DRN-5380918

The complaint

Miss A is unhappy with Inter Partner Assistance SA's (IPA) decision to decline her claim.

What happened

Miss A had travel medical insurance with IPA. In September 2023 she purchased a single trip policy with it by phone for a holiday to Spain. Whilst on holiday, Miss A needed urgent medical treatment after suffering with ischemic heart disease. Miss A was unable to return home until 9 February 2024. She claimed for cover on her policy, however, her claim was declined.

Miss A disagreed with the reason IPA gave to decline her claim. She explained that she answered all the health-related questions accurately and honestly during the call prior to being offered the policy.

IPA said Miss A failed to disclose her pre-existing medical conditions. It said that after reviewing her medical history, it discovered Miss A was diagnosed with acute ischemic heart disease in 2010 and had other related medical conditions that she didn't tell it about. IPA said had it known about this at the time, it wouldn't have offered her cover. And so, it declined her claim.

Our investigator upheld Miss A's complaint. He said that despite asking IPA for evidence to support its position, it didn't provide a copy of the sales call. He felt that without this evidence to establish the facts, IPA hadn't satisfactorily shown a qualifying misrepresentation had taken place. And so, he said IPA should pay Miss A's claim and £250 compensation for the distress and inconvenience caused.

Miss A accepted his findings, however, IPA said it would like to submit the requested evidence for further review. IPA, to date, hasn't provided us with any further evidence and so, it's now for me to make a final 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.

Having done so, I too have decided to uphold it. My reasons for doing so are the same as those already explained by our investigator. In short, IPA must be able to demonstrate that it's assessed Miss A's claim fairly. And as it's been unable to produce the sales call where the alleged misrepresentation took place, I've not seen any evidence that persuades me that's happened. I'll explain why.

Miss A said she told IPA about her medical history. Her testimony is that she explained as best and as honestly as she could during the sales call in September 2023. Miss A's recollection was that she was asked health-related screening questions and that she answered accurately. And so, she asked that IPA listen to the call and send her a copy of the recording. Miss A said IPA never did that and so she firmly believes this is an attempt to

avoid paying her claim.

IPA's reasons for not paying Miss A's claim are that she misrepresented her medical history in order to gain cover. However, it's been unable to produce the call recording and I note this has been requested on a few occasions by our investigator. This is a key piece of evidence in this case which IPA relied upon to decline Miss A's claim. The onus is on IPA to evidence its position here and show that a qualifying misrepresentation, as defined under the Consumer Insurance Disclosure and Representations Act 2012 (CIDRA) took place.

CIDRA says Miss A must take reasonable care not to make a misrepresentation whilst taking out the policy. However, if IPA can show Miss A didn't do that, then CIDRA sets out the action it can take in the circumstances.

But because IPA is unable to persuasively show that a qualifying misrepresentation took place, I think the action it took in these particular circumstances was unfair. That's because without this evidence, I remain unpersuaded that it would be fair to apply the exclusion and decline the claim. The onus is on IPA to show the exclusion applies. In this case, it has obtained the medical history which does show Miss A's pre-existing medical conditions, but without the sales call, I'm unable to consider the sales journey.

That means IPA hasn't shown how the policy was sold, the questions Miss A was asked, or the answers she gave. So, I cannot be satisfied that 1) she misrepresented her pre-existing medical history, or that she failed to answer questions accurately. So, I think in this case it's fair and reasonable for IPA to treat the claim as covered and pay it, in line with the remaining policy terms as it has failed to provide the information requested by the investigator numerous times.

I therefore agree with the outcome reached by our investigator and that's why I'm upholding Miss A's complaint.

My final decision

My final decision is that I uphold Miss A's complaint and Inter Partner Assistance SA must now pay her claim and £250 compensation for the overall distress and inconvenience caused.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss A to accept or reject my decision before 15 April 2025.

Scott Slade
Ombudsman