DRN-4062424

The complaint

Miss D has complained that Legal and General Assurance Society Limited (L&G) has terminated the income protection claim she made under a group income protection policy.

What happened

The details of this complaint are well known to the parties. In summary Miss D became absent from work in 2010 due her health conditions and L&G admitted her claim.

L&G reviewed her claim. In January 2022, although her GP felt she wouldn't be able to carry out her role due to chronic pain and fatigue, it terminated the claim on the basis that Miss D wasn't receiving specialist input or ongoing treatment. In addition, L&G had arranged an independent assessment (a Chronic Pain Abilities Determination) which concluded, in October 2021, that Miss D wasn't incapacitated to the extent that she wouldn't be able to carry out her role.

Initially our investigator didn't recommend that her complaint be upheld. Miss D appealed. She said that she often spoke to her GP and had been referred to specialists. As L&G hadn't seen Miss D's medical records for the last few years our investigator recommended that L&G request Miss D's full medical records and then reassess her claim.

Miss D agreed to this course of action.

L&G didn't agree. It said it had written to Miss D's GP to understand the objective medical reasons and ongoing treatment they were providing. It was in the absence of ongoing objective medical evidence that it sought the independent medical examination. L&G didn't feel it was in Miss D's best interests to delay the matter and requested a decision.

As no agreement has been reached the matter has been passed to me to determine.

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 agree with the conclusion reached by our investigator. I'll explain why.

Firstly though, I'm aware I've set out the background to this complaint in less detail than the parties. No discourtesy is intended by this. Instead, I've focused on what I find are the key issues here. Our rules allow me to take this approach. It simply reflects the informal nature of our service as a free alternative to the courts. If there's something I haven't mentioned, it isn't because I've ignored it. I've reviewed the complete file. I'm satisfied I don't need to comment on every individual argument to be able to reach what I think is the right outcome.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. So I've considered, amongst other things, the terms of the insurance contract and the available medical evidence, to decide whether I

think L&G treated Miss D fairly.

L&G is aware that it bears the onus of showing that Miss D no longer meets the policy definition of 'disabled member'. It has conducted a thorough assessment – commissioning an independent report, seeking the input of its Chief Medical Officer and asking Miss D's GP for further information.

I understand why L&G feels it has demonstrated that it was able to terminate Miss D's claim. However I am satisfied that a full review of the objective evidence *should* include the medical notes. Miss D says that she spoke to her GP often seeking medical help and received referrals. Whilst this isn't objective evidence in itself, it does seem to me that L&G should assess the medical notes to see if anything has been overlooked in order to determine whether it makes any difference to its decision to terminate the claim. I do accept that GPs will base the reports they write on the medical records and Miss D's GP has written in support of her claim. But without having seen the full notes and checked that they accord (or otherwise) with Miss D's evidence, I'm not persuaded L&G could be satisfied that Miss D no longer met the policy definition of incapacity.

Miss D should be aware that I am not directing L&G to continue paying her benefit, only to reassess her claim in the light of the GP records from 2015 to the date of the termination of benefit, which it hasn't yet seen.

If Miss D's condition has deteriorated since the final response from L&G, she is able to make a new claim. Likewise if she feels she has new evidence not previously shared with L&G, she can submit that for L&G's consideration.

My final decision

For the reasons given above my final decision is that:

- Legal and General Assurance Society Limited should obtain the medical records from Miss D's GP from 2015

- Once in possession of these records it should re-assess its decision to terminate Miss D's claim

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss D to accept or reject my decision before 17 July 2023.

Lindsey Woloski
Ombudsman