DRN-5834124

The complaint

Mr L is unhappy that Inter Partner Assistance SA (IPA) declined a claim made on a travel insurance policy ('the policy') after he required emergency medical treatment whilst abroad. All reference to IPA includes its agents.

What happened

Whilst abroad, Mr L experienced a cardiac arrest and was taken to hospital for emergency treatment.

After being contacted for assistance, IPA ultimately declined to cover any costs associated with Mr L's medical emergency. It concluded that Mr L hadn't disclosed his pre-existing medical conditions when applying for the policy and had acted recklessly by failing to do so. IPA says it was therefore entitled to decline the claim made under the policy.

Unhappy, Mr L brought a complaint to the Financial Ombudsman Service. Our investigator looked into what happened and partially upheld Mr L's complaint.

In our investigator's opinion, Mr L had acted carelessly when not declaring any pre-existing medical conditions when applying for the policy. And that made a difference in this case.

Because, if Mr L had correctly declared his medical conditions in his application, the policy would've still been offered but he would've been required to pay a higher premium for it. And Mr L had only paid around 55% of the premium he would've been changed.

So, our investigator ultimately recommended that IPA pay 55% of the claim and to pay compensation to Mr L in the sum of £1,000 for the distress and inconvenience.

IPA disagreed and raised further points in reply. IPA maintained that Mr L had acted recklessly (rather than carelessly) when applying for the policy.

These further points didn't change our investigator's opinion, so this complaint has been passed to me to consider everything afresh 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.

That includes IPA's regulatory obligation to not unreasonably decline a claim.

Because it's relevant here, I've also considered 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, the insurer (in this case, IPA) must show it would have offered the insurance 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.

Did Mr L make a misrepresentation?

Mr L applied for the policy via a comparison website. In its final response letter to Mr L dated May 2024, IPA sets out the gateway question it says Mr L would've been asked about his health and pre-existing medical conditions at the time of applying for the policy. That is:

> Does anyone in your party have a pre-existing medical condition, or is anyone on a waiting list for treatment or investigation?

Underneath (and within the same box), it says:

> What is a pre-existing medical condition?
>
> This is a medical condition or injury that you've been diagnosed with and have had or are currently receiving treatment for. Examples include stroke, high blood pressure, anxiety and broken bones.
>
> Don't worry, it may not always cost more to include your medical conditions. If you don't tell us, then you may not be covered if you need medical treatment abroad or for any costs to get you back home.

I'll refer to this as 'the medical question'. And I'm satisfied that it's reasonably clear.

After the complaint was brought to the Financial Ombudsman Service, and during our investigator's investigation, IPA provided an example of the online journey it says Mr L would've followed when applying for the policy.

The gateway question about his health and pre-existing medical conditions differs slightly. It says:

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

I'll refer to this as "the other medical question".

Again, underneath it says: "what is a pre-existing' medical condition?" and then:

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

> Don't worry, it may not always cost more to include your medical conditions. If you don't tell us, then you may not be covered if you need medical treatment abroad or for any costs to get you back home.

The final response letter is from May 2024, and the medical question is also referred to in IPA's email to Mr L dated March 2024, explaining why it wouldn't be providing cover. It's the question that Mr L has also quoted as having been asked in his letter to IPA dated January 2025 and in his complaint form to the Financial Ombudsman Service.

On the balance of probabilities, I'm therefore satisfied that the medical question is most likely to be the question Mr L was asked when applying for the policy.

The other medical question (which IPA says formed part of the online sales journey) was sent to the Financial Ombudsman Service almost a year later in April 2025. Although it's again referred to in IPA's responses to our investigator's view, I think it's likely that the other medical question was the one in place in 2025 and had changed since Mr L applied for the policy in January 2024.

However, when considering whether Mr L took reasonable care, I'm not persuaded that it ultimately matters whether Mr L was asked the medical question or the other medical question. That's because regardless of which of the two questions he was asked, given how they're drafted, I'm satisfied that IPA has fairly and reasonably concluded that Mr L didn't take reasonable care when answering the medical question (or the other medical question). To avoid any confusion, for the remainder of this decision, I'll refer to the medical question and the other medical question collectively as 'the medical gateway question'.

IPA has provided a screenshot showing that no pre-existing medical conditions were declared by Mr L. In the absence of any information to the contrary, I'm therefore satisfied Mr L answered 'no' to the medical gateway question.

However, I'm satisfied that he reasonably should've answered 'yes' because:

- Mr L's medical records reflect that around four months before applying for the policy, he was prescribed medication for erectile dysfunction as part of a repeat prescription.
- IPA's contact notes show that it had contacted Mr L's GP and they'd confirmed that Mr L had high cholesterol and had previously been prescribed medication. Mr L doesn't dispute this. Although, the last prescription was issued at the end of 2020 and had not been re-ordered since, given the medical gateway question (including the definition of pre-existing medical condition), I'm satisfied IPA has reasonably concluded that high cholesterol should've been disclosed. It's a significant medical condition and one that had been ongoing for many years (although the medical records indicate that it may have been under control in more recent years).

