DRN-5505270

The complaint

Ms G is unhappy that Zurich Assurance Limited stopped paying the monthly benefit following a successful claim made on a group income protection insurance policy.

What happened

Ms G had the benefit of a group income protection insurance policy ('the policy'). Subject to the remaining terms, the policy can pay out a monthly benefit if Ms G is unable to work due to illness after the deferred period.

Many years ago, a successful claim was made on the policy because Zurich accepted that Ms G was incapacitated as defined by the policy terms.

The claim was reviewed in 2023 and Ms G attended an independent medical evaluation (IME) in December 2023. Thereafter Zurich arranged for a transferable skills assessment (TSA) to be carried out, which was completed in March 2024.

Zurich notified Ms G at the end of March 2024 that it would be ending the monthly benefit under the policy as it concluded that she was no longer incapacitated as defined by the policy terms.

It said it would continue paying the benefit for three months to allow her time to find another job. If Ms G did find another role, it said it would be happy to pay her an additional benefit of three months (so a maximum of six months in total). If Ms G couldn't find a suitable role within three months, Zurich said it would still pay Mrs G three monthly benefit payments and then bring the claim to an end. If Ms G didn't want to return to work, Zurich said it would pay her an equivalent of six-monthly benefits and bring the claim to an end.

Ms G appealed that decision and provided a letter from her psychotherapist dated April 2024. Zurich then said it would refer Ms G back to the occupational therapist who carried out the IME in December 2023, and when they were unavailable arranged for Ms G to attend a further IME with a consultant psychiatrist.

Whilst Zurich considered the appeal and obtained further information, it told Ms G in July 2024 that it would remove the timescales for Ms G returning to work and the monthly benefit would continue in the usual manner whilst the claim was reviewed.

Ms G attended the second IME in September 2024 and Zurich concluded in October 2024 that it would be maintaining the decision to end the claim as Ms G no longer met the policy definition of incapacity.
Due to Ms G's personal circumstances at the time, and the impact on her mental health, it issued the final response dated 8 October 2024 to Ms G's GP to go through with her. By this time, Ms G's complaint had already been brought to the Financial Ombudsman Service.

Ms G's GP didn't think it was appropriate to go through the final response letter with Ms G.

As a result, having received no communication from Zurich about the outcome of her appeal

and the further claim review, Ms G says she was shocked to discover that the monthly benefit wasn't paid at the end of October 2024 as she'd been expecting.

Zurich says this was due to it having paid six months monthly benefits in line with what it told Ms G in March 2024, when informing her that it would be ending her claim.

Our investigator didn't uphold Ms G's complaint. She concluded that Zurich had acted fairly and reasonably by relying on the medical evidence and ending the claim.

Ms G didn't agree. So, this complaint has been passed to me to consider everything afresh to decide.

……..

Firstly, I acknowledge and accept that Ms G has been through a very difficult time with her mental health and nothing in this decision should be taken to mean that I've overlooked that, or the impact Ms G's conditions have on her.

I have every empathy for her situation, and I know that Zurich's decision to end the income protection claim has financially impacted Ms G greatly. Ms G has also disclosed some sensitive information to the Financial Ombudsman Service, and I appreciate this is likely to have been very difficult for her to do.

The main focus of my decision is whether Zurich has acted fairly and reasonably by taking the decision to end the claim when it did. I'm not a medical expert, so I've considered all the medical evidence when determining this issue.

Relevant to this complaint, the policy terms define incapacity as:

> Suited
>
> The member cannot perform the material and substantial duties of their current employment, or any other occupation they could do because of their transferable skills at that time.
>
> Any occupation should provide a reasonable, though not necessarily comparable, salary and status to the current occupation.
>
> When we assess transferable skills, we'll consider training and experience…

When making a claim, it's for Ms G to establish that she met this definition of incapacity. She was able to do that, and the monthly benefit was paid by Zurich.

As Zurich ended the claim, it's for it to show on the balance of probabilities that Ms G no longer met the definition of incapacity, based on medical evidence. It's not for Ms G to show that she continued to do so.

Has Zurich acted fairly and reasonably by ending the claim?
The insurance industry regulator, the Financial Conduct Authority ('FCA'), sets out rules and guidance for insurers in the 'Insurance: Conduct of Business Sourcebook' ('ICOBS').

ICOBS says insurers should act honestly, fairly and professionally in accordance with the best interests of its customers. It also says insurers should handle insurance claims promptly and fairly - and shouldn't unreasonably reject a claim.

I know Ms G will be very disappointed but I'm intending to find that Zurich did act fairly when ending the claim when it did. I'll explain why.

When a claim is accepted, and monthly benefit paid, the policy terms say that Zurich will carry out periodic review to make sure the claim remains valid. It says that it may need to obtain more medical (and other) evidence.

That's common with income protection policies and in principle, I'm satisfied it was fair for Zurich to review the claim, and as part of that review, to ask Ms G to attend the IME in December 2023.

The IME report concluded that:

- Ms G was capable of returning to the workplace, although not in a similar role to the one she'd been doing previously, which appears to be unsuited for her.

