DRN-5555505

The complaint

Mr and Mrs F complain because Inter Partner Assistance SA ('IPA') hasn't paid a claim under their travel insurance policy.

What happened

Mr and Mrs F are insured under a travel insurance policy provided as a benefit by a bank and underwritten by IPA.

Unfortunately, while abroad, Mr F fell and injured himself. Mr F was later taken to a private hospital and made a claim with IPA for his medical treatment and other costs. IPA said the claim wasn't covered because Mr F hadn't told it about his pre-existing medical history. IPA said, if Mr F had done so, it would have charged him an increased premium.

Unhappy, Mr and Mrs F complained to IPA before bringing the matter to the attention of our service. One of our investigators looked into what had happened and said she didn't think IPA had acted unfairly or unreasonably in the circumstances. Mr and Mrs F didn't agree with our investigator's opinions, so the complaint was referred to me as the final stage in our process. I made my provisional decision about Mr and Mrs F's complaint in April 2025. In it, I said:

'The Financial Ombudsman Service doesn't act on behalf of consumers. We're independent and impartial and my remit under the rules that govern our service is to reach an outcome which is fair and reasonable for both parties to the dispute.

This complaint only relates to IPA's actions as the underwriter of the insurance policy. IPA is the business responsible for the decision to turn down Mr F's claim. The bank is a separate financial business, which is responsible for different regulated activities. If Mr and Mrs F are unhappy with any of the bank's actions, then they'd need to make a separate complaint to our service about the activities which the bank is responsible for.

When making this provisional decision, I've taken into account relevant regulatory rules which say an insurer must handle claims fairly and shouldn't unreasonably reject a claim. I've also taken into account the law, namely The Consumer Insurance (Disclosure and Representations) Act 2012 ('CIDRA').

IPA appears to be attempting to rely on the legislative remedies set out under CIDRA to decline Mr F's claim. While I accept that annual reminders about the requirement to declare medical conditions were sent to Mr and Mrs F based on the evidence provide by IPA, Mr F didn't complete a medical screening. As Mr F didn't make any disclosures or representations to IPA, this means that CIDRA (and the remedies for qualifying misrepresentations set out therein) doesn't apply to the circumstances of this case. So, IPA cannot rely on CIDRA to decline Mr F's claim.

I've considered the terms and conditions of Mr and Mrs F's policy. Page 23 sets out the details of cover for 'Medical Emergency and Associated Expenses'. This section says there is no cover for:

‘any claim arising directly or indirectly from a 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 cover.’

The policy defines a ‘pre-existing medical condition’ as

‘1. Any past or current medical condition that has given rise to symptoms or for which any form of treatment or prescribed medication, medical consultation, investigation or follow-up/check.up has been required or received during the two years prior to:

a) booking any trip, or
b) upon the renewal of your medical health declaration, whichever is the later, and

2. Any cardiovascular or circulatory condition (e.g. heart condition, high blood pressure, blood clots, raised cholesterol, stroke, aneurysm) that has occurred at any time prior to any trip.’

I’ve seen no medical evidence that the claim which Mr F is making is linked (either directly or indirectly) to a pre-existing medical condition as defined within the policy. So, I don’t think it’s fair or reasonable for IPA to rely on the policy exclusion relating to pre-existing medical conditions to decline Mr F’s claim.

I note the policy also states under the heading ‘Conditions and Exclusions’:

‘Important Health Requirements

You must comply with the following conditions in order to have full protection under these benefits. If you do not comply we may refuse to deal with your claim or reduce the amount of any claim payment.

If you have a pre-existing medical condition you must make a medical health declaration.’

While I accept Mr F didn’t make a medical health declaration as required by the policy, the Financial Conduct Authority’s ‘Insurance: Conduct of Business sourcebook’ says the rejection of a claim for the breach of a policy condition is unreasonable unless the circumstances of the claim are connected to the breach. As I’ve seen no medical evidence showing that this claim is related to Mr F’s pre-existing medical conditions, I don’t think it’s fair or reasonable for IPA to rely on this policy condition to turn down Mr F’s claim either.

So, overall, this means I don’t think IPA acted fairly or reasonably when it said Mr F’s claim wasn’t covered.

Based on the circumstances of this case, I’m satisfied that an appropriate recommendation is for IPA to now pay Mr F’s claim for his hospital treatment. I appreciate the terms and conditions of Mr and Mrs F’s policy say private treatment is only covered in certain situations, but I think it’s reasonable to conclude that IPA has lost the opportunity to further consider this issue and/or to explore the possibility of negotiating costs with the hospital as a result of its unfair decision to decline cover for Mr F’s claim. In any event, I note Mr F did himself obtain a discount from the hospital before paying the outstanding amount due earlier this year.

I also think it would be fair and reasonable in the circumstances for IPA to pay Mr and Mrs F compensation for the impact of this situation on them. Mr and Mrs F have experienced

considerable upset and worry as a result of being chased by debt collectors for the monies owed to the hospital abroad, before taking the decision to clear the outstanding balance themselves. Overall, Mr and Mrs F have had to go to a lot of extra effort in order for this matter to be resolved and I think the impact of IPA's actions on them falls into the category of our published compensation bands which I'd consider significant.'

So, my provisional decision was that I intended to direct IPA to reimburse Mr and Mrs F for their hospital bills together with interest, reassess their claim for taxis and medication and to pay them £400 compensation for the distress and inconvenience they experienced.

Mr and Mrs F accepted my provisional decision and set out the details of the amount they paid to the hospital, as well as the amounts they paid for taxis and medication. IPA didn't respond to my provisional 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'm pleased to hear that Mr F is returning to good health.

It's not appropriate for me to include details of the exact claim settlement amounts which IPA should pay to Mr and Mrs F within this decision. It's for IPA to calculate the claim settlement due after the deduction of any relevant policy excesses and in line with the remaining terms and conditions of the policy, subject to the provision of reasonable evidence of the payments by Mr and Mrs F if these haven't already been provided. It's also for IPA to calculate the interest due.

I'd expect IPA to now get in touch with Mr and Mrs F directly to explain what, if any, additional information it needs to do this. If there's any subsequent dispute about the claim settlement amount paid by IPA, then this would need to be the subject of a new complaint.

So, my provisional decision remains unchanged.

Putting things right

Inter Partner Assistance SA must put things right and do the following:

- reimburse Mr and Mrs F for the money they paid to the hospital, together with interest at 8% simple per annum from the dates the money was paid until the date of settlement[1];
- reassess Mr and Mrs F's claim for taxis and medication in line with the remaining terms and conditions of the policy;
- pay Mr and Mrs F a total of £400 compensation for the distress and inconvenience they experienced.

Inter Partner Assistance SA must pay the compensation within 28 days of the date on which we tell it Mr and Mrs F accept my final decision. If it pays later than this, it must also pay interest on the compensation from the deadline date for settlement to the date of payment at 8% a year simple.

[1] If Inter Partner Assistance SA considers that it's required by HM Revenue & Customs to deduct income tax from that interest, it should tell Mr and Mrs F how much it has taken off. It should also give Mr and Mrs F a tax deduction certificate if they ask for one, so they can reclaim the tax from HM Revenue & Customs if appropriate.

My final decision

I'm upholding Mr and Mrs F's complaint about Inter Partner Assistance SA, and I direct it to put things right in the way I've outlined above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr F and Mrs F to accept or reject my decision before 11 June 2025.

Leah Nagle
Ombudsman