

The complaint

Mr C and Miss P are unhappy with Inter Partner Assistance SA's (IPA) decision to only pay part of their claim.

What happened

Mr C and Miss P planned to go on holiday between 26 August 2024 – 9 September 2024. Two days into their holiday, Mr C became unwell, suffering with stomach pain, nausea and vomiting. Mr C went to hospital on 28 August and underwent diagnostic tests and a surgical procedure. They claimed on their travel medical policy, however, their claim was only paid in part. Mr C and Miss P would like IPA to pay the full cost of their claim.

IPA said Mr C hadn't declared his previous medical history and that had it known the full extent of his pre-existing conditions, it would have charged a higher premium for the policy. It said Mr C and Miss P paid £44.33 for the policy, when it should have cost £130.97, meaning they'd only paid 34% of the actual cost of the policy. On that basis, IPA decided to settle the claim proportionately and only paid 34% of the medical costs incurred. IPA also said the policy excludes cover for any pre-existing medical conditions that aren't declared and accepted by it.

Our investigator upheld this complaint. He said IPA had relied on the Consumer Insurance Disclosure and Representations Act 2012 (CIDRA) to proportionately settle the claim. He said IPA couldn't fairly rely on this law in this case as Mr C and Miss P weren't asked any health screening questions at the point of sale, or by IPA. He also highlighted that IPA's exclusion for undeclared pre-existing medical conditions wasn't included in the insurance product information document (IPID) or displayed prominently within the policy terms. He said IPA should pay the claim in full because this significant exclusion wasn't made clear to Mr C and Miss P.

IPA, unhappy with this, asked that an ombudsman review this complaint. IPA didn't provide any further arguments in response to our investigator's opinion. 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 decided to uphold it and for the same reasons explained by our investigator. I agree this complaint doesn't fall within the scope of CIDRA as IPA didn't ask Mr C or Miss P any health-related screening questions. So, there wasn't the opportunity for a misrepresentation to take place. Therefore, I'm persuaded IPA's decision to settle the claim proportionately is unfair and it should pay the claim in full. I'll explain why.

The relevant rule in this case comes from the Insurance Conduct of Business Sourcebook (ICOBS) which says IPA must provide Mr C and Miss P with appropriate information about a policy in good time and in a way that's easy to understand. This should include an IPID

which gives a summary of the policy, including excluded risks.

I've also considered Consumer Duty here as I think it's relevant. Consumer Duty says IPA must give Mr C and Miss P the information they need, at the right time and in a way they can understand, enabling them to make properly informed decisions.

I've carefully reviewed the IPID sent to Mr C and Miss P and it doesn't say the policy won't cover undeclared pre-existing medical conditions. This is important because I'm persuaded it's a significant limitation to the policy and therefore, it should be noted in the IPID. And because it's not, Mr C and Miss P weren't reasonably aware of that limitation. I'm persuaded had they known the policy wouldn't have covered their pre-existing conditions, they would have likely opted to find cover elsewhere that was suitable for their needs.

IPA argued the policy terms make it clear there's no cover for undeclared medical conditions. But it also accepted it would have offered cover for Mr C for a higher price had it known the full extent of his medical history.

ICOBS says IPA must give appropriate information in a way that's easy to understand and the IPID should give a summary. And so, whilst it's listed within the body of the policy terms, it didn't make this clear in the IPID and so I'm persuaded Mr C and Miss P weren't given clear information in a way they were able to easily understand. It's for these reasons I think it's fair that IPA pay the claim in full.

Mr C was admitted to hospital with a related condition two days before the holiday began. IPA said this should have been shared with it as it's considered a change in health. I understand the point IPA is making here, but the policy terms aren't clear a consumer should tell the insurer about any health changes prior to travel. And so, I find IPA's argument unpersuasive in these particular circumstances.

It's for these reasons I've decided to uphold this complaint and that IPA should pay the claim. I've not seen any evidence to show that Mr C or Miss P have paid the hospital's costs and so IPA should contact the hospital directly to settle the remaining balance. Had Mr C or Miss P paid those costs out of their own pocket, I'd have awarded interest on the amount they'd paid. But because they didn't do that, I make no further award in this case.

My final decision

My final decision is that I uphold Mr C and Miss P's complaint. Inter Partner Assistance SA must now pay the remainder of their claim.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr C and Miss P to accept or reject my decision before 26 February 2026.

Scott Slade
Ombudsman