DRN-5251953

The complaint

Mr R complains that AXA PPP Healthcare Limited has turned down a claim he made on a private medical insurance policy and that it's applied exclusions to the contract.

Mr R's represented by Mrs R.

What happened

Mr R had held a personal private medical insurance policy with AXA for a number of years and AXA had previously paid out claims for Mr R's private treatment.

In August 2023, Mrs R contacted AXA to look into options to bring down Mr R's renewal price. One option was to reduce the policy benefits. Mrs R went through medical screening with AXA on Mr R's behalf at that point and agreed to take out a new, cheaper underwritten policy. So Mr R's old policy was cancelled and a new policy was set-up.

Subsequently, in January 2024, Mr R needed to make a claim on the policy for a stent to be inserted into his right leg. At this point, AXA learned that following Mr R having an aortic aneurysm in 2016, and subsequently, a bypass in his right leg and a stent in his left leg, he'd been under regular review at a hospital for monitoring.

On that basis, AXA concluded that Mrs R hadn't answered its medical questions correctly when she took out the new policy on Mr R's behalf. It said that if it had known about Mr R's monitoring, it would have offered cover on different terms. It applied two exclusions to Mr R's policy – one for any investigations or treatment for aortic aneurysm and the second for any investigations or treatment related to ischaemic heart disease and related conditions. It also turned down Mr R's claim.

Mr R underwent the stent surgery privately at his own cost. And he made a complaint to AXA because he didn't agree that its screening questions had been answered incorrectly. He didn't agree that he'd had any treatment for either condition or that he'd seen a specialist in the 12 months before he took out the policy.

But AXA maintained its stance and so Mrs R asked us to look into Mr R's complaint.

Our investigator thought AXA had treated Mr R fairly. He thought it had asked Mrs R clear questions about Mr R's health which ought to have been answered correctly. And he was satisfied that if AXA's questions had been answered correctly, AXA would've applied the exclusions to the policy from the start. So he thought Mrs R had made a qualifying misrepresentation under relevant law. This meant he thought it was fair for AXA to have turned down Mr R's claim and applied exclusions to his policy.

Mrs R disagreed. In brief, she said she'd answered AXA's questions in the way she had because Mr R hadn't had any consultations, diagnostic tests, investigations or treatment planned or pending at the time. She said Mr R's condition was monitored – but that monitoring wasn't planned. She also said she'd declared Mr R's surgery in 2019 and she

hadn't thought AXA was asking about anything other than planned treatment in hospital. She added too that she thought AXA's questions were ambiguous.

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 very sorry to disappoint Mr R, I don't think AXA has treated him unfairly and I'll explain why.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. So I've considered, amongst other things, regulatory principles, the law; the terms of the insurance contract; and the available medical evidence, to decide whether I think AXA handled Mr R's claim fairly.

The relevant law in this case is The Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA). CIDRA requires consumers to take reasonable care not to make a misrepresentation when taking out a consumer insurance contract. 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.

When Mrs R applied to take out a new policy on Mr R's behalf by phone, she was asked information about Mr R and his medical history. AXA used this information to decide whether or not to offer Mr R a new policy and if so, on what terms. AXA says that Mrs R didn't correctly answer the questions she was asked about Mr R's health during the sales process and during a follow-up call. This means the principles set out in CIDRA are relevant. So I think it's fair and reasonable to apply these principles to the circumstances of Mr R's claim.

AXA thinks Mrs R failed to take reasonable care not to make a misrepresentation when she took out the policy on Mr R's behalf. So I've considered whether I think this was a fair conclusion for AXA to reach.

First, when considering whether a consumer has taken reasonable care, I need to consider how clear and specific the questions asked by the insurer were. I've listened carefully to the calls between Mrs R and AXA which took place on 4 August 2024, when Mrs R first looked into taking out a new policy for Mr R and the follow-up call which took place on 7 August 2024 – prior to the policy starting.
At the start of the call, AXA's call handler explained the importance of answering its medical questions correctly and the potential implications on cover if Mrs R failed to do so. During the first call, AXA explained that it would generally exclude things that had happened during the past year. Mrs R explained that Mr R had had an aneurysm in 2016 and that in the previous five years, he'd had a stent inserted in his left leg and a bypass in his right leg.

The call handler asked whether Mr R had had treatment in hospital or consulted a specialist in the last 12 months. Mrs R answered 'no'. She was then asked: '*Does he have any consultations, treatment, investigations or diagnostic tests planned or pending?'* Again, Mrs R answered 'no'.

AXA asked when the last time Mr R had claimed was and how many claims he'd had during the past five years. The call handler asked:

'In the last five years has he had or received any treatment for a heart condition or problem?' Mrs R answered 'no'. She said he had blood pressure and blood thinner medication, but that he didn't have a heart problem.

