DRN-5240005

The complaint

Ms S complains that Legal and General Assurance Society Limited (L&G) stopped paying benefit for 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 main events.

Ms S is insured under her employer's group income protection insurance policy. In September 2018, Ms S was signed-off from work suffering from a number of diagnoses, including a cyst on her brain. An incapacity claim was made on the policy and L&G started paying benefit in 2019.

L&G periodically reviewed Ms S' claim to check benefit was still payable. In July 2021, Ms S told L&G that she was being referred to a neurologist and that she hoped to undergo brain surgery. In August 2021, L&G let Ms S know that it needed to ask for her medical records from her GP. And the following month, L&G wrote to Ms S' GP to ask for her medical records from July 2020 onwards, so it could continue to assess whether Ms S was still incapacitated in line with the policy terms and how her illness affected her function.

The GP surgery told L&G that it had sent Ms S' records to her to review. But Ms S didn't send the records on to L&G. That's because she said reviewing them negatively affected her mental health. And L&G also arranged for Ms S to speak to its vocational clinical team (VCT). However, despite the VCT's attempts to get in touch with Ms S, it was unable to do so.

Therefore, L&G let Ms S' employer know that if Ms S didn't send on her medical records or engage with it, it would need to stop paying her claim. That's because it considered it didn't have enough objective medical evidence to show that Ms S remained incapacitated by her illness.

As Ms S didn't engage with the VCT or provide the medical evidence L&G had asked for, in May 2022, it suspended benefit. And in September 2022, it closed the claim. It seems Ms S' employer let her know about L&G's decision.

In May 2024, Ms S appealed. She explained that she'd undergone brain surgery in late 2022 and that she'd also since undergone treatment for blood and other disorders. She felt that her UK treating doctors had not provided her with effective treatment and that she'd received negligent care. She provided evidence of treatment she'd received since benefit had ended.

L&G reviewed the new medical evidence but it didn't change its position. That's because it said it still didn't have objective medical evidence to show how Ms S' symptoms had prevented her from working from July 2020 onwards.

Unhappy with L&G's position, Ms S asked us to look into her complaint.

Our investigator didn't think Ms S' complaint should be upheld. She felt the policy terms made it clear that L&G was entitled to periodically review an incapacity claim and to ask for further medical evidence. As L&G hadn't been sent the medical information it had asked for, the investigator didn't think it had been unfair for it to conclude that it couldn't validate the ongoing payment of the claim and to therefore stop paying benefit.

Ms S disagreed. She provided further details about the treatment she'd undergone and the impact this had had on her life. She said she'd received legal advice which stated that L&G should have continued to pay benefit. She didn't think it had been fair for L&G to stop paying benefit when she'd been so unwell. And she reiterated her concerns about the standard of medical care she'd received from her UK doctors.

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 Ms S, I don't think L&G has treated her unfairly and I'll explain why.

First, I'd like to say how sorry I was to read about Ms S' illness and the impact it's had on her life. I'd also like to reassure her that while I've summarised the background to her complaint and her detailed submissions to us, I've carefully considered all she's said and sent us. In this decision though, I haven't commented on each point she's raised and nor do our rules require me to. Instead, I've focused on what I think are the key issues.

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, amongst other relevant considerations, such as regulatory principles, the policy terms and the available evidence, to decide whether I think L&G treated Ms S fairly.

I've first considered the policy terms and conditions, as these form the basis of the insurance contract between L&G and Ms S' employer. This policy is an income protection insurance policy which pays insured members a monthly benefit if they're incapacitated from working due to accident or sickness. This isn't a private medical insurance policy and it isn't designed to cover the costs of medical treatment an insured member might need.

The policy defines what L&G means by 'incapacity'. In order for an incapacity claim to be both accepted and to remain in payment, L&G must be satisfied that an insured member meets the following definition of incapacity:

'The insured member is incapacitated by a specific, diagnosed illness or injury which prevents him from performing the essential duties of the job he carried out under his contract of employment immediately before the start of the deferred period.'

This means that L&G needs to be satisfied that an illness or injury prevents an insured member from carrying out the essential duties they had before they became unfit for work. It isn't enough for an insured member to simply be deemed medically unfit for work. Generally, I think an insurer is reasonably entitled to assess whether an insured member's claim meets the policy definition of incapacity - not only when a claim's first made but also by periodically reviewing a claim that's in payment to check whether it still meets the policy terms.

In 2019, L&G accepted that Ms S had made a valid incapacity claim and so it began to pay

incapacity benefit. The contract includes a section called 'Duration of Benefit'. This says:

'Subject to production to us of evidence of the insured member's entitlement to benefit, in such format and at such times as we may reasonably require, and to the remaining provisions of this section, payment of member's benefit will continue so long as the insured member is a disabled member but not in any event after the benefit termination date or, if earlier, the death of the insured member.'

