DRN-5402716

The complaint

Mrs A is unhappy that Legal and General Assurance Society Limited (L&G) terminated her income protection claim.

What happened

Mrs A has a group income protection policy with her employer. L&G is the underwriter. The policy provides a benefit in certain circumstances after a deferred period of 13 weeks on an own occupation basis.

Mrs A was first absent from due to illness on 21 February 2022. She was experiencing palpitations, breathlessness, insomnia, anxiety, fatigue, depressions and confusion. She was referred for further investigations and was diagnosed with bipolar disorder. She had cardiac investigations.

Mrs A submitted a claim to L&G after the deferred period. The claim was fully accepted on 20 May 2022. Following a review of her claim, L&G stopped paying Mrs A the benefits. Mrs A provided further information and appealed L&G's decision. It maintained its position.

Unhappy, Mrs A brought her complaint to this service. Our investigator didn't uphold it. She didn't think L&G had unfairly ceased Mrs A's income protection claim.

She disagreed and asked for the complaint to be referred to an ombudsman. So, it's been passed to me.

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.

At the outset, I wanted to acknowledge that the situation has been difficult for Mrs A. So, whilst I understand that Mrs A was diagnosed for her condition and things have been difficult for her mentally, my role is to reach an independent and impartial outcome that's fair and reasonable, based on the information available to me. I don't doubt that Mrs A is unwell, but this doesn't automatically mean that L&G must continue to pay her claim.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. So, I've considered, amongst other things, the terms of this income protection policy and the circumstances of Mrs A's claim, to decide whether I think L&G treated her fairly.

It's important to point out that we're an informal dispute resolution service, set up as a free alternative to the courts for consumers. In deciding this complaint I've focused on what I consider to be the heart of the matter rather than commenting on every issue or point made in turn. This isn't intended as a discourtesy to Mrs A. Rather it reflects the informal nature of our service, its remit and my role in it.

I've first considered the terms and conditions of this policy, as it forms the basis of the

contract between Mrs A's employer and L&G.

The policy states for a claim to be paid the definition of incapacity must be met. Incapacity is defined as:

> *'Own occupation definition*
>
> *A member is incapacitated if:*
>
> - *An illness or injury prevents them from performing the essential duties required of their occupation….*
>
> *We'll pay benefit if medical evidence supports that they can't carry out the essential duties of their occupation because of illness or injury.*
>
> *When we assess a claim under this definition, we'll compare what a member can and can't do (we call these their functional capabilities) against the essential duties of their occupation. In our assessment we'll also consider if a member is able to carry out the essential duties of their occupation with a different organisation.*
>
> *We won't pay benefit if there are other non-medical reasons preventing the member returning to the essential duties of their occupation.'*

L&G initially accepted the claim based on the diagnosis of Mrs A's mental health condition. But as the claim progressed and the benefits were being paid, L&G carried out regular reviews. This isn't unusual. In a situation like this, where an insurer has accepted a claim and subsequently terminates that claim, it's for the insurer to show that the claimant no longer meets the definition of incapacity.

For the avoidance of doubt, I'm not medically qualified so it's not for me to reach any determinations about Mrs A's medical diagnosis or to substitute expert medical opinion with my own. Instead, I've weighed up the available medical evidence to decide whether I think L&G acted fairly and reasonably in terminating Mrs A's claim.

I've been provided with detailed medical and additional information relating to Mrs A's claim. L&G said Mrs A was actively involved in three companies and she didn't declare this when she submitted her claim. She didn't accurately complete the questions she was asked, and she didn't disclose material information that was relevant to her claim. L&G also said Mrs A had stopped attending her psychotherapy and psychiatric appointments and she stopped taking the medication she was prescribed for her mental health condition. It said whilst her diagnosis of her mental health condition was confirmed, the policy looks to assess her functional capability. Her involvement in the businesses suggested that she isn't incapacitated as per the requirement of the policy terms and conditions.

The medical evidence confirms Mrs A was diagnosed with bipolar disorder. L&G accepted the claim based on the medical evidence, including the clinical assessments Mrs A had initially. In 2022 and 2023, Mrs A had various other investigations for her heart, menopause, thyroid and blood tests. There's no evidence of any significant concern. Mrs A was also prescribed anti-depressant medication but shortly after she started taking this, she stopped. I can't see that any further referrals for her mental condition or interventions took place to manage and support this. She self-reported her symptoms but in terms of evidence which shows her symptoms worsening or further developments, there is little.

The Independent Medical Examination (IME) in January 2023 suggested a phased return to work in six weeks if Mrs A was on the right medication. The report also said it would be

unusual if no progress was made at all in this time period.

Mrs A was also more recently referred to a gynaecologist and to orthopaedics, but I'm not persuaded that this would have prevented her from carrying out the duties of her own role entirely. These appointments were attended as an outpatient. The information shows Mrs A did cancel appointments, didn't continue with medication that was prescribed and there has been no worsening of symptoms.

L&G has provided evidence that Mrs A was involved in three businesses and was a joint director in all of these. One of the businesses was active at the time it carried out the investigation. She's also noted as a person of significant control.

L&G said Mrs A was asked to complete a claim continuation form in May 2023. She was asked:

- *'Are you able to do any part of your normal job?*
- *Do you intend to find other employment either full or part time?*
- *Are you currently doing any paid work?'*

She answered '*No*' to these questions.

Mrs A was also asked to sign a declaration to confirm that the statements made in the form were true, complete and accurate. Based on the evidence available, I'm not persuaded that Mrs A did complete this accurately and to the best of her knowledge as she was a joint director of three companies – one of these was most active and was home based. There's evidence also of online activity. I can't see that Mrs A explained she was involved in the businesses which would have allowed L&G to take into account the impact of this in terms of assessing the claim.

I note Mrs A's comments that she wasn't earning an income – but that's not the issue here and not relevant. The issue is that Mrs A didn't accurately complete the questions which impacted L&G's assessment of her overall functional capability for work under the policy.

I've considered Mrs A's appeal and the information she sent to L&G. She provided self-referral letters for pain in her shoulder and elbow, menopause, liver function and her pelvis. Whilst she had these appointments and tests, these wouldn't be considered as conditions rendering total incapacity.

Mrs A also sent financial accounts to L&G to show she didn't receive any income from the three companies. However, as I've said above, the test is whether she was incapacitated to the level that prevented her from carrying out the duties of her own role. The evidence suggests she had some degree of involvement in one of the businesses specifically but was also a director in the other two. They may have been created during lockdown, but the fact is that she was a joint director, and she didn't accurately complete the questions asked of her. This impacted the claim L&G paid to Mrs A.

I acknowledge that Mrs A has also provided further comments and a letter from her husband for me to consider. Having done so, I'm satisfied that the evidence provided by L&G is on balance more persuasive. Mrs A had the responsibility to ensure she provided accurate and complete information during the claim process. I think L&G has sufficiently provided evidence to support the claim being ceased.

Having looked at everything, I don't think L&G has ceased Mrs A's income protection claim unfairly or outside the terms and conditions of the policy. I'm sorry to disappoint Mrs A, but I can't reasonably ask L&G to reinstate the claim in the circumstances here. It follows that I

don’t require L&G to do anything further.

My final decision

For the reasons given above, I don’t uphold Mrs A’s complaint about Legal and General Assurance Society Limited.

Under the rules of the Financial Ombudsman Service, I’m required to ask Mrs A to accept or reject my decision before 16 July 2025.

Nimisha Radia
Ombudsman