DRN-5020614

## The complaint

Mr M is unhappy that Legal and General Assurance Society Limited ('L&G') declined a claim made on a group income protection insurance policy.

## What happened

Mr M had the benefit of a group income protection insurance policy ('the policy'). Subject to the remaining terms, the policy can pay out a monthly benefit if Mr M is unable to work due to illness (or injury) after the deferred period.

In October 2023, Mr M was signed off by his GP, initially as being too ill to work due to a lower respiratory tract infection post Covid-19 and then post Covid-19 syndrome. A claim was made on the policy during the deferred period.

L&G declined the claim on the basis that there was not enough evidence to conclude that Mr M was incapacitated as defined by the terms of the policy.

Mr M appealed that decision and L&G subsequently arranged a chronic pain abilities determination (CPAD). In light of the CPAD report, L&G issued its final response letter in July 2024 maintaining its decision to decline the claim. By that stage Mr M had already brought a complaint to the Financial Ombudsman Service.

Our investigator looked into what happened and didn't uphold his complaint.

Mr M disagreed so this complaint has been passed to me to consider everything afresh 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.

### The relevant terms and conditions of the policy

The policy terms and conditions say:

> Subject to terms of this policy, the benefit will be paid in respect of an insured member from the benefit start date provided he is a disabled member.

Disabled member means:

> An insured member who at any time
>
> - meets the incapacity definition…
> - is not engaged in any other occupation, other than one which causes

payment of a partial benefit…

The definition of incapacity relevant to this complaint is 'own occupation' as confirmed by the policy schedule. Own occupation means:

> The insured member is incapacitated by illness or injury that prevents him from performing the essential duties of his occupation immediately before the start of the deferred period.

**Did L&G fairly and reasonably decline the claim?**

I'm not a medical expert. So, I've relied on all the evidence available to me when considering whether L&G reasonably declined the claim.

I know Mr M will be very disappointed but for reasons I'll go on to explain below, I'm satisfied L&G has acted fairly and reasonably here.

- L&G has an obligation to handle insurance claims fairly and promptly - and it shouldn't unreasonably reject a claim. And when making a claim, it's for Mr M to establish that he was incapacitated.
- The claim form completed by Mr M in January 2024 in support of his claim lists extreme fatigue, brain fog and muscular pain and weakness as the symptoms which stop him from working.
- There's not much mention in Mr M's GP records during the deferred period explaining how his condition was affecting his functionality or why, in October 2023, his condition deteriorated to the point that he was unable to work for an extended period.
- Further, much of the medical evidence I've seen during the deferred period, sets out Mr M's symptoms as self-reported by him. That includes the vocational clinical specialist's report dated January 2024 which reflects that, in their opinion, Mr M wasn't currently fit to return to the insured job role. But it's reflected that this is "based on the member's reporting today".
- During the deferred period, it doesn't look like he underwent any objective functional tests to assess the impact post Covid-19 syndrome was having on him (by itself or in conjunction with other conditions) and his ability to work.
- As a result, I'm satisfied L&G's conclusion in March 2024 – and before the end of the deferred period – that Mr M didn't meet the policy definition of incapacity was fair and reasonable. When making this finding I note that Mr M had been signed off as being unable to work by his GP because of his condition and I've taken that into account. However, there's a specific incapacity definition that needs to be met under the policy for the benefit to be paid.
- After Mr M's appeal against the decision to decision to the claim, I think L&G acted reasonably in the circumstances of this case by arranging a CPAD assessment, which took place over two days in mid-2024.
- The CPAD assessment was undertaken by an occupational therapist and qualified functional capacity evaluator ('the evaluator'). And the report that was subsequently produced says the purpose of the assessment was to explore Mr M's physical and cognitive abilities in addition to restrictions and limitations. And to compare these to the functional requirements of his own occupation, according to the various CPAD protocols. The evaluator concluded: "the functional abilities demonstrated by Mr M cannot represent his true capabilities and I can only therefore conclude that his

actual abilities are far greater than he was willing to perform…This conclusion is based on the number of inconsistencies and discrepancies demonstrated by Mr M throughout testing, and which are listed in the report…"

- Given the contents and conclusions of this report – and in light of the available medical evidence during the deferred period – I'm satisfied L&G has reasonably concluded that the medical evidence doesn't support that Mr M was incapacitated as defined by the policy. So, I find that that it has fairly and reasonably declined Mr M's claim.
- When making this finding I've taken into account all comments made by Mr M including what he says about the results of the CPAD assessment, the conclusions in the report and that the use of CPAD assessments can be unreliable. I've also taken into account Mr M's comments that his symptoms are variable so how he performed over two days isn't reflective of how he feels at other times.
- L&G did forward Mr M's comments to the evaluator and based on their replies, I'm satisfied L&G acted reasonably by relying on the contents of the CPAD report despite Mr M's concerns about the assessment. And as I've explained above, there's little in Mr M's medical records during the deferred period to indicate that he met the incapacity definition. Further, it is standard industry practice for CPAD assessments to be used when assessing the impact of conditions such as the one Mr M has been diagnosed with. So, I don't think the reliance on this assessment is unfair in principle.
- I've also taken into account the surveillance report which was based on observations of Mr M over a number of days. Although not determinative, it does support that Mr M had a greater functionality than he'd reported. And whilst I appreciate that Mr M says the severity of his symptoms did fluctuate, the surveillance is consistent with some of the conclusions of the CPAD report.
- Mr M also says that he's now in receipt of disability related welfare benefits. However, the requirements of successfully claiming certain welfare benefits are different to what needs to be established under the policy for a successful claim to be made. So, whilst I've taken what Mr M says about that into account, I've placed more weight on what was reflected in the medical records during the deferred period and subsequent CPAD report.

**The handling of the claim and appeal**

I'm satisfied that L&G has reasonably promptly assessed the claim and then after the appeal, proactively took steps to obtain further evidence relevant to the claim.

That included referring information received from Mr M to its medical officer and thereafter arranging the CPAD assessment. I think it then promptly referred the surveillance to the CPAD evaluator and its medical officer to review and comment on, before maintaining its decision to decline the claim.

**My final decision**

I don't uphold Mr M's complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr M to accept or reject my decision before 20 November 2024.

David Curtis-Johnson
**Ombudsman**