DRN-5491780

The complaint

Mrs V complains that Vitality Life Limited ('*Vitality*') has unfairly refused an income protection claim she made under her VitalityLife Essentials policy. To resolve her complaint, Mrs V wants the claim to be paid in full, along with compensation for the emotional distress she has been caused and a commitment from Vitality for it to improve its claims handling processes.

What happened

Mrs V's complaint concerns the insurance policy she holds with Vitality. It provides life assurance and serious illness cover. It also provides income protection benefit for Mrs V if, by reason of illness or injury, she is unable to perform her the material and substantial duties of her own occupation. The benefit is payable after a deferred period of three months.

In January 2024, Mrs V made a claim to Vitality noting she had been suffering with a type of malignant skin cancer since June 2023. Over the next few months, financial and medical evidence was sought by Vitality, and a treating specialist report was received in May 2024. A claim payment was made to Mrs V for serious illness benefit, at Severity Level D.

However, in June 2024, Vitality rejected the income protection claim. It said the medical information it had received did not provide sufficient evidence to conclude that the definition of incapacity had been met. It hadn't seen any suggestion by Mrs V's doctors that she had been prevented from performing her duties in her job because of her illness. Vitality did also consider whether Mrs V's circumstances met the terms and conditions under her policy for waiver of premiums, but it had not seen any evidence to support a claim.

Mrs V appealed the decision on the grounds that she had been off work throughout the deferred period and had now been without any income for over a year; she had needed to undergo several additional excisions of other moles, following her diagnosis.

However, Vitality refused the appeal in August 2024 on the same grounds. It didn't consider that any symptoms or treatment for the subsequent mole removals required Mrs V to be off work for more than three months. And though Mrs V had said she was suffering with stress, it hadn't seen any evidence that she was incapacitated as required by her policy wording.

In September 2024, Mrs V complained about the claim refusal, the time Vitality had taken to process the claim and its failure to provide her with regular updates which meant she'd had to chase Vitality via telephone and email on several occasions.

In October 2024, Vitality upheld the complaint in part. It said it had fairly refused the claim and had completed Mrs V's appeal within its eight-week service standard. However, the claim assessment had taken longer than should have, due to a backlog of workloads in its assessment team. For this, it offered Mrs V £100 compensation, but she didn't accept it.

Mrs V then brought her complaint here. She said that her GP has considered her unfit for work since August 2023, and this ought to be deemed sufficient evidence of her incapacity. She also explained how she had two further mole excisions upcoming in December 2024.

One of our investigators reviewed the complaint, but she didn't think that Vitality needed to do anything further to resolve it. She said Vitality had reasonably concluded that Mrs V wasn't functionally unable to perform the material and substantial duties of her insured occupation during the policy's deferred period. And in respect of the administrative issues, she considered that Vitality's £100 offer of compensation for its failure to provide timely updates was fair and reasonable in the circumstances.

Mrs V disagreed with the investigator's findings. She supplied a letter from her GP along with medical history evidence that demonstrated how stress had been a key factor in her condition from the outset. She also said, in summary:

- The GP said that stress wasn't explicitly mentioned on her sick note purely because her cancer diagnosis took precedence.
- Nonetheless, she's consistently stated that stress has prevented her from working, and she has actively sought help for it.
- If it is necessary that she seeks referral for psychiatry, she is willing to do so – but Vitality has never told her this was the case.
- She has specifically paid for her insurance to protect her financially, yet she has been abandoned at the very point she needs the insurance to pay out.
- Vitality's poor complaint handling has only serviced to exacerbate her stress.
- She feels the £100 offer is entirely inadequate, since it doesn't reflect the distress, hardship, and emotional toll that the claim process has created.

Vitality confirmed it had nothing else to add. The complaint has now 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.

I've fully reviewed all the information before me, including representations Mrs V made after our investigator's assessment. However, in reaching my findings, I've focused on what I consider to be the central issues. I don't need to comment on every argument to be able to reach what I think is the right outcome in the circumstances. Our rules allow me to take this approach; it reflects the informal nature of our service, as a free alternative to the courts.

On that basis, I haven't set out the complete details of Mrs V's medical circumstances, though I have carefully considered all of the evidence when reaching my decision. I also send Mrs V my best wishes at what I realise continues to be an upsetting time for her.

Regulatory rules require Vitality to handle claims promptly and fairly and to not unreasonably reject a claim. I've therefore considered the terms and conditions for Mrs V's policy alongside the evidence to determine whether I believe Vitality treated her fairly.

Though I realise it will be a disappointment for Mrs V, I've reached the same overall outcome as the investigator. That means beyond directing Vitality to pay the £100 compensation it has already offered her relating to customer service failings, I don't consider it needs to do anything further to resolve the complaint. I'll explain my reasons for this view below.

