DRN-5877494

The complaint

Mrs G has complained that Inter Partner Assistance SA (IPA) declined a claim she made on a travel insurance policy.

What happened

Mrs G originally took the annual policy out in April 2023 and it auto-renewed in April 2024.

Mrs G was on a trip abroad in September 2024 when she unfortunately became ill and had to seek hospital treatment. She therefore made a claim for the medical costs incurred.

IPA declined the claim on the basis that Mrs G 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. Mrs G 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 April 2023, Mrs G 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 2024 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.

Mrs G didn’t make contact with IPA and so the policy auto-renewed on 27 April 2024. 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 Mrs G 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 PEMCs.

The period in question is the two years prior to renewal, so from April 2022. Mrs G’s medical records show that she’d been in regular contact with her GP surgery, including in the period immediately prior to renewal. There were also a number of medications that she had been prescribed during that period. Therefore, these were things that she should have declared by answering ‘Yes’ to the above question.

There’s no suggestion that Mrs G intended to mislead IPA. But she didn’t take enough care to ensure she answered the question correctly. 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.

Mrs G says the illness she suffered during the trip is completely unrelated to any of her PEMCs. However, the matter at hand is, what would IPA have done if she had correctly answered ‘Yes’ to the above question.

She says that CIDRA doesn’t give insurers carte blanche to reject any claim on the basis of non-disclosure of a PEMC. That is indeed the case. The remedies available to an insurer under CIDRA depend on what would have happened if the non-disclosure hadn’t happened. 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.

Mrs G says she made a ‘reasonable’ misrepresentation and that, as such, IPA must pay the claim. However, under CIDRA, there is only ‘careless’ or ‘deliberate and reckless’ misrepresentation. If it was careless, the insurer should return the premiums, whereas if it was deliberate and reckless, they can retain the premiums.

As already mentioned, IPA had concluded that Mrs G’s misrepresentation was careless. She says that, in such cases, CIDRA provides a proportionate remedy. However, a proportionate remedy would only come into play where it is shown that the insurer would still have offered the policy but would have charged a higher premium. That is not the case here.

Mrs G has done her own research by running through a dummy application. However, the outcome simply serves to show that she would not have been offered this policy if she had declared her medical history. Prior to declaring any medical conditions, the options she is given includes this policy type (a standard policy). After declaring medical conditions, the available options no longer include the standard policy. Instead, she is offered a range of ‘select’ policies, which are medical policies that do cover PEMCs.

Based on the underwriting evidence provided by IPA, I’m satisfied that it would not have offered her this policy but on different terms. I’m satisfied that it would not have offered the policy to Mrs G at all if she had declared her PEMCs.

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 a great deal of sympathy for Mrs G’s situation. She was taken ill on holiday and is out of pocket as a result. But 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 the complaint.

As an aside, Mrs G had made two separate claims (although relating to the same events in September 2024) and technically this complaint only relates to the first claim. However, as I’ve concluded that she wouldn’t have been eligible to purchase this policy if she had answered the medical questions correctly, it stands to reason that cover was also not in place for the second claim.

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 Mrs G to accept or reject my decision before 5 December 2025.

Carole Clark
Ombudsman