DRN-5385512

The complaint

Mr and Mrs D are unhappy that Inter Partner Assistance SA (IPA) declined a claim made on their annual, multi-trip, 'standard plus' travel insurance policy ('the policy') after Mrs D required urgent medical treatment on holiday.

All reference to IPA includes its agents. And although Mr and Mrs D are represented, for ease, I've referred to them throughout.

What happened

Whilst abroad in 2024, Mrs D was taken ill and hospitalised. She was diagnosed with a brain condition and required emergency medical treatment.

Mr D contacted IPA for assistance. After obtaining Mrs D's medical history from her GP, IPA declined to cover any claim relating to Mrs D's medical costs and other associated expenses.

That's because shortly before the policy renewed in May 2024, Mr and Mrs D were asked to contact IPA if they had received any medical treatment within the last two years.

It concluded that Mrs D had received treatment for a number of medical issues within the two years before the policy renewed and had been prescribed medication. IPA said it wasn't told about this.

IPA concluded that had Mrs D declared all medical treatment as she should've done, it wouldn't have ended up renewing the 'standard plus' policy. And as this policy wouldn't have been in place at the time, it wasn't covering the claim.

Unhappy Mr and Mrs D complained to IPA. After it maintained its position to decline the claim, a complaint was referred to the Financial Ombudsman Service.

Our investigator looked into what happened and didn't uphold the complaint. Mr and Mrs D disagreed and raised further points in reply. These didn't change our investigator's opinion, so the complaint was referred to me to consider everything afresh to decide.

I issued my provisional decision in February 2025, explaining in more detail than our investigator why I wasn't intending to uphold the complaint. An extract of my provisional decision is set out at the end of this final decision.

I invited both parties to provide any further information.

Mr and Mrs D replied disagreeing with my provisional decision. Although it was accepted that there had been a misrepresentation, and that it was neither reckless or deliberate, they said (in summary):

- IPA say that if Mrs D hadn't made a misrepresentation, she may have been offered a different policy or it may not have provided cover at all.

- concluding no cover was available at all is tantamount to denying cover for any woman on hormone replacement therapy (HRT).
- if IPA had been aware that Mrs D had taken HRT, what would it have done? It could've renewed the policy with an exclusion of HRT-related claims, renewed the policy at a higher premium (covering HRT related claims), offered a policy with more extensive cover such as 'select' cover or offered a single trip policy on appropriate terms. All these options would've indemnified Mrs D for the costs claimed under the policy and IPA has unfairly failed to consider these options.
- it's wrong to focus solely on renewal of the 'standard plus' policy.
- it's unfair and disproportionate for IPA to reject a high value claim for careless non-disclosure of a 'common… unrelated condition' which impacts women.

Mr and Mrs D also:

- provided quotes showing that they were able to obtain travel insurance with Mrs D declaring that she was taking HRT without an increase in premium or altered terms.
- referred to a final decision made by another ombudsman.

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.

That includes the detailed submissions provided on behalf of Mr and Mrs D in response to my provisional decision, some which had been previously raised and I'd considered when provisionally deciding this case. I'm thankful for the further information received but I'm not going to respond to each point made. I hope Mr and Mrs D understand that no discourtesy is intended by this. Instead, I've focussed on what I think are the key issues here. The rules that govern the Financial Ombudsman Service allow me to do this as we are an informal dispute resolution service. If there's something I've not mentioned, it isn't because I've overlooked it. I haven't. I'm satisfied I don't need to comment on every point to fulfil my statutory remit.

I know Mr and Mrs D will be very disappointed and I empathise with the situation they find themselves in, but the further points haven't changed my mind. I'll explain why.

- Nothing in my decision should be taken to mean that Mrs D can't obtain travel insurance because she was taking HRT. Indeed, the evidence provided by Mr and Mrs D support that there are other policies available had only HRT been declared.

- However, at renewal, I'm satisfied that IPA wanted to know whether anyone to be insured under the policy were waiting to receive, or had received, any medical treatment (including prescribed medication, surgery, tests or investigations) within the last 2 years. And ultimately all medical treatment Mrs D received in the last two years wasn't declared to IPA then. Had IPA been made aware of any medical treatment in the last two years, I'm persuaded, that the standard plus travel insurance wouldn't have been renewed and Mr and Mrs D would've had to take out an entirely different policy to the one they had (if they wanted travel insurance).

- I'm also satisfied it wasn't just HRT that Mrs D didn't disclose ahead of the policy renewing. Looking at the information IPA wanted Mr and Mrs D to confirm / declare when renewing the policy in conjunction with Mrs D's medical records, they should've

disclosed other medical treatment including Mrs D being prescribed medication for other symptoms.