I'm therefore satisfied Mr L made a misrepresentation when applying for the policy.

Was this a 'qualifying' misrepresentation?

I've considered whether this amounted to a qualifying misrepresentation under CIDRA. And I think it did. Had Mr L answered the medical gateway question correctly, I'm satisfied that he would've been presented with other follow up questions about his health. These include (but are not limited to):

> Have you or anyone in your party been prescribed medication, received treatment or had a consultation with a doctor or hospital specialist for any medical condition in the past 2 years?

And

> Have you or anyone in your party ever been diagnosed with or treated for any of the following:
>
> …any circulatory condition (problems with blood flow, including strokes, high blood pressure and cholesterol)?...

I'll refer to the questions that followed collectively as 'the follow up questions'.

Further once medical conditions had been disclosed, IPA has provided evidence (which I'm persuaded by), that further sub-questions would've been asked about those conditions.

I'm satisfied that IPA has acted fairly by carrying out a retro screening.

Based on the available medical evidence, I'm satisfied that IPA has reasonably concluded that Mr L would've declared three medical conditions in response to the follow up questions, had he answered the gateway question correctly. Those conditions would've been high cholesterol, erectile dysfunction and – additionally – depression.

I'm satisfied Mr L would've most likely disclosed those conditions had he taken care to answer the medical gateway question correctly.

I'm also satisfied that IPA has answered the sub-questions which would've followed the declaration of each of those conditions fairly.

Based on that retrospective screening, and the pricing information provided by IPA, I'm satisfied that had Mr L taken reasonable care to answer the medical gateway question - and gone on to declare high cholesterol, erectile dysfunction and depression - IPA would've charged around £125 more for the policy.

So, I find that the answer to the medical gateway question mattered to IPA.

Was the qualifying misrepresentation deliberate or reckless?

The actions IPA can take are different depending on whether the qualifying misrepresentation was deliberately or recklessly made, or if it was careless.

IPA says Mr L's qualifying misrepresentation was reckless; he had a conscious disregard for the truth or an indifference to whether the information was true or false. It says this shows a reckless attitude given his significant health issues. IPA says Mr L should've been prompted to fully disclose his conditions.

If the qualifying misrepresentation is deliberate or reckless, CIDRA says the insurer may avoid the contract and refuse all claims made on it. And the insurer doesn't need to return the premiums paid for the policy.

Further, section 5(2) of CIDRA says:

> A qualifying misrepresentation is deliberate or reckless if the consumer –
>
> - knew that it was untrue or misleading, or did not care whether or not it was untrue or misleading, and
> - knew that the matter to which the misrepresentation related was relevant to the

insurer, or did not care whether or not it was relevant to the insurer.

Section 5(3) of CIDRA says:

> A qualifying misrepresentation is careless if it is not deliberate or reckless.

And section 5(4) of CIDRA makes clear that:

> It is for the insurer to show that a qualifying misrepresentation was deliberate or reckless

As explained above, I'm satisfied Mr L would've been asked the follow up questions if he'd taken reasonable care to answer the medical gateway question. However, when considering whether Mr L made a misrepresentation (and whether that misrepresentation was deliberate, reckless or careless), I've focused on the medical gateway question. That's because Mr L didn't declare that he had any pre-existing medical conditions when applying for the policy when answering the medical gateway question. IPA has therefore said that the follow up questions would've been bypassed. I accept that.

As such, I'm satisfied Mr L wouldn't have seen the follow up questions and so, wouldn't have had an opportunity to answer them. So, I'm focusing on the medical gateway question.

I have considered all the available evidence including IPA's reasons for categorising the misrepresentation as reckless, the medical evidence provided and Mr L's submissions around why he answered 'no' to the medical gateway question.

On the balance of probabilities, I'm not persuaded that IPA has reasonably established that Mr L's qualifying misrepresentation was reckless (or deliberate). I'll explain why.

- I don't think it's fair and reasonable for IPA to conclude that when answering 'no' to the medical gateway question, Mr L knew that this answer was untrue or misleading or he didn't care whether or not it was untrue or misleading.

