DRN-3307071

The complaint

Ms W complains AXA Insurance UK Plc unfairly declined her claim and avoided her policy.

What happened

Ms W took out an annual travel insurance policy with AXA in 2018 and renewed it in 2019. In November 2019, Ms W travelled abroad, and unfortunately became unwell and was treated in hospital.

Ms W made a claim for her medical expenses, which were around £30,000. However AXA declined the claim.

Ms W complained to AXA. In response it said Ms W had not declared medical investigations in November 2018, when renewing her policy in January 2019. And it said Ms W had set her policy to renew automatically, and that it had sent her an email advising that her medical history needed to be declared.

AXA said if Ms W had declared her medical conditions, it would have been unable to sell her the same policy. So it had been correct to avoid it and decline the claim. And it said the policy premium would be refunded.

Unhappy with AXA's response, Ms W brought her complaint to this service. An investigator here looked into what had happened, and said they didn't think AXA had acted unfairly. They thought Ms W had made a qualifying misrepresentation, and as such, AXA was entitled to decline the claim.

AXA made no further comments. However Ms W disagreed. She made a detailed submission. In summary she said she thought AXA may have applied the incorrect terms and conditions when assessing her claim, and the online screens and email AXA provided were also incorrect and not the ones in use or sent at the time. She said the condition she was treated for abroad wasn't connected to any pre-existing condition, and AXA had previously accepted this. And, she said she wasn't under investigation for any heart condition in when she took out her policy or when she renewed it.

Following Ms W's response, the investigator asked AXA for further details about the renewal email. AXA later provided a copy of an email which stated Ms W had opted out of the 'auto renewal process' and her policy would expire in February 2019.

As Ms W disagreed with the investigator's view, the case has been passed to me.

My provisional decision

I issued a provisional decision to both parties, saying I intended to uphold the complaint. In summary I said:

Misrepresentation

The relevant law in this case is The Consumer Insurance (Disclosure and Misrepresentation) 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 said AXA has the right to ask relevant questions before agreeing to provide a policy, so it can assess the risk posed. So I looked at what happened when Ms W renewed her policy in 2019.

AXA said Ms W failed to take reasonable care not to make a misrepresentation when she renewed her policy. It said her policy was set to renew automatically, and that she was sent an email advising her to make a medical declaration, and a website link for her to do so. However, AXA later said Ms W's original policy was not set to auto-renew. It provided a copy of an email it sent to Ms W, which stated she had opted out of the 'auto renewal process' and her policy would expire in February 2019. And this email didn't make any reference to medical declarations.

I thought about this, but I didn't think it automatically meant Ms W didn't need to provide any medical information. And I still needed to consider the renewal process Ms W went through, and any questions she was asked about her medical history.

AXA provided a copy of a screen it said Ms W would have seen, had she followed the link it provided in an email about auto-renewal. This screen gave a warning of the importance of declaring pre-existing medical conditions within the prior five years, and provided a process to complete a medical screening. However, I wasn't persuaded Ms W was presented with this screen, as at the top it stated the policy was set to renew in February 2019. And AXA had since confirmed Ms W's policy was never set to auto-renew. So, I wasn't satisfied that the screen AXA has provided was an accurate representation of one Ms W saw when she renewed her policy.

AXA hadn't provided any other evidence of any questions it asked Ms W when she renewed her policy in 2019, or of the answers she gave. And because of this, I didn't think it had sufficiently evidenced that Miss W made a misrepresentation. And so it

follows, I wasn't persuaded it was fair for AXA to avoid Miss W's policy and turn down her claim.

I said I'd also considered what happened when Ms W took out her first policy in early 2018, although this was prior to the medical investigations she underwent in November 2018. However, no evidence of the answers Ms W gave to any questions asked at that time had been provided by AXA.

Exclusion for pre-existing conditions

AXA referenced the terms and conditions, in relation to there being no cover for a list of pre-existing medical conditions requiring medical advice or treatment, within the prior five years to taking the policy out. And Ms W raised concerns over later changes in AXA's policy wording, and whether these later versions of policy wording had been applied to her claim by AXA. However I found the same exclusion to be present in the 2018 policy terms and conditions, which applied to Ms W's claim.

