DRN-4660418

The complaint

Miss L complains that Aviva Life & Pensions UK Limited has turned down an incapacity claim she made on a group income protection insurance policy.

What happened

The background to this complaint is well-known to both parties. So I haven't set it out in detail here. Instead, I've set out a summary of what I think are the key events.

Miss L is insured under her employer's group income protection policy. The policy provides cover in the event that Miss L is unable to work in her own or a suited occupation, as a result of illness or injury. The deferred period is 26 weeks.

In March 2023, Miss L was signed-off from work, suffering from depression. Her employer made an incapacity claim on the policy.

Aviva requested medical evidence to allow it to assess the claim. It said Miss L needed to show she'd been incapacitated due to illness for the whole of the deferred period and afterwards. Having considered the medical evidence, although it noted Miss L had a number of personal stressors, it concluded that the trigger for Miss L's absence was workplace stress. This was specifically excluded by the policy terms. And Aviva didn't think there was enough medical evidence to show either that Miss L was functionally impaired or how her symptoms prevented her from working. So it didn't think Miss L had met the policy definition of incapacity and it turned down her claim.

Miss L was unhappy with Aviva's decision and she asked us to look into her complaint.

Our investigator didn't think Miss L's complaint should be upheld. He didn't think there was enough medical evidence to show Miss L was incapacitated in line with the policy terms. So he thought it had been fair for Aviva to turn down her claim.

Miss L disagreed. In summary, she said her medical notes were limited because she'd learned to self-manage her symptoms. She said she didn't realise how important her medical records would be to the assessment of her claim. She told us there'd been stress in her personal life, as well as at work. She said that were it not for the personal stressors, she'd have been able to deal with her workplace issues.

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, whilst I'm very sorry to disappoint Miss L and I know how upsetting my findings will be to her, I don't think it was unfair for Aviva to turn down her claim. I'll explain why.

First, I'd like to reassure Miss L that while I've summarised the background to her complaint and her detailed submissions to us, I've carefully considered all that's been said and sent. It's clear Miss L has experienced very difficult and challenging circumstances and I was very sorry to hear about the situation that led to Miss L needing to make a claim. I don't doubt what a worrying and upsetting time this has been for her.

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 this policy and the available medical evidence, to decide whether I think Aviva handled Miss L's claim fairly.

I've first considered the terms and conditions of the policy, as these form the basis of Miss L's employer's contract with Aviva. Miss L made a claim for incapacity benefit, given she wasn't fit for work. So I think it was reasonable and appropriate for Aviva to consider whether Miss L's claim met the policy definition of incapacity. This says:

'*The member's inability to perform on a full and part time basis the duties of their job role and other occupations for which they are suited by reason of education, training or experience, as a result of their illness or injury.'*

This means that in order for Aviva to pay Miss L incapacity benefit, it must be satisfied that she had an illness or injury which prevented her from carrying out the material and substantial duties of her own role or any other occupation she was suited to given her education, training or experience.

The policy says that Aviva will begin to pay incapacity benefit after the end of the deferred period. This means that in order for benefit to be paid, Miss L needed to have been incapacitated in line with the policy terms for the entire deferred period and afterwards.

It's a general principle of insurance that it's for a policyholder to show they have a valid claim on their policy. This means it was Miss L's responsibility to provide Aviva with enough medical evidence to demonstrate that an illness had led to her being unable to carry out the duties of her own occupation or a suited occupation for the full 26-week deferred period following the start of her absence from work in March 2023.

Aviva considered the available medical and other evidence. While it sympathised with Miss L's position, it concluded that she wasn't suffering from a functionally impairing illness which prevented her from carrying out her role. So I've next looked at the available medical and other evidence to assess whether I think this was a fair conclusion for Aviva to draw.

It's clear that Miss L was signed-off work by her GP in March 2023, suffering from depression. I appreciate she was also prescribed thyroid medication and she's told us that she has osteoporosis and spinal problems. Miss L has provided us with GP fit notes which state that she wasn't fit to work in March, June and July 2023 due to depression. It's clear from Miss L's medical records that she has suffered from depression over a number of years and has been on prescription medication to treat it for some years, too.
However, as Miss L accepts, the available medical evidence from the time of the claim is limited. Miss L's GP records don't indicate a deterioration in her symptoms or a referral to secondary care. Nor is there any evidence to suggest how or why Miss L's symptoms prevented her from working or why she wouldn't be able to undertake a suited role for any other employer. And the GP's records don't indicate either that Miss L was unable to work

due to any thyroid issue or bone disease. While I entirely understand that Miss L often self-manages her symptoms, there's simply very little medical evidence from around March 2023 and during the deferred period to show that her condition had worsened or that she was incapacitated by it.

From the evidence Miss L has provided to both our service and to Aviva, it appears that she was experiencing ongoing issues at work over a prolonged period, as well as a number of very upsetting personal stressors. Miss L says that but for the personal stressors, she would have been able to deal with workplace issues and I accept this may be the case. But given the evidence and testimony she provided to Aviva, which set out in detail some of the workplace problems she'd experienced, I don't think it was unreasonable for it to conclude that workplace stress was at least a part of the reason for Miss L's absence. And the policy clearly excludes claims which are caused by workplace matters.

I've thought very carefully about all of the evidence that's been provided and which was available to Aviva when it made its final decision on Miss L complaint. It's important I make it clear that I'm not a medical expert. In reaching a decision, I must consider the information provided (including the medical evidence) decide what evidence I find most persuasive.

It's clear that Miss L was suffering from symptoms which can also be indicative of both a significant mental health condition. But, I have to bear in mind the contemporaneous medical evidence which was available to Aviva when it assessed the claim and when it issued its final response to Miss L's complaint. And, as I've set out above, there's simply very little evidence to show why or how Miss L was or would be incapacitated from carrying out the duties of her role or any suited occupation as a result of her illness.

As such, taking into account the totality of the medical and other evidence available to Aviva when it assessed this claim, I don't think it unfairly concluded that Miss L hadn't shown she met the policy definition of incapacity. So I don't think it was unreasonable for Aviva to turn down Miss L's claim.

It remains open to Miss L to obtain further medical evidence in support of her claim should she wish to do so and to send any new evidence to Aviva for its review. I'd expect Aviva to consider any new evidence in line with the policy terms and its regulatory obligations. If Miss L is unhappy with the outcome of any further review of her claim, she may be able to make a new complaint about that issue alone.

My final decision

For the reasons I've given above, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss L to accept or reject my decision before 23 April 2024.

Lisa Barham
Ombudsman