

We considered the reasons why an insurer might exclude cover for off-piste skiing without an instructor. We acknowledged that, in general, having an instructor would be likely to lessen the risk that someone who wasn't familiar with skiing off-piste would injure themselves while doing it.

We then took Mr P and his friend's particular circumstances into account. The evidence we'd seen suggested they had a significant level of skiing experience and familiarity with the area. In that light, it seemed likely they'd have a relatively similar level of knowledge to a guide or instructor.

So we didn't think it was fair or reasonable to say that, in being off-piste, Mr P had exposed himself to danger. And we decided the insurer should pay the claim in full, adding interest to reflect the fact that Mr and Mrs P had already paid the medical costs themselves.

case study 143/7

Mr K complains that insurer has turned down cancellation claim after Foreign and Commonwealth Office issues travel advice

Mr K complained to us after his insurer turned down a claim on his travel insurance policy.

He explained he'd booked a trip abroad with his wife to visit her family. A few weeks before travelling – aware that there'd recently been political unrest in the country in question – he'd checked the Foreign and Commonwealth Office's (FCO) website for official advice.

Mr K said the FCO's website had advised against all but essential travel, because of increased levels of violence. And because of this, he'd decided to cancel the holiday. However, the insurer wouldn't pay his claim – saying his policy didn't cover cancellation resulting from wars, uprisings, civil unrest and revolutions.

Mr K said he'd complained to the insurer, pointing to the FCO guidance. The insurer had responded to say they believed their decision was correct. But Mr K disagreed, and asked for our view.

putting things right

We got in touch with the insurer to get the full picture about their decision. They sent us a copy of the policy terms and conditions, highlighting the exclusions they'd relied upon.

First, we considered the exclusion relating to civil unrest. The insurer said there'd been a number of media reports about the turbulence in the region in question – and it was reasonable to think Mr K should have been aware of these before booking his trip.

We acknowledged that Mr K's claim fell under this exclusion on a strict reading of the policy. However, we saw there'd been coverage of public demonstrations around the time Mr K booked his holiday. In our view, Mr K couldn't have been expected to predict things would deteriorate as they had. We didn't think it was fair to say he should have known, at the point he booked, that he might need to cancel his trip.

We also saw there was a general policy exclusion for travelling to places where a UK government agency – or the World Health Organisation – had advised the public not to travel. In this particular case, the FCO had told people in the area in question to take great care, to avoid public gatherings, and to avoid all but "essential travel" to the region.

We agreed with Mr K's judgement that a holiday wasn't "essential travel". It seemed Mr K had faced a choice between travelling completely uninsured to a high risk location, or cancelling the trip and having his cancellation claim turned down.

And we didn't think it was fair or reasonable for the insurer to put Mr K in a position where he wouldn't be covered if he did travel – but also wouldn't be covered if he didn't.

In these circumstances, we recommended that the insurer pay Mr K's cancellation claim, together with interest at 8%.

case study 143/8

Miss D complains after parents' travel cancellation claim is rejected because of age limit

Miss D contacted us about her parents' travel insurance, which was included with their bank account.

She said that shortly before her parents were due to go on holiday, her father, Mr D, had been taken to hospital – and they'd needed to cancel their trip. But when they'd phoned the insurer to make a cancellation claim, they'd been told they weren't covered as they were both over the policy age limit of 75.

According to Miss D, the insurer said her parents should have contacted them to say they were over 75. The insurer had said that, if Mr and Mrs D had contacted them, they would have then both needed to answer medical screening questions, and to pay more to remain covered under the policy. However, Mrs D was sure she *had* phoned the insurer before booking the holiday, and said she'd been told she and Mr D would be covered.

After Miss D complained, the insurer had looked back over their file. But they'd said they couldn't find any record of Mrs D calling them. Miss D didn't think her elderly parents had been treated fairly – and asked for our help to resolve things.

putting things right

We asked the insurer for a copy of the terms and conditions of Mr and Mrs D's travel insurance – as well as all their records about the claim.

When we reviewed these records ourselves, we found a note confirming that Mrs D had phoned the insurer to check the details of their cover. We asked the insurer for a recording of this call. And when we listened to it, we heard Mrs D asking what her policy included. The insurer had outlined the main features of the policy – but hadn't mentioned any issues with an age limit. So we thought it was reasonable, in the circumstances, that Mrs D had concluded that she and Mr D were covered.

We also asked the insurer how they'd communicated the age limit – to check whether it had been made clear to Mr and Mrs D beforehand. The insurer said they didn't send reminders to their customers each year. They felt it was clear in the policy documents that people needed to contact them to confirm cover once they'd reached the age of 75.

