DRN-5358484

The complaint

Mrs A complains because Legal and General Assurance Society Limited ('L&G') hasn't paid her income protection insurance claim.

What happened

Mrs A is insured under her employer's group income protection insurance policy, provided by L&G. The policy has a deferred period of 26 weeks and cover is on an 'own occupation' basis for the first two years of incapacity.

In October 2023, Mrs A was certified by her GP as unfit to work and a claim was subsequently made with L&G for absence due to depression and anxiety, a shoulder injury and an autoimmune disease. Unfortunately, during the deferred period, Mrs A also experienced severe back pain.

L&G said it didn't think Mrs A's symptoms met the policy criteria for a claim to be paid to her. L&G also said Mrs A's barriers in returning to her job appeared to be work-related. Mrs A appealed and provided further medical evidence, but L&G maintained its position to decline her claim.

Unhappy, Mrs A brought her complaint to the attention of our service.

One of our investigators looked into what had happened and said she didn't think L&G had acted unfairly or unreasonably in the circumstances. Mrs A didn't agree with our investigator's opinion, so the complaint has been referred to me to make a decision as the final stage in our process.

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'm sorry to hear Mrs A has experienced such a challenging time. I don't doubt that she has been unwell, and I hope her health improves in the future. But being unwell doesn't automatically mean that Mrs A qualifies for an income protection insurance benefit. Mrs A must demonstrate that she meets the policy requirements for a claim to be paid to her.

Mrs A needs to provide medical evidence to show she meets the definition of 'incapacity' set out in the policy terms and conditions. I'm aware Mrs A may not have seen a copy of these policy terms and conditions. This is because the contract is between L&G and her employer, but the policy requires Mrs A to show she had an illness or injury which prevented her from performing the essential duties of her occupation throughout the deferred period (which, in this case, ran from October 2023 to April 2024) and beyond.

I'm not a medical expert, and its not for me to reach my own medical opinions or to substitute the opinions of qualified medical professionals with my own. Instead, my role is to weigh up the available medical evidence to decide whether I think L&G acted fairly and

reasonably in the circumstances when making its decision about Mrs A's claim. When doing so, I've taken into account industry rules and guidance, alongside other relevant considerations.

I've thought very carefully about the medical evidence in this case. Generally speaking, certain medical evidence does carry more persuasive weight than others based on the context in which that medical evidence is provided, and the qualifications and level of specialist expertise of those providing it.

GP statements of fitness for work are, for the most part, based on self-reported symptoms and don't contain any details about an insured's functional abilities. The threshold for a GP to issue statements of fitness for work isn't necessarily the same as L&G's requirements for a benefit to be paid under the policy. I understand Mrs A says her GP's statements of fitness for work were based on her consultants' reports but, overall, I'm not satisfied that the GP certificates or the content of the GP records which I've seen demonstrate that Mrs A was unable to perform the essential duties of her occupation throughout the deferred period.

The three occupational health reports which I've been provided with all refer to Mrs A as being medically unfit for work. However, I would point out that these reports are also based on self-reported symptoms. I'm not suggesting that Mrs A didn't accurately describe her symptoms and I note what Mrs A has said about her exemplary sick record. But the context in which these reports were prepared does inevitably affect how persuasive they are when considered alongside other medical evidence.

I've thought about the medical reports provided by Mrs A's consultant dermatologists, consultant trauma and orthopaedic surgeon and consultant neurosurgeon and spine surgeon. While these outline various symptoms and diagnoses affecting Mrs A, and I acknowledge it seems clear that Mrs A requires shoulder surgery, I don't think these reports demonstrate that Mrs A met the policy definition of incapacity throughout the entire deferred period either. This remains the case whether Mrs A's injuries and/or illnesses are considered in isolation or considered together.

I've taken into account Mrs A's comments about L&G's Vocational Clinical Specialist's report. This report alone isn't necessarily persuasive evidence of whether Mrs A meets the policy definition of incapacity. But, when considered together with the other medical evidence in this case (including the comments of L&G's Chief Medical Officer), I don't think L&G has acted unfairly or unreasonably in the circumstances by turning down Mrs A's claim.

I should also explain that income protection insurance policies don't usually cover claims relating to absence from work caused by stress. This is because stress caused by situational circumstances isn't the same as suffering from a clinically impairing mental health condition which affects the ability to perform an occupation more generally. While I accept what Mrs A has said about stress pre-dating issues relating to the location of her employment, this doesn't change the fact that Mrs A herself, her GP records, the occupational health reports and the Vocational Clinical Specialist's report all make some reference to stress at work.

Overall, this means Mrs A hasn't demonstrated that her claim is covered under this policy.

I'm sorry to disappoint Mrs A and I wish her well going forward, but I don't think L&G has acted unfairly or unreasonably by declining her claim in the circumstances and I won't be directing it to do anything more.

My final decision

My final decision is that I don't uphold Mrs A's complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs A to accept or reject my decision before 14 April 2025.

Leah Nagle
Ombudsman