DRN-4998395

The complaint

Mr N complains that Assicurazioni Generali SpA (Generali) has turned down an incapacity claim he made on a 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.

Mr N was insured under his employer's group income protection insurance policy. The policy provided cover for Mr N's own occupation if he was incapacitated due to accident or sickness and it included a deferred period of 26 weeks.

Unfortunately, in July 2022, Mr N was diagnosed with Covid-19 and he was signed-off from work. Ultimately, he was diagnosed with long Covid. As Mr N remained unfit for work, a claim was made on the policy.

Generali requested medical evidence to allow it to assess Mr N's claim. Initially, it received very little medical evidence and so it didn't think there was enough information to show that he'd met the contractual definition of incapacity throughout the full deferred period. And it turned down Mr N's claim.

Mr N appealed and provided Generali with additional medical evidence in support of his claim, including letters from consultants and physiotherapists.

However, Generali wasn't persuaded that there was enough objective medical evidence which showed that Mr N was incapable of performing the material and substantial duties of his desk-based own occupation for the full 26-week deferred period and beyond. So it maintained its decision.

Mr N was very unhappy with Generali's decision and he asked us to look into his complaint. He told us that as a result of its decision, his employment of many years had ended and he'd also lost his ability to access private medical cover through his employer's group scheme. He considered he'd provided extensive evidence to show that he'd met the policy definition of incapacity and that Generali had failed to request relevant information from him. He also told us that Generali's claim handling and ultimate decision had caused setbacks in his recovery. And he also provided evidence that he'd been awarded Personal Independence Payments (PIP) by the DWP for his mobility issues.

Our investigator didn't think Generali had treated Mr N unfairly. She acknowledged that Mr N had been given a diagnosis of long Covid. But she didn't think it had been unfair for Generali to rely on the totality of the medical evidence it had obtained and which Mr N had provided to conclude that he hadn't shown he met the policy definition of incapacity for the full deferred period between July 2022 and January 2023. And she didn't think she could fairly hold Generali responsible for any decisions made by Mr N's employer. Nor did she think she could fairly conclude that Generali had discriminated against Mr N.

Mr N disagreed and I've summarised his detailed submissions below:

- He considered that both Generali and the investigator had overlooked basic information;

- He had sought advice and had been told that the fit notes his GP had issued were legally binding evidence of his impairment to work and therefore, they were admissible as evidence of his incapacity. He considered Generali and our refusal to accept the fit notes as evidence of incapacity was discriminatory;

- He provided further evidence from an occupational therapist (OH) at the Long Covid clinic to supplement a report the OH had written in November 2023. He said he was aghast that the OH's conclusions had counted for nothing with either our service or Generali. And he provided evidence that his employer had discouraged him from seeking help from its OH;

- He maintained that Generali hadn't asked him for any of the information it required to substantiate his claim throughout the claims process. Indeed, one of its claims handlers had discouraged him from doing so, by telling him that it would be in touch if it needed any information. Therefore, he considered Generali had shifted the burden of proof in this particular case. And under the policy terms, Mr N didn't think Generali had any right to decline the claim at all. He considered he'd fully complied with the policy terms but Generali had failed to request claims visits or ask him for information. He also questioned what evidence Generali would have needed to see in order to accept his claim;

- Whilst the investigator and Generali had referred to Mr N's self-reported symptoms, Mr N said that any person who ever visited a doctor would need to self-report their symptoms. But after that point, medical specialists had diagnosed him as having long Covid and as being unfit for work;

- He listed 27 different medical practitioners and entities he'd been treated by or involved with but noted that Generali had only engaged with two of them. And he described additional symptoms he'd developed post the decline of the claim;

- Mr N set out the duties of his role and the travelling that was involved. He felt that it was insulting to dismiss his role as sedentary, especially given the DWP had awarded PIP recognising his mobility issues. And he explained how his symptoms prevented him from carrying out some of his main duties. He said it was his cognitive issues which mainly prevented him from returning to work, so the weighting given to his physical symptoms showed a lack of understanding as to what he was going through;

- He felt that he was being discriminated against because neither Generali nor our service accepts long Covid as being severe enough to keep him from working;

- Mr N considered we were overlooking the continued errors of the insurer;

- He maintained that his employment had ended because of Generali's failure to accept the claim and he felt its actions had defamed his character;

- He was dumbfounded by the investigator's conclusions that she hadn't seen enough medical evidence to show that the claim should be accepted;

- He set out a detailed list of his symptoms and the effect each of these symptoms had

had on his ability to carry out his role.

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 Mr N, I don't think that Generali has treated him unfairly and I'll explain why.

