DRN-5747963

The complaint

Mr and Mrs J complain because Inter Partner Assistance SA ('IPA') hasn't paid a claim under their travel insurance policy. All references to IPA include the agents appointed to handle claims and complaints on its behalf.

What happened

Mr and Mrs J bought a 'Silver Plus' travel insurance policy in January 2024. The policy was provided by IPA and covered Mr J, Mrs J and their son, Master J. Unfortunately, while abroad, Master J fell ill and Mr and Mrs J needed to extend their stay. They paid for the costs associated with this themselves, while IPA obtained Master J's medical records.

IPA declined Mr and Mrs J's claim around three months later. It initially said the claim wasn't covered because Mr and Mrs J hadn't told it about Master J's eczema when buying the policy. When Mr and Mrs J complained, IPA said the claim wasn't covered because Mr and Mrs J hadn't told it about a viral upper respiratory tract infection which Master J had. IPA paid Mr and Mrs J £100 compensation for the level of service it had provided when handling their claim.

Unhappy, Mr and Mrs J brought their complaint to the attention of our Service. IPA subsequently contacted Mr and Mrs J again to say the claim wasn't covered because they hadn't told it about Master J's lymphadenopathy, as well as his eczema.

One of our Investigators looked into what had happened. He initially concluded, based on the information which IPA had provided at the time, that it wasn't fair or reasonable for IPA to decline Mr and Mrs J's claim. However, after IPA provided additional evidence, he said he thought IPA's decision to decline the claim wasn't unfair but that it should refund the premiums paid for this policy together with interest.

Neither IPA nor Mr and Mrs J accepted our Investigator's opinions, so the complaint was referred to me. I made my provisional decision about Mr and Mrs J's complaint in July 2025. In it, I said:

'I understand why Mr and Mrs J are unhappy with IPA's actions in this case and I sympathise with the situation they have found themselves in. But, when reaching my decision, I must do so independently and impartially based on the specific facts of the individual complaint. IPA's failure to comply with deadlines set by our Service and/or the level of IPA's company profits don't have any bearing on the outcome.

Industry rules set out by the regulator say an insurer must handle claims promptly and fairly, shouldn't unreasonably reject a claim and must provide a policyholder with appropriate information on the progress of a claim. I've taken these rules into account when making my provisional decision.

IPA has sought to rely on a policy exclusion relating to pre-existing medical conditions when declining Mr and Mrs J's claim. But, as Mr and Mrs J were asked to answer questions about the health of those to be insured when buying the policy, the relevant law is The Consumer

Insurance (Disclosure and Representations) Act 2012 ('CIDRA'). CIDRA cannot be contracted out of by an insurer to the detriment of the consumer and, so, the legislation generally takes precedence over any policy terms and conditions. I'm satisfied that it's fair and reasonable to apply the principles set out under CIDRA to the circumstances of Mr and Mrs J's complaint.

CIDRA requires consumers to take reasonable care not to make a misrepresentation when taking out an insurance policy. The standard of care required is that of a reasonable consumer. If a consumer fails to do this, the insurer has certain remedies available to it provided the misrepresentation is - what CIDRA describes as – a 'qualifying misrepresentation'.

For a misrepresentation to be a qualifying one, the insurer must 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 a 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 thinks Mr and Mrs J failed to take reasonable care not to make a misrepresentation because they answered 'no' to the following questions which they were asked when they bought their policy.

> *'Do any travellers have, or have any travellers had any pre-existing medical conditions or is anyone on a waiting list for treatment or investigation?*
>
> *…*
>
> *What is a 'pre-existing medical condition?*
> *This is a medical condition or injury that you've been diagnosed with and have had or are currently receiving treatment for. Examples include stroke, high blood pressure, anxiety and broken bones.'*
>
> *and*
>
> *'Within the last 2 years, has anyone you wish to insure on this policy suffered any medical or psychological condition, disease, sickness illness or injury that has required prescribed medication (including repeat prescriptions) or treatment including surgery tests or Investigations?'*

I'm satisfied these questions were clear and specific, and the questions didn't relate only to recurring medical issues. I've reviewed Master J's medical records. These state that medication was prescribed for eczema and tonsilitis in the two years before the policy was taken out and also show a referral to a consultant for swollen lymph nodes in the same time period. It wasn't up to Mr and Mrs J to determine what information they thought IPA wanted to know about, or whether they considered these medical issues to be minor or usual for a young child. There was a duty on Mr and Mrs J to take reasonable care to accurately answer the questions IPA asked.