During the call on 7 August, the call handler asked again: '*Does he have any consultations, treatment, investigations or diagnostic tests planned or pending?'* Mrs R answered 'no'.

In my view, AXA's questions were clear and specific enough to have prompted Mrs R to provide it with the information it wanted to know about Mr R's health so it could decide whether or not to offer him a new policy. In particular, I think Mrs R was asked a clear question about whether or not Mr R had investigations or diagnostic tests planned or pending.

Next, I need to consider whether I think AXA has shown that Mrs R, on Mr R's behalf, didn't take reasonable care to answer its questions. I accept, both from Mr R's testimony and from the evidence provided by his doctor, that he wasn't receiving specialist treatment or seeing a specialist (within the meaning given to specialist by AXA) when he applied for the policy. I'm also mindful that Mrs R told AXA about Mr R's aneurysm, stent and bypass.

However, both Mr and Mrs R later told AXA that Mr R underwent regular scans at the hospital for routine check-ups of his stent and bypass. Mrs R referred to the check-ups being every three-six months. I note Mr R told AXA that his routine check-ups were not requested but were '*insisted upon'* by the hospital ever since his operation in 2016. He also referred to obligatory check-ups. And Mr R's specialist stated that Mr R had been under surveillance, having frequent scans to make sure his graft and stent were '*running nicely'* and '*to pick up any problem that can be treated and salvaged before reaching an unsalvageable situation'*.

So it seems to me that from 2016 onwards, it was fair for AXA to conclude that Mr R did undergo regular tests which were intended not only to monitor his condition but also to investigate or diagnose whether his condition had worsened. I consider it reasonable to say that these were broadly ongoing investigations into Mr R's condition – given the specialist said these were to pick-up any problems. And I also think it was reasonable for AXA to have concluded that these scans were planned or pending, given they happened routinely. Therefore, I think Mrs R ought to have answered 'yes' to this question.

During a later call with AXA, Mr R told it that his artery was narrowing which was why he needed surgery. And AXA asked Mrs R whether the monitoring was for the aneurysm or for his coronary artery. Mrs R replied that he was being monitored for everything. Based on that evidence, I don't think it was unreasonable for AXA to have concluded that Mrs R ought to have answered 'yes' to its question as to whether Mr R had received treatment for a heart problem or condition.

Taking the above into account, I don't think it was unfair for AXA to have concluded that Mrs R did make a misrepresentation under CIDRA.

Next, in order for AXA to rely on the legal remedy available to it under CIDRA, it needs to

show, on balance, that Mrs R made a 'qualifying' misrepresentation on Mr R's behalf. In other words, that it would have offered cover on different terms - or not at all - if it had been aware of all the facts.

AXA has provided us with commercially sensitive, confidential underwriting information which shows that if it had been aware of the routine monitoring Mr R underwent, it would have offered cover, but applied the following exclusions to his policy:

'No benefit is payable for any investigations and treatment related to Aortic Aneurysm and conditions arising therefrom or associated therewith.

No benefit is payable for any investigations and treatment related to ischaemic heart disease and associated conditions. By this we mean heart attack, angina, heart failure and cardiac arrhythmias.'

This means then that I think AXA has shown that Mrs R did make a qualifying misrepresentation under CIDRA and that it's therefore entitled to rely on the remedy available to it under the Act.

It seems to be that AXA has classified the misrepresentation as careless. I think that was a reasonable response from AXA. That's because I don't think Mrs R or Mr R intended to mislead AXA. But I don't think Mrs R took enough care to ensure she gave it accurate information.

CIDRA says that in cases of careless misrepresentation, an insurer is entitled to rewrite the policy as if it had all of the information it wanted to know from the start. As I've said, in this case, AXA has shown that it would have offered Mr R a new policy, but it would have applied the exclusions I've outlined above from the outset. So I think AXA has acted in line with CIDRA.

As AXA would never have offered cover for Mr R's aortic aneurysm or ischaemic heart disease, it follows that it would never have agreed to pay for Mr R's stent surgery in 2024. So therefore, I don't think it was unfair for AXA to rely on those exclusions to turn down the claim.

Mr and Mrs R raised concerns about the sale of the new policy. But having considered everything, I don't think AXA made any errors when it sold Mrs R the new contract. I say that because it asked Mrs R clear questions, it reduced the price of medical cover as Mrs R had requested and it seems it went on to send the relevant policy documentation. So I think it met its regulatory obligations.

Overall, I sympathise with Mr R's position and I'm sorry to disappoint him. But I don't think AXA has treated him unfairly or unreasonably. And I'm therefore not directing it 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 R to accept or reject my decision before 1 May 2025.

Lisa Barham
Ombudsman