DRN-4814234

Financial Ombudsman Service

The complaint

Mrs S complains that Vitality Life Limited has turned down an incapacity claim she made on the income protection cover provided by a Vitality Essentials insurance plan.

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.

Mrs S took out a Vitality Essentials insurance plan. This included income protection insurance cover, which provided cover for up to 24 months if a policyholder was incapacitated by illness or injury. The policy included a deferred period of 1 week.

In March 2020, Mrs S was signed-off from work. And in April 2020, she made an incapacity claim on the policy. She was diagnosed with functional neurological disorder (FND) and also fibromyalgia. She was under the care of her GP, a consultant neurologist who I'll call Dr D and a rheumatologist.

Initially, Mrs S was unhappy with delays in Vitality assessing her claim. She brought a complaint to this service about those delays, which was considered by an investigator.

Subsequently, having assessed the available medical evidence, Vitality turned down Mrs S' claim. It had referred Mrs S for a functional capacity and cognitive evaluation (FCCE), which had found a disparity between Mrs S' reported symptoms and the results. Taking everything together, Vitality didn't think Mrs S had shown she met the policy definition of incapacity.

In March 2021, Mrs S cancelled the Essentials plan, meaning that her income protection cover ended from that date.

Mrs S was unhappy with Vitality's decision to decline her claim and so she made a further complaint about that issue. Vitality issued its final response to that complaint in January 2021. So in April 2021, our investigator considered the medical evidence and FCCE results which had been available to Vitality up until January 2021. And he felt it had been reasonable for Vitality to turn down Mrs S' claim.

Later in 2021, Mrs S went on to provide Vitality with further evidence. She continued to send evidence until late 2023 – including from Dr D and the rheumatologist. She also provided evidence that she'd been awarded employment support allowance (ESA).

However, Vitality maintained its stance and it issued a further claim decline in October 2023. But it acknowledged that its reassessment of the claim had taken far too long and so it offered Mrs S £1000 compensation to reflect this.

Remaining unhappy with Vitality's position, Mrs S asked us to look into a new complaint.

Our investigator considered the evidence which had been available to Vitality since January 2021. And she still didn't think it had been unreasonable for Vitality to conclude that Mrs S hadn't shown she met the policy definition of incapacity.

Mrs S disagreed and so the complaint was passed to me to decide.

I issued a provisional decision on 20 May 2024 which explained why I thought Vitality had already made a fair offer to settle Mrs S' complaint. I said:

'*First, I must make the parameters of this decision clear. I will only be considering whether it was fair for Vitality to maintain its decision to decline the claim after it issued its final response to Mrs S' complaint in January 2021. That's because, in April 2021, one of our investigators considered Vitality's actions up until that point and he was satisfied it had been reasonable for Vitality to have declined the claim. His review of the complaint included all of the medical evidence which had been available to Vitality when it issued its final response in January 2021. That evidence included a letter to Vitality, from Mrs S' GP, dated September 2020. I appreciate Mrs S feels this is new evidence which ought to be considered as part of this complaint. But I'm satisfied the letter was included in Vitality's previous case file and that our investigator took this evidence into account when he assessed Mrs S' complaint. That complaint was closed around two years ago. And therefore, I won't be commenting any further on that piece of evidence.*

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 taken those rules into account, along with other regulatory rules and guidance, amongst other relevant considerations, to decide whether I think Vitality has treated Mrs S fairly.

I've first considered the terms and conditions of the policy, as these form the basis of Mrs S' contract with Vitality. Mrs S made a claim for incapacity benefit, given she'd been signed-off work. So I think it was reasonable and appropriate for Vitality to consider whether Mrs S' claim met the policy definition of incapacity. This says:

'Incapacity means that illness or injury makes you unable to perform the material and substantial duties of your own occupation. These are the duties that are normally needed to do your own occupation and that cannot reasonably be omitted or modified by you or your employer. To meet this definition, you must also not be working in any other occupation for payment or profit.'

This means that in order for Vitality to pay Mrs S 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 occupation, for the entirely of the one week deferred period and afterwards. And, given Mrs S cancelled the policy in March 2021, Vitality must be satisfied that she was incapacitated, in line with the policy terms, while the policy was still in force.

