DRN-5831838

The complaint

Miss B has complained that Inter Partner Assistance SA declined a claim she made on a travel insurance policy.

What happened

Miss B originally took out the annual policy in May 2022 and it auto-renewed in May 2023. She was due to go on a trip abroad in March 2024. Unfortunately, she became ill and was too unwell to travel. So, she cancelled the trip and made a claim on the policy for unrecoverable costs.

IPA declined the claim on the basis that Miss B hadn't declared some pre-existing medical conditions (PEMCs). It said that, had she done so, it wouldn't have agreed to provide this cover. However, it offered to refund the premium that had been paid.

Our investigator thought that IPA had acted reasonably in declining the claim, in line with the policy terms and conditions. Miss B disagrees and so the complaint has been passed to me for a 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.

I've carefully considered the obligations placed on IPA by the Financial Conduct Authority (FCA). Its 'Insurance: Conduct of Business Sourcebook' (ICOBS) includes the requirement for IPA to handle claims promptly and fairly, and to not unreasonably decline a claim.

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.

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.

IPA has provided evidence of the renewal process. I'm satisfied that if an applicant had declared any recent medical history, they wouldn't have been offered this particular policy.

During the original online sales journey in May 2022, Miss B was asked:

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

She answered ‘No’ to this question.

In 2023 she was sent a renewal notification letter. This stated:

‘Important information

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.’

It’s clear from the above wording that the policy is not designed for anyone that has any sort of medical history in the previous two years.

Miss B didn’t make contact with IPA and so the policy auto-renewed in May 2023. Had she made contact, she would have been asked the same question that she was asked when originally taking out the policy, as set out above.

Had Miss B answered ‘Yes’ to this question, she would have been unable to complete the purchase of this policy. Instead, she would have been advised that she needed a medical policy instead and returned to an earlier point in the process to amend any missing or incorrect information. She would then likely have been offered an alternative policy that did cover those with a medical history.

The period in question is the two years prior to renewal, so from May 2021. Miss B’s GP had completed a form for IPA but had left the medical history section blank. However, IPA were also given a copy of a report that the hospital had sent to her GP in relation to an A&E visit in February 2024.

At the top of the report, it states that Miss B had had two emergency department attendances in the last 12 months. It goes on to say that she’d had:

‘intermittent infrequent palpitations over the last 2-3 years. Initially quite short duration but becoming a lot more frequent and marked.

Previously had 24 hour tape in 2022 but didn’t experience any episodes during that.’

Given the contents of this report, IPA concluded that she should have declared this medical history at renewal.
Miss B says the hospital doctor has recorded the information she provided incorrectly. So, she says that she was talking about palpitations she experienced over 2-3 years ago. She’s also said that the report is an informal note that doesn’t form part of her official medical history. However, the report constitutes a record from a qualified medical professional and was sent as an update to her GP to add to her medical records. Overall, I’m satisfied that IPA was entitled to take this information at face value to conclude that she’d experienced palpitations and had investigations for that in the two years prior to the policy start date.

With regard to the mention of a 24-hour tape, she says she has no recollection of undertaking that. That does beg the question of where the hospital doctor got that information from. She's provided a screenshot of a response from her GP surgery which says: *'we have no record of the tape you had in 2022'.* However, I don't know what question she asked to illicit that response.

Whilst on the one hand saying she has no recollection of undertaking the 24hr tape (officially known as a Holter monitor), she has alternatively argued that it pre-dated the relevant period and did not result in a diagnosis anyway – meaning that she didn't have a medical condition that needed to be declared. I'm not persuaded by that argument. I would say that having the sensation of heart palpitations is a condition and that the 24hr tape is a test or investigation for that condition. Regardless of that, the 'important information' in the renewal notice doesn't mention 'conditions' at all but instead focuses on any treatment (including prescribed medication, surgery, tests or investigations) within the last 2 years.

On balance, I consider that IPA has assessed the available information reasonably to conclude that she'd had heart palpitations that she should have declared.

I've seen that Miss B also provided IPA with a medications list showing what she was prescribed during the relevant period. Although she has mentioned that she later provided her fuller medical records, it's unclear to me whether or not that is the case. However, I'm not persuaded that would make a difference anyway.

This policy is designed for people with no recent medical history at all. Miss B has said herself that she has eczema. And I can see that she was prescribed medication for this. Whilst I'm satisfied it was reasonable for IPA to use the information in the hospital report to decline the claim, even if it disregarded the information about heart palpitations, it would still be able to decline the claim on the basis that Miss B hadn't disclose her eczema.

There's no suggestion that Miss B intended to mislead IPA. But she didn't take enough care to make a correct declaration. As she didn't take reasonable care, this is a qualifying misrepresentation under CIDRA and so IPA is entitled to apply the relevant remedy available to it under the Act.

Miss B says she had a virus and it was this that caused her to cancel her trip, rather than palpitations or any other PEMC. However, that's not the most relevant consideration here. The matter at hand is, what would IPA have done if she had correctly declared her medical history. CIDRA says that an insurer is entitled to apply cover as if it had all of the information it wanted to know at the outset.

Miss B has carried out her own research to conclude that IPA would still have offered her the policy if she had declared arrhythmia. IPA has alternative, medical, policies that do cover people who declare certain conditions. I think it's likely that it's one of these types of policies she's been able to get a quote for rather than the identical 'Bronze' policy that she held.

Based on the underwriting evidence provided by IPA, I'm satisfied that it would not have offered the policy to Miss B at all if she had declared her medical history.

Therefore, as it wouldn't have offered cover, there would have been no policy to make a claim on. It follows that I consider it was reasonable for IPA to decline the claim and offer to refund the premiums.

I have sympathy for Miss B's situation. She was too unwell to travel and is out of pocket as a result. The question is whether IPA has done anything wrong – and I'm unable to conclude

that it has. I consider that it correctly declined the claim, in line with the policy terms and conditions and relevant legislation. It follows that I do not uphold this complaint.

My final decision

For the reasons set out above, my decision is that I do not uphold the complaint. However, Inter Partner Assistance SA should refund the policy premium now if it hasn't already done so.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss B to accept or reject my decision before 24 December 2025.

Carole Clark
Ombudsman