DRN-5106471

The complaint

Mrs M has complaint that Aviva Life & Pensions UK Limited has declined her income protection claim.

What happened

Mrs M is covered under her employer's group income protection policy. This will pay income protection benefit after a deferred period of 26 weeks if the following policy definitions are met:

We will pay total benefit if immediately before the start of incapacity the member was actively at work and following their job role and, after the start of incapacity they are not following any other occupation, and the deferred period has finished.

The definition of incapacity is:

The member's inability to perform on a full and part time basis the duties of their job role as a result of their illness or injury.

Mrs M is employed in a sedentary role and she is able to work from home. She works 3.5 days per week. Mrs M's last day at work was 28 March 2023, her deferred period ended on 28 September 2023. She was suffering with various symptoms including fibromyalgia and kidney disease. When Aviva declined her claim, Mrs M brought a complaint to this Service. Our investigator didn't think that Aviva had treated her unfairly on the basis of the medical evidence it had.

Mrs M appealed. She raised several points which I will address below. However, she raised a new point in relation to Aviva's complaints process and compliance. As that hasn't been raised with Aviva in relation to this complaint, I have not considered it here.

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.

I'm aware I've summarised the background and some sensitive medical details - no discourtesy is intended by this. Instead, I've focused on what I find are the key issues here. Our rules allow me to take this approach. It simply reflects the informal nature of our service as a free alternative to the courts. If there's something I haven't mentioned, it isn't because I've ignored it. I've reviewed the complete file and considered the representations made after our investigator's view. I'm satisfied I don't need to comment on every individual argument to be able to reach what I think is the right outcome. For the following reasons I agree with the conclusion reached by our investigator. I'll explain my reasons below:

- The relevant regulator's rules say that insurers mustn't turn down claims unreasonably. So I've considered, amongst other things, the terms of Mrs M's policy and the available evidence, to decide whether I think Aviva treated her fairly.

- I won't repeat all the medical evidence in detail here as it has been seen by the parties. It is not disputed that Mrs M suffered with various conditions when she stopped work in March 2023. Her GP signed her off work so I've looked carefully at the evidence overall to determine whether it was fair for Aviva to conclude in May 2024 that Mrs M didn't meet the policy criteria for a benefit claim to be paid. I note that things have moved on since that time and Mrs M commenced a phased return to work. It may be that a partial benefit is payable for this later period but this decision focuses on the period referred to above.

- Mrs M's GP records indicate that on 28 March 2023 tests were requested and an NHS 111 report was received on 30 March 2023. I can fully accept that Mrs M was feeling unwell and had experienced severe abdominal pain. A further fit note was issued on 20 April 2023. Mrs M had been diagnosed with fibromyalgia and had lower abdominal pains. But there is nothing further to explain why she was and continued to be signed off work. That is, how her symptoms impacted her ability to carry out her insured role.

- I don't think it was unreasonable for Aviva to take into account that fibromyalgia had been diagnosed some years previously and Mrs M had been able to manage her symptoms whilst working. The same was true for several other of her her conditions.

- Mrs M had a telephone consultation with Occupational Health (OH) in May 2023. She reported daily symptoms of fatigue, severe headaches, cramps and high blood pressure. She said that her symptoms prevented her from being able to engage in physical tasks around managing the home. Mrs M reported that she was under the care of a Nephrologist. The OH opinion was that Mrs M was unfit for work as she was experiencing ongoing symptoms which impacted her daily life. The OH felt that on her return to work she would benefit from a phased return over a four week period. A further OH report is dated 18 December 2023 (after the expiry of the deferred period). The conclusion was that Mrs M was able to return to work *'for the foreseeable future'*. I haven't disregarded this evidence, but the reports are based on Mrs M's reporting of her abilities and don't fully explain how she is prevented from performing her occupation.

- There is a report from a Consultant Nephrologist dated June 2023. They acknowledged that Mrs M was concerned with pain on her left side but didn't find anything concerning to explain the pain. It is apparent that Mrs M did subsequently have a renal biopsy – the biopsy findings were explained, and advice was given about how to prevent the disease from progressing. I fully accept how worrying this chronic disease and its implications are for Mrs M.

- Mrs M is concerned that relevant details in her medical records could have been overlooked. She has not said what she thinks may have been overlooked but I understand her point to be that medical notes often work cumulatively and even minor references can contribute to the broader understanding of the progressive nature of a condition. This is a valid point, particularly in Mrs M's case as she has numerous symptoms. However there is nothing to suggest that the evidence hasn't been viewed cumulatively or holistically by Aviva. Nevertheless Aviva concluded that there was an absence of evidence or explanation as to how Mrs M's symptoms prevented her from carrying out her occupation. I don't find that was an unfair conclusion on the basis of the evidence it had seen.

- Mrs M has said, and I accept, that the battle to have her claim recognised has taken a severe toll. She has various diagnoses and has said that her mental health has suffered. This is supported by evidence from her GP dated 18 October 2023. But in

order for a claim to be admitted it is for Mrs M to show that she was unable to perform the material and substantial duties of her occupation during the deferred period and beyond. There is no suggestion that Mrs M wasn't experiencing symptoms. But Aviva concluded that the evidence didn't demonstrate that, with the right help and support in place, these conditions and symptoms meant that she met the policy definition in order for her complaint to be paid. The bar is a high one, and having considered all the evidence, I'm not persuaded that this was an unreasonable conclusion to reach.

- Mrs M believes that there have been regulatory breaches on the part of Aviva. She has referred to ICOBS 8.1.1(2) and complained that Aviva failed to provide reasonable guidance to help her make her claim. She has said too that Aviva didn't specify that a medical report was necessary instead of medical notes. But in order for a claim to be admitted Mrs M needed to demonstrate that she met the policy definition – this could be by notes or reports. Additionally, Aviva advised that she could provide any further evidence, which she did. I have seen nothing to suggest that it failed to treat Mrs M fairly or failed to pay due regard to her information needs.

- I have no doubt that this has been a challenging period for Mrs M and I'm sorry that my decision doesn't bring her welcome news.

My final decision

My final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs M to accept or reject my decision before 13 March 2025.

Lindsey Woloski
Ombudsman