DRN-5999822

Financial Ombudsman Service

The complaint

Mr P complains because Inter Partner Assistance SA ('IPA') hasn't paid a claim under his travel insurance policy.

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

What happened

Mr P holds a travel insurance policy, underwritten by IPA. The policy was first taken out in 2018 and renewed annually thereafter.

Mr P made a claim with IPA for medical expenses incurred abroad under the 2024 policy. IPA said the claim wasn't covered. At first, IPA said this was because of a policy exclusion relating to pre-existing medical conditions (including conditions which could reasonably be expected to result in a claim). When Mr P complained, IPA said the claim wasn't covered because Mr P had answered 'no' to a question asked about his medical history during the sales process. IPA offered to refund the premium paid for the policy to Mr P.

Unhappy, Mr P brought the matter to the attention of our Service.

Our Investigators looked into what had happened and said they didn't think IPA had acted unfairly or unreasonably by declining Mr P's claim. However, the second Investigator said she thought IPA should pay Mr P £75 compensation for the distress and inconvenience caused by giving incorrect reasons for the claim decline.

IPA agreed but Mr P didn't, so the complaint has now been referred to me to make a decision as the final stage in our process.

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 thought about all the detailed submissions which Mr P has sent to us, but I won't be commenting on every complaint point raised, and I'm not obliged to. This isn't intended as any discourtesy. Our Service is an informal alternative to the civil courts, and I'll only be addressing what I consider to be the key issues.

When making my final decision, I've taken into account relevant considerations such as the policy terms and conditions, the law, regulatory rules and what I consider to be good industry practice. My overall remit is to make a decision based on what I think is fair and reasonable in the individual circumstances of Mr P's specific complaint.

While I appreciate one of our Investigators sent Mr P guidance from our website about changes in a policyholder's health during the term of a contract, this isn't relevant to Mr P's complaint. Mr P's complaint is about representations made at the renewal of the policy – not about a mid-term change in circumstances which alters the pre-agreed risk. The fact that

IPA's policy documentation mentions changes in a policyholder's health doesn't mean the scenario which Mr P has referred to on our website applies to Mr P's situation. In any event, previous decisions made by or case studies set out by our Service don't set precedent and I'm not bound to follow them.

IPA originally relied on a policy exclusion relating to pre-existing medical conditions when turning down Mr P's claim. The policy exclusion didn't apply to Mr P's circumstances. IPA, in its final response letter, subsequently relied on a different reason for turning down the claim and this was also incorrect. None of this is in dispute. But this doesn't prevent IPA from subsequently raising other reasons for declining Mr P's claim. And, our Service has an inquisitorial remit to consider complaints as a whole, to reach an independent and impartial outcome which I think is fair and reasonable to both parties. So, I'm not limited to only considering the reasons which IPA initially gave for the claim decline either.

As Mr P was asked to confirm details about his health when this policy renewed, the relevant law is The Consumer Insurance (Disclosure and Representations) Act 2012 ('CIDRA'). I think 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.

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. Any questions which Mr P was asked about his health when this policy was first purchased in 2018 related only to the 2018 annual contract. Those questions aren't relevant to my consideration of whether a qualifying misrepresentation was made under the new annual contract which renewed from March 2024.

I'm satisfied, based on screenshots provided by IPA and information which Mr P submitted to our Service, that a renewal email was sent to and received by Mr P in February 2024.

While the renewal email said: *'if you're happy with your renewal quote and the details of your new policy, you don't need to do anything'*, this was subject to the information set out within the rest of the renewal email. The email went on to say:

> *'**Important 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*
>
>   *…*
>
> *If either of these circumstances apply, please contact us.'*

This was a request by IPA for Mr P to confirm particulars. Failure to confirm particulars is

capable of being a misrepresentation under CIDRA and I'm satisfied that this request was clear and specific. I'm also satisfied that the renewal email set out the importance of providing the information and the consequences of a failure to respond (i.e. that a claim might not be paid).

I've reviewed the medical information which I've been provided with. This shows Mr P was given prescription medication for an eye condition and for tonsilitis in the two years prior to the policy renewal in 2024.

I understand Mr P considered these to be minor, transient medical conditions but these were issues which IPA wanted to know about in response to the renewal information it sent, regardless of whether Mr P considered them to be serious. IPA is entitled to decide the level of risk it is willing to cover and isn't obliged to apply the same underwriting criteria as other insurers. The fact that IPA might offer cover for similar illnesses under different policies it provides doesn't make IPA's position unreasonable either. IPA has commercial discretion to decide what type of policies it is prepared to offer on the market, under what terms and at what cost. The Financial Ombudsman Service isn't a regulator and cannot tell IPA to change its sales practices. The suitability of this policy for other policyholders doesn't affect the outcome of Mr P's complaint.

