DRN-6107471

The complaint

Mr and Mrs B are unhappy with the way Inter Partner Assistance SA ('IPA') has handled a claim made on their single trip travel insurance policy ('the policy'). The claim was for out-of-pocket expenses connected to Mrs B needing emergency medical treatment abroad.

All reference to IPA includes its agents.

What happened

Earlier in January 2026, I issued a provisional decision explaining why I was intending to partially uphold this complaint. An extract of my provisional decision is set out below:

……

Just so everyone is clear, I've focused on what happened after the initial final response letter dated 22 July 2024. That's because Mr and Mrs B didn't bring a complaint to the Financial Ombudsman Service about the issues complained about and addressed in that final response letter within six months. From what I've seen, I'm satisfied that there aren't any exceptional circumstances for Mr and Mrs B not bringing those concerns to the Financial Ombudsman Service within the stipulated timeframe.

IPA has a regulatory obligation to handle insurance claims fairly and promptly. And it mustn't unreasonably decline a claim. I'm not currently persuaded that it has acted fairly and reasonably here. I'll explain why.

IPA declined Mrs B's claim in December 2024, following a review of her two-year medical history. Its internal contact notes suggest that this was because Mrs B didn't specify any medical conditions when applying for the policy.

So, I've taken into account The Consumer Insurance (Disclosure and Representations) Act 2012 ('CIDRA') as I'm satisfied that it's relevant law here.

This requires consumers to take reasonable care not to make a misrepresentation when taking out a consumer insurance contract. The standard of care expected 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 (in this case IPA) has to show it would have offered the insurance 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.

The decision to decline the claim

IPA has provided the online journey Mr and Mrs B would've followed when applying for the policy. In the absence of anything to contrary I accept this is accurate. IPA says Mr and Mrs B would've been asked:

> Does any person to be insured have a pre-existing medical condition?

IPA says that Mr and Mrs B answered 'yes' to this question. The online journey then shows that Mr and Mrs B would've then been asked other questions about their health. That includes:

> Have you, or anyone named on the policy, ever been diagnosed with or treated for any:
>
> Cancerous, respiratory, heart or circulatory conditions (including problems with blood flow, strokes, high blood pressure, and cholesterol)?
>
> Psychological conditions such as stress, anxiety, depression or psychiatric conditions such as eating disorders?

I'll refer to this as 'the have you ever question?'

And:

> Within the last 2 years, have you or anyone to be named on the policy:
>
> Been prescribed medication, received treatment or had a consultation with a doctor or hospital specialist for any medical condition?

I'll refer to this as 'the two-year question'.

IPA says Mr and Mrs B answered 'no' to these questions.

In the absence of anything to the contrary I accept that. Otherwise, I would reasonably expect Mr and Mrs B to have received a medical declaration certificate setting out the conditions they did declare.

IPA says that based on the two-year medical history it has received from Mrs B's GP, and in light of the two-year question, Mrs B should've declared that she'd experienced headaches, a head injury, essential tremor, and otitis externa. It's also concluded that the medical records it's received reflect that she's had low mood and anxiety. IPA concluded these two conditions should've also been disclosed.

Having considered the two-year medical history, I'm satisfied that IPA has fairly concluded that all of these conditions should've been disclosed in response to the questions asked. And that Mr and Mrs B failed to take reasonable care when applying for the policy.

I've considered whether this amounted to a qualifying misrepresentation under CIDRA. And I'm satisfied it did.

However, I'm satisfied that IPA would've still offered the policy to Mr and Mrs B if they had disclosed these conditions when applying for the policy. That's because IPA has undertaken a retrospective medical rescreening and has retrospectively fairly and accurately answered the follow up questions relating to each of those conditions.

This shows that the policy would've still been offered but at a higher price (£47.46 instead of

£37.96 paid by Mr and Mrs B). Based on the evidence I've seen, I accept this would've been the case.

