DRN-5360052

The complaint

Miss L complains about how Liverpool Victoria Financial Services Limited ("LV") handled a claim under her income protection policy.

What happened

Miss L took out an income protection policy on 26 March 2024 through an independent broker. The policy was provided by LV. The policy paid a benefit of 60% of Miss L's income, up to £1,200 per month, if she was too unwell to work. An exclusion was applied for "disease or disorder of the skin" based on what Miss L declared when she took out the policy.

Miss L made a claim to LV in July 2024 as she was signed off work for six months. Miss L has raised several issues about LV, but those that I'm considering under this complaint are:

- How long it took for LV to assess the claim up until 18 December 2024 (when it issued its final response on the delays).
- How LV calculated the benefit Miss L was entitled to under the policy. Miss L says this should be £1,200 per month as she'd signed up, and paid a premium, for.
- How long it took for LV to send her the policy documents (final response issued on 20 November 2024).

LV said it sent the policy documents when Miss L took out the policy, and as soon as it was made aware she hadn't got them, LV re-sent the documents to her by email and post. LV also said it had calculated the benefit Miss L would be entitled to from the policy in line with the policy terms and the information it received from Miss L. Overall, it didn't think it had caused any delays in handling the claim.

One of our investigators reviewed what had happened. Having done so, he didn't think LV had handled the claim as well, or as quickly, as it should have done. At first, our investigator recommended LV should pay Miss L £250 for the distress and inconvenience caused, but he later increased this to £500 to recognise the individual impact on Miss L. But he didn't think LV had done anything wrong in the way it had sent Miss L the policy documents or calculated the benefit.

Miss L didn't agree with our investigator's recommendation as she didn't think £500 was a fair for the impact on her. LV also disagreed with the investigator's findings, but it agreed to pay Miss L £250 for the distress and inconvenience caused due to the delays in handling her claim.

As there was no agreement, 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.

For clarity, I haven't considered LV's decision to add an exclusion on Miss L's policy and to decline her claim under this complaint. This is because this was still in dispute and LV was still reviewing this when Miss L first brought a complaint to our service. This is now considered under another complaint, along with other issues Miss L has raised.

Miss L has sent many detailed submissions in support of her complaint. I've reviewed everything, but I've focused on the points that I think are important to the outcome of this complaint. So, I haven't replied to everything Miss L has raised in detail. This isn't meant to cause upset, it simply reflects the informal role of our service.

Industry rules set by the regulator (the Financial Conduct Authority) say insurers must handle claims promptly and fairly, and they should provide reasonable information about the progress of a claim. I've taken these rules, and other industry guidance, into consideration when deciding what I think is fair and reasonable in the circumstances of Miss L's complaint.

Policy documents

It's my understanding that LV sent the policy documents electronically when Miss L took out the policy, but she couldn't access them due to security issues. But I haven't seen persuasive evidence that Miss L got in touch with LV directly to request these to be sent again.

I have seen that the broker got in touch with LV about sending the policy documents on 10 April 2024 and explained that Miss L hadn't had them. LV then sent these to her on 17 April 2024 by email and post.

I know Miss L says she didn't get the full terms and conditions at this point either. But LV doesn't have any records of Miss L contacting it to let it know about this at this point.

Overall, I'm not persuaded that LV has done anything wrong in the way it sent Miss L her policy documents in the circumstances of this complaint. It sent her the policy documents after she took out the policy. And as soon as LV was made aware Miss L hadn't had them, it re-sent them by email and post.

Miss L has raised further concerns about LV needing to make reasonable adjustments in the way that it communicated with her, but I'm not considering these as part of this complaint. LV has responded to her concerns in a new final response letter, and these issues are considered under a new complaint.

Benefit calculation

Miss L's policy pays a benefit of 60% of her monthly income, up to £1,200 per month. The policy terms define this as follows:

"'Monthly income before the claim' is the income you received from your occupation each month averaged over the 12 months before you became unable to work. If you are not working when you claim, and have been unable to work for 30 days or less, we'll average your income from the last 12 months when you were working. If you have been unable to work for 31 days or more when you claim then we will treat you as a homemaker.
[…]
If we cannot pay you your full amount of cover based on your income over the last 12 months then we may agree to average your income over a longer period of up to 36 months, if this would more accurately reflect your usual income. You will need to request this at the time of your claim. If we agree to your request this will be confirmed to you in writing."

So, I think LV has acted fairly and reasonably by saying it will average Miss L's monthly income over the 12 months before she became unable to work when calculating her benefit. This is in line with the policy terms and conditions.

So far, it doesn't look like LV has all of Miss L's payslips from the 12 months before she became unable to work. So, LV has used Miss L's annual salary from her P60, as well as three more payslips after this. However, this would mean LV has used an average of 15 months of Miss L's salary. And it's my understanding that at the start of the financial year in 2023, Miss L wasn't earning an income as she was off sick. So, taking the three months into consideration from the start of the financial year in 2023, it's possible the benefit LV has calculated is less than Miss L would be entitled to from the policy.

