

The complaint

Mrs T complains that MetLife Europe d.a.c has turned down an incapacity claim she made on her employer's 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.

Mrs T is insured under her employer's group income protection insurance policy, which provides cover if Mrs T is incapacitated from work due to accident or illness. The policy deferred period is 13 weeks.

In late October 2023, Mrs T was signed off by work by her GP. She was signed off in part due to an existing medical condition but also due to a stress-related problem. The GP subsequently signed Mrs T off with work-related stress. As Mrs T wasn't fit to return to work, her employer made an incapacity claim on her behalf.

MetLife assessed Mrs T's claim and it considered the available medical evidence. Ultimately, MetLife concluded that Mrs T was suffering from work-related stress rather than suffering from a functionally impairing or sustained mental health condition throughout the deferred period. So it didn't consider that Mrs T had shown she met the policy definition of incapacity throughout the deferred period and it therefore turned down her claim.

Mrs T was very unhappy with MetLife's decision and she asked us to look into her complaint.

Our investigator didn't think it had been unfair for MetLife to rely on the available medical evidence to conclude that Mrs T had been suffering from work-related stressors rather than a medical condition. So he thought it had been reasonable for MetLife to turn down her claim. But he thought there been some unreasonable delays in MetLife communicating with Mrs T during the claim and so he recommended that it should pay her £200 compensation.

MetLife accepted the investigator's findings but Mrs T did not. In brief, she reiterated that she'd been suffering from overwhelming physical, psychological and mental health problems during the deferred period. She also felt that MetLife had discriminated against her.

The complaint's 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.

Having done so, whilst I'm very sorry to disappoint Mrs T, I don't think MetLife acted unfairly when it turned down her claim and I'll explain why.

First, I'd like to say how sorry I was to read about Mrs T's symptoms, the impact these have

had on her and the difficult personal and work-related situations she's faced. It's clear that she's been through a very difficult and upsetting time.

In making my decision, I've taken into account relevant regulatory rules, which say that an insurer must handle a claim promptly and fairly and that it mustn't unreasonably reject a claim. I've also considered other relevant considerations, such as regulatory principles, the policy terms and the available evidence, to decide whether I think MetLife handled Mrs T's claim fairly.

First, I've very carefully considered the policy terms and conditions, as these form the basis of the contract between Mrs T's employer and MetLife. As Mrs T's employer made a claim on her behalf, I find it was appropriate for MetLife to consider whether Mrs T met the policy definition of incapacity. This says:

'an insured member, eligible employee or eligible partner, is incapacitated if:

- they are unable to perform, due to illness or injury, the material and substantial duties required of them in their own occupation which they were performing immediately prior to being incapacitated; and*
- are not following any other occupation.'*

This means that in order for MetLife to accept a claim and pay incapacity benefit, it must be satisfied that an insured member is unable to perform the material and substantial duties of their own occupation because of an injury or illness, for the full 13-week deferred period and afterwards.

As the investigator explained, it's a general principle of insurance that it's an insured member's responsibility to show they have a valid claim on their policy. This means it was for Mrs T to provide MetLife with enough medical evidence to demonstrate that an illness had led to her being unable to carry out the material and substantial duties of her own occupation throughout the full deferred period and beyond.

MetLife assessed the evidence Mrs T provided in support of her claim, including with clinical staff. And it concluded that she wasn't suffering from a functionally impairing illness which prevented her from carrying out her role. Instead, it felt that Mrs T was suffering from a reaction to work-related stressors and other stressors. So I've next looked at the available medical and other evidence to assess whether I think this was a fair conclusion for MetLife to reach.

I've first considered the claim form which was completed by Mrs T's employer. This stated that the nature of Mrs T's illness was 'personal and work stress'.

Next, I've looked carefully at the GP notes and the fit notes the GP issued. I can see that in early November 2023, Mrs T requested a fit note for a flare up of her existing medical condition which she said was triggered by work and home stress. Following a consultation the next day, the GP recorded that Mrs T had ongoing stress at work and at home. They noted that Mrs T's employer had told her to take some time off. The GP issued a fit note which stated Mrs T wasn't fit for work due to a stress-related problem. A couple of weeks later, the GP signed Mrs T off due to a flare of her existing condition.

In early December 2023, Mrs T had a further consultation. The GP notes show that Mrs T *'wasn't ready to go back to work yet...stressed at work.'* She was diagnosed with a stress-related problem.

Subsequently, in January 2024, Mrs T requested a further fit note and described her illness as 'work related stress ongoing'. She was issued fit notes which stated that she wasn't fit for work due to work-related stress.

It's clear that Mrs T was referred to a Primary Mental Health Care Team, but she later saw a private counsellor for therapy. In February 2024, Mrs T requested a fit note extension due to work-related stress. It doesn't appear that she had any further consultations with the GP after the deferred period had ended, although fit notes were still requested and issued.

Mrs T's employer also referred Mrs T to occupational health (OH). I've seen a copy of the resulting report, dated 30 April 2024 (which I appreciate post-dates the deferred period). I've set out below what I consider to be the key findings of the report:

1. 'Is there an underlying medical condition affecting their ability to work?'

(Mrs T) is reporting poor mental health which has been triggered by (a) workplace incident in October 2023.

