DRN-5356402

The complaint

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

What happened

Miss S had the benefit of a group income protection policy ('the policy') through her then employer. Subject to the remaining terms of the policy, it can pay a monthly benefit after she'd been off work for 26 weeks due to illness or injury. This is referred to as the deferred period and is defined by the policy terms as:

> The period of consecutive weeks…starting the first day [the insured member] was:
>
> - unable to work
> - only able to work reduced hours; or
> - only able to work in a reduced capacity;
>
> Because of an injury or illness that resulted in [her] becoming a disabled member.
> If a disabled member returns to work during the deferred period, but becomes unable to work again because of [her] injury or illness, we will link the separate periods of absence together as long as:
>
> - each absence is for at least five consecutive days;
> - each absence is because of the same or related injury or illness; and
> - the last day of all previous absences are within 52 weeks of the first day of the last absence.

Miss S' claim form reflects that she became absent from work due to anxiety and depression in early September 2023 and that she had previously experienced the same or similar condition (and was off work) between mid-May to early November 2022.

A claim was made on the policy in early 2024 which was declined by L&G. It concluded that the evidence didn't establish that Miss S met the policy definition of being incapacitated. Miss S appealed and after L&G maintained its position to decline the claim, she brought a complaint to the Financial Ombudsman Service.

Our investigator didn't uphold Miss S' complaint. Miss S obtained further medical evidence from her GP which our investigator forwarded to L&G to comment on. L&G said this further information didn't alter its position and having considered the further evidence in light of the other evidence available, our investigator concluded that L&G had fairly declined the claim.

Miss S disagreed so this complaint has been passed to me to consider 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.

That includes L&G's obligation to handle insurance claims promptly and fairly – and that it mustn't unreasonably decline a claim.

I know Miss S will be very disappointed and I can see that she has been through a very difficult time. However, for a claim to be successful, it's for Miss S to establish that she meets the definition of incapacity throughout the entire deferred period. I'm satisfied L&G has fairly and reasonably concluded that the overall medical evidence doesn't support this. So, I don't uphold her complaint. I'll explain why.

For the benefit to be paid under the policy, Miss S must be a 'disabled member' meaning that she meets the 'incapacity' definition.

Relevant to this complaint, incapacity is defined by the policy terms as:

> The insured member being incapacitated by illness or injury that prevents her from performing the essential duties of her occupation immediately before the start of the deferred period.

And the 'essential duties' are:

> The duties that are normally required for the performance of the insured member's insured occupation and which cannot reasonably be omitted or amended.

So, the focus is on whether the insured member can carry out the essential duties with reasonable adjustments more generally, rather than for a particular employer.

Miss S' claim form reflects that she couldn't work because of anxiety and depression. A GP certificate dated January 2024 reflects that Miss S was signed off work for six weeks due to mixed anxiety and depressive disorder.

An occupational health report dated from around the same time also concluded that Miss S was medically unfit for work at that time. The report says Miss S:

- was struggling to manage everything with ongoing caring responsibilities, personal stressors (including a close bereavement) and perceived work issues.
- was managing all her daily activities in regard to caring for her children, personal cares, attending meetings with school and driving. However, she felt stressed, anxious and overwhelmed and this was affecting her sleep, mood and concentration levels.
- had been prescribed increased medication to help and was getting support with recent diagnosis of ADHD and autism.

Being deemed unfit to work by medical professionals is relevant. So is Miss S' medication being increased and her accessing counselling. However, I don't think this is determinative by itself in establishing that the specific definition of incapacity has been met.

From what I've seen, Miss S was managing her various symptoms and circumstances between November 2022 (when she returned to work) and September 2023 when she

stopped working again. It's not entirely clear what changed from a medical perspective, meaning that she could no longer work due to illness in September 2023.

In support of her appeal against the decision to decline the claim, Miss S's GP provided a letter dated April 2024. That reflects:

- When being signed off work in September 2023 Miss S' symptoms met the criteria of a major depressive episode with overlaying anxiety.
- The cause of these symptoms was discussed and "it became apparent there was a large component of work induced stress and…lack of understanding and empathy from senior management that was causing this".
- Miss S was under some stress at home but "she had been dealing with and coping with this well for the previous year without it having any major impact on her own mental health. I felt she needed to be away from the major source of stress i.e. the work environment…"
- Being told towards the end of 2023 that she was being made redundant increased her anxiety levels although the depressive symptoms had started to improve and by early 2024 there "had been no improvement in the anxiety component of her illness, largely due to the increased stress caused by the handling of her illness by HR at work (personal and family stressors had improved over the last few weeks)"
- Work induced stress was the most significant cause of her symptoms.

Overall, I'm satisfied that the medical evidence gives limited insight into how Miss S' symptoms – as reported by her - impaired her functionality or impacted her ability to perform the essential duties of the insured occupation throughout the deferred period.

Further, I'm satisfied that L&G has fairly concluded Miss S' absence wasn't primarily medical in nature; it was directly related to her personal stressors and perceived workplace stress. And that the main barrier to Miss S returning to work were those issues, particularly work-related stressors – rather than illness. If those issues weren't present, based on the medical evidence, I'm persuaded that Miss S would've most likely been able to carry out the essential duties of the insured occupation.

When making this finding, I've also taken into account the letter Miss S provided from her GP dated January 2025, after our investigator sent her view.

This is dated almost a year after the end of the deferred period, and I've placed more weight on the medical evidence from the time and referred to above as it's more contemporaneous. The letter provides more information about the symptoms Miss S was experiencing and says her decline in mental health remains. I'm sorry to read this.

However, other than saying symptoms of anxiety and depression extend far beyond personal stressors, I don't think it provides any more objective medical insight into how these symptoms (if they were all present throughout the entirety of the deferred period, which isn't supported by the medical evidence I've seen at the time) prevented Miss S from carrying out the essential duties of the insured occupation. Further, the letter doesn't detract from the medical evidence provided from the time which supports that work-related stressors were the most significant cause of Miss S' symptoms.

My final decision

I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss S to accept or reject my decision before 23 April 2025.

David Curtis-Johnson
Ombudsman