DRN-6056606

The complaint

Mrs B, Mr B and Miss B are unhappy that Inter Partner Assistance SA declined a claim they made on a travel insurance policy.

What happened

Mrs B, Mr B, Miss B are the adults named on an annual travel insurance policy together with another family member who, at the relevant time, was under 16. The policy was taken out in August 2023 and was renewed in 2024.

Mrs B and Miss B were due to go on holiday but unfortunately Mrs B's other child became unwell with a serious medical condition. They were therefore unable to travel as planned. This all occurred at around the time the policy renewed and, when she renewed the policy, Mrs B contacted the seller of the policy to explain she was going to need to claim for the holiday as she wasn't going to be able to go.

IPA declined the claim as they said this policy didn't cover any pre-existing medical conditions. Mrs B complained to IPA. In their final response letter, they acknowledged they hadn't been as clear as they could have been about why the claim was declined and explained it was because Mrs B hadn't accurately declared information about her child's health when taking out the policy. They said that had she done so, they wouldn't have offered this policy. However, they awarded £50 compensation for the distress and inconvenience caused and agreed to refund the premiums from the 2024 policy. Unhappy, Mrs B complained to the Financial Ombudsman Service.

Our investigator looked into what happened and partly upheld the complaint. She explained that the relevant policy information that needed to be considered was from 2023, not the 2024 renewal. This was because the holiday was booked within the 2023 policy year and the reason for cancellation arose prior to the renewal. IPA accepted this. However, they said they still wouldn't have offered the 2023 policy had they known all of the relevant medical information about Mrs B's child because this policy didn't offer cover for any pre-existing medical conditions.

Our investigator concluded that was reasonable, but she recommended IPA refund the premiums for the 2023 policy year as that was the remedy set out in the relevant legislation. IPA accepted the investigators recommendation, but Mrs B asked an ombudsman to review her complaint. In summary, she said that her child had recovered from the relevant condition and then became ill again very suddenly. She also said she hadn't been party to her daughter's medical records until the claim was made so she wasn't aware of how information had been recorded and had no concerns that she wouldn't be able to go on holiday. So, the complaint was referred to me to make a 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.

I'm very sorry to read of the circumstances which caused Mrs B and Miss B to claim. I have a lot of empathy with what Mrs B has said about the situation they were facing as a family. I can appreciate that it was a very worrying and upsetting time for them, especially given the nature of the medical condition and the severity of the illness.

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.

I'm satisfied, and IPA accepts, that the relevant information to consider is what happened when Mrs B first took out the policy in 2023. IPA says Mrs B failed to take reasonable care when she provided information about the medical history of those insured on the policy, which in this case relates to the younger child named on the policy.

I've looked at the information from the sales process, when Mrs B took out the policy online. One of the questions said:

> "Does anyone in your party have a pre-existing medical condition, or is anyone on a waiting list for treatment or investigation?"

Mrs B answered 'no' to this question. IPA says she ought to have answered 'yes'.

The question also had information which said:

> "Why is this important?
>
> You must tell us the medical history of all named travellers, to make sure pre-existing medical conditions are fully covered".

And:

> What is a 'pre-existing medical' condition?
>
> This is a medical condition or injury that you've been diagnosed with and have had or are currently receiving treatment for. Examples include, stroke, high blood pressure, anxiety and broken bones.

Having selected 'no' to the above question Mrs B was also asked:

> "Within the last 2 years has anyone you wish to insure on this policy suffered any medical condition, (medical or psychological disease, sickness, condition, illness or injury) that has required prescribed medication (including repeat prescriptions) or treatment including surgery, tests or investigations?"

Mrs B also answered 'no' to this question. Again, IPA says she ought to have answered

‘yes’.

I’ve carefully reviewed the medical information that’s available and I think that IPA has reasonably concluded the questions ought to have been answered ‘yes’. Mrs B’s younger child had visited their GP in relation to anxiety, low mood and another medical condition within the previous two years.

I’ve taken into account what Mrs B has said about not being party to all conversations with the GP and/or her daughters medical records. However, I can see that there were discussions between Mrs B and the GP about the child’s health and wellbeing during the relevant timeframe, including in the months before the policy was taken out. There were also third parties involved in the discussions. So, overall, I’m persuaded she had sufficient awareness and knowledge of the circumstances to answer ‘yes’ to the relevant questions.

IPA has provided evidence that if Mrs B had answered ‘yes’ to the questions she wouldn’t have been offered this policy. Instead, she’d have been directed to policies which offered cover for consumers with pre-existing medical conditions. This means I’m satisfied that the misrepresentation was a qualifying one.

IPA has said that Mrs B’s misrepresentation was ‘careless’ rather than deliberate or reckless. I agree as I don’t think Mrs B sought to mislead IPA. I think it’s more likely that she didn’t appreciate the significance of this information to IPA. As I’m satisfied Mrs B’s misrepresentation should be treated as ‘careless’ I’ve looked at the actions IPA can take in accordance with CIDRA.

In such circumstances IPA can decline the claim, avoid the policy and return the premiums. That’s what they’ve now agreed to do as they’ve said agreed to refund the 2023 premiums in addition to the 2024 premiums.

IPA acknowledged they could have made it clearer to Mrs B the reasons why the claim was being declined. I think a total of £50 compensation fairly reflects the impact of the distress and inconvenience caused by that lack of clarity.

I’m aware that Mrs B contacted another business prior to the 2024 policy renewing, saying that she was expecting to claim on the policy as she was unable to take her trip. However, IPA is a separate business and there’s no evidence they were made aware of that information before the policy renewed. And, in any event, the main reason for the trip being cancelled took place during the 2023 policy year. So, this hasn’t changed my thoughts about the overall outcome of this complaint.

Putting things right

IPA needs to put things right by refunding the policy premiums for the 2023 policy, plus 8% simple interest, from one month from the date of the claim until the date settlement is paid.

They also need to pay £50 compensation for the distress and inconvenience caused by not explaining the reasons for the claim being declined as clearly as they could have done (if they haven’t made the payment already).

My final decision

I’m partly upholding Mrs B, Mr B and Miss B’s complaint and direct Inter Partner Assistance SA to put things right in the way I’ve outlined above.

Under the rules of the Financial Ombudsman Service, I’m required to ask Mrs B, Miss B and

Mr B to accept or reject my decision before 3 February 2026.

Anna Wilshaw
Ombudsman