DRN-5940505

## The complaint

Mr C is unhappy that AXA PPP Healthcare Limited trading as AXA Health (AXA) declined his private medical insurance claim.

## What happened

Mr C has a private medical insurance policy which started on 7 March 2025. AXA is the underwriter.

The policy was set up on a moratorium underwriting 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. And any pre-existing conditions from the previous five years of starting the plan are excluded which can become eligible for cover if the policyholder has been symptom free for two continuous years after the start of the plan.

In June 2025, Mr C had an appointment with a private GP, through AXA, who provided referral to a consultant for tonsil stones. AXA pre-authorised the initial consultation and diagnostic tests. Surgery was recommended. However, AXA declined cover for the surgery as it said Mr C's condition was pre-existing. Mr C made a complaint to AXA, but it maintained its position to decline cover.

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

Mr C 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 key issue on this complaint is that AXA has declined cover for a condition which it says was pre-existing. Mr C says AXA has mis-applied the moratorium clause - his condition arose after joining and this was confirmed in the consultant's follow-up letter. So, I'll focus on this issue to determine whether AXA has applied the moratorium clause fairly and in line with the policy terms and conditions.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, amongst other relevant considerations, such as industry principles and rules, the policy terms and the available evidence, to decide whether I think AXA handled Mr C's claim fairly.

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 Mr C. Rather it reflects the informal nature of our service, its remit and my role in it.

I've started by looking at the relevant policy terms and conditions.

A pre-existing condition is defined on page 20 as:

*'Your cover depends on if you have any pre-existing conditions*

*A pre-existing condition is any disease, illness or injury that you've had medication, advice or treatment for or symptoms of, in the three years before your cover started. It doesn't matter if your condition has been diagnosed or not.'*

Based on the above, the policy is clear that pre-existing conditions are not covered, whether the condition has been diagnosed or not.

And the policy is also clear in that treatment for any conditions a member has in the three years before joining the plan won't be covered, including having symptoms of a condition that hadn't been diagnosed.

I've considered the Medical Information Form (MIF) completed by Mr C and his NHS GP. In part 1, Mr C said he was claiming for '*recurring tonsil stones causing persistent halitosis'*. The GP also said in part 2 of the form that Mr C had '*no previous attendances for tonsillitis, or tonsillar stones*.' And that he had not seen the GP about this previously. AXA therefore approved an initial consultation and requested a clinic letter from the consultant. So, I don't think AXA acted unreasonably in authorising the initial consultation.

The clinic letter, dated 29 July 2025, was provided to AXA. The consultant said: '*he* [Mr C] *has a long history of recurrent tonsil stones. These build up every day and cause discomfort and bad breath…he also gets sore throats around four times per year. During these episodes, the glands in his neck swell, he gets pain in his throat and his tonsils become inflamed. He does not require antibiotics, and he is able to drink and eat.'*

AXA assessed this clinic letter in line with the policy requirements. It declined Mr C's cover based on the information the consultant provided. It said the letter showed Mr C had a long history of tonsil stones and that he gets a sore throat four times a year. As such the symptoms he experienced would be considered pre-existing. I realise Mr C says he didn't know he had tonsil stones and he also hadn't consulted his NHS GP. But the symptoms he experienced are shown to be prior to the policy start date of 7 March 2025. I don't think the claim has been declined unfairly. From the letter made available, I'm not persuaded that the symptoms weren't pre-existing at the start of the policy.

Additionally, having carefully considered the second clinic letter provided by Mr C's consultant, I haven't seen reason to change my opinion that the claim has been declined fairly. I say this because I find the first consultant letter to be the most contemporaneous and to be the most plausible. The consultant has written what Mr C has self-reported about the symptoms he experienced. The second letter was sent only after the claim had first been declined by AXA. In any case, the letter didn't retract from what was said in the first letter that there was a long history rather it explained that Mr C had no medical treatment or appointments prior to May 2025. Mr C says '*long history'* refers to the period of time since May 2025, but I don't agree. Usually, '*long history'* means a significant or extensive period stretching back years rather than recent or a few months. I haven't seen anything that persuades me otherwise. I also don't agree that the letter written by the consultant about the sore throats is casual – he clearly stated that Mr C had sore throats around four times per year.

Whilst I don't doubt that Mr C hadn't consulted his NHS GP and didn't have any treatment before 7 March 2025, that doesn't necessarily mean that the condition isn't pre-existing.

I also note AXA asked Mr C in an email dated 9 June 2025 whether he had episodes of this, or similar symptoms, before. Mr C replied '*No – this is the first time I've experienced these symptoms to this degree and frequency.'* My understanding from this is that Mr C did experience symptoms before but not to the same degree or frequency as he did in May 2025.

On balance, I think there's sufficient evidence to show Mr C experienced symptoms prior to the policy being taken out, even if the condition hadn't been diagnosed. So, I can't reasonably make AXA responsible for paying the claim in the circumstances of this complaint.

I appreciate Mr C had to take time off from work for the surgery and AXA confirmed the decline to provide cover only 24 hours before his first hospital appointment. I also understand this situation has left Mr C stressed and financially exposed as he is being chased for costs that AXA initially said would be covered. However, I've seen communication between Mr C and AXA. I don't think AXA said it would provide cover and Mr C took the decision to go ahead and book the pre-operative tests and surgery without receiving authorisation from AXA even though he was aware on 31 July 2025 that there was no cover for these costs. The only evidence I've seen is that AXA authorised the initial consultation, diagnostic tests and a follow-up consultation. And AXA informed Mr C how long it would take to assess the claim, so I don't think it set expectations that Mr C wasn't aware of and I don't think it delayed providing a decision to his claim.

Mr C says he's being chased to pay for the initial out-patient consultation fee which was for £145. My understanding is that this is because the excess on the policy is £250 and therefore Mr C has to pay the first £250 towards the cost of treatment in any one year. This is therefore his responsibility to pay rather than AXA's, as per the terms and conditions of the policy. This issue doesn't form part of this complaint so if Mr C is unhappy about having to pay the £145, he should first contact AXA directly.

Overall, taking everything into account, I'm not persuaded that AXA declined Mr C's claim unfairly or outside the terms and conditions of the policy. I'm sorry to disappoint Mr C 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 Mr C's complaint about AXA PPP Healthcare Limited trading as AXA Health.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr C to accept or reject my decision before 14 January 2026.

Nimisha Radia
**Ombudsman**