DRN-4250372

## The complaint

Mr T complains that Legal and General Assurance Society Limited (L&G) has terminated benefit for an incapacity claim he made on a personal income protection insurance policy.

## What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I think are the main events.

Mr T holds a personal income protection insurance policy. In 2019, Mr T made an incapacity claim on the policy, after he required bypass surgery. A short time later, Mr T was diagnosed with probable chronic migraine by a consultant neurologist. He was prescribed a variety of medications to try and bring his symptoms under control. Mr T did return to work, but on a part-time basis. He said that instead of working 32 hours per week over four days, he worked 24 hours per week – sometimes over three days, but sometimes over more, depending on his symptoms. He made a claim on the income protection insurance policy.

L&G accepted Mr T's claim and it remained in payment on a proportionate benefit basis until 2022. However, in September 2022, L&G arranged for Mr T to speak with a vocational clinical specialist (VCS), who concluded that Mr T was fit to return to work on a full-time basis and that he no longer met the policy definition of incapacity. So L&G terminated Mr T's claim in October 2022.

Mr T appealed and provided further medical evidence in support of his claim. L&G's medical officer (MO) reviewed the claim and the new evidence but maintained that Mr T no longer met the definition of incapacity. So Mr T asked us to look into his complaint.

Our investigator recommended that Mr T's complaint should be upheld. He explained that it was L&G's responsibility to provide enough evidence to show, on balance, that Mr T no longer met the policy definition of incapacity. He didn't think it had done so here. He didn't think the VCS' report accurately recorded Mr T's working patterns. And he also felt that L&G had wrongly focused on the number of hours Mr T was able to work, rather than whether or not his income had reached its pre-incapacity level. He didn't think it had been fair for L&G to terminate Mr T's claim and he recommended that it should reinstate the claim; pay any backdated benefits Mr T was entitled to and that it should also add interest to each backdated payment.

L&G disagreed and I've summarised its responses. It said Mr T self-reported that he suffered from 20 hours of migraines per month, which left 640 hours per month in which he could work over the course of a normal five day working week. The definitions set out in the policy weren't dependent on income, but also a policyholder's ability to carry out their own occupation. It questioned what objective evidence there was that Mr T was unable to carry out his self-employment – or that his migraines always happened during working hours. Additionally, it considered that Mr T's response to migraines wasn't consistent with NHS information about migraines. It noted that Mr T's company had three employees – so it queried who managed the workload and what one of the other director's (Mr T's close relative) income had been since Mr T stopped working. It considered that the business

continued to operate without Mr T's input. And it maintained that Mr T was fit to resume full-time work and it queried why he hadn't implemented any environmental adjustments which could negate his symptoms.

The complaint's 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.

Having done so, I don't think it was fair for L&G to terminate Mr T's claim and I'll explain why.

First, I'd like to reassure both parties that while I've summarised the background to this complaint and the parties' detailed submissions, I've carefully considered all that's been said and sent to us. Within this decision though, I haven't commented on each point that's been made and nor do our rules require me to. Instead, I've focused on what I think are the key issues.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. So I've carefully considered, amongst other things, the policy terms and conditions and the available evidence, to decide whether I think L&G has handled Mr T's claim fairly.

It's a general principle of insurance that it's for a policyholder to provide enough evidence to show that they have a valid claim on their policy. This means that at the outset, it was Mr T's responsibility to provide L&G with enough medical and other evidence to demonstrate that he met the policy definition of incapacity. It's common ground that L&G was satisfied that Mr T was incapacitated in line with the policy terms and it accepted his claim in 2019. Once an insurer accepts an income protection insurance claim, the burden of proof switches. I generally take the view that in order for it to terminate Mr T's claim fairly and reasonably, L&G needs to provide enough evidence to show that Mr T no longer meets the definition of incapacity.