I said although Ms W's medical records showed she had been undergoing tests for a potential heart condition, I wasn't satisfied the exclusion applied. The exclusion stated there was no cover for claims arising '*directly or indirectly*' from the conditions listed, which included heart related conditions, in the past five years. And AXA had said it accepted the cause of Ms W's hospitalisation abroad was not linked to any pre-existing medical condition.

As I wasn't satisfied AXA has adequately evidenced Ms W made a misrepresentation, I said I intended to direct it to remove all reference to the avoidance of the policy from its records. And to re-assess her medical expenses claim, subject to the terms and conditions of the policy.

Ms W said she had been caused distress and inconvenience by AXA's actions. In particular because she has been chased by the overseas provider in relation to the medical bills, which she said she couldn't afford to pay. I accepted this must have been very upsetting for her, and had gone on for some considerable time. So I thought AXA should also pay Ms W £500 in respect of the distress and inconvenience caused.

The response to my provisional decision

Ms W responded to my provisional decision and made a number of points. In summary she said:

- she was not under investigation for a heart condition at the time her policy was purchased;
- she would like AXA to pay interest on the claim, should it be paid following the re-assessment;

- providing the re-assessment leads to the claim being paid, she would like a letter from AXA confirming that she has no financial responsibility for the medical bills, so she can use this as evidence if needed on her future travels; and
- she would like to deal with AXA directly in regard to the re-assessment, and not its agents.

I shared the further points Ms W raised, and my thinking on them, with AXA. It confirmed it had received this, but had nothing to add.

Ms W also provided further details about the expenses she had incurred as part of her claim, in relation to the re-assessment, and this has been passed on to AXA.

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 also considered again my provisional findings in light of the response.

Ms W has stated that she was not under investigation for a heart condition when her policy was purchased. So I've looked at this evidence again.

Ms W took out her original policy in February 2018 and it was renewed on 21 January 2019, to start in February 2019. Her medical records show she was referred to a cardiologist for some investigation following an episode of fainting and high heart rate in November 2018. She had attended hospital and underwent tests including an echocardiogram and was later referred for further tests. The consultant stated in a letter in December 2018, that he thought the symptoms were not related to any abnormal heartbeat.

I reviewed a further letter from the consultant dated 27 February 2019 relating to a consultation with Ms W on 8 January 2019. Within this letter the consultant confirmed a diagnosis of vasovagal syncope – a reaction of fainting in the presence of particular triggers. The consultant had listed measures Ms W could take to alleviate her symptoms including increasing water and salt intake, and there was no suggestion that any further investigation was to take place in regard to this or any heart condition.

Although the consultant's letter was dated 27 February 2019, the consultation took place on 8 January 2019. So I'm persuaded Ms W was no longer under investigation for a potential heart condition when her policy was renewed on 21 January 2019.

I'd noted AXA had accepted the cause for Ms W being hospitalised aboard was not linked to any pre-existing condition she had, so my opinion remains the same that I don't think the exclusion around pre-existing conditions could be fairly applied here. And for the reasons set out in my provisional decision, it's still my view that AXA should re-assess the claim, subject to the remaining terms and conditions of the policy.

Should the claim be paid following AXA's re-assessment, I think it would be fair and reasonable for Ms W to receive interest on the settlement (from the date the claim was originally declined, to the date of settlement), due to my finding that the claim was originally unfairly declined.

Ms W asked that AXA correspond with her directly during the re-assessment for the claim, and that if the claim is paid, provide a letter confirming she's not responsible for the debt relating to the medical bills. It's not my role to dictate AXA's policies and procedures, but I think it's reasonable to expect that the re-assessment of the claim be undertaken without unnecessary delay and that Ms W is kept updated regularly. And I think her request for a letter confirming the position, should the claim be paid, is not unreasonable. This is something Ms W and AXA should discuss directly.

My final decision

For the reasons I've given, I direct AXA Insurance PLC to remove the avoidance of the policy, re-assess the claim subject to the remaining terms and conditions of the policy, and pay Ms W £500 in respect of the distress and inconvenience caused. And should the re-assessment result in the claim being paid, AXA Insurance PLC must also pay Ms W interest at 8% simple from the date the claim was originally declined, to the date of settlement.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms W to accept or reject my decision before 11 March 2022.

Gemma Warner
Ombudsman