DRN-5991604

The complaint

Miss H is unhappy that Inter Partner Assistance SA haven't fully settled a claim she made on her travel insurance policy.

What happened

Miss H became unwell whilst on holiday with gastroenteritis and was admitted to hospital. She claimed on her travel insurance policy. IPA proportionately settled the claim on the basis that Miss H hadn't accurately declared her medical history. They said, had she done so, they'd have charged a higher premium.

Miss H complained to IPA but they maintained their decision was fair. However, they offered £150 compensation as they said that they hadn't offered to proportionately settle the claim when they should have done. Miss H asked the Financial Ombudsman service to review IPA's decision.

Our investigator looked into what happened and didn't uphold the complaint. She explained that Miss H had the policy for a while and, when the policy renewed, she'd been asked to check her medical declaration was accurate. The investigator concluded that Miss H hadn't given IPA all the relevant information and, had she done so, they'd have charged a higher premium. So, she thought the decision to settle the claim was fair, and in line with the relevant legislation.

Miss H didn't agree and asked an ombudsman to review the complaint. In summary, she highlighted that when the policy was taken out, she'd had an in-depth conversation with the insurer and explained Miss H's health conditions in detail. She also highlighted that the reason for the claim was completely unconnected to Miss H's health conditions.

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'm really sorry to read of the circumstances of Miss H's claim, and the broader information about Miss H's health. She experienced a significant and traumatic health event in 2020 and I have a lot of empathy with the circumstances Miss H has described and the lasting impact this has had on her.

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 Miss H failed to take reasonable care to declare her medical history when the policy renewed. They said that she ought to have checked the information provided, and contacted them to declare other information about her history.

Whilst I have a lot of empathy with what Miss H has said, both about her health and about what happened when the policy was taken out, I don't think IPA's position is unreasonable. I'll explain why.

IPA wasn't the original insurer of the policy. So, it's not responsible for information or guidance given by the previous insurer. The policy renewed in 2024 and so that's the relevant information for me to consider.

At renewal Miss H was sent an email which said:

> Please note the following list of Medical Conditions which must now be declared on renewal (this does not change any of the other requirements in respect of the declaration of Medical Conditions).
>
> Any of the following medical conditions from 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)
>
> And/or
>
> - 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.

There was a link to check what conditions had been declared and the email went on to say:

> You must let us know or re-screen here if you or anyone on the policy has any Medical Condition(s) as outlined above that are not accurately represented by your currently Declared Medical Conditions listed above. Click here for full details of the Health Conditions of your policy. If you do not let us know of any changes, your cover may be cancelled and any claims you make may be reduced or refused.

So, I think it was made clear that Miss H needed to check the medical declaration and update it if it wasn't accurate.

Miss H had declared a number of health conditions. However, IPA said she ought to have declared volvulus, bowel infarct, ulcerative colitis, cyclic vomiting syndrome, fatty liver syndrome and factor VII deficiency.

It's accepted that Miss H didn't have ulcerative colitis but, ultimately, this didn't impact the premium charged. So, I don't need to make a finding about whether she needed to declare that condition or not. However, I do think she ought to have declared the other conditions.

Miss H did have low factor VII which was attributed to the significant health event she experienced. Factor VII is a protein made by the liver which affects blood clotting. Miss H was investigated by haematology in relation to this. She was also diagnosed with mild fatty liver during the investigations into the possible ulcerative colitis. Furthermore, Miss H had been admitted to hospital with symptoms of vomiting within 12 months of the policy being taken out. So, she was treated for this and could have disclosed the admission, even if she wasn't sure of the name of the condition. Miss H was also diagnosed with volvulus and bowel infarct and continued to be under regular review for these conditions within the relevant time frame set out in the questions. In the circumstances I think it was reasonable for IPA to conclude that included forms of treatment. I think it's reasonable for IPA to conclude that these issues ought to have been disclosed in relation to the questions asked.

IPA has provided evidence which shows that if Miss H had disclosed this information they'd have charged a higher premium for the policy. This means I'm satisfied Miss H's misrepresentation was a qualifying one.

IPA has said Miss H's misrepresentation was careless and I think that's fair and reasonable. I don't think Miss H intended to mislead IPA. I think it's more likely that she failed to disclose some of the further detail of her medical history, which I acknowledge was complex. As I agree that the misrepresentation should be treated as careless, I've looked at the actions IPA can take in accordance with CIDRA. In such circumstances they are entitled to settle the claim proportionately, reflecting the proportion of the premium paid. That's what IPA has done and I think that's fair and reasonable in the circumstances.

I fully appreciate that Miss H's admission whilst abroad was unrelated to the above conditions. I understand her partner also had similar symptoms which developed after they'd eaten a meal. However, if pre-existing conditions aren't declared (regardless of whether they aren't connected to the medical condition which has given rise to the claim) IPA is entitled to settle the claim in line with the appropriate remedy in CIDRA. That's what they've done in the circumstances of Miss H's case, and I think that's fair.

IPA acknowledged that the claim was initially declined in full rather than proportionately settled. They offered £150 compensation to acknowledge the distress and inconvenience caused. I think that's fair and reasonable in the circumstances. Unfortunately, the claim was never going to be settled in full due to the circumstances I've outlined above. However, IPA ought to have applied the correct remedy under CIDRA and communicated this to Miss H. I think this caused her some avoidable distress and inconvenience. However, I think £150 fairly reflects the impact of being given the incorrect information.

My final decision

Inter Partner Assistance SA has already made an offer to pay £150 to Miss H to settle the complaint and I think that's fair in all the circumstances.

My final decision is that Inter Partner Assistance SA should pay £150 to Miss H if it hasn't already done so.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss H to accept or reject my decision before 6 January 2026.

Anna Wilshaw
Ombudsman