DRN-5029963

The complaint

Mr H is unhappy that Aviva Life & Pensions UK Limited (Aviva) has terminated his income protection claim.

What happened

Mr H has an income protection policy through his employer. The policy provides cover for benefit to be payable in the event that Mr H can't work in his own occupation due to illness or injury. The policy has a 26-week deferred period and is underwritten by Aviva.

In 2020, Mr H was unfortunately diagnosed with cancer. He received treatment for this and then stopped work in November 2020 after experiencing fatigue. Mr H continued to receive treatment and returned to work in May 2021 on a phased basis. In September 2021, Mr H stopped work again because of fatigue.

Mr H submitted a claim to Aviva, which was accepted, and he received a benefit as per the terms of the policy.

Aviva reviewed Mr H's claim in 2023 and requested an independent medical examination (IME). This was carried out by telephone and the report concluded that Mr H could return to work on a phased basis, and he no longer met the definition of incapacity as per the terms of the policy. Aviva decided to terminate Mr H's claim.

Further evidence was provided by Mr H. But Aviva maintained its position to terminate Mr H's claim and paid the benefit until December 2023 to support his phased return to work.

Unhappy with Aviva's decision, Mr H brought his complaint to this service. Our investigator didn't uphold it. She didn't think Aviva's decision to terminate Mr H's claim was unreasonable based on the evidence she'd been provided with.

Mr H disagreed and asked for the complaint to be referred to an ombudsman. So, it's been passed to me.

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 regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. So, I've considered, amongst other things, the terms of this income protection policy and the circumstances of Mr H's claim, to decide whether Aviva treated him fairly.

First, I'd like to reassure Mr H that whilst I've summarised the detailed background to his complaint and his submissions to us, I've carefully considered all he's said and sent us. Within this decision though, I haven't commented on each point he's raised and nor do our rules require me to. Instead, I've focused on what I consider to be the key issues.

I note that Mr H has provided further points as to why he disagrees with Aviva's decision to terminate his claim since the final response was issued on 6 March 2024. But I confirm I can only consider his complaint up to the point of the final response. Any further complaint points Mr H has should be directed to Aviva in the first instance.

I've first considered the terms and conditions of this policy, as it forms the basis of the contract between Mr H's employer and Aviva.

The policy states for a claim to be paid the definition of incapacity must be met. Incapacity is defined as:

> *'Own. The member's inability to perform on a full time or part-time basis the duties of his or her job role as a result of their illness or injury.'*

A point to note is that generally, in insurance, it's for the consumer to show their claim is valid. In this case, Mr H is required to provide medical evidence to show he is unable to work and cannot perform the material and substantial duties of his own occupation due to injury or illness.

To decide whether Mr H met the definition of incapacity for the benefit to be paid, I've looked at the evidence provided to me by both parties.

In 2023, Aviva decided, as per the policy terms, to review Mr H's claim. It instructed an IME to be carried out. A report was provided to Aviva by a consultant in occupational medicine (who I'll call Dr A), following an assessment of Mr H's condition by telephone in February 2023. I've considered the report.

This confirms that Dr A had reviewed all of Mr H's medical records to that date and assessed Mr H by telephone. Dr A concluded that Mr H no longer met the definition of incapacity and that he could perform the duties of his own occupation.

He stated in the report that Mr H's status at the time was that he had fatigue, muscle pain, joint pain discomfort and was breathless if walking up inclines. He'd developed generalised arthralgia and myalgia over the past four months. In late June 2021, he'd joined a light fitness programme but discontinued the membership as he had chronic fatigue symptoms. He'd had a recent chest x-ray and the results were normal. In terms of his present activities, Mr H was walking about a half a mile to the local town and back, and longer than that, his breathing became very laboured. He said he was doing some household chores such as making the bed and washing up and undertook light shopping. He prepared food and cooked occasionally but his wife mainly undertook this activity. He was also driving intermittently. He said on a typical day he woke up at around 7am and went to bed around 10pm. His slept during the night but had naps in the afternoon. He read books and watched TV. He didn't really see friends but went out occasionally for a meal with his family. He'd arranged to go on holiday in April 2023 and May 2023.

