DRN-5362740

The complaint

Ms J complains that Assicurazioni Generali SpA (Generali) has turned down an incapacity claim she made on a group income protection insurance policy.

What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I think are the main events.

Ms J was insured under her employer's group income protection insurance policy. The contract provided cover if Ms J was incapacitated by illness or injury from working in her own occupation. The policy deferred period was 13 weeks.

In September 2022, Ms J was signed-off work due to a range of symptoms. She was under the care of a number of specialists, including ophthalmology, dermatology, immunology and rheumatology. In February 2023, an incapacity claim was made on the policy.

Generali considered the available medical evidence and it asked Ms J's GP for her medical records as well as writing to other specialists. Ms J's GP provided Generali with a letter, but it seems her medical records weren't sent on to it. And Generali arranged for Ms J to undergo an assessment with a Vocational Rehabilitation Consultant (VRC). The assessment took place in May 2023.

Based on the medical evidence it had, Generali concluded that Ms J hadn't shown she met the policy definition of incapacity throughout the whole of the deferred period. It didn't think there was enough objective medical evidence to show Ms J had been functionally incapable of carrying out the material and substantial duties of her role. So it turned down Ms J's claim.

Ms J was very unhappy with Generali's decision and she asked us to look into her complaint. She went on to provide us with a copy of an occupational health (OH) report which had followed an assessment her employer had arranged for her with OH in April 2023.

Ultimately, our investigator didn't think it had been fair for Generali to turn down Ms J's claim. She felt there was enough evidence to show that Ms J was suffering from a range of symptoms which would most likely have led to her being incapacitated from her role. So she recommended that Generali should pay Ms J's claim.

Generali disagreed and so the complaint was passed to me to decide.

I issued a provisional decision on 13 February 2025, which explained the reasons why I thought it was it was fair for Generali to turn down her claim. I said:

'First, I'd like to reassure Ms J that while I've summarised the background to this complaint and her submissions to us, I've carefully considered all that's been said and sent. I'm very sorry to hear about the circumstances that led to Ms J needing to make a claim and I don't doubt what a worrying and upsetting time this has been for her. I was also sorry to read about the distressing nature of her symptoms.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, amongst other relevant considerations, such as the policy terms and the available medical evidence, to decide whether I think Generali handled Ms J's claim fairly.

I've first looked closely at the terms and conditions of the policy, as these form the basis of Ms J's employer's contract with Generali. Ms J made a claim for incapacity benefit, given she wasn't fit for work. The contract says that a policyholder shall notify Generali of a claim as soon as 'reasonably practicable', but no later than six weeks before the deferred period is due to expire. Ms J first became absent from work in September 2022 and the deferred period ended in December 2022. As Ms J's employer didn't complete a claim form until late February 2023, it seems that Generali was notified about Ms J's claim significantly later than it should have been.

However, Generali went on to assess the claim. And so I think it was reasonable and appropriate for Generali to consider whether Ms J's claim met the policy definition of incapacity. This says:

'As a result of illness or injury, the Member is incapable of performing the Material and Substantial duties of their own occupation and they are not carrying out any other Work or occupation'.

Generali's also defined what it means by 'material and substantial' as follows:

'means duties that are normally required for the performance of a Member's occupation and cannot reasonably be omitted or modified by their Employer.'

This means that in order for Generali to pay Ms J incapacity benefit, it needed to be satisfied that she had an illness or injury which prevented her from carrying out the material and substantial duties of her role for the entire 13 week deferred period between September and December 2022 and afterwards.

It's a general principle of insurance that it's for a policyholder to show they have a valid claim on their policy. This means it was Ms J's responsibility to provide Generali with enough medical evidence to demonstrate that an illness had led to her being incapacitated from carrying out her role.

Generali assessed the evidence Ms J provided in support of her claim. And it wasn't persuaded that she'd shown she met the policy definition of incapacity. So I've next looked at the available medical evidence to assess whether I think this was a fair conclusion for Generali to draw.

I can see that in line with the consent form Ms J signed, Generali wrote to her GP to ask for Ms J's medical records. While it seems the GP practice sent a copy of those records on to Ms J, to date, it doesn't appear that Ms J has forwarded that information on to Generali. Instead, Ms J's GP wrote a letter to Generali, dated 13 April 2023. I've looked carefully at that letter.

The GP has explained in detail the symptoms Ms J had experienced; the treatments she'd tried, the referrals that had been made to different medical specialities; the working diagnoses she'd been given and the complex nature of her medical conditions. The GP also explained the impact Ms J's symptoms had on her mental health. The GP was clearly supportive of Ms J's claim and felt that a summary of Ms J's medical situation could be more helpful to Generali than a simple copy of a medical report.

