DRN-5976930

The complaint

Mr D is unhappy that Inter Partner Assistance SA ('IPA') declined a claim made on his annual, multi-trip, 'standard plus' travel insurance policy ('the policy').

The claim was for expenses connected to Mr D being unwell abroad and needing medical attention.

All reference to IPA includes its agents. And although Mr D is being represented in this complaint, for ease, I'll refer to him throughout.

What happened

The details of this complaint are well known to both parties, so I won't repeat them again here. I'll focus on giving the reasons for my 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.

That includes IPA's regulatory obligation to handle insurance claims fairly and promptly. And to not unreasonably decline a claim.

I've also taken into account The Consumer Insurance (Disclosure and Representations) Act 2012 ('CIDRA') as I'm satisfied that it's relevant law.

This requires consumers to take reasonable care not to make a misrepresentation when taking out a consumer insurance contract. The standard of care expected 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've offered the insurance 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.

I can see that Mr D feels very strongly that IPA hasn't acted fairly here. I know he'll be very disappointed, but for reasons set out below, I'm satisfied IPA has fairly and reasonably declined his claim.

Did Mr D make a misrepresentation?

IPA has provided an example of the renewal notice that would've been sent to Mr D a few weeks before the travel insurance policy originally taken out was due to annually renew

around September 2024. In the absence of anything to contrary I accept this is what Mr D would've been sent.

The renewal notice contains the following 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 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.

Mr D would've then been referred to the policy terms and the information product information document (IPID). Hyper-links were provided to click onto these documents.

I'm satisfied that it was clearly set out to Mr D that if he'd received any medical treatment (including prescribed medication, surgery, tests or investigations) within the last two years, IPA should be told.

CIDRA says a failure by the consumer to comply with the insurer's request to confirm or amend particulars previously given is capable of being a misrepresentation.

Mr D didn't contact IPA before the policy renewed to declare any medical conditions.

When concluding that Mr D made a misrepresentation when renewing the policy, IPA has relied on his medical records. This reflects that within the two years before the policy renewed, Mr D had medical treatment for more than one medical condition, including knee pain.

Based on the important information contained on the renewal notice, I'm satisfied that IPA has fairly concluded that Mr D reasonably ought to have contacted it to declare his medical conditions. And because he didn't do so, he'd made a misrepresentation at renewal.

When making this finding, I've taken into account that Mr D says he isn't computer literate. However, I've seen nothing which persuades me that IPA was made aware of this at the time of renewal or that Mr D contacted it for support around that time.

Was this a 'qualifying' misrepresentation?

I've considered whether this amounted to a qualifying misrepresentation under CIDRA. And I'm satisfied it did.

IPA says had Mr D declared the medical treatment he'd received in the last two years the policy he benefitted from wouldn't have renewed. That's because the standard plus policy isn't meant for those who have pre-existing health conditions.

I'm satisfied that's supported by the demands and needs statement which appears at page three of the standard plus policy booklet. This says:

> Annual multi trip - This policy meets the Demands and Needs of a customer intending to travel more than once within the period of insurance, wishing to buy a basic travel insurance policy with exclusions for pre-existing medical conditions.

Further, in my experience determining these types of complaints, IPA will only offer 'standard plus' travel insurance policies to those who don't have pre-existing medical conditions.

Did IPA act fairly and reasonably?

IPA has offered to refund the premium paid for the policy. So, I think it's fair to conclude that IPA decided that Mr D acted carelessly by not telling it he'd received medical treatment in the two years before the policy renewed in 2024 (as opposed to deliberately, or acting recklessly by, not doing so). I think that's fair and reasonable.

I've looked at the actions IPA can take in line with CIDRA. IPA is entitled to do what it would've done if a careless qualifying misrepresentation hadn't been made.

I'm satisfied that the standard plus policy wouldn't have ended up being renewed. I'm therefore persuaded it's fair and reasonable for IPA to not pay the claim. In line with CIDRA, I would reasonably expect IPA to cancel and refund the premium paid for the policy, which it's said it would do in its final response to Mr D (dated June 2025). I think that's fair and reasonable.

I have a lot of empathy for Mr D's situation, and the medical expenses he's personally responsible for. I also appreciate that the reason Mr D needed medical treatment abroad wasn't related to the medical treatment he'd had (and wasn't disclosed) before the policy renewed in 2024. However, if Mr D had contacted IPA to tell it about the medical treatment he'd had in the two years before the policy renewed, the standard plus policy wouldn't have been in place to cover the medical expenses subsequently incurred whilst abroad.

Claim handling

Mr D is also unhappy with the way the claim declination has been handled by IPA, resulting in him being chased for payment of medical expenses.

I'm satisfied that IPA was contacted when Mr D first needed medical attention and it opened a case file. However, I've seen nothing which convinces me that IPA provided a confirmation at that stage that the claim had been verified or a guarantee that costs would be paid.

I know being chased for payment would've been very worrying and distressing. However, I'm satisfied that IPA isn't ultimately responsible for the medical expenses incurred. And I'm satisfied that it promptly notified Mr D that this would be the case.

I'm satisfied that IPA was trying to proactively contact Mr D several times whilst abroad to discuss his claim and the medical records it had received from his GP. However, Mr D didn't contact IPA back. I don't think it was then unreasonable for IPA to notify the treating hospital that the claim wasn't covered. This then prompted Mr D to contact IPA on 7 January 2025 to find out what was going on. Mr D says the phoneline and the information provided to him wasn't clear.

However, having listened to the call, I'm satisfied Mr D was told - and he understood - that the claim had been declined, and the reasons for this. Mr D disputed that he'd failed to declare certain medical conditions when applying for the policy. But I don't think IPA acted unfairly by relying on the information it had been provided when he first applied for the policy – and its subsequent renewal by concluding that he hadn't declared any medical conditions.

IPA has provided a copy of the email it says was then sent to him to confirm his claim wasn't covered on the same date. Mr D says this wasn't received. However, on the balance of probabilities, I think it was sent by IPA. So, even if Mr D hadn't received this, as far as IPA was aware at the time, I'm satisfied that IPA was fair to assume that he'd been notified of the reason why the claim had been declined.

I also note that Mr D emailed IPA at the end of March 2025 to say that he was being chased for payment of medical expenses. However, I'm satisfied by that stage he'd been reasonably aware that IPA wasn't covering the claim. I think it's fair to assume that if he hadn't received IPA's email dated 7 January 2025 as he says, he would've most likely chased this up sooner, after the phone call also dated 7 January 2025.

My final decision

I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr D to accept or reject my decision before 19 January 2026.

David Curtis-Johnson
Ombudsman