There was a duty on Mr P to take reasonable care to confirm the details set out in the renewal notification. I'm satisfied a reasonable person would have realised from the information set out in the renewal notification that IPA wanted to know about Mr P's medical history which I've mentioned. So, based on the overall circumstances of this case, I don't think Mr P took reasonable care when the policy renewed in 2024. The fact that Mr P willingly provided his medical records doesn't change this. IPA is entitled to ask for medical records when considering a claim such as this one, and I'd expect a policyholder to cooperate which such reasonable requests.

I'm satisfied, if IPA had been made aware of Mr P's medical history, it would never have offered this insurance policy to him.

I understand Mr P says he completed a quote on the website where he first bought the policy, and travel insurance would have been sold to him anyway even if he'd declared the medical issues I mentioned. However, although a similarly branded insurance policy may have been offered to him, I'm satisfied this particular type of policy wouldn't have been. So, IPA wouldn't have offered this policy to Mr P at all, so the proportionate settlement remedy set out under CIDRA doesn't apply.

The fact that this policy automatically renewed again in 2025 also isn't evidence that this policy would still have been offered to Mr P. The medical information which Mr P provided to IPA was for the purposes of making a claim. I wouldn't expect IPA's claims department to contact the renewal department, tell them about Mr P's medical conditions and answer a medical declaration on his behalf. In fact, it's likely I'd consider it unreasonable for IPA to do that. If Mr P had contacted IPA in response to the policy renewal email to declare the relevant medical information, as he was required to do, then IPA wouldn't have renewed this policy.

This means I think IPA has demonstrated that Mr P made a 'qualifying misrepresentation' under CIDRA, So, it is entitled to apply the relevant remedy set out under the legislation, regardless of whether the condition claimed for was linked to the conditions which were misrepresented and/or regardless of the value of the claim. I'm satisfied that it's fair and reasonable for IPA to rely on the applicable legislative remedy set out under CIDRA, irrespective of the content of Mr P's policy terms and conditions.

IPA has treated the qualifying misrepresentation as a careless one. This means IPA is entitled to avoid the relevant contract and decline the claim but must refund the premium paid for the policy. IPA has already offered to do this, and I'm satisfied this is fair and reasonable in the circumstances.

For the avoidance of doubt, the premium refund relates to the 2024 policy year only, which is the year in which this qualifying misrepresentation took place. I haven't investigated or concluded there was a qualifying misrepresentation in any previous years, and IPA was carrying the risk in other years of a valid claim being made, so it wouldn't be fair or reasonable in the circumstances to require it to refund those premiums.

Mr P has made a number of comments about the suitability of this policy for him and whether it was mis-sold to him. This didn't form part of his original complaint, nor did any issues surrounding his eligibility for the 2025 policy. Under the rules that govern the operation of our Service, we have no power to consider a complaint unless the business involved has been given the opportunity to comment on the issues first. So, if Mr P is unhappy with any of these things, he'd need to complain directly to the relevant business in the first instance before we could investigate matters.

I accept IPA gave Mr P incorrect information about why the claim wasn't covered on a number of occasions. IPA could have given more accurate and clearer explanations to Mr P, and its failure to do so will have been confusing and stressful for Mr P. But this doesn't change the fact that I don't think Mr P's claim is covered anyway.

I've seen no evidence which would reasonably lead me to conclude that IPA deliberately falsified information or lied. And complaint handling isn't a regulated activity, so I can't take IPA's failure to accurately respond to Mr P's complaint into account when awarding compensation.

I have no power to seek to punish or fine a business through an award of compensation and, as I've already explained, I'm not bound by compensation awards made in previous cases. I'm considering only the circumstances of Mr P's individual case, and our published guidance on the payment of compensation for distress and inconvenience. Overall, I'm satisfied that an award of £75 compensation is fair and reasonable in the circumstances of this case.

I'm sorry to disappoint Mr P and I understand he feels strongly about what has happened, but I won't be directing IPA to do anything more than it has already offered to do.

Putting things right

Inter Partner Assistance SA needs to put things right by refunding Mr P the premiums he paid for the 2024 policy and paying £75 compensation for the distress and inconvenience he experienced.

Inter Partner Assistance SA must pay the compensation within 28 days of the date on which we tell it Mr P accepts my final decision. If it pays later than this it must also pay interest on the compensation from the deadline date for settlement to the date of payment at 8% a year simple[1].

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[1] If Inter Partner Assistance SA considers that it's required by HM Revenue & Customs to deduct income tax from that interest, it should tell Mr P how much it has taken off. It should also give Mr P a tax deduction certificate if he asks for one, so he can reclaim the tax from HM Revenue & Customs if appropriate.

My final decision

I'm upholding Mr P's complaint about Inter Partner Assistance SA in part, and I direct it 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 P to accept or reject my decision before 13 January 2026.

Leah Nagle
Ombudsman