- Although IPA may have offered Mr and Mrs D another travel insurance policy if a misrepresentation had not been made at renewal, for reasons set out in my provisional decision, I'm satisfied that IPA wouldn't have offered to renew the standard plus policy.
- I'm satisfied that's important as the standard plus policy wouldn't have been in place for the claim to be made on. So, even if Mr and Mrs D ended up with another policy underwritten by IPA, it would've been an entirely different policy to the one that was in place at the time of the claim. The standard plus policy wouldn't have been offered at a higher premium or with exclusions as Mr and Mrs D has suggested. I'm satisfied it isn't offered if those to be insured under the policy declared that they'd had medical treatment in last two years.
- I've taken into account the final decision I've been referred to and issued by another ombudsman. However, I'm satisfied the circumstances are different to the complaint I'm determining. From the background section of that decision, it concerned a consumer contacting their insurer to declare a change in health during the period of insurance. That's not what happened here.
- In any event, I've considered the individual circumstances of this case when deciding whether IPA has acted fairly and reasonably by not covering the claim made on the policy. For the reasons I've given, and those set out in my provisional decision (an extract of which is set out below and forms part of my final decision), I'm satisfied that it has.

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An extract of my provisional decision dated February 2025

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

That 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 expected 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 insurance 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 Mr and Mrs D will be very disappointed, but I intend to find that IPA has acted fairly and reasonably by not covering the costs relating to Mrs D's medical treatment whilst abroad.

Did Mr (and Mrs) D make a misrepresentation?

IPA has provided the renewal notice sent to Mr D (as the main policyholder) by email in April 2024, a few weeks before the travel insurance policy he'd originally taken out in 2023 was due to annually renew in May 2024.

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.

Mr D 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 him 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 Mr D that if he (or anyone else to be insured under the policy) had received any medical treatment (including prescribed medication, surgery, tests or investigations) within the last two years, IPA should be told.

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.

I've seen nothing which persuades me that Mr or Mrs D contacted IPA before the policy renewed in May 2024 to tell it about Mrs D's medical treatment.

IPA has relied on entries in Mrs D's medical records within the two years before the policy renewed to conclude that she'd received medical treatment and therefore Mr and Mrs D made a misrepresentation.

Looking at Mrs D's medical records, I think that conclusion is fair and reasonable.

Was this a 'qualifying' misrepresentation?

I've considered whether this amounted to a qualifying misrepresentation under CIDRA. And I'm currently satisfied it did.

From the information provided by IPA, I'm satisfied that had Mr or Mrs D contacted IPA to tell it about the medical treatment Mrs D had, it most likely wouldn't have renewed the 'standard plus' policy in 2024. That's because the standard plus policy isn't meant for those who have

pre-existing health conditions.

I think that's supported by the demands and needs statement which appears at page 3 of the standard policy booklet which says:

> Annual multi trip - This policy meets the Demands and Needs of a customer intending to travel more than once within the period of insurance, wishing to buy a basic travel insurance policy with exclusions for pre-existing medical conditions.

IPA will only offer 'select' annual, multi-trip, policies to those with pre-existing medical conditions. For example: 'select' silver plus, 'select' gold and 'select' platinum, depending on the level of cover required. So, that doesn't include the 'standard plus' policy Mr and Mrs D had.

I'm satisfied IPA has fairly concluded that Mr (and Mrs) D acted carelessly when not contacting IPA to inform it that Mrs D had received medical treatment in two years before the policy renewed in 2024 (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 a careless qualifying misrepresentation hadn't been made.

I'm satisfied that the standard plus policy wouldn't have ended up being renewed.

I'm therefore persuaded that it's fair and reasonable for IPA to not pay the claim. That's because the policy wouldn't have been in place because Mr and Mrs D would've needed to have taken out a different travel insurance policy. So, I'm satisfied IPA doesn't have to cover the claim.

I've taken on board the point that Mr and Mrs D may have ended up with a similarly branded travel insurance policy, underwritten by IPA. However, I don't think that matters. Ultimately, I'm satisfied on the balance of probabilities that Mr and Mrs D wouldn't have ended up with the standard plus policy that was annually renewed in May 2024 and was in place at the time Mrs D required urgent medical treatment abroad.

In line with CIDRA, I would still reasonably expect to see IPA cancel and refund the premium paid for the policy, which it's offered to do here. I think that's fair and reasonable, and if they haven't already done so, Mr and Mrs D should contact IPA if they want to accept this offer.

I have a lot of empathy for the situation Mr and Mrs D and their family were in, and the significant amount of expenses that they're now being asked to personally pay. I also appreciate that the reason Mrs D needing urgent treatment abroad was not related to the medical treatment she'd had (and wasn't disclosed) before the policy renewed in 2024.

However, if they'd contacted IPA to tell it about the medical treatment in the two years before the policy renewed, the standard plus policy wouldn't have been in place to cover the medical expenses subsequently incurred whilst on holiday during the policy year 2024/2025.

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My final decision

I don't uphold this complaint.

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

David Curtis-Johnson
Ombudsman