DRN-5319890

## The complaint

Ms W is unhappy that MetLife Europe d.a.c. have declined a claim she made on a group income protection policy.

## What happened

Ms W is the beneficiary of her employer's group income protection scheme. In January 2023 she became absent from work due to symptoms linked to a longstanding diagnosis of Multiple Sclerosis (MS).

Ms W claimed on the policy, but the claim was declined. She appealed the decision but MetLife maintained their decision to decline the claim was fair. In April 2024 MetLife issued their final response to Ms W's appeal. Ms W complained to The Financial Ombudsman Service.

Our investigator looked into what happened and didn't uphold the complaint. He thought that the medical evidence provided to MetLife for the relevant period of time (known as 'the deferred period') didn't support that the policy definition of incapacity was met. He acknowledged that Ms W had provided other medical evidence but explained that a lot of the evidence post-dated MetLife's assessment of the claim and hadn't been reviewed by MetLife during the claim.

Ms W didn't agree and asked an ombudsman to review the complaint. She highlighted that MetLife hadn't taken into account her cognitive function, which had been triggered by the relapse and/or changes in her symptoms. So, she asked an ombudsman to review her complaint.

## 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.

## The policy terms and conditions

The policy terms and conditions set out the definition of incapacity which needs to be met in order to successfully claim on the policy. In Ms W's case that's the 'own occupation' definition which says incapacity is defined as the insured member is:

- Unable to perform, due to illness or injury, the material and substantial duties required of them in their own occupation which they were performing immediately prior to being incapacitated; and

- Not following any other occupation.

The policy has a 26 week deferred period, which commences from the first date of absence, before the insured member can make a claim.

**Have MetLife unfairly declined the claim?**

The relevant rules and industry guidelines say that MetLife has a responsibility to handle claims promptly and fairly. And they shouldn't reject a claim unreasonably. It's for Ms W to demonstrate she had a valid claim on the policy, it's not for MetLife to show she doesn't.

I'm not upholding this complaint because I'm persuaded, on balance, that it was fair and reasonable for MetLife to decline the claim. I say that because:

- I'm not persuaded that the available medical evidence, and other supporting information Ms W has provided demonstrates that she met the policy definition of incapacity throughout the deferred period.

- There's no dispute that Ms W did experience a relapse and/or changes to her symptoms. But I think the medical evidence from the relevant time gives limited insight into why she wasn't able to carry out the material and substantial duties of her role.

- I've considered the information about Ms W's cognitive ability, which Ms W feels has been overlooked. There are some references to her cognitive symptoms becoming more marked. But there's no detailed report or information, for the relevant time period, about how it was impacting Ms W or why the change in her symptoms would have prevented her from working in her own occupation. In reaching that conclusion I've taken into account Ms W's testimony about the impact on her cognitive functionality. But, that's not clearly and consistently reflected in the medical evidence for the relevant time period.

- Ms W has provided a lot of information about what happens when a new MS lesion is identified and has highlighted that it may not always be visible on MRI scans until sometime later. Even if I accept her representations on this point it's not persuaded me that MetLife were unreasonable to decline the claim. That's because the available evidence gives limited information about how any changes impact on her ability to carry out her own occupation.

- Ms W provided reports from her consultant neurologist and an occupational physician, dated February 2024, both of whom commented on Ms W's cognitive function. However, I don't think it was unreasonable that MetLife placed less weight on this further medical evidence as it was provided over a year after Ms W first became absent and several months after the deferred period ended. And, whilst the occupational physician referred to Ms W's mental and physical fatigue symptoms, I don't think the report clearly and persuasively explained why Ms W was unable to carry out the material and substantial duties of her occupation.

- The final response in relation to this complaint was issued April 2024. Ms W has provided further medical evidence in relation to her condition which post-dates the final response letter. However, that's not something I can consider as part of this complaint as I can only look into what happened up until the complaint was referred to The Financial Ombudsman Service. I understand that Ms W has provided that further information to MetLife and it is for them to consider whether it changes their view about the outcome of the claim.

- Overall, I'm satisfied that MetLife has fairly and reasonably assessed the medical evidence that's been provided during the initial claim and subsequently during the appeals process. I can see that this was carefully considered by MetLife and, whilst I understand Ms W will be very disappointed, I think the claim has been fairly declined.

## My final decision

I'm not upholding this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms W to accept or reject my decision before 1 May 2025.

Anna Wilshaw
**Ombudsman**