DRN-5898446

The complaint

Mr H and Miss K complain that Inter Partner Assistance SA ("IPA") declined Miss K's claim for medical expenses and voided their travel insurance policy.

What happened

Mr H and Miss K had an annual multi-trip travel insurance policy which was provided by IPA. The relevant policy period here was between 21 June 2024 and 20 June 2025, following a renewal on 18 June 2024.

Whilst on a trip abroad, Miss K unfortunately had to seek medical treatment. Mr H and Miss K made a claim to IPA for the costs on 8 July 2024. IPA requested Miss K's previous medical history to validate the claim. After reviewing this, IPA declined the claim on 4 December 2024. It said this was because Miss K had two previous medical conditions which weren't declared when Mr H and Miss K renewed the policy. IPA also thought an exclusion applied to the claim in any event.

Mr H and Miss K disputed this and made a complaint. IPA then clarified in its final response letter on 4 February 2025 that Miss K had one previous medical condition that should have been declared when the policy was renewed. Had Mr H and Miss K done so, IPA said it wouldn't have renewed the policy, as it wasn't suitable for anyone with pre-existing medical conditions. So, it voided the policy and refunded Mr H and Miss K the premium they paid. IPA also paid them £125 compensation for the distress and inconvenience caused by the service it gave.

Mr H and Miss K disagreed with IPA's position and brought a complaint to this Service. Mr H said that when he took out the policy, he didn't think Miss K's medical condition was relevant as she would never need to make a claim for it. Mr H and Miss K also didn't think IPA had fairly applied the policy terms, as Miss K's claim didn't relate to her previous medical condition. Mr H said that if the policy terms were clearer, he would have cancelled the policy within the cooling off period and taken alternative cover. Mr H and Miss K consider that IPA should pay them significantly higher compensation for all the distress and inconvenience caused.

One of our investigators reviewed the complaint. Having done so, she didn't think IPA had acted unfairly or unreasonably when it declined Miss K's claim and voided the policy, for the reasons it did. She also thought IPA had acted fairly when it refunded Mr H and Miss K the premium they paid and paid them £125 compensation for the distress and inconvenience caused.

Mr H and Miss K didn't agree with the investigator's findings. In short, they made the following key arguments:

- The treatment for Miss K's medical condition wasn't due to health reasons, rather, it was for her self-confidence.

- The policy terms for pre-existing medical conditions don't make it clear that the policy isn't suitable for anyone who's had any medical conditions in the previous two years. The wording states that only specific medical conditions won't be covered under the policy.

- Miss K's claim wasn't related to her previous medical condition. So, her claim isn't excluded by the terms for pre-existing medical conditions.

- The impact of IPA's actions has been significant on both Mr H and Miss K, and this should be taken into account in the amount of compensation.

As no agreement was reached, the complaint was passed to me to decide. I issued my provisional decision in October 2025. Here's what I said:

"Industry rules set out by the regulator (the Financial Conduct Authority) say insurers must handle claims promptly, fairly and shouldn't unreasonably reject a claim. I've taken these rules, and other industry guidance, into account when deciding what I think is fair and reasonable in the circumstances of this complaint.

Firstly, as IPA has said Mr H and Miss K should have declared a medical condition before they renewed the policy, the key considerations under this complaint are the principles set out in the Consumer Insurance (Disclosure and Representations) Act 2012 ("CIDRA"). This is designed to make sure that consumers and insurers get an appropriate remedy if a policyholder makes what is called a "qualifying misrepresentation" under the Act.

A misrepresentation is a "qualifying misrepresentation" when 1) a consumer fails to take reasonable care not to misrepresent facts which the insurer has asked about, and 2) the insurer shows that without the misrepresentation it would not have entered into the contract at all or would have done so only on different terms. If there is no qualifying misrepresentation, the insurer cannot take any action.

I've considered if Mr H and Miss K failed to take reasonable care. The standard of care required is that of a reasonable consumer. And one of the factors to be considered when deciding if a consumer has taken reasonable care is how clear and specific the questions asked by the insurer were.

IPA sent Mr H a renewal invitation email on 30 May 2024. In this email, under the heading "Important information", it says the following:

> *"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 cutting short of a trip)*
>
> *If either of these circumstances apply, please contact us. If we have not been made aware of the 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."*

Miss K was diagnosed with a medical condition on 29 June 2022, and she received treatment for this on 20 January 2023 (prescribed medication). So, I think it would have been reasonable for Mr H and Miss K to get in touch with IPA before the policy renewed. This is because the above email made it clear that the policy would only continue to provide cover if no one on the policy had received any medical treatment in the previous two years. And Miss K had.

Mr H and Miss K didn't get in touch with IPA at this point. So, I've considered what would have happened had they done so – what questions IPA would have asked, and how Mr H and Miss K should reasonably have answered those questions.

