DRN-5581592

The complaint

Miss A, Mr A, Mrs A and Miss C are unhappy with the service they've received from Inter Partner Assistance SA when they claimed on their travel insurance policy.

What happened

Mr and Mrs A were on holiday with their family when Mrs A became unwell and needed hospital treatment. Mrs A is unhappy with the service she received and IPA's decision to decline her claim.

IPA said that Mrs A hadn't declared all her previous medical history during the application process and, had she done so, they wouldn't have offered her a policy. Mrs A complained to the Financial Ombudsman Service.

Our investigator looked into what happened and upheld the complaint. He thought that IPA hadn't offered a good level of service when dealing with the claim. And he wasn't satisfied that IPA had demonstrated that cover would have been declined. He thought IPA should pay the claim, 8% simple interest and £350 compensation for the distress and inconvenience caused.

IPA didn't agree and provided some further evidence. This didn't change our investigator's thoughts about the outcome of the complaint as he didn't think it adequately demonstrated that the policy wouldn't have been offered. Mr and Mrs A accepted the investigator's recommendation.

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.

The relevant rules and industry guidelines say that IPA should handle a claim promptly and fairly. And, they shouldn't reject a claim unreasonably.

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 says that Mrs A failed to take reasonable care not to make a misrepresentation when she answered questions about her medical history. IPA has provided the example questions in relation to the medical screening and what it considers the answers to those questions should have been, based on Mrs A's medical history. However, they've not provided a copy of the sales journey Mrs A would have seen, despite our investigator asking for it.

However, even if I accepted that there was a misrepresentation about Mrs A's medical history IPA also needs to demonstrate that it was a 'qualifying misrepresentation'. That means they need to show that they'd have either not offered cover at all or that they'd have offered cover but on different terms.

IPA also has not provided any detailed or meaningful breakdown of how the declaration of Mrs A's medical conditions would have impacted their decision to offer cover. So, I'm not persuaded they've provided enough evidence to demonstrate that the disclosure of the conditions would have made a difference to the premium, how it would have impacted the premium charged or persuasive evidence to support that cover would not have been offered at all. They've provided general statements to say that cover wouldn't have been offered. But, they've not provided detailed information to support this, such as underwriting guidance.

IPA has also relied on an exclusion in the policy relating to pre-existing medical conditions. There is no cover for:

> Pre-existing medical conditions as described in the Pre-existing medical conditions section (unless you have contacted us and we have accepted in writing).
>
> 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(s)."

However, IPA still needs to demonstrate, with reference to appropriate evidence, that the pre-existing conditions Mrs A didn't declare would have impacted their decision to offer cover and how. It's for IPA to demonstrate they'd applied the exclusion fairly. And, based on the evidence that has been provided, I'm not persuaded that they have.

Taking all of the above into account, based on the available evidence, I'm not satisfied that IPA has adequately demonstrated Mrs A made a qualifying misrepresentation or that the policy terms have been applied fairly. Therefore, I'm not persuaded it was fair and reasonable to decline the claim in the circumstances of this case. So I think IPA should settle the claim in full, subject to the remaining policy terms and limits.

Customer service

IPA accepted there were delays in handling the claim, including a delay in requesting the medical history. They offered £150 compensation to acknowledge the poor service including delays and communication issues.

I think it's fair and reasonable for IPA to pay a further £200 compensation (bringing the total to £350 compensation). I think a further £200 compensation more fairly reflects the impact of the delays in handling and settling the claim on Mr and Mrs A and their family. It's caused them unnecessary worry and upset over a prolonged period of time particularly in relation to the delay in Mrs A being released from hospital and the outstanding claims costs.

Putting things right

IPA needs to put things right by paying:

- The claim costs in line with the remaining policy terms and conditions. Mr and Mrs A may need to provide further information in support of their claim.

- 8% simple interest from the 10 July 2024 (the date the claim was declined) to the date of settlement.

- A total of £350 as compensation for the distress and inconvenience caused by delays in handling the claim.

My final decision

I'm upholding this complaint and direct Inter Partner Assistance SA to put things right in the way I've outlined above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss A, Mr A, Mrs A and Miss C to accept or reject my decision before 24 June 2025.

Anna Wilshaw
Ombudsman