And the contract also includes a section called 'Termination of Benefit'. This sets out the following term:

'We reserve the right to immediately discontinue payment of benefit:

- *where there is delay on your part or that of the disabled member in producing satisfactory evidence of entitlement to benefit which in our opinion is prejudicial to our consideration of such entitlement.'*

In my view, the policy terms make it clear that in order for benefit to continue to be paid, L&G will require evidence to show that an insured member is still incapacitated. And that it may stop paying claims if there's a delay in providing evidence L&G has asked for.

L&G paid Ms S benefit from 2019 onwards. I can see that she completed claim continuation forms during this period. However, in August 2021, it concluded that it needed objective medical evidence to show how Ms S' illness had affected her ability to function and perform the essential duties of her job role from July 2020 onwards. I don't think this was an unreasonable position for L&G to take and I think its request was in line with the policy terms.

I can see from the evidence on file that L&G let both Ms S and her employer know that it needed further medical evidence – in the form of Ms S' GP records which would include any hospital records or notes, too. I can also see that L&G promptly asked the GP for this information. However, while the GP released the medical records to Ms S, she didn't send these on to L&G, despite its chasers to her employer. I appreciate Ms S says reviewing the records affected her mental health and I sympathise with her position. But I don't think it was unreasonable for L&G to conclude that it simply didn't have enough objective medical evidence to show how Ms S' symptoms impacted her function or affected her ability to perform the essential duties of her occupation. And I also think it's possible that Ms S could have sent the records directly to L&G.

In the absence of this medical evidence, L&G wanted Ms S to speak with its VCT – qualified medical practitioners, to discuss her symptoms and her ability to work. Again, I don't think this was unreasonable – and in my experience, many insurers ask insured members to speak with VCTs as part of an incapacity claim. However, Ms S doesn't appear to have engaged with this process, despite L&G chasing things up with her employer. It seems Ms S told her employer that she was too unwell to speak with the VCT and that it would be unable to help her, as it wasn't a neuro-specialist team. While I can appreciate why Ms S may have preferred to speak with a neuro-specialist, there was no obligation under the terms of this policy for L&G to make such an arrangement.

Ms S has provided a great deal of medical evidence which shows the treatment and surgery she's undergone since L&G stopped paying benefit. L&G has reviewed this evidence and it hasn't changed its position. That's because it says this still isn't objective medical evidence to show how Ms S' illness affected her function between July 2020 and May 2022. It's important I make it clear that I'm not a medical expert. It isn't my role to interpret medical evidence to make a clinical finding and it would be inappropriate for me to do so. This means it wouldn't be reasonable for me to reach a clinical decision as to whether or not Ms S was

incapacitated from her own occupation based on the medical evidence she's now provided.

L&G doesn't dispute that Ms S underwent major surgery, nor that she's undergone treatment since. But given Ms S didn't send it the medical records it asked for or speak to VCT, it's concluded it doesn't have enough information to show she remained incapacitated in line with the policy terms or how her condition affected her function. I can see that L&G made a number of attempts from August 2021 onwards to obtain the evidence it needed and it made the consequences of the failure to provide that evidence clear. And based on all I've seen and taking into account the contract terms; I don't think L&G acted unfairly. In the absence of the evidence L&G had asked for, I don't find it was unreasonable for it to conclude it couldn't be satisfied that Ms S remained incapacitated in line with the policy terms.

I appreciate Ms S has real concerns about the medical care she received in the UK. But L&G isn't responsible for the medical care or treatment Ms S received. Its responsibility was initially to assess whether Ms S' claim should be accepted and then, to assess whether the claim should remain in payment. As I've explained, I don't think it unreasonably concluded that it didn't have enough medical evidence to show the claim should continue to be paid after May 2022, following several months of information requests. This means I'm not telling L&G to reinstate Ms S' claim or to pay any backdated benefit.

It's open to Ms S to now provide L&G with the relevant medical evidence it requested to allow it to reconsider its decision to stop paying benefit in May 2022. It will be for L&G to assess whether or not that evidence alters its understanding of Ms S' claim. If Ms S is unhappy with the outcome of any reassessment of her claim, she may be able to ask us to look into a new complaint about that issue alone once L&G has had a chance to respond to any complaint.

Overall, whilst I'm sorry to cause Ms S further upset, I don't find L&G acted unfairly when it decided to stop paying her incapacity benefit in May 2022.

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 Ms S to accept or reject my decision before 17 February 2025.

Lisa Barham
Ombudsman