DRN-3983041

The complaint

Mr A is unhappy with how Legal & General Assurance Society Limited has dealt with a claim he made under his income protection policy.

What happened

Mr A took out an income protection policy, through an intermediary, in 2005.

The policy provided was designed to provide Mr A with a monthly benefit, until the policy's end date, should he become incapacitated. The monthly benefit, and the premium payable for the policy were index-linked. So, both the monthly benefit, and the premium increased each year. The policy held a deferred period of 52 weeks. Meaning that any monthly benefit would only be paid if Mr A was still incapacitated following that point.

Mr A has explained that from 5 October 2020, he was unwell, and unable to work as a result. So, in May 2021 he contacted his insurer to make a claim under the income protection policy.

L&G, the insurer of Mr A's policy, reviewed and validated the claim, and accepted it. It told Mr A that the monthly benefit he would receive would be £164.41 It said this was calculated in line with the policy terms and taking into account any income Mr A was receiving from elsewhere.

Mr A didn't consider this monthly benefit to be correct. He said that L&G were basing his monthly benefit on the wrong pre-incapacity salary. And, based on the correct salary, the benefit he should be receiving, using L&G's methodology should be £232.08 a month.

Further that this, Mr A felt L&G were acting unfairly by taking into account other income he had – in the form of an ill-health pension, when calculating his monthly benefit. Mr A said he didn't know that the funds coming from his ill-health pension would be taken into account when providing him with settlement under the policy. Mr A said the intermediary he had purchased the policy through didn't tell him this. And that the yearly policy details he had received from L&G hadn't detailed this either.

Mr A said he had anticipated a monthly benefit of £2,376.40 a month. So, to be receiving £164.41 was significantly different to this anticipation.

L&G considered Mr A's concerns but didn't change its position on the matter. L&G was satisfied it had calculated Mr A's monthly benefit correctly, based on the financial information provided to it, and in line with the policy terms. L&G said the calculation was clearly outlined to Mr A in an email it sent to him, on 4 May 2022.

In terms of the yearly documents sent to Mr A, referencing the increase in benefit and premium, based on index-linking, L&G said it wouldn't be expected to detail any deductions to the benefit, based on other income the policyholder had, in these documents. And it wasn't its responsibility to assess the suitability of the policy for Mr A. It said this was Mr A's

responsibility, or his independent financial advisor's responsibility. So, L&G didn't think it had done anything wrong here either.

Lastly, L&G acknowledged there had been some delays in the progress of Mr A's claim. It said it aimed to deal with contact from its policyholders within 10 working days and noted there were times it hadn't acted in line with this timeframe. L&G said that most of the delays arose before 7 February 2022. And the delays before that point didn't have a substantial impact on the claim, as L&G was waiting for medical information for Mr A. But L&G recognised the delays had caused distress and inconvenience to Mr A and offered Mr A £250 in respect of this.

Mr A remained in disagreement with the settlement amount being provided for his claim and remained of the opinion that L&G should have done more to make him aware of the policy limitations – as well as carrying out checks to make sure the policy remained suitable for him. As Mr A remained dissatisfied, he referred his complaint to this service for an independent review.

Our investigator considered this complaint and didn't think it should be upheld. The investigator said they were satisfied L&G used the correct figures for assessing Mr A's claim and providing him with the monthly benefit amount.

They also said that L&G didn't sell the policy and so it wouldn't be responsible for checking the policy was suitable for Mr A at each renewal. Instead, that would be something for Mr A or any independent financial advisor he had to do.

In addition, our investigator also said L&G didn't need to provide the terms around the maximum benefit to be received under the policy in the yearly letters sent to Mr A.
Our investigator agreed there were some delays in the progression of Mr A's claim and considered the £250 compensation to be fair for this.

Mr A didn't agree. He reiterated his previous points about the complaint. As Mr A didn't agree, this complaint has been referred 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.

Having done so, I'm satisfied the £250 offered by L&G is a fair and reasonable outcome in relation to this complaint.

I appreciate this is going to be disappointing to Mr A. It's clear he feels strongly about the matter, and I appreciate why. But I'd like to reassure the parties that I have considered all evidence supplied to this service when coming to my decision. I've explained my reasons for this decision below.

Claims decision

When considering complaints such as this, I need to consider the relevant law, rules and industry guidelines. The relevant rules, set up by the Financial Conduct Authority, say that an insurer must deal with a claim promptly and fairly. So, I've thought about whether L&G acted in line with these requirements, when it agreed to settle £164.41 a month of Mr A's claim.

