DRN-5502215

The complaint

Mr G complains that Aviva Life & Pensions UK Limited ('*Aviva*') has unreasonably refused to reinstate the total benefit that he was previously receiving from his employer's group income protection policy.

What happened

Though the timeline is well-known, to assist both parties I will recap it summarily below.

Mr G is a member of a group income protection policy, underwritten by Aviva. The policy is designed to pay a total monthly benefit of 50% of Mr G'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. The policy also pays a proportionate benefit if Mr G is incapacitated through illness or injury to the extent that he can perform his own job role, but on a reduced part-time basis.

Mr G works in the legal sector. He sadly went off sick in January 2021, due to diagnosis of two types of cancer in December 2020 and August 2021 respectively. After the deferred period ended, Aviva began paying a claim to Mr G for total income protection benefit in July 2021. Mr G remained off work until January 2023, following which he returned on a phased basis.

In October 2022, Aviva informed Mr G that his total income protection benefit claim would cease. Mr G appealed that decision, noting that he would be going back on reduced hours, not full-time. Accordingly, Aviva confirmed that a proportionate benefit claim would begin in February 2023, after Mr G had begun working part-time hours. That benefit is still in force.

Mr G returned to work for 14 hours per week in January 2023, increasing to 17.5 hours per week from June 2023. The following month, Mr G told Aviva he was struggling with the increased hours, because the complex nature of his role meant that he was working in excess of 17.5 hours per week in order to complete all of his duties.

At Aviva's request, Mr G underwent an independent medical examination in August 2023. The Occupational Consultant concluded that Mr G could not return to work full-time, and the proportionate benefit payment would be ongoing, because he was only able to work the recommended 14 to 17.5 hours each week across three days, to ensure he had four days each week to provide appropriate rest and recovery.

In November 2023, Mr G told Aviva of all the ongoing symptoms he continued to experience resulting from the types of treatment he had undergone. He noted how his treating Oncologist had said he shouldn't exceed 12 to 14 hours per week in a report issued that month. This was because he was actually working 22 to 25 hours each week in an attempt to meet his duties – in a role where he had worked approximately 55 hours per week before falling ill.

Mr G said he felt Aviva should consider a claim for total benefit again, as he clearly could not perform the material duties of his job. Aviva disagreed. In March 2024, it issued a final

response letter to Mr G in which it confirmed it could not change the basis of his income protection benefit.

Mr G supplied further medical evidence and asked Aviva to change its stance on the decision to refuse total benefit – but it would not do so and in June 2024 it issued a further final response letter.

Mr G said he disagreed and also supplied a report from his Oncologist from September 2024 which recommended discontinuing work altogether along with confirmation from his employer of October 2024 that he had a 'contractual' 17.5-hour week, but the employer accepted that the job actually required additional hours. He explained that he felt Aviva had failed to consider the practicalities of his insured role which couldn't be completed.

Aviva was not persuaded to change its view that a claim for total benefit could not be agreed and it thereafter treated Mr G's ongoing unhappiness as an additional complaint.

In November 2024, Aviva rejected the third complaint. It said it was prepared to amend the amount of proportionate benefit (and profit share benefit) if Mr G reduced his hours to 12 or 14 per week. However, it could not agree that the total benefit claim should be paid. It explained that it could only pay total benefit under the group policy if Mr G was not working in any capacity; and the medical evidence it held demonstrated that Mr G's symptoms were not of such severity as to prevent him from working altogether. As Mr G could work in a reduced capacity, the proportionate benefit payment was appropriate.

