DRN-4918895

The complaint

Mr H is unhappy that Assicurazioni Generali SpA ('AGS') declined a claim he made on his employers group income protection policy.

What happened

Mr H became absent from work in May 2022 due to symptoms linked to a suspected sleep disorder. After the deferred period of the policy had ended, he claimed on his employer's group income protection scheme as he said he was unable to work.

AGS declined the claim as they said the policy definition of incapacity wasn't met. Mr H appealed the decision but AGS maintained their decision was fair. Unhappy, Mr H complained to the Financial Ombudsman Service.

Our investigator looked into what happened and didn't uphold the complaint. In summary, he thought the decision was fair based on the available medical evidence.

Mr H didn't agree and asked an ombudsman to review his complaint. He provided more medical evidence in support of his position. However, this didn't change our investigator's thoughts about the overall outcome of the complaint. So, the complaint was referred to me to make a 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.

The relevant rules and industry guidelines say that AGS has a responsibility to handle claims promptly and fairly. And they shouldn't reject a claim unreasonably.

In order to make a successful claim on the policy Mr H needed to demonstrate he met the policy definition of incapacity. The policy terms and conditions definition of incapacity is:

> As a result of illness or injury, the Member is incapable of performing the Material and Substantial duties of their occupation, and they are no carrying out any other Work or occupation.

Mr H's claim for payment of benefit was eligible for payment from 52 weeks after his first date of absence. I'm not upholding Mr H's complaint as, on balance, I'm not persuaded it was unreasonable for AGS to conclude that the policy definition of incapacity was not met. I'll explain why.

Mr H was referred to see a consultant neurologist at around the time he became absent from work. In August 2022 Mr H had an MRI scan of the head which came back as normal. Mr H was also referred for an EEG and the results were within normal limits. In February 2023, shortly before the deferred period expired, the consultant prepared a report. He said the neurological examination was within normal limits and there was no evidence of nocturnal seizures or epileptiform discharges. Mr H was referred to a sleep clinic for further assessment. When asked to comment on Mr H's symptoms and level of restriction and capabilities he said:

> From the description he potentially has these symptoms very regularly, potentially almost every night. It affects his sleep pattern waking him up from sleep and thereby resulting in daytime tiredness.

There was no extensive comment on the symptoms which prevented him from being unable to do the material and substantial duties of his occupation. So, I don't think it was unreasonable for AGS to conclude Mr H didn't meet the policy definition of incapacity.

I appreciate that Mr H saw an occupational health advisor who concluded he wasn't fit to work. However, I don't think it was unreasonable for AGS to place more weight on the evidence from the consultant neurologist. The consultant's opinion was based on the results of several tests, and he was a specialist in the relevant field. Furthermore, the occupational health reports are based on Mr H's reporting of his symptoms.

Mr H has since been diagnosed with REM behaviour disorder (without obstructive sleep apnoea or periodic limb movements of sleep). However, that diagnosis wasn't available at the time Mr H made his claim. And, in any event, the medical evidence available to AGS at the time didn't provide any detailed insight into why Mr H was unable to work.

I've considered what Mr H has said about not being able to drive due to guidance from the DVLA. He's provided screen shots from enquiries he made with the DVLA and also says he discussed the guidance with his GP. However, I don't think that information is broadly consistent with the overall available medical information. If there was a concern about Mr H's ability to drive, I think it's reasonable to expect that information to have been reflected more specifically in the consultant's letters to Mr H's GP. Whilst the screen shots demonstrate that Mr H made some form of enquiries with the DVLA, it doesn't demonstrate that he was told not to drive. Furthermore, the GP notes from July 2023 indicate that Mr H asked for confirmation that he wasn't fit to drive. The GP notes say:

> 'Adv no specific evidence provided for this. He has up to date fit note and we all have responsibility as drivers to ensure we are safet (sic) to drive and not to drive against medical advice'.

Mr H has highlighted other health issues which he says prevented him from working. But I don't think it was unreasonable for AGS to focus on the main symptoms which Mr H reported were preventing him from working. I appreciate that he did refer to pain in some areas of his body, but I don't think the medical evidence indicates that they were the main focus of the ongoing medical investigations and the main barrier to him returning to work. And, in any event, I note that the medical evidence Mr H has provided in relation to his physical symptoms does not comment in detail on his inability to do his job as a result of these other issues during the relevant time. Furthermore, the medical evidence he more recently provided postdates the deferred period, the assessment of the claim and the final response letter. So, I don't think it's central to the outcome of this complaint.

My final decision

I'm not upholding this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr H to accept or reject my decision before 2 January 2025.

Anna Wilshaw
Ombudsman