IPA has said that had Mr H and Miss K got in touch, it would first have asked them the following question:

> *"Within the last 2 years, has anyone to be insured received treatment, tests or investigations for any medical condition (including any prescriptions)?"*

Again, as Miss K had received treatment (prescribed medication) for a medical condition in the previous two years, I think it would have been reasonable for them to answer this question as "yes".

IPA has then shown several eligibility questions that it would have asked, with the relevant ones being as follows:

> *"Has anyone you wish to insure on this policy:*
> *[…]*
> *B: Been prescribed medication (including repeat prescriptions) for any medical condition within the last 2 years?*
> *C: Received treatment (including surgery, tests or investigations) for any medical condition within the last 2 years?"*

Again, I think Mr H and Miss K should have answered this question as "yes" for the same reason they should have answered the previous question as "yes".

So, as Mr H and Miss K didn't get in touch with IPA and answer the above questions it would have asked them as "yes", I think they failed to take reasonable care. This means that they made a misrepresentation.

IPA has explained that this type of policy isn't sold to anyone with any pre-existing medical conditions, and where the above questions are answered as "yes". I'm satisfied that's the case. This means that IPA has shown the misrepresentation was qualifying. And as IPA wouldn't have entered into the contract at all, it can void the policy and decline any claims made under CIDRA.

IPA hasn't considered the misrepresentation to have been reckless or deliberate, rather, it considered it to have been careless. This means that IPA needs to refund Mr H and Miss K the premium they paid, which it has done. So, I'm satisfied that IPA has acted fairly and reasonably, and in line with CIDRA.

I appreciate the policy terms for pre-existing medical conditions don't set out that the policy isn't suitable for anyone who has had medical treatment for any medical condition in the previous two years. But firstly, this term isn't relevant here – what's relevant are the questions IPA would have asked Mr H and Miss K, had they got in touch before renewing the policy. And in any event, I think the renewal invitation email does make this clear (as I've explained earlier in this decision), as does the "Demands and Needs Statement" on page 3 of the policy terms and conditions which says the following:

> *"Annual multi trip – This policy meets the Demands and Needs of a customer […] who has not suffered a medical condition nor required prescribed medication, surgery, treatment, tests or investigations within the two years leading up to the policy purchase date."*

So, I'm satisfied that IPA did give Mr H and Miss K enough information to decide if the policy was right for them.

It's clear that IPA took a long time to give Mr H and Miss K an answer on the claim. They originally made the claim already on 8 July 2024, but IPA didn't decline it until 4 December 2024. But I'm mindful that it also needed to review Miss K's previous medical history before it could do so. That said, I agree it should have reached an answer sooner. IPA also gave additional reasons for declining the claim at first, which weren't relevant in the circumstances.

Overall, I think the £125 compensation IPA has paid Mr H and Miss K for the distress and inconvenience caused is fair and reasonable in the circumstances. I don't think I could fairly hold IPA responsible for the worry Mr H and Miss K have had about the medical costs, and the resulting impact, as IPA was never responsible for these.

I'm sorry to disappoint Mr H and Miss K but I don't think there's anything else IPA needs to do, to put things right."

IPA accepted my provisional decision, but Mr H and Miss K didn't. They accept that they inadvertently made a misrepresentation by not declaring Miss K's treatment. But they made the following key points:

- They would not have entered into the contract, had the policy documents been clear.
- It's unfair to refuse this policy for anyone taking prescribed medications that can also be bought over the counter.
- It's unfair to punish Miss K, as she didn't obtain the medication for medical reasons, rather, it was to improve her self-confidence.
- Miss K's medical condition wasn't directly or indirectly related to the claim. So, this isn't caught by the policy conditions relating to health, and therefore the claim should be paid out.

As both parties have now had the opportunity to review and respond to my provisional findings, I'm issuing my final 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 appreciate Mr H and Miss K are disappointed with my findings. But I considered all the points they've raised when I reached my provisional decision.

The key here is that Mr H and Miss K should have got in touch with IPA before renewing the policy, because of the information in the renewal invitation email, and Miss K's circumstances. The policy conditions relating to health that they've quoted don't change this. And had Mr H and Miss K done so, for the reasons I set out in my provisional decision, I'm satisfied IPA wouldn't have renewed the policy.

Additionally, I'm satisfied the policy terms under "Demands and Needs Statement" make it clear that the policy is suitable for anyone who hasn't received medical treatment in the previous two years, and this is also set out in the renewal invitation email. Again, I don't think the policy conditions relating to health change this.

It's not in dispute that Miss K was diagnosed with a medical condition, to which she was prescribed medication. So, these are the circumstances I've considered, along with the questions IPA asked (and would have asked).

I'm sorry to disappoint Mr H and Miss K but I see no reason to depart from the findings I reached in my provisional decision. So, I've reached the same conclusions, for the same reasons. Overall, I'm satisfied IPA has acted fairly and reasonably in the circumstances of their complaint.

My final decision

My final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr H and Miss K to accept or reject my decision before 20 November 2025.

Renja Anderson
Ombudsman