DRN-5300762

The complaint

Ms F has complained that Assicurazioni Generali SpA trading as Generali (Generali) terminated a claim she made under her group income protection policy.

What happened

Ms F is covered by her employer's income protection policy. Benefit is payable after a deferred period of 26 weeks if the following definition is met:

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.

Generali accepted Ms F's claim in 2019. However, on review it commissioned a Chronic Pain Abilities Determination (CPAD) assessment and based on this report concluded that she no longer met the policy definition. In 2023 Generali terminated Ms F's claim.

Unhappy, Ms F brought her complaint to this service. Our investigator didn't recommend that it be upheld. They considered all the evidence and concluded that it wasn't unreasonable for Generali to terminate the claim on the grounds that Ms F no longer met the policy terms.

Ms F appealed. She didn't feel that aspects of the evidence and policy terms had been adequately considered or weighed.

As no agreement was reached the matter was passed to me to determine. I issued a provisional decision saying as follows:

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

Firstly whilst I've summarised the background to this complaint and Ms F's detailed submissions, I've carefully considered all that the parties have said and sent to us. In this decision though I haven't commented on each point or piece of evidence rather I've focused on what I find are the key issues and evidence here. Our rules allow me to take this approach. It simply reflects the informal nature of our service as a free alternative to the courts. Having done so I'm minded to uphold this complaint. I'll explain why.

The relevant regulator's rules say that insurers mustn't turn down claims unreasonably. So I've considered, amongst other things, the terms of the group policy and the available medical evidence, to decide whether I think Generali treated Ms F fairly in terminating her claim. Importantly, when terminating a claim, it is for Generali to show that Ms F was no longer incapacitated from performing her own occupation.

Ms F's treating consultant, whom I'll refer to as Dr J, has reported that Ms F is incapable of performing the material and substantial duties of her occupation. He has been Ms F's treating consultant since 2020. Dr J has detailed (letter February 2024) how the symptoms of Ms F's illness prevent her from performing her role. I won't repeat the contents of the letter

here as it has been seen by the parties. Generali says it is less independent that the CPAD results, which it says are the most reliable evidence of Ms F's functional ability.

Generali commissioned the CPAD report to explore Ms F's physical and cognitive abilities as well as restrictions and limitations and compare this to the functional requirements of her own occupation. The assessment was carried out over two days in 2023. The results indicated that Ms F's functional abilities didn't represent her true capabilities and the conclusion drawn was that her actual abilities were far greater than she was willing to perform. I quote from the report's conclusion:

(Ms F) Has been diagnosed with post viral fatigue, and has stated that based on this condition, she is unable to return to work on any basis. On the assumption that a person provides reliable and consistent effort during the CPAD assessment it is possible using the detailed protocols contained within the assessment to objectively determine their level of functional (physical and cognitive) ability and therefore fitness for work. However, in (Ms F's) case she performed with very poor reliability of effort and there was also evidence of significant symptom exaggeration in the physical and cognitive tests on both days of CPAD. Therefore (Ms F's) demonstrated level of function cannot be relied upon to reflect what she is truly capable of performing, and the CPAD results cannot therefore be used to infer any barriers preventing her from returning to her normal role.

I'm satisfied that the CPAD assessor was an independent third party and I do understand why Generali felt this evidence was persuasive. Ms F doesn't accept many of the comments written in the report and has said some requests on her part, that would evidence fatigue, weren't included. But even if I were to accept what the assessor has concluded about her performance, and that the results can't infer barriers preventing a return to work, this wouldn't automatically lead to the conclusion that a return to work was possible.

To this end, and as Ms F's condition is variable, I asked Generali for a medical opinion from its Chief Medical Officer (CMO). The CMO responded, fairly in my opinion, that they were unable to give their opinion as they believe the case should be reviewed by an Occupational Health specialist. This seems reasonable to me. Although Generali has said that it didn't require a further opinion on work when it has the CPAD results, for the reason given I don't find those results are determinative. That is not to say they have no relevance but must be seen in the context of Ms F's diagnosis and taken together with the other medical evidence. This includes the evidence from Dr J, which paints a different picture entirely. It follows that at present I'm not satisfied by the evidence that Generali has shown that Ms F no longer meets the definition of incapacity.

This being so I don't currently think Generali acted fairly when it relied on the independent CPAD assessment findings to conclude that Ms F no longer met the policy definition of incapacity and terminated Ms F's claim. My provisional decision is that it should now reinstate her policy and pay the outstanding benefit with interest.

I invited the parties to provide any further comments or evidence for me to consider but advised that unless the information changed my mind, my final decision was likely to be along the lines of my provisional decision.

Ms F accepted my provisional decision and made no further comments. Generali did comment. It said that it was very disappointed that the independently commissioned objective evidence (CPAD) which clearly supported function greater than the individual was willing to display, was not sufficient to persuade me of the fair and reasonable decision to cease the claim. And rather that I chose to place more weight on the opinion of a treating professional whose opinion was not independent and objective in the same way as the CPAD

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.

I acknowledge Generali's comments, but I explained in my provisional decision the reasons for the conclusion I had reached based on all the evidence. I'm not persuaded to change my provisional findings, which I adopt here.

It is of course open to Generali to continue to review the claim, as Ms F will no doubt be aware.

My final decision

My final decision is that I uphold this complaint and require Assicurazioni Generali SpA trading as Generali to reinstate Ms F's policy and pay the benefit owed.

It should add simple interest at 8% per annum from the date each payment was due until settlement.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms F to accept or reject my decision before 28 February 2025.

Lindsey Woloski
Ombudsman