DRN-5130142

## The complaint

Ms C complains because Legal and General Assurance Society Limited ('L&G') hasn't paid her income protection insurance claim.

## What happened

Ms C was insured under a group income protection insurance policy held by her former employer with L&G.

After being signed off work in January 2023 due to depression, anxiety and stress, Ms C made a claim under the policy. L&G said the claim wasn't covered because Ms C's symptoms didn't meet the policy definition of 'incapacity'. Ms C appealed and provided additional medical evidence, which L&G considered, but said its position remained unchanged.

Unhappy, Ms C brought a complaint to the attention of our service.

One of our investigators looked into what had happened and said she didn't think L&G had acted unfairly or unreasonably in the circumstances. Ms C didn't agree with our investigator's opinion and provided further new medical information. The complaint has now been referred to me to make a decision as the final stage in our process.

## 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.

It's clear that Ms C has been through a very difficult time and I'm sorry to hear about the circumstances which led to this complaint. I appreciate Ms C will be disappointed with my final decision but my role is to reach an independent and impartial outcome which is fair and reasonable to both parties, not just to Ms C.

Industry rules set out by the regulator (the Financial Conduct Authority) say insurers must handle claims fairly and shouldn't unreasonably reject a claim. I've taken these rules into account when making my final decision.

This policy pays a benefit if Ms C met the policy definition of incapacity throughout, and beyond, a deferred period of 26 consecutive weeks from the date of her first absence from work.

Ms C was insured based on a 'suited occupation' definition of incapacity. The terms and conditions of the policy define this as where the insured member *'is incapacitated by an illness or injury so that he is unable to undertake all occupations which we consider appropriate to his experience, training or education'*.

This means, in order for a benefit to be paid, L&G must be satisfied that a member is suffering from an illness which prevents them from carrying out all occupations which are appropriate for them for any other employer and in any other workplace. A member doesn't

meet this ‘suited occupation’ definition of incapacity if they are unable to carry out their particular job role for their particular employer only.

It’s not in dispute that Ms C has been unwell and that she felt she couldn’t work – but an income protection benefit isn’t payable to her in all circumstances. Ms C needs to provide medical evidence to show that she met the policy definition of incapacity.

*Claims relating to mental health*

Ms C has sought justification from L&G as to the cover available for claims relating to stress and mental health issues under this policy.

It may be helpful if I explain that an income protection insurance policy like the one Ms C was insured under may cover incapacity due to a recognised mental health condition in certain circumstances, subject to the insured member providing medical evidence that they meet the policy definition of incapacity.

However, I wouldn’t generally expect an income protection insurance policy to pay a benefit for absence from work which is solely caused by stress. This is because workplace difficulties with an employer which mean a person is unable to do their own job isn’t the same as being unable to perform their occupation or a suited occupation due to illness more generally. Similar considerations can also apply to personal external stress factors which, when removed or reduced, mean that an insured person can return to work.

*The medical evidence*

I’m not medically qualified and it’s not my role to reach my own medical conclusions or to substitute expert medical opinion with my own. It’s also not for me to make any assumptions based on the medical evidence provided, or to draw any inferences into what the medical evidence says. Instead, I’ve weighed up the information I’ve seen to decide whether I think L&G acted fairly and reasonably when declining Ms C’s claim.

Ms C has provided numerous ‘Statements of Fitness for Work’ from her GP saying that she wasn’t fit for work. The reasons stated include ‘anxiety’, ‘stress and anxiety at work’, ‘depressed mood’ and ‘self-injurious thoughts’. While these certificates completed by a GP do carry evidential weight, the certificates contain limited information and are based on symptoms which were self-reported by Ms C. As such, I wouldn’t generally consider that GP medical certificates alone are sufficient evidence to demonstrate that a person is unable to perform their own, or any suited, occupation. The threshold for a GP to issue such certificates is not necessarily the same as the policy requirements for a claim to be paid.

L&G arranged for a Vocational Clinical Specialist Report to be carried out, and I think this was reasonable action for L&G to take when making enquiries into the claim. The report is dated 22 May 2023 and says Ms C identified her triggers for absence from work to be personal issues and work matters. The report concluded that Ms C was fit to return to her insured job role on a phased return, with adjustments.