Mr G brought his complaint to this service. He said Aviva's decision was erroneous. He noted:

- Aviva is only paying proportionate benefit because Mr G appealed the decision for it to cease paying his total benefit claim.
- He had to pursue a different claim against Aviva for medical treatment related to one of his cancer diagnoses and this was paid without argument once it was brought to the Financial Ombudsman Service.
- Aviva has failed to take out expert advice as to the extent of the hours he can work.
- By definition, his job role cannot be the same – as it has been adjusted to a part-time role.
- Working additional hours for the last 18 months had been detrimental to his health and is unsustainable – something the Oncologist has identified, yet Aviva refuses to acknowledge this.
- The Occupational Consultant reached a different threshold of 14 to 17.5 hours per week than the 12 hours per week that the Oncologist suggested; and the Oncologist recommended that the situation "*requires the opinion of a professional who understands the type and pattern of work involved*".
- Aviva has reached an unreasonable conclusion that the medical evidence shows he can work part-time.
- An external body assessing his work expressed its concern about the amount of hours he was undertaking, given this was contrary to medical advice.

Mr G explained how his health was compromised by working excessive hours, but he could not cease working – though medical advice now suggested he do so - if Aviva would not pay him total income protection benefit.

One of our investigators reviewed the complaint, but she didn't think it should succeed. She said that Aviva had reasonably concluded that Mr G wasn't eligible for total benefit under the policy, since there was no objective medical evidence to show that he was totally

incapacitated from performing his own role. She also noted how she hadn't seen evidence that Mr G was unable to perform his role on a part-time basis. Overall, she was satisfied that Aviva had acted fairly in refusing the claim.

Mr G said he disagreed. He felt that the investigator had reached her decision mistakenly and he asked that his complaint be passed to an ombudsman. He said he does not believe Aviva needs medical evidence to determine whether he meets the policy definition for total benefit. Rather, Mr G considered that the question should be put to a legal professional – as only another legal professional familiar with his role would be able to understand that it was not possible to perform his role for 12 hours per week.

Aviva explained that it could not comment on whether Mr G's return to work for the hours set out was feasible or not; it said it was simply looking at Mr G's capacity – and the evidence remained that he could work part-time and therefore the ongoing payment of the proportionate claim was correctly being paid, whether Mr G was working those hours or not.

Mr G referred back to the email from his employer's human resources department of October 2024 whereby it had been confirmed he was contracted to work 17.5 hours per week – and the job necessitated those hours despite adjustments having been made. However, his Oncologist had explained that he could not work more than 14 hours per week, with four clear days between each set of working hours. He said that those two issues taken together must show he qualifies for total benefit under the group scheme, because he cannot work the complete hours insisted upon by the employer. Mr G said that it cannot be the case that his insurance was designed to fail him in the event that he stopped working altogether.

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 was sorry to learn of Mr G's circumstances and I recognise how difficult things have been – and continue to be - for him. I also thank both parties for their patience whilst this matter has awaited an ombudsman's decision, particularly as Mr G continues to suffer with his health.

I've fully reviewed all the information before me, including the further representations Mr G has 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 intend any discourtesy by doing this, but 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.

It's also important that I make the parameters of this decision clear. I will only be considering the evidence which was available to Aviva up to the point it issued its final response to Mr G's complaint in November 2024, endorsing its decision to refuse his claim for total income protection benefit. I can see that in his most recent communication, Mr G has told our investigator that he has met his Oncologist thereafter (such as in May 2025) and he has since sent us evidence from that appointment. As explained, I cannot consider that new information here; however, if Mr G believes this is relevant regarding his ongoing claim, then he remains free to present any new medical evidence to Aviva for review.

Regulatory rules require Aviva to handle claims promptly and fairly and to not unreasonably reject a claim. My role isn't to make findings of medical fact, but rather to consider the

evidence provided by the parties alongside the terms and conditions for Mr G's group scheme to determine whether I believe Aviva treated him fairly and reasonably in refusing to amend his benefit level from a proportionate claim payment to a total claim payment.

Having done so, I agree with our investigator that this complaint should not be upheld. I recognise that this will not be the outcome Mr G has hoped for, but I'll explain my reasons for reaching this overall conclusion below.

Where an insurer terminates a claim which had been in payment, it would be for the insurer to show that the claimant no longer met the policy's definition. Contrastingly in this complaint, it is for Mr G to show that his circumstances meet the policy terms in respect of his total benefit claim – as he currently receives proportionate benefit.

