DRN-5268553

The complaint

Miss D and Mr G have complained about the way Inter Partner Assistance SA (IPA) has handled a claim they made on a travel insurance policy.

As it is Miss D leading on the complaint, I will mostly just be referring to her in this decision.

What happened

Miss D was on holiday abroad with her family in July 2024 when her daughter became unwell. She was seen by a doctor and prescribed medication. Miss D therefore made a claim for medical expenses and associated costs.

IPA incorrectly declined the claim initially on the basis that there was no medical report from the treating doctor. However, it then accepted that Miss D had provided this and so it resumed its assessment of the claim. It subsequently declined the claim again as it had not received a medical certificate from her daughter's GP.

In responding to the complaint, IPA accepted that there had been some poor service. So, it apologised and paid £100 compensation. However, it maintained its decision to decline the claim.

Our investigator thought that £100 was sufficient compensation for the poor service that had occurred. However, he concluded that, as IPA had previously offered to pay for the medical certificate from the GP, it should abide by that offer.

Miss D disagrees with the investigator's view and so the case 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.

It was on 31 July 2024 that IPA told Miss D that it had declined the claim. However, it realised its error later the same day. There's what looks like an internal email, which was forwarded to Miss D, stating that it had the relevant documents on file. It further stated that compensation should be added to the claim due to this error. It then spoke to Miss D on 1 August 2024 to explain that the claim would be reassessed.

On 5 August 2024, it rang Miss D to further explain that it needed a report from her daughter's GP to check that the condition being claimed for wasn't pre-existing. Miss D questioned why this would be necessary, especially as IPA had already admitted fault for

incorrectly saying it didn't have a document containing the diagnosis, which had already led to delay. She made her position clear that she would not be providing a GP report.

The adviser acknowledged that the report should have been asked for from the beginning. She said that, due to that inconvenience, she was going to offer to pay for the report, had Miss D not refused to get one.

Having listened to the call, I understand Miss D's frustration about the way that the claim had been handled to that point. I also understand her point about the type of illness suffered by her daughter being something that anyone could get, so she felt that IPA was putting barriers in the way of being able to make a successful claim.

However, it's a common feature of travel insurance policies that policyholders are required to declare pre-existing medical conditions. And, looking at the policy terms, under 'How to make a claim', it states that, for a medical claim, a policyholder must provide:

'Information and medical history from your GP (if this is requested you may need to sign a release form with your surgery to obtain this).'

Based on the available evidence, I'm satisfied that IPA has acted reasonably in asking for a GP report to enable it to resume its assessment of the claim.

There was clearly some poor claims handling initially. IPA didn't identify that it had a document from the treating doctor containing a diagnosis. And it also should have asked for the GP report at a much earlier point. This is not in dispute – IPA has acknowledged this and paid compensation for it.

IPA originally told Miss D it was going to offer to pay for the report, if she had consented to get one. However, it didn't repeat this offer in its final response letter.

As mentioned, our investigator recommended that IPA should also pay for the cost of the GP report, in addition to the £100 compensation. I'm not sure what Miss D's position is now and whether she remains unwilling to obtain one. However, should she choose to do so, I think it would be fair for IPA to reimburse any fee for that, in line with its previous offer.

I appreciate that Miss D feels a higher amount of compensation is warranted, particularly as she is a vulnerable person and her mental health has been affected. However, as an informal dispute resolution service, our awards are more modest than she might expect and likely less than a court might award. On balance, I'm satisfied that £100 is appropriate compensation for the distress and inconvenience caused.

In summary, I'm satisfied that IPA has acted reasonably in declining to reconsider the claim further at this point and in paying £100 compensation. However, if Miss D decides to continue with the claim by providing a GP report, then IPA should also reimburse the cost of the report and reassess the claim.

My final decision

For the reasons set out above, my decision is that I uphold the complaint and require Inter Partner Assistance SA to reimburse the cost of the GP medical report if Miss D provides one, in addition to the £100 compensation already paid.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss D and Mr G to accept or reject my decision before 14 March 2025.

Carole Clark
Ombudsman