However, the GP hasn't explained how the symptoms Ms J was experiencing affected her functional capacity or how they would prevent her from carrying out the material and substantial duties of her insured role for the full 13 week deferred period.

Generali asked Ms J's treating ophthalmologist for information about her condition. Given one of Ms J's diagnoses was an eye condition, I think this was a reasonable request from Generali. The consultant responded to Generali's request in May 2023. They noted that Ms J's condition did cause inflammation and irritation in her eyes, which caused pain and photophobia. And they stated that whenever Ms J had inflammation, her vision was affected.

The consultant also said: 'If Ms J's eyes are stable and no inflammation, then that should not be restricting her from going to work. If Ms J does a lot of computer-related work, then she should be given lots of breaks to rest her eyes and put some lubricating eye drops in, to prevent irritation, pain and dryness.'

Ms J provided Generali with copies of scan results, which showed some of the scans she was undergoing and the findings made during those scans. She also provided it with further detailed information about her condition. But none of this medical evidence referred to how her symptoms affected Ms J's ability to carry out the material and substantial duties of her own occupation – which seems to have often been desk-based.

Given the lack of available evidence, Generali arranged for Ms J to be assessed by a VRC. In my experience, this isn't unusual in claims of this nature. The VRC's report set out Ms J's medical history and Ms J's self-reported symptoms and the effect of these symptoms on her ability to work. The report said that Ms J had requested a return to work meeting in January 2023, but her employer had made unrealistic suggestions, including driving to meetings. The VRC noted that given Ms J's fluctuating condition, she'd benefit from a flexible role. And they also suggested that Ms J should be given micro breaks and the option to utilise assistive technology.

The VRC report noted that Ms J's role was 'at risk' but stated that once a suitable, alternative role had been found, a phased return to work plan of 8-12 weeks should be developed.

I've thought very carefully about all of the evidence that's been provided and which was available to Generali when it made its final decision on Ms J's complaint. It's important I make it clear that I'm not a medical expert. In reaching a decision, I must consider the evidence provided by both medical professionals and other experts to decide what evidence I find most persuasive. It isn't my role to interpret medical evidence to reach a clinical finding – or to substitute expert medical opinion with my own. And it would be entirely inappropriate for me to do so.

It's clear from the evidence that Ms J has been suffering from upsetting symptoms over a prolonged period and that she's been on a difficult journey to an overall diagnosis. And I accept that she is under a multi-disciplinary team and that her condition is complex.

However, I don't think it was unreasonable for Generali to conclude that the medical evidence Ms J provided didn't provide an explanation as to how her illness incapacitated her from carrying out the material and substantial duties of her insured role. That's because the GP didn't comment on Ms J's functional capacity throughout the deferred period. Generali didn't have an opportunity to review Ms J's GP notes or refer them to its clinical team for review to gain a greater understanding of her health during the relevant time. The ophthalmologist didn't indicate that Ms J's eye condition would prevent her from working – they seemed to suggest Ms J could work, with some adjustments. And the VRC didn't conclude that Ms J was incapacitated from carrying out the material and substantial duties of her own occupation. Much of the report focuses on Ms J's job being at risk and whether her

employer would be able to find an alternative role, which Ms J could then return to with adjustments.

Based on the evidence then, I don't think Generali unfairly concluded that Ms J hadn't shown she met the policy definition of incapacity throughout the entire 13 week deferred period and beyond.

During our own investigations, Ms J provided us with a copy of an OH report, dated April 2023, following an assessment which had been arranged by her employer. Generali has had a chance to view and comment on that report, so I think I can fairly comment on the report in this decision.

The OH assessment was carried out by phone. It clearly details the symptoms Ms J had self-reported to the OH doctor. They concluded that Ms J was yet to feel the benefits of medication she'd commenced and was still symptomatic. They considered Ms J was unfit for work.

Generali didn't think the new report was enough evidence to change its decision, given the OH doctor hadn't physically assessed Ms J and given the report was based on Ms J's self-reporting of her symptoms. And it noted that the report didn't explain how Ms J's symptoms prevented her from working. So Generali didn't think this represented objective medical evidence that Ms J met the definition of incapacity.

I've considered the OH report carefully and I appreciate that the doctor is a specialist in occupational medicine. But I don't think it's unreasonable for Generali to conclude that the OH's findings are based on Ms J's own self-reporting of her symptoms, rather than an objective visual assessment of her condition and don't provide an objective assessment of functionality. So I don't think it was unfair for Generali to conclude that the OH report wasn't sufficient objective evidence which demonstrated that Ms J met the definition of incapacity.