The policy wording sets out:

> "*1 What benefits are covered*
> *1.1 Total benefit*
>
> *We will pay total benefit if immediately before the start of incapacity the member was actively at work and following their job role and, after the start of incapacity they are not following any other occupation, and the deferred period has finished.*
> *The benefit payable will be shown in the policy schedule.*"

Proportionate benefit is defined as:

> "*2 Proportionate benefit*
> *We will pay a proportionate benefit after the deferred period:*
> - *if before incapacity the member was actively at work and following their job role and;*
> - *if incapacity has lasted for at least five consecutive working days; and as a result of illness of injury the member is either;*
>   - *following their job role on a part-time basis; or*
>   - *following any other occupation*
>
> *in either case with a reduction in earnings.*"

And incapacity (on an own occupation basis) is defined as:

> "*The member's inability to perform on a full or part-time basis the duties of his or her job role as a result of their illness or injury*".

Mr G has explained the difficulties he is facing with completing an understandably technical and varied job role on reduced hours, and it is clear that he cannot perform the substantive duties of his part-time employment within the contracted hours arranged with the employer. I recognise that this is frustrating and detrimental to Mr G's health, and he's explained to both Aviva and his treating Oncologist that the current position can no longer be sustained.

However, I don't agree with the conclusion Mr G reached on Aviva's approach to his total benefit claim. Nor do I consider that Aviva has made an unfair decision in the circumstances.

Given the proportionate benefit claim continues to be paid, Aviva has – rightly – agreed that Mr G cannot perform the duties of his job role on a full-time basis. However, he is able to work reduced hours across three days, though the number of hours this entails is in dispute. In my view, there is clearly a discord between the amount of work required for Mr G's current reduced capacity job role versus the hours Mr G is physically able to undertake due to the

persisting symptoms caused by his cancer treatment. However, this isn't something Aviva can influence; the functions of Mr G's role are a matter between Mr G and his employer.

The right approach is for Aviva to apply the policy wording objectively against the medical evidence it has before it. And though the employer may say it is unprepared to reduce the 17.5-hour part-time contract, the policy wording doesn't look at that – it is based upon incapacity.

Mr G's treating Oncologist confirmed the position relating to Mr G's capacity in his letter of September 2024 (something Mr G agrees with) as follows:

> "*You report that despite my recommendation that you reduce your working hours to 12 to 14 hours per week, and the recommendation of the insurer's occupational therapist to work for just three consecutive days a week leaving four clear (with which I agree), the actual work which needs to be done to fulfil your role requires you to work at least 22 hours per week and sometimes more.*
>
> *As the work and your job role is client-facing, unpredictable and includes additional management responsibilities, this usually requires you working over four days a week or sometimes more to deliver these hours. This is despite the medical advice given above.*
>
> *As a consequence of this, you find yourself fatigued and stressed and unable to perform all the aspects of personal care required for someone who has been treated for an advanced cancer.*
>
> *This has led to [medical symptoms]. This is not conducive to your long-term health and if you work cannot be confined to the hours recommended as above, then I would recommend that you should consider discontinuing work altogether.*"

Both Aviva's appointed Occupational Consultant and Mr G's treating Oncologist agree that Mr G's working hours should be 12-14 per week. It follows that the medical evidence shows Mr G could work in a reduced part-time capacity (albeit less than he is currently doing) and therefore Aviva's continued decision to pay proportionate income protection under the policy – and to refuse a claim for total benefit - is reasonable in the circumstances. A claim for total benefit is based on a member being totally incapacitated, and Mr G can work on a limited hours basis across three days as set out by the medical specialists.

I can see that in its most recent final response letter to the complaint, Aviva has told Mr G that if he reduced his hours in line with the medical recommendation it will be able to adjust his proportionate benefit, and his claim would not be affected. I also find that to be fair, and I do not believe Aviva needs to do anything further to resolve the complaint.

My final decision

Despite my sympathy for Mr G's position, I cannot uphold his complaint. I am satisfied that Aviva has reasonably declined his claim for total income protection benefit.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr G to accept or reject my decision before 7 July 2025.

Jo Storey
Ombudsman