DRN-5326617

The complaint

Mr N complains that Liverpool Victoria Financial Services Limited ("LV") declined a claim under his income protection policy.

What happened

Mr N has held a personal sick pay policy provided by LV since April 2016. The policy paid a benefit if Mr N was unable to work due to an accident or illness. It provided cover for Mr N's own occupation and included a waiting period of one week.

Mr N was signed off work by his GP between 15 April and 1 July 2024 due to work related stress, hypertension and gout. He made a claim to LV under his policy and said that he had been unable to work due to the hypertension. However, LV declined the claim as it said the policy didn't pay a benefit for absences due to work related stress. And LV didn't consider the medical evidence showed Mr N had been unable to work due to the hypertension or gout.

Mr N provided a letter from his GP in support of his claim. LV reviewed this but said its position hadn't changed. It said that the letter wasn't specific in terms of dates of Mr N's symptoms, it didn't provide blood pressure readings or the outcomes of any investigations.

One of our investigators looked into Mr N's complaint. Having done so, she didn't think LV had acted unfairly or unreasonably when it declined Mr N's claim, for the reasons it did.

Mr N didn't agree with our investigator's findings. In short, he doesn't think it's his fault that the GP didn't record the blood pressure readings every time he spoke to them. Mr N says it should be self-explanatory that the GP signed him off due to the symptoms he was experiencing due to the hypertension. And the GP has confirmed how severe his diagnosis was, and he was prescribed medication for this when he was signed off from work.

As no agreement was reached, the complaint has 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.

Industry rules set out by the regulator (the Financial Conduct Authority) say insurers must handle claims fairly and shouldn't unreasonably reject a claim. I've taken these rules, and other industry guidance, into account when deciding what I think is fair and reasonable in the circumstances of Mr N's complaint.

Mr N's policy pays a monthly benefit if he's *"too unwell to carry out the main tasks of [his] occupation"*. The policy schedule sets out what Mr N's occupation was, and it confirms that own occupation cover applies. This means that the medical evidence needs to show that Mr N was unable to carry out the main tasks of his occupation, with any employer, due to an accident or illness. The policy terms clarify that *"by main tasks we mean the things which can't reasonably be left out of your role, or changed by you or your employer"*. And as a policyholder, it's for Mr N to demonstrate that he has a valid claim under the policy.

When Mr N made a claim, he described his symptoms as dizziness, headaches, eye aches, numbness in fingers, lack of concentration, palpitations and feeling like he is going to explode. His GP signed him off work between 15 April and 5 June 2024 due to work related stress and hypertension, and between 4 June and 1 July 2024 due to work related stress, hypertension and gout. Mr N returned to work on 2 July 2024.

Mr N accepts his policy doesn't pay a benefit for work related stress – this isn't an illness. He says he was unable to work due to the hypertension.

Mr N saw a GP on 15 April 2024. The notes recorded his blood pressure to be raised, and the GP prescribed medication for this. The GP notes include the following:

> *"thinks BP raised again, feels some stress, thinks related to work. […]*
> *had some time off on hols- felt well, then back to work and stressed again, not sleeping, waking at night […]*
> *was under cardiology- advised restart [medication] if BP raised again*
> *some headaches, throughout the day- not early morning, no vomiting […]"*

The treatment plan included a repeat blood pressure reading in two weeks to *"see if [blood pressure] abnormal or stress ongoing/headaches worsening"*. It was also noted Mr N was going through redundancy at the time.

The GP signed Mr N off work due to work related stress and hypertension until 12 May 2024. This fit note was renewed on 9 May until 5 June 2024. Mr N sought medical help on 10 May 2024 regarding his toe. No blood pressure reading was recorded during this visit. Mr N saw a GP on 17 May 2024 about his toe and on 24 May 2024 about blood test results. No blood pressure reading was recorded during either of these visits.

The GP signed Mr N off work again on 4 June until 1 July 2024 due to work related stress, hypertension and gout. No blood pressure reading was recorded during this visit either.

Whilst Mr N's GP provided fit notes for the relevant time period which said he was unfit to work, these notes don't explain why the hypertension prevented Mr N from carrying out the main duties of his occupation. The medical records also don't provide further information on this. Mr N's GP filled out a claim form in which they said that stress was affecting Mr N's ability to work. The GP answered the question *"in your opinion, what symptoms prevent or have prevented them from returning to work"* as *"stress, pain - headaches/toe pain"*.

Mr N also provided a letter from his GP dated 14 October 2024. The GP confirmed Mr N had been diagnosed with stage 2 hypertension in 2020. The GP said the following:

> *"He has been struggling with recurrent headaches and palpitations over the last few months and has attended to see his GP for this. On some occasions his blood pressure was quite severe, reaching what we classify as stage 3 hypertension.*
>
> *Had multiple investigations and referred to the cardiologist due to his raised blood pressure because of the unusual presentation for his age."*

Based on the medical records during Mr N's absence, his hypertension was only discussed during the visit on 15 April 2024. LV's Chief Medical Officer ("CMO") said that the blood pressure reading that was recorded during this visit shouldn't have prevented him from working. LV accepts Mr N has a history of hypertension, but it says the medical records don't show any blood pressure readings after 15 April 2024. And it says the letter from the GP in October 2024 doesn't give any specific detail either, or how Mr N's symptoms prevented him from carrying out the main duties of his occupation.

LV also noted that Mr N had had significantly higher blood pressure readings from 2020 onwards, and this hadn't prevented him from working. LV didn't consider the gout and the related pain to prevent Mr N from working as he had a sedentary office-based role. LV declined Mr N's claim as it considered it was the work related stress which prevented him from working, rather than an illness.

I'm sorry to disappoint Mr N but I don't think LV has acted unfairly or unreasonably when it declined the claim, for the reasons it did.

As Mr N accepts, work related stress isn't an illness, and therefore it's not something covered under the policy. Mr N says he was unable to work due to the hypertension. However, I don't think the medical evidence demonstrates Mr N was unable to carry out the main duties of his occupation due to the hypertension. LV's CMO has said the blood pressure reading on 15 April 2024 shouldn't have prevented Mr N from working, and there are no further readings recorded during Mr N's absence. I can't see that Mr N visited the GP again because of the hypertension during his absence. There's also no evidence of further investigations carried out due to the hypertension after he was signed off from work.

I appreciate Mr N says his blood pressure fluctuated and at times this was significantly higher than the reading on 15 April 2024. And he says the doctors advised him to take time off due to the symptoms he was experiencing, and that it would have been dangerous to put himself in a stressful environment. But I don't think LV acted unfairly by relying on the available medical evidence when assessing the claim. And LV has said it will consider any further medical evidence Mr N provides in support of his claim. I think this is fair and reasonable.

I've looked at how long LV took to assess Mr N's claim. And I accept it must have been frustrating for Mr N to only be told on 9 September 2024 that his claim would be declined when he had notified LV about the claim on 13 May 2024. But I can see that LV requested medical information a few times during this period, and this was reviewed by the relevant team once received. I've also listened to the call Mr N had with LV on 9 September 2024, and I'm satisfied the staff member handled the call appropriately.

Overall, I don't think LV caused any significant unnecessary delays when considering Mr N's claim. And I think it treated him fairly and reasonably in all the circumstances of the complaint. So, I don't think there's anything LV needs to do, to put things right.

My final decision

My final decision is that I don't uphold Mr N's complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr N to accept or reject my decision before 15 April 2025.

Renja Anderson

Ombudsman