DRN-5776688

The complaint

Miss A is unhappy that Inter Partner Assistance SA (IPA) declined a claim made on her travel insurance policy ('the policy') which she took out for her benefit and the benefit of her children. The claim related to costs associated with her daughter requiring medical attention abroad.

All reference to IPA includes its agents and medical assistance team.

What happened

The details of this complaint are well known to both parties, so I won't repeat them again here. I'll focus on giving the reasons for my 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.

That includes 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.

The standard of care expected 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 it's for the insurer to show it would have offered the insurance policy on different terms, or not at all, if a misrepresentation hadn't been made.

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.

The decision to decline the claim

IPA has provided the medical questions Miss A would've been asked in respect of her and her children when applying for the policy. That includes:

> Have you or any of the travellers had any medical condition for which you have received prescribed medication or check-ups within the last 12 months?
>
> Have you or any of the travellers had any of the following medical conditions for which you have received prescribed medication or treatment including surgery, tests, investigations or check ups within the last 5 years?

- Respiratory conditions
- Heart conditions
- High blood pressure and/high cholesterol
- Cancerous conditions
- Neurological conditions (for example stroke, brain hemorrhage, multiple sclerosis, epilepsy and dementia)
- Mental health conditions (for example anxiety, depression and eating disorders)
- Diabetes
- Are you or any travellers on a waiting list for treatment, tests or investigations or awaiting the results of any tests or investigations?

Miss A did declare some conditions in respect of her daughter.

However, IPA says there were other conditions she should've disclosed but didn't. Had she done so, she would've been asked further questions about those conditions.

I don't think I need to make a finding on whether Miss A made a misrepresentation when answering the medical questions above. Even if she did, IPA needs to show that the policy wouldn't have been offered – or that it would've been offered on different terms.

IPA says the policy wouldn't have been offered at all if other conditions had been declared and the follow up questions about those conditions had been answered correctly.

I've seen an internal email chain from IPA dated September 2024 asking for a retro-screening based on the conditions it says should've been declared and to confirm the new premium to be paid.

The reply is:

> This has now been completed and the medical conditions have been added to the policy and the customer has paid the premium.

When the representative is asked to confirm that no additional premium is to be paid for the undeclared conditions, the reply is:

> When we add the other medical conditions to the policy we are unable to obtain any quotes for the customers.

A screenshot it then provided which simply says: "unable to obtain any quotes for customer(s)". IPA says this would've happened because once the other conditions were added, its system didn't return a quote due to the risk exceeding the accepted threshold.

Our investigator asked IPA to provide evidence showing that:

- the additional conditions were input into its system; and
- the score increased and exceeded the threshold.

IPA said it couldn't provide anything further.

Based on everything I've seen, I'm not persuaded that IPA has shown that declaring the other conditions, and answering the further questions about those conditions, would've resulted in the policy not being offered. It's provided a screen shot showing no quotes

would've been returned but it hasn't, for example, shown how that message was generated and the information inputted to generate that message.

It follows that I'm not persuaded Miss A made a qualifying misrepresentation. So, I don't think it's fair and reasonable for IPA to cancel the policy back to the inception date and decline the claim.

Other issues

IPA has also relied on the pre-existing medical condition exclusion in the policy terms to decline the claim. However, from the medial evidence I've seen, I'm satisfied that the treatment Miss A's daughter required whilst abroad related to a pre-existing condition which had been declared and accepted by IPA when taking out the policy. So, I don't think IPA can fairly rely on the pre-existing medical condition exclusion to decline the claim.

Claim handling

As well as its regulatory obligation to not unreasonably decline an insurance claim, IPA should also handle claims fairly and promptly.

In its final response letter dated October 2024, IPA accepts that the service provided should've been better. After Miss A initially contacted IPA for assistance about her daughter's medical condition, it said Miss A would need to complete some documents which it would be sent.

I'm satisfied the guarantee of payment was sent to an incorrect email address which caused unnecessary delays. This resulted in a delay in getting her daughter treatment.

Impact

IPA offered £100 compensation. However, I don't think fairly reflects the impact on Miss A. This would've already been a very worrying and upsetting time for her, and I think IPA's actions made that unnecessarily worse.

I know Miss A says that the delay made her daughter's condition worse and she should've had a bed rather than sitting in a chair awaiting to be admitted. However, the medial facility had a duty to care to Miss A's daughter and if she needed to lie down and they didn't accommodate this, I'm don't think it would be fair to hold IPA responsible for that.

However, I do think IPA's failure to send the guarantee of payment to the correct email address meant that Miss A had to "pay the bond" to the medical facility at her own expense. Miss A says that the money she paid the medical facility meant that she had depleted funds for the rest of the holiday for her and her family. I've got no reason to doubt what she says, and I accept that. This would've also been upsetting.

IPA hadn't verified the claim by the time the holiday ended, and Miss A and her family returned to the UK. However, I don't think it's unreasonable for IPA to contact Miss A's daughter's GP to access her medical records before verifying the claim. That's standard industry practice when someone becomes ill abroad and seeks medical assistance through their travel insurance. I don't think I can reasonably hold IPA responsible for the time taken by the GP surgery to provide the medical records in this case.

However, having the claim unfairly declined would've been worrying and Miss A has had to spend time challenging IPA's decision to decline the claim. So, she was put to unnecessary inconvenience. I'm also satisfied that Miss A believed the decision to decline her claim was

being reviewed by IPA, but it wasn't addressed in its first final response letter. I accept that also would've been frustrating and confusing.

I'm satisfied £300 total compnesation for the distress and inconvenience Miss A experienced is more reasonable.

Putting things right

I understand that Miss A has already paid the medical fees to the treating facility and other associated costs relating to the claim. I direct IPA to:

- pay Miss A's claim (less any excess and policy financial limits) and subject to documentary evidence from Miss A that the costs claimed have been paid.
- pay Miss A simple interest at a rate of 8% per year on the amount claimed from either a month after the claim was made or the date on which she paid the medical fees and other associated costs (whichever is later) to the date IPA settles the claim*.
- pay £300 compensation to Miss A for distress and inconvenience (it can deduct the £100 it offered if this has already been paid to Miss A).

*If IPA considers that it's required by HM Revenue & Customs to take off income tax from any interest paid, it should tell Miss A how much it's taken off. It should also give her a certificate showing this if she asks for one. That way Miss A can reclaim the tax from HM Revenue & Customs, if appropriate.

My final decision

I uphold Miss A's complaint. I direct Inter Partner Assistance SA to put things right as set out above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss A to accept or reject my decision before 27 October 2025.

David Curtis-Johnson
Ombudsman