First, I was very sorry to hear about the circumstances that led to Mr N needing to make a claim and I don't doubt what a worrying and upsetting time this has been for him. I was also sorry to read about the impact of Mr N's poor health on him and the distressing nature of his symptoms.

I'd like to reassure Mr N that while I've summarised the background to his complaint and his very detailed submissions to us, I've carefully considered all that he's said and sent us. In this decision though, I haven't commented on each and every point he's raised and nor do our rules require me to. It also reflects the informal nature of our service as an alternative to the courts. So I've focused on what I consider to be the key issues.

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 considerations, such as industry principles and guidance, the policy terms and the available medical evidence, to decide whether I think Generali handled this claim fairly.

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

'As a result of illness or injury, the Member is incapable of performing the Material and Substantial duties of their occupation and they are not carrying out any other work or occupation.'

The policy says material and substantial duties: '*means duties that are normally required for the performance of a Member's occupation and cannot reasonably be omitted or modified by their Employer.'*

This means that in order for L&G to pay Mr N incapacity benefit, it must be satisfied that he had an illness or injury which prevented him from carrying out the material and substantial duties of his own occupation, after the end of the deferred period. So, in order for benefit to be paid, Mr N 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 Mr N's responsibility to provide Generali with enough medical evidence to demonstrate that an illness had led to him being unable to carry out the duties of his own occupation for the full 26-week deferred period between July 2022 and January 2023 (and beyond). As such, the medical evidence needs to show that Mr N was prevented from carrying out the material and substantial duties of his own occupation for that material period of time.

I appreciate Mr N feels that Generali effectively shifted the burden of proving the claim, given it told him early on in the claim that it didn't need him to provide any further information and that it would ask for the information it needed. However, I don't agree. In my experience, most, if not all, insurers will contact treating doctors on a member's behalf to ask for the medical evidence it believes it needs. This is often for cost and convenience reasons. I've seen a copy of the medical report request Generali's agent made to Mr N's GP, dated 25 January 2023. The request says:

'*As they need to understand how your patient's illness or injury affects their income and ability to work, it is important you give Generali as much detail as possible.'*

The report also asked the GP to provide copies of all clinical notes and medical correspondence from January 2021 onwards.

In my view, this was a clear request and set out the information Generali needed in order to assess Mr N's claim. I think it was reasonable for Generali to ask for all clinical notes and medical records from the GP, given a GP is often best placed to provide full clinical records in a patient's stead. And given the clarity of its agent's request for evidence, I find too that it was reasonable for Generali to rely on the limited information sent to it by the GP when it initially assessed the claim. I'd also add that we wouldn't generally tell an insurer what information it should and shouldn't ask for, or what evidence it must accept as proof of claim.

Generali assessed the evidence which was provided in support of Mr N's claim. While it sympathised with Mr N's position, it concluded that there was a lack of objective medical evidence detailing his ability to carry out his own occupation. So I've next gone on to consider whether I think this was a fair conclusion for Generali to draw.

Before I do explore the medical evidence in detail though, I must make clear that in my experience, most, if not all, income protection insurers don't simply accept GP fit notes as evidence that an insured member is incapacitated in line with the policy terms. They generally require more detailed evidence, which may be provided by a treating specialist, which makes it clear how and why a policyholder's illness prevents them from carrying out their role.

I acknowledge that a GP fit note is medical evidence which shows that a person has been clinically signed-off as medically unfit to attend work and to potentially be entitled to company sick pay or statutory sick pay. But I don't think it was unreasonable for Generali to conclude that Mr N's fit notes weren't enough evidence to show that he met the policy definition of incapacity throughout the entire deferred period.

Both parties accept that the evidence the GP sent Generali was limited in nature. And so, following its decline of the claim, Mr N sent it additional evidence to consider. I've summarised below the evidence both parties had available at the point Generali assessed this claim:

- Appointment notes for July and August 2022, which set out Mr N's symptoms, including fatigue and sleep issues;

- A referral form completed by Mr N's GP, dated 30 September 2022, to a post-Covid syndrome assessment clinic. The form stated that Mr N's 'detailed history of the presenting complaint' was '*covid 7/7 since then long Covid symptoms'.* There is a reference to Mr N experiencing breathlessness and poor concentration, but no clear detail as to how his symptoms affected him;

- A letter from a cardiologist, who I'll call Dr G, dated 9 December 2022. This stated

that since Mr N had had Covid-19 in July 2022, he'd suffered significant breathlessness, some chest pain and tightness. It also stated that Mr N had noted that other symptoms were a problem, such as insomnia, fatigue, gastric and urinary issues; persistent headaches, eye pain and brain fog with word-finding difficulties. Dr G recommended that Mr N should undergo cardiac testing and also that he should be referred to another specialist, Mr H, for investigation into Mr N's respiratory symptoms. The letter did not set out whether Mr N was or wasn't fit for work or how these symptoms would prevent him from carrying out the material and substantial duties of his role;

