DRN-5624221

The complaint

Mrs C is unhappy with the service she received from Inter Partner Assistance SA when she made a claim on her travel insurance policy.

What happened

Mrs C had an accident which caused her to cancel a holiday. She claimed on her travel insurance policy. She is unhappy that IPA asked for medical evidence from her GP as she didn't think it was relevant to the claim. And, she was unhappy with how the claim had been handled.

In their final response letter IPA said they'd not received the medical records in the correct format until around a month after the claim was logged. They also said the claim was being declined, subject to a retrospective screening taking place. Mrs C subsequently received a settlement for 50% of the costs she'd claimed for.

Our investigator clarified the settlement with IPA. They explained they'd settled half of the total amount claimed as Mrs C had claimed for two people but as only Mrs C was covered on the policy they had paid half of the costs claimed for. So, they said the settlement reflected her proportion of the claim and the deduction of the policy excess.

Having reviewed the complaint our investigator thought IPA had reasonably settled half of the amount Mrs C had claimed for. He acknowledged that IPA hadn't always been consistent in the time frame of medical information they'd asked for. However, he didn't think this had caused a delay as IPA would have still needed to check the medical information.

Mrs C didn't agree and asked an ombudsman to review the complaint. She felt that her medical history was held against her and that none of her current medication was responsible for the fall. She said she'd missed some steps and landed heavily so the intrusion into her medical history was unwarranted. So, the complaint was referred to me to make 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.

The relevant rules and industry guidelines say that IPA has a responsibility to handle claims promptly and fairly. And they shouldn't reject a claim unreasonably.

I'm sorry to hear of the circumstances which led Mrs C to claim and to the cancellation of her holiday. However, I'm not upholding her complaint because:

- Mrs C was the only person named on the policy schedule. So, IPA is only responsible for paying her share of the cancellation costs. Therefore, I think it was fair and reasonable for them to settle half the claim and deduct the excess, in line with the policy terms.

- I don’t think it was unreasonable for IPA to look into Mrs C’s medical history. A GP report from Mrs C’s GP recorded that the fall was ‘secondary to Vasovagal Syncope’ (fainting). GP also noted that there were pre-existing medical conditions which related directly or indirectly to the cause of the accident. So, I don’t think it was unreasonable for IPA to obtain more information from Mrs C’s medical records to check that there had been full disclosure of the relevant medical information.

- I appreciate that Mrs C feels that the fall and her current medication were unrelated. She’s also said that the fainting happened after the fall. However, I think it was reasonable for IPA to look into her medical history and to rely on the information as it was presented by the GP. So, this doesn’t persuade me Mrs C’s complaint should be upheld.

- In any event, it’s very common for insurers to review a consumer’s medical history in the event of a claim, even in circumstances involving an accident or fall. That’s because an insurer is entitled to validate the claim, including checking whether the policyholder has accurately declared their medical history and paid the correct premium before settling any claim. That’s standard industry practice.

- IPA wasn’t always clear about the timeframe for the medical information they required. However, based on the available evidence I’m not persuaded that caused a material or substantial delay to the claim being settled. The GP needed to provide further information and IPA wasn’t able to settle the claim until that was received. So, I don’t think the evidence demonstrates that the lack of clarity about the timescale had a significant impact on the overall outcome of the claim.

My final decision

I’m not upholding this complaint.

Under the rules of the Financial Ombudsman Service, I’m required to ask Mrs C to accept or reject my decision before 11 July 2025.

Anna Wilshaw
Ombudsman