It's important I reassure Ms J that I'm not suggesting that she was fit for work. I appreciate she was medically signed-off. And I understand she's been through a very difficult time. But I need to decide whether I think Generali acted unfairly when it concluded that she hadn't shown she met the policy definition of incapacity for the whole of the deferred period and afterwards. As I've explained above, I don't think it has.

As such then, I don't think Generali acted unreasonably when it turned down Ms J's claim.

It's open to Ms J to obtain new medical evidence in support of her claim, should she wish to do so and to send this to Generali for its consideration. It would then be for Generali to decide whether the new evidence showed Ms J had met the policy definition of incapacity while she was still employed by her employer, as I understand her employment ended. If Ms J is unhappy with any further assessment of her claim, she'd need to make a new complaint to Generali about that issue alone.'

I asked both parties to send me any additional evidence or comments they wanted me to consider.

Generali had nothing to add.

Ms J didn't accept my provisional findings. She provided a detailed letter in support of her claim from her GP, dated 27 February 2025. And, in summary, she considered her employer had worked closely with Generali to ensure her claim was submitted on time and it was the responsibility of those two parties to ensure those deadlines were met. She stated that Generali had been given details of her treating practitioners but had chosen not to obtain

evidence from them. And she felt Generali could have written to her GP directly if it didn't think the GP's letter was detailed enough. This meant she'd been reliant on the evidence she'd provided to Generali – which she'd believed would be enough. Ms J stated that Generali's claims decision had led to her losing her job, which had had a significant impact on her health – including her ability to recover.

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, whilst I'm very sorry to disappoint Ms J, and I know my decision will cause her further upset, I still don't think it was unfair for Generali to turn down her claim for the same reasons I gave in my provisional decision. But I'll now move on to consider Ms J's additional points.

New GP evidence

Ms J's GP has written a very detailed letter in support of her claim and has explained why he believes Ms J's condition caused her to be incapacitated in line with the policy terms.

But I don't think it would be reasonable or appropriate for me to take that evidence into account as part of this decision. That's because, as I explained in my provisional decision, I'm deciding whether I think Generali fairly relied on the medical evidence it had at the point it issued its final response to Ms J's complaint on 21 December 2023 to turn down her claim. The GP's new evidence post-dates Generali's final response letter by many months. This means Generali hasn't had a chance to review or comment on that evidence.

And it's important to reiterate that it isn't my role to interpret medical evidence to reach a clinical finding – or to substitute expert medical opinion with my own. That's because I'm not a medical expert. Nor would it be appropriate or fair for me - under the rules of natural justice - to take a claims decision on Generali's behalf when it hasn't had a chance to assess the new evidence and to decide whether it alters its understanding of Ms J's claim.

As I set out in my provisional decision, Ms J should send the GP's new letter to Generali for its consideration. It will be for Generali to decide whether it thinks the new evidence shows Ms J met the policy definition of incapacity while she was still employed by her employer. And if Ms J is unhappy with any further assessment of her claim, she'll need to make a new complaint to Generali about that issue alone before we can potentially consider it.

Generali's handling of the claim

I've considered Ms J's comments about the timing of the submission of her claim. But regardless of whether the claim was made late or not, Generali still considered the claim in line with the terms of the policy. So I don't think it made a material difference to the way Generali handled the claim.

Ms J feels that Generali didn't take steps to contact some of her medical practitioners to ask for more information. I've thought about this. But as I've explained, it's a member's responsibility to provide an insurer with enough evidence to show they have a valid claim on their policy. So I don't think Generali had any obligation to request detailed reports from Ms J's multi-disciplinary team even though I can understand why Ms J might have wanted it to.

Instead, I think Generali acted fairly by assessing the claim based on the evidence Ms J and her GP had sent it. Based on the medical evidence Ms J provided to Generali, and taking

into account the VRC's report, it concluded that there wasn't sufficient, objective evidence which showed Ms J met the policy definition of incapacity for the whole deferred period and beyond. I still don't think Generali unfairly relied on the information it had available at that time when it decided not to pay Ms J's claim.

I was sorry to hear that Ms J's employment ended and I understand she believes Generali to be responsible for her employer's decision. However, Generali's role was to assess whether Ms J's claim met the policy definition of incapacity and to handle her claim in line with the contract terms. It wasn't responsible for any actions taken or employment decisions made by her employer.

Overall, while I'm very sorry to disappoint Ms J and I was sorry to hear about the impact this situation has had on her, I still don't think Generali acted unfairly when it concluded that Ms J hadn't shown her claim met the policy definition of incapacity. And so I still don't find it acted unfairly or unreasonably when it turned down her claim.

My final decision

For the reasons I've given above and in my provisional decision, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms J to accept or reject my decision before 31 March 2025.

Lisa Barham
Ombudsman