DRN-5073331

The complaint

Mr R complains that HSBC Life (UK) Limited has turned down an incapacity claim he made on a personal income protection insurance policy.

Mr R's representative brought this complaint on his behalf.

What happened

Mr R has held a personal income protection policy for a number of years. The policy provides cover if Mr R is incapacitated due to illness or injury for more than the four-week deferred period.

In mid- March 2023, Mr R made an incapacity claim on the policy for myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS).

HSBC looked into Mr R's claim and it requested both medical evidence and information from his employer. It noted that Mr R had resigned from his role the day before he made the claim and was due to leave his job in mid-April 2023. It also noted that Mr R had only taken three complete days off work, suffering from fatigue and that he'd worked half days up until the date he left work. Mr R's medical records showed that he'd received a diagnosis of ME/CFS around five years previously but that he'd self-managed his symptoms since then. And the records also showed that Mr R hadn't spoken to a GP about his symptoms for a number of years until after he'd claimed on the policy and resigned from his role. Mr R's employer also told HSBC that it hadn't referred Mr R to its occupational health provider (OH) because he managed his symptoms.

On that basis, HSBC didn't think Mr R had provided enough medical evidence to show that he met the policy definition of incapacity and it turned down his claim.

Mr R was unhappy with HSBC's decision and so his representative asked us to look into his complaint. The representative subsequently provided both HSBC and this service with a copy of a medical report, dated March 2024, from a medical professional I'll call Dr M. Dr M had assessed Mr R in March 2024. And Dr M concluded that based on Mr R's reporting, he hadn't been managing to carry out the material and substantial duties of his occupation whilst he'd been at work due to his health issues and wasn't able to do so at the time he made the claim.

HSBC let us know that Dr M's report didn't change its conclusions.

Our investigator didn't think HSBC had handled Mr R's claim unfairly. He didn't think the available medical evidence was enough to demonstrate that Mr R had met the policy definition of incapacity during the deferred period and beyond.

Mr R disagreed and I've summarised his representative's response to the investigator:

- ME/CFS is a condition for which there is no objective medical testing. There was no question that Mr R suffers from it and Dr M's report was unequivocal in stating that

Mr R was eligible for incapacity benefit;

- They considered that Mr R had provided sufficient medical and other evidence of his incapacity and that it was unreasonable for the investigator to disregard such evidence, when HSBC had done nothing to investigate the claim;

- They didn't feel that the fact Mr R had only seen his GP once was determinative and nor did they think it would have been reasonable for Mr R to have referred himself to OH;

- The representative felt the questionnaire HSBC had sent Mr R's employer was poorly focused, generic and didn't ask the employer case-specific questions. And they considered that HSBC should have known that the questions asked by the employer and the resulting answers weren't good enough;

- They questioned why the investigator had disregarded Dr M's evidence. The representative set out why they felt Dr M's report made it clear that they were commenting on Mr R's health at the material time and that he hadn't been fit for work;

- The representative also referred to witness statements which had been provided by Mr R's family and other third parties in support of his claim.

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 R, I don't think it was unfair for HSBC to turn down his claim and I'll explain why.

First, I'd like to reassure Mr R that while I've summarised the background to his complaint and his representative's detailed submissions to us, I've carefully considered all that's been said and sent. I'm very sorry to hear about the circumstances that led to Mr R needing to make a claim and I don't doubt what a worrying and upsetting time this has been for him.

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, amongst other relevant considerations, such as regulatory principles and guidance, the terms of this policy and the available medical evidence, to decide whether I think HSBC handled Mr R's claim fairly.

I've first considered the terms and conditions of the policy, as these form the basis of Mr R's contract with HSBC. Mr R claimed for incapacity benefit, given he said he wasn't fit for work. The policy provides cover for loss of earnings due to a policyholder's incapacity. So I think it was reasonable and appropriate for HSBC to consider whether Mr R's claim met the policy definition of incapacity. This says incapacity means that:
'The Life insured is unable to carry out the Material and Substantial Duties of his Occupation because of illness or injury.'

