DRN-5552358

The complaint

Mr H is unhappy that AXA PPP Healthcare Limited (AXA) declined his private medical insurance claim.

What happened

The background to this complaint is well-known to both parties. So, I've simply set out a summary of what I think are the key events.

Mr H took out a private medical insurance policy on 4 April 2024.

The policy is underwritten by AXA and was set up on a moratorium basis. This means that no medical underwriting takes place at the start of the policy. Instead, claims are assessed based on information the policyholder provides and any medical information that's required.

Mr H submitted two claims for symptoms of coughing and a diagnosis of IBS in August 2024. Further medical information was requested and reviewed by AXA. The claim was declined as AXA said the symptoms pre-dated Mr H taking out the policy. Unhappy Mr H made a complaint to AXA. It maintained its position to decline the claim.

So, Mr H brought his complaint to this service. Our investigator didn't uphold the complaint. He didn't think AXA had unfairly declined Mr H's claim.

Mr H disagreed and asked for the complaint to be referred to an ombudsman. So, it's been passed to me.

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.

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, the terms of this policy and the circumstances of Mr H's claim, to decide whether AXA treated him fairly.

The policy terms and conditions

I've started by looking at the terms and conditions of Mr H's policy as this forms the basis of the insurance contract between the two parties.

Page 16 sets out what *'Moratorium'* means*:*

> *If you joined us on moratorium terms, you won't have cover for treatment of any conditions you had in the five years before you joined. This includes if you had symptoms of a condition that hadn't been diagnosed. Once you've been a member for two years in a row we may be able to start covering treatment of these conditions.*

You will need to have been trouble free from that condition for at least 12 months in a row after the date you joined before we can cover it.'

Page 15 provides a definition of pre-existing:

'Am I covered for treatment of any conditions I was aware of when I joined?

We call conditions you were aware of when you joined pre-existing conditions.

The definition of pre-existing condition
A pre-existing condition is any disease, illness or injury that:

- *you have received medication, advice or treatment for in the five years before the start of your cover, or*
- *you have experienced symptoms of in the five years before the start of your cover whether or not the condition was diagnosed.*

What if you didn't tell us about a condition, symptom or treatment you knew about when we asked?

When you joined, we may have asked you some medical questions before agreeing your cover. We worked out your terms of your subscription based on your answers. If you did not answer fully or accurately, even if this was by accident, we may not cover treatment for the condition.

This includes any pre-existing condition, whether you had treatment for it or not. It also includes any previous medical condition that comes back and any medical condition that you should reasonably have known about. It doesn't matter if your condition has been diagnosed or not.'

Has the claim been fairly declined?

It's not in dispute that Mr H took out the policy on a moratorium underwriting basis.

Mr H doesn't agree that the symptoms he experienced were pre-existing.

Mr H claimed for two separate medical issues – coughing symptoms and IBS.

AXA requested a Medical Information Form (MIF) to be completed by Mr H and his GP, which I've considered. Referral forms that were completed by the online GP which included notes of the appointments have been provided and which I've also considered.

The first claim was for coughing symptoms. There's a note on 20 August 2024 when Mr H went to see the doctor for a referral. This note states:

'Patient complained of cough for at least 4-5 months.'

'Constant for last 6 weeks.'

The MIF confirms that he first consulted on 20 August 2024 about the coughing. It's clear that Mr H reported to the online GP that he'd had the cough for at least 4-5 months. The emphasis here is the '*at least'* and that would mean that he'd been experiencing this since at least before the policy started on 1 April 2024.

Whilst I can see that Mr H said: *'Has been to XXX, for 10 days, after cough started',* I don't think this means that he still hadn't been experiencing the symptoms for at least 4-5 months.

The second claim was for IBS. There's a note on 21 August 2024 which states:

> '*Patient presented with worsening IBS symptoms.'*
>
> *'Feels has IBS – ongoing'.*
>
> '**History of presenting complaint & examination**:
> *Feels unwell over the last 8 months.'*

The MIF states Mr H first consulted for this on 21 August 2024. And the first form provided confirms that he had IBS symptoms for years. A second form was submitted which then left the same question blank and no answer was provided.

Mr H's policy states there's an exclusion and no benefit will be payable for pre-existing medical conditions during the first 2 years of membership. And Mr H has to show that he's had a trouble-free period of 12 months at the time of receiving treatment.

I note trouble-free means Mr H has not consulted a medical practitioner, received any treatment or advice, followed a special diet, or taken medication, including over the counter medication.

Based on the evidence Mr H and the GP provided, this shows he had the symptoms or the condition before he took the policy out in April 2024.

I understand Mr H's comments that the reference to him being unwell for around eight months was regarding his general health issues. I understand that this could be possible. But equally this was noted on the referral form by the online GP so it's difficult to ignore this. And even if I don't take this into account, the condition was noted as worsening and ongoing.

As Mr H hadn't been to see his GP prior to the appointments in August 2024, the medical information that has been presented is relevant. This says Mr H had cough symptoms for *at least* four to five months. And the IBS symptoms were ongoing and worsening. This suggests that the symptoms and condition were likely pre-existing prior to the policy starting.

Mr H said he never had any GP appointments, consultations or discussions about stomach issues prior to 21 August 2024. But I don't think that's relevant here. He doesn't necessarily need to have visited his GP, and the point is that the referral forms and the MIF show it's more likely that Mr H had those symptoms prior to taking out the policy.

I've also considered that a second MIF form was completed and sent to AXA. However, I don't think this is as persuasive as the first form that was completed. I think the first completed form would have been more accurate and contemporaneous.

Overall, based on the available evidence, the medical information doesn't sufficiently persuade me that Mr H didn't experience the symptoms for coughing and IBS prior to taking out the policy. I'm satisfied AXA declined Mr H's claim fairly and didn't do so outside the terms and conditions of his policy. I'm sorry to disappoint Mr H but it follows therefore that I don't require AXA to do anything further.

My final decision

For the reasons given above, I don't uphold Mr H's complaint about AXA PPP Healthcare

Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr H to accept or reject my decision before 15 July 2025.

Nimisha Radia
Ombudsman