DRN-5702266

The complaint

Mr and Mrs S have complained about Inter Partner Assistance SA's ("IPA") handling and decline of a claim made under their travel insurance policy.

References to IPA in this decision also include its authorised agents.

What happened

The background to this complaint is known to the parties. In summary Mr and Mrs S bought a single trip travel insurance policy underwritten by IPA in February 2024. It insured them for a holiday booked to take place in August 2024 and included cancellation cover.

Sadly, later in February, Mr S was diagnosed with a brain tumour. Mr and Mrs S cancelled their holiday and submitted a claim under the policy. IPA declined the claim – it said that Mr S had failed to disclose pre-existing medical conditions. Mr and Mrs S disputed this – they said that they had accurately answered the eight questions at the time of sale.

IPA admitted there was delay in the handling of the claim and offered £100 in compensation.

Unhappy, Mr and Mrs S referred their complaint to our Service.

We requested IPA send its business file on three occasions, but no response was received. Our investigator considered the circumstances on the evidence to hand and recommended that the complaint be upheld.

Mr and Mrs S accepted this but felt that IPA had been disrespectful in not replying.

IPA didn't respond to the investigator's view or to a further letter saying that the complaint would be reviewed by an ombudsman.

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 regulator's rules say that insurers mustn't turn down claims unreasonably. So I've considered, amongst other things, the answers given to the medical questions when the policy was taken out to decide whether I think IPA treated Mr and Mrs S fairly when declining their claim.

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.

In its final response letter IPA said Mr S failed to take reasonable care not to make a misrepresentation when he answered questions relating to his past medical history. It said that he didn't declare migraine aura without headache in October 2023 and ophthalmic migraine in November 2022. The relevant question only asks about: *any other medical condition which you have suffered in the last 12 months for which you have been referred to or seen by a hospital doctor.* Mr S says that he answered the eight questions asked correctly – he hadn't been referred to or seen by a hospital doctor in the 12 months prior to taking out the policy.

IPA hasn't shown this is incorrect. Rather it sought to rely on a policy term which says: *You must tell us or 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.* This term came *after* Mr S had entered into the contract.

So on the basis of the evidence before me I don't find that Mr S failed to take reasonable care when taking out the policy. It follows that I don't find that there was any misrepresentation and this being so the action taken by IPA is not in line with CIDRA.

For completeness I would add that even if I hadn't reached this conclusion, IPA advised Mr and Mrs S that it needed to re-screen in order to determine whether what it deemed to be the missed the conditions would have meant there were any changes to the premium or coverage offered. It didn't do so. It follows that IPA hasn't demonstrated it would have done anything differently had it know about the medical entries referred to above. Or to put it another way, it hasn't shown that there was a 'qualifying misrepresentation' under CIDRA.

In all the circumstances I'm not satisfied that IPA had any grounds to decline the cancellation claim.

With regard to the handling of the claim IPA have admitted that there was a significant delay in processing the claim (approximately six weeks) which would have caused frustration at what was already a difficult time. I agree that compensation is due for this delay, and I find that £100 is fair in the circumstances. However I don't find that IPA was required to disclose the name, address and qualifications of its medical adviser(s).

My final decision

My final decision is that I uphold this complaint. Inter Partner Assistance SA should:

- Pay the cancellation claim, adding simple interest at 8% per annum from the date of claim until settlement.

- Pay £100 in compensation to Mr and Mrs S.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs S and Mr S to accept or reject my decision before 15 August 2025.

Lindsey Woloski
Ombudsman