DRN-5857116

The complaint

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

What happened

In August 2024, Mr and Mrs C took out a single trip travel insurance policy through a price comparison website to cover a forthcoming trip. The policy was underwritten by IPA. During the sales process, Mr and Mrs C declared a number of medical conditions they both had and IPA agreed to provide them with cover.

Unfortunately, while Mr and Mrs C were away, Mr C became unwell and was taken to hospital. Mrs C got in touch with IPA to make a claim for Mr C's medical expenses, which she paid directly to the hospital.

IPA assessed Mr C's claim, taking into account the medical report from the treating hospital and copies of Mr C's GP records. It concluded that in addition to the conditions Mr C had declared, he'd also been suffering from chronic kidney disease (CKD) and a renal cyst.

Ultimately, IPA carried out a retroactive screening to determine whether it would still have offered Mr C cover if it had also known about the CKD and renal cyst. And it said that if it had been aware of all Mr C's medical conditions, it wouldn't have offered Mr C cover. So it concluded that Mr C had made a qualifying misrepresentation under relevant law and it turned down the claim. It did acknowledge that there'd been unreasonable delays in its handling of the claim and so it paid Mr and Mrs C £250 compensation.

Mr and Mrs C were very unhappy with IPA's decision and they asked us to look into their complaint. In brief, they said they hadn't known that Mr C had CKD or a renal cyst. They also didn't think IPA had provided Mrs C with enough support when Mr C was taken to hospital.

Our investigator thought Mr and Mrs C's complaint should be upheld. He noted that IPA hadn't provided us with a copy of the questions Mr and Mrs C had been asked during the online sales process. And he wasn't satisfied there was evidence to show that Mr C had answered its questions incorrectly. So he didn't think there was enough evidence to show that Mr C had made a qualifying misrepresentation under relevant law and he recommended that IPA should reassess the claim. He was satisfied that the £250 compensation IPA had paid Mr and Mrs C was fair and reasonable to recognise its claims handling errors.

IPA provided further evidence in the form of the online sales process Mr and Mrs C would've followed. It also sent us a copy of the retroactive screening to show that it would never have offered Mr and Mrs C cover if it had known about all of Mr C's medical conditions.

The complaint was passed for an ombudsman's decision and it was allocated to me.

I emailed IPA to ask for further information. I noted that it hadn't sent us a copy of Mr C's GP records, so I couldn't assess what conditions Mr C had been diagnosed with, whether he had been given a formal diagnosis of CKD and if so, what treatment he'd received for it. I

also noted that the retroactive screening included an entry for renal failure with dialysis – but it hadn't provided any medical evidence to show that Mr C had this diagnosis or was undergoing dialysis. On that basis, I told IPA I wasn't satisfied it had shown Mr C had made a qualifying misrepresentation under the relevant law. I explained that if it wanted to provide further evidence in support of its position, it needed to do so by 29 October 2025. I explained too that given the evidence I'd seen, I was likely to conclude that Mr and Mrs C's complaint should be upheld and that the claim should be paid, in line with the policy terms and conditions, together with interest.

IPA didn't respond by the final deadline that I gave and therefore, I've gone on to make a decision based on the evidence I have.

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.

Having done so, I find that Mr and Mrs C's complaint should be upheld and that IPA must now pay the claim in line with the policy terms and conditions. I'll explain why.

First, I'd like to say how sorry I was to hear about Mr C's ill health. I don't doubt what a worrying and upsetting time this has been for Mr and Mrs C. I do hope Mr C has made a good recovery.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. So I've taken those rules into account, amongst relevant considerations – including relevant law and industry principles – to decide whether I think IPA has treated Mr and Mrs C 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.

When Mr and Mrs C applied for the policy online, they were asked a number of questions about themselves and their health. IPA used this information to decide whether or not to insure Mr and Mrs C and if so, on what terms. IPA says that Mr C didn't correctly answer all 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 and Mrs C's claim.

IPA thinks Mr C 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

how clear and specific the questions asked by the insurer were. Since the investigator issued his assessment, IPA has provided us with a copy of the sales process Mr and Mrs C followed. I've considered these carefully.

Mr and Mrs C were initially asked the following 'gateway' question:

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

The sales process set out IPA's definition of a pre-existing medical condition. It said:

'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.'

