DRN-5790844

The complaint

Mr and Mrs J complain that Inter Partner Assistance SA (IPA) has turned down a cancellation claim they made on a travel insurance policy.

As Mr J brought the complaint to us, for ease, I've referred mainly to him.

What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I think are the main events.

In January 2018, Mr and Mrs J took out an annual travel insurance policy which was arranged by a broker I'll call C. The policy was underwritten by IPA. The policy subsequently renewed in January of each year.

Unfortunately, in April 2024, Mr J suffered a serious medical condition and needed surgery. So he had to cancel a planned trip he was due to take in June 2024. He made a cancellation claim on the policy.

IPA asked for information so it could assess Mr J's claim, including his medical records. It noted that Mr J had been diagnosed with medical conditions and prescribed medication in the two years before he took out the policy in 2018.

On that basis, IPA concluded that Mr J hadn't answered its eligibility questions correctly when he applied for the policy. And it said that if he'd told it about his diagnoses and the medications he took, it would never have offered him this particular contract. So, it concluded that Mr J had made a qualifying misrepresentation under the relevant law when he took out the policy. It turned down Mr J's claim and it offered to refund the premium Mr J had paid for the policy for the 2024-25 policy year.

Mr J was very unhappy with IPA's position and he asked us to look into his complaint. He was also unhappy with the way IPA had responded to his concerns and the way it had dealt with things.

Our investigator concluded that Mr J had made a qualifying misrepresentation under the law in 2018. He didn't think Mr J would ever have been eligible for this particular policy and so he recommended that IPA should refund all of the premiums Mr J had paid for the cover. And he also recommended that IPA should pay Mr J £150 compensation for its delays in responding to him.

IPA accepted the investigator's recommendations, but Mr J did not. So the complaint was passed to me to decide.

I issued a provisional decision on 18 August 2025, which explained the reasons why I planned to award different redress to our investigator. I said:

'First, I'd like to say that I was sorry to hear about Mr J's illness and subsequent surgery. I appreciate this must have been a very difficult time for Mr and Mrs J and their family and I do

hope that he's made a good recovery. I'd also like to reassure Mr J that while I've summarised the background to this complaint and his submissions to us, I've carefully considered all that's been said and sent. In this decision though, I haven't commented on each point Mr J's made and nor do our rules require me to. Instead, I've focused on what I think are the key issues.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, amongst other relevant considerations, such as regulatory principles, the law, and the available evidence, to decide whether I think IPA treated Mr J fairly.

The relevant law in this case is The Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA). CIDRA requires consumers to take reasonable care not to make a misrepresentation when taking out a consumer insurance contract. 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 this particular complaint, the original policy was sold in 2018. IPA concluded that Mr J had made a qualifying misrepresentation at that point, which it relied on to decline the 2024 claim. I should point out to IPA that this isn't an approach which we would usually take, or which CIDRA allows for. Instead, like the investigator, I think it's reasonable to treat the original policy and the policies which were subsequently taken out at each renewal separately.

And, generally speaking, IPA could only avoid the contract and refuse a claim for a qualifying misrepresentation that took place in that same policy year. However, based on the very specific facts of this individual case, I'm satisfied that the outcome which IPA has arrived at is fair and reasonable in the circumstances and I'll explain why.

The 2018 sale

When Mr J applied for the policy online, he was asked questions about himself and his health. IPA used this information to decide whether or not to insure Mr J and if so, on what terms. IPA says that Mr J didn't correctly answer some of the questions he was asked at application. This means the principles set out in CIDRA are relevant. So, I think it's fair and reasonable to apply these principles to the circumstances of Mr J's claim.

IPA thinks Mr J failed to take reasonable care not to make a misrepresentation when he applied for and took out the policy. So, I've carefully considered whether I think this was a fair conclusion for IPA to reach.

First, when considering whether a consumer has taken reasonable care, I need to consider whether the questions they were asked during the sales process were clear. IPA has provided me with a copy of the online questions that were asked during the sales process.

Mr J was asked:

'Do any travellers have, or have any travellers had any pre-existing medical conditions or is anyone on a waiting list for treatment or investigations?...

