DRN-5894556

The complaint

Mr and Mrs P are unhappy that AXA PPP Healthcare Limited declined a claim they made on their private health insurance policy.

What happened

Mr and Mrs P's daughter is named on their private medical insurance policy. She claimed on the policy for investigations into symptoms. The claim was ultimately declined because AXA said the circumstances fell within the policy moratorium exclusion.

Mr and Mrs P complained to AXA. They highlighted that they didn't agree the records relating to their daughter's medical history were correct and they'd taken steps to have this information amended. But AXA maintained their decision to decline the claim was fair, based on the available evidence. Unhappy, Mr and Mrs P referred their complaint to the Financial Ombudsman Service.

Our investigator looked into what happened and didn't uphold the complaint. She thought AXA had reasonably declined the claim. She also explained that she couldn't consider a new complaint about a different claim as part of this complaint because that issue had arisen since AXA issued their final response letter.

Mr and Mrs P didn't agree. In summary, they said there was continuing detriment to their daughter and AXA had mischaracterised the condition as pre-existing. They said AXA's decision rested entirely on disputed data and they bore responsibility for the accuracy of the health data relied on when making decisions. Mr and Mrs P also reiterated that they wanted both claims to be dealt with together as part of one complaint and re-iterated their concerns about the more recent claim. They felt that there was a wider public interest issue which exposed a broader consumer protection concern.

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.

At the outset I acknowledge that I've summarised this complaint in far less detail than Mr and Mrs P have, and in my own words. I won't respond to every single point made. No discourtesy is intended by this. Instead, I've focussed on what I think are the key issues here.

The rules that govern our service allow me to do this as we are an informal dispute resolution service. If there's something I've not mentioned, it isn't because I've overlooked it. I haven't. I'm satisfied I don't need to comment on every individual point to be able to fulfil my statutory remit.

My decision focuses on the complaint raised to AXA in relation to Mr and Mrs P's daughter experiencing symptoms which led to a diagnosis of an ovarian cyst. These concerns were addressed by AXA in a final response letter dated in January 2025. I understand that Mr and

Mrs P have had cause to complain about a claim for another issue which has also been declined. However, as our investigator explained, that's not something that the Financial Ombudsman Service is considering as part of this complaint.

I appreciate that Mr and Mrs P feel it would be appropriate to deal with both issues together, as they consider them to be linked. But, as the more recent complaint arose after AXA issued their final response letter, and have been investigated as a separate complaint, it's not something I am addressing as part of this decision.

The relevant rules and industry guidelines say that AXA has a responsibility to handle complaints promptly and fairly. And they shouldn't reject a claim unreasonably.

The relevant policy terms and conditions say:

> "Moratorium
>
> 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 trouble-free from that condition for at least two years in a row after the date you joined, we can start covering treatment of these conditions. If you joined us from another health insurer or a company membership you might have joined on different moratorium terms. Your membership certificate will show some details about how your moratorium works."

The policy schedule confirms that the policy is underwritten on moratorium terms. It says:

> "Your cover for existing medical conditions is on moratorium terms – see below for what this means.
>
> Your membership has been accepted on moratorium underwriting terms. This means that treatment for pre-existing medical conditions and specified medical conditions are excluded for at least the first two years from your date of joining. Please refer to Section 3.3 of your membership handbook which provides further information about how we treat existing medical conditions. Moratorium start date 1 April 2024."

I'm not upholding this complaint because:

- Mr and Mrs P have concerns about the sale of the policy. They'll need to refer any concerns to the business who sold the policy as AXA wasn't responsible for the sale of it.

- Mr and Mrs P's daughter presented with acute abdominal pain and bleeding in August 2024. During the discussion Mrs P disclosed what she described as minor, historic tummy discomforts. The relevant notes from the healthcare provider said, 'abdominal pain for 6 month- A year of changed in bowel constipated /bloating and diarrhoea- no weight loss family tried changing diet - in a recent holiday had diarrhoea with blood when opening bowels see it in water- no urinary symptoms….'

- Mr and Mrs P feel that vague and incidental remarks have been interpreted as a pre-existing condition and that the symptoms have been mischaracterised. But, based on the above information I think AXA reasonably concluded the claim fell within the moratorium exclusion as their daughter had experienced symptoms prior to the policy start date within the relevant time frame and was claiming for investigations into

related symptoms.

- The diagnosis was for an ovarian cyst rather than a gastroenteric condition. However, I still think AXA reasonably applied the exclusion. That's because I think AXA reasonably concluded there was a link between the symptoms, such as abdominal pain, and the diagnosis of the cyst.

- Mr and Mrs P strongly dispute the accuracy of the medical records and have taken steps to have the information amended. In a letter dated December 2024 the provider declined to amend the records and maintained their stance that the symptoms reported included long standing abdominal issues of up to a year. I think it's reasonable for AXA to rely on the information as presented in the records. I don't think there's a compelling or persuasive reason for AXA to disregard the contents of the records in the circumstances of this case.

- AXA isn't responsible for how the information is recorded by the clinician. Mr and Mrs P have been referred to the Information Commissioner's Office (ICO) by the relevant business if they want to pursue this matter further.

- In reaching my conclusions I've considered what Mrs P has said about the relevance of ADHD diagnoses in the family and that as a parent she'd have taken her daughter to a doctor if she'd had symptoms for such a long time. But, this hasn't persuaded me that the claim has been handled unfairly. On balance, I'm persuaded that AXA is reasonably entitled to rely on the records for the reasons I've explained.

- My role is to decide whether AXA treated Mr and Mrs P fairly when the claim was declined. It is not my role to make a finding about the wider implications of insurers relying on disputed medical records and direct AXA to make changes to their wider processes. My decision therefore relates to the specific circumstances of this case. If Mr and Mrs P have ongoing concerns that this complaint has wider public interest issues they may wish to refer their concerns to the ICO.

My final decision

I'm not upholding this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs P and Mr P to accept or reject my decision before 12 February 2026.

Anna Wilshaw
Ombudsman