I’ve taken into account Ms C’s comments about the activities which the report notes she was carrying out in her personal life, as well as her comments around her ability to return to work not being immediate. But ultimately, the report doesn’t support Ms C’s contention that she met the policy definition of incapacity at the time the assessment was carried out.

A letter from Ms C’s GP dated 13 July 2023 refers to Ms C as having *‘struggled with low mood, anxiety and ongoing stress surrounding the demands and needs of her workplace’*. The letter says Ms C reported that she was unable to work and Ms C was advised to have a

workplace assessment through her occupational health team. So, I'm not satisfied this letter demonstrates that Ms C met the policy definition of incapacity either.

I've also considered a report from a psychiatric assessment of Ms C dated 12 September 2023. While this report gives a diagnosis of a *'moderate-severe depressive episode'* and refers to Ms C as not feeling ready to return to work, the psychiatrist doesn't describe Ms C's functional limitations in relation to her job in any detail nor does the report set out any expert medical opinion about Ms C's ability to carry out her own, or any suited, occupation.

I understand Ms C says L&G didn't contact her GP to ask for further information but, in these circumstances, this isn't something which I'd necessarily expect L&G to have done. L&G was entitled to assess the claim based on the evidence presented to it, and it's not L&G's role to gather evidence in support of Ms C claim. I also understand Ms C says both her GP and her psychiatrist deflected her requests to provide further evidence but this is a matter between Ms C and her treating medical professionals and isn't something which L&G could reasonably be expected to intervene in.

After this complaint was brought to our service, Ms C provided further new medical evidence. This new evidence was shared with L&G, who consented to our service considering it within this complaint, and our investigator has already set out her opinion about the new medical evidence to both parties, so I think it's appropriate for me to address it within this final decision. The new medical evidence is contained within two reports dated 10 December 2023 and 9 September 2024 respectively.

The report dated 10 December 2023 from a consultant psychiatrist providing Ms C with a diagnosis of a new medical condition states that this medical condition has impacted on her work. However, no further information or details are given about what the extent of that impact was.

I've also considered the report from a remote CBT therapist dated 9 September 2024 stating that Ms C's work function was *'severely impaired'* and that she was not fit for work throughout the time the therapist worked with her. This was stated to be from January 2024 to July 2024. However, Ms C was first absent from work in January 2023 so I don't think this report demonstrates that Ms C met the policy definition of incapacity throughout the deferred period.

L&G has provided comments from its Chief Medical Officer based on all the medical evidence which has now been provided. These comments note, as of November 2023, Ms C wasn't taking any medication and there was no planned treatment escalation. The Chief Medical Officer's comments are that there were no *'persistent and pervasive symptoms of mental illness of sufficient severity to result in total incapacity throughout the deferred period and beyond for a less-demanding 'suited' role…'*.

L&G's Chief Medical Officer subsequently commented that his view in light of the new medical evidence (the reports dated 10 December 2023 and 9 September 2024) remained the same and that the diagnosis which Ms C was given in the earlier of these two reports *'does not typically form the basis for total exclusion of the member from the workplace, particularly for a less-demanding suited occupation…'*.

Overall, on balance, I don't think the totality of the medical evidence demonstrates that it's more likely than not that Ms C met the policy definition of incapacity at the relevant time. So, I don't think Ms C has demonstrated that she had a valid claim which L&G ought to have paid.

As a final point, I'm satisfied that any information which Ms C may have been given by her

former employer about the consequences of an occupational health referral on this income protection insurance claim didn't reflect L&G's position on the matter. I wouldn't expect L&G, as the insurer, to become involved in any employment-related disputes. It was up to Ms C's former employer to follow its own internal processes in relation to reasonable adjustments and a return to work for Ms C.

I understand Ms C has experienced financial consequences as a result of her claim being declined and that the claim decline has caused her further stress and anxiety. While I can sympathise with Ms C's position, I don't think L&G acted unfairly or unreasonably in the circumstances.

I wish Ms C well for the future, but I won't be directing L&G to do anything more.

## My final decision

My final decision is that I don't uphold Ms C's complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms C to accept or reject my decision before 30 December 2024.

Leah Nagle
**Ombudsman**