DRN-5478007

The complaint

Mr and Mrs F have complained that Inter Partner Assistance SA (IPA) declined a claim they made on a travel insurance policy.

What happened

The start date of the policy was 6 July 2023. In January 2024 Mr and Mrs F booked a trip for 27 March 2024. On the day of the trip, Mrs F became unwell and so they were unable to travel. Upon making a claim, IPA declined it on the basis that the reason for cancelling was due to a pre-existing medical condition.

In response to the complaint, IPA accepted that there had been some poor service and so it offered £75 compensation. However, it maintained its decision to decline the claim.

Our investigator didn't think that IPA had acted fairly. So, she recommended that it should re-assess the claim and pay £200 compensation for the service issues.

Mr and Mrs F disagree with the investigator's opinion 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.

Mrs F became unwell on the day of the trip and attended her GP surgery, where it was recorded that she was suffering from abdominal pain, nausea and possible diverticulitis. When IPA received her medical records during the claims process, it noted that she had previously visited the GP on 13 November 2023 with her symptoms noted as bloating, nausea and right upper quadrant abdominal pain. As she hadn't informed IPA of that event, it declined the claim for non-disclosure of a pre-existing medical condition.

Looking at the policy terms, they state:

'*You must tell us of all your pre-existing medical conditions. If you fail to declare any pre-existing medical conditions we may refuse to deal with your claim or reduce the amount of any relevant claims, even if a claim is not related to an undisclosed pre-existing medical condition.'*

The visit to the GP in November 2023 took place after the policy had started, so was not pre-existing at the point of sale. However, the policy includes an ongoing duty of disclosure and also states:

'*If your health changes (requiring you to seek medical assessment or treatment by a medical practitioner at a surgery, clinic or hospital) after the start date of your policy and the date your travel tickets or confirmation of booking were issued, you must contact us to make sure your cover is not affected.'*

The declination letter from IPA was unclear and so Mr and Mrs F thought the claim had been declined due to not declaring Mrs F's asthma at the time of purchasing the policy. However, it was declined due to not declaring the condition requiring the GP visit in November 2023, which IPA said was directly linked to the medical condition resulting in the cancellation of the trip

I appreciate Mr and Mrs F's argument that they didn't declare it because it was a minor issue and further medical investigations came back clear. However, in such circumstances, it's not a matter for their judgement or common sense to decide whether to inform the insurer or not. The policy terms, which it was their responsibility to familiarise themselves with, state that a policyholder must let them know about any health condition for which treatment by a medical practitioner was sought. As Mrs F consulted a GP in November 2023, and the condition was serious enough to require a referral for further tests, I think that constitutes a significant change in health that IPA should have been told about. So, they should have contacted it within a reasonable amount of time following that event, and prior to booking the trip in January 2024.

In response to the investigator's assessment, Mr and Mrs F have said they were unaware they were meant to report changes of health that occurred within the period of an annual policy. Whilst IPA could have made the ongoing duty of disclosure clearer, I'm not persuaded that Mr and Mrs F suffered detriment due to that. Based on the available evidence, as the policy covered them for ill health, it appears they had some awareness of needing to inform IPA of changes to their health. It was their characterisation of Mrs F's abdominal pain as a minor illness that meant they omitted to do so. That's a similar stance to Mr F saying he thinks he neglected to tell IPA about his wife's pre-existing asthma because she'd had it a long time and it is well managed, whereas a requirement of the policy is to inform the insurer of all pre-existing medical conditions.

They've said that the symptoms Mrs F suffered in March 2024 are completely unrelated to those she had in November 2023 and that IPA has connected them as a way to decline the claim.

Whether or not the conditions are related is a slightly secondary issue. The matter at hand is, what would have happened had Mrs F informed IPA of her symptoms and the November 2023 visit to the GP at the appropriate time. Had she done so, she would likely have been taken through a health screening process to determine whether her change in health would affect the terms upon which IPA was willing to offer the policy.

Therefore, when IPA did receive the medical information as part of the claims process, it should have carried out a retro-screening to determine what the outcome would have been. However, IPA hasn't provided any evidence of what it would have done if Mrs F had made a timely disclosure of her medical condition prior to booking the trip. On that basis, I consider that it has unfairly declined the claim.

With regard to the service issues, our investigator has previously set out the errors that occurred, including delays in asking for medical information, so I won't repeat that again here. On balance, I consider that £200 compensation is a reasonable and proportionate amount to compensate Mr and Mrs F for the distress and inconvenience caused.

Putting things right

IPA should:

- Carry out a retro-screen to determine what the outcome would have been if Mrs F had declared the medical condition she suffered in November 2023.
- Re-assess the claim, based on the results of the retro-screen.
- Pay £200 for distress and inconvenience as a result of poor service. If IPA has already paid the £75 it originally offered, it can deduct this from the £200 total payment.

Following the above, if Mr and Mrs F are unhappy with the outcome of the re-assessed claim, they can make a new complaint to IPA, and then to this service if necessary.

My final decision

For the reasons I've explained, 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 F and Mr F to accept or reject my decision before 9 July 2025.

Carole Clark
Ombudsman