To do this, I've reviewed the terms and conditions of Mr A's policy. This explains that Mr A will receive a monthly benefit, following the deferred period, during a period of incapacity, until end of his incapacity, his death or the fixed end date of the policy. It isn't disputed that Mr A was incapacitated from 15 October 2020. And so, the benefit under the policy is due.

The policy explains the monthly benefit payable in any year will be limited to 55% of Mr A's total yearly earnings up to £50,000, plus 35% of his total yearly earnings over £50,000 – less any other earnings he receives whilst incapacitated. Other earnings include any pension payments.

So, I've looked to see whether L&G has acted in line with these policy terms. And I think it has. Mr A has said the above calculation should be based on him having a salary of £73,681.57. But I've seen Mr A's payslips for July – September 2020, which is the three months proceeding his incapacity. This evidences his salary as £71,681.71. So, I'm satisfied L&G acted fairly in using this figure as the basis for its calculations.

L&G then took into account Mr A's income from his pension – which is £33,003.43 a year. And arrived at the monthly benefit of £164.41. Having seem this calculation, I can see it is in line with the above policy terms. So, I don't think L&G has done anything wrong here.

Mr A has said he wasn't aware that the benefit amount due to him would be reduced by other income, and so he doesn't feel L&G should take this into account when settling his claim. But L&G has acted in line with the policy terms. So, I don't find it needs to do anything differently here.

Mr A has said the monthly benefit provided to him has been increased from £164.41 to £179.21. I haven't seen any information as to why this is. But I don't need to. I'm satisfied that L&G's calculation of £164.41 was in line with the policy terms. So, any amount above this is more than the terms and conditions of the policy, and therefore fair.

Suitability of the policy

Mr A feels the policy wasn't suitable for him. But L&G didn't sell the policy to Mr A. So, I don't hold L&G accountable for anything that happened at the point of sale.

I have however seen the policy schedule provided to Mr A when the policy was first taken out in 2005. And I'm satisfied this did explain that other income will be taken into account when the benefit is paid. So, I'm satisfied that L&G did what it needed to do, to let Mr A know of the key policy terms.

Mr A says that L&G should have checked the policy was suitable for him, in years following him taking the policy out. But that isn't for L&G to do – it simply provides the policy. It would be for Mr A, or an independent financial advisor if Mr A had one, to review the policy and decide whether it still met Mr A's needs.

Mr A has said that L&G should have told him about other income being deducted from any monthly benefit in the yearly letters sent to him, detailing the new premium and maximum monthly benefit. I've seen a document sent to Mr A in 2006, which his policy was index linked, which did explain:

"Important, if this increases your benefit above the maximum allowed by your income, then this may be more than we can pay out if there is a claim. The maximum protection benefit that you can receive is 55% of your pre-incapacity earnings up to £50,000 a year, and 35% of your pre-incapacity earnings over £50,000 up to a maximum benefit of £120,000 a year."

I think the above is clear in what is taken into account when the monthly benefit is calculated.

I haven't seen the letters detailing the new premium and monthly maximum benefit for all of the following years. But I don't think this alters the outcome of this element of the case. I wouldn't expect L&G to detail the terms around the benefit limit in these letters – as the terms hadn't changed from when the policy was taken out. And the terms were provided at that point. So, I don't think L&G did anything wrong here. There were reasonable prompts during the lifetime of the policy for Mr A to check his cover was still right for him. And it would then be for him to speak to any independent financial advisor or speak to L&G if he wanted to.

Claim progression

As above, L&G are required to deal with a claim promptly and fairly. Mr A has raised concerns about the time that was taken for L&G to deal with his claim. So, I've considered this element of the complaint.

L&G has accepted there was some delays in the progress of the matter. It said it aimed to deal with information relating to claims within 10 days, and it hadn't done that. But it said there was also a long delay caused by Mr A's GP, when it asked for information from it which it wasn't responsible for.

From looking at the contact notes provided to me, I can see there was some unavoidable delays – where L&G were waiting for medical information. But I agree there was times that L&G could have moved the matter forward more efficiently, as per its summary above. I can see how this would have been distressing and inconvenient to Mr A.

So, I've thought about whether the £250 compensation L&G offered to Mr A is fair. And I do think it is. I say this because I think it fairly recognises the trouble and upset caused to Mr A as a result of avoidable delays – such as needing to chase the progress of his claim. So, if L&G hasn't paid this already, it should now do so.

My final decision

Given the above, my final decision is that the £250 compensation offered by Legal & General Assurance Society Limited is fair and reasonable in the circumstances. I require Legal and General to pay this to Mr A – if it hasn't done so already.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr A to accept or reject my decision before 23 March 2023.

Rachel Woods
Ombudsman