

The complaint

Mr and Mrs S are unhappy with Inter Partner Assistance SA's handling of their claim.

Although both Mr and Mrs S are listed on the policy schedule, for simplicity, I'll refer to all submissions as being made by Mr S personally.

What happened

This complaint stems from a previous complaint Mr S brought to our service about IPA's decision to decline his travel insurance claim. IPA said it wouldn't pay their claim until it received further information related to Mr S's health and our investigator agreed that was fair in May 2025. The new complaint is borne from what's happened since then.

Mr S said he provided IPA with a medical certificate from his private GP which noted he was admitted to hospital between 9 – 12 June 2024. He said IPA then asked him to provide a medical certificate from his NHS GP, which his surgery refused to provide. Mr S said when he told IPA about that, it changed its position and wanted to see the past two-years' of his medical history.

Mr S said IPA was supposed to send him a medical release form to sign, so it could request this information directly from his surgery, and that this didn't happen in good time which has resulted in more unnecessary delays paying his claim.

IPA said it sent Mr S the medical release form on 2 August 2024 and again on 5 September 2025. It said Mr S didn't return the signed form and so it's not been able to review his claim any further. IPA said it needs this information because Mr S's hospital discharge notes say he was medically fit to undertake the trip and so it needed to review his medical history.

Our investigator didn't uphold this complaint. He said it's reasonable for IPA to request to see Mr S's medical history. He also noted Mr S had received the medical release form to sign, however, he noted it didn't specify the date range IPA wanted to see. He also noted Mr S queried that in September 2025 and that IPA reiterated it was for the two-years preceding the policy's inception, in October 2023.

Mr S, unhappy with this, asked for an ombudsman to review his complaint. In summary, he said our investigator's findings are biased in favour of IPA and that it's unfair to allow IPA to move the goalposts about the information it wants to see. Mr S highlighted IPA had previously said it had everything it needed to reach a decision on his claim and feels it's now changed its position. And so, it's now for me to reach a 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.

Having done so, I've also decided to not uphold it and for the same conclusions reached by our investigator. I know this'll come as a disappointment to Mr S, but I don't think IPA has

done anything wrong here or caused unnecessary delays. I'll explain why.

I may not respond to every point Mr S has raised, that's not to say I've not considered everything he's said – I have. The rules that govern this service enable me to focus on what I consider to be the crux of his complaint and to address the points I feel are relevant to that outcome. The relevant rule that applies in this case comes from the Insurance Conduct of Business Sourcebook (ICOBS) and is set by the Financial Conduct Authority.

ICOBS says IPA must handle Mr S's claim promptly and fairly and must not reject his claim unreasonably. I've considered IPA's obligations under ICOBS whilst assessing Mr S's complaint.

Mr S has argued our investigator's opinion on his complaint shows bias towards IPA. To be clear, I've reviewed those findings and I disagree with what he's said about that. I should say that whilst Mr S feels the insurer's position on his claim is unfair, I'm not persuaded it is. I accept IPA initially asked Mr S to produce a medical certificate from his GP and later asked for something different. But that was because Mr S was unable to gather the evidence from his GP. Mr S said his GP declined to issue a medical certificate and so, IPA said instead it would try to obtain his GP medical records on his behalf.

I'm persuaded this was intended to be a helpful workaround suggested by IPA so it could determine whether there's cover under the policy for Mr S's claim. IPA's current position is that it's been unable to confirm cover as it's been unable to validate the claim. It's also not unusual for insurers to ask to see this information to help it verify a claim.

IPA has provided evidence that shows it asked Mr S to complete the release of information form in June and September 2025, however, IPA didn't receive the signed form on both occasions. IPA needed Mr S's consent so it could approach the GP surgery and ask for the necessary information. Mr S said the form didn't specify the timeframe it wanted to see his medical records or address the name of the person at the GP surgery. But I didn't think that was reason enough not to sign and return it, given IPA had already explained this and that it was going to request the information on his behalf.

I also saw that Mr S discussed this with IPA in September 2025, upon receipt of the consent form, and it was explained the insurer would check two-years' worth of medical history from the date the policy was incepted. IPA said without this information, it's unable to review the claim. So, whilst there have been delays and no further action has been taken on Mr S's claim, I'm not persuaded they were unnecessary.

Mr S also said IPA contacted Mrs S about the claim when it wasn't supposed to. I saw it apologised for doing that, but I've not seen any evidence that persuaded me the insurer made a mistake there either. Both Mr and Mrs S are listed on the policy schedule and therefore both are policy holders. IPA was unaware it shouldn't contact Mrs S about this claim as both have an interest in its outcome and both were intending to travel. In any event, IPA amended its records so that Mr S is the primary contact – which is what I'd expect it to do, but only after it's made aware of their preference.

My final decision

For the reasons I've explained, I don't uphold this complaint.

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

Scott Slade
Ombudsman