DRN-5839994

The complaint

Mr G is unhappy that Inter Partner Assistance SA (IPA) declined a claim made on his single trip 'standard' travel insurance policy ('the policy') after he required medical treatment whilst on holiday, abroad.

All reference to IPA includes its agents.

What happened

Earlier in September 2025, I issued my provisional decision explaining why I was intending to depart from our investigator's opinion. An extract of my provisional decision is set out below:

…….

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.

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) has to 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.

I know Mr G will be very disappointed and I can see that he's incurred a financial loss by IPA's decision not to cover the claim. I have a lot of empathy for the situation he's in.

However, I'm currently satisfied IPA has acted fairly and reasonably by declining the claim for the medical costs Mr G incurred whilst abroad. I'll explain why.

Did Mr G make a misrepresentation?

IPA has provided the medical question Mr G would've been asked when applying for the policy via a comparison website. That is:

> Do any of these travellers have a pre-existing medical condition?

I'll refer to this as 'the medical question'. He answered this 'no'.

Immediately under the question it says:

> We need to know about any health concerns you've spoken to your doctor about in the last 12 months, to make sure you have the right cover for your trip.
>
> Please also tell us about any serious illness you've had in the last five years, such as cancer or diabetes even if you've now recovered or are in remission.
>
> If you have a medical condition and you don't declare it, your insurer could void your entire policy, so you wouldn't be able to claim for anything.

It then says in box:

> This includes the following:
>
> Physical and mental health conditions, like:
>
> • Diabetes
> • High blood pressure
> • Asthma
> • Depression
> • And anxiety
>
> You should also include minor illnesses, like:
>
> • Headaches
> • Water infections
> • And flu

IPA says that Mr G should've declared hypertension/high blood pressure. Had he done so, it says he wouldn't have been offered the policy he ended up with. So, IPA has declined the claim and offered to cancel the policy and reimburse Mr G the premium paid for it.

I've looked at Mr G's medical records and I'm satisfied that he hadn't spoken to his doctor about his blood pressure/hypertension in the 12 months before applying for the policy.

However, there is reference in Mr G's medical records to him having high blood pressure between 12 months and five years before applying for the policy.

His medical records reflect that in May 2022 Mr G attended a review at his GP surgery for essential hypertension. His blood pressure was taken, and three readings were taken; the best of which is high. It's a score within the band of 'hypertension, stage one'. This is in addition to his blood pressure being recorded as high a few weeks earlier.

So, I'm satisfied that given high blood pressure was expressly named as one of the health conditions Mr G should disclose when applying for the policy, I'm satisfied IPA has fairly concluded that Mr G had made a misrepresentation. I know Mr G wasn't prescribed medication to help manage his high blood pressure but it's still a condition he had in the last five years.

Was this a 'qualifying' misrepresentation?

I've considered whether this amounted to a qualifying misrepresentation under CIDRA. And I think it did.

I'm satisfied that if the medical question had been answered correctly, Mr G wouldn't have been able to take out the policy he ended up with – as he wouldn't have been offered the 'standard' policy. Instead, he would've been offered policies which could've covered pre-existing medical conditions which his policy didn't.

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

I think Mr G acted carelessly when answering the two-year question (rather than deliberately giving the wrong answer or acting recklessly when answering it).

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 G hadn't made a careless qualifying misrepresentation.

Because I'm currently satisfied that the standard policy wouldn't have been offered to him, I think it's fair and reasonable for IPA to decline the claim and cancel the policy. The policy he ended up with wouldn't have been in place and so IPA doesn't have to cover any claims.

However, IPA should refund the premium paid for the policy to Mr G, which it's offered to do. I think that's fair and reasonable.

Claim handling

As well as its regulatory obligation to not unreasonably decline an insurance claim, IPA should also handle claims fairly and promptly. It accepts that it didn't do so in this case and offered £100 compensation to Mr G.

Mr G was waiting far longer than reasonable for the claim outcome, and I accept this would've been upsetting and frustrating for him. I'm satisfied £100 fairly reflects the impact on him.

……..

I invited both parties to provide any further information in response to my provisional decision.

IPA didn't reply.

Mr G disagreed with my provisional decision. In summary he said:

- He was treated for a bacterial infection whilst abroad in hospital (and so this wasn't connected to a pre-existing medical condition).
- He didn't attend a review at his GP surgery for essential hypertension in May 2022; he'd changed GP surgeries around that time and he attended a health check-up as required when joining a new GP surgery. Other than the readings taken, his blood pressure wasn't discussed.
- When taking out a subsequent multi-trip annual policy, he'd declared high blood pressure, and the policy didn't cost anymore.

- If he'd declared high blood pressure when taking out the policy which is subject to this complaint, he thinks he would've paid the same (or a very similar) premium for it.

- He doesn't know why IPA considered medical records going back five years from before applying for the policy.

Mr G also offered to pay the difference between what he paid for the policy and what the policy should've cost, so IPA could pay the claim. He said this is likely to be a few pounds at most and it's disproportionate for a claim in the region of £1,600 to be forfeited because of this.

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 information provided by Mr G in response to my provisional decision.

I know Mr G will be very disappointed, but I've seen nothing which convinces me to depart from my provisional findings.

For the reasons set out below and in my provisional decision (an extract of which is set out above and forms part of this final decision), I'm satisfied IPA has acted fairly and reasonably by relying on CIDRA to decline the claim. That's on the basis that the policy wouldn't have been offered had Mr G declared high pressure when applying for the policy.

- I'm satisfied IPA is entitled to rely on the medical records as being a true reflection of what was discussed. Particularly in the absence of the GP correcting any information and a reasonable explanation as to why what's recorded isn't accurate.

- Although the reason Mr G needed treatment abroad wasn't related to high blood pressure, I'm satisfied that the policy he ended up with wouldn't have been in place (for him to make a claim on) had he declared high pressure when applying for the policy.

- It's possible that Mr G would've ended up with a similarly branded travel insurance policy (also underwritten by IPA) had he declared high blood pressure. And there may not have been a big difference in cost. But I'm satisfied that Mr G wouldn't have ended up with the 'standard' policy. So, he wouldn't have entered the same insurance contract with IPA for the standard policy. I don't think it would be fair and reasonable for me to direct IPA to depart from the principles of CIDRA in the circumstances of this case and direct it to pay the claim (less any additional premium Mr G would've needed to pay for a different travel insurance policy had he declared high blood pressure).

- I don't think it's unreasonable for IPA to request Mr G's medical records going back to 2018 to see whether he'd accurately declared his medical history. When applying for the policy he was asked to tell IPA about any serious illness he'd had in the last five years.

Putting things right

I direct IPA to refund the premium Mr G paid for the policy (£9.22). And if it hasn't done so already, to pay Mr G £100 compensation for distress and inconvenience.

My final decision

I partially uphold Mr G's complaint but only to the extent set out above. 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 Mr G to accept or reject my decision before 23 October 2025.

David Curtis-Johnson
Ombudsman