DRN-4119527

The complaint

Miss G is unhappy that CIGNA Life Insurance Company of Europe SA-NV stopped making payments to her following a successful claim on a group income protection insurance policy she had the benefit of.

What happened

Miss G had the benefit of an income protection insurance through her employer ('the policy'). Subject to the remaining terms, the policy can pay out a monthly benefit if Miss G was unable to work due to illness after the waiting period.

Several years ago, Miss G became absent from work due to anxiety and depression. A claim was made on the policy which was accepted by CIGNA. It ended up paying the monthly benefit to Miss G until early 2021 when it concluded that Miss G had been partially fit to work at 50% incapacity since October 2020.

CIGNA then took the decision to terminate the claim in its entirety in early 2022. It deemed that Miss G was no longer incapacitated and should be able to return to work on a phased basis and with reasonable adjustments.

Miss G didn't think that was fair, so she complained to our service. Our investigator looked into what happened and upheld her complaint. He recommended CIGNA reinstate the claim and pay Miss G the monthly benefit payments she'd missed out on (plus simple interest at 8% on each backdated payment). He also recommended CIGNA pay £300 compensation for distress and inconvenience.

CIGNA didn't agree. So, Miss G's complaint was passed to me to determine. I issued my provisional decision in April 2023 explaining, in more detail, why I was intending to uphold Miss G's complaint - an extract of which appears below.

……..

The insurance industry regulator, the Financial Conduct Authority ('FCA'), has set out rules and guidance for insurers in the 'Insurance: Conduct of Business Sourcebook' ('ICOBS'). ICOBS says that insurers should act honestly, fairly and professionally in accordance with the best interests of their customers. It also says they should handle claims promptly and fairly - and shouldn't unreasonably reject a claim.

When making a claim, it's for Miss G to demonstrate that she met the definition of incapacity, and she was able to do that. As CIGNA reduced the monthly benefit - and thereafter terminated the claim - it's for it to show that Miss G no longer met the definition of incapacity, based on medical evidence. It's not for Miss G to show that she continued to do so.

The policy terms do allow for CIGNA to review the claim during the period of incapacity. Relevant to this complaint, the policy says:

> After a two (2) years of period continued Working Incapacity, a formal review will be

> undertaken by the Insurer. If the Insured Person is then still totally or partially unable to carry out his/her own occupation within [the policyholder], is not carrying out another occupation within [the policyholder] for which he or she might [sic] is reasonably fit by reason of education, training or experience, while protecting the social status, the benefits will continue to be paid on the basis of the above until a next review, with a maximum duration until the end of the Insured's Person's contract with [the policyholder].

And:

> Insured Persons who (after the one hundred thirty (130) working day waiting period) are benefiting from the monthly lump sum and whose condition is improving to such an extent that they are capable of partially resuming work, with medical consent, may continue to receive an allowance. The amount of this allowance will however be reduced, and will be calculated by multiplying the (total monthly) sum insured by the percentage of the (remaining) incapacity.

In early 2021, CIGNA evaluated Miss G to be partially fit to work (at 50% incapacity) and reduced the monthly benefit by 50% with effect of April 2021.

It also confirmed in November 2021 that its medical board were of the medical opinion that Miss G should be able to return to work on a phased return and would be ceasing payment in early 2022. It said there was no evidence that this would negatively impact Miss G's mental health. And concluded that the main challenge to Miss G returning to work was due to her being off work for several years and living abroad for a lot of this time. As such, it didn't think Miss G's claim could be medically justified any longer.

I'm not a medical expert. So, I've relied on all the evidence available to me when considering whether CIGNA reasonably reduced the monthly benefit, and thereafter terminated Miss G's claim, when it did. Having done so, I don't think it has acted fairly or reasonably for the reasons set out below.

- Miss G's consultant psychiatrist reported in 2019 that there had been no significant change in her condition (after several years), and she continued to struggle with low mood and anxiety. It was unlikely, in their view, that Miss G would return to her previous employment as "her current levels of anxiety preclude a return to work, quite apart from the geographical constraints". She felt anxious at the prospect of any voluntary work.

