

The complaint

Mr N is unhappy that Inter Partner Assistance SA has declined a claim he made on his travel insurance policy.

What happened

Mr N claimed on his travel insurance policy following an admission to hospital with chest pains. IPA declined the claim because they said Mr N hadn't accurately declared his medical history during the application process. They said, had he done so, he wouldn't have been offered this policy.

Mr N complained to IPA but they maintained their decision was fair. Unhappy, Mr N complained to the Financial Ombudsman Service.

Our investigator looked into what happened. He thought the claim had been fairly declined but thought that IPA should refund the premium and pay £100 compensation for delays in assessing the claim. IPA accepted the investigator's recommendation, but Mr N asked an ombudsman to review the 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.

The relevant law in this case is The Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA). This requires consumers to take reasonable care not to make a misrepresentation when taking out a consumer insurance contract (a policy). 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.

IPA says Mr N failed to take reasonable care when he took out the policy. During the online sales process Mr N was shown information which said the policy excluded cover for all pre-existing medical conditions. The sales process included a definition of pre-existing medical conditions which said:

Pre-existing medical condition means you:

- Have any condition which you have suffered from or received medical advice, treatment (including surgery, tests, investigations by your doctor/consultant

/specialist) or prescribed drugs or medication in the last five years:

- Any cancer condition,
- Any heart-related or blood circulatory condition (including high blood pressure and high cholesterol)
- Any diabetic condition
- Any neurological condition
- Any breathing condition,
- Any renal, kidney or liver condition
- Any psychiatric or psychological condition (including anxiety, stress and depression)
- Any other medical condition for which you have been prescribed medication or which you have received or are waiting to receive treatment including surgery, tests, or investigations) within the last 12 months.”

And below it stated the following:

“To be covered by this policy we assume:

- You do not have any medical conditions (as outlined above)”

Mr N was required to select ‘yes’ or ‘no’. IPA says Mr N should have answered ‘yes’ rather than ‘no’ to this question as he’d seen his GP due to anxiety. I agree as Mr N did consult his GP about anxiety within the relevant time period.

IPA has provided evidence that if he’d answered ‘yes’ to this question he wouldn’t have been offered this policy. Instead, he’d have been directed to policies which offered cover for pre-existing medical conditions. That means I’m satisfied that Mr N’s misrepresentation was a qualifying one.

IPA has classified Mr N’s misrepresentation as ‘careless’. I think that’s fair and reasonable as there’s no evidence that Mr N was trying to mislead IPA. I’m satisfied it’s more likely he didn’t appreciate the significance of declaring his medical history. As I think the misrepresentation was ‘careless’ I’ve looked at the actions IPA can take in line with CIDRA.

In cases of careless misrepresentation CIDRA says that if the policy wouldn’t have been offered IPA can decline the claim, cancel the policy and refund the premiums. IPA hadn’t initially refunded the premiums but they’ve now agreed to do so. I think that’s fair and reasonable and in line with CIDRA.

IPA accepts that there were delays in giving the claim decision. However, some of the delays were due to Mr N’s GP. I think a total of £100 compensation fairly reflects the impact on Mr N of the claim decision not being made as quickly as it could have been. I appreciate that Mr N received letters relating to the medical costs from the hospital. However, I don’t think that’s something IPA is responsible for in the circumstances of this case.

Putting things right

IPA needs to put things right by refunding the premiums and paying £100 compensation for the distress and inconvenience caused by the delay in delivering the decision about the claim.

My final decision

I’m partly upholding this complaint and direct Inter Partner Assistance SA to put things right

in the way I've outlined above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr N to accept or reject my decision before 12 January 2026.

Anna Wilshaw
Ombudsman