DRN-5497938

The complaint

Mr H has complained that AXA PPP Healthcare Limited (trading as AXA Healthcare) withdrew cover for an ongoing claim made on a private medical insurance policy.

What happened

The policy started in April 2021. In October 2021 Mr H obtained a GP referral to see a therapist and he received pre-approval for this from AXA on 19 October 2021.

He carried on receiving treatment until 29 July 2024 at which point he received confirmation that AXA wouldn't pay for any further sessions as it had it continued to pay for the treatment in error. It hadn't paid any invoices from February 2024 onwards.

In response to the complaint, AXA said in its final response letter (FRL) of 16 September 2024 that it couldn't settle the outstanding invoices until it received a medical information form (MIF) from Mr H's GP. However, it sent him a cheque for £100 as an apology for the errors that occurred when setting up the claim in 2021. I understand that Mr H didn't cash the cheque.

Our investigator didn't think AXA had acted fairly. She recommended that it should settle the outstanding invoices plus an invoice for a further psychiatric assessment that it had required him to undergo. She also recommended that it should pay an extra £150 compensation in addition to the £100 already offered.

Following this, AXA said that, if the completed MIF confirms the claim is eligible from an underwriting point of view, it will settle the claim for therapy sessions up to and including the one on 29 July 2024 plus the invoice from the psychiatrist for the assessment on 6 August 2024, subject to the remaining terms and conditions of the policy. However, it would not pay for any further treatment due to the exclusion for chronic conditions in the policy. If the MIF confirms that Mr H's condition was pre-existing, then it would still settle the invoices but would do so on an ex-gratia basis and no further treatment would be covered. It also agreed to pay the extra £150 compensation (so, £250 in total) for the negative impact that service issues had on Mr H.

Our investigator's response was that, as the costs were going to be covered in any event, Mr H shouldn't have to return the MIF and that the settlement should be made on a ex-gratia basis. Itt was, however, made clear to Mr H that any future claims would be subject to him supplying a MIF.

The parties have reached an impasse – AXA says that the provision of the MIF is non-negotiable, whereas Mr H is refusing to provide it. Therefore, the complaint has come to me for a 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.

I've carefully considered the obligations placed on AXA by the Financial Conduct Authority (FCA). Its 'Insurance: Conduct of Business Sourcebook' (ICOBS) includes the requirement for AXA to handle claims promptly and fairly, and to not unreasonably decline a claim.

AXA made a number of mistakes during the claims process. It should have asked for the MIF at the start of the process to see if the condition was pre-existing. If that was the case, as there is a moratorium clause on the policy, it wouldn't cover claims for conditions that were present in the five years before Mr H joined. So, potentially, the claim could have been declined at that point. AXA also should not have continued to pay invoices beyond the initial ten sessions when it hadn't authorised ongoing treatment.

There was also miscommunication in that Mr H was told in a phone call on 29 July 2024 that the costs to that point would be covered, plus the cost of the assessment with the psychiatrist, which was different to the information provided in the FRL.

There were also things that Mr H should have done differently. I'm persuaded by the available evidence that he was told at the start of the claim that he was covered for ten sessions and that he understood that, so he should have contacted AXA to seek reauthorisation. He also didn't respond to contact from AXA during April to July 2024 stating that his cover could only continue if he provided a report from the therapist. He only made contact on 29 July 2024 after finding out from the therapist that she hadn't been paid. So, from AXA's point of view, it could reasonably decline cover from 8 April 2024 when it first indicated to him that future cover might stop. And I understand AXA's frustration at Mr H's resistance to providing the MIF.

However, ultimately it is AXA that bears the bulk of the responsibility for ensuring that the claim was managed correctly and that it wasn't paying for unauthorised treatment. It shouldn't have taken it so long to get to grips with the situation. So, I'm glad that AXA has recognised this and that it has offered to settle the costs and to pay £250 compensation in order to draw a line under the matter. The sticking point is how it does that.

AXA says it needs the MIF to enable it to settle the claim in the correct manner. As Mr H has a workplace policy, there could be implications for his employer in terms of what claims are registered against the corporate policy.

So, if the MIF shows that the claim is eligible from an underwriting point of view – meaning that Mr H's medical history confirms that the condition wasn't pre-existing in the five years before the policy start date - the settlement would be made as part of the benefits of the policy.

However, if the MIF shows that the condition was pre-existing, the settlement would be made on an ex-gratia payment, thereby not affecting the employer's claims experience. There would be some additional administration involved in this as the payments made so far would need to be transferred from being a benefit against the policy to being ex-gratia.

Mr H hasn't said anything about when the symptoms of his condition started. His stated objections about providing the MIF are around the timing of the request for it and his suspicions about what AXA will do with the information – even though he's been told that there would be no attempt to recoup the payments from him in any event. He says that concerns about AXA's intentions have caused him severe stress and worry.

AXA's assumption is that Mr H doesn't want to provide the MIF because it will probably reveal that the condition was pre-existing and therefore shouldn't have been covered at all.

Whether or not it is the case, based on a lack of information to the contrary, I consider it's reasonable for AXA to assume that the condition was likely pre-existing.

I understand AXA's reasons for trying to insist that matters can't move on without the MIF. However, as it is going to settle the outstanding invoices in any event, on balance, I consider that it should continue with its assumption that the condition was pre-existing and settle the claim on an ex-gratia basis, without access to the MIF. It follows that I uphold the complaint.

More recently, Mr H has said that he wants a higher amount of compensation to account for personal damages. Whilst acknowledging Mr H's difficulties and how stressful he has found his dealings with AXA, I'm not persuaded that I should award an increase to the compensation already agreed by AXA. As mentioned above, there are instances where Mr H has contributed to the issues that have arisen. And, based on the available evidence, he has likely benefitted from a longer period of treatment than he was entitled to, and is not being asked to repay any costs.

Putting things right

AXA should put things right by:

- Settling the remainder of the claim by paying the outstanding invoices on an ex-gratia basis.
- Paying Mr H a total of £250 for distress and inconvenience.

My final decision

For the reasons I've explained, I uphold the complaint and require AXA PPP Healthcare Limited (trading as AXA Healthcare) to put things right as set out above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr H to accept or reject my decision before 8 August 2025.

Carole Clark
Ombudsman