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 Mrs S' responsibility to provide Vitality with enough medical evidence to demonstrate that an illness had led to her being unable to carry out the duties of her own occupation during the deferred period and in the following months, up until the point the policy was cancelled.

Following its original decision to turn down the claim, Vitality assessed the further evidence Mrs S provided in support of her claim, including seeking the opinion of its clinical staff. And it wasn't persuaded to change its original conclusion. So I've next looked at the medical and other evidence which was available to Vitality after January 2021 to assess whether I think this was a fair conclusion for Vitality to draw.

Mrs S sent Vitality a number of letters, from Dr D and from her rheumatologist. There's no dispute that Mrs S has been diagnosed with FND and fibromyalgia and that she's reported a number of distressing symptoms. I can see that in May 2021, Dr D referred to the fact that

Mrs S' reported symptoms caused her difficulty with her occupation. In November 2021, her rheumatology consultant referred to Mrs S having symptoms over a prolonged period of time. Mrs S was referred to a multi-disciplinary team, including occupational therapy. Her GP notes after January 2021 show Mrs S spoke with her practice on a number of occasions about her symptoms.

In March 2022, Dr S noted Mrs S' condition was improving. But her symptoms seem to have continued to be reported, she continued to speak to medical practitioners and remained medicated for her symptoms. She was also seen by another neurologist in May 2023. Subsequently, in September 2023, Dr D wrote to Vitality again. I note they said:

'You will note that there is a specific issue in terms of (Mrs S) reporting a momentary movement issue in terms of holding objects and fine motor control specifically in terms of using a (specific implement) and again, clinically I would class this as been [sic] part of a functional neurological disorder…

I understand (Mrs S) had tried to return to work in March 2020 but then felt there was a safety issue in terms of continuing. Again there was difficulty in terms of using … instruments, and again in hindsight, this would relate to her functional neurological disorder.'

I'm mindful too that in June 2021, Mrs S was assessed by a clinical expert at the DWP who awarded her ESA.

I've thought very carefully about all of the evidence that's been provided and which was available to Vitality when it reassessed Mrs S' claim. It's important I make it clear that I'm not a medical expert. In reaching a decision, I must consider the evidence provided by both medical professionals and other experts to decide what evidence I find most persuasive. It isn't my role to interpret medical evidence to reach a clinical finding – or to substitute expert medical opinion with my own.

In my view, the majority of the evidence Mrs S has provided post-dates the cancellation of her policy. She was awarded ESA after her policy ended (and I'd add that an award of ESA doesn't mean that an insurer's policy definition of incapacity has been met). While I've carefully weighed-up the medical evidence which was available to Vitality after January 2021, it appears largely to be based on Mrs S' self-reporting of her symptoms. And I don't think any of her treating doctors have expressly indicated that Mrs S was incapacitated by her symptoms during the deferred period and up until the point the policy was cancelled. Nor do I think there's enough medical evidence which undermines the findings of the FCCE taken in 2020. I do understand Mrs S' symptoms may have worsened since that time – but after March 2021, no policy existed. So I don't think I can reasonably direct Vitality to accept the claim on this basis.

Based on the evidence I've seen so far; I don't currently think Mrs S has shown she met the policy definition of incapacity during the deferred period and afterwards. And therefore I don't think Vitality acted unfairly when it concluded again that Mrs S' claim wasn't covered by the policy terms.

With that said, Vitality acknowledges there were clear and unreasonable delays in its reassessment of this claim. It seems to have taken Vitality around 18 months to review the new evidence and make a new claims decision. This is in clear breach of its obligation to handle claims promptly. And I don't doubt that the delay in reassessment and the inconvenience of chasing Vitality up caused Mrs S additional, material trouble and upset. As such, I think it's appropriate that Vitality should pay Mrs S compensation to reflect this.

Vitality has offered to pay Mrs S £1000 compensation. In my view, this is a very fair and reasonable award to reflect what I consider to be the likely impact of the claim delay on Mrs S. And so I'm satisfied Vitality has already made a fair offer to resolve this complaint. Vitality should pay Mrs S £1000 compensation if it hasn't already done so.'

I asked both parties to send me any additional evidence or comments they wanted me to consider.

Vitality had nothing more to add.