- To achieve this vocational guidance and rehabilitation would be the appropriate route rather than medical treatment.

- For the time being public-facing roles would be unsuited but working in a small team, perhaps in a horticultural environment or caring for animals, would be better suited.

- Ms G had demonstrated her ability to commit to "endeavours where individuals rely on her. Her recognition of this and transference of this acceptance of responsibility to a supportive workplace is the barrier to overcome. If a role which Ms G enjoys can be identified, there is no particular reason as to why she would not be able to return to full-time work".

In light of the conclusions of the IME report, I'm satisfied that Zurich acted fairly by arranging a TSA to identify the potential of her training, skills and education in relation to suited return to work options. The report reflects that the assessor had been provided with Ms G's relevant medical and employment history and IME report.

The TSA report identified three suited roles for Ms G. Having considered the contents of the report and the roles identified, I'm satisfied that Zurich has reasonably relied on the TSA and IME report to conclude at the end of March 2024 that Ms G was no longer incapacitated as defined by the policy.

The roles identified weren't primarily public facing, the suggested salaries were reasonable and although more manual than her previous role (which was sedentary in nature), they were reasonably comparable in terms of status. Further, based on Ms G's experience and hobbies, I'm satisfied that Zurich has fairly relied on the TSA report to conclude that Ms G had the transferable skills to do at least one of the roles.

Once Zurich took the decision to end the claim, given the amount of time that Ms G hadn't worked for and the IME's observation that she have become "occupationally deconditioned", I'm satisfied Zurich's decision to continue paying the monthly benefit for up to six months to allow Ms G to find (and start a new role) was fair and reasonable.

I'm also satisfied that having considered Ms G's appeal against the decision to end her claim (with notice), Zurich fairly requested any further medical evidence from Ms G supportive of her remaining incapacitated. And that it thereafter considered the letter provided by her psychologist.

As a result of the appeal, I'm also satisfied Zurich fairly carried out a review of the decision to end the claim, which included asking Ms G to attend a second IME in September 2024. The independent consultant psychiatrist who met with Ms G for the second IME had considered the medical history and concluded:

- The barriers returning to work are expressed as perceptions around coping and Ms G feeling as if she is being forced to do something she doesn't want to do.

- Ms G was able to work but given the significant time Ms G had been out of the workforce, it's understandable that there may be a difference in her response to adapting to a return-to-work process. It would therefore be reasonable for any return to work to be phased over eight weeks, if available.

I've taken into account the letter from Ms G's psychologist prepared in support of her appeal dated April 2024 and the conclusion that Ms G was not fit to work in any capacity. However, the letter doesn't provide any insight as to why Ms wasn't able to work in a suited occupation or comment on the roles that had been identified by the TSA as being suited occupations and why the psychologist didn't think this was the case.

I'm satisfied that Zurich acted fairly and reasonably by relying on the second IME report along with the first, by not upholding Ms G's appeal against the decision to end the claim on the basis that Ms G no longer met the policy definition of being incapacitated. The reports set out in detail why, in their opinion, Ms G could return to work, and on what basis.

Although it's relevant that Ms G had been accessing regular therapy, had been prescribed medication to help with her symptoms and had been signed off work by her GP, I don't think those things mean that she wasn't able to carry out a suited occupation. I also note an entry in Ms G's GP records from July 2024 (whilst Ms G's appeal was being considered) which says: "I could not support patient to be off work long term as for most people benefit with employment".

Notifying Ms G that the decision to end the claim stands

I'm satisfied that Zurich notified Ms G in July 2024 that whilst the investigation into her appeal was ongoing it had "taken the decision to remove the previously advised time scale i.e. the 3 months [from] 1 April 2024 and then a further 3 months if you were able to obtain a suitable role or did not wish to return to work. Therefore, monthly benefit will continue in the usual manner whilst I continue with my review of your claim and complaint".

As explained above, I'm persuaded Zurich had fairly concluded in March 2024 (based on the evidence available then) that Ms G no longer met the policy definition of being incapacitated. And that decision was maintained having considered the further medical evidence obtained as part of the appeal. I'm therefore satisfied that Zurich's decision to end the claim in October 2024 was still fair and reasonable.

I'm satisfied that Zurich notified Ms G in March 2024 that it would only continue to pay the monthly for six months maximum. And as the decision to end the claim was maintained at that six-month period, and notwithstanding what Ms G was told in July 2024 about the monthly benefit continuing whilst the review was ongoing, I'm satisfied that it wouldn't be fair and reasonable for Zurich to pay the monthly benefits for another six months after October 2024. Given the July 2024 communication, I'm satisfied that had the review not concluded within that six-month period, the monthly benefit would've probably continued until it had been concluded. However, that didn't end up being the case.

However, I'm currently intending to find that Zurich didn't do enough to communicate the

outcome of the review into the decision to end the claim to Ms G.

The final response letter set out Zurich's decision to maintain ending the claim and that the benefit would cease as it had been paid for six months. However, this wasn't sent directly to Ms G but to her GP to go through with her. And although Zurich told Ms G on 8 October 2024 that a letter had been sent to her GP and she should contact them to make a arrangements to discuss, she wasn't given any substantive information about the outcome.

