DRN-5108745

The complaint

Mr S complains that Inter Partner Assistance SA ("IPA") hasn't paid a cancellation claim under his travel insurance policy.

What happened

Mr S took out a single trip travel insurance policy online through a price comparison website on 30 March 2024 to cover a trip between 5 and 9 April 2024. The insurer was IPA.

Unfortunately, Mr S had to cancel his trip due to a medical issue. So, he made a cancellation claim to IPA. To assess the claim, IPA asked for Mr S' medical records. Following this, IPA declined the claim because it said the policy Mr S had wasn't suitable for someone with pre-existing medical conditions within the last two years prior to policy inception. IPA said that had Mr S declared his previous medical history before taking out the policy, it would not have sold this policy to him. So, IPA declined the claim Mr S made under the policy, but it offered to cancel the policy and issue a refund. Unhappy with IPA's position, Mr S brought a complaint to our service.

One of our investigators looked into the complaint. Having done so, she thought it would have been reasonable for Mr S to declare his previous medical history to IPA. And had he done so, IPA wouldn't have offered him this policy. So, she thought IPA had acted fairly and reasonably when it declined Mr S' claim, but it should refund Mr S the premium he paid for the policy and pay him 8% simple interest on this amount.

In response, Mr S sent our investigator evidence that IPA does offer policies with pre-existing conditions covered. He also said IPA hadn't declined his claim due to misrepresentation at the point of sale, rather, it had declined the claim based on pre-existing medical conditions which he didn't think he had as per the policy terms.

Our investigator explained that, ultimately, IPA had declined the claim because Mr S hadn't declared his pre-existing medical conditions when he took out the policy. So, this is what she looked into. Our investigator also clarified that had Mr S declared pre-existing medical conditions when taking out the policy, he would have been directed back to the price comparison website where he would have been given a range of options for policies that provided cover for pre-existing medical conditions. Overall, she said she didn't think she could fairly say Mr S would have chosen a similarly branded but more expensive policy with IPA at this point.

Mr S didn't agree with our investigator's findings. As no agreement was reached, the complaint has been passed to me to decide.

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.

Industry rules set by the regulator (the Financial Conduct Authority) say insurers must handle claims fairly and shouldn't unreasonably reject a claim. I've taken these rules, and other industry guidance, into account when deciding what I think is fair and reasonable in the circumstances of Mr S' complaint.

I think the key considerations under this complaint are the principles set out in the Consumer Insurance (Disclosure and Representations) Act 2012 ("CIDRA"). This is designed to make sure that consumers and insurers get an appropriate remedy if a policyholder makes what is called a "qualifying misrepresentation" under the act.

A misrepresentation is a "qualifying misrepresentation" when 1) a consumer fails to take reasonable care not to misrepresent the facts which the insurer has asked about, and 2) the insurer shows that without the misrepresentation it would not have entered into the contract at all or would have done so only on different terms.

I've first looked to see if Mr S failed to take reasonable care. The standard of care required is that of a reasonable consumer. And one of the factors to be considered when deciding if a consumer has taken reasonable care is how clear and specific the questions asked by the insurer were.

When taking out the policy through a price comparison website, Mr S was asked the following:

> *"**Does anyone in your party have a pre-existing medical condition, or is anyone on a waiting list for treatment or investigation?***
> *[…]*
> ***Why is this important?***
> *You must tell us the medical history of all named travellers, to make sure pre-existing medical conditions are fully covered.*
>
> ***What is a 'pre-existing' medical condition?***
> *This is a medical condition or injury that you've been diagnosed with and have had or are currently receiving treatment for. Examples include, stroke, high blood pressure, anxiety and broken bones.*
> *Don't worry, it may not always cost more to include your medical conditions. If you don't tell us, then you may not be covered if you need medical treatment abroad or for any costs to get you back home."*

Mr S answered "no" to this question.

Before completing the purchase of his policy, Mr S was asked to answer a second question about his medical history. This said:

> *"Within the last 2 years, has anyone you wish to insure on this policy suffered any medical or psychological condition, disease, sickness illness or injury that required prescribed medication (including repeat prescriptions) or treatment including surgery, tests or investigations?"*

Mr S again answered "no" to this question.

IPA says that had Mr S answered either of these questions "yes", he wouldn't have been able to buy this policy.

Our investigator didn't think Mr S acted unreasonably when he answered the first question "no" because he hadn't been diagnosed with any condition, and she hadn't seen evidence that he was receiving treatment at the time of taking out the policy. But she thought the second question was clear, and it would have been reasonable for Mr S to answer this question "yes".

I don't intend to make a finding whether I think Mr S took reasonable care in answering the first question, as I don't think this affects the outcome of the complaint. This is because I think Mr S should have answered the second question "yes".

I've looked through Mr S' medical records. And I can see that he had consulted a doctor and been prescribed with medication for low mood in the two years prior to taking out the policy, including trying different medications for this. He'd also suffered from a sprain and joint pain that he was prescribed medication for.

I think a reasonable consumer would have realised these were something IPA would want to know about in response to the second question asked. I say this because the severity of Mr S' low mood was such that he was prescribed medication for it. The medical records also show Mr S had suffered from joint pain for a significant period of time, and he was prescribed medication for it. So, I think Mr S failed to take reasonable care when answering the second question in the way he did.

IPA says that had Mr S answered "yes", he wouldn't have been offered the option to buy this policy, as it wasn't suitable for someone with pre-existing medical conditions. Instead, he would have been directed back to the price comparison website and been shown policies from a variety of insurers that do cover pre-existing medical conditions.

Overall, I'm satisfied that had Mr S answered the question "yes", IPA wouldn't have sold him the policy. When directed back to the price comparison website, Mr S would have been presented with a range of options from different insurers at different prices and different benefits. I don't think I can fairly say that it's more likely than not that Mr S would have chosen to take out a similarly branded but more expensive policy with IPA which did cover pre-existing medical conditions.

So, I think Mr S made a qualifying misrepresentation that IPA has treated as careless (rather than deliberate or reckless). This means the remedy available for IPA under CIDRA is to void the policy from inception – this means to treat it as if it never existed – and refuse all claims. IPA should then refund the premium Mr S paid, which it has already offered to do. I think this offer is fair and reasonable in the circumstances of this complaint.

For completeness, it's not unusual for insurers to ask a policyholder's GP to complete a medical certificate when a claim is made due to medical reasons. This is also set out in the terms and conditions of the policy. And I can see that the certificate the GP completed included indications that Mr S had pre-existing medical conditions, which this policy wasn't suitable for. So, I don't think it was unreasonable for IPA to request Mr S' full medical records so it could assess the claim.

My final decision

My final decision is that Inter Partner Assistance SA should refund Mr S the premium he paid and add interest at 8% simple per annum from the date the claim was declined until the date settlement is paid.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr S to accept or reject my decision before 27 November 2024.

Renja Anderson
Ombudsman