Page 14 includes a section called 'Acceptance and Continuation of Claims'. This says:

'Admission and continuation of claims will be subject to the Company receiving necessary, sufficient and satisfactory medical evidence to substantiate incapacity,

i. including evidence of the presence of an impairment of sufficient severity and duration as to satisfy the test of incapacity;

ii. the continuing attendance by the Life Insured at a medical practitioner or practitioners registered by the General Medical Council (or an appropriate equivalent body overseas if resident outside the United Kingdom) whose training and speciality are appropriate to such an impairment and whose professional status and standing is recognised by the Company as frequently as such a practitioner would reasonably recommend;

iii. evidence which demonstrates to the satisfaction of reasonable medical opinion that all appropriate treatment options have been thoroughly investigated and explained to the Life Insured.'

I think the terms make it clear that in order for HSBC to pay Mr R 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 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 R's responsibility to provide HSBC 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 four-week deferred period and afterwards.

HSBC assessed the information with which it was provided and concluded that it wasn't enough to show Mr R had been incapacitated in line with the policy terms. So I've gone on to consider whether I think this was a fair conclusion for HSBC to draw.

I've first considered the claims information which was sent to HSBC, including the employer questionnaire.

The employer's questionnaire stated that Mr R had been absent due to fatigue for three full days and that he'd worked half days until the date he left the role. The employer told HSBC that it had an OH provider but that Mr R hadn't been referred to it before he left. HSBC went back to ask the employer further questions following its review of the questionnaire. It asked why Mr R hadn't been referred to the OH provider. And it asked what discussions were held with Mr R about resigning/finishing work and when these took place. Mr R's employer told HSBC that:

'No referral was made for (Mr R) as he appeared to be managing his symptoms, it was not impacting his work or his absence levels. No reason to refer was identified by his line manager and (Mr R) did not request to be seen by occupational health.'

And the employer said that during Mr R's exit interview, he'd told his line manager that there was nothing further it could do to support him.

I appreciate Mr R's representative considers the questionnaire wasn't specific enough to obtain the relevant information HSBC wanted to know. But it isn't my role to tell HSBC what information it should ask for when it's assessing claims. And in my view, the questions included on the questionnaire were sufficiently clearly drafted. I'm also satisfied that HSBC appropriately asked Mr R's employer for further information to clarify its answers to the original questions. So I find it was reasonable for HSBC to rely on the evidence provided by Mr R's employer.

Next, I've turned to consider the available medical evidence. I can see that in September 2017, Mr R saw his GP with symptoms of long-standing fatigue, malaise and general reduced exercise capacity. The GP subsequently referred Mr R to endocrinology, also stating that Mr R had around a 15-year history of fatigue, but that his symptoms had worsened after a procedure earlier that year.

In June 2018, Mr R was diagnosed as having mild chronic fatigue symptoms and was referred for individualised fatigue management and given self-management techniques. In August 2018, he was referred by a chronic fatigue clinic, who also felt Mr R was likely suffering from CFS. And in October 2018, Mr R was assessed for cognitive behavioural therapy (CBT) and Graded Exercise Therapy. The assessing physiotherapist recommended that Mr R should undergo both treatments.

The GP's records show that Mr R next spoke with a doctor about ME/CFS on 27 March 2023 – a few days after he'd made the claim and after he'd already resigned from his role. The GP noted: '*ongoing chronic fatigue for about 5 years, struggling on and off over the years, worse last few weeks/longer, CBT few years ago – helped mental health, over years – works & then recovers at weekends.'*

Based on the information which was available to HSBC when it initially assessed Mr R's claim, I don't think it was unreasonable for it to conclude that there was insufficient evidence to show Mr R met the policy definition of incapacity. It's clear Mr R had had a diagnosis of ME/CFS a few years previously and that he'd self-managed his symptoms. His employer didn't suggest that Mr R had had previous episodes of absence due to this condition – and indeed, it specifically referred to Mr R having previously managed his illness. Nor did the employer suggest it had had concerns about Mr R's performance or ability to carry out his role. And the available medical evidence didn't suggest that Mr R had experienced a deterioration in his condition between 2018 and 2023 which required medical support or further treatment.

