

The complaint

Mr M and Ms M complain that Inter Partner Assistance SA (IPA) hasn't settled a personal accident claim they made on a travel insurance policy.

As Mr M brought the complaint to us, for ease, I've referred mainly to him.

What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I think are the main events.

Mr M was abroad in mid-August 2025 when he unfortunately had an accident. He suffered a leg fracture and required surgery.

On 1 September 2025, Mr M made a personal accident claim on the policy. Following update requests from Mr M, IPA asked him for some information, including a medical report and invoices, so it could assess his claim. Mr M told IPA he didn't have any medical expenses to claim.

Subsequently, in mid-November 2025, IPA turned down Mr M's claim. That's because it didn't think the claim was covered by the policy terms, as Mr M hadn't suffered a bodily injury in line with the contract terms. It did accept that there'd been unreasonable delays in responding to the claim and so it paid Mr M £50 compensation.

Mr M was unhappy with IPA's decision and he asked us to look into his complaint. While the complaint was with us, he provided us with a schedule of his losses – including medical and travel costs. He felt IPA hadn't properly directed him to make a medical expenses and repatriation claim. And he didn't think £50 compensation was a reasonable award to reflect the impact of the matter on him.

Our investigator didn't think IPA needed to do anything more. He thought it had been fair for IPA to decide that Mr M's personal accident claim wasn't covered by the policy terms. And he felt it had already paid Mr M fair compensation for its claim delays. He told Mr M that he'd need to make a new medical expenses claim to IPA for any medical and repatriation expenses he'd incurred.

Mr M disagreed and so the complaint's been passed to me to decide.

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, whilst I'm sorry to disappoint Mr M, I don't think IPA has treated him unfairly and I'll explain why.

First, I was sorry to hear about Mr M's painful accident and the impact his injury has had on him. It's clear this has been a very worrying time for Mr M and his family. I'd also like to

reassure Mr M that while I've summarised the background to his complaint and his detailed submissions to us, I've carefully considered all he's said and sent us. In this decision though, I haven't commented on every point he's made and I'm not required to under our rules. Instead, I've focused on what I think are the key issues.

The relevant regulator's rules say that insurers must handle claims promptly and fairly; that they must provide reasonable guidance to help a policyholder make a claim and appropriate information on its progress; and that they mustn't turn down claims unreasonably. I've taken those rules into account, amongst other relevant considerations, such as regulatory principles, the policy terms and the available evidence, to decide whether I think IPA has handled Mr M's claim fairly

Medical expenses claim

I must make it clear that I won't be making any finding as to whether or not IPA should cover Mr M's emergency medical and other expenses. Since the complaint has been with us, Mr M has sent us a schedule of his losses, including medical and travel expenses he's incurred. I can understand why he'd like me to tell IPA to pay them. However, I can see that when Mr M first made a claim, his claim form stated he was claiming for personal accident. On 15 October 2025, IPA wrote to ask Mr M for information, such as a copy of his medical report and medical invoices. Subsequently, on 28 October 2025, Mr M emailed IPA to say:

'I suffered an injury while travelling, but I do not have any medical invoices or expenses, as I did not have to pay for treatment. However, I do have proof of the injury and medical records from the doctor.

Could you please confirm if I can still make a claim under the Personal Accident section, even though I do not have medical expense receipts?'

Based on Mr M's response, I don't think IPA could have reasonably known that Mr M had any medical emergency or repatriation expenses he wanted it to consider. Instead, I think it was fair for IPA to conclude that he wasn't making a medical emergency and repatriation claim and instead, to focus on assessing a personal accident claim. This means I don't think IPA failed to give Mr M reasonable guidance on how to make a claim or that unfairly failed to properly inform him what section of the policy applied to his claim. Nor would I have reasonably expected IPA to assess a medical emergency and repatriation claim when it didn't have the evidence it needed (such as invoices, transport costs, etc.) to do so.

