DRN-3712834

The complaint

Mr M is unhappy with the way Legal and General Assurance Society Limited handled his claim and their decision to decline it.

What happened

Mr M had income protection insurance. His policy was underwritten by L&G and would pay a benefit if he was unable to work due to an illness.

In May 2020 Mr M became absent from work as he was suffering with symptoms of anxiety and depression. So he submitted a claim at the end of September. In November L&G instructed a telephone assessment which took place between Mr M and their rehabilitation consultant. Following this assessment, L&G declined Mr M's claim. They said this was on the basis his absence was due to a combination of personal issues and workplace stressors, rather than a clinical condition.

Mr M appealed and provided evidence from his treating doctor. This led to L&G reviewing the claim again and instructing an Independent Medical Examination in April 2021 as they said there was conflicting opinions. The IME also concluded Mr M was absent from work due to personal issues rather than a medical condition. So L&G maintained the claim was still declined.

Our investigator looked at what had happened and partially upheld the complaint. He agreed with L&G that there wasn't enough evidence to show Mr M met the definition of incapacity - so it was fair to decline the claim. But he said L&G should award £150 to recognise the upset it caused Mr M, who feels his claim wasn't fully considered because they didn't obtain his medical records from his GP.

Mr M didn't respond to the view. L&G disagreed with the compensation award. In summary they said:

- Clinicians working both within the NHS and private practice will regularly assess individuals without access to full medical records
- Numerous IMEs, doctors etc give opinions without full medical evidence. They take appropriate history, assess presentation and determine this need on a case by case basis.
- It is arguably excessive to routinely request GP records

So the case has been 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.

The relevant regulator's rules say an insurer must handle claims promptly and fairly. And they shouldn't turn down claims unreasonably.

I think it was fair for L&G to rely on the April 2021 opinion of the consultant psychologist and maintain their decision to decline to claim because Mr M didn't meet the definition of incapacity.

Although Mr M also doesn't meet the definition prior to this date, I don't think L&G acted fairly when they initially declined the claim in December 2020. I'll explain why.

- Part of Mr M's complaint is that he gave L&G permission to contact his GP surgery, but this wasn't done. And he feels his claim was declined on the basis of one telephone assessment. It's not in dispute that initially, L&G solely relied on the assessment from their rehabilitation consultant before declining Mr M's claim. So I need to consider if this was reasonable in the circumstances of this case.
- In section 2.4 of Mr M's member's statement he confirmed he has suffered from depression in the past. He also said he was on medication and was receiving regular treatment at a wellbeing centre since July 2020. This was all also confirmed during his assessment with the rehab consultant - in addition to him confirming he has regular appointments with his GP who has signed him off.

  Based on the above, I think it was unreasonable for L&G to not conduct further investigation before declining the claim - this could include seeing what Mr M's treating doctors had to say about his condition.
- I agree with L&G' points about medical professionals conducting assessments and giving opinions without access to full medical records. But my role is to decide if L&G handled Mr M's claim fairly. And in the circumstances of this particular claim I think it would've been reasonable for L&G to request further medical evidence, before they initially declined the claim.
- I appreciate L&G's point about it being excessive to routinely request GP records on every claim. But as above, I am just looking at what I think would've been fairest in the circumstances of Mr M's claim. As he'd suffered from depression in the past, was receiving therapy and medication through his GP, and wellbeing therapy, I think L&G should've requested further medical evidence before they declined the claim in the first instance.

I agree with our investigator that L&G's failure to investigate Mr M's condition beyond one telephone consultation caused him upset at an already difficult time.

Putting things right

I'm partially upholding Mr M's complaint in relation to the handling of his claim and direct Legal and General Assurance Society Limited to put things right by paying Mr M £150 compensation for the upset caused when they first declined the claim after only the telephone assessment.

My final decision

I partially uphold this complaint against Legal and General Assurance Society and direct them to put things right in the way I've outlined above.
Your text here

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr M to accept or reject my decision before 25 October 2022.

Georgina Gill

Ombudsman