In terms of his treatment, Mr H had been seen by an endocrinologist and had low testosterone but decided he wouldn't take this, and his level was now normal. He had six monthly reviews with his oncologist and he was in remission with his cancer. He wasn't taking any medication. His clinical examination appeared to be normal. In September 2022, the endocrinologist letter showed that Mr H's phosphate level was low but the remainder of his tests showed as normal.

He recommended that Mr H attempt a further return to work with careful monitoring of his workload and progress. Following a request from Aviva to clarify what the phased return looked like in a practical sense, Dr A provided a breakdown. He said Mr H should return to

work and start with doing to 12 to 16 hours per week, over three days and work from home. He should look to work up to full time over the following four to five months, with some office attendance.

Based on the evidence Dr A had been provided with and reviewed, I don't think it was unreasonable for Aviva to conclude that Mr H was able to return to work on a phased basis. I also think the approach recommended by Dr A and Aviva was not unreasonable either. It said while Mr H was returning to work and gradually phasing in, it would continue to pay him the benefit until December 2023. And it would stop the claim at that point. This looks in line with Dr A's recommendation and I don't find this unfair or unreasonable.

In November 2023, Mr H made an appeal to Aviva. He provided Aviva with further evidence from the endocrinologist which said that Mr H had post cancer fatigue which was managed in a similar way to other types of chronic fatigue syndrome. She stated that she hoped Mr H's symptoms would improve, and he would recover over time but couldn't predict how long this might take.

Aviva reviewed the new evidence, including all the information from the appointments with the endocrinologist and sent this to Dr A for a further opinion.

Dr A concluded, based on the new evidence, that Mr H could still return to work over the six months, from home, but on less hours initially than he'd first recommended. He also said he couldn't say that full-time hours could be achieved.

Aviva agreed to support Mr H with a proportionate claim once Mr H started his return to work in line with the updated recommendations from Dr A. I think this was reasonable.

Whilst I note Mr H's comments about Dr A's qualification and independence, this isn't a point I can comment on. It's not unusual for insurers to appoint for an IME. Doctors are regulated by the General Medical Council and have their own codes of conduct. The purpose of an IME is to get an independent opinion from a suitably qualified person. I don't think it was unreasonable for Aviva to have arranged this.

Mr H questions Aviva's decision following his diagnosis of post cancer fatigue syndrome which is usually compared to chronic fatigue syndrome. He says he received this diagnosis from a medically qualified consultant of endocrinology, and which clearly stated the range of symptoms suffered with the severity of this condition: his symptoms correspond to a 'moderate' from of the condition and this category of sufferers are no longer able to work. He also says according to the National Institute for Health and Care Excellence (NICE) guidelines, this should have been sufficient to allow the claim to be continued under the policy. I don't agree. NICE guidelines are for general reference and whilst I appreciate Mr H's comments, I can't see any further medical evidence that points to Mr H not being able to return to work as per the policy terms. I also note Mr H said he'll be seeking a further medical review to confirm the categorisation of his condition. Should he have any further medical evidence of his condition, Mr H should send this to Aviva directly as this isn't a point that we can consider as part of this complaint. Having said that, I can see the diagnosis his endocrinologist provided in November 2023, was already considered by Dr A in his review and he concluded that the return to work should be attempted by Mr H.

The test here is whether the claim has been stopped in line with the policy terms and conditions and whether it's been done fairly and reasonably. I don't think Aviva's decision to stop Mr H's claim because he didn't meet the definition of incapacity was unfair in the circumstances of this complaint.

I'm sorry to disappoint Mr H, having taken everything into account, and despite my natural

sympathy with his position, I don't find that there are any reasonable grounds upon which I could direct Aviva to reinstate the claim. It follows therefore that I don't require Aviva to do anything further.

My final decision

For the reasons given above, I don't uphold Mr H's complaint about Aviva Life & Pensions UK Ltd.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr H to accept or reject my decision before 2 December 2024.

Nimisha Radia
Ombudsman