I appreciate the reasons why Mr R said he didn't seek medical advice during the relevant period and I've borne this in mind. But I don't think HSBC acted unreasonably when it decided that the medical evidence didn't show Mr R had a valid claim on the policy.

Following the initial decline of the claim, Mr R was assessed by Dr M in March 2024. I've carefully considered their report, as I appreciate that they're an expert in their field and that they had an opportunity to assess Mr R virtually. Dr M set out how ME/CFS can affect patients and also how Mr R had reported the condition affected him, his lifestyle and his ability to do his job. Dr M recorded that there had been no precedent for Mr R's job being performed part-time and they explained how Mr R felt his condition affected his performance and ability to do his job. I've summarised below what I consider to be some of Dr M's key findings:

'From the information I have gathered from Mr R's records and from interviewing him myself, I do not consider that he was managing his health problems while working in a full-time role…

Mr R reports having significant difficulties at work…and he was making significant mistakes.... In my opinion that demonstrates that he was not managing to carry out the material and substantial duties of his occupation while he was at work as a result of his ME/CFS symptoms…

It was clear from the early stages of his illness and his time attending 2 therapy services that it was his ongoing high level of work demand that was perpetuating his fatigue symptoms…

Therefore the factor that changed in March 2023 was that Mr R finally accepted that he was not well enough to continue working and that his efforts to try to maintain this work role was having a very negative impact on his health…

I support Mr R's claim and in my opinion Mr R was not able to perform the material and substantial duties of his job due to his ME/CFS symptoms when he made the claim... He has continued to experience the same symptoms since that time with an overall gradual reduction in his function so he has remained incapable of work continuously from that date.'

I've thought very carefully about all of the evidence that's been provided. It's important I make it clear that I'm not a medical expert. In reaching a decision, I must consider all of the evidence provided 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 medical opinion with my own.

As I've said, I accept Dr M is an expert in their field. I've also taken into account their opinion that Mr R was incapacitated at the material time in March 2023. With that said, I've also borne in mind that Dr M assessed Mr R's condition around a year after the claim was made, based on Mr R's self-reporting of his symptoms. And the contemporaneous medical evidence from the five years between Mr R's diagnosis and the date of claim doesn't indicate that he was experiencing a deterioration in his symptoms or in his ability to self-manage his illness. It's still the case too that Mr R doesn't seem to have taken any time off sick with his condition after beginning work with his employer until a few days before the claim and there appear to have been no recorded concerns about his illness or his performance. Moreover, even after Mr R's resignation date, I haven't seen any medical evidence to suggest that the GP certified Mr R as unfit to work full-time in March 2023.

This means that I still don't think HSBC acted unfairly or unreasonably when it placed more weight on the contemporaneous medical evidence from the years preceding and around the time of claim than on Dr M's report.

It's clear Mr R's representative feels HSBC should have done more to investigate this claim, such as arranging an examination of Mr R. But I don't agree. In this case, I think HSBC weighed-up the evidence it did have and concluded that it could reasonably make a claims decision based on the information it already had. I don't think this was an unfair or inappropriate position for HSBC to take.

Overall, taking into account the totality of the available medical and other evidence provided by both parties, I don't think it was unfair for HSBC to conclude that Mr R's absence wasn't due to an incapacity in line with the policy definition. And so whilst I'm sorry to disappoint Mr R, I don't find HSBC acted unfairly when it turned down this claim.

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 R to accept or reject my decision before 18 November 2024.

Lisa Barham
Ombudsman