Mrs S didn't accept my provisional findings. I've summarised her response:

- She'd had a positive Hoover test both in 2020 and in 2023 – which is a tool specialists use to diagnose FND. The outcomes of those tests weren't self-reported;
- ESA had been paid since May 2020 – not June 2021, as I'd said;
- The FCCE report had missing results – which Mrs S considered should affect the report's overall conclusions;
- Vitality had told her that stopping her premiums wouldn't prevent her from making a claim;
- Mrs S continues to be under the care of specialists for further treatment, as she remains incapacitated;
- It was hard enough managing pain and fatigue each day. But Mrs S felt Vitality's failure to properly handle her claim had had a detrimental impact on her life; home and family;
- She asked that Vitality pay the compensation it had already offered to the account from which it had previously collected her policy premiums.

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 S, I still think Vitality has made a fair offer to settle her complaint and I'll explain why.

First, I would reiterate that Mrs S' policy was cancelled in March 2021. So in order for me to be persuaded that Vitality ought reasonably to accept and pay a backdated claim, I'd need to be satisfied that there's sufficient evidence that Mrs S was incapacitated, in line with the policy terms, prior to the cancellation date of the policy and afterwards. Mrs S *could* still make a valid claim on the policy, despite its cancellation, *if* the available evidence indicated she'd become incapacitated while the policy was still in force.

As I explained in my provisional decision, it's a policyholder's responsibility to provide enough evidence to show they have a valid claim on their policy. And it remains the case that as I set out above, much of the medical evidence refers to Mrs S' largely self-reported symptoms.

I do accept that one of Mrs S' treating specialists noted that Mrs S had displayed a positive Hoover's sign in May 2023. Mrs S says a positive Hoover's sign can be a tool in the diagnosis of FND. And Mrs S also told us that a positive Hoover's sign had been noted in 2020 – when she was first diagnosed with FND. However, I don't think this, in and of itself, is sufficient evidence that Mrs S' diagnosed FND had caused her to be incapacitated. And I still don't think Mrs S' treating doctors have expressly suggested that Mrs S was incapacitated by her symptoms during the deferred period or up until the point was cancelled.

Mrs S says she began to be paid ESA in May 2020, rather than in June 2021. Mrs S' ESA assessment with a medical professional took place in June 2021 and it was the resulting report which concluded she had a limited capability for work. But, as I've explained, the award of ESA doesn't mean a policyholder meets an insurer's policy terms. So I don't find this to be compelling evidence that Mrs S was incapacitated prior to the cancellation of the policy, even if Mrs S was paid ESA earlier than the date of the report.

It's clear Mrs S has concerns about the FCCE and she believes it had missing results. But as I've said, this service has already previously taken the FCCE into account as part of the assessment of Mrs S' separate – closed – complaint. So it wouldn't be appropriate for me to comment on that issue here. Notwithstanding this, I still don't think Mrs S has provided Vitality with enough medical evidence to undermine the findings of the FCCE.

Overall, I sympathise with Mrs S' position because I appreciate she's experienced symptoms for a number of years now and that she's in a difficult situation. I'd also add that I'm not suggesting that Mrs S is fit for work. – I understand her GP has signed her off and that she continues to require treatment. However, I've carefully considered the medical evidence available to me. And I simply don't think it was unfair for Vitality to maintain its decision that Mrs S hasn't shown she met the policy definition of incapacity throughout the deferred period and up until the point the policy was cancelled. So it follows that I still don't think Vitality acted unfairly when it turned down her claim.

As I set out in my provisional decision, Vitality has already offered Mrs S £1000 compensation for the acknowledged, unreasonable delays in reassessing the claim. In the circumstances, I remain satisfied that £1000 is a very fair and reasonable offer of compensation to reflect the material distress and inconvenience I think Mrs S was caused by these delays and in needing to chase things up. Mrs S has asked that Vitality pay this amount to the account from which it collected her direct debit payments while the policy was in force. Given the time that's passed since the policy was cancelled, it's possible that Vitality may no longer hold this information. So it would be helpful if Vitality could contact Mrs S to arrange settlement of the compensation if it hasn't yet been paid.

My final decision

For the reasons I've given above and in my provisional decision, my final decision is that I don't think Vitality acted unfairly when it turned down Mrs S' claim.

And I find that Vitality has already made a fair offer to settle this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs S to accept or reject my decision before 26 June 2024.

Lisa Barham
Ombudsman