DRN-5139096

The complaint

Mr J is unhappy that Liverpool Victoria Financial Services Limited ('LV') didn't start paying a claim made under his income protection insurance policy ('the policy') from an earlier date.

What happened

Mr J stopped working in March 2023. His absence was covered by medical certificates provided by his GP, reflecting that he wasn't fit to work. The reason given was depression.

Subject to the remaining terms of the policy, a benefit can be paid if Mr J was unable to work due to illness after a waiting period of four (4) weeks ('the deferred period').

A claim was made on the policy which LV declined. It concluded there wasn't enough objective medical evidence to support the claim.

A complaint about that decision was brought to the Financial Ombudsman and an ombudsman decided in September 2023 that LV had acted fairly and reasonably by declining the claim and she didn't uphold Mr J's complaint.

Regarding the available medical evidence when declining the claim, the ombudsman's final decision said:

> It's clear that Mr J was suffering from symptoms which can also be indicative of a significant mental health condition. But at the point Mr J was signed-off in March 2023, the evidence indicates that the reason he wasn't fit for work was because he wasn't coping with a potential investigation at work, rather than because of a significant, impairing mental health condition. And the OH report concluded that Mr J had experienced several work-place stressors, including an incident which appears to have resulted in the planned investigation.
>
> While I appreciate Mr J's fit notes stated depression at this time, the notes don't indicate how Mr J was precluded from work in March or April 2023 and nor do they show, objectively, why or how he was functionally impaired when the deferred period began.
>
> So I think it was reasonable for LV to conclude that the evidence showed Mr J was suffering from an understandable reaction to the very difficult situation in which he found himself, as opposed to a mental health condition which met the definition of 'unable to work' for the whole of the deferred period. This means I don't think it was unfair for LV to consider that Mr J hadn't met the policy definition of incapacity for the entirety of the deferred period when it initially assessed the claim.

In respect of further medical evidence dated May and June 2023, Mr J had provided to LV when challenging its original decision to decline the claim, the ombudsman said:

> Having assessed the new medical evidence, LV maintained its position. It said that the majority of the consultations point to a depressed low mood, which isn't

depression and it said the later entry referred to ‘mild depression’. It stated that a depression diagnosis and medication doesn’t mean that a person is unable to work. It pointed to the fact that much of the evidence referred to Mr J’s issues with work and the potential workplace investigation. So it still felt there was no objective medical evidence which supported a claim.

Again, I’ve considered this evidence carefully. But I don’t think LV has reached an unreasonable conclusion. The GPs’ letters seem to be based on Mr J’s self-reporting of his symptoms. The online GP didn’t examine Mr J in person. And there remains reference to Mr J’s fears about work. I agree too that the GP’s records suggest that Mr J had ‘mild depression’ and don’t indicate that Mr J was significantly functionally impaired. So I don’t think LV acted unfairly when it concluded that this evidence didn’t show Mr J was unable to work in line with the policy terms.

I appreciate Mr J says his medication could affect his ability to do his job. But the GPs’ letters don’t state that Mr J couldn’t do his job because of the medication he was taking. And the medication information leaflet he sent us only says that the medication could influence a patient’s ability to do certain things (such as driving) and that a person should wait to find out how the medication affected them before attempting to undertake those activities.

Overall then, I don’t think it was unfair for LV to conclude that the June 2023 evidence didn’t change its position and to maintain its decision that Mr J hadn’t shown he met the policy definition of ‘unable to work’ during the full deferred period and afterwards.

I sympathise with Mr J’s position and I accept that medical professionals have found that he is unable to work. But that isn’t enough to show that a claim meets an insurer’s policy terms. And based on all I’ve seen, I’ve decided that LV didn’t act unfairly when it relied on the medical evidence up to and including 28 June 2023, to conclude that Mr J’s claim wasn’t covered. So I find it was fair for LV to turn down Mr J’s claim.

The ombudsman also made clear that she hadn’t considered a psychological evaluation report dated 8 September 2023 (‘the September 2023 report’) provided by Mr J as that was dated after the final response issued by LV. She said LV had been given this to review (and to see whether it changed its position on the claim). And that if Mr J was unhappy with the outcome of any assessment of that evidence by LV, he might be able to make a new complaint about that issue alone.

LV considered the September 2023 report and by way of a letter dated 4 October 2023 confirmed that it would accept the claim from the date of the September 2023 report. So, taking into account the deferred period, the benefit under the policy was payable from October 2023.

Mr J is unhappy because he says the claim should be accepted back to the date he was first off work in March 2023. LV disagreed so Mr J brought a further complaint to the Financial Ombudsman Service.

Our investigator didn’t uphold his complaint. He concluded that LV acted fairly by starting the claim from September 2023. He said there was no new objective medical evidence to support that there was an illness which prevented Mr J from working before the September 2023 report.

Mr J disagreed and raised further points in reply. These didn't change our investigator's opinion. So, this complaint has been passed to me to look at everything afresh 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, I don't uphold it. I know Mr J will be very disappointed but for reasons I'll go onto explain, I'm satisfied LV has acted fairly and reasonably by relying on subsequent medical evidence to accept an income protection claim from September 2023 (rather than March 2023).

The relevant policy terms

The policy says:

> We'll pay you if you're too unwell to work in your own occupation (due to illness or injury only) and you aren't doing any other paid or unpaid work – for example, voluntary work.

Unable to work means that:

> due to illness or injury you cannot carry out the main tasks of your occupation, and you aren't doing any other type of work whether this is paid or voluntary (unpaid) work. The main tasks are the parts of the job you do which can't reasonably be left out, or changed.

The decision to accept the claim from September 2023

LV has a regulatory obligation to handle insurance claims promptly and fairly – and it mustn't unreasonably decline a claim.

It's for Mr J to establish a claim under the policy, including that he was unable to work as defined by the policy terms throughout the deferred period. It's not for LV to show he didn't meet that definition.

LV has accepted that the September 2023 report reflected that a psychological evaluation had been carried out on 8 September 2023 which confirmed Mr J had predominant depressive mood equivalent GAD7 and PHQ9 scores came out with medium intensity depression.

However, LV has also said that the medical evidence received before this didn't support that Mr J's absence met the policy definition of being unable to work.

I accept that Mr J was signed off work for depression by his GP in March 2023 (and beyond) and LV ultimately accepted the claim based on the diagnosis of depression in the September 2023 report.

However, another ombudsman has already determined that LV fairly concluded that the overall medical evidence up to the end of June 2023 didn't establish that Mr J met the policy definition of being unable to work during the initial deferred period, or afterwards.

I'm satisfied that the September report doesn't provide insight into how long Mr J had been clinically depressed, the triggers for this or specifically why – and for how long – he was unable to do the main tasks of his job because he'd been clinically depressed.

So, I find that LV has fairly accepted the claim from September 2023 (when Mr J was still off work) and applying the deferred period from that date. I'm not persuaded that the medical evidence I've seen from after the end June 2023 supports that LV's original decision to initially decline the claim (on the basis that Mr J was unable to work during the initial deferred period of four weeks starting March 2023) – and determined to be fair and reasonable by another ombudsman's decision dated September 2023 – is unfair.

My final decision

I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr J to accept or reject my decision before 12 May 2025.

David Curtis-Johnson
Ombudsman