I've first considered the policy terms and conditions, as these form the basis of Mr T's contract with L&G. L&G concluded that Mr T no longer met the policy definition of incapacity and so I've looked closely at the definition of incapacity. This is defined as: *'Own occupation: If you are in gainful employment or gainful self-employment at the time of incapacity we will consider you to be incapacitated once we have assessed your claim as set out in the section headed "Assessing your claim" and are satisfied that you have no capacity for working in your own occupation, on any basis, as a direct result of your injury or illness.'*

L&G paid Mr T's claim on a proportionate basis. So I've looked at the terms relating to proportionate benefit. These say:

*'If you return to gainful employment or gainful self-employment on a lower level of earnings than you received immediately before your incapacity,* ***directly as a result of your incapacity****, the proportionate monthly benefit will be payable.* (My emphasis added).

*The Proportionate Benefit will be equivalent to the reduction in your earnings compared to your earnings in the 12 months before incapacity.'*

I've gone on to consider then whether I think L&G has provided enough evidence to show both that Mr T no longer met the policy definition of incapacity and that his self-employed income was lower for reasons other than his incapacity.

I've looked closely at the available medical evidence – including clinic letters; Mr T's GP records and the findings of both L&G's MO and the VCS. It's clear that since 2019, Mr T has suffered from a diagnosis of probable chronic migraine, from a consultant neurologist – an expert in their field. Mr T has been prescribed a number of medications to try and treat his symptoms. The neurologist concluded that the aim was to get Mr T to a position where he was suffering less than 20 hours of migraine per month.

In January 2022, the neurologist wrote to Mr T saying:

'*There have been months in the past 6 months where you have been less than 20 hours a month, for example in autumn of last year but things have been upset by the Covid vaccination and getting Covid in January, both of which caused a migraine spike. I think we need to see how the next 4 months go and as long as your migraine hours are falling month by month then I think (medication) will have you on track.*

*If not we may take up (another neurologist's) suggestion and put you on one of the drugs he has advised.'*

In August 2022, the neurologist wrote to L&G, reiterated their comments above, explained that Mr T was seeing another neurologist through the NHS and stated: *'a phased return to work through a rehabilitation consultant would be entirely reasonable.'*

And in November 2022, the neurologist stated:

'*Unfortunately, this year has been up and down for you. Your migraine can be as good as 35 hours per month but should you get COVID or get stressed, it can be very much worse. It is a sign that we don't have things quite right for you.'*

In my view, the neurologist, who had been treating Mr T since his original diagnosis, appeared to consider that Mr T's migraine symptoms could be significantly worse than 35 hours per month. It isn't at all clear to me, based on the neurologist's evidence in November 2022, that they felt Mr T's symptoms had improved from January 2022. In January 2022, the claim had still been in payment, which indicates that L&G still considered Mr T met the policy definition of incapacity.

Additionally, on top of regular fit-notes during the relevant period, which state that Mr T was only fit to work three days a week due to migraine, his GP also provided a letter to L&G in November 2022. This included the following:

'*He has suffered from migraine type headaches since his heart surgery in June 2019 and has been under (consultant neurologist) since September 2019. Over this time he has tried several treatments and changes in his work patterns, with the aim of reducing the migraine frequency and severity.*

*Prior to the migraine issues he was working 32 hours a week over 4 days but since the migraines have started, he has found he is usually only able to manage a maximum of 6 hours of work before the onset of headache. He tends to work therefore 6 hours a day over 4 days. Even with this reduced working pattern and regular breaks throughout the day, he is still troubled with significant headaches and remains under (neurologist's) care for this.*

*To put this into context; over the past 3 months he has experienced 30 days of headaches lasting a total of 183 hours. This is a significant burden.*

*This pattern of headaches has changed the pattern of work also in that it limits his ability to travel, and in that stress seems to make the headaches worse and this limits the type of*

*contract he has been able to take.'*

L&G now questions the self-reported nature of Mr T's symptoms. It seems to me that L&G has been prepared to rely on the neurologist's evidence, the GP fit notes and Mr T's description of his working patterns and symptoms since 2019. While I've borne in mind it's MO's evidence and the NHS link it referred to, I find the neurologist's evidence more persuasive, given they're an expert in their field. I'm mindful too that Mr T has also seen another neurologist who has suggested treatment for migraine. It seems more likely than not then that the neurologists who've had the opportunity to examine and treat Mr T think he does have probable chronic migraine and they've spent some time in trying to find the right treatment for him. And it isn't clear to me why L&G now questions Mr T's self-reported symptoms and probable diagnosis, so far into the claim.

