DRN-4011313

The complaint

Mr and Mrs L complain that AXA PPP Healthcare Limited declined Mr L's claim against their private medical insurance policy.

What happened

The details of this complaint are well known to both parties, so I won't repeat them again here in full. In summary, on 23 December 2021, Mr and Mrs L took out a private medical insurance policy underwritten by AXA. On 29 December 2021, Mr L saw his GP about upper and mid back pain and asked for a referral to a chiropractor.

On 4 January 2022, Mr L contacted AXA about a claim for chiropractor treatment for abdominal pain. AXA set up a claim for abdominal pain and sent Mr L a medical information form for his GP to complete.

On 5 January 2022, Mr L's GP referred Mr L to a chiropractor in relation to his upper and mid back pain. In the letter of referral, Mr L's GP told the chiropractor that Mr L had an ongoing problem with low back pain, in relation to which he was seeing Dr B, a consultant in pain management, but that Mr L required the chiropractor's assistance with his upper and mid back pain.

On 14 January 2022, Mr L told AXA that he'd made a mistake in referring to abdominal pain and that it was actually mid back pain. AXA amended Mr L's claim to middle and upper back pain.

On 27 January 2022, Mr L's GP completed AXA's medical information form. AXA reviewed the information and in February 2022, it declined Mr L's claim. It said that based on the information provided by Mr L's GP, it appears that the claim relates to a condition he had before he took out the policy. AXA said that Mr L's upper and mid back pain was a pre-existing condition, so it wasn't covered by the policy. It said that it can't cover Mr L's claim for upper and mid back pain unless it received a clinic letter which confirms that it's not linked to his pre-existing conditions.

Mr L provided AXA with a letter dated 20 May 2022 from his GP in which the GP said the referral to a chiropractor for mid back pain wasn't related to Mr L's previous problems with neck pain and low back pain.

There were further exchanges between the parties, which I won't set out here. Essentially, AXA maintained its decision to decline Mr L's claim. AXA said that Mr L's previous diagnosis of spondylosis can affect the whole spine, so it's unlikely that it would cover any claims for back pain. It said that it doesn't have confirmation that the upper and mid back pain isn't Mr L's spondylosis or lower back pain progressively getting worse.

Mr and Mrs L complain that AXA's decision to decline Mr L's claim is unfair. They also complain that they were misled in the sales process as AXA said that other insurers may

not cover a new condition if there is a possibility of it relating to past conditions whereas it doesn't associate new medical conditions to pre-existing conditions.

I understand that Mr L proceeded with the chiropractic treatment which he self-funded. Mr and Mrs L want AXA to settle Mr L's claim.

One of our investigators looked at what had happened. His initial view was that AXA hadn't acted unfairly in declining Mr L's claim. Mr L provided some further information. The investigator reconsidered the matter and said that both Mr L's GP and chiropractor say that the condition which led to the claim is unrelated to Mr L's pre-existing conditions. He thought that AXA should settle Mr L's claim. Mr L agreed with the investigator's second view, but AXA didn't.

AXA provided further comment. It said, in summary:

- In the telephone calls before Mr L took out the policy he said that he'd recently been to A&E and the GP referral letter provides that he'd recently attended A&E for back pain. In addition, Mr L asked how a claim for chiropractor treatment would work and said that he'd been in contact with local chiropractors. This demonstrates an intention to claim against the policy.

- On 4 January 2022, 12 days after taking out the policy, Mr L made a claim for abdominal pain. He said that his GP had recommended chiropractor treatment rather than physiotherapy. But the medical information form from the GP says that '*Mr L… requested a private referral to a chiropractor',* so it wasn't the GP who recommended the course of treatment.

- In the phone call on 4 January 2022, Mr L said that he'd had symptoms for one week, so which started one day after the policy began and one day before his appointment with his GP on 29 December 2021. It is concerned about the lack of information in the medical information form completed by the GP and doesn't understand why the GP said that there's '*No record of patient being aware something is wrong'*.

- The GP referral letter is dated 5 January 2022, not 29 December 2021, which was the date of Mr L's appointment. The GP referral letter was written a day after Mr L phoned AXA. In a subsequent call, Mr L said that he'd explained the underwriting conditions to his GP. Also, the GP's referral letter provides very little detail about Mr L's upper and mid back pain and gives no time frame for the symptoms, which is unusual. The referral letter enclosed Mr L's notes and a list of medications, but Mr L didn't provide it with those documents.

- Mr L's reference to his symptoms have changed from abdominal pain (4 January 2022), middle back pain (11 January 2022), upper back pain (14 January 2022), to middle back and shoulder pain (18 February 2022).

- Mr L hasn't provided it with all the clinical letters and scan reports which it repeatedly asked him to submit.

- The letter dated 28 July 2022, from Mr L's chiropractor was written for the purposes of Mr L's claim and isn't a clinic letter. In any event, it supports its decision to decline the claim as it refers to treatment for low back pain – a pre-existing condition - and there's no mention of treatment for mid or upper back pain.

- It maintains its decision to decline Mr L's claim and it proposes that Mr L submits all clinic letters from the treating consultants, scan/x-ray results, full records from the chiropractor, the GP consultation notes and clinic letters from any other specialist involved in his treatment.

The investigator revised his view. He said that it was reasonable for Mr L to provide further information to AXA, so that it can assess the claim fully. He didn't think that he could reasonably ask AXA to settle the claim without it having the information it had requested.

Mr and Mrs L didn't agree with the investigator and asked that an ombudsman consider the matter, so it was passed to me to decide.

