

The complaint

Mr A and Ms I complain because Inter Partner Assistance SA ('IPA') paid only part of Mr A's travel insurance claim.

All references to IPA include the agents appointed to handle claims and complaints on its behalf.

What happened

Mr A and Ms I held a travel insurance policy, underwritten by IPA. There were no pre-existing medical conditions disclosed to IPA when the policy was taken out.

Unfortunately, while on holiday abroad, Mr A fell ill and contacted IPA before going to the hospital. IPA subsequently said it would only pay 77% of Mr A's medical bills because he hadn't told it about some pre-existing medical conditions when the policy was purchased.

Unhappy, Mr A complained to IPA before bringing the matter to the attention of our Service.

One of our Investigators looked into what had happened and said he didn't think Mr A needed to tell IPA about all the medical conditions it had listed. Ultimately, our Investigator concluded that IPA hadn't provided evidence to show what additional premium it would have charged Mr A if he had told IPA about some of his medical conditions, so he recommended that IPA should pay Mr A's claim in full.

IPA didn't agree with our Investigator's opinion, so the complaint was referred to me as the final stage in our process. I made my provisional decision about the complaint earlier this month. In it, I said:

'Industry rules set out by the regulator say an insurer must handle claims promptly and fairly and shouldn't unreasonably reject a claim. I've taken these rules, as well as other relevant considerations, into account when making this provisional decision.'

IPA has quoted policy wording relating to pre-existing medical conditions when partially settling this claim. But, as Mr A was asked to answer questions about his health when buying this policy, the relevant law is The Consumer Insurance (Disclosure and Representations) Act 2012 ('CIDRA'). I'm satisfied that it's fair and reasonable to apply the principles set out under CIDRA to the circumstances of this complaint.'

CIDRA requires consumers to take reasonable care not to make a misrepresentation when taking out an insurance policy. The standard of care required is that of a reasonable consumer. If a consumer fails to do this, the insurer has certain remedies available to it provided the misrepresentation is - what CIDRA describes as - a 'qualifying misrepresentation'. For a misrepresentation to be a qualifying one, the insurer must show it would have offered the policy on different terms, or not at all, if the consumer hadn't made the misrepresentation.'

The remedy available to the insurer under CIDRA depends on whether the qualifying

misrepresentation was deliberate or reckless, or careless and these remedies apply regardless of whether the medical condition being claimed for is linked to the medical conditions which were misrepresented.

CIDRA sets out a number of considerations for deciding whether a consumer failed to take reasonable care – including how clear and specific the insurer's questions were. IPA says Mr A failed to take reasonable care not to make a misrepresentation because he answered 'no' to the following question which he was asked when he bought the policy.

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

We need to know about any condition, even a minor one, that you've seen a doctor about in the past 2 years.'

I'm satisfied this question is clear and specific. If Mr A had answered 'yes' to this question, then he would have been directed to a further set of questions asking about various other aspects of his medical history.

I've reviewed the medical information which I've been provided with, including the letter from Mr A's GP dated 19 December 2024. I'm satisfied Mr A saw a qualified medical professional at his doctor's surgery about a number of medical conditions, and was prescribed medication for some of these issues, in the two years before this policy was purchased. These include a respiratory tract infection, tendonitis, otitis media and blepharitis.

It wasn't up to Mr A to decide what information IPA wanted to know about the risk it was agreeing to insure. There was a duty on Mr A to take reasonable care to accurately answer the question IPA asked, regardless of whether he considered the conditions to be common and/or minor. Our Service's website lists examples of certain pre-existing medical conditions, but this isn't intended to be an exhaustive list. We consider each case based on its own individual circumstances and the fact that the specific conditions which Mr A had medical consultations for aren't listed on our website doesn't mean that these can't also fairly be considered to be pre-existing medical conditions.

I'm satisfied a reasonable person would have realised from the question asked that IPA wanted to know about Mr A's medical history which I've mentioned. So, based on the overall circumstances of this case, I don't think Mr A took reasonable care when answering the question IPA asked him when he was buying the policy.

IPA has provided evidence to our service which I'm satisfied demonstrates it would have charged an additional premium of £39.60 if Mr A had told it about the medical conditions which I've listed above. This evidence is commercially sensitive so I can't share it with Mr A but I wish to assure him that I've carefully considered it to satisfy myself that it is accurate and that IPA would treat other policyholders in the same situation in the same way.

As I think IPA has demonstrated that Mr A made a 'qualifying misrepresentation' under CIDRA, it is entitled to apply the relevant remedy set out under the legislation. IPA has treated Mr A's misrepresentation as careless so it is entitled to settle the claim on a proportionate basis calculated with reference to the additional premium it would have charged for the policy. Based on IPA's retrospective screening, which now excludes some other medical conditions which were originally included in its initial calculations, it has offered to pay 79.17% of Mr A's claim (so, an additional 2.17% on top of what it already paid). I'm satisfied this is fair and reasonable in the circumstances and I don't intend to direct IPA to pay any more than this. It wouldn't be fair or reasonable in these circumstances to allow Mr A to simply now pay the additional premium to benefit from full cover for the claim – this isn't how CIDRA operates.