- Miss G's psychologist's report dated September 2020 details her diagnoses to be moderate/severe depression with anxiety, she continued to be prescribed antidepressants, she'd fully engaged with therapy and had eight therapy sessions that year to date - impacted by Covid-19 lockdowns in 2020. Miss G's clinical complaints are reflected to be: depression, anxiety, stress, lack of motivation and loss of self-confidence, low self-esteem and poor sleep.

- CIGNA arranged a report from a psychiatrist for early 2021 ('the psychiatrist'). The report concludes that "in view of the intensity and characteristics of the neuropsychic disorders displayed by the person concerned, the current temporary working incapacity benefit does not appear to be justified. Indeed, the person concerned could certainly resume a professional capacity at 50%". The report seems to be based on questions asked of Miss G during a short virtual meeting, where there was a language barrier and interpreter present. The report doesn't identify which of Miss G's medical records were considered (if any) or whether the psychiatrist had considered Miss G's job description, or any other job descriptions available within the

policyholder or the policy terms around incapacity. There's also nothing to explain why a percentage of 50% was appropriate.

- Looking at correspondence between Miss G and CIGNA's clinical claims specialist (and qualified psychotherapist) – 'the claims specialist' - in April 2021, I'm satisfied CIGNA said it didn't follow some of the conclusions of the psychiatrist as the medical opinions expressed in their report might not be reliable based on symptoms the claims specialist had witnessed. It was accepted that Miss G did exhibit symptoms indicative of moderate depression and moderate anxiety – whereas the psychiatrist had described these as mild. However, the claims specialist did agree – based on their own assessment - that Miss G should be able to return to work on a part time basis. This was based on an assessment by phone and the claims specialist advised that Miss G was able to carry out activities of daily living most of the time but as there are days when her mood is much worse, she refrained from concluding that she was fully fit to return to work. However, again, I've seen nothing to show why a percentage of 50% was used. And although Miss G was able to manage aspects of everyday living, it doesn't automatically follow that she was able to work given her symptoms. In the circumstances of this particular case, I've placed more weight on the opinions of Miss G's own psychologist, who'd she been having therapy with over a number of years and advised that she wasn't fit to work. That's consistent with other medical evidence I've referred to below.

- The psychiatrist's report is also inconsistent with another report from a medical practitioner with medicolegal experience arranged by CIGNA in October 2020 ('the medical practitioner') – so less than three months before the psychiatrist's report – which does set out some medical history and confirm the medical records reviewed. The report also sets out Miss G's reported symptoms and concludes: "in view of the length of the ailment and of the incapacity for work, a fundamental change in the situation should no longer be expected…"

- I know there's an extract from a report from the medical practitioner referred to in an email from CIGNA to Miss G dated 2 February 2021 where it's reflected that the medical practitioner agrees with the psychiatrist's conclusions in the report dated January 2021 in terms of the diagnosis and incapacity for work being assessed at 50% at that stage. However, that's based on a report which CIGNA subsequently accepted wouldn't be relied upon. Further, the medical practitioner's opinion differs from their own opinion only months before without any explanation as to why they've changed their mind. So, I've placed less weight on the extract from February 2021.

- So, overall, I'm intending to find that the decision taken to reduce the monthly benefit by 50% with effect of April 2021 isn't fair and reasonable based on the totality of the medical evidence up to that point.

- Prior to the decision taken by CIGNA to terminate the claim in its entirety it did request further information from Miss G's psychologist. Her answer reflects that she'd been working with Miss G since 2012, the number of sessions depended on Miss G's mental state; they may connect twice in one week or maybe once a month. And that she "suffers with persistent depression and this has a knock-on effect on her levels of anxiety, on her lack of self-confidence, and on her self-belief. These problems are all barriers to a return to work. Currently I do not consider her psychologically strong enough to engage in a search for work, nor a return to work".

- That's consistent with a report from an occupational health physician dated August 2021 which reflects that they took time to understand the nature of the role Miss G

was doing before she was unable to work due to illness to understand the general nature of work she might be required to undertake is she was successful in a job search process. It concludes that the clinical assessment they carried out indicated how very distressed Miss G was. And "objective assessment using validated depression and anxiety questionnaires confirmed symptoms to be in the severe range, this being consistent with her self-report and also in line with my clinical observations during the consultation". It concludes that Miss G wasn't "fit to engage in any form of job search activity and wouldn't be fit to undertake any work even if she were to be successful. Her level of functioning is currently so reduced, even on her better days, she would not be able to cope with the challenge of day-to work and perform in any way that would be acceptable".

