DRN-5293373

The complaint

Ms C is unhappy that Legal and General Assurance Society Limited (L&G) declined her claim under her income protection policy.

What happened

Ms C has a group income protection policy arranged through her employer. The policy provides a benefit in certain circumstances after a deferred period in an own occupation basis. L&G is the underwriter.

She was first absent from work on 23 August 2022 due to spinal and muscle pain and severe fatigue. She has a medical history that pre-dates this first absence from work and is on various forms of medication for her pain and for her mental health.

Ms C submitted a claim to L&G. It reviewed the medical information it had and declined her claim. It said the objective medical evidence was not supportive of Ms C's incapacity and the claim was declined as it didn't meet the definition of incapacity as per the terms and conditions of the policy.

Unhappy, Ms C brought her complaint to this service. Our investigator didn't uphold the complaint. She didn't think Ms C's medical information met the definition of incapacity as required within the L&G policy terms and conditions.

Ms C disagreed and asked for the complaint to be referred to an ombudsman. So, it's been passed to me.

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.

At the outset, I acknowledge that Ms C's been experiencing considerable pain and fatigue related to her condition. Whilst I understand this, my role is to reach an independent and impartial outcome that's fair and reasonable, based on the information available to me.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. So, I've considered, amongst other things, the terms of this income protection policy and the circumstances of Ms C's claim, to decide whether I think L&G treated her fairly.

It's important to point out that we're an informal dispute resolution service, set up as a free

alternative to the courts for consumers. In deciding this complaint I've focused on what I consider to be the heart of the matter rather than commenting on every issue or point made in turn. This isn't intended as a discourtesy to Ms C. Rather it reflects the informal nature of our service, its remit and my role in it.

I've first considered the terms and conditions of this policy, as it forms the basis of the

contract between Ms C's employer and L&G.

The starting place is the policy definition of incapacity. In order for the claim to be successful, Ms C has to show her claim is valid under the terms and conditions of the policy. In other words, she has to demonstrate that she cannot perform the essential duties of her own occupation due to injury or illness - during the 28-week deferred period and beyond - from 23 August 2022 to 7 March 2023.

The wording in the policy document is as follows:

> *'Own occupation*
>
> *Means the insured member is incapacitated by an illness or injury that prevents him from performing the essential duties of his own occupation immediately before the start of the deferred period.*
>
> *The insured member's capacity to perform the essential duties of his own occupation will be determined whether or not that occupation remains available to him.'*

For the avoidance of doubt, I'm not medically qualified so it's not for me to reach any determinations about Ms C's medical diagnosis or to substitute expert medical opinion with my own. Instead, I've weighed up the available medical evidence to decide whether I think L&G acted fairly and reasonably in declining Ms C's claim.

I've been provided with medical evidence relating to Ms C's condition and symptoms from 2022 onwards. So, the issue for me to determine is whether I think the medical evidence supports L&G's decision that Ms C doesn't meet the definition of incapacity.

Ms C had a clinical assessment in December 2022. The Vocational Clinical Specialist (VCS) stated Ms C wasn't fit to return to perform her own role as she was restricted by pelvic pain, lower back pain and neck pain, weakness and numbness in her hands and leg. Ms C reported that she returned to work briefly in September 2022, but due to various medical issues she was absent from work again and her symptoms were impairing her daily function. The specialist made no other recommendations and said there was nothing clinical that could be offered.

I note L&G requested medical records from Ms C's GP. The surgery did not respond. So, in May 2023, a Functional Capacity Evaluation (FCE) was carried out to determine Ms C's level of functional restrictions that were preventing her from working her sedentary role. L&G said the evaluation was carried out in the absence of objective medical records. The FCE involved conducting a series of physical tests to determine her fitness to undertake her own occupation. The assessment lasted 3.5 hours. The results concluded when, compared to her self-reported symptoms, from a functional perspective, Ms C was fit to return to her normal role. L&G declined the claim based on the objective FCE.

Ms C's GP medical records were provided to L&G in August 2023. I've reviewed these and it's clear that Ms C has a history of medical conditions which she's been to see her GP about. The notes suggest Ms C having family issues who also have medical conditions and her focus being on this. I note that fibromyalgia and lupus were discounted after further tests and whilst Ms C reported severe pain and fatigue, there was no other medical evidence supporting Ms C's incapacity to return to work.

L&G's medical team also reviewed Ms C's medical history and records. Their overall opinion was that there was insufficient objective evidence of injury or illness (physical or mental) of sufficient severity to result functional restriction precluding Ms C from returning to work.

I've thought carefully about the medical evidence and the other information provided. But I have to look at the medical evidence in its totality. The GP records and the VCS opinion are based on self-reported symptoms.

Whereas the FCE is based on an objective and independent assessment of Ms C's functional capability to carry out her own role. And L&G's medical team reviewed all of Ms C's related medical history and medical records. So, on balance, I think they carry more persuasive weight.

The test here is whether Ms C meets the definition of incapacity as per the terms and conditions of the policy. And having reviewed everything, I don't think it's likely she does. There isn't sufficient evidence to say that Ms C is currently incapable to carry out the essential duties of her own occupation.

I understand Ms C recently provided further medical information from her GP to this service. The letter was provided to L&G to comment on. Its Medical Officer reviewed the letter and the supporting evidence. L&G's opinion remained that there is insufficient medical evidence to support Ms C's incapacity to work. I've carefully reviewed this also. It's clear that Ms C's circumstances are difficult, and I don't doubt there's a further impact on her health as a result. The GP states Ms C's not fit to return to work, but this is based on Ms C's self-reported symptoms so it's not as persuasive to me as an independent examination of Ms C's medical circumstances. So, I don't think she's demonstrated her incapacity to work in her own occupation.

I do understand Ms C is experiencing a difficult time with her painful symptoms. And I'm sorry to disappoint her but this doesn't automatically mean that L&G must pay her claim.

Overall, I've taken everything into account, and I don't think on balance, the medical evidence demonstrates that Ms C meets the definition of incapacity as per the terms and conditions of the policy. I therefore don't find that there are any reasonable grounds upon which I could direct L&G to pay her claim. It follows therefore that I don't require L&G to do anything further.

My final decision

For the reasons given above, I don't uphold Ms C's complaint about Legal and General Assurance Society Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms C to accept or reject my decision before 27 March 2025.

Nimisha Radia
Ombudsman