

The complaint

Ms B is unhappy that Legal and General Assurance Society Limited (L&G) stopped the benefit payments under her income protection policy.

Ms B is being represented on this complaint.

What happened

Ms B has a group income protection policy with her employer. The policy provides a benefit in certain circumstances after a deferred period of 26 weeks, on an own occupation basis. L&G is the underwriter.

Ms B was first absent from work on 9 May 2023 having initially tested positive for Covid-19. She reported physical, mental and emotional fatigue and was diagnosed as having long Covid. Her symptoms included breathlessness, fatigue, brain fog, muscle aches, headaches and anxiety. In June 2023, she was referred to the long Covid clinic and was put on a physiotherapy programme for breathlessness and started fatigue management sessions with an Occupational Therapist (OT).

Ms B submitted a claim on the policy. L&G accepted Ms B's claim and following the deferred period, payments started from 14 December 2023.

Assessments were carried out by a Vocational Clinical Specialist (VCS) in January 2024, February 2024 and March 2024. From February 2024, the VCS reported that Ms B was fit to return to work in her insured role. In April 2024, Ms B's medical evidence was reviewed by L&G, and the benefits payments were terminated.

Unhappy, Ms B made a complaint to L&G. It issued a final response and maintained its position to terminate the claim. Ms B's claim was reviewed, and her medical information was passed to L&G's Chief Medical Officer (CMO). He said there was insufficient evidence of illness or injury of sufficient severity to support total and ongoing incapacity relative to the demands of her own occupation. L&G maintained its position again to terminate the claim.

Ms B brought the complaint to this service. Ms B said the primary reason she's brought the complaint to this service was that she disagrees with how the VCS reported that she was fit for work, when she wasn't. Our investigator didn't uphold the complaint. She didn't think L&G had acted unfairly in terminating the claim.

Ms B disagreed with the investigator's findings and asked for the complaint to be referred to this service. 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.

Having done so, whilst I'm very sorry to disappoint Ms B, and I know how upsetting my

findings will be to her, I don't think it was unfair for L&G to stop her income protection benefits payments. I'll explain why.

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 B is unwell, but this doesn't automatically mean that L&G must continue to pay her claim.

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 Ms B's claim, to decide whether I think L&G treated her 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 Ms B. Rather it reflects the informal nature of our service, its remit and my role in it.

I've first considered the terms and conditions of this policy, as it forms the basis of the contract between Ms B's employer and L&G.

Under the terms of the group income protection policy, it states on page 9:

'We will immediately end payment of benefit if:

i. The insured member ceases to be a disabled member..'

A disabled member is defined as *'an insured member who at any time, meets the definition of incapacity.'*

The definition of incapacity under own occupation means:

'the insured member is incapacitated by illness or injury that prevents him from performing the essential duties of his occupation immediately before the start of the deferred period.'

In a situation like this, where an insurer has accepted a claim and subsequently terminates that claim, it's for the insurer to show that the claimant no longer meets the definition of incapacity.

For the avoidance of doubt, I'm not medically qualified so it's not for me to reach any determinations about Ms B'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 L&G acted fairly and reasonably in terminating Ms B's claim.

I've been provided with medical evidence relating to Ms B's diagnosis and symptoms. It's not in dispute that Ms B met the policy definition of incapacity until the claim was terminated or that Ms B was diagnosed with long Covid. L&G paid the claim during the time. The issue for me to determine is whether I think the medical evidence supports L&G's decision that Ms B no longer meets the policy definition of incapacity.

The first VCS report in January 2024 stated that Ms B was unfit to return to work and was being supported by the long Covid team with physiotherapy and the OT. The VCS report dated 27 February 2024 states Ms B's breathing had improved and no further appointments were booked with the physiotherapist. She was still meeting with the OT and whilst brain fog

and fatigue were being managed, a return to work in April 2024 was agreed with Ms B and her manager, on a phased basis. Ms B reported her typical day as showing good function.

In the March 2024 VCS assessment, Ms B showed good daily function, good focus and concentration during the call. Ms B had a setback to her health as her mother was unwell, but she was able to continue to support her. So, the report concluded that Ms B was fit to return to work on a phased basis although her OT said she wasn't fit to return to work. Ms B also said her work hadn't been able to offer adjustments to enable her to return to work.

Ms B's benefit payment was until 30 April 2024.

Further evidence was reviewed by L&G, but it maintained its decision to stop the payments. I've considered this. The GP letter dated 19 September 2024 says that they cannot comment on the expected level of functional impairment as long Covid is a relatively new phenomenon, and they couldn't comment on whether Ms B will be medically fit to return to work. The letter is shown to be inconclusive. And whilst Ms B was successful in claiming for Employment and Support Allowance (ESA), the criteria used for this is different to that used against the income protection policy. Whilst the evidence shows Ms B is being supported by the OT and by a physiotherapist, overall, this isn't sufficient. There's no evidence of Ms B's functional capacity.

I'm also mindful that the OT's letter of April 2024 provides a picture of Ms B's symptoms affecting her fitness to return to work. This was as a follow up from the VCS call in March 2024. I accept that Ms B's symptoms potentially might have shown a setback, but I'm not persuaded this was sufficient evidence as Ms B was overall showing an improvement to the level that she said, in March 2024, that a return to work was planned. And reasonable adjustments were recommended with a phased return. There's no evidence to suggest total incapacity which would mean that Ms B couldn't consider a phased return. And I'd add that simply being unfit for work and in receipt of ESA doesn't mean a policyholder will necessarily meet the terms of an income protection policy.

L&G's CMO reviewed all of the medical evidence. He concluded there was insufficient evidence to support Ms B's total incapacity to carry out the essential duties of her own role. I can see that Ms B's medical evidence was provided to the CMO for review. I would expect that the CMO had sight of Ms B's information in reaching a clinical opinion. In this case, he did have all the information so I can't say L&G acted inappropriately.

Having taken into account the detail and specific conclusions contained within the VCS as well as L&G's assessment of the claim, I'm satisfied that, on balance, the evidence shows it's more likely than not that Ms B no longer met the policy definition of incapacity when L&G terminated her claim in April 2024.

The test here is whether Ms B continues to meet this definition as per the terms and conditions of the policy. And having reviewed everything, I don't think it's likely she does. There isn't sufficient evidence to say that Ms B was incapable to carry out the essential duties of her own occupation. I appreciate Ms B has provided further information from her OT. But this doesn't form part of this complaint as it only relates up to the point until the claim was terminated and the final response provided by L&G. I note that this has been referred to L&G separately.

I have every sympathy for Ms B and that she's experiencing a difficult time with her ongoing symptoms. And I'm sorry to disappoint her but this doesn't automatically mean that L&G must pay her claim.

Overall, despite my natural sympathy with Ms B's position, I don't think the claim has been

terminated unfairly in the circumstances. I therefore don't find that there are any reasonable grounds upon which I could direct L&G to reinstate Ms B's claim. It follows that I don't require L&G to do anything further.

My final decision

For the reasons given above, I don't uphold Ms B's complaint about Legal and General Assurance Society Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms B to accept or reject my decision before 9 September 2025.

Nimisha Radia
Ombudsman