I'm satisfied that a reasonable person would have realised from the questions asked that IPA wanted to know about this medical information. So, I don't think Mr and Mrs J took reasonable care when answering the questions IPA asked them when they were buying the policy.

I'm satisfied IPA would never have offered this particular type of 'Silver Plus' insurance

policy to Mr and Mrs J if they had answered the medical questions they were asked in the way I think they reasonably ought to have. I understand Mr and Mrs J have provided evidence which they say demonstrates that IPA would have offered cover for a higher premium, but this is a different (although similarly branded) 'Select' policy and is not the same policy which Mr and Mrs J actually purchased.

This means I think IPA has demonstrated that Mr and Mrs J made a 'qualifying misrepresentation' under CIDRA and it's therefore entitled to apply the remedies available to it under the legislation. I've taken into account what Mr and Mrs J have said about the condition claimed for being unforeseen and unlinked to Master J's previous medical issues but the remedies set out under CIDRA apply regardless of whether the condition being claimed for is linked to the conditions which were misrepresented.

IPA appeared to agree with our Investigator's findings that this misrepresentation should be treated as careless. I think this is fair and reasonable in the circumstances. This means IPA is entitled to avoid the contact and refuse Mr and Mrs J's claim, but it must refund the premium they paid for the policy.

I appreciate this isn't the outcome Mr and Mrs J were hoping for, and I'm sorry to disappoint them, but I won't be directing IPA to pay their claim.

IPA doesn't agree with our Investigator's conclusion that it should add interest at 8% to the premium refund due to Mr and Mrs J. IPA says it didn't refund the premium previously because Mr and Mrs J didn't accept the stance set out in its final response letter and instead referred the matter to our Service, so it shouldn't be required to pay interest on the delayed premium refund. I don't think IPA's stance in this regard is reasonable. If IPA wishes to invoke a remedy under CIDRA then I think it would be fair and reasonable for it to apply the full remedy in accordance with the law, and in a case involving careless misrepresentation that is to refund the premium to the policyholder when the policy is voided. So, I intend to direct IPA to pay interest on the premium refund, in line with our current general approach to awards of interest.

However, I don't agree with our Investigator's findings on the level of compensation which I think is appropriate in this case. I have no power to seek to punish a business through an award of compensation, but I don't think IPA handled this claim in line with industry rules and I don't think the £100 which IPA has paid fairly reflects the impact of the situation on Mr and Mrs J.

While some of the delays in this case do seem to have been caused by Master J's GP, I'm not currently satisfied based on IPA's contact notes that it accurately requested and expediently chased all the information it needed to verify the claim. I also note, in early June 2024, IPA told Mr and Mrs J that they'd need to obtain additional medical records themselves, which isn't what I'd consider to be usual practice. I think there were avoidable delays by IPA in providing an answer about the claim to Mr and Mrs J, and it could have done this sooner than it did. I think it's clear from the contact notes that IPA wasn't proactive in keeping Mr and Mrs J updated about the claim. Mr and Mrs J were making repeated calls for updates at what was already a stressful and financially difficult time for them. When IPA did decline Mr and Mrs J's claim, I think it could have been much clearer about the reasons why the claim wasn't covered. Mr and Mrs J repeatedly pointed out that the wording of the policy exclusion which IPA was quoting referred to claims linked to pre-existing medical conditions, which this claim wasn't. The wording of a letter which Mr and Mrs J were sent after the initial claim decline then raised their expectations that the claim would be covered, and IPA went on to subsequently decline the claim on two further occasions for various different reasons.

Overall, I think a payment of a total of £300 compensation would be fair and reasonable in the circumstances for the impact of IPA's handling of the claim on Mr and Mrs J. For the avoidance of doubt, this includes the £100 compensation which IPA has already paid.'

IPA accepted my provisional findings. Mr and Mrs J also accepted my provisional decision, although they said they were disappointed with the overall outcome.

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.

As neither party has provided any further submissions, I see no reason to change my provisional decision.

Putting things right

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

- refund Mr and Mrs J the premiums they paid for the policy;
- add interest at 8% simple per annum from one month after the claim was made until the date the settlement is paid;
- pay Mr and Mrs J a total of £300 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 J 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.

My final decision

I'm upholding Mr and Mrs J's complaint about Inter Partner Assistance SA in part, 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 Mrs J and Mr J to accept or reject my decision before 11 September 2025.

Leah Nagle
Ombudsman