2. Is the employee fit for normal hours and duties required by their post?

(Mrs T) does not feel able to return to work until the pending (work matter) has been heard).

3. When will they be able to return to work/return to normal hours/duties?

(Mrs T) is unlikely to return to work in any capacity until the outcome of the (work matter) is known.

4. How does this condition affect the employee at present?

(Mrs T) informed me that she can manage every day activities well and does not become anxious until she thinks of returning to work.

5. Please state whether the condition is a physical or mental impairment.

(Mrs T) has poor mental health which she perceives is triggered solely by workplace stress.'

Additionally, Mrs T provided MetLife with medical evidence that showed she'd experienced very upsetting and worrying personal family stressors. And she'd also had a referral for an unrelated medical problem after the deferred period. I note too that in her complaint form, Mrs T told us that part of the redress she sought was for MetLife to send her employer 'a revised report...that concedes her health has been impacted by work and personal issues since October 2023.'

I've very carefully considered all of the evidence that's been provided. Like the investigator, I'm not a medical expert. When making my decision, I need to think about the evidence provided by both medical professionals and other experts to decide which evidence I think is most persuasive.

It's clear that Mrs T suffers from a long-term condition which flared up during the early part of the deferred period. And the medical evidence (together with Mrs T's testimony) shows that she suffered from symptoms which can indicate a significant mental health condition. I appreciate Mrs T was referred for therapy and that she undertook regular counselling.

But, based on the totality of the medical and other evidence available to MetLife, I find it was fair and reasonable for it to conclude that the evidence indicated that Mrs T was suffering from an understandable reaction to work and serious personal stressors. And that the main

reason for Mrs T's absence was likely the workplace stress she was experiencing rather than a functionally impairing mental health condition. I say that because the GP records and fit notes show that while Mrs T's long-term condition was a contributory factor to the earlier part of her absence, they make it clear that Mrs T's diagnosis was work related stress. The OH report states that Mrs T's absence was triggered by a workplace situation and clearly states that she wouldn't be in a position to return to work until the workplace issues had been resolved. These notes and report were based on Mrs T's self-reporting of her symptoms.

As such, I don't think it was unfair for MetLife to rely on the medical evidence to conclude that the main cause of Mrs T's symptoms was work related stress. This means I don't think it was unreasonable for MetLife to reach the view that Mrs T wasn't prevented from carrying out the material and substantial duties of her own occupation because of a functionally impairing illness. Instead, I think it reasonably concluded that Mrs T was suffering from an understandable reaction to her personal situation and work-related stress.

So, I don't find MetLife acted unfairly when it concluded that Mrs T's absence wasn't due to an incapacity in line with the policy definition. Instead, I think it fairly concluded that Mrs T's absence was more likely due to workplace stress. I'd add though that I don't doubt the other external stressors Mrs T was experiencing impacted on her mental health and I was sorry to read about those stressors.

I'd add that I'm not suggesting that Mrs T was medically fit for work. Her GP signed her off from work because of her symptoms. But I don't think the evidence she's provided is enough to show MetLife that she was incapacitated from carrying out her own role throughout the deferred period and beyond in line with the contract.

Mrs T says she feels MetLife discriminated against her, because it referred to her 'perceived work stressors' in its letters with her. It's not our role to say whether a business has acted unlawfully or not – that's a matter for the Courts. Our role is to decide what's fair and reasonable in all the circumstances. In order to decide that, however, we have to take a number of things into account, including relevant law and what we consider to have been good industry practice at the time. So, although it's for the Courts to say whether or not Unum has breached the Equality Act 2010, we're required to take the Equality Act 2010 into account, if it's relevant, amongst other things when deciding what is fair and reasonable in the circumstances of the complaint.

In this case, I understand that Mrs T was unhappy with the way MetLife described her symptoms. But I note it explained to her that its terminology wasn't meant to be offensive or to suggest that the stressors weren't significant to an individual. I think its explanation was reasonable. I do hope that it helps Mrs T to know that someone impartial and independent has looked into these concerns.

With that said, MetLife accepts that there were delays in it dealing with Mrs T's communications. I don't doubt this caused her unnecessary trouble and upset when she was already going through a difficult time. Our investigator recommended that MetLife should pay Mrs T £200 compensation to reflect her distress and inconvenience, and I was pleased to note that MetLife accepted this recommendation. In the circumstances, I think this is a very fair award of compensation for a relatively brief period of delay and so I now direct MetLife to pay Mrs T £200 compensation.

Overall, despite my natural sympathy for Mrs T's position, I don't think it was unfair for MetLife to turn down her income protection insurance claim. But I find it must pay Mrs T £200 compensation.

My final decision

For the reasons I've given above, my final decision is that I find MetLife didn't act unfairly or

unreasonably when it declined Mrs T's claim.

But I direct MetLife Europe d.a.c. to pay Mrs T £200 compensation to reflect the impact of its claim handling delays on her.

MetLife must pay the compensation within 28 days of the date on which we tell it Mrs T accepts my final decision. If it pays later than this, it must also pay interest on the compensation from the deadline date for settlement to the date of payment at 8% a year.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs T to accept or reject my decision before 9 September 2025.

Lisa Barham
Ombudsman