DRN-3253346

The complaint

Mr and Mrs D are unhappy with the way AXA PPP Healthcare Limited has handled their claim.

What happened

Mr and Mrs D had private medical insurance with AXA. They were initially covered by Mr D's corporate policy, however, Mr D cancelled this policy in June 2020. That policy ended on 20 June and a new personal policy was put in place to effectively continue to provide cover for both Mr and Mrs D.

Three days later, Mrs D saw her GP for a lump on her finger and was referred to a specialist privately. She made a claim on the policy, however, she gave the old policy number when she called to log it. The referral was authorised by AXA under the old policy and her consultation fee was £175.

Mr and Mrs D then received notification from AXA in September 2020 that it wasn't prepared to cover the cost of treatment because this was for a pre-existing medical condition that wasn't disclosed at the point of sale. Mr and Mrs D said this was unfair because AXA had previously agreed her treatment at an overall cost of £250.

AXA said it declined the claim because neither Mr D nor Mrs D told it about the lump on her finger when they called to arrange the new policy. It said that had it been made aware of this, then it would've increased the price of the policy to cover the condition. AXA said that Mrs D provided the old policy details, which was still showing as active on its systems when she called to claim, and that this was the reason authorisation was incorrectly given. AXA said it's for these reasons, it's not responsible for the error, and that it won't pay the claim.

Our investigator disagreed with AXA and said that it reasonably should have been aware that Mrs D gave out of date details when she made the claim. She explained that AXA had sold the new personal policy and that the adviser should have realised this. She said that because it didn't, AXA gave Mrs D incorrect information, which she acted upon and made the decision to have the treatment privately. She said had AXA given correct information then it's likely that Mrs D would have waited to be treated by the NHS.

Our investigator also highlighted several service-related issues throughout the claims period and said that AXA should pay £100 compensation for the overall distress and inconvenience. She also recommended AXA pay the consultation fee of £175 and the additional £75 treatment cost.

AXA didn't accept this. It maintained that Mrs D was also to blame for the mistake, but accepted it should have realised the information she gave was for the old policy, and so it offered £50 compensation. It also said that Mr and Mrs D were asked clear questions at inception about pre-existing medical conditions, particularly whether they intended to seek medical advice for any symptoms. AXA explained that Mrs D had the lump on her finger since March 2020 and that therefore this should have been disclosed when asked. AXA also said the policy excesses were different between the two policies, the old policy was £100

and the new was £250. It highlighted that the overall cost of this claim was £250 – the same as the policy excess and so therefore a claim wouldn't have been brought. AXA made clear that Mr and Mrs D were sent all the necessary policy documents outlining this and therefore doesn't think it needs to do anything more in respect of this complaint.

Mr and Mrs D rejected AXA's offer and so it's now for 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.

It's important to think about the information given at the time Mr and Mrs D made their claim. I accept that Mrs D gave the old policy number when she called AXA on 23 June to make her claim, but, like our investigator, I'm still not persuaded by AXA's arguments that this means there's an even level of responsibility that would negate AXA's responsibility. I say that because I think it reasonable to suggest that AXA ought to have known that Mrs D had given incorrect, or out or date information, especially as the new personal policy was active and the existing policy should have closed a few days prior.

I think AXA should have considered the information given more carefully and questioned Mrs D about the two policies it seemingly held active at that time. I think this is further supported because the old policy was due to end on 20 June, yet, according to AXA, it was still showing as active the day Mrs D called to make her claim. It's unclear why that happened but I don't think it helped matters here and likely added to the confusion.

Mrs D was given incorrect information about the policy excess being £100, as well as the claim being authorised, because of this error. This in turn meant that Mrs D made a decision to have the consultation and treatment, totalling £250, because it made sense financially.

AXA's argument, in summary, is that despite Mrs D giving the old policy number, it'd recently sent all the new policy details, which outlined the increased policy excess of £250, meaning that Mr and Mrs D should have reasonably realised the information AXA gave during the claims call was incorrect. But I'm less persuaded by this because I think it more reasonable to expect that Mrs D rely on the information given during the claims call would have been accurate. The same way I'd have expected AXA to establish the correct policy details when Mrs D called.

I'm also not persuaded by any of the arguments made by AXA in response to this for all the reasons given by our investigator. AXA had oversight of Mr and Mrs D's policy information and I think it should have probed more to establish which policy the claim should have been set up against. I also note some of AXA's commentary about this being Mr D's fault for not updating Mrs D about the new policy information but I think that argument is slightly offensive and inappropriate;

"Mr D was given the tools on 5 June 2020 to review his new policy and included within this email was the new membership number. He's admitted to not reviewing this key piece of information. Had he done so, he would have provided his wife with the correct membership number and contact telephone number in which to make a claim"

AXA's made several arguments about setting up the new policy and whether this was a non-disclosure claim, in other words, whether Mr and Mrs D told it everything about their previous medical history prior to setting up the new policy. But I'm not persuaded that it's central to the complaint being considered here. I think this complaint is about whether AXA gave correct information during the claims call, which I'm satisfied it didn't, and whether this had a

material impact on Mrs D's decision-making that followed, which I'm satisfied it has.

I think it's fair to say that had AXA given the correct information to Mrs D, it's likely she wouldn't have gone ahead with the private treatment because the cost was the same as the new policy excess. So, I'm satisfied by Mrs D's argument that she'd have waited to be treated by the NHS. This is further supported by Mrs D's testimony about her pain levels. She explained that although painful, it wasn't unbearable, or at a level that she lost functionality. She'd also had the lump for three months prior to seeking medical advice, which I think demonstrably shows a low-level pain. And so, I don't think it was a priority in terms of treatment and therefore I think, on balance, that Mrs D would have likely waited to be treated by the NHS in the circumstances.

Our investigator recommended that AXA effectively settle the claim under the existing policy terms because these were the terms explained to Mrs D during the claims call, and this is what prompted her to get treatment. And so, to retrospectively correct the mistake made by AXA, would be to Mrs D's detriment. I agree with the investigator's suggestion because I think it's fair. I've also not seen any exclusion on the existing policy that would persuade me that AXA could have declined this claim fairly. AXA authorised diagnostic treatment during the claims call and the consultation. This cost £175 and the actual treatment was £75 – taking the total to £250. AXA should pay this, less the £100 excess it told Mrs D about. I'm also satisfied that AXA had ample opportunity to consider this as it was recommended by our investigator and a rationale provided, however, AXA didn't agree with her findings.

I agree with the £100 compensation awarded by the investigator because I think the level of service AXA provided was poor. I say that because there were several issues throughout the claims period, which, although individually relatively small, when considered holistically, they're impactful enough to warrant a compensatory award. The cancellation of the corporate policy wasn't done in good time, the misinformation given in the claims calls, the unclear change of branding and the embarrassment caused by AXA declining to pay the specialist's invoice. I feel this is a fair resolution to this complaint.

My final decision

AXA PPP Healthcare Limited must now pay Mr and Mrs D's claim of £250, less the £100 excess. It must also pay the 8% simple interest on this amount and;

Pay Mr and Mrs D £100 compensation for the distress, inconvenience and embarrassment caused.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs D and Mr D to accept or reject my decision before 13 April 2022.

Scott Slade
Ombudsman