

## The complaint

Miss B has complained that AXA PPP Healthcare Limited declined a claim she made on a private medical insurance policy and about poor customer service.

## What happened

Miss B purchased the policy in September 2024. She then made a claim in November 2024.

AXA declined the claim on the basis that the circumstances are not covered under the policy terms, namely that not enough information had been provided to be able to verify that the condition being claimed for was not pre-existing.

Our investigator thought that AXA had acted fairly and reasonably. Miss B disagrees and so the complaint has been passed 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.

Miss B took out the policy on a moratorium basis.

Looking at the terms of the policy, they state:

*'When you joined AXA, you did so under "moratorium" underwriting – also called a "two-year watch and wait" policy. That means AXA don't cover for any medical condition – or symptoms of one – that were present in the five years prior to joining, until you've been free of that condition (without advice, medication, or symptoms) for two consecutive years after joining. This is clearly set out in the policy handbook.'*

The handbook then states:

*'We may need more detailed information in any of the following ways:*

*We may need your GP or specialist to send us more details about your medical condition.*

*We may also ask you to give consent to access your medical records.*

*If you do not give us the information we ask for, or do not consent to our accessing your medical records when we ask, we will not be able to assess your claim and so will not be able to pay it. We may also ask you to pay back any money that we have previously paid to do with this medical condition.'*

And:

*'If you joined us on moratorium terms, you won't have cover for treatment of any conditions that you had in the five years before you joined. This includes if you had symptoms of a condition that hadn't been diagnosed.'*

The policy defines a pre-existing medical condition as:

*'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.'*

Because Miss B made a claim so soon after taking out the policy, AXA required her to provide a medical information form (MIF), part of which had to be completed by her GP.

Miss B rang AXA on 4 December 2024 for advice in relation to the way the GP had filled in the form. That's because the GP had indicated that Miss B had earlier symptoms of the condition being claimed for, which she disputed. She said she wanted her claim to be accepted and so was asking if the form, as it was currently written, would be ok. The adviser said it sounded as if the claim wouldn't be eligible because it related to symptoms she already had, but he asked her to send in the form so it could see what was written on it.

When Miss B later provided the form, it didn't contain the information that she'd discussed, so AXA considered that it must have been amended. As such, it needed further information and requested Miss B's consent to access her medical records for the previous five years, which she refused.

Miss B says the form is confusing, especially for someone who hasn't used private medical insurance before. I've listened to a later phone call she had with AXA in which she says neither she nor the GP knew how to fill out the form. She says the GP, in trying to be helpful, had included things about symptoms she had before, which was a lot of rubbish. So, she went back to the GP and said that's not going to help, and so they amended the form.

Miss B doesn't agree that AXA needs to see her medical records going back five years. The symptoms she was making a claim about were totally new. She says that everything was clear from the first information she provided and that deeper investigations are not required.

I understand that Miss B considered that she had brand new symptoms. I also appreciate that she would want to ensure that she was doing everything possible to enable the claim to be accepted. However, given the circumstances described above, it's reasonable that AXA concluded it needed additional information about Ms B's medical history to verify the claim. The above policy wording sets out its entitlement to request fuller medical records and how a claim might not be able to progress without that information.

Overall, based on the available evidence, I'm satisfied that AXA acted reasonably in declining the claim. So, I do not uphold this part of the complaint.

Miss B subsequently cancelled the policy. However, she would like compensation for the poor service she received. Looking at the timeline of how the claim progressed, I'm satisfied that AXA is not responsible for any unnecessary delay. And from listening to the phone calls,

I think it communicated with her clearly and respectfully. It follows that I also do not uphold the complaint about poor service.

**My final decision**

For the reasons set out above, I do not uphold the complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss B to accept or reject my decision before 9 October 2025.

Carole Clark  
**Ombudsman**