- A letter dated 23 January 2023, which confirmed an appointment for Mr N at the long Covid clinic in mid-February 2023;

- A clinic letter dated 22 February 2023, from a physiotherapist at the long Covid clinic. This stated that Mr N had ongoing symptoms of breathlessness, brain fog, fatigue, chest pain and a rash. The letter stated that the fatigue was so bad that Mr N had been signed-off work since his acute infection in July 2022, as he couldn't physically attend the office and also couldn't mentally attend to his duties. The letter also said that Mr N presented with a typical brain fog picture with decreased concentration and memory and difficulty in daily mental tasks. And the letter said that improvements could take months to years, patient dependent. The physiotherapist provided Mr N with some self-management techniques and felt he might have a breathing pattern disorder;

- A home blood pressure monitoring sheet, which post-dates the deferred period;

- Lung function test results

- A letter from Dr G dated 28 February 2023, which stated that Mr N had symptoms of long Covid, marked by breathlessness. The letter said that Mr N's cardiology results didn't highlight PoTS but that they suspected Covid-19 had had an effect on Mr N's blood pressure, although it was not profound;

- Respiratory physiotherapy advice from a specialist respiratory physiotherapist, dated 21 March 2023. The physiotherapist noted that Mr N's respiratory investigations had indicated that he had a dysfunctional breathing pattern. The advice said: *'this may explain some of your symptoms'.* It also stated that Mr N's cardiac issue and long Covid symptoms were contributing to his breathlessness and fatigue. They recommended that Mr N should practice 'good breathing' to retrain his breathing pattern and that Mr N should try to do this once a day, lying somewhere comfortable. They recommended that Mr N should try and rebuild his fitness slowly and breathing through his nose as much as possible;

- Follow-up physiotherapy advice dated 4 April 2023 and 31 May 2023;

- A letter from the physiotherapist to Dr H dated 9 May 2023, which stated that Mr N was still feeling fatigued and tired, but that his breathing felt improved. The letter said that Mr N would need to work on rebuilding his exercise tolerance, although progress could be slow due to coexisting symptoms of fatigue, brain fog and post exertional malaise;

- An article published in the Physical Therapy and Rehabilitation Journal;

- A further letter from Dr G, dated 9 May 2023 and I've copied much of the text below:

I first reviewed this gentleman on 19/11/2022 noting that he developed significant breathlessness after a COVID infection in July 2022. Simple investigations through the GP did not highlight an abnormality but because of my interest in autonomic abnormalities producing cardiovascular symptoms post-COVID, he came to see me. He noted symptoms of chest pain, breathlessness, palpitation, insomnia, fatigue, diarrhoea, urinary frequency, headaches and brain fog.

Subsequent investigations highlighted an echocardiogram revealing good heart function although there were some signs of high blood pressure. An active stand test highlighted a moderately significant heart rate increase with blood pressure variability suggesting some strain on the BP control system although insufficient to diagnose POTS. This would be defined as orthostatic intolerance. Breathing control abnormalities but preserved exercise abilities were noted on a cardiopulmonary exercise test. General blood tests and a chest x-ray through the GP were normal.

His current diagnosis therefore is long-COVID, dominated by dysfunctional breathing syndrome and orthostatic intolerance. Simple lifestyle management have been suggested including respiratory physiotherapy and medications are possible in the future, if we do not make progress.

With regard to that treatment, it is early days but no doubt we will be discussing the situation further to assess progress. I will review his care over the next few weeks and further medications can be instituted depending on progress.

It is very difficult to define prognosis. This is certainly not a dangerous or life-threatening condition but patients can remain symptomatic in the longer term. In my experience, a number of patients are improving and their symptoms resolving but in others, symptoms remain problematic and we need to continue to provide input and advice to assist. In a small number of patients, they remain very limited however at this stage it is very difficult to predict.'

- A letter to Mr N's GP, dated 15 May 2023, from the physiotherapist at the Long Covid clinic, which restated Mr N's presenting symptoms. It stated that '*fatigue can really wipe (Mr N) out and he continues to describe a post-exertional malaise picture. Physically, he is doing much less than he previously was and does not feel able to adjust this.'* The letter stated that the physiotherapist had encouraged Mr N to seek OH support from his employer and that they felt it might be beneficial for him to be referred to a vocational rehabilitation service to receive support for workplace adjustments and a phased return appropriate for his recovery.

