DRN-4797239

The complaint

Mrs K complains that Zurich Assurance Ltd terminated benefit for an incapacity claim she made on her employer's group 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 key events.

In 2013, Mrs K was signed-off of work suffering from back pain. An incapacity claim was made on Mrs K's employer's group income protection insurance policy. Zurich accepted the claim and benefit was paid.

Subsequently, in 2016, Mrs K began a phased return to work plan and was due to return to full-time hours by December 2016.

In January 2017, Mrs K was signed-off work with an unrelated virus, before being signed-off again with complications of another treatment between March and June 2017. In July 2017, Mrs K began to see a new consultant about a flare-up of her back pain. I'll call the consultant Mr E. Mrs K considered her claim should remain in payment.

However, Zurich terminated the claim with the last benefit payment representing benefit for December 2016. That's because it considered she'd been fit to return to full-time hours in December 2016, in line with the phased return to work plan. And it said there was no medical evidence that Mrs K had been incapacitated due to her back pain between January and June 2017. It concluded her absence had been caused by complications of another treatment – a new and unrelated condition. And by the time Mrs K's benefit had been terminated, her employer had switched income protection insurers.

Separately, Mrs K went on to make a claim with the new income protection insurer. Zurich paid benefit during the new insurer's deferred period, in line with the policy, but it didn't agree to reinstate Mrs K's claim.

Unhappy with Zurich's decision, Mrs K complained to our service about Zurich's decision to end benefit in 2016. Our investigator considered all of the available medical evidence and didn't think it had been unfair for Zurich to terminate benefit at the end of 2016.

Subsequently, Mrs K provided a new letter from Mr E in support of her position. Zurich assessed this piece of evidence but didn't change its position. So Mrs K asked us to look into a new complaint about Zurich's decision to maintain its stance.

Our investigator explained that she could only consider whether it had been fair for Zurich to maintain its decision to have ended benefits based on the new medical evidence from Mr E. She didn't think the new evidence showed that Mrs K had been incapacitated in line with the policy terms between the end of 2016 and July 2017. Therefore, she didn't think it had been unfair for Zurich maintain its decision to end benefit at the end of 2016.

Mrs K disagreed and so 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 sorry to disappoint Mrs K, I don't think Zurich has treated her unfairly and I'll explain why.

First, I must make it clear that this decision will *only* consider whether Zurich acted reasonably when it assessed Mr E's letter of May 2023 and maintained its decision to stop paying Mrs K's claim at the end of 2016. I won't be commenting on any of the medical evidence which has already been considered by this service or any further on the merits of the case we've already looked at.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, together with other relevant regulatory rules and guidance (amongst other things) when deciding whether I think Zurich treated Mrs K fairly.

As the investigator explained, in order for Zurich to continue to pay Mrs K incapacity benefit, she needed to continue to meet the policy definition of incapacity. The policy says that incapacitated means:

'an illness or injury that causes the Member to be unable to work and is applicable under this policy. The Incapacity definition that applies is in your policy schedule. The Member must be under the regular supervision and treatment of a Medical Practitioner.

We can ask for medical evidence at regular intervals throughout a claim.'

The policy then explains the 'standard' definition of incapacity as follows:

'The Member cannot perform the Material And Substantial Duties of their employment and they are not doing any paid work.'

Zurich concluded that benefit should cease at the end of 2016 because it wasn't satisfied Mrs K had been incapacitated in line with the policy terms after that date. It considered Mr E's letter dated 9 May 2023, as I'd expect it to do, and maintained that this didn't change its position. So I've looked carefully at Mr E's letter. I've set out what I think are his key points below:

'*This letter is to confirm that (Mrs K) has been under my care since 2017…*

Once (another doctor) had completed his course of radiofrequency denervation procedures in 2016 Mrs K was then referred to physiotherapy for further improvements of her residual symptoms as she was still unable to return to work due to residual pain and symptoms, Mrs K did contact our office in 2016 as she felt that pain was increasing due to her phased return to work, but was advised by me to continue carrying out physiotherapy treatment to see if the symptoms would improve, however due to no further improvement, she then attended her initial consultation.'

It's clear that Mrs K did contact Mr E's office in 2016 as she'd believed her pain was increasing. But Mr E doesn't suggest that he felt Mrs K was unable to work at that point due to her back condition – instead he simply advised her to continue with physiotherapy. And it

remains the case that Mrs K ultimately didn't go on to consult with Mr E until July 2017 – some months after she'd been signed-off work with other medical conditions.

So on that basis, I don't think it was unfair for Zurich to maintain its earlier claims decision because I don't think Mr E's letter indicates that Mrs K was incapacitated by her back pain in line with the policy terms in late 2016 . And I don't think it shows either that she *was* incapacitated or *why* she was incapacitated between January and July 2017. I'd add that it's still the case that in July 2017 – at the time of Mrs K's first consultation with Mr E - Zurich was no longer Mrs K's employer's income protection insurer. As such, I don't think it was unreasonable for Zurich to conclude that Mr E's evidence didn't show that Mrs K met the policy definition of incapacity after the date benefit ended.

Overall then, whilst I sympathise with Mrs K's position and I was sorry to read about the circumstances of her claim, I'm not telling Zurich to pay her any further benefit.

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 Mrs K to accept or reject my decision before 14 June 2024.

Lisa Barham
Ombudsman