DRN-5460199

The complaint

Mr Z has complained that Inter Partner Assistance SA (IPA) declined a claim he made under his travel insurance policy.

The policy was branded under a different name, but for simplicity here all references to IPA include the actions of its appointed agents.

What happened

The policy was taken out online in December 2023. Mr Z paid a premium of £197.28 to cover him and his family from 25 December 2023 to 6 January 2024.

On 25 December 2023, while on the flight to his holiday destination – a country I'll call M, Mr Z fell ill. He was taken to hospital and was discharged on 31 December 2023, and returned to the UK on 6 January 2024.

IPA were notified of the claim on 26 December 2023, and just before Mr Z was due to fly back to the UK, it informed him that the claim had been declined. IPA initially declined the claim because he hadn't made them aware of his liver cirrhosis when taking out the policy. IPA later stated it was because he hadn't disclosed Renal Failure, Gastrointestinal bleed, UTI, Depression, Pneumonia and Varicose Eczema.

Mr Z was unhappy with this decision and made a complaint. IPA maintained its decision to decline the claim was correct. As IPA said it wouldn't have offered Mr Z cover, it offered to refund the premium he'd paid.

As Mr Z remained unhappy with this decision, the matter was referred to our service to consider. He said he spent a lot of time chasing IPA for claim updates, and it failed to provide any advice or support, or have any sense of urgency over the claim whilst he was ill abroad.

Our investigator didn't recommend that the complaint be upheld. They felt that IPA had acted fairly.

Mr Z appealed. He didn't agree that cover wouldn't have been offered as he said that he had gone back to the website and inputted all his medical issues and full coverage was offered. He didn't think people were aware that they needed to declare every illness from the last 2-5 years.

As no agreement has been reached the matter has been passed to me to determine.

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.

Although I've summarised the background to this complaint - no discourtesy is intended by this. Instead, I've focused on what I find are the key issues here. Our rules allow me to take this approach. It simply reflects the informal nature of our service as a free alternative to the courts.

The regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. So I've considered, amongst other things, the relevant law, the policy terms and the available evidence, to decide whether I think IPA treated Mr Z and his family fairly.

The relevant law in this case is 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 (a policy). 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 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.

IPA thinks that Mr Z failed to take reasonable care not to make a misrepresentation when buying the policy, so I've looked carefully at the relevant question.

When taking out the policy Mr Z was asked:

Do you or any person to be covered by the policy have any medical condition for which in the last 12 months before taking out this insurance policy or booking your trip (whichever is later), you:

• *Were prescribed medication*

• *Received treatment or consulted a doctor or other medical practitioner for any medical condition;*

• *Attended hospital or a clinic as an outpatient or inpatient;*

• *Were referred for tests, investigations, treatment or surgery and are currently waiting for results, a diagnosis or treatment/surgery*

When reviewing the claim, IPA obtained a copy of Mr Z's medical records which showed he had renal failure, gastrointestinal bleed, UTI, depression, pneumonia and varicose eczema, which should've been disclosed when answering the above questions. I understand Mr Z's point – he didn't think people would be aware that they needed to declare every illness in the last 2-5 years. This question only asks about the last 12 months, so it is likely to be fresher in the minds of those proposing for insurance. But I find that taking reasonable care would mean checking to ensure that the answer given was correct.

I also accept Mr Z's point that he was seen by eight consultants before leaving the UK and they were confident in his ability to fly safely. But the question specifically asks about medical conditions in the last 12 months – not whether or not the person proposing for insurance has been certified as fit to fly or whether they consider themselves to be in good

health. Mr Z has said that he took the policy out in good will with no intent to defraud and I accept this is so. But the question is clear so for the reason given I don't find that IPA's conclusion that Mr Z failed to take reasonable care was incorrect.

In these circumstances, we need to consider what IPA would've done had they been provided with this information at the time of sale. IPA has provided evidence showing they carried out a retrospective screening of Mr Z's conditions, and this shows that they wouldn't have offered him a policy. This means the misrepresentation is qualifying. I have not disregarded Mr Z's submission that he input his medical issues recently into the same web site and a policy was offered. But I haven't seen evidence of the questions asked or the answers given. Mr Z has said that they have changed – and it is likely that the underwriter has changed too. Therefore I'm not able to conclude that this is a like for like comparison or that IPA's underwriting statement is incorrect.

IPA offered to refund the premium paid by Mr Z, which is in accordance with the remedies given in CIDRA for careless misrepresentation. I think that is fair.

I have no doubt that this was a very frightening and deeply traumatic experience for Mr Z, being severely ill abroad. I've thought carefully about the service he received but I don't find that IPA failed to handle his claim promptly or that there were any undue delays on the part of IPA. It is unfortunate that there was a delay in receiving the information it needed from Mr Z's GP – but I can't hold IPA responsible for this. I can see that Mr Z called IPA multiple times, but I don't find it was unreasonable for IPA to assess the claim before giving a response on whether cover would be provided under the policy. I note that the reason initially given for the claim decline was liver cirrhosis, but IPA accepted Mr Z's explanation with regard to that diagnosis. This led to a second response from IPA. I understand this would have been frustrating for Mr Z, but I'm not persuaded that the conclusion IPA reached was wrong.

I do recognise the enormity of the situation for Mr Z and his family financially. But for the reasons given I don't find that IPA has treated then unfairly, unreasonably or contrary to law. I'm very sorry that this decision doesn't bring Mr Z welcome news.

My final decision

My final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr Z, Mr Z, Ms Z and Mr F to accept or reject my decision before 6 June 2025.

Lindsey Woloski
Ombudsman