DRN-5562696

The complaint

Ms C is unhappy that Liverpool Victoria Financial Services Limited (LV) declined her income protection claim. She's also unhappy with the service LV has provided in handling her claim.

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 key events.

Ms C has an executive income protection policy with LV. The policy started in October 2022 and LV is the underwriter. The policy is designed for small businesses to cover the cost of providing a benefit in certain circumstances to the insured person if they suffer an illness or injury and are unable to work. The policy had a deferred period of three months, and the insured person has to show they are unable to work continuously through the chosen deferred period and beyond.

Ms C is a director of her own company, and her role is mainly administration. On 26 September 2023, Ms C was signed off from work. Her symptoms were noted as being complications caused by menopause - depression, anxiety, insomnia and joint pain. Based on her deferred period, her claim would start from 27 December 2023 if it was considered valid and accepted.

In February 2024, she submitted a claim to LV. It declined the claim as the medical evidence didn't show Ms C had met the policy definition. LV also said the medical evidence showed Ms C had experienced joint pains before the cover started in October 2022. Ms C sent in further information which was reviewed and assessed. LV maintained its decision to decline the claim.

Unhappy, Ms C brought her complaint to this service. Our investigator didn't uphold it. She didn't think it was unreasonable to decline the claim based on the available medical evidence. And she didn't think LV's handling of Ms C's complaint was unreasonable either.

Ms C 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 very difficult for Ms C. Whilst I understand that she has been unwell, my role is to reach an independent and impartial outcome that's fair and reasonable, based on the information available to me. I don't doubt that Ms C has been impacted by her symptoms, but this doesn't automatically mean that LV must pay her claim.

I also fully appreciate Ms C's strength of feeling on the matter and I want to reassure her that I've seen and considered the detailed submissions she has provided about her complaint. But it is 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 Ms C. Rather it reflects the informal nature of our service, its remit, and my role in it.

I understand LV declined the claim due to Ms C not sufficiently evidencing that she was unable to work as per the policy definition - and not because of the joint pains Ms C had before the policy started. LV commented on the joint pains Ms C had before the policy started and informed her about placing an exclusion. In October 2024, her consultant confirmed her symptoms had not started earlier than October 2022. LV accepted this and therefore only looked at the issue of assessing the claim based on the medical evidence provided by Ms C. I therefore won't be commenting further on the joint pain issue.

I can only look at the complaint on the basis of the information LV had available to it at the time it made the decision to decline the claim. It would be unfair for me to say that LV behaved unreasonably on the basis of evidence it hadn't seen and couldn't have seen at the time that decision was made.

If Ms C feels she has additional evidence that might cause LV to change its mind, it's open to her to send this to LV. If she does so, LV should review this evidence and decide whether this causes it to reconsider their position.

In practice, I note that LV confirmed its decision to maintain the decline on 17 December 2024. This means, I'm not going to consider any evidence after that date.

The policy terms and conditions

I've started by looking at the policy terms and conditions as this forms the basis of the insurance contract.

Page 3 of the policy document defines '*Unable to work, inability to work, able to work, ability to work'* as:

> *'Unable to work, inability to work, able to work, ability to work – the way we measure these under this policy, depends on the person insured being unable to carry out the main tasks of their occupation, due to illness or injury, and they aren't doing any other type of work whether this is paid or voluntary (unpaid) work. The main tasks are the parts of the job the person insured carries out, which can't reasonably be left out, or changed. This policy doesn't cover being unable to work for any other reason (for example unemployment, bereavement, a normal pregnancy, or because of restricted access to work as a result of a lockdown, quarantine or periods of mandatory or precautionary isolation).'*

For a claim to be accepted, the test here is whether Ms C meets this definition under her policy.

Has the claim been fairly declined?

The insurance industry regulator, the Financial Conduct Authority ('FCA'), has set out rules and guidance for insurers in the 'Insurance: Conduct of Business Sourcebook' ('ICOBS'). ICOBS says that insurers should act honestly, fairly and professionally in accordance with the best interests of their customers, and that they should handle claims promptly and fairly.

It's for Ms C to demonstrate to LV that she has a valid claim. It's not for LV to show that she doesn't. LV's role is to review the information Ms C has provided in order to decide whether it meets the criteria of its policy terms or not. That's standard industry practice and so I don't think LV is treating Mr E unfairly by taking this approach.

LV says the claim has been declined. It didn't think Ms C was incapacitated to the extent that she couldn't fully carry out her role with some adjustments. And the medical evidence didn't support any active medical treatment or management of the condition.