Mr and Mrs C answered 'yes' to IPA's gateway question and were asked further questions. They declared a number of medical conditions they both had. IPA says Mr and Mrs C were asked:

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

Have you or anyone in your party ever been diagnosed with or treated for any of the following:

- *Any heart or respiratory condition?*
- *Any circulatory condition (problems with blood flow, including strokes, high blood pressure and cholesterol)?*
- *Any liver condition?*
- *Any cancerous condition?'*

In my view, these questions were asked in a clear and understandable way and ought to have prompted a reasonable consumer to realise what information IPA wanted to know. And it's clear that in response to IPA's questions, Mr and Mrs C did declare a number of medical conditions, including heart disease and cancer.

IPA considers that Mr and Mrs C ought to have declared CKD and renal cyst. I can see from the retroactive screening it sent us that it also indicated that Mr C had a diagnosis of renal failure and that he was being treated with dialysis. There's no reference to renal cyst on that screening. And, despite a number of requests from this service, IPA has failed to provide us with a copy of Mr C's medical records which show both that he'd been given these diagnoses and what treatment he was receiving for them.

Mr and Mrs C say they were never told that Mr C had CKD and that their GP said his symptoms had been unchanged for many years. IPA hasn't provided any medical evidence which shows that Mr C had been given a diagnosis of CKD, that he'd received treatment for it or that he'd had a consultation about it in the two years before the policy was taken out. Nor is there any medical evidence that Mr C had a renal cyst. And I've seen no evidence at all which shows Mr C had a diagnosis of renal failure which was treated by dialysis. I'd add too that IPA has also included a diagnosis of renal failure with dialysis for Mrs C on the retroactive screening, too – when there's previously been no suggestion that she had this condition.

On that basis, I'm not persuaded that IPA has provided any medical evidence which shows,

on balance, that Mr C failed to take reasonable care to answer the medical questions it asked at the time of sale. It follows then that I don't think I could fairly find that Mr C made a misrepresentation when he took out the policy.

Even if I'm wrong on that point though, I'd add that even if I'd concluded Mr C had made a misrepresentation, it would be for IPA to demonstrate that the misrepresentation was a qualifying one. That means it would have offered cover on different terms – or not at all – if it had had all of the relevant information at the start.

In this case, as I've said, IPA ultimately provided us with a retroactive screening which shows that it wouldn't have offered any insurance quotes if Mr C had declared his full medical history. But that screening includes CKD and renal failure with dialysis for both Mr and Mrs C. As I've explained, IPA hasn't provided the medical evidence which shows that Mr and Mrs C had these conditions and that they therefore ought to have told IPA about them. So I don't think IPA's shown it's fair or reasonable to include these conditions in its retroactive screening.

Therefore, I'm not satisfied that IPA has shown that Mr C made a qualifying misrepresentation under CIDRA either.

It follows then that as I don't think IPA has shown either that Mr C made a misrepresentation when he applied for the policy or that any misrepresentation was a qualifying one, I don't find that it's fairly or reasonably entitled to rely on CIDRA to turn down Mr and Mrs C's claim.

This means I've decided that IPA must now settle Mr and Mrs C's claim, in line with the policy terms and conditions. It must add interest to the settlement at an annual rate of 8% simple, from one month after the claim was made until the date of settlement.

IPA acknowledges that it didn't handle Mr and Mrs C's claim as well as it should have done. There were clear delays in it progressing the claim and I don't doubt this caused Mr and Mrs C unnecessary additional trouble and upset. I've borne in mind what Mrs C said about the way IPA handled the claim at the outset, but IPA's notes indicate that it did take broadly reasonable steps to communicate with Mrs C. Instead, it seems there were difficulties with the line and with the phone connection. In the round, I'm satisfied that the £250 compensation IPA has already paid Mr and Mrs C is a fair, reasonable and proportionate award to reflect the impact of its claims handling mistakes on them.

Putting things right

I direct Inter Parter Assistance SA to:

- Settle Mr and Mrs C's claim in line with the remaining terms and conditions of the policy; and
- Add interest to the settlement at an annual rate of 8% simple from one month after the claim was made until the date of settlement.

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

My final decision

For the reasons I've given, my final decision is that I uphold this complaint 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 C and Mr C to accept or reject my decision before 28 November 2025.

Lisa Barham
Ombudsman