DRN-5355193

The complaint

Mr S is unhappy that Legal and General Assurance Society Limited (L&G) declined a claim under a group income protection insurance policy.

What happened

Mr S was originally signed off work by his GP with sciatica. He was later signed off work by his GP with work related stress.

Mr S had the benefit of a group income protection policy ('the policy') through his employer at the time. Subject to the remaining terms of the policy, it can pay a monthly benefit after Mr S had been off work for 26 weeks due to illness or injury ('the deferred period').

A claim was made on the policy which was declined by L&G. It concluded that the medical evidence supported that his knee and back pain had resolved and the reason for his ongoing absence was due to work related stress as a result of raising a grievance.

Mr S appealed this decision, but L&G maintained its position to decline the claim. Although Mr S referred to other physical symptoms which had kept him off work – including to his hands – it concluded that perceived workplace stressors were the direct trigger for Mr S's absence.

Our investigator looked into what happened and didn't uphold Mr S's complaint. Mr S disagreed so his complaint has now been passed to me to look at everything afresh 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, I don't uphold it. Before I explain why, I'd like to assure Mr S that my decision is in no way intended to be dismissive of the health issues he's experienced. But for reasons I'll go onto explain, I'm satisfied L&G has fairly and reasonably declined his claim.

The relevant policy terms

Subject to the terms of the policy, the benefit will be paid in respect of an insured member provided he is a disabled member.

- A disabled member means an insured member who at any time meets the incapacity definition and isn't engaged in any other occupation.
- Relevant to this complaint, incapacity is defined as: "the insured member is incapacitated by illness or injury that prevents him from performing the essential duties of his occupation immediately before the start of the deferred period".
- Essential duties mean: "the duties that are normally required for the performance of

the insured members insured occupation and which cannot reasonably be omitted or amended".

The decision to decline the claim

L&G has a duty to handle insurance claims promptly and fairly – and it mustn't unreasonably decline a claim. And it's for Mr S to establish a claim under the policy, including that he was incapacitated as defined by the policy terms throughout the deferred period.

Mr S's claim form reflects that he was absent from work due to work related stress. And his then employer lists the reason for absence as: "work related stress whilst waiting for the outcome of grievance and its appeal".

Although Mr S was initially signed off work by his GP with sciatica, the medical evidence reflects that this ended a couple of months after being off work and there were no further flare ups. The GP notes reflect that he was later signed off with work related stress.

Having considered the evidence available to me, I'm persuaded that L&G has fairly concluded that work-related stress was the main cause for Mr S being off work for the majority of deferred period. There's a GP entry from the end of October 2023 which says Mr S would "like fit note for the next 2 months whilst ongoing issue at work is getting sorted".

If the work-related issues Mr S describes hadn't been present I'm persuaded that he would've been able to perform the essential duties of the occupation. So, I'm satisfied that the main barriers for Mr S returning to work were work-related (rather than due to illness or injury) and L&G has fairly and reasonably concluded that he wasn't incapacitated as defined by the policy terms throughout the deferred period.

When deciding this complaint, I've taken into account that there were other physical issues Mr S says were impacting his ability to work, including to his hands. However, the medical evidence from the entirety of the deferred period doesn't support that the physical conditions were the reason why he couldn't work. And the available medical evidence gives limited insight into how Mr S's physical symptoms impacted his ability to perform the essential duties of his occupation.

Although Mr S was certified as being unfit to work by his GP (and an occupational health report dated March 2024 also says he wasn't fit to return to work at that stage), the policy has a specific definition which needs to be met. The GP notes and occupational health report don't provide much detail as to why Mr S couldn't perform his occupation because of illness or injury or how his functionality was impacted.

Mr S has also said he'd be willing for L&G to refer him for independent tests, and it hasn't offered to do this. However, I think L&G has reasonably relied on the available medical evidence to decline the claim. And in the circumstances of this case, I don't think it acted unfairly by not referring Mr S for further tests, and nor was it under any obligation to do so. It's for Mr S to establish his claim.

I note that Mr S is in receipt of disability related welfare benefit, but I'm not persuaded this means he met the specific definition of incapacity as defined by the policy. The criteria for claiming welfare benefits are different.

My final decision

I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr S to accept or

reject my decision before 10 April 2025.

David Curtis-Johnson
Ombudsman