What is a pre-existing medical condition?

This is a medical condition or injury you've been diagnosed with and have had or are receiving treatment for. Examples include, stroke, high blood pressure, anxiety and broken bones.'

Mr J answered 'no' to this question, which acted as a gateway question allowing C to provide him with information about this particular policy.

But the 'gateway' question I've referred to above wasn't the only question Mr J was asked about his health during the application process. IPA asked Mr J its own questions about his health and circumstances. In particular, it asked a list of 'eligibility' questions to ensure that Mr J was eligible for this policy. IPA's provided us with evidence of the questions Mr J was asked. This included the following question:

'Within the last 2 years has anyone you wished to insure on this policy suffered any medical condition, (medical or psychological disease, sickness, illness, condition or injury) that has required prescribed medication (including repeat prescriptions) or treatment including surgery, tests or investigations?'

Mr J answered 'no' to this eligibility question.

In my view, the medical and eligibility questions Mr J was asked during the sales process were clear – and also referred directly to high blood pressure as an example of something IPA would consider to be a pre-existing condition. I'm satisfied then that the sales process was clear. And I think the questions were clear enough to prompt a reasonable consumer to understand what information IPA wanted to know.

IPA believes that Mr J failed to answer its screening questions correctly. So I've looked at the available medical records to decide whether I think this was a reasonable conclusion for IPA to draw.

Mr J's GP completed a medical certificate which was sent to IPA. On the certificate, the GP stated that Mr J had been diagnosed with hypercholesterolaemia in 2016 and had been prescribed medication. The GP described the condition as ongoing. Mr J's medical records also show that in April 2016, Mr J was diagnosed with hypertension and in May 2016, he'd agreed to take medication. Mr J's GP records indicate that he was prescribed medication to treat these conditions throughout 2016, 2017 and 2018.

On that basis, I think the medical evidence shows that Mr J had suffered from medical conditions in the two years before the policy was taken out which had required prescribed medication. This was something which was specifically asked about in the eligibility question. And therefore, I don't think it was unreasonable for IPA to conclude that Mr J ought to have answered 'yes' to its eligibility question. So I find it was fair and reasonable for IPA to conclude that Mr J made a misrepresentation during the application process.

Next, I've considered whether IPA has shown that Mr J's misrepresentation was a qualifying one under CIDRA. It's provided us with evidence which shows it doesn't offer any cover at all for pre-existing medical conditions under this particular policy. This is also made clear in the policy documentation. So I'm satisfied that had Mr J answered 'yes' to IPA's questions, it wouldn't have offered him this policy at all, although it may have been able to direct him to a similarly branded but different policy which would offer medical cover had he told it about his

conditions at the outset. This means I think IPA has demonstrated that Mr J made a qualifying misrepresentation and that it's reasonably entitled to apply the remedy available to it under the Act.

While IPA hasn't told us how it classified Mr J's misrepresentation, it's agreed to refund the premiums he paid for the cover. CIDRA says that in cases of careless misrepresentation, an insurer may rewrite the policy as if it had all of the information it wanted to know at the outset. And if it wouldn't have offered cover at all, it may decline a claim, avoid the policy and refund the premiums. So it seems to me that IPA's treated Mr J's misrepresentation as careless. And I think this was reasonable in the circumstances.

On that basis, I don't think it was unfair for IPA to conclude that Mr J had made a qualifying misrepresentation under CIDRA in 2018. So I find its offer to refund the premium for that year reasonable.

Policy renewals between 2019 and 2023

I appreciate that at each renewal between 2019 and 2024, Mr J didn't go through an online question and answer process. And unfortunately, IPA hasn't been able to provide us with the renewal paperwork it sent to Mr J ahead of each renewal between 2019 and 2023. So it doesn't currently seem to me that IPA has shown Mr J was asked a clear question about his health during those particular policy years or that he answered it incorrectly. As such, I don't think I could fairly or reasonably conclude that IPA has shown Mr J made a misrepresentation about his health between 2019 and 2024 or that it wouldn't have insured him. And therefore, it seems to me that Mr J has had the benefit of cover during the life of those policies. So I don't think it would be fair or reasonable for me to direct IPA to refund the premiums Mr J paid during these particular policy years.

