DRN-5483573

The complaint

Mr R complains that Zurich Assurance Ltd has unreasonably declined a claim he made under his employer's group income protection policy. To resolve his complaint, he wants Zurich to pay his claim and consider compensation for the upset it has caused him.

What happened

Mr R is a member of his employer's group income protection policy, which is provided by Zurich. The policy is designed to pay monthly benefit of 66.67% of Mr R's salary should he be incapacitated due to an illness or injury preventing him from completing the essential duties of his occupation throughout a deferred period of 26 weeks and beyond.

Mr R's employer lodged a claim with Zurich, noting Mr R hadn't been able to work since November 2021. It confirmed he had been off sick with stress, which had first begun in October 2021. Mr R returned to work on a phased basis in September 2022.

In January 2023, Zurich told Mr R's employer that it was declining the claim. It explained that it did not feel Mr R's barriers to work were due to a mental health condition, but rather, personal stressors that had impacted his wellbeing. Since this did not meet the policy definition, the claim was rejected.

The employer appealed on Mr R's behalf. In July 2023, Zurich told Mr R's employer that it had rejected the appeal. It said Mr R's absence was not caused by a medical illness or injury but was a result of the unfortunate sequence of life events that he experienced during the deferred period and briefly afterwards before he returned to work in September 2022.

In October 2024, Mr R approached Zurich noting he hadn't been given the chance to complain in his own right. So, Zurich looked into a new complaint regarding the claim refusal.

On 30 October 2024, Zurich rejected the complaint. It said it had referred Mr R's further appeal to its Chief Medical Officer ('*CMO*'), who believed Mr R's absence from work was a stress-related reaction secondary to a sequence of major life events. The CMO felt that though it was understandable why Mr R would have become overwhelmed at work, this was not due to an underlying medical issue. The CMO also felt it was clear that when the external personal factors started to resolve, there was an improvement in Mr R's symptoms. Overall, Zurich did not conclude that the absence was because of a mental health disorder.

Mr R therefore lodged his complaint with this service. One of our investigators reviewed the complaint, but he didn't think it should succeed. He said he understood that Mr R had not been fit for work, but this did not mean that his circumstances met the policy definition for incapacity. And he thought it was fair for Zurich to conclude that Mr R hadn't met the policy definition, but rather, that his absence had been primarily caused by personal stressors.

Mr R disagreed with our investigator. He said, in summary:

- He didn't think that the two letters issued by his GP from March 2023 and June 2023 had been properly considered.

- His claim to Zurich was limited to 15 working days from 1 August 2022 to 22 August 2022, this being the time he was off sick after the deferred period and before he returned to work on a phased basis.
- The GP had clearly said he was suffering with both stress and anxiety, both of which are recognised illnesses as classified by the World Health Organization ('*WHO*').
- The personal triggers for his illness are irrelevant, and he believes Zurich has unfairly focused on those.
- Only his GP was best placed to establish the nature of his illness at that time.
- The GP said he wasn't able to work, and so for Zurich to insist otherwise is insulting and disgraceful.

Our investigator did not change his view on the complaint. Mr R asked that his complaint be referred to an ombudsman. Zurich confirmed it had nothing else to add.

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've set out the background to this complaint in less detail than the parties and I've done so using my own words. And, in reaching my conclusions, I've focused solely on what I consider are the key issues. Our rules allow me to take this approach; it simply reflects the informal nature of our service as a free alternative to the courts and no discourtesy is intended by it. If there's something I haven't mentioned, it isn't because I've ignored it. It's since I don't need to comment on each individual argument to be able to reach what I consider is the right outcome in the circumstances.

On that basis – and to ensure privacy is maintained - I haven't set out the complete details of Mr R's medical, personal, or employment circumstances, though I've carefully considered everything I've seen when reaching my decision.

Regulatory rules require Zurich to handle claims promptly and fairly and to not unreasonably reject a claim. I've therefore considered the evidence provided by the parties alongside the terms and conditions for Mr R's employer's group policy to determine whether I believe Zurich treated him fairly and reasonably by refusing his claim. And though I realise it will be a disappointment for Mr R, I've reached the same overall outcome as the investigator. That means I won't be asking Zurich to do anything further to resolve this complaint. I'll explain my reasons for reaching this view below.