The policy terms set out when the income protection benefit is payable after the deferred period, as follows:

> "***B3.1 When we will pay***
> *We will pay if you become ill, injured, or disabled, and your incapacity meets one of*

the following definitions:

A special definition means that:
1. For the first 12 months, we will pay you the full monthly benefit if illness or injury makes you unable to perform the material and substantial duties of your own occupation. As with the standard definition, these are the duties that are normally needed to do your own occupation and that cannot reasonably be omitted or modified by you or your employer. You must also not be working in any other occupation for payment or profit.

When we will start paying your claim
Your benefit will be due at the end of your deferred period. The deferred period starts on the date you become incapacitated according to the definition that applies to your plan. It ends when you have been continuously incapacitated for [three months]."

I recognise that Mrs V went off on maternity leave in March 2023, and she was planning to return to work by December 2023 – though she had hoped this would be sooner. And because of the impact of the first biopsy, her diagnosis, the subsequent excisions of the original mole and many other moles periodically thereafter, Mrs V says she hasn't ever been well enough to consider working due to the discomfort and stress of the ongoing procedures.

It is clear from the evidence that Mrs V has been through a very difficult period, and I do understand why she may not have felt able to carry out her occupation for the reasons she has given. Unfortunately, this doesn't mean the above policy definition was met.

Mrs V has explained how each excision (and she had undergone some ten procedures up to September 2024 with two further excisions planned) entailed stitches being in place for two weeks, causing pain and the inability to undertake basic movements – because one such excision had burst open. I understand how a restriction of movement may be at odds with a job of a physical nature, such as Mrs V's and I appreciate her explanation of the impact of these procedures.

I've thought carefully about everything Mrs V has said. Vitality has concluded that it hasn't seen enough medical evidence to ascertain that Mrs V was continuously incapacitated for a three-month period. And I find Vitality's decision to be fair in these circumstances.

Mrs V's account is not supported by either her treating medical profession or her GP – and Vitality has sought medical reports from both doctors. Mrs V's medical records do make note of her suffering from stress and worry, but the medical certificates - each covering several months over the period August 2023 to October 2024 – say she was signed off because of skin cancer. However, there is no objective evidence to demonstrate how the effects of this illness prevented Mrs V from completing the material and substantial duties of her role.

I cannot therefore agree that Vitality has treated Mrs V unfairly or unreasonably in concluding that she hadn't met the policy definition of incapacity during the deferred period and beyond.

It follows that I do not believe that this complaint should succeed in respect of Vitality's decision to decline Mrs V's income protection claim. Though I appreciate my decision will be disappointing for Mrs V, she is not prevented from submitting new medical evidence to Vitality for its consideration.

Turning to the administrative issues, I agree with both parties that – at some points - Vitality should have proactively updated Mrs V about the status of her claim. I am pleased to note that Vitality accepts that its customer service fell short on occasion, whereby it failed to offer

timely updates to Mrs V. I agree that this failure caused additional concern to Mrs V at what was already a difficult time for her, and some compensation ought to be awarded for that.

What this service does is consider if a business has treated a customer unfairly because of actions or inactions. And if it has done so, we then go on to consider what ought to be done to put the mistake(s) right. As well as putting right any financial losses in a complaint (though there are none in this circumstance since I agree the claim was fairly declined), we also consider the emotional or practical impact of any errors on a complainant.

Overall, I believe the proposed payment of £100 was reasonable in the circumstances where Vitality caused upset and frustration for Mrs V. The mistake had a medium-term impact on Mrs V since she was periodically chasing Vitality for answers at a time when she was dealing with the stress and worry relating to further medical procedures.

I recognise Mrs V feels that the compensation ought to be higher, but when we consider awards of this nature, we do not fine or punish businesses; the Financial Conduct Authority undertakes the role of regulator. Instead, we consider the impact upon a complainant. It may also be helpful for Mrs V to review to the guidance available on our website which explains the amounts and types of awards made in instances of upset, trouble, inconvenience and distress caused by businesses in the complaints we see at this service.

Putting things right

I believe that Vitality has taken reasonable steps to resolve the complaint, by apologising to Mrs V and by offering to pay her £100 for the upset she had been caused by the impact of its mistakes.

I think this offer is fair in all the circumstances. I note Mrs V did not accept this offer. So, my decision is that Vitality should pay £100 to Mrs V, as it hasn't been able to make that payment to her to date.

My final decision

For the reasons explained, I uphold this complaint in part. I do not uphold the complaint regarding the declined income protection claim.

However, I agree that the delay in providing Mrs V with timely updates was unreasonably frustrating for her, when she had actively chased Vitality on a number of occasions, at an already difficult time. I find that Vitality's offer to pay Mrs V £100 as compensation for the impact of its customer service is reasonable in the circumstances.

I direct Vitality Life Limited to pay Mrs V £100. I make no other award.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs V to accept or reject my decision before 14 May 2025.

Jo Storey
Ombudsman