DRN-5174475

The complaint

Mrs J complains that Assicurazioni Generali SpA (Generali) has turned down an incapacity claim she made on a group income protection insurance policy.

What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I think are the key events.

Mrs J is insured under her employer's group income protection policy. The policy provides cover in the event that Mrs J is unable to work in her own occupation, as a result of illness or injury. The deferred period is 26 weeks.

In November 2023, Mrs J was signed-off from work suffering from post-partum depression (PPD) and anxiety. As she remained unable to work, Mrs J's employer made a claim on the policy.

Generali requested medical evidence to allow it to assess the claim. It calculated that Mrs J's deferred period would end in May 2024 and so it determined that Mrs J needed to show she'd been incapacitated due to illness for the whole of the deferred period. In addition to the medical evidence it considered, which included medical records and an occupational health (OH) report, Generali arranged for Mrs J to be assessed by a Vocational Rehabilitation Consultant (VRS).

Having considered the information provided, Generali didn't think there was enough objective medical evidence to show that Mrs J was absent from work due to a medical condition which prevented her from carrying out the functional requirements of the material and substantial duties of her own occupation. It also noted that Mrs J was able to carry out the activities of daily living. So it didn't think Mrs J had met the policy definition of incapacity and it turned down her claim.

Mrs J was very unhappy with Generali's decision and she provided further evidence from her GP in support of her claim. But Generali maintained its position and so Mrs J asked us to look into her complaint.

Our investigator didn't think Mrs J's complaint should be upheld. In summary, he didn't think it had been unfair for Generali to rely on the available medical evidence to conclude that Mrs J hadn't shown her claim met the policy definition of incapacity. And therefore, he felt it had been fair for Generali to turn Mrs J's claim.

Mrs J disagreed. She felt she'd provided objective, independent medical evidence which showed she was unfit for work. She questioned why medical opinion had been overruled. She also thought Generali and the investigator had taken her ability to complete social activities as evidence that she was fit to carry out her role. But she said this was a defence mechanism. She said she'd found Generali's position very upsetting and that she wished to return to work as soon as she could – but that she was prevented from doing so by her mental health. She also questioned what we would consider to be an independent medical

source.

The complaint's been passed to me 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, whilst I'm very sorry to disappoint Mrs J and I know how upsetting my findings will be to her, I don't think it was unfair for Generali to turn down her claim. I'll explain why.

First, I'd like to reassure Mrs J that while I've summarised the background to her complaint and all of the submissions to us, I've carefully considered all that's been said and sent. I'm very sorry to hear about the circumstances that led to Mrs J needing to make a claim and I don't doubt what a worrying and upsetting time this has been for her.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, together with other relevant considerations, such as regulatory principles, the policy terms, and the available medical evidence, to decide whether I think Generali handled Mrs J's claim fairly.

I've first considered the terms and conditions of the policy, as these form the basis of Mrs J's employer's contract with Generali. As Mrs J's employer made a claim on her behalf for incapacity benefit, I think it was reasonable and appropriate for Generali to consider whether Mrs J's claim met the policy definition of incapacity. This says:

'As a result of illness or injury, the Member is incapable of performing the Material and Substantial duties of their occupation, and they are not carrying out any other Work or occupation.'

This means that in order for Generali to pay Mrs J incapacity benefit, it must be satisfied that she had an illness or injury which prevented her from carrying out the material and substantial duties of her own occupation for the full deferred period and afterwards.

It's a general principle of insurance that it's for a policyholder to show they have a valid claim on their policy. This means it was Mrs J's responsibility to provide Generali with enough medical evidence to demonstrate that an illness had led to her being unable to carry out the duties of her own occupation for the full 26-week deferred period between November 2023 and May 2024. I should add that it isn't for us to tell Mrs J what evidence she should provide or to tell Generali what evidence it should accept in order for it to pay a claim.

Generali assessed the evidence Mrs J provided in support of her claim, including seeking the opinion of an independent VRC. While it sympathised with Mrs J's position, it concluded that she wasn't suffering from an illness which met the policy definition of incapacity. So I've next looked at the available medical and other evidence to assess whether I think this was a fair conclusion for Generali to draw.

