DRN-5530890

The complaint

Mr E is unhappy that Assicurazioni Generali S.p.A (Generali) declined his income protection claim.

What happened

Mr E is covered under his employer's group income protection policy. The aim of the policy is to pay a monthly benefit in the event the insured becomes unable to work due to injury or illness. The policy has a deferred period of 13 weeks.

Mr E was first absent from work on 16 October 2023 due a major depressive episode. He returned to work in June 2024. In summary, Mr E experienced depression, exhaustion and sleep disorder. He was prescribed medication, and he found everyday tasks difficult.

He submitted a claim in January 2024 which was declined by Generali. Mr E appealed this, but Generali maintained its position to decline the claim. Generali said there was a lack of medical evidence to support that Mr E was incapable of performing his insured occupation. When Mr E appealed, an independent psychiatrist assessment was carried out which reported that Mr E's absence from work was caused by his workplace environment rather than a medical condition.

Mr E brought his complaint to this service. Our investigator initially upheld the complaint and following further evidence didn't uphold the complaint. He didn't think the medical evidence met the definition of incapacity as required within Generali's policy terms and conditions.

Mr E disagreed and asked for the complaint to be referred to an ombudsman. So, it's 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.

At the outset, I wanted to acknowledge that the whole situation has been difficult for Mr E. Whilst I appreciate that he's experienced symptoms related to his mental health, my role is to reach an independent and impartial outcome that's fair and reasonable, based on the information available to me.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. So, I've considered, amongst other things, the terms of this income protection policy and the circumstances of Mr E's claim, to determine whether I think Generali treated him fairly.

It's important to point out that we're an informal dispute resolution service, set up as a free alternative to the courts for consumers. In deciding this complaint I've focused on what I consider to be the heart of the matter rather than commenting on every issue or point made in turn. This isn't intended as a discourtesy to Mr E. Rather it reflects the informal nature of

our service, its remit and my role in it.

Incapacity is defined in the policy terms and conditions as:

> '*As a result of illness or injury, the Member is incapable of performing the Material and Substantial duties of their occupation, and they are not carrying out any other Work or occupation.'*

For the claim to be successful, Mr E has to show his claim is valid under the terms and conditions of the policy. In other words, he must demonstrate that he cannot perform the material and substantial duties of his insured occupation due to injury or illness. The policy states Mr E's deferred period is 13 weeks. So, the medical evidence needs to show that Mr E couldn't carry out those duties from 16 October 2023 to 15 January 2024 and beyond.

For the avoidance of doubt, I'm not a medical expert. So, it's not for me to reach any determinations about Mr E's medical diagnosis or to substitute expert medical opinion with my own. Instead, I've weighed up the available medical evidence to decide whether I think Generali acted fairly and reasonably in declining Mr E's claim.

I've been provided with medical evidence relating to Mr E's condition and symptoms for consideration.

Mr E didn't have a UK GP, but he was seeing a consultant psychiatrist in the country he was living in. The psychiatrist provided sick notes from 16 October 2023 to 31 March 2024. The reason given in the sick notes for the absence was '*maladie*', which translated is disease or illness.

A specialist report was provided by a consultant psychiatrist dated 4 March 2024. This stated that Mr E had a major depressive episode with burnout. Symptoms were described in the report as depression, sleep problems, feeling sad, exhaustion, low energy, unable to focus on simple tasks and a notable loss of weight. The report also stated professional burnout was present which resulted from overwork and excessive pressure. Sick leave was recommended to concentrate on his recovery.

After Mr E appealed, a further report was provided by the same consultant dated 26 May 2024. This stated similar symptoms as the previous one and concluded that Mr E presents all the characteristics of major depressive episode, as described in the diagnostic and statistical manual of mental disorders. Additionally, presence of professional burnout, resulting from an overload of work was reported, which worsened the symptoms.

I've considered the letter from Mr E's GP (not from the UK) dated 6 May 2024. This reported the main diagnosis of a major depressive episode with burnout and stated similar symptoms as the previous reports. The treatment plan included cognitive behavioural therapy (CBT) and medication. Factors identified included excessive stress at work.

An independent psychiatric assessment was carried out by Generali which took place on 10 July 2024. This reported Mr E's medication dosage was average and was being tapered down. At this point, Mr E had returned to work with an amended role with less travel. Mr E had reported that his workload was the biggest factor in his absence. The report concluded that Mr E had a depressive episode in 2023 triggered by personal and workplace stress, he was entering remission, and his daily functioning was improving, and he was being effectively treated. While he wasn't feeling 100%, Mr E was fit to return to work on a full-time basis.

I've also taken into account the further letters from Mr E's consultant psychiatrist and his GP

dated 15 January 2025 and 16 January 2025 respectively. They both re-affirm what they said in their previous communication.

The test I have to consider here is whether Mr E meets the definition of incapacity as per the terms of the policy. Having reviewed everything, I don't think it's likely he does. Whilst I appreciate the evidence Mr E has provided, this isn't sufficient in the light of the requirement of the policy. The evidence doesn't show Mr E was incapable of carrying out the material and substantial duties of his insured occupation – in other words, Mr E's functional capability isn't evidenced. Whilst there's no doubt there was, and now to a lesser degree, continues to be a mental health condition, there's no suggestion that its severity would have made Mr E incapable of working. The sicknotes and seeing a psychiatrist at the time Mr E was off work don't sufficiently explain that the definition of incapacity as per the policy terms and conditions have been met. The symptoms Mr E presented were predominantly self-reported. It's also evident in the reports that the trigger factors were work-related and therefore points to his symptoms caused by performing his own occupation. I'm not persuaded, or been provided sufficient evidence, that Mr E was incapable of performing his insured role.

I agree the independent report said there was a presence of a mental health condition. But I don't agree that it said the illness couldn't be solely attributed to work-related factors. On the contrary, the report showed that the absence wasn't triggered by a mental health condition rather by work-related factors as well as some personal related matters. The report is objective and independent and all of Mr E's medical evidence was reviewed alongside the assessment of his functional capability. I realise by this point, Mr E had just returned to work, but based on all the available evidence, it doesn't sufficiently persuade me that Mr E met the definition of incapacity.

Overall, I've taken everything into account, and I'm not persuaded the medical evidence demonstrates that Mr E met the definition of incapacity as per the terms and conditions of the policy. I'm sorry to disappoint Mr E, but I don't find there are any reasonable grounds upon which I could direct Generali to pay Mr E's claim. It follows therefore that I don't require Generali to do anything further.

My final decision

For the reasons given above, my final decision is that I don't uphold Mr E's complaint about Assicurazioni Generali S.p.A.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr E to accept or reject my decision before 12 June 2025.

Nimisha Radia
Ombudsman