DRN-5175743

The complaint

Miss O has complained about the service she received from AXA PPP Healthcare Limited trading as AXA Health ('AXA') when she made a claim.

What happened

Miss O had a private medical insurance policy, underwritten by AXA.

She made a claim which AXA declined. Unhappy, Miss O complained as AXA hadn't explained why the claim was declined when it first contacted her. And she had to contact AXA to ask for a reason. At that point she was told she could provide further information from her GP.

AXA responded to the complaint and accepted that it should have provided an explanation and guidance about further medical evidence when it declined the claim.

Dissatisfied, Miss O referred her complaint to the Financial Ombudsman Service.

Our investigator looked into the complaint and found that AXA caused distress and inconvenience to Miss O for which he recommended £50 compensation. He also recommended that AXA calculate and refund the premium with 8% interest from the first time that Miss O asked to cancel the policy.

Miss O agreed with the investigator's recommendation but AXA didn't. In summary, it agreed to calculate and refund the premiums, with interest. But it didn't think compensation was warranted as it said the impact of its error was minimal on Miss O.

And so the case has been passed to me for a final 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.

Having done so, I agree that this complaint should be upheld. I'll explain why. AXA has agreed to calculate and refund the premium plus interest so I will focus on the compensation amount the investigator has recommended. AXA has referred to our compensation guidelines which can be found on our website. I think they are quite clear on when and how we award compensation. The starting point in every complaint is the impact on the specific individual in the circumstances and whether or not that error has caused any distress or inconvenience.

The relevant rules and industry guidelines say an insurer should handle claims promptly and fairly. And shouldn't unreasonably reject a claim.

Miss O's policy started in September 2023. She contacted AXA in early 2024 due to pelvic pain. AXA asked Miss O to have a medical information form completed by her GP. Miss O had spoken to a virtual GP and had explained when her symptoms had started.

Miss O provided the completed form to AXA which it acknowledged on 14 March 2024. Miss O chased AXA for a response on 27 March as AXA has said she should hear back within 7 days.

AXA said the claim wasn't covered but without any explanation.

Miss O contacted AXA via the online chat to ask why her claim wasn't covered. She was told that the start date of her symptoms were different when comparing the doctor's form and the online consultation. And it said Miss O could provide further information from her GP.

Miss O was unhappy that she hadn't been told when the claim was initially declined. And asked how she could cancel her policy.

AXA responded to the complaint and accepted that it could have told Miss O that it needed further information. And it cancelled the policy from September.

Having considered all of the above, I agree that AXA needs to do more. I would expect AXA to help Miss O understand the reason why her claim was declined and provide her with adequate support and guidance, for her to make a claim. AXA required further information from Miss O but didn't tell her what this was until Miss O contacted AXA and asked why her claim was declined. Miss O also asked how she could cancel her policy.

Overall, I think AXA' service fell below a reasonable standard and I don't agree that the impact to her was minimal or that the error made by AXA is something she can expect as part of everyday life as normal nuisances, such as phone lines being busy.

Miss O made a claim and was asked to complete a form. She was told she should receive a response within 7 days but didn't. AXA says it didn't guarantee that she would receive a response within 7 days. However, if a business provides a timescale of 7 days, but then can't meet that timescale, I would expect it to provide an update together with a new timeframe. Alternatively, AXA should manage expectations at the outset and explain that it may take longer than 7 days. I think this was poor service.

Miss O received a decision shortly after her chaser to say that her claim wasn't covered but with no clear explanation or further guidance. She then had to contact AXA again and ask why her claim was declined. At this point, she learnt that AXA needed further information from her GP as there was a discrepancy with dates.

Taking all of the above into account, I think there was a combination of factors which caused Miss O distress and inconvenience in having to chase for a decision and then being sent an unhelpful response and realising that she could provide further evidence. She wouldn't have known this had she not questioned the decision.

I don't agree that the impact on Miss O was minimal. I think the interactions were frustrating and caused inconvenience to Miss O although I agree the impact wasn't long lasting. And so I think £50 compensation is fair and reasonable in all the circumstances of this case to recognise the impact.

My final decision

For the reasons set out above, I uphold this complaint and direct by AXA PPP Healthcare Limited trading as AXA Health to:

- Pay Miss O £50 compensation
- Calculate a pro rata refund of premiums from the date of Miss O's initial cancellation

request

- Pay 8% simple interest on the refund from the date the policy should have been cancelled, to the date of payment.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss O to accept or reject my decision before 28 January 2025.

Shamaila Hussain
Ombudsman