DRN-5159705

The complaint

Mrs R is unhappy that Aviva Life & Pensions UK Limited stopped paying a proportionate monthly benefit following a successful claim made on a group income protection insurance policy.

What happened

Mrs R has the benefit of a group income protection insurance policy ('the policy'). Subject to the remaining terms, the policy can pay out a monthly benefit if Mrs R is unable to work due to illness (or injury) after the deferred period.

Under the policy, if a successful claim is made, and the member returns to work on reduced hours, the policy does provide for a proportionate benefit to be paid. That's what happened here.

However, in 2022, Aviva arranged for Mrs R to meet with an independent medical expert (IME) and to provide a report on whether Mrs R was able to return to work full time. Relying on the contents of that report, Aviva stopped paying a proportionate benefit.

Mrs R appealed that decision and Aviva issued its final response letter maintaining its decision to stop paying the proportionate monthly benefit.

Unhappy, Mrs R brought a complaint to the Financial Ombudsman Service.

Our investigator looked into what happened and didn't uphold her complaint. Mrs R raised further points in reply, but these didn't change our investigator's view. So, her complaint has been passed to me to consider 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.

The insurance industry regulator, the Financial Conduct Authority ('FCA'), sets out rules and guidance for insurers in the 'Insurance: Conduct of Business Sourcebook' ('ICOBS'). ICOBS says insurers should act honestly, fairly and professionally in accordance with the best interests of its customers. It also says insurers should handle insurance claims promptly and fairly.

The policy terms and conditions say:

> 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 benefit payable will be shown in the policy schedule.

And:

> We will pay a proportionate benefit after the deferred period:
>
> If before the incapacity the member was actively at work and following their job role and;
>
> If incapacity has lasted for at least five consecutive working days; and as a result of illness…the member is either;
>
> following their job role on a part-time basis…

Relevant to this complaint, incapacity is defined as:

> 'Own'. 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 of injury.

Job role means:

> A member's job role with the policyholder at the time incapacity starts.

Duties are defined as:

> The material and substantial duties that:
>
> - are normally required to perform the job role of the policyholder; and
> - perform a significant and integral part of the performance of their job role for the policyholder; and
> - cannot reasonably be omitted or modified by the member of the policyholder.
>
> Duties do not include the journey to and from work.

When making a claim, it's for Mrs R to establish that she was incapacitated. She was able to do that, and Aviva paid a monthly benefit under the policy. As Aviva has now stopped paying the claim it's for it to show (on the balance of probabilities) that she no longer met the definition of incapacity, based on medical evidence.

Did Aviva act fairly and reasonably when stopping Mrs R's claim?

I'm not a medical expert. So, I've relied on all evidence available to me when considering whether Aviva reasonably ended Mrs R's claim, when it did. Where there is conflicting medical evidence, I've had to consider what I think is more persuasive in the circumstances of this case.

I know Mrs R will be very disappointed, but I'm satisfied Aviva acted fairly and reasonably when ending the claim. I don't in any way seek to minimise the impact Mrs R's condition has on her, and I have a lot of empathy for the situation she finds herself in, but for reasons I'll go onto explain, I find that Aviva reasonably concluded in 2022 that she no longer met the policy definition of incapacity.

- I'm satisfied from what I've seen that Mrs R was contracted to work 35 hours per week, although she says in reality she was working many more hours than that before she was incapacitated.
- The IME report dated July 2022, prepared by a consultant in occupational medicine noted that at that time Mrs R worked three days each week (mainly from home) from around 9.15 or 9.30am until 4 or 4.30pm with a lunch break. And then she did two to

three hours work at night, as needed. It was noted that Mrs R also did additional work on days that were, at that stage, scheduled as non-working days. On her days off, it was reported that Mrs R cared for her child, did shopping and cooking and that Mrs R reported that "her caring activities are more demanding that her working role, but she cannot afford full time nursery care".

- The IME report also reflects that Mrs R reported fatigue symptoms but was able to undertake a full range of activities "with work, including childcare and social interactions".
- The IME report concludes that Mrs R "is currently at work and is, in my opinion, fit to increase to full time hours. I do not believe her residual symptoms necessitate a reduction in working hours and do not expect full-time work to present any hazard to her".
- In response to the IME report, Mrs R's consultant neurologist prepared a letter dated November 2022. Current symptoms were noted to include fatigue, "triggered by mental stress such as work deadlines, working long days or evening work". The letter also reflects that the commute to and from work causes fatigue and heat levels when travelling on the underground can significantly exacerbate her symptoms. The consultant neurologist concludes that they'd recommend that Mrs R was given the option of reducing her working week from 5 days to 4 days with a hybrid system of working for those four days.
- However, I'm less persuaded by the contents of this letter as the policy terms say that duties don't include travelling to and from work. And further, from the contents of the IME report, Mrs R had told the IME that she wasn't regularly working from the office and so wasn't required to regularly commute. Further, Mrs R's employer – the policyholder – would be required to make reasonable adjustments under the Equality Act 2010 to alleviate any disadvantage caused by working practices and it seems from what Mrs R says (and is reflected in the IME report) that her manager was flexible and supportive overall, and she was able to effectively carry out her duties working from home.
- Another neurology consultant provided a letter dated October 2022 and said that fatigue was a dominant symptom for Mrs R. And that she would benefit from reasonable adjustments to her work schedule, working 4 days per week rather than 5 days as this would "have a positive impact on physical, cognitive and emotional function" and fatigue is likely to be better managed. However, whilst working less days may have been more beneficial for Mrs R, I think Aviva has fairly concluded that Mrs R no longer continued to be incapacitated to the extent that she was unable to carry out her duties and work her contractual hours (due to her condition). And there's nothing in the letter to indicate that the consultant neurologist was aware of the hours she worked or her work pattern at the time, as the IME was.
- The IME's follow up report dated January 2023, commenting on the letters of both consultant neurologists, reiterated that they believed that Mrs R was fit to work her normal full-time hours from 9.30am to 5.30 pm, five days per week (not a variable pattern which includes work until 11pm). The IME's opinion remained the same: that she could work 35 hours per week over five days, and to not work late into the evenings. Whilst they "accept that [Mrs R] has symptoms of fatigue, which can vary at times" they "do not believe that the evidence indicates that she is medically unable to undertaken her normal role".
- I've also taken into account an occupational health report dated March 2024 which highlights that Mrs R stated that fatigue is the most persistent and debilitating symptom of her condition (in addition to other symptoms such as maintaining focus) and recommends that Mrs R maintains a work pattern of 30 hours per week, over

four days. And that working five days would be above the capacity Mrs R could tolerate as “she has already experienced detriment to her health and wellbeing from working 4 consecutive days”. However, I’ve placed less weight on the contents of this report because it was prepared around 18 months after the decision was taken to end the claim. I think the medical evidence from 2022 and early 2023 is more relevant and persuasive given that it was contemporaneous and considering Mrs R’s circumstances around the time the decision was taken to end the claim. Further, looking at the documents that the occupational therapist had considered before their assessment with Mr R, they hadn’t considered the IME’s further report dated January 2023 (commenting on both consultant neurologist’s reports) nor Mrs R’s GP records, so it doesn’t look like they had access to all the relevant medical evidence when preparing the report. The March 2024 report also doesn’t explain why the opinion of the occupational therapist differs from the IME’s opinion.

My final decision

I don’t uphold Mrs R’s complaint.

Under the rules of the Financial Ombudsman Service, I’m required to ask Mrs R to accept or reject my decision before 27 January 2025.

David Curtis-Johnson
Ombudsman