- In support of the decision to terminate the claim, CIGNA's doctor said at the time that Miss G was able to manage a complex life and had very sporadic input from a therapist. And that she should be able to return to work on a phased basis with adjustments. However, because of the brevity of their email it's not clear what medical evidence that doctor had seen before making these conclusions. I don't think the medical evidence from Miss G's psychologist (particularly from 2020 and 2021), the occupational health physician and the medical practitioner's report from October 2020 supports that view.

- Considering the totality of the medical evidence, I don't think it's fair and reasonable for CIGNA to conclude that the reasons for not returning to work were unconnected to her medical condition such as living abroad or a concern about being made redundant – and wouldn't cause an impact of her mental health.

- I know when replying to Miss C's concerns towards the end of November 2021, CIGNA said that Miss G's psychologist's observations weren't sufficient, and no psychometric tests had been carried out since 2014. But I don't think the absence of psychometric tests is determinative and there is other medical evidence available in this case which I don't think CIGNA placed sufficient weight on. I don't think it's been fairly and reasonably able to establish that its acted reasonably when reducing the monthly benefit and terminating the claim.

Distress and inconvenience

From reading the correspondence passing between Miss G and CIGNA, I'm satisfied she's been put to significant and unnecessary inconvenience having to write to CIGNA multiple times setting out why her monthly benefit shouldn't be reduced and terminated. From reading the correspondence, I accept that she was also upset and frustrated at the way she was being treated. I'm satisfied that she would've been worried about losing the monthly benefit and this source of income under the policy whilst she was too ill to work. I propose that CIGNA pay her £500 compensation to reflect the distress and inconvenience it caused her.

Putting things right

I intend to direct CIGNA to do the following:

- reinstate the claim and continue to pay the monthly benefit in line with the terms of the policy;

- pay the full benefit for the benefit of Miss G for the period of time it reduced the benefit by 50% (less the amounts it paid during this period). It should also pay

directly to Miss G simple interest at 8% per annum on the difference between what Miss G did receive during that period and what she ought to have received.

- pay the monthly benefit for the benefit of Miss G from the date the claim was terminated to the date on which it's reinstated. It should also pay simple interest directly to Miss G in respect of the backdated payments at the rate of 8% per annum, from the date each monthly benefit was due to the date of settlement.

- pay Miss G £500 compensation for the distress and inconvenience CIGNA caused her by having the benefit reduced and thereafter terminated.

I also intend to direct CIGNA to provide Miss G with a written breakdown of all interest calculations set out above within 21 days from the date on which it makes payment to her. And if CIGNA considers it's required by HM Revenue & Customs to take off income tax from any interest paid, it should tell Miss G how much it's taken off. It should also give her a certificate showing this if she asks for one. That way Miss G can reclaim the tax from HM Revenue & Customs, if appropriate.

……

I invited both parties to provide me with any comments in response to my provisional decision. CIGNA said it had no further submissions to make but highlighted some extracts of medical reports it had previously provided. Miss G raised some further points around the internal appeal process, but she said she accepted my provisional decision.

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.

When provisionally deciding this complaint, I'd considered the medical reports referred to me by CIGNA in response to my provisional decision. I'd also considered the points Miss G has summarised when replying to my provisional decision.

In the absence of any further and new substantive information, I'm satisfied that there's no reason for me to depart from my provisional decision (an extract of which appears above and forms part of my final decision). So, I uphold Miss G's complaint.

Putting things right

I direct CIGNA to do the following:

- reinstate the claim and continue to pay the monthly benefit in line with the terms of the policy;

- pay the full benefit for the benefit of Miss G for the period of time it reduced the benefit by 50% (less the amounts it paid during this period). It should also pay directly to Miss G simple interest at 8% per annum on the difference between what Miss G did receive during that period and what she ought to have received.

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My final decision

I uphold Miss G's complaint and direct CIGNA Life Insurance Company of Europe SA-NV to put things right by doing what I've set out above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss G to accept or reject my decision before 7 June 2023.

David Curtis-Johnson
Ombudsman