With that said, IPA did offer to refund the premiums Mr J paid in 2019, 2020, 2021, 2022 and 2023. So it's open to Mr J to contact IPA to check whether it's still prepared to pay him a refund of premiums between 2019 and 2023.

IPA has provided us with a copy of the renewal paperwork it emailed to Mr J on 5 January 2024, to the email address it sent to him. The renewal email included a section called 'Important Information'. This set out the following:

'We would like to remind you that your chosen policy will continue to provide cover as long as you, or anyone you wish to insure on this policy, are not:

- *waiting to receive, or have received, any medical treatment (including prescribed medication, surgery, tests or investigations) within the last 2 years; or*
- *currently aware of any reason that may cause you to claim (such as suffering symptoms not yet discussed with a doctor or the health of relatives or other third parties which may cause the cancellation or the cutting short of a trip)*

If either of these circumstances apply, please contact us. If we have not been made aware of changes to the health of the people named on your policy, your insurer could treat it as if it never existed, or refuse a claim or not pay a claim in full.'

I'm satisfied that the renewal invite makes it clear that IPA won't provide cover for any person who's been prescribed medication within the previous two years and the steps a person should take if they were receiving medical treatment or if they'd been prescribed medication in the previous two years.

Again, I've looked carefully at Mr J's medical records and the medical certificate. Mr J was prescribed antibiotic medication in February and December 2022. And the records also show that in early January 2020, Mr J was placed on statins, with further prescriptions being issued in January, February, April and May 2022. While I note Mr J says these statins were given as routine and he didn't take them, the medical notes show these medications were prescribed and issued.

As such, I'm satisfied the evidence clearly shows that Mr J had been prescribed medications in the two years preceding the 2024 policy renewal. So I think he ought to have been prompted to contact IPA to declare these medications and his diagnoses to it. IPA's confirmed that had he done so, it couldn't have offered the renewal of this particular policy in 2024.

On that basis, I think it was fair and reasonable for IPA to conclude that Mr J made a qualifying misrepresentation to it when the policy renewed in 2024. Again, it seems that IPA treated this misrepresentation as careless. As it wouldn't have offered him cover for that particular policy year, I think it was reasonable for IPA to turn down Mr J's claim, avoid the policy for that year and to offer to refund his premiums for the 2024-25 policy year is fair and reasonable. That's because it's applied the remedy available to it under CIDRA. I also find that it would be fair and reasonable for IPA to add interest to this particular refund amount, at an annual rate of 8% simple, from the date the premium was paid until the date the refund is made.

Service issues

Mr J's very unhappy with IPA's delays in dealing with his concerns. I think there were some unreasonable delays in IPA getting back to Mr J with information he requested and I don't doubt that this caused him caused unnecessary trouble and upset. I agree with our investigator that compensation of £150 is a fair, reasonable and proportionate award to recognise Mr J's trouble and upset. I was pleased to note IPA agreed to this recommendation.'

I asked both parties to send me any further evidence or comments they wanted me to consider.

IPA accepted my provisional findings.

Mr J asked for an extension to respond to my provisional decision. But he didn't reply by the extended deadline I gave.

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 substantive response to my provisional findings, I see no reason to change them.

So my final decision is the same as my provisional decision and for the same reasons.

Putting things right

I direct IPA to:

- Refund the premiums Mr J paid for the 2018-19 and 2024-25 policy years;

- Add interest of 8% simple on the 2024-25 premium refund from the date it was paid until the date of settlement*; and
- Pay Mr and Mrs J £150 compensation.+

* If IPA considers that it's required by HM Revenue & Customs to deduct income tax from that interest, it should tell Mr and Mrs J how much it's taken off. It should also give Mr and Mrs J a tax deduction certificate if they ask for one, so they can reclaim the tax from HM Revenue & Customs if appropriate.

+ IPA 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.

My final decision

For the reasons I've given above and my provisional decision, my final decision is that I uphold this complaint in part and I direct Inter Partner Assistance SA to put things right as 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 9 October 2025.

Lisa Barham
Ombudsman