I can understand that Zurich has protocols in place, and I can see why this option was considered given the consultant psychiatrist said in their IME report that the content of that report should only be made available after her treating clinician has had the opportunity to review the contents and recommendations. So, I think Zurich took the same view that the final response letter should be sent to a medical professional who knew Ms G to go through with her.

Although well-intentioned, I've seen nothing to support that Zurich had spoken to the GP surgery to see whether it was willing to go through the contents of the final response with Ms G and from what I've seen I'm persuaded that Ms G's GP was surprised to receive this without explanation beforehand. It ultimately said it wasn't their role to do so.

I'm satisfied that Zurich should've reasonably considered other ways of communicating the outcome to Ms G in a supportive way, including involving her in that process.

As a result of not doing so, the monthly benefit ended without Ms G being aware that it would be or that this was because the decision had been taken to maintain the original decision to end the claim.

I can see that Ms G was, understandably, very upset and confused by this. And it was left to our investigator to forward the final response letter to Ms G, after agreeing with Ms G in advance how best to do this.

As a result of Zurich's oversight to ensure that Ms G was aware of the outcome to her appeal before stopping the monthly benefit – despite assurances that Ms G received in July 2024 that the monthly benefit would continue until the investigation had concluded – I'm satisfied that Ms G experienced significant distress and inconvenience at a time when she was situationally vulnerable and already very worried about the monthly benefit ending. She was then left without receiving the monthly benefit when she (reasonably I think) was still expecting to receive it (having not heard anything more Zurich at that time).

Although it was fair for Zurich to end the benefit, I think the way in which it went about communicating this to Ms G should've handled better.

I'm intending to direct Zurich to pay Ms G £750 compensation to reflect the impact on her.

……..

I invited both parties to provide any further information in response to my provisional decision.
Ms G replied reiterating that once Zurich reached its decision to end the claim in October 2024, it was at that point necessary for it to provide the support initially offered in its earlier email dated March 2024, to pay six month's further benefit. In support she relies on its email dated July 2024.

Zurich also replied, disagreeing with my provisional decision. It said it acted in line with the guidance on the disclosure of health data when forwarding the final response letter to Ms G's

GP surgery and explained why it felt it was appropriate to do so. Zurich also says that it let Ms G know a letter had been sent to her GP and from what it can see, Ms G didn't contact the GP surgery to discuss. It asked me to reconsider the intended direction for Zurich to pay £750 compensation for distress and inconvenience.

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.

That includes the points raised by both parties in response to my provisional decision. Having done so, I find no compelling reason to depart from my provisional findings as these points had been raised previously by the parties and I'd considered them.

In additional to the findings in my provisional decision, in the particular circumstances of this case, I don't think it was reasonable for Zurich to rely on the serious harm exemption it refers to in respect of the final response letter dated October 2024. I'm satisfied that it could've reasonably sought to communicate the outcome directly to Ms G in a way that didn't quote from the second IME report to inform her that Zurich would be maintaining its position to end the claim and to confirm when the benefit under the policy would cease. This would've prevented the significant distress and inconvenience caused to Ms G by not receiving the money she'd been expecting from Zurich at the end of October 2024 (having not received the outcome to its further investigation).

Further, even if Ms G had contacted her GP at the time, as directed to do so by Zurich, from what I've seen and on the balance of probabilities, I'm not persuaded the GP surgery would've made her aware of the contents.

I can understand why Ms G says that, relying on Zurich's email dated the end of July 2024, she feels that Zurich should pay an additional six moths benefit when it decided to maintain its position to end the claim in October 2024. As that's when it had concluded its investigation.

However, I remain satisfied that Zurich had fairly concluded in March 2024 (based on the evidence available then) that Ms G no longer met the policy definition of being incapacitated. And that decision was maintained having considered the further medical evidence obtained as part of the appeal. I'm therefore satisfied that Zurich's decision to end the claim in October 2024 was still fair and reasonable – and the IME report only supported its earlier decision to end the claim, as Ms G no longer met the definition of incapacity.

I'm satisfied that Zurich notified Ms G in March 2024 that it would only continue to pay the monthly for six months maximum. The decision to end the claim was maintained at that six-month period. And notwithstanding what Ms G was told in July 2024 about the monthly benefit continuing whilst the review was ongoing, I'm satisfied that it wouldn't be fair and reasonable for Zurich to pay the monthly benefits for another six months after October 2024.

The July 2024 email said: "the monthly benefit will continue in the usual manner whilst I continue with my review of your claim and complaint". So, had the review not concluded within that six-month period, the monthly benefit would've probably continued until it had been concluded. However, that didn't end up being the case.

For these reasons and for reasons set out in my provisional decision (an extract of which is set out above and forms part of this final decision), I partly uphold this complaint.

My final decision

I uphold Ms G's complaint but only to the extent set out above and direct Zurich Assurance Limited to put things right by paying her £750 compensation for distress and inconvenience.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms G to accept or reject my decision before 26 May 2025.

David Curtis-Johnson
Ombudsman