The fact that IPA was contacted before Mr A went to hospital doesn't mean it would be reasonable for it to fully cover this claim. IPA was entitled to make reasonable enquiries into Mr A's medical history before confirming cover. It's not common practice – or reasonable – to expect a travel insurer to do this before offering a policy. And, the fact that IPA didn't provide information to our Service as promptly as it should have doesn't mean it would be fair or reasonable to require it to disregard Mr A's qualifying misrepresentation and accept the entire claim regardless. Our rules require me to make an independent and impartial decision, and I can't fairly ignore evidence which IPA has ultimately provided.

I understand Mr A originally disputed the remaining amount of the bill which IPA said was due, but the hospital has now communicated this directly to Mr A. If Mr A is questioning the amount due, then this is something he'd need to raise with the hospital.

I've considered IPA's overall handling of Mr A's claim, including the time taken to consider it, but I don't think there were excessive or unreasonable delays in this case. I appreciate Mr A has spent time dealing with the matter and I'm sorry to disappoint him, but as I don't think IPA has done anything wrong overall, it wouldn't be fair or reasonable in the circumstances to require it to pay any compensation.'

IPA accepted my provisional decision, but Mr A didn't. In summary, Mr A said:

- he can't recall being asked about medical conditions that he'd seen a doctor about in the past two years when buying the policy, and this wasn't openly displayed on the broker's website or mentioned on the policy schedule;
- he has spoken to numerous people who agree they wouldn't have declared what is, in layman's terms, a cold, mild wrist pain, ear wax and dry eyes. Mr A says his failure to declare these was an honest mistake, these issues are unrelated to the matter claimed for and some of these appointments weren't with a doctor;
- an additional premium of £39.60 is a lot for IPA to charge for such low-level medical issues and Mr A feels he is being punished with a remedy of proportionate settlement of the claim rather than being allowed to pay the additional premium.

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 everything Mr A has said in response to my provisional decision.

I'm not bound by our Investigator's findings and, in line with my statutory remit, I've reviewed all the available evidence to make an independent and impartial decision which I think is fair and reasonable to both parties to the complaint.

This policy was sold by a broker via an insurance comparison website. The insurance comparison website (not the broker's website) is where the 'two-year' question which I've quoted above was displayed. I'm satisfied, based on the information I've seen, that Mr A was asked this question. The comparison website is a separate and independent financial business to IPA and is regulated in its own right. If Mr A thinks information on that website wasn't clearly displayed, then he'd need to complain to the comparator in the first instance.

The issue for me to determine in this case is whether I think Mr A made a qualifying misrepresentation before the insurance contract was entered into. The content of the policy schedule which was issued after the sale had already concluded doesn't change my decision about whether I think Mr A took reasonable care to answer the question he was

asked.

I've already set out in my provisional decision why I don't think Mr A did take reasonable care. I think Mr A was asked a clear question about pre-existing medical conditions which he'd seen a doctor about in the last two years. The fact that Mr A considered the conditions to be minor doesn't mean he didn't need to tell IPA about them, and the fact that Mr A didn't see a doctor about some of these illnesses doesn't change my decision either. Mr A saw qualified medical professionals at his doctor's surgery who provided him with medical advice, and I remain satisfied that a reasonable consumer would have realised IPA wanted to know about these issues in response to the question asked. If a policyholder is unsure of their medical history when buying a policy like this, then the onus is on them to check whether there is anything in their medical records which they should reasonably be telling the insurer about.

It's not for me to determine what is a reasonable additional cost for IPA to charge for covering medical conditions. That's for IPA to decide using its own commercial judgment, based on the level of risk it is willing to accept, as long as it is treating customers in the same situation in the same way. I'm satisfied, based on the evidence which IPA has provided, that the additional premium of £39.60 which it said it would have charged has been correctly calculated. IPA's remedy to pay a proportionate settlement of the claim applies even though the condition claimed for may not be linked to the conditions which have been misrepresented. I don't agree that the application of a proportionate settlement is disproportionate, or unfair or unreasonable in the circumstances. IPA didn't agree to accept the risk which was misrepresented, so it wouldn't be fair or reasonable to now require it to accept the claim in full in return for the retrospective payment of the additional premium.

I'm sorry that Mr A is unhappy and I accept Mr A didn't intentionally misrepresent his medical conditions to IPA but for these reasons, as well as those set out in my provisional findings, I won't be changing my decision.

My final decision

Inter Partner Assistance SA has offered to pay a total of 79.17% of Mr A's claim and I think this offer is fair in all the circumstances, so my final decision is that Inter Partner Assistance SA should pay this.

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

Leah Nagle
Ombudsman