- Mr L says he stopped taking medication to manage his cholesterol levels many years ago as it made him feel unwell. He, instead, chose to manage this condition through diet and exercise. I think that's plausible and explains why no further medication was prescribed for this condition since the end of 2020. So, whilst he'd previously been diagnosed with high cholesterol and treated for it, I can understand why this condition wasn't at the forefront of his mind when applying for the policy and answering the medical gateway question. Particularly as there's nothing in his medical records which show that he was having regular reviews with his GP about his cholesterol in the time leading up to applying for the policy. Although careless, I'm not persuaded that this was reckless.
- Mr L says that he'd seen his GP about erectile dysfunction, but it never entered his head that the clinical state of his sex life would be relevant to purchasing a travel insurance policy and that he didn't purposely not declare it. I find his submissions on this point to be plausible. So, whilst it was a condition that he'd been prescribed medication for, I don't think IPA has fairly concluded that Mr L acted recklessly by not answering 'yes' to the medical gateway question for this condition. I'm satisfied that he acted carelessly.
- IPA has also relied on Mr L not declaring depression as being a reckless misrepresentation. However, I don't think it's fair and reasonable for it to do so. There's brief mention of depression in Mr L's GP records dated around four months before applying for the policy. But there's no information about what was discussed

> with his GP around the time or the reasons causing his depression. Mr L says that depression was noted as a one-off. He'd experienced an accident at work the year before the entry in his GP notes and then later began to feel 'exhausted'. He says his GP documented 'depression' as the reason to sign him off sick for a month before he returned to work. However, I've seen nothing to suggest that Mr L was prescribed medication for this or had been referred for onward specialist treatment. From what Mr L says this was an isolated episode. I accept that he says, and the medical records are consistent with that. So, in the circumstances of this case, I don't think the medical gateway question should've reasonably alerted Mr L to have answered 'yes' in respect of depression (although, for the reasons set out above, I do think it was fair for IPA to have included depression in the retro screening as it's a condition he would've reasonably expected to have disclosed in response to at least one of the follow up questions).
>
> Further, and in the alternative, even if Mr L's depression (as a standalone condition) should've reasonably alerted him to have answered the medical gateway question 'yes', I don't think IPA has established that he acted recklessly by failing to do so in the circumstances. Mr L says it didn't occur to him that this would be relevant. I'm conscious that the reference to him having depression is dated around four months before applying for the policy. So, it was a relatively recent episode. However, given the circumstances set out above, I can understand why it wasn't at the forefront of his mind when answering the medical gateway question.

I've looked at the actions IPA can take in line with CIDRA. It's entitled to do what it would've done if Mr L hadn't made a careless qualifying misrepresentation.

Because I'm satisfied Mr L would've been changed around £125 more for the policy, I'm satisfied that it would be fair and reasonable for IPA to proportionately settle the claim for costs associated with Mr L's medical emergency abroad. That's based on the proportion of the premium he paid for the policy compared with what he should've paid for the policy, around 55%.

Pre-existing medical condition exclusion

IPA has also relied on the policy exclusion, not covering any claim directly or indirectly resulting from a pre-existing medical condition (as defined by the policy terms) unless it had agreed to cover those conditions in writing - which it hadn't done here.

However, Mr L was asked the medical gateway question when applying for the policy. For reasons set out above, I've found that CIDRA is therefore relevant law and that Mr L made a qualifying misrepresentation which was careless. If he hadn't done so, the policy would've cost more, and I think it's fair and reasonable for IPA to settle the claim in proportion to the percentage of the policy premium he did pay.

Section 10(1) of CIDRA says:

> a term of a consumer insurance contract, or of any other contract, which would put the consumer in a worse position as respects the matters mentioned in subsection (2) than the consumer would be in by virtue of the provisions of this Act is to that extent of no effect.

Section 10(2) says:

> The matters are:

(a) disclosure and representations by the consumer to the insurer before the contract is entered into or varied, and

(b) any remedies for qualifying misrepresentations (see section 4(2)).

So, I don't think it's fair or reasonable in the circumstances of this case for IPA to default to the policy terms and rely on the policy exclusion relating to pre-existing medical conditions to decline Mr L's claim.

The impact on Mr L

As well as the financial impact on Mr L, I'm satisfied that he has been put to significant distress and inconvenience because of IPA's unfair decision to classify the qualifying misrepresentation he made as reckless, and therefore not cover his claim.

His medical costs were substantial – around half a million pounds. He says he came close to having to file for bankruptcy because of the vast amount he would owe. This, I accept, would've been extremely worrying at a time when he was situationally vulnerable, recovering from his illness. Whilst I accept that he is still personally responsible for a large sum of money, this is significantly less than the total sum of the claim.

He's also had the unnecessary stress of challenging IPA's decision during a difficult time. I'm satisfied that £1,000 fairly reflects the impact on Mr L.

Putting things right

I direct IPA to pay:

- 55% of the claim for costs associated with Mr L's medical emergency abroad. If Mr L has already paid any of these costs, IPA should also pay simple interest at a rate of 8% per year from the date Mr L made payments to the date IPA makes payment to him*.
- £1,000 compensation for distress and inconvenience to Mr L.

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

My final decision

I partially uphold Mr L's complaint and 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 Mr L to accept or reject my decision before 18 December 2025.

David Curtis-Johnson
Ombudsman