DRN-5890910

The complaint

Miss O has complained that Inter Partner Assistance SA (IPA) declined a claim she made on a travel insurance policy. She is also unhappy about delays in the claims process.

What happened

The single-trip policy was taken out on 5 May 2025.

Whilst abroad in June 2025, Miss O unfortunately became unwell and needed surgery. She therefore made a claim on the policy.

IPA declined the claim on the basis that she 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.

In response to the complaint, it maintained its position in declining the claim. However, it accepted that there had been some delay in the claims process, for which it offered £25 compensation.

Our investigator thought that IPA had acted reasonably in declining the claim, in line with the policy terms and conditions. She also thought that its offer of £25 compensation for delay was fair. Miss O 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 sales journey. I'm satisfied that if an applicant had declared a PEMC, they wouldn't have been offered this particular policy.

IPA thinks that Miss O failed to take reasonable care not to make a misrepresentation when taking out the policy. When considering whether someone has taken reasonable care, I need to consider how clear and specific the questions asked were.

Within the declaration section of the sales process, one of the questions asked was:

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

Miss O answered 'No' to this question.

Had she answered 'Yes' she would have been unable to complete the purchase of this policy. Instead, she would have been referred back to an earlier stage in the process whereby she could input the relevant medical information. She would then likely have been offered an alternative policy that did cover PEMCs.

Miss O's medical records show that she'd been prescribed two types of medication in November 2024 for two different conditions and that these were repeat prescriptions. Therefore, she should have answered 'Yes' to the question.

Miss O says she wasn't on any medication, undergoing treatment or awaiting investigations at the time of purchasing the policy. However, the question is not asking someone to use their own discretion to only disclose conditions that they consider to be relevant. It clearly asks an applicant to answer the question with reference to the last two years.

She says the question is misleading as it is too broad and doesn't distinguish between short-term and long-term medication. I'm afraid I don't agree that the question is open to interpretation. I'm satisfied it was clear that, rather than basing her answer on her current health status, she was required to declare any (meaning all) conditions and medications she'd had from May 2023.

Furthermore, upon buying the policy, IPA sent her a welcome letter, thanking her for her purchase. This letter stated:

'To ensure you have the right cover for your trip, it is important that all the questions asked during the application process were answered accurately, honestly and completely.
Please note that this policy will be suitable as long as you, or anyone insured 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

(…….)

if you are unsure whether the questions within the application process were correctly completed, please contact us as soon as possible. If the answers provided were not accurate, honest and complete, your insurer could cancel your policy, treat it as if it never existed, refuse a claim or not pay a claim in full.'

I consider this reinforces that the policy is only suitable for people without any recent medical history. However, if Miss O found the application question confusing, this explained her opportunity to double check with IPA.

I don't think Miss O 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.

Miss O says the illness she suffered during the trip is completely unrelated to any of her PEMCs. However, IPA isn't really disputing that and it's not a relevant consideration here. The matter at hand is, what would IPA have done if she had correctly answered 'Yes' to the above question.

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. Based on the evidence provided by IPA, I'm satisfied that it would not have offered the policy if Miss O had correctly 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.

With regard to the claims process, there was a delay in obtaining her medical records from the GP. Miss O had told IPA on 16 June 2025 that her GP surgery would only accept such requests by post and it said that it would action this. However, she found out on 24 June 2025 that the letter had still not been sent. She then forwarded the medical records by email on 27 June 2025.

IPA has apologised for the delay and offered £25 for the distress and inconvenience caused. There would still have been some delay even if IPA had written to the GP on 16 June 2025. The GP had said that it might take up to a week to respond. And Miss O had requested to see a copy of the records prior to them being released to IPA, which would have added extra time. On balance, I'm satisfied that the amount of £25 is reasonable and proportionate compensation for the error that occurred.

Miss O has talked about her experience of calling IPA from the hospital on 16 June 2025, but instead of providing help, the only advice she received was to go to a public hospital instead of remaining at a private facility.

Based on the evidence I've seen, I'm satisfied that IPA made it clear that it wouldn't be able to verify the claim until it had seen details of her past medical history, particularly because this type of policy did not cover any PEMCs. She was advised that she could use her GHIC card at a public hospital and therefore avoid the private hospital fees, so that she could make an informed choice about what to do.

I have a great deal of sympathy for Miss O's situation. She became unwell with a very painful condition whilst abroad, which must have been stressful and scary. But the question is whether IPA has done anything wrong, and I'm unable to conclude that it has. 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.

My final decision

For the reasons set out above, I do not uphold the complaint. However, Inter Partner Assistance SA should refund the premium and pay the £25 compensation now if it hasn't already done so.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss O to accept or reject my decision before 19 November 2025.

Carole Clark
Ombudsman