DRN-5231846

The complaint

Mr W is unhappy that Assicurazioni Generali SpA ('Generali') declined a claim made on a group income protection insurance policy.

What happened

Mr W has the benefit of a group income protection policy through his employer ('the policy'). Subject to the remaining terms of the policy, it can pay a monthly benefit after he'd been off work due to illness or injury throughout an initial deferred period of 52 weeks.

A claim was made on the policy during the deferred period and Generali considered Mr W's medical records. It also arranged for Mr W to have a functional capacity evaluation ('FCE'). Based on the results of the FCE, and the available medical records, Generali concluded that there was not enough evidence that Mr W was incapacitated as required by the policy terms. So, it declined the claim.

Mr W appealed. When Generali maintained its decision, Mr W brought a complaint to the Financial Ombudsman Service.

Our investigator looked into what happened and didn't uphold Mr W's complaint. Mr W disagreed, so this complaint has now 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.

Generali has an obligation to handle insurance claims promptly and fairly. And it shouldn't reject a claim unreasonably.

The policy terms and insurance schedule set out the relevant definition of incapacity as:

> 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.

It's for Mr W to demonstrate he has a valid claim under the policy, including that he was incapacitated.

I know Mr W will be very disappointed, but I don't uphold his complaint. Before I explain why, I'd like to assure him that my decision is in no way intended to be dismissive his health issues. I can see Mr W been through a difficult time. However, for reasons I'll go onto explain, I'm satisfied Generali has fairly and reasonably declined his claim.

- Mr W's claim form reflects that he was prevented from working due to health issues which left him short of breath and with a persistent cough. He also said that he was in pain, depressed and prone to infections so he limited interactions with others. The claim form completed by his employer reflects that most of Mr W's time would be

spent at a desk, but he'd have access to an area which includes walking up and down stairs at regular intervals during the day.

- I'm satisfied Generali has carried out a fair and reasonable review of the medical evidence when taking the decision to decline the claim.
- Having considered Mr W's GP and other medical records, I'm satisfied that there's limited medical evidence to support that Mr W was incapacitated as defined by the policy throughout the deferred period. The available medical evidence gives limited insight into how Mr W's condition impacted his ability to perform the material and substantial duties of his occupation or how his condition would affect his functionality more generally.

- An occupational health report dated November 2023 (so part way through the deferred period) does conclude that Mr W was unfit for all duties, and he was short of breath and coughing a lot during the assessment. It's also reflected that Mr W reported ongoing coughing and shortness of breath with minimal exertion, struggling with washing and dressing and only being able to walk short distances. However, the policy has a specific definition which needs to be met. The report gives little meaningful insight into why Mr W was unable to work and is largely based on his self-reporting.

- I'm satisfied that it was fair and reasonable for Generali to arrange a FCE which it can do under the terms of the policy. The FCE was undertaken by an osteopath and accredited functional capacity assessor. It concludes that of the tasks Mr W could do, Mr W demonstrated a severe level of disability which didn't match his reported abilities to do some activities of daily living. And this indicated his actual level of function is "far greater than he demonstrated during the FCE testing". It also says that limited physical workday tolerances during formal testing can't be viewed as barriers preventing Mr W from returning to his normal role.

- I've taken on board Mr W's concerns about the FCE and the assessor. However, I'm satisfied that Generali has fairly relied on the contents of the FCE in support of its decision to decline the claim. But in any event, as I've said above, it's for Mr W to establish his claim. So, based on his medical records and occupational health report dated November 2023, in the absence of further objective medical evidence about his medical condition and how it impacts his ability to function, I'm satisfied Generali has fairly and reasonably concluded that Mr W wasn't incapacitated as defined by the policy.

- When making this finding, I've taken on board that Mr W says he's receiving personal independent payment (PIP). However, the criteria for a claim being accepted for this welfare benefit is different to what needs to be established under the policy to successfully claim the monthly benefit.

- Mr W has also provided a further occupational health report dated January 2025. However, I've considered Generali's decision – and the available medical evidence - up to the date of the final response letter dated June 2024.

My final decision

I don't uphold this complaint.

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

David Curtis-Johnson
Ombudsman