It remains open to Mr M to make a medical emergency and repatriation claim to IPA and to provide it with evidence in support of his claim should he wish to do so. It will be for IPA to review any evidence in line with the policy terms and its regulatory obligations. If Mr M is unhappy with the outcome of any assessment of a medical emergency and repatriation claim, he may be able to make a new complaint to us about that issue alone.

The personal accident claim

I've carefully considered the policy terms and conditions, as these form the basis of the contract between Mr M and IPA. Section six of the policy explains personal accident cover. It says:

'Up to the amount shown in the Benefit table, if you suffer a bodily injury caused by an accident during a trip, which within 12 months directly results in your

- *Death; or*
- *Loss of sight; or*

- *Loss of limb; or*
- *Permanent total disablement.*

IPA defines an accident as: *'a physical injury caused by sudden, unexpected, external and visible means including injury as a result of unavoidable exposure to the elements.'*

And it defines 'bodily injury' as: *'an identifiable, physical injury caused by a sudden, violent, external, unexpected specific event. Injury as a result of your avoidable exposure to the elements shall be deemed to be a bodily injury.'*

Permanent total disablement is defined as: *'disablement which, having lasted for a period of at least 12 consecutive months from the date of occurrence will, in the opinion of an independent qualified specialist, prevent you from engaging in, or giving any attention to, any business or occupation for the remainder of your life.'*

The Insurance Product Information Document which sets out an at-a-glance summary of the main benefits of the policy and restrictions on cover says: *'Personal Accident – Up to £10,000 Cover for accidental bodily injury which within 12 months causes your death (up to the maximum age limit for your policy) or loss of limb, loss of sight or permanent total disablement.'*

In my view, IPA's policy documentation sets out in a clear, fair and not misleading way that personal accident benefit is only payable if both the accident and bodily injury definitions are met *and* the accident results in a policyholder's death, loss of sight or limb or total permanent disablement.

IPA reviewed the medical reports Mr M provided and it wasn't persuaded Mr M met the policy terms I've outlined above. Having also reviewed the evidence, I don't think this was an unreasonable conclusion for IPA to reach. That's because while it's clear Mr M's leg needed surgery, there's no medical evidence to suggest that the injury resulted in the loss of the limb. And as 12 months hadn't elapsed since Mr M's injury when IPA assessed the claim, I don't think it unfairly concluded that his claim didn't fall within the definition of permanent total disablement either.

Therefore, I don't find IPA acted unfairly or unreasonably when it decided that Mr M's personal accident claim wasn't covered by the policy terms.

Claims handling

IPA accepts that Mr M made his claim on 1 September 2025 but that it didn't let him know the claim had been declined until 12 November 2025. And it seems that Mr M needed to prompt IPA for updates in order for progress to be made on his claim. So I agree that IPA didn't handle Mr M's claim as promptly as it could have done.

In the round though, I think the £50 compensation IPA has already paid Mr M is fair, reasonable and proportionate to reflect the impact of this period of delay on him. I say that because ultimately, while the delay was frustrating and I understand Mr M was put to time in chasing IPA, ultimately, the claim wasn't payable. So Mr M wasn't left without access to money he was entitled to. And while Mr M has pointed to a level of compensation he believes should be due, I don't agree that the amount he's suggested is reasonable or appropriate in these circumstances. I'd also add that while I appreciate Mr M has concerns about IPA's approach to his claim, I'm satisfied the evidence shows that IPA assessed the evidence in line with the terms and conditions of the policy. I've seen no persuasive evidence that IPA singled Mr M out unfairly or that it treated him any differently to any of its other policyholders in the same situation.

Summary

While I sympathise with Mr M's position, I find that it wasn't unfair or unreasonable for IPA to turn down his personal accident claim. And I'm satisfied it's already paid him fair compensation. So I'm not telling IPA to do anything more.

My final decision

For the reasons I've given above, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr M and Ms M to accept or reject my decision before 19 May 2026.

Lisa Barham
Ombudsman