We looked at the policy documents in question – and saw these said people over 75 needed to contact the insurer. However, we pointed out Mr and Mrs D *had* contacted the insurer. And the insurer could have taken the opportunity to discuss the age limit then – but they didn't.

Having taken all the circumstances into account, we decided the insurer should cover the cancellation claim, adding interest. Because Mr and Mrs D would have needed to pay extra for their cover, we thought it was fair for the insurer to take this amount off the money they were paying for the claim.

case study 143/9

Mrs M complains that insurer hasn't paid her enough after she broke her arm on a cruise holiday.

Mrs M told us about the problems she'd had with her travel insurance after breaking her arm on the second day of her cruise. She explained that, due to her injury, she hadn't been able to enjoy the trip – especially as she'd had to cancel many of the activities she'd planned.

Mrs M said she'd contacted her insurer after her accident, and had decided to stay on the cruise rather than to go home. She'd also asked for the insurer's help in upgrading her return flight, as she didn't think she'd be able to travel comfortably in economy class with her arm how it was. She felt the insurer had messed her about – first saying they'd help, but later saying she wasn't entitled to an upgrade.

It seemed the insurer had acknowledged the confusion about the return flights could have been avoided, and had offered Mrs M some compensation. They'd also offered to pay her medical costs from the cruise and the cost of the activities she'd missed.

But Mrs M thought the insurer should reimburse the full cost of her cruise – and compensate her for the pain and disappointment she'd felt while stuck in her cabin. She also wanted the insurer to pay for the medical treatment she'd had since she'd got back to the UK. She asked for our help to get things put right.

putting things right

Both Mrs M and the insurer sent us information about the claim and the costs Mrs M had incurred. We also asked the insurer for the terms and conditions of Mrs M's policy – looking carefully at the cover Mrs M had had in place, and what her options had been.

Looking at the policy, it seemed Mrs M could have got the whole cost of the cruise back only if she'd cancelled the trip. Or she could have got part of the cost back if she'd cut her trip short. From the records we had, it looked like the insurer and Mrs M had explored all these courses of action at the time. And she'd decided to stay on the ship, saying she felt she was being looked after by the medical team on board.

We considered whether Mrs M's trip had been effectively cut short – for example, whether she'd been required to stay in her cabin for the rest of the trip. But this hadn't been the case. She'd been able to get out and about on the ship, including taking part in some of the activities she'd wanted to. All in all, we decided it was fair for the insurer to pay only Mrs M's medical costs and expenses.

We explained to Mrs M that her travel insurance, like most policies, wouldn't compensate her for loss of enjoyment or for being in pain. In line with the policy, the insurer had already offered to pay for the financial cost of the activities she'd missed. And we clarified that her policy only covered medical expenses abroad, not in the UK too.

We then looked into how the insurer had handled Mrs M's request for a flight upgrade. In all the records about Mrs M's injury and her claim, there wasn't any evidence to suggest an upgrade would have been medically necessary.

So – although we acknowledged Mrs M felt she would have been better off with more space – we explained that we didn't think it was unfair for the insurer to refuse to pay for the upgrade. And in our view, they'd already offered appropriate compensation.

case study 143/10

Q? &A

I've heard there have been some changes to how complaints should be handled. What's happened and what does my business need to do?

On 13 January 2018, the revised Payment Services Directive – often referred to as "PSD2" – took effect in the UK. One consequence is that businesses should give their final response to complaints about payment services within 15 days (or 35 days in exceptional circumstances) – rather than the eight weeks they had previously.

There's more information on the FCA's website – and in its handbook in DISP 1.6.2A – about exactly what's meant by "payment services", and how you should handle any complaints you receive about them.

Some of the things that come under the umbrella of payment services were already covered by our service – such as direct debits and payments made by card. And there are also some things we didn't previously cover, but now do. These include "account information services" – commonly known as open banking – and payment methods such as taking money directly from an account when buying goods online, and charging purchases to mobile phone bills. Either way, we'll be able to get involved when the 15-day timeframe is up – or earlier, if you consent to us doing so.

Remember: when responding to complaints, you need to send your customers a copy of our leaflet, *your complaint and the ombudsman*. We've recently updated this – including adding a reference to the time limit for making a complaint about PPI. Soon you'll be able to order the latest version from our website (although it's fine to run down any supplies you've got in stock).

If your business doesn't have much contact with us – and you've got any more questions about how we work – you can contact our technical advice desk on 0207 964 1400, or at technical.advice@financial-ombudsman.org.uk.

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