For the avoidance of doubt, I'm not medically qualified and it therefore wouldn't be appropriate for me to make a finding on the conditions referred to here. Instead, the key issue for me to decide is whether I think LV's decision to decline Ms C's claim was unfair or unreasonable based on the information which has been provided.

I've considered the relevant medical evidence provided:

- GP fit notes – the reasons noted for the absences were depression and perimenopause.
- GP medical records:
    - On 7 December 2023, Ms C was referred to a rheumatologist for her inflammation and pain in her hands, ankles and elbows. The GP said Ms C's bloods were normal, there was no significant joint swelling and no clinical evidence of active inflammation.
    - Antidepressant medication prescribed in January, February and March 2025. and Hormone Replacement Therapy (HRT) medication was prescribed to Ms C by her GP.
    - Ms C had counselling in February 2025 - Ms C had personal family issues and trauma. Ms C reported feeling low in mood and difficulties with early menopause and suspected ADHD from July 2024.
- Letter from Consultant Rheumatologist dated 22 January 2024 – Ms C reported severe pain on hands and feet which lasted two to three weeks. She was on HRT and things were significantly better. Her bloods were satisfactory, and this happened with a background of being perimenopausal but there were no concerns at the time.

The medical evidence relating to this complaint confirms Ms C had perimenopausal symptoms. There were no concerns noted following a consultation with the rheumatologist and the GP notes Ms C's bloods were normal. There's also no clinical evidence of active inflammation. LV declined the claim based on this medical evidence. No further referrals, or active management of the symptoms were recommended and there's no indication of Ms C's functional capability to carry out the main tasks of her role. Whilst medical evidence after December 2024 shows Ms C was referred for counselling and was given medication for the low mood, I can't consider this, as stated above.

Ms C raised a number of points in response to our investigator's findings. And based on what I can consider which relates to the medical evidence above, there is insufficient evidence that Ms was unable to carry out her role – I don't doubt that she had symptoms which affected her working but it's not enough to say that they prevented her fully from working. Therefore, I think her claim has been declined fairly. I don't agree LV's rationale rested on speculative assumptions, but it's based on the evidence she provided. The test isn't whether Ms C could carry out her own role to a professional standard but to a standard that allowed for the symptoms she suffered.

I've reviewed everything and I'm satisfied that LV did take into account the medical evidence Ms C provided. I'm also satisfied that LV didn't decline Ms C's claim unfairly or outside the terms and conditions of her policy. Based on what's available, I don't think the evidence supports Ms C was unable to fully carry out the tasks of her sedentary role.

How did LV handle the claim?

Ms C said, from the beginning, there's been a lack of transparency with the claims process. And she's experienced poor communication, delays and there's been a lack of meaningful support. She says this has caused significant harm to her financial situation and her well-being.

I've reviewed what happened. I don't agree there was poor communication – the claims process started in February 2024 and Ms C was kept updated. I also don't think avoidable delays were caused in providing a claims decision - it's not unusual that some delays will be caused when information is requested through third parties such as GP surgeries. Whilst Ms C provided further information regarding her joint pain because LV informed her an exclusion would be placed on the policy; this needed a further review. And I can see that LV decided not to place the exclusion. Based on the medical evidence, I don't think LV's actions to place the initial exclusion was unfair as the GP notes did suggest joint pain was discussed prior to taking out the policy.

It's not up to LV to inform Ms C what further information was necessary to assess her claim. As I've said above, it's up to Ms C to provide her information and for LV to review this in line with the policy terms and conditions. Whilst I appreciate that Ms C has been going through a difficult time with her financial situation and her health, this doesn't necessarily mean that LV has acted unfairly. And whilst Ms C thinks the evidence she has provided has been disregarded by LV, I don't agree. LV has taken into account Ms C's medical evidence and just because she doesn't agree with LV's decision to decline, this also doesn't mean that the evidence has been disregarded. I've reviewed everything and I'm satisfied that LV did take into account the medical evidence Ms C provided. I'm not persuaded that LV's handling of Ms C's complaint was unreasonable.

Ms C says she was discriminated against due to her vulnerabilities and has referred to the Equality Act 2010. I understand why she might have felt this, but having looked at the evidence presented to me, I don't think LV has done anything wrong. Nor do I think LV has acted unfairly or unreasonably.

What I've decided

Overall, I'm sorry to disappoint Ms C. In the circumstances of this complaint, I don't think LV unfairly declined Ms C's claim or it did so outside the terms and conditions of her policy. I also don't think the claim was handled unfairly, taking everything into account. It follows that I don't require LV to do anything further.

My final decision

My final decision is that I don't uphold Ms C's complaint about Liverpool Victoria Financial Services Limited

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms C to accept or reject my decision before 8 July 2025.

Nimisha Radia

Ombudsman