It's clear that L&G feels strongly that based on Mr T's discussion with its VCS, he is fit to work full time. Like the investigator, I've listened to the call between Mr T and the VCS. I can understand why the VCS might have concluded that Mr T worked 24 hours over three days. But he did say that sometimes he spread those three days over the other days of the week, rather than doing eight hours per day – and that he needed regular breaks. Mr T told the VCS that he hadn't increased his hours and described his activities of daily living and leisure activities. The VCS concluded:

*'Based on the customer's reporting today, in my clinical opinion and with no evidence to the contrary, the customer is likely to fit to resume his full contracted hours in his insured role.'*

I don't think this is strong enough evidence to show that Mr T no longer meets the definition of incapacity. It relies on 'no evidence to the contrary' to prove the claim should be terminated. But as I've explained, it isn't for Mr T to demonstrate he's still incapacitated – it's for L&G to show he isn't. And I don't think the VCS' findings are enough to negate the neurologist's and GP's evidence. Instead, I think the medical evidence from the treating specialists and Mr T's GP are persuasive enough to show that Mr T is still incapacitated in line with the policy terms.

As the investigator explained, the policy says that L&G will pay proportionate benefit if a policyholder returns to employment and receives a lower level of earnings than they were receiving immediately before their period of incapacity. Mr T was still earning a lower level of income than before his incapacity began in 2019. L&G has questioned Mr T's business structure and the income of another director. I can't see that L&G has previously raised this with Mr T in any meaningful way. Nonetheless, the policy refers to 'you' – which is defined as *'The person who is named as the life insured in this Policy Booklet.'* Mr T is the only named insured under this policy and therefore, it's his income which is relevant.

If L&G wishes to terminate Mr T's claim because it considers his earnings are now lower for reasons other than his incapacity, again, I think it needs to provide enough evidence to show, on balance, that that's the case. And based on the evidence I've seen; I don't find that's it's done so here.

Overall then, I find that L&G hasn't provided enough evidence to show, on balance, that Mr T no longer meets the policy definition of incapacity; or that Mr T's income is lower than his pre-incapacity income for reasons other than his incapacity. So it follows that I'm not satisfied that L&G has shown it was fair and reasonable to terminate Mr T's claim.

Accordingly, I find that it must now reinstate and pay Mr T's claim, backdated to the date of termination. And it must add interest of 8% simple to each monthly benefit payment from the date it was due until the date of settlement. If Mr T has paid any monthly premiums which wouldn't have been collected if the claim had remained in payment, L&G should include a

refund of those premiums, together with interest, in the settlement.

I must make clear that L&G remains entitled to periodically review the claim, in line with the policy terms and conditions to assess whether the claim remains payable. This may include asking Mr T to provide further evidence or undergo further medical assessment.

**My final decision**

For the reasons I've given above, my final decision is that I uphold this complaint.

I direct Legal & General Assurance Society Limited to:

- Reinstate and pay Mr T's claim, backdated to the date it was terminated;

- Add interest at an annual rate of 8% simple to each backdated monthly benefit from the date it was due until the date of settlement; *

- Refund Mr T any premiums he wouldn't otherwise have paid if the claim hadn't been terminated, along with interest on that refund amount of 8% simple per year.

*If L&G considers that it's required by HM Revenue & Customs to deduct income tax from that interest, it should tell Mr T how much it's taken off. It should also give Mr T a tax deduction certificate if he asks for one, so he can reclaim the tax from HM Revenue & Customs if appropriate.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr T to accept or reject my decision before 8 September 2023.

Lisa Barham
**Ombudsman**