If Miss L makes a successful claim, I think LV should calculate the benefit by using her payslips for 12 months before to the incapacity start date, as long as they receive them from Miss L.

Otherwise, I think the policy documents are clear that LV will calculate the benefit by using the income the policyholder had each month averaged over the 12 months before being unable to work. If this wasn't clearly explained to Miss L when she bought the policy, she should raise this with the broker.

Claim delays

Miss L contacted LV about a claim on 29 July 2024 – she had been off sick since 23 July 2024. She said she had been signed off work for six months. LV responded the same day asking for information it needed to consider the claim. Miss L discussed the claim with LV over the phone on 31 July 2024. LV sent her an email the same day asking for detailed information so it could consider the claim. This included a medical consent form that Miss L needed to sign, so LV could request her medical records. She signed this form on 6 August 2024, and LV requested Miss L's medical records from her GP on 15 August 2024.

Miss L called LV on 21 August 2024 to ask when it had requested the medical records, so that she could chase this up with her GP. LV wrote to Miss L on 22 August 2024 and said it was still waiting for information from her GP, and it explained how it had calculated the benefit she would be entitled to under the policy. But LV asked for more information which may allow it to increase the benefit. Miss L responded the same day.

Miss L called LV for an update on 29 August 2024 and said she would chase the GP again. And LV wrote to Miss L on 6 September 2024 to discuss the benefit again, and other issues. Miss L responded the same day to the other issues, but not the benefit.

LV recorded on 18 September 2024 that it had received the medical records from Miss L's GP and it reviewed these on 24 September 2024, and again on 1 October 2024. After this, LV thought it needed more detailed information from Miss L's GP, based on what it read in the medical records. LV wrote to Miss L that day to explain what information it needed, and the amount of benefit she'd be entitled to, if her claim was successful.

LV spoke with Miss L on the phone on 2 October 2024. She explained that her income in 2023 was lower due to being off sick for six months at the start of the year. LV also explained it would need to refer the claim to the underwriters based on this information, as this was different to what she had declared on the application form. LV then requested information from the broker on 2 October 2024 to assess what information Miss L declared when she applied for the policy, and it asked Miss L's GP more detailed information again on 7 October 2024.

LV received the information from the broker on 9 October 2024, and this was assessed on the same day. Miss L also sent it more information the next day.

LV chased the GP on 15, 24 and 29 October 2024 for the information it had requested. This was received on 8 November 2024 and reviewed on 12 November 2024. LV updated Miss L on the same day to say it would be referred to a technical team. LV wrote to Miss L's GP again on 19 November 2024 to ask for more information about a hospital inpatient stay she had in early 2023.

LV discussed what it found about Miss L's mental health in her medical records over the phone on 21 November 2024. LV noted that Miss L said she could send more information about this. LV spoke with her again on 25 November 2024 and said it would apply an exclusion on her policy for mental health, and it sent her an email the same day to confirm this.

Miss L wrote to LV the same day to dispute its understanding of her medical records and said she could send more evidence. LV has said it would review its decision on Miss L's claim, once it had received all the information requested.

Having reviewed the above timeline, I do think there were times where LV could have been quicker. And LV requested information from Miss L's GP several times, which delayed giving her a decision on the claim. LV has accepted these delays and offered to pay Miss L £250 in compensation for the distress and inconvenience caused. I think this is fair compensation for any and all delays during this time that I can consider.

LV discussed Miss L's pre-existing medical history over the phone on 21 November 2024, which she disputed and said she could send more evidence. But without waiting for this, LV told Miss L on 25 November 2024 over the phone and by email that it would be applying a mental health exclusion on her policy from its start

LV has since said it's fair for it to let policyholders know of a potential exclusion on their policy as soon as possible. And I agree. But here, I don't think LV told Miss L this was a potential exclusion, or that it was likely this would be added, depending on the new information she was sending. The email LV sent Miss L just confirms the exclusion will be applied, and it was waiting for information to see if more amendments were needed. But LV later agreed to review the exclusion once it had all the information it needed.

I think it's clear that LV saying it would apply the exclusion, despite Miss L already having said she could send more evidence to dispute this, was very distressing for Miss L and had a big impact on her mental health. I think some of this could have been avoided, if LV had made it clear in its email that it wouldn't apply the exclusion before reviewing the evidence Miss L wanted to send.

I think LV has caused Miss L unnecessary distress and inconvenience, and the impact on her has been greater than to another policyholder in an otherwise similar situation. So, I think in the individual circumstances of this complaint, LV should pay Miss L further compensation.

Having considered all the circumstances of Miss L's complaint, I think a fair and reasonable outcome is for LV to pay her a total of £500 for the distress and inconvenience caused.

My final decision

My final decision is that I uphold Miss L's complaint in part and Liverpool Victoria Financial Services Limited should pay her a total of £500 for the distress and inconvenience caused.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss L to accept or reject my decision before 12 June 2025.

Renja Anderson
Ombudsman