I've first considered the claim form Mrs J completed. This stated that she was absent due to PPD and anxiety. She said that she was suffering from a lack of concentration, emotional volatility, excessive crying, fatigue and panic attacks. She stated that she was switching anti-depressant medication and she set out the daily activities she was able to complete – which included socialising.

Next, I've looked carefully at the GP records, which set out details of Mrs J's consultations with her GPs. In November 2023, the GP noted that Mrs J had previously been on medication for PPD but had stopped taking it. The notes say: *'(Mrs J) had really struggled past few months, mood low, anxious, feels overwhelmed. Work...long days…feels has no time for family, feels constantly rushing and inefficient.'*

The GP noted that Mrs J was having talking therapy and prescribed her new medication. They signed her off with 'depression/anxiety'.

In December 2023, Mrs J's GP records say: *'Anxiety/depression. Feeling a bit better. Focused on lifestyle measures, exercise, slowly getting better.'* Mrs J was still seeing the talking therapist and taking medication. She was signed off again with depression/anxiety.

Subsequently, in January 2024, the GP noted that Mrs J's mood remained anxious. And in February 2024, the records show her mood remained low and she was tearful. The notes state she was no longer experiencing any benefit from her medication and so a weaning and switch plan was put in place. The notes also show that OH had suggested that Mrs J might benefit from a psychiatry referral, which the GP actioned. Mrs J's fit note said she was signed off with 'depression/anxiety.'

In March 2024, Mrs J's GP recorded that Mrs J felt guilty about being off and that this was helping her return. The notes say she felt emotionally labile and that her emotions were everywhere. The notes describe that Mrs J was able to socialise with friends and refer to an increase in the switched medication.

The psychiatry team reviewed Mrs J's situation in March 2024. I've set out what I consider to be key points in the psychiatrist's resulting letter of March 2024 says: '*The presentation within the content of your referral would indicate that Mrs J does have a depressive illness, but it also appears to respond to an SSRI to an extent…The MDT would suggest that we follow the usual protocol to change Mrs J to (another medication)…We were also reassured that Mrs J is undergoing private therapy…'*

Accordingly, in April 2024, the GP notes show that the doctor discussed *'psych referral rejected with advice to switch to (new medication)….Reports a lot better on (medication) than previous medication, but still good and bad days. Anxiety less.'*

I've next considered the OH report of February 2024. I've set out below what I believe to be their key conclusions:

'(Mrs J) continues to experience significant physical symptoms of anxiety with sleep disturbance and she says she feels exhausted all the time. She has ongoing episodes of low mood…

Mrs J has postnatal depression which is significantly impacting on her function. She is currently not fit to work. She is being appropriately managed by her GP and it is likely that her symptoms will continue to improve with the increased dose of medication. Once her symptoms are under control, the likelihood of recurrence to the detriment of future employment will be reduced.

I would anticipate that she would be fit to undergo a phased return to work in around 4-6 weeks' time with modifications in place.'

As I've explained, Generali appointed a VRC, who assessed Mrs J in July 2024 to understand her barriers to returning to work. The VRC explained Mrs J's symptoms in depth

and the treatment she was undergoing. They also explained that Mrs J had initially been undergoing talking therapy every two weeks, but that this had become more sporadic over the past months. The VRC set out Mrs J's daily activities and function, and also noted that Mrs J was able to attend groups etc. They concluded that Mrs J was making progress on her new medication and that: '*therefore it is reasonable to expect her to be able to return to work in her role with the opportunity to build confidence and resilience with a phased return to work plan.'*

Following the initial decline of Mrs J's claim, her GP wrote a letter of support and again, I've set out what I think are the GP's key comments:

'She has had regular GP consultations over the past few months with anxiety and depression. Her contact has always been appropriate and she has actively sought support and assistance with her recovery both privately and via the NHS. Over these consultations she has appeared motivated to improve and genuine. She has had contact with both myself and two other senior experienced GP colleagues who have all on their own assessment deemed her unfit for work and provided her with sick note certifications.

