DRN-5208596

The complaint

Ms F is unhappy that Inter Partner Assistance SA (IPA) declined a claim made on her annual, multi-trip, 'standard' travel insurance policy.

All reference to IPA includes its agents.

What happened

The details of this complaint are well known to both parties, so I won't repeat them again here. I'll focus on giving the reasons for my 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 considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint. That includes IPA's regulatory obligation to handle insurance claims fairly and promptly. And to not unreasonably decline a claim.

It also includes The Consumer Insurance (Disclosure and Representations) Act 2012 ('CIDRA'). This requires consumers to take reasonable care not to make a misrepresentation when taking out a consumer insurance contract.

The standard of care is that of a reasonable consumer. And 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 (in this case IPA) has to show it would have offered the policy on different terms, or not at all, if the consumer hadn't made the misrepresentation.

CIDRA sets out a number of considerations for deciding whether the consumer failed to take reasonable care. And the remedy available to the insurer under CIDRA depends on whether the qualifying misrepresentation was deliberate or reckless, or careless.

I know Ms F will be very disappointed, but I'm satisfied that IPA has acted fairly and reasonably by declining the claim relating to her being unwell abroad and needing medical treatment.

Did Ms F make a misrepresentation?

When first taking out the policy in 2021 Ms F didn't declare any medical conditions and the policy automatically renewed each year thereafter.

IPA has provided the renewal notice it says Ms F would've received before her policy annually renewed in July 2023. I'm satisfied on the balance of probabilities that this was

most likely sent to Ms F, in line with IPA's regulatory obligations when insurance policies are up for renewal.

Under the section headed 'important information', it says:

> We would like to remind you that your chosen policy will continue to provide cover as long as you, or anyone you wish to insure on this policy, are not:
>
> - Waiting to receive, or have received, any medical treatment (including prescribed medication, surgery, tests or investigations) within the last 2 years; or
> - Currently aware of any reason that may cause you to claim (such as suffering symptoms not yet discussed with a doctor or the health of relatives or other third parties which may cause the cancellation or the cutting short of a trip)
>
> If either of these circumstances apply, please contact us. If we have not been made aware of changes to health of the people named on your policy, your insurer could treat it as if it never existed, or refuse a claim or not pay a claim in full.

Ms F was then referred to the 'important conditions relating to health' section of the policy terms and the information product information document (IPID). Hyper-links were provided for her to click onto these documents. The IPID says under: 'what are my obligations?', you are obliged to notify us of changes to health of anyone named on your policy schedule prior to the renewal of an annual multi-trip contract.

I'm satisfied that it was clearly set out to Ms F that if she had received any medical treatment within the last two years, she should contact IPA to let them know.

CIDRA says a failure by the consumer to comply with the insurer's request to confirm or amend particulars previously given is capable of being a misrepresentation.

IPA has relied on entries in Ms F's medical records reflecting that she attended GP appointments, had tests and was prescribed medication in the two years before the policy renewed when concluding that she made a misrepresentation. I think that's fair and reasonable given the information in Ms F's medical records, the diagnoses she received (including diabetes) and medication she was prescribed in the months leading to the policy renewing in July 2023.

I've seen nothing which persuades me that Ms F did contact IPA before the policy renewed in July 2023 to let them of these GP consultations, blood tests and prescribed medication.

Was this a 'qualifying' misrepresentation?

I've considered whether this amounted to a qualifying misrepresentation under CIDRA. And I find that it did.

From the information provided by IPA, I'm satisfied that if Ms F had contacted IPA to tell it about her health issues, it most likely wouldn't have renewed the 'standard' policy in 2023. That's because the standard policy isn't for those who have pre-existing health conditions.

I'm satisfied IPA has fairly concluded that Ms F acted carelessly when not contacting it to inform it that she'd received medical treatment in the last two years before the policy renewed in 2023 (as opposed to deliberately (or acting recklessly by) not doing so).

I've looked at the actions IPA can take in line with CIDRA, and it's entitled to do what it would've done if Ms F hadn't made a careless qualifying misrepresentation. As I'm satisfied

that the standard policy wouldn't have ended up being renewed, I think it's fair and reasonable for IPA to not pay the claim. That's because the policy wouldn't have been in place and so IPA doesn't have to cover any claims.

However, in line with CIDRA, I would reasonably expect to see IPA to refund the premium paid for the policy, which I understand it has done here.

I appreciate that the reason Ms F needed treatment abroad may not have been related to the conditions she didn't disclose before the policy renewed. However, I don't think that's a relevant consideration here. If she'd contacted IPA to tell it about receiving medical treatment in the last two years before renewal in 2023, the standard policy wouldn't have been in place to cover the medical expenses she incurred whilst abroad in May / June 2024.

Claim handling

IPA initially gave a different reason for declining the claim. However, IPA promptly said it had incorrectly declined the claim and requested medical records to continue its assessment. Upon receipt of medical records, IPA declined the claim because Ms F didn't let it know about her change in health before the policy renewed. Whilst I do think IPA should've more promptly reviewed the medical history upon receipt (the contact notes reflect that the notes were with its medical team for several weeks to review) I ultimately find that the upset Ms F experienced was due to her claim being declined.

So, even if the claim hadn't been incorrectly declined (and quickly reversed) initially, and if the medical history had been reviewed a couple of weeks earlier, I think it's most likely that she would've still been upset by the claim being ultimately declined.

I'm not persuaded that IPA's initial errors, whilst annoying, had too much impact on her. I don't think it would be fair and reasonable for IPA to pay any compensation for distress and inconvenience in the circumstances of this complaint.

My final decision

I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms F to accept or reject my decision before 24 February 2025.

David Curtis-Johnson
Ombudsman