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 clear and quite understandable that Mr L in particular has very strong feelings about this matter. He has provided detailed submissions to support the complaint, which I have read and considered. AXA has also provided extensive comments. I'm conscious that I've condensed what happened into a short narrative. That reflects our service that, wherever possible, aims to be informal. I'm satisfied that I've captured the essence of what happened. I trust that neither party will take as a discourtesy the fact that I focus on what I consider to be the central issue, that is whether AXA acted fairly and reasonably in declining Mr L's claim.

the relevant terms and conditions

The starting point is the terms and conditions of the policy, the relevant part of which says as follows:

'***3.4 > How your membership works with pre-existing conditions and symptoms of them***
[…]
Health insurance is usually designed to cover ***treatment*** *of new* ***medical conditions*** *that begin after you join. Your cover for* ***treatment*** *of conditions you were aware of or had already had (sic) when you joined depends on what you told us about your medical history when you joined.*

What cover is there 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 a ***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*.*'

Mr and Mrs L's policy is on a moratorium basis. That means that it doesn't cover pre-existing medical conditions they had in the five years before the policy began until they have been a member for two years in a row and had a period of two years in a row trouble-free from that condition.

has the claim been declined unfairly?

The relevant rules and industry guidance say that AXA has a responsibility to handle claims promptly and fairly and it shouldn't reject a claim unreasonably. I'm not upholding Mr and Mrs L's complaint because I don't think that AXA treated them unfairly or unreasonably in declining Mr L's claim and that its proposal to consider further medical information is fair and reasonable. I say that because:

- Insurance policies aren't designed to cover every eventuality or situation. An insurer will decide what risks it's willing to cover and set these out in the terms and conditions of the policy document. The onus is on the consumer to show that the claim falls under one of the agreed areas of cover within the policy. If the event is covered in principle but is declined on the basis of an exclusion set out in the policy the onus shifts to the insurer to show how that exclusion applies.

- I've set out above the relevant exclusion in Mr and Mrs L's policy in relation to pre-existing conditions. The policy doesn't provide cover for any disease, illness or injury that Mr L has received medication, advice or treatment for, or experienced symptoms of, in the five years before the policy began.

- The central question for me to decide is whether AXA acted unfairly in concluding that Mr L's upper and mid back pain was a pre-existing condition, as defined by the policy. I think there's been confusion here as there are two separate issues to consider which have become conflated. First, Mr L needs to show that his symptoms of upper and mid back pain started after the start date of the policy. If Mr L can establish that, AXA is entitled to consider whether his symptoms are in fact part of his pre-existing conditions.

- It's not in dispute that Mr L had cervical spondylosis (neck pain) and low back pain before he took out the policy. The claim which led to this complaint was also for back pain. On receipt of the medical information form completed by Mr L's GP on 27 January 2022, AXA referred the matter to medical underwriting, which is what we'd expect it to do. I don't think that AXA treated Mr L unfairly in concluding that, at that stage, there wasn't any medical information about when Mr L's symptoms of upper and mid back pain started. And I think that AXA was entitled to rely on the advice of its medical underwriters that the claim was linked to Mr L's pre-existing conditions.

- The medical information form completed by Mr L's GP says that Mr L had neck pain and low back pain since 2018. It also says that he first saw Mr L about his mid back pain on 29 December 2021. In answering the question about how long Mr L had been aware that something was wrong, the GP doesn't give a date but says there's '*No record of patient being aware something is wrong'*. I don't think that AXA was at fault in concluding that the information provided by Mr L's GP lacks detail in relation to the date of onset of his symptoms of upper and mid back pain. Similarly, the GP's letter of referral dated 5 January 2022 to the chiropractor doesn't say when Mr L's mid back pain started. So, AXA wasn't able to establish that Mr L's symptoms of upper and mid back pain first started after the policy began.

- When Mr L first contacted AXA on 4 January 2022, he indicated that he'd had symptoms for the past week, so starting on 28 December 2021, one day before he saw his GP and five days after his policy start date. I don't think that AXA was at fault in concluding that it's unlikely that Mr L had middle and upper back pain for only one day before he had a GP appointment about it.

- Given the information AXA had, I don't think it was unreasonable for it to conclude that it's more likely than not that Mr L had symptoms of upper and mid back pain before he took out the policy. That means that it was entitled to decline the claim.

- I don't think that AXA was obliged to change its position following the letters dated 20 May 2022 and 28 July 2022 written in support of Mr L's claim by his GP and chiropractor respectively. The information in those letters doesn't establish that Mr L's symptoms of upper and mid back pain were present only after the start date of the policy.

- Mr and Mrs L have complained that they were misled during the sales process. Specifically, they say that on 20 December 2021, AXA said in an e-mail that its specified moratorium means that whilst it excludes pre-existing conditions, it wouldn't associate other new medical conditions to the pre-existing conditions. I don't think that's inconsistent with AXA's decision in this case. Mr L hasn't established that his symptoms were present only after the start date of the policy.

- Under the terms of the policy, AXA is entitled to ask for more detailed medical information, including access to medical records. AXA proposes that Mr L submits all clinic letters from the treating consultants, scan/x-ray results, full records from the chiropractor, the GP consultation notes and clinic letters from any other specialist involved in his treatment. I think that proposal is reasonable, but Mr L is unsure about what's missing. If Mr L wishes to pursue the claim, I suggest he asks AXA what records and documentation it needs to see. It may be that AXA asks Mr L to sign a medical consent form so that it can contact the providers of treatment.

- For the reasons I've explained, I don't think that AXA acted unfairly in declining Mr L's claim and that its proposal that Mr L submit further medical information is fair and reasonable.

My final decision

My final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr L and Mrs L to accept or reject my decision before 21 August 2023.

Louise Povey
Ombudsman