DRN-5417096

The complaint

Mrs W has complained that Inter Partner Assistance SA (IPA) declined a cancellation claim she made on a travel insurance policy.

Mrs W has been represented by a family member in making this complaint. However, for ease, I will just be referring to Mrs W in this decision.

What happened

In February 2023 Mrs W booked a trip abroad that was due to start on 4 September 2023. She didn't take out insurance at that time. It was on 12 August 2023 that she purchased the policy. On 13 August 2023 she visited her GP about a health condition. It was this condition that led to her having to cancel the trip.

IPA declined the claim on the basis that the circumstances aren't covered under the policy terms.

Our investigator didn't think that IPA had acted reasonably in declining the claim. IPA disagree 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 policy terms state:

'General Exclusions applying to your policy

5. Claims arising when you have any undiagnosed symptoms that require attention or investigation in the future (that is symptoms for which you are awaiting investigations or consultations, or awaiting results of investigations, where the underlying cause has not been established) are not covered.

Section 1 – Cancelling or Cutting short your trip

What is not covered?

5. Circumstances known to you before you purchase your policy or at the time of booking any trip which could reasonably have been expected to lead to cancelling or cutting short of the trip.

6. Any pre-existing medical condition affecting you unless you have declared ALL pre-existing medical conditions to us, and we have written to you accepting them for insurance.'

IPA has said that the condition Mrs W attended the doctor for on 13 August 2023 was known to her at the time of taking out the policy. However, it seems to have made that assumption based on the fact that she attended the GP the day after taking out the policy.

As part of the claims assessment, Mrs W's GP was sent a medical certificate to complete. There's an error on this form (made by IPA) in that, although the form is asking for information about Mrs W's health, by question 8 it names her husband instead of her.

The doctor gives a detailed description of the symptoms and says that 'further investigations are ongoing'. Mrs W thinks this must be a mistake as the GP can't have known all of this information at the time. However, the GP completed the form on 22 January 2024 and was writing the information in retrospect with the benefit of further information that had become available by then. The doctor clearly confirms that the first consultation for this condition was on 13 August 2023.

IPA has not asked for Mrs W's medical records to ascertain if there's any information in them that would confirm or rebut the idea that she had symptoms of the condition at the time she purchased the policy on 12 August 2023. Its own internal notes state: '*Med cert shows significant medical history, but none related to a nerve condition.'*

Therefore, based on the available evidence, I consider it unfair that IPA declined the claim on the basis that she had a pre-existing, undiagnosed, condition.

Its declination letter of 3 July 2024 doesn't make it clear what condition it is relying on to reject the claim. However, it says it has a second reason for saying that it would have declined the claim. It says that Mrs W made a misrepresentation when applying for the policy because she didn't declare a pre-existing heart condition that was mentioned on the medical certificate.

To reach a fair and reasonable outcome in this case, I need to apply the principles set out in the Consumer Insurance (Disclosures and Representations) Act 2012 (CIDRA).

Setting aside that Mrs W says she was unaware she had a heart condition, 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.

Our investigator asked IPA for underwriting evidence that it would have done something different if Mrs W had declared both conditions. IPA's response was only in terms of the heart condition. It has provided an internal email which states that cover wouldn't have been offered if the heart condition had been declared because her medical score would then have exceeded the maximum allowable.

We would expect to see something like the relevant section of IPA's underwriting guidance, a copy of the actual retro-screening or a declaration from an underwriter. I'm afraid an internal email doesn't meet the evidential standards required to show there has been a qualifying misrepresentation.

Overall, I'm not persuaded that IPA has done enough to show that Mrs W had an undiagnosed condition that she knew about when buying the policy, or that she made a qualifying misrepresentation. Therefore, it has no recourse under CIDRA to decline the claim on the basis of non-disclosure of pre-existing medical conditions. It follows that I uphold the complaint.

Putting things right

To put things right, IPA should:

- Pay the claim
- Add 8% simple interest from one month after the claim was made until the date it is settled.

My final decision

For the reasons I've explained, my decision is that I uphold the complaint and require Inter Partner Assistance SA to put things right as set out above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs W to accept or reject my decision before 21 April 2025.

Carole Clark
Ombudsman