So, based on the two-year medical history, I don't think it was fair and reasonable for IPA to decline the claim in December 2024 based on the non-disclosure of medical conditions.

I know IPA has now requested that Mrs B provide her five-year medical history to see if Mrs B failed to disclose any other conditions under the "have you ever" question.

In principle, I can understand why IPA would want this medical history as it could be relevant to the "have you ever" question. This could've prompted further medical conditions to be disclosed in addition to the two-year question.

However, IPA had been requesting the two-year history from Mr and Mrs B for some time and once received, it declined the claim. It then said it would reconsider the claim if Mrs B provided her five-year medical history. The medical evidence provided to date does also set out Mrs B's past medication history going back to 2008 and IPA hasn't identified any medication which could've been prescribed for any cancerous, respiratory, heart or circulatory issues based on those entries – which may have been relevant to the "have you ever" question.

Whilst I know the "have you ever" question isn't restricted to being prescribed medication for the conditions listed, given the overall claims journey, the errors made by IPA to date, and that it's almost two years since the incident date, I don't think it's fair and reasonable in the circumstances of this individual case for IPA to now be in a position to request further medical evidence going back five years from before the application. It had every opportunity to request the medical evidence going back that far from the outset of the claim and didn't do so, even though it would've been aware of the questions asked at the time of the application.

I'm satisfied by the evidence provided that Mr and Mrs B paid around 80% of the premium they would've been charged if Mrs B had declared the conditions IPA has identified as not being disclosed in response to the two-year question.

I'm satisfied that it's fair and reasonable to conclude that Mr and Mrs B acted carelessly by not declaring those conditions, given the entries in her medical records.

I've looked at the actions IPA can take in line with CIDRA. IPA is entitled to do what it would've done if a careless qualifying misrepresentation hadn't been made.

So, I'm satisfied that it should proportionately settle the claim in proportion to the premium Mr and Mrs B paid for the policy (around 80%).

The way the claim was handled

As set out above, I'm satisfied that IPA unfairly declined the claim in December 2024. I'm think this would've been confusing and upsetting for Mr and Mrs B. Particularly considering that after Mr B went to the trouble of challenging that decision, IPA introduced for the first time that it would now need Mrs B's five-year medical history rather than the two-year history it had previously requested, and had been provided.

Mr B had also been chasing IPA for updates given the delays and confusion around assessing the claim, which would've caused him further inconvenience and frustration. He didn't always receive prompt responses (if at all) and was asked to provide information already given. I'm satisfied that IPA should pay Mr and Mrs B £300 further compensation for the distress and inconvenience they've experienced because of these errors.

…….

I invited both parties to provide any information in response to my provisional decision. Neither party replied.

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 not been provided with any new information to consider. So, I'm satisfied that there's no compelling reason to depart from my provisional findings. For this reason, and for reasons set out in my provisional decision (an extract of which is set out above and forms part of this final decision), I partially uphold this complaint.

Putting things right

I direct IPA to:

A. proportionately settle the claim made in proportion to the premium Mr and Mrs B paid for the policy and what they should've paid for the policy (around 80%).

B. pay simple interest at a rate of 8% per year on the amount set out in A. above covering the period one month after IPA first received Mrs B's two-year medical history to the date of settlement. If IPA considers it's required by HM Revenue & Customs to take off income tax from any interest paid, it should tell Mr and Mrs B how much it's taken off. It should also give them a certificate showing this if they ask for one. That way Mr and Mrs B can reclaim the tax from HM Revenue & Customs, if appropriate.

C. pay Mr and Mrs B £300 compensation for distress and inconvenience.

My final decision

I partially uphold this complaint and direct Inter Partner Assistance SA to put things right as set out above. Under the rules of the Financial Ombudsman Service, I'm required to ask Mr and Mrs B to accept or reject my decision before 24 February 2026.

David Curtis-Johnson
Ombudsman