DRN-6006179

The complaint

Mr and Mrs R complain because Inter Partner Assistance SA ('IPA') hasn't paid their travel insurance claim.

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

What happened

Mr and Mrs R were insured under a travel insurance policy, provided by IPA. The policy was taken out in 2022 and renewed annually thereafter.

Unfortunately, while on holiday abroad during the 2024 policy year, Mr R needed medical treatment and made a claim for the cost of this with IPA. IPA said the claim wasn't covered because Mr R hadn't told it about pre-existing medical conditions when the policy was issued. IPA offered to cancel the policy and refund the premiums.

Unhappy, Mr and Mrs R brought a complaint to the attention of our Service. One of our Investigators looked into what had happened and said he didn't think IPA had acted unfairly or unreasonably in the circumstances. Mr and Mrs R didn't agree with our Investigator's opinion, so the complaint was referred to me. I made my provisional decision in November 2025. In it, I said:

'IPA originally relied on a policy exclusion relating to pre-existing medical conditions when turning down Mr and Mrs R's claim. However, as I'm satisfied Mr and Mrs R were asked to confirm details about their 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. I've also taken into account relevant industry rules about the handling of insurance claims.

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 and Mrs R were asked about their health when this policy was first purchased in 2022 related only to the 2022 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 May 2024.

IPA has provided evidence by way of system screenshots which I'm satisfied confirm a renewal email was sent and delivered to Mr R's email address at approximately 5.52am on 16 April 2024. I can't share these screenshots with Mr R as they are commercially sensitive information, but I wish to assure him I've carefully considered them, and I'm persuaded by their accuracy. The renewal email said:

> *'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 …*

If either of these circumstances apply, please contact us…'

I'm satisfied this request to confirm information was clear and specific.

I've reviewed the medical information which I've been provided with. This shows Mr R was prescribed inhalers, antibiotics and nasal sprays in the two years prior to the renewal and Mr R's medical records also note a diagnosis of type two diabetes within that time frame too. Regardless of what medical condition(s) Mr R believed the medication was prescribed for and/or how long he had inhalers for and whether they were used, these were issues which IPA wanted to know about in response to the renewal information it sent. I understand Mr R disputes he has diabetes. I'm not a medical expert so it's not for me to seek to interpret test readings myself, but a diagnosis of type 2 diabetes is clearly set out in Mr R's medical records, and IPA was reasonably entitled to rely on this. If Mr R believes his medical records are incorrect then this is something he'd need to raise with his GP. However, even if I were to disregard the mention of diabetes entirely, I'd still be reaching the same provisional outcome based on other entries in Mr R's medical records in the two years prior to the policy renewal.

There was a duty on Mr R to take reasonable care to confirm the details set out in the renewal notification, regardless of whether Mr R considered his medical history to be significant. 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 R's medical history which I've mentioned. So, based on the overall circumstances of this case, I don't think Mr R took reasonable care when the policy renewed in 2024.

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

This means I think IPA has demonstrated that Mr R 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. The remedy which is most beneficial to Mr R, and which is how IPA appears to be treating the qualifying misrepresentation, is to consider it 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 the qualifying misrepresentation took place. I haven't investigated or concluded there was a qualifying misrepresentation in any other 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. I understand Mr R is unhappy because

IPA renewed the policy in 2025 (although, as I understand it, that policy has since been cancelled) but this didn't form part of his original complaint to IPA, so I have no power to comment on the matter here.

IPA was entitled to carry out reasonable investigations into the claim, and this included asking for Mr R's medical history. However, while I have no power to punish or fine a business for how it handled a claim, I think IPA could have done this more promptly and I understand Mr R requested call-backs which never took place. I appreciate Mr R wanted IPA to get in touch with him before reaching an outcome but, while this may have been better customer service, it was entitled to reach a decision based on the evidence presented to it.

I'm sorry to disappoint Mr and Mrs R but I don't currently intend to direct IPA to do anymore than it has already offered to do.'

IPA didn't respond to my provisional decision. Mr and Mrs R didn't agree with my provisional findings and, in summary, said:

- IPA can't evidence that a renewal email for the 2024/2025 policy year was sent:
- the medical records which have been considered don't take account of Mr R's health prior to the policy being taken out initially:
- Mr R's GP never told him that an exacerbation of asthma was being noted on his medical records, and he is currently on a waiting list for tests which confirm he doesn't have asthma:
- being provided with a prescription isn't the same as being given a diagnosis:
- Mr R's GP has told him the entry I referred to on his medical records doesn't mean he has diabetes:
- Mr and Mrs R also made comments about the suitability of the policy for other policyholders, and about the autorenewal.

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 everything Mr and Mrs R have said.

IPA has provided evidence to show a renewal notification email was sent and successfully delivered to Mr R's correct email address on the date and at the time set out above. This evidence is in the form of screenshots from IPA's computer system, so it is commercially sensitive information that I can't share. I'm satisfied, based on the information available to me, that the email was sent. So, IPA did what it needed to.

The policy which renewed in 2024 was an entirely separate annual contract to those that came before it. Previous policies aren't relevant in determining whether I think Mr R made a qualifying misrepresentation at the 2024 renewal. I'd expect IPA to limit its consideration of sensitive, personal medical information to solely the period of relevance, and that is the two years before this policy renewed.

Mr R wasn't asked about diagnosed medical conditions. He was asked about treatment received, which was specifically stated to include prescribed medication. IPA relied on the information set out in Mr R's GP records, and it was entitled to do this. I appreciate Mr R says his GP has told him he doesn't have diabetes. I wouldn't expect IPA to accept this verbal description of events as evidence that medical records are wrong, I'd expect to see a written statement from the GP confirming this. But, as I've already explained, I don't think this changes things anyway. Mr R was still prescribed medication which he didn't tell IPA

about.

The suitability of this policy for other policyholders doesn't affect the outcome of Mr and Mrs R's complaint. Under the rules that govern how our Service operates, I simply do not have the authority to comment on the autorenewal within this final decision, because this issue didn't form part of Mr and Mrs R's original complaint.

I'm afraid this means I won't be changing my provisional findings.

My final decision

My final decision is that I don't uphold Mr and Mrs R's complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr and Mrs R to accept or reject my decision before 8 January 2026.

Leah Nagle
Ombudsman