The policy terms set out when the income protection benefit is payable to the employer on a member's behalf, as follows:

> "*The policy provides insurance that pays you a regular Income Benefit if a Member:*
>
> - *has an Incapacity for longer than the Deferred Period, and*
> - *suffers a loss of earned income.*"

Incapacity is defined as "*Incapacity or incapacitated means an illness or injury that causes the member to be unable to work and is applicable under this policy.*" And Mr R's policy provides cover within the standard definition for incapacity which requires, "*The Member cannot perform the Material and Substantial Duties of their employment, and they are not doing any paid work."*

This means that for Zurich to pay Mr R incapacity benefit under the policy, it must be satisfied he had an illness or injury which prevented him from carrying out the material and substantial duties of his insured occupation throughout the deferred period and beyond. That period ended (as Mr R has set out) on 22 August 2022, as Mr R thereafter returned to work.

I understand Mr R endured a number of extremely difficult personal stressors which combined over many months, and the impact of the situation meant he could not attend work over the period from November to February 2022, and again from June to August 2022.

I know Mr R feels strongly that his fitness certificates – alongside his GP records and the two 2023 letters written by his GP regarding the situation – ought to provide sufficient evidence that he was unable to work. However, I must be fair to both parties in a complaint. Having looked at Mr R's records, there is no objective evidence to demonstrate how the diagnoses of stress and anxiety prevented him from completing the material and substantial duties of his role from November 2021 to August 2022 (the deferred period with a break in between) and beyond. Rather, Zurich has, in my view, reasonably concluded that the combination of stressors caused by Mr R's his particularly challenging personal circumstances resulted in him taking time off work to deal with the impact of those situations.

I believe Zurich has reached a fair conclusion where it hasn't seen evidence that supports Mr R's stress and anxiety led to his functional capacity being impaired to the point of no longer being able to perform his insured role. Instead, the evidence demonstrates how a set of distressing circumstances caused Mr R to be unable to work – rather than a defined illness.

I realise Mr R says that his two GP letters were not considered properly by Zurich – however, I can see that the CMO provided a medical view having reviewed the available evidence, which included those letters.

In the second of the letters, the GP said "*please reconsider this gentleman's insurance claim. He had been seeing us for stress and anxiety due to some personal circumstances. It is worthy of note that regardless of the triggers, stress is an ICD-10 listed condition (Z73.3), hence the impact of which on one's mental wellbeing and ability to work ought to be considered.*"

The listed condition referred to by the GP is 'stress – not elsewhere classified; under problems related to life management difficulty'. However, Zurich hasn't disagreed that stress is a listed condition by the WHO. What Zurich said is that Mr R's documented circumstances haven't amounted to an illness – an underlying medical issue – that rendered him incapacitated for the purposes of the policy, i.e., that illness or injury prevented him from completing the substantial duties of his occupation.

Instead, Zurich's CMO concluded that the medical evidence showed how external triggers caused Mr R to suffer with stress symptoms as an understandable reaction to life events, but this hadn't reached a threshold whereby he was deemed as suffering with a mental health condition. I don't think Zurich was unfair in reaching that view on the facts before it.

Nor do I consider that the distinction of events causing stress compared to diagnosis of stress as an illness was unreasonable for Zurich to identify in the circumstances. This is since the GP expressly set out that Mr R "*had been seeing the surgery for stress and anxiety in regards to some personal circumstances*". This was supported by the psychiatrist assessment in the occupational health reports. The second of those reports explained how Mr R had been able to resume work when the pressure from the personal events had eased.

It is clear Mr R went through a very difficult set of events; I understand why he may not have felt able to carry out his occupation, notwithstanding any adjustments the employer may

have offered (and I note Mr R did return to work on an adjusted basis following discussions with the occupational health psychiatrist). Unfortunately, not feeling able to work doesn't principally mean that the policy definition of incapacity was met, given wording requires the absence to be caused by an illness or injury.

It follows that I do not believe that this complaint should succeed in respect of Zurich's decision to decline Mr R's income protection claim. Though my decision will not bring Mr R welcome news, I cannot agree that Zurich has treated Mr R unfairly or unreasonably in concluding that he hadn't met the policy definition of incapacity during the deferred period and beyond.

My final decision

For the reasons explained, I do not uphold this complaint or make any award.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr R to accept or reject my decision before 18 August 2025.

Jo Storey
Ombudsman