DRN-5759798

The complaint

Ms D and Ms M complain because Inter Partner Assistance SA ('IPA') hasn't paid a cancellation claim under their travel insurance policy.

What happened

Ms D and Ms M bought a travel insurance policy online, provided by IPA. Ms D telephoned IPA's agent afterwards to declare some pre-existing medical conditions, as she had been asked to do in an email.

Unfortunately, Ms D fell ill shortly before her and Ms M were due to travel, so they cancelled their holiday and made a claim with IPA for their irrecoverable costs.

IPA said the claim wasn't covered because Ms D hadn't told it about a medical condition from 2016. Unhappy, Ms D and Ms M complained to IPA before bringing the matter to the attention of our Service. IPA paid Ms D and Ms M a total of £75 compensation for issues including delays in dealing with the claim.

One of our Investigators looked into what had happened and said, based on the limited information we had from IPA at the time, that IPA should reassess Ms D and Ms M's claim.

IPA didn't agree with our Investigator's opinion, so the complaint was referred to me, as the final stage in our process. I made my provisional decision earlier this month. In it, I said:

'Industry rules set out by the regulator say insurers must handle claims promptly and fairly, shouldn't unreasonably reject a claim and must provide a policyholder with appropriate information about a claim's progress. I've taken these rules, as well as Consumer Duty principles, into account when making this provisional decision.

IPA has sought to rely on policy exclusions relating to pre-existing medical conditions when declining this claim. I don't think this is fair or reasonable in the circumstances. This is because Ms D and Ms M were asked to tell IPA about their medical history and Ms D went through a telephone medical screening process with IPA's agent to confirm or amend particulars of her pre-existing medical conditions.

This means that I think the principles set out in the Consumer Insurance (Disclosure and Representations) Act 2012 ('CIDRA') are relevant and I'm satisfied it's fair and reasonable to apply these to the circumstances of Ms D and Ms M's complaint. I would remind IPA that an insurer cannot contract out of CIDRA by using a policy term which would put the consumer in a worse position than they would be in under the legislation, which is what IPA has attempted to do here by fully excluding a claim via a policy exclusion when it would in fact have offered cover for the relevant medical condition for an additional premium.

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 provided the misrepresentation is – what CIDRA describes as – a qualifying one. For the

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. The remedies available to an insurer under CIDRA depend on the classification of the misrepresentation.

CIDRA set outs a number of considerations for deciding whether a consumer failed to take reasonable care. One of these considerations is how clear and specific the questions asked by the insurer were.

IPA has provided no evidence to show what questions its agent asked Ms D about her pre-existing medical history during the telephone call, so it therefore has not demonstrated that there has been any misrepresentation under CIDRA.

A retrospective medical screening which IPA has provided sets out the following questions:

> *'Anxiety*
>
> *Have you been treated for depression within the last 2 years?*
>
> *Anxiety and depression*
>
> *Have you been referred to a psychiatrist for any of these conditions within the last 2 years?*
>
> *Have these conditions caused you to cancel or cut short any travel plans?*
>
> *How many hospital admissions have you had for these conditions in the last 2 years?*
>
> *Have you had a compulsory admission to hospital as a result of these conditions?'*

If I accept that these were the questions which IPA's agent asked Ms D about her medical history then, based on the medical evidence I've seen, Ms D wouldn't have been required to declare a condition which she had last experienced symptoms of in 2016 when this policy was purchased in 2024. And, even if the questions asked about medical conditions referred to a period of the last five years as is mentioned in the policy terms and conditions, Ms D also wouldn't have needed to tell IPA about the medical condition in question.

So, even if I were to accept that IPA had asked a clear and specific question, based on the limited information which is available to me about the call between Ms D and IPA's agent, I don't think Ms D failed to take reasonable care not to make a misrepresentation.

This means I don't think it's fair or reasonable for IPA to seek to rely on any of the remedies available under CIDRA to either decline Ms D and Ms M's claim or to settle the claim on a proportionate basis. So, I intend to direct IPA to now pay this claim.

I don't think IPA handled this claim in line with industry rules. IPA has already accepted there were unreasonable delays and has paid £75 compensation. IPA also failed to provide any clear or accurate explanation to Ms D and Ms M as to why it was declining their claim, and there were mistakes in IPA's letters which caused Ms D and Ms M annoyance and frustration. Overall, I'm satisfied that IPA's decision to unfairly decline this claim has caused Ms D and Ms M more than minimal impact, which has required a reasonable amount of effort to sort out. I therefore think a total payment of £250 compensation (so, an additional £175) would be fair and reasonable in the circumstances.'

All parties accepted 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.

As all parties accepted my provisional findings, I see no reason to change them.

Putting things right

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

- pay Ms D and Ms M's claim, subject to the remaining terms and conditions of the policy but disregarding any exclusions relating to pre-existing medical conditions;
- add interest to the claim payment at 8% simple per annum from one month after the date the claim was made until the date the settlement is paid[1];
- pay Ms D and Ms M an additional £175 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 Ms D and Ms M 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 Ms D and Ms M'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 Ms D and Ms M to accept or reject my decision before 15 September 2025.

Leah Nagle
Ombudsman

[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 Ms D and Ms M how much it has taken off. It should also give Ms D and Ms M a tax deduction certificate if they ask for one so they can reclaim the tax from HM Revenue & Customs if appropriate.