DRN-5775600

## The complaint

Mr and Mrs D complain about how Inter Partner Assistance SA ("IPA") has handled a claim under their travel insurance policy.

## What happened

Mr and Mrs D bought an annual multi-trip travel insurance policy to cover them between 18 January 2024 and 17 January 2025. The insurer was IPA. They had a trip booked abroad for September 2024, but unfortunately, they had to cancel it due to Mr D's health considering the type of trip they were due to go on.

Mr and Mrs D submitted a claim for cancellation, and Mr D's GP had filled out IPA's medical certificate confirming he wasn't fit to travel. IPA first said it would apply a limit of £250 for excursions on the claim. After Mr and Mrs D disputed this, IPA apologised in its final response letter and it paid them £75 compensation for the distress and inconvenience caused because of this, and for other failures in its communication.

The crux of Mr and Mrs D's complaint is that IPA has asked for Mr D's previous medical history ("PMH") over the past five years prior to them taking out the policy. They don't think this request is reasonable, or in line with the policy terms. And Mr D's GP has already provided information about his PMH over the past two years, which they say is in line with the policy terms.

One of our investigators reviewed the complaint. Having done so, he didn't think the request IPA had made for Mr D's PMH was unreasonable. And he thought that the £75 IPA had paid Mr and Mrs D for the distress and inconvenience caused was fair in the circumstances of their complaint.

Mr and Mrs D didn't agree with the investigator's findings. They said they'd be willing to provide written information from Mr D's GP in relation to the listed conditions in the policy terms that go beyond the two-year term to allow IPA to consider the claim. But they maintain that the request IPA has made exceeds the policy definition of a pre-existing medical condition, and it could be regarded as excessive.

As no agreement was reached, the complaint has been passed to me to decide.

## 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.

Industry rules set out by the regulator (the Financial Conduct Authority) say insurers must handle claims promptly and fairly, and shouldn't unreasonably reject a claim. I've taken these rules, and other industry guidance, into account when deciding what I think is fair and reasonable in the circumstances of this complaint.

Mr and Mrs D's policy defines a pre-existing medical condition ("PEMC") to mean the following:

> *"i. Any medical condition which falls into any of the following categories which you have, or have had for which you have ever received treatment (including surgery, tests or investigations by your doctor or a consultant/specialist and prescribed drugs or medication):*
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> - *Cardiovascular condition (any condition relating to the heart, arteries, veins or blood pressure)*
> - *Respiratory condition (relating to the lungs or breathing)*
> - *Stroke*
> - *Cancer*
> - *Crohn's disease*
> - *Epilepsy*
> - *High cholesterol*
> - *Diabetes*
>
> *ii. Any medical condition for which you have taken or been prescribed medication (including repeat prescriptions) or for which you have received, or are waiting to receive, treatment (including surgery, tests or investigations) within the last 2 years."*

Mr and Mrs D submitted a medical certificate provided by a GP confirming that Mr D wasn't fit to travel, and the GP included details of Mr D's PMH within the last two years prior to Mr and Mrs D booking their trip.

But IPA said it needed Mr D's PMH covering the past five years prior to the issue of the policy, including all consultations, diagnoses, active problems, tests and medications in detail. Mr and Mrs D consider this request to be unnecessary, excessive and intrusive. They say they're prepared to request the GP to provide information in relation to the medical conditions included in the definition i. above covering the past five years. But overall, they don't consider IPA's request to be reasonable for it to assess their claim.

It's not up to Mr and Mrs D, or their GP, to decide what evidence IPA reasonably needs to assess whether there is a valid claim under the policy. IPA has confirmed that the request it has made for Mr D's PMH is a standard request for medical claims. It has also said that it has asked for the previous five years of PMH because the PEMC definition i. above relates to the eligibility, and sale, of this policy. Considering these, I don't think IPA has acted unfairly or unreasonably by requesting the information it has. I'm satisfied it hasn't treated Mr and Mrs D any differently than it would any other policyholder in a similar situation.

It's not for this Service to tell a business how it should operate. It's also not for this Service to decide if a business has breached any data protection laws – that's a matter for the Information Commissioner's Office ("ICO"). My role and remit is to consider and decide if IPA has treated Mr and Mrs D fairly and reasonably in all the circumstances. For the reasons I've explained above, I'm satisfied it has.

Lastly, IPA apologised in its final response for referring to Mr and Mrs D's trip as an excursion, and that it hadn't always communicated with them as promptly as it should have done. IPA paid them £75 compensation for the distress and inconvenience caused. Whilst it's clear that there were some delays in IPA considering the claim, I think the main delay has been caused by Mr and Mrs D not agreeing to submit the further evidence IPA requires to consider their claim. So overall, I think the compensation IPA has paid them is fair and reasonable in all the circumstances of the complaint.

## My final decision

My final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs D and Mr D to accept or reject my decision before 21 October 2025.

Renja Anderson
**Ombudsman**