

The complaint

Miss V is unhappy with AXA PPP Healthcare Limited trading as AXA Health (AXA) for the following reasons:

- The policy features on her private medical insurance policy were mis-sold to her.
- Her claim was declined.
- AXA caused administrative delays and impact.
- She had issues with the clinic letter and her second clinic letter was denied.

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.

Miss V took out a private medical insurance policy in February 2024. AXA is the underwriter on the policy and Miss V took the policy out directly with AXA.

In November 2024, Miss V contacted AXA as she needed to get a diagnostic test authorised. AXA asked Miss V what she needed the test for, but she said she didn't know. Unhappy with the questions she was being asked by AXA, Miss V made a complaint.

Miss V said she was paying a very high premium so AXA should not ask any questions or more information. AXA explained that it needed further information about the test she needed to see if the claim was eligible and this was part of the claim validation process. AXA requested a specialist's clinic letter. It also explained that it wasn't excluding the claim, but it needed to see further information before it could authorise the claim and see if it was eligible.

On 30 December 2024, Miss V called AXA and said she wanted to cancel the policy as she wasn't willing to submit any medical evidence.

AXA issued a final response on 8 January 2025. AXA said it didn't think it was unreasonable for it to request a clinic letter from Miss V's specialist to understand which diagnostic tests she needed. AXA explained that before authorisation for any tests is given, it has to see if the test is eligible for cover. AXA confirmed there were no specific exclusions to Miss V's conditions and although the underwriting on her policy is 'medical history disregarded' that doesn't mean that every test or treatment is covered under the policy. And a policy with a higher premium doesn't mean that AXA would cover everything. AXA didn't agree that the policy was mis-sold and that Miss V's claim hadn't been rejected but pending further information.

Unhappy Miss V brought her complaint to this service. Our investigator didn't uphold the complaint. He didn't think AXA had done anything wrong.

Miss V 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.

It's important to point out that we're an informal dispute resolution service, set up as a free alternative to the courts for consumers. In deciding this complaint I've focused on what I consider to be the heart of the matter rather than commenting on every issue or point made in turn. This isn't intended as a discourtesy to Miss V. Rather it reflects the informal nature of our service, its remit and my role in it.

At the outset I understand and have every empathy for the health challenges that Miss V is experiencing, and I am sorry for this. Whilst I appreciate that it's been difficult for Miss V, I have to decide based on the evidence available what's fair and reasonable in the circumstances of this complaint.

I've carefully considered the available evidence and listened to the call recordings provided. Having done so, I won't be upholding the complaint. I'll explain why.

The insurance industry regulator, the Financial Conduct Authority ('FCA'), has set out rules and guidance for insurers in the 'Insurance: Conduct of Business Sourcebook' ('ICOBS'). ICOBS says that insurers should act honestly, fairly and professionally in accordance with the best interests of their customers, and that they should handle claims promptly and fairly. I've taken these rules into account when looking at this complaint.

Miss V took out the policy in January 2024 and she accepted the policy on the underwriting basis of 'medical history disregarded'. I've reviewed whether the policy was mis-sold, and I don't think it was. I've listened to the call recordings when Miss V took out the policy. She said she paid a very high premium, the policy was supposed to be unlimited, and she is therefore eligible regardless. The policy is not providing what she's paid for.

Whilst I appreciate the advisor explained that diagnostic tests were covered, and they would be unlimited, there's no evidence to suggest that authorisation wouldn't be required or that AXA wouldn't need any medical information to validate the claim regardless. I'm satisfied that the policy information AXA provided was clear about the features and limits of the cover when Miss V took it out. I think AXA provided appropriate information so Miss V could make an informed decision, and I note she was satisfied with the information the advisor provided at the time of the sale.

Miss V sought authorisation from AXA to have a diagnostic test. When a policyholder submits a claim, the responsibility is for them to provide the relevant information and to prove the claim is valid. It's not unusual for insurers to require further medical information. So, whilst Miss V believes her policy is unlimited in terms of having diagnostic tests, I don't agree.

The clinic letter was the second letter which Miss V read out on the telephone call. Miss V read that she was being treated for dry eye and confirmed her symptoms. The advisor said the claim may not be valid, but she'll have to check and call back.

Following the call, AXA requested Miss V send the letter to it and it would provide a response as to whether the claim was valid. I've reviewed Miss V's policy terms and conditions and it's clear that AXA may request more detailed medical information if needed.

So, I'm not persuaded that AXA did anything wrong in requesting the clinic letter. Whilst I appreciate Miss V no longer has the policy, from the information available, the claim hadn't been declined but it was pending further information.

Given Miss V's symptoms and that AXA considered the information she read out on the telephone, it wasn't unreasonable that it asked her to send the clinic letter for review. I think this was fair and reasonable.

Miss V asked on numerous occasions for a list of conditions that were excluded under the policy. But AXA said there was no specific list and it would need to see the specialist's clinic letter before the diagnostic test could be validated. I note that the advisor provided examples of conditions that could possibly be excluded under the policy at the point of sale. But even if he hadn't, the policy terms and conditions provide sufficient information about what is and isn't covered in relation to eye conditions. I think AXA could have explained this better.

The crux of the issue is the authorisation for the diagnostic test that Miss V required. It's clear in the policy that further medical information may be required and AXA has a right to ask for this. I don't agree that Miss V's policy has unlimited access to treatment without providing supporting evidence, should AXA require it to be necessary.

I understand that Miss V is unhappy about the customer service and the tone of communication provided by AXA. I've reviewed everything but I'm not persuaded AXA failed in its customer service or in its communication to Miss V. Whilst it's clear that Miss V was distressed, I think overall AXA handled the communication and the issues as it would have been expected to.

I also haven't seen any evidence that Miss V was treated unfairly or was discriminated by AXA. I don't think it's unreasonable that AXA has asked for a specialist clinic letter to validate her claim. But that doesn't mean that AXA treated her unfairly or that the diagnostic test should be authorised. I don't think AXA has acted outside the requirements of Miss V's policy terms and conditions. I'm sorry to disappoint Miss V but it follows that I don't require AXA to do anything further.

My final decision

For the reasons given above, I don't uphold Miss V's complaint about AXA PPP Healthcare Limited trading as AXA Health.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss V to accept or reject my decision before 14 October 2025.

Nimisha Radia
Ombudsman