You will be aware having had access to her medical records that she has presented with symptoms of anxiety and depression including emotional lability and anhedonia as well as biological symptoms associated with these conditions such as unrefreshed sleep, poor concentration and poor appetite. She has been noted to be tearful on more than one occasion at the practice. You will also be aware that failure to respond to two anti-depressants at reasonable doses prompted a referral to specialist psychiatric team in February 2024. Whilst this was rejected the Psychiatrist provided some advice regarding pharmacological management and recommended recontacting them if further support was required. As you will be aware Mrs J has also been getting private therapy…

I wish to reiterate that Mrs J has had regular appropriate GP contact since November 2023 regarding her difficulties and that her story has remained consistent throughout. As a GP we would only issue a sick note if we believed the patient to be medically unfit to undertake their usual occupation and she has received continuous sick note certification since November 2023. I was disappointed to read the comments in the correspondence from yourselves that she provided to me, "I have taken into account Mrs J's self reported symptoms. These are relevant but also somewhat subjective". As senior experienced GPs we would not provide somebody with sick note certification unless we felt they were unfit to undertake their usual occupation and fully support her appeal against the decision to decline her income Protection claim.'

I've thought very carefully about all of the evidence that's been provided and which was available to Generali when it made its final decision on Mrs J's complaint. It's important I make it clear that I'm not a medical expert. In reaching a decision, I must consider the evidence provided by both medical professionals and other experts to decide what evidence I find most persuasive. It isn't my role to interpret medical evidence to reach a clinical finding – or to substitute expert medical opinion with my own - and it would be inappropriate for me to do so.

It's clear that Mrs J was suffering from symptoms which can also be indicative of a significant mental health condition. I appreciate her GP signed her off as unfit to work and I've borne in mind their supportive letter.

But the evidence shows that at times, during the deferred period, Mrs J's condition did seem to be improving. While her GP referred her to psychiatry, the relevant team didn't consider it needed to see or assess Mrs J, and instead suggested a change to her medication to manage her symptoms. I don't think it was unreasonable for Generali to therefore conclude that the psychiatry team didn't think Mrs J's condition was serious enough to require psychiatric intervention. And, in February 2024, the OH – a specialist in occupational medicine – concluded that Mrs J was likely to be fit to return to work on a phased basis in four to six weeks. This means that the OH doctor felt Mrs J was likely to be fit to return to work within the deferred period. I also think Generali was reasonably entitled to take into account Mrs J's daily activities, which she reported to OH, her GP and the VRC – including social activities, as well as housework and childcare – when it considered the likely impact of her illness on her functional ability.

Taking the above into consideration, I don't think it was unreasonable for Generali to place more weight on the objective evidence of the OH and the VRC – both occupational health specialists – than on the fit notes and letter provided by Mrs J's GP. That's because neither the fit notes, nor the GP records or letter, explain how or why Mrs J's symptoms prevented her from carrying out the material and substantial duties of her own occupation. Instead, as I've said, there is evidence that her condition improved at times and that she did have functional ability.

On this basis then, I don't think it was unfair for Generali to ultimately conclude that Mrs J's illness wasn't of a severity which would preclude her from carrying out the material and substantial duties of her own occupation. So I don't think it unfairly concluded that she hadn't shown she was incapacitated in line with the policy definition

I'd like to reassure Mrs J that I'm not suggesting that she was fit for work. I appreciate she was medically signed-off. And I understand she's been through a very difficult time. But I need to decide whether I think she's shown she met the policy definition of incapacity for the whole of the 26-week deferred period. As I've explained, I don't think she has.

It's open to Mrs J to obtain new medical evidence in support of her claim, should she wish to do so. Mrs J would need to send any new medical evidence to Generali for it to consider and to decide whether or not it alters its understanding of her claim. If Mrs J is unhappy with the reconsideration of any new evidence, she may be able to make a new complaint to us about that issue alone.

Overall, despite my natural sympathy with Mrs J's position, I don't find it was unfair or unreasonable for Generali to turn down her claim.

My final decision

For the reasons I've given above, 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 J to accept or reject my decision before 16 January 2025.

Lisa Barham
Ombudsman