DRN-5167501

The complaint

Mr and Mrs M have complained that Inter Partner Assistance SA (IPA) declined a claim they made on a travel insurance policy and about delays with the claims process.

What happened

Mr and Mrs M were on a trip abroad in September 2023 when their daughter became ill and had to be hospitalised. They therefore made a claim on the policy for medical and other out of pocket expenses.

IPA declined the claim on the basis that they hadn't declared their daughter's pre-existing medical condition (PEMC). It said that, had they done so, it wouldn't have agreed to provide cover.

In responding to the complaint, IPA offered to refund the premium cost and pay compensation of £150 for delays. However, it maintained its decision to decline the claim.

Our investigator thought that IPA had acted fairly in declining the claim. However, she recommended that it should pay an additional £100 for poor service.

Mr and Mrs M disagree with the investigator's opinion and so the complaint has been passed to me for a decision.

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 considered the obligations placed on IPA by the Financial Conduct Authority (FCA). Its 'Insurance: Conduct of Business Sourcebook' (ICOBS) includes the requirement for IPA to handle claims promptly and fairly, and to not unreasonably decline a claim.

The relevant law in this case 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 a consumer insurance contract.

If a consumer fails to do this, the insurer has certain remedies provided the misrepresentation is - what CIDRA describes as - a qualifying misrepresentation. For it to be a qualifying misrepresentation, the insurer has to show it would have offered the policy on different terms - or not at all - if the consumer hadn't made the misrepresentation.

Mr and Mrs M purchased the policy online on 3 September 2023. IPA has provided evidence of the online sales journey. I'm satisfied that if an applicant had declared a PEMC, they wouldn't have been offered this particular policy.

When considering whether someone has taken reasonable care, I need to consider how clear and specific the questions asked were.

Upon the comparison website presenting a list of possible policies, when clicking through to this particular policy, an applicant is asked:

'*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 has required prescribed medication (including repeat prescriptions) or treatment including surgery, tests or investigations?'*

Their daughter's medical records show three consultations (the first in November 2021 and then two more in 2022) for a respiratory issue for which an inhaler had been prescribed.

Mrs M has said that it was her that requested the inhaler, that the visits to the GP stemmed from her being an anxious mother and that it should be expected that a young child will have had numerous visits to the doctor.

I can see from the medical notes that the doctor prescribed the inhaler initially, although it was Mrs M that requested a re-issue as she thought it was beneficial. Despite there being no diagnosis, their daughter had suffered from an illness for which she'd been treated with medication.

The matter at hand is not really about why or how many times their daughter went to the doctor. It's about whether they should have declared this information at the time of purchasing the policy.

I consider the above question to be clear and so, based on the available evidence, Mr and Mrs M should have answered 'yes', but they instead answered 'no'.

Had they answered 'yes', a pop-up would have appeared to advise that they needed an alternative policy that covered PEMCs and therefore to return to the quotations page.

There's no suggestion that Mr and Mrs M intended to mislead IPA. But they didn't take enough care to ensure they answered the questions correctly. As they didn't take reasonable care, this is a qualifying misrepresentation under CIDRA and so IPA is entitled to apply the relevant remedy available to it under the Act.

CIDRA says that an insurer is entitled to apply cover as if it had all of the information it wanted to know at the outset. Based on the available evidence, I'm satisfied that it would not have offered the policy if Mr and Mrs M had declared their daughter's PEMC.

Therefore, as it wouldn't have offered cover, there would have been no policy to make a claim on. It follows that it was therefore reasonable for IPA to decline the claim. In such a scenario, IPA should refund the policy premiums, which it has offered to do.

Overall, based on the available evidence, I'm satisfied that IPA has acted reasonably in declining the claim and offering a refund of premiums.

In relation to the claims handling process, our investigator has previously set out the timeline of events, so I won't repeat it all here. IPA was in a position to decline the claim upon receipt of the medical history from the GP in November 2023. However, it wasn't until February 2024 that Mr and Mrs M finally understood that the claim had been declined. I also agree with our investigator that it was unfair for IPA to tell the treating hospital about the claim being declined before it had told Mr and Mrs M.

On balance, I don't think IPA did enough in offering £150 compensation. I consider that total compensation of £250 is fair and reasonable for the distress and inconvenience caused by the delays.

My final decision

For the reasons set out, my decision is that I partially uphold the complaint.

It was reasonable to decline the claim. However, there were unreasonable delays in the claims process.

Inter Partner Assistance SA should pay a total of £250 compensation and refund the premium amount, if it hasn't already done so.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr M and Mrs M to accept or reject my decision before 26 December 2024.

Carole Clark
Ombudsman