DRN-5157206

The complaint

Mr A is unhappy with the way Dentists' Provident Society Limited ('the Society') has handled a claim made under his income protection policy ('the policy').

What happened

The details of this complaint are well known to both parties, so I won't repeat them again here. I'll focus on giving the reasons for my 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.

Both parties have made detailed submissions and I've been provided with a significant number of documents. I'm not going to respond to each point. No discourtesy is intended by this. Instead, I've focussed on what I think are the key issues here. The rules that govern the Financial Ombudsman Service allow me to do this as we are an informal dispute resolution service. If there's something I've not mentioned, it isn't because I've overlooked it. I haven't. I'm satisfied I don't need to comment on every point to be able to fulfil my statutory remit.

Further, I've only considered issues up to the date of the Society's final response letter dated December 2023 (from its legal representative). I'll refer to this as "the final response letter". I know matters have progressed since that date but if Mr A is unhappy with anything that has occurred since then, he'll need to raise a further complaint to the Society to investigate initially. If he doesn't receive a reply within eight weeks or he's unhappy with the Society's response to his further concerns, he may be able to bring another complaint to the Financial Ombudsman Service.

Has the Society acted fairly and reasonably when handling the claim?

The Society has an obligation to handle claims fairly and promptly. And it mustn't unreasonably decline a claim.

Subject to the remaining terms and condition, and after the deferred period, the policy can provide Mr A a monthly benefit if he's incapacitated. In this case that means:

- he is unable to perform the material and substantial duties of his occupation.
- he isn't following any other occupation.
- his income from his occupation has reduced as a result.

I know Mr A will be very disappointed but reasons I'll go on to explain, I'm satisfied that the Society has acted fairly and reasonably overall when handling his claim.

- The policy terms say that the Society will review a claim at least once every 12 months (and more frequently if it considers this necessary) on both medical and financial bases to make sure that "cumulative we have paid you the appropriate benefits under your claim and we reserve the right to recover any overpaid benefits by any reasonable means…"
- The policy terms go on to say: "you should tell us as soon as possible if there is any change to your health, financial or personal circumstances that may affect your benefits". And "if you do not fulfil our requirements regarding claims we may refuse or stop paying your benefits".
- In line with the policy terms, I think it was reasonable for the Society to request updated medical information for Mr A when reviewing the claim, and his latest financial documents (including last financial accounts and tax return and confirmation of whether Mr A had received any Covid-19 related grants of furlough payments during his incapacity).
- The claim had been paid using the Mr A's pre-incapacity income, taken from his 2019 accounts, and in line with how the benefit is calculated (as set out in the policy terms) any income or profits received during the account year 2020 will be taken into account when calculating the benefit amount for the relevant period.
- Looking at the correspondence provided, I'm satisfied that the Society paid the monthly benefit under the policy up to February 2021. I'm also satisfied that it chased Mr A for the medical and financial information it (reasonably) requested to consider whether Mr A continued to meet the incapacity definition, to calculate the benefit and to assess whether a benefit was payable under the policy.
- Once the Society heard back from Mr A, I'm satisfied that it promptly requested updated information from Mr A's GP, immunologist, haematologist and accountant. And having not received this information, it regularly and proactively chased for this information. I'm also satisfied it kept Mr A up to date about this delay and progress trying to access his updated medical information.
- I'm also satisfied that Mr A was told that some of the medical professionals wouldn't provide the information without a dated consent form which it returned to Mr A for completion. I'm satisfied this was out of the Society's control and not something it can be held reasonably responsible for. I'm also satisfied that having not received this from Mr A, the Society reasonably chased him for this.
- I'm satisfied that after the Society received the financial information from Mr A's accountant it promptly considered this. Based on the financial information received at the time, I'm satisfied that it fairly notified Mr A in April 2022 of the reasons why it felt the benefit payments it had made from February to August 2020 were higher than Mr A was entitled to under the terms of the policy and that there had been an overpayment which it was looking to recover. I think it was reasonable for the Society to seek to agree a repayment plan with Mr A at that stage.
- As Mr A subsequently said he and his accountant disagreed with the Society's calculations, I'm satisfied that the Society reasonably proposed a meeting with Mr A and his accountant to discuss. As an alternative, I'm satisfied that it reasonably proposed contacting Mr A's accountant directly to understand exactly what aspects of the calculations they disagreed with.
- Thereafter, I'm satisfied that the Society regularly contacted Mr A's accountant in attempt to discuss the calculations.
- Based on further financial information received relating to the period in which the

benefit was paid to February 2021, the Society concluded that Mr A hadn't incurred a loss and so no benefit is actually payable and had again been overpaid for this further period. Having again set out its position of the overpayment and, based on his financial information, why it doesn't think Mr A has continued to incur a financial loss, I'm satisfied that the Society fairly offered in the final response letter to have a further meeting with Mr A and his accountant to discuss the financials, to resolve this issue.

- I'm also satisfied that the Society acted fairly and reasonably by arranging for an independent third party to meet with Mr A to help him complete a claim review form and discuss his current level of psychological and physical functioning following his absence from work.
- Notwithstanding the issue of whether Mr A has been overpaid a benefit and whether he has experienced a financial loss (based on the calculations set out in the policy terms), I'm satisfied that the society has fairly and reasonably concluded based on the available medical evidence – and after a referral to its chief medical officer - that Mr A didn't meet the incapacity definition as set out in the policy terms from February 2021.
- Although Mr A had been diagnosed with an underlying medical condition, which put him at a higher risk of infections, the medical evidence doesn't provide much insight into how his condition impacted his ability to work and the impact on him is largely self-reported.
- The medical evidence also supports Mr A missed a number of appointments and was discharged from the care of his haematologist because of this and the last contact they had with Mr A was in March 2021. Further, his GP notes reflect in January 2022 (so around year after the benefit stopped pending further information being provided to assess the claim) Mr A had requested backdated sick notes and his symptoms were gradually improving and felt better to return to work in the coming weeks. But the medical evidence doesn't explain what prevented Mr A working in the year before this or support that Mr A met the policy definition of incapacity.
- Overall, whilst there were significant delays in this case, I'm satisfied that these weren't caused by the Society. I'm satisfied that it acted reasonably by requesting further information, and despite proactively chasing, Mr A didn't respond or delayed responding to correspondence and so did third parties that the Society reasonably requested more and updated information from. Those delays were outside of the Society's control.

Further issue

- The policy terms and conditions say that the policyholder should complete and return a claim form.
- As I've found above that the Society reasonably concluded that the medical evidence didn't support that Mr A was incapacitated from when it stopped paying the benefit in February 2021 and the ongoing issue of whether Mr A had been overpaid the benefit received under the policy up to that date, I'm satisfied that the Society acted reasonably by telling Mr A that he'd need to complete a new claim form for another, separate, medical condition he said he was unable to work because of.
- At the time of the final response letter, I've seen nothing to persuade me that Mr A did complete and provide the Society with a claim form relating to this other condition with supporting documents (indeed a further blank claim form was said to be enclosed with the final response letter). So, having not received a completed claim form, I think the Society has acted reasonably by not considering and assessing a

further claim under the policy up to that stage.

My final decision

I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr A to accept or reject my decision before 19 February 2025.

David Curtis-Johnson
Ombudsman