DRN-5080060

The complaint

Mr M complains that Assicurazioni Generali SpA trading as Generali ('AGS') declined a claim he made on his employer's income protection policy.

What happened

Mr M is a member of his employer's group income protection policy. He claimed on the policy for symptoms related to suspected long covid. Mr M says this has prevented him from working his contractual hours.

AGS declined the claim as they didn't think Mr M had provided enough information to meet the policy definition of incapacity. Mr M appealed but AGS maintained their decision was fair. Unhappy, Mr M complained to the Financial Ombudsman Service.

Our investigator looked into what happened and didn't think AGS had acted unreasonably, based on the available medical evidence. Mr M didn't agree and asked an ombudsman to review his complaint. In summary, he says he was not able to negotiate or agree to the terms of the policy and had never seen any policy documents. He cited caselaw in support of his position. Furthermore, he highlighted that long covid was a condition that was diagnosed by exclusion, and he couldn't be expected to know what information the insurer needed without AGS explaining what information was specifically needed. So, the complaint was passed 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.

The policy terms and conditions say that in order to successfully claim on the policy Mr M needs to meet the policy definition of incapacity. The relevant definition 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 not carrying our any other work or occupation.'

I'm not upholding this complaint because:

- Mr M is a member of a group scheme and it's his employer who decides on the policy they offer to their employees. The purpose of the policy isn't to cover members of the scheme who are unable to work their contracted hours or who find it difficult to do so. If Mr M is unhappy with the policy available or not being provided with the relevant documents that's something he'll need to address with his employer, who is the policyholder.

- I don't think AGS reached an unreasonable conclusion that the policy definition of incapacity was not met. I don't think, on the balance of probabilities, there was clear or compelling evidence which explained clearly and persuasively why Mr M wasn't able to perform the material and substantial duties of his occupation. For example, there's no detailed medical commentary from Mr M's consultant cardiologist which reflects how his condition impacts his ability to do his job.

- I'm not persuaded Mr M's claim has been dismissed simply because there is no test, scan or visible symptom which can confirm long covid. The medical evidence that's available doesn't provide a detailed insight into Mr M's functionality, beyond his reporting of it. So, I think it was reasonable, in the circumstances of this case, for AGS to conclude the policy definition of incapacity wasn't met.

- I've considered whether it would have been reasonable for AGS to arrange for their own evaluation of Mr M's functionality to be carried out. I'm satisfied this was considered by AGS. However, I think they reasonably concluded that it was for Mr M to demonstrate he had a valid claim and/or there was sufficient evidence for the claim to be declined. Therefore, I don't think AGS has acted unfairly, in the circumstances of this complaint, by not obtaining their own expert report.

- I appreciate that Mr M wants AGS and/or the Financial Ombudsman Service to specify what evidence he needs to provide in order to demonstrate that he has a valid claim. It's for Mr M to demonstrate that he has a valid claim on the policy by providing information in support of it. I wouldn't expect AGS to specify what information would persuade them Mr M has a valid claim. I think they've considered the evidence and provided an outcome based on that evidence and the policy terms. That's standard industry practice. Furthermore, it's not for the Financial Ombudsman Service to specify what evidence ought to be provided. We're an informal dispute resolution service and my role is to determine whether AGS has acted fairly and reasonably. It's not for me to assess the claim and direct Mr M as to what evidence is missing or would lead to a valid claim.

- I'm not persuaded the decision by AGS reached was unreasonable and failed to take into account relevant matters such as the consistent body of medical evidence which Mr M feels should be interpreted in his favour. I'm satisfied AGS completed a detailed review of the available medical evidence and has reasonably explained their decision to decline the claim.

My final decision

I'm not upholding this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr M to accept or reject my decision before 7 January 2025.

Anna Wilshaw
Ombudsman