Following Generali's decision to maintain its decline of his claim and its sending of its final complaint response, Mr N has provided further medical evidence from an OH at the long Covid clinic dated November 2023 and letters from the clinical lead at post-Covid vocational service dated July and August 2024, as well as an undated letter. Generali has also had an opportunity to review these letters. But it's stated that these letters are dated over a year after the original deferred period ended, that they most likely followed Mr N's referral to the post-Covid vocational service in May 2023 and after his employment appears to have ended at the end of 2023. So I don't think it was unreasonable for Generali to conclude that this new evidence doesn't provide sufficiently persuasive evidence of Mr N's inability to carry out the material and substantial duties of his own occupation during the material deferred period.

I've thought very carefully about all of the evidence that's been provided and which was available to Generali when it made its final decision on Mr N's complaint. It's important I make it clear that I'm not a medical expert. In reaching a decision, I must consider the expert evidence and other evidence provided to decide which 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 - and it would be inappropriate for me to do so.

There's no dispute that Mr N was diagnosed with long-Covid syndrome and that all of the treating medical practitioners during the deferred period and shortly afterwards stated that Mr N consistently reported suffering a number of symptoms, including fatigue and brain fog. It was noted that these affected his memory and concentration. It's also clear that Mr N has undergone a range of tests and seen a number of medical professionals. And I know he's been awarded mobility PIP. I don't doubt that this has been a very difficult time for him.

But I simply don't find that it was unreasonable for Generali to conclude that the medical evidence from the material time (July 2022 until January 2023) and shortly afterwards doesn't show that Mr N was incapacitated in line with the policy terms. I accept that Mr N has told us how his fatigue and brain fog, along with his other symptoms, impacted on his ability to do his role. But I don't think Mr N's treating doctors made any clear finding as to how or why Mr N's symptoms would incapacitate him from carrying out the material and substantial duties of his insured occupation. Nor did the Covid-19 physiotherapists Mr N saw, Dr H or Dr G state that Mr N was incapacitated from carrying out his role, as defined by the policy terms. And there was no employer referral to OH for expert occupational assessment of Mr N's fitness to work. So I think it would be unreasonable for me to then infer from the medical evidence that Mr N was totally incapacitated and that Generali had interpreted the evidence in an unfair way.

I accept Mr N feels that Generali ought to have written to many more of his treating doctors and asked for wider evidence. But I think Generali was reasonably entitled to review Mr N's claim based on the evidence he provided to it. I don't think there was anything in the information Mr N sent Generali which ought to have prompted it to ask for further evidence in support of his claim. Neither do I think that Generali had any reason to request a claim visit or medical assessment for Mr N, when it concluded it already had enough medical evidence to make a claims decision. I understand too that Mr N feels he's been penalised because his employer discouraged him from seeing an OH. But this wasn't a decision Generali made and I can't fairly hold it responsible for the employer's actions here.

Overall then, despite my natural sympathy with Mr N's position, I don't think it was unfair for Generali to conclude that Mr N's absence wasn't due to an incapacity in line with the policy definition. And so I don't think it acted unfairly or unreasonably when it turned down Mr N's claim.

It's clear how strongly Mr N feels that Generali's actions led to the ending of his employment and associated loss of private medical cover. I can see that his employer linked Mr N's continued employment to the decline of the claim. However, as the investigator said, ultimately, it was for Mr N's employer to decide whether or not to continue to employ Mr N, irrespective of the claim. That was its own decision to make.

Mr N has also told us that he feels discriminated against because he believes that Generali (and this service) don't understand long Covid-19. Given the decline of the claim, I can understand why Mr N believes that he may not have been treated fairly.

It's not our role to say whether a business has acted unlawfully or not – that's a matter for the Courts. Our role is to decide what's fair and reasonable in all the circumstances. In order to decide that, however, we have to take a number of things into account including relevant law and what we consider to have been good industry practice at the time. So although it's for the Courts to say whether or not Generali has breached the Equality Act 2010, we're required to take the Equality Act 2010 into account, if it's relevant, amongst other things when deciding what is fair and reasonable in the circumstances of the complaint.

Having considered all of the evidence, I can see that Generali did make minor mistakes, such as spelling Mr N's name wrongly. I don't doubt that this would have caused Mr N frustration and upset and led to him questioning whether Generali had appropriately considered his claim. But based on all I've seen; I don't think that, in the round, Generali has handled Mr N's claim unfairly.

In summary, I'm sorry to cause Mr N further upset and disappointment. But I've decided that it wasn't unfair for Generali to turn down his claim. And therefore, I'm not telling it to do anything more.

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 Mr N to accept or reject my decision before 22 November 2024.

Lisa Barham
Ombudsman