DRN-5580704

The complaint

Mrs M complains that Legal and General Assurance Society Limited ('*L&G*') has unreasonably refused a claim she made under a group income protection policy. To resolve the matter, she wants L&G to apologise and pay the claim.

What happened

The background to this complaint is well known to the parties, so I won't repeat it in detail here.

Mrs M is a member of her employer's group income protection policy. Benefit of 60% of Mrs M's salary is provided under the policy in the event that she is incapacitated due to illness or injury, for the duration of a 26-week deferred period and beyond.

In July 2024, Mrs M submitted an income protection claim to L&G. She had become absent from work since 5 February 2024, due to a number of interlinked health concerns of a physical nature, along with stress and anxiety.

In February 2025, L&G declined the claim. It said that many of Mrs M's chronic conditions appeared well-managed; it also noted that her absence may be impacted by non-medical factors, such as issues with working relations. It said its chief medical officer ('*CMO*') took the view that with adjustments and ongoing treatment for both her physical and mental health symptoms, Mrs M should be able to work in some capacity.

L&G also issued a second complaint outcome the same month addressing issues Mrs M had raised about its customer service, including the time taken to decide her claim. L&G rejected the complaint. It said it felt it had behaved fairly and reasonably and had updated Mrs M's employer throughout. L&G did agree that one delay in December 2024 had occurred due to awaiting a referral to its CMO which took longer than it ought to; and it apologised for that.

Mrs M appealed the claim decision, submitting evidence including her recent fibromyalgia diagnosis through a rheumatology referral, information about her physical limitations from her physiotherapist, confirmation of receipt of disability benefits and a letter from her psychologist.

However, L&G wouldn't change its view that the claim shouldn't succeed nor that the complaint about the claim should be upheld. It maintained that there wasn't persuasive evidence of illness or injury of sufficient severity to support incapacity relative to the demands of Mrs M's own role at any employer throughout the deferred period and beyond.

L&G also referred to a policy clause which set out how it would not pay benefit if there were "*other non-medical reasons preventing the member returning to the essential duties of their occupation. For example, a non-medical reason might be a lifestyle choice, or a breakdown in the relationship between the member and their employer*". And the rheumatologist had referenced Mrs M suffering with stress due to matters in her personal life as well as previously with her employer.

Mrs M brought her complaint to this service, noting she had a secondary benefit paid in respect of her care and a referral for body-reprogramming specific to her condition, that had been recommended by the rheumatologist. She explained it had taken some 12 months to finally establish her diagnosis. However, the personal problems she has suffered from commenced after her diagnosis, not before.

Our investigator did not think the complaint should be upheld. She said that she was in no doubt Mrs M suffered from many chronic medical issues along with undergoing a very challenging time in her personal and professional life. However, she didn't find it was unreasonable for L&G to say that Mrs M's circumstances didn't meet the policy definition of incapacity.

Mrs M disagreed. She said she wanted her complaint to be passed to an ombudsman.

Mrs M made extensive written submissions, all of which I have read in their entirety though I shan't repeat them here. She said, in summary:

- She now has new physiotherapist and psychologist evidence, along with additional incapacity documentation.
- She feels L&G hasn't complied with the fair treatment of customers or regulatory standards, as required by the Financial Conduct Authority ('*FCA*').
- Various legal cases determine that fibromyalgia is a recognised disability.
- L&G has failed to identify the early-stage manifestations of fibromyalgia – which wasn't diagnosed until February 2025.
- Her pain medication has gradually increased since she has been off sick.
- She has also undergone physiotherapy since June 2024 and cognitive behavioural therapy since February 2024.
- She has been continuously signed off work by her GP from February 2024 up to July 2025.
- Her job demands sustained focus, analytical thinking, interpersonal sensitivity, and physical stamina — all of which are adversely affected by the fluctuating symptoms of fibromyalgia, including fatigue, pain, cognitive impairment and mobility limitations which occur as flare ups.
- The nature of fibromyalgia renders it extremely difficult to meet the consistent and high-functioning demands of her employment.
- In the call with the L&G assessor, she was clear that pain prevented her return to work, not work stress.
- It is not lack of motivation or willing that prevents her from going back to work, it is physical ill health.
- Both the original decline letter and the subsequent appeal outcome from L&G set out that her continued absence from work was due to non-medical or personal reasons, including suggestions of a breakdown with her employer. These assertions were baseless and highly distressing.
- She had claimed under the policy previously in 2020, for unrelated diagnoses relating to blood conditions. At that time, she had returned to work after many months off with medical supervision. This demonstrates her commitment to working and to her employer.
- This claim – which relates to fibromyalgia – is distinct and should be assessed as such.
- She feels that this service must agree that her condition ought to be covered by the incapacity wording based on the evidence she has supplied, as well as finding consequentially that L&G has followed a fundamentally flawed claim process.

As no agreement has been reached the case has been passed to me to determine.

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 hear how difficult things have been- and continue to be - for Mrs M due to her ongoing health concerns. I also appreciate that Mrs M has taken considerable time and detail in setting out her written submissions both to L&G and to this service; she discussed the full impact of her various diagnoses, and I thank her for her efforts in producing these.

However, I will not be setting out my decision in the same format that Mrs M has used. That is because this service's role is to investigate disputes and resolve complaints informally, including taking into account relevant laws, regulations and industry guidance, such as the regulatory requirements Mrs M has referred to in her written submissions.

So, I've set out the background to this complaint in less detail than the parties and I've done so using my own words. And, in reaching my conclusions, I've focused solely on what I consider are the key issues. Our rules allow me to take this approach; it simply reflects the informal nature of our service as a free alternative to the courts and no discourtesy is intended by it. If there's something I haven't mentioned, it isn't because I've ignored it. It's since I don't need to comment on each individual argument to be able to reach what I consider is the right outcome in the circumstances.

On that basis, I haven't set out the complete details of Mrs M's medical or employment circumstances, though I've carefully considered everything I've seen when reaching my decision.

It's also important that I make the parameters of this decision clear. I will only be considering the evidence which was available to L&G up to the point it issued its final response to Mrs M's complaint in March 2025, endorsing its decision to refuse her claim for income protection benefit.

We do not act in the capacity of a regulator. That remit falls to the FCA, where it may look at wider issues governing how businesses conduct their operations or exercise what may be commercial judgement on the provision of a particular service.

Regulatory rules require L&G to handle claims promptly and fairly and to not unreasonably reject a claim. I've therefore considered the evidence provided by the parties alongside the terms and conditions for Mrs M's employer's group policy to determine whether I believe L&G treated her fairly and reasonably by refusing her income protection claim.

Having done so, I agree with our investigator that this complaint should not be upheld. That means I won't be asking L&G to pay the claim retrospectively. I know this will be a disappointment for Mrs M, but I'll explain my reasons for reaching this view below.

The policy terms set out when the income protection benefit is payable after the deferred period, as follows:

> "*1 BENEFIT PAYABLE*
>
> *Subject to the terms of this policy, the benefit will be paid in respect of an insured member from the benefit start date provided he is a disabled member.*"

The policy wording explains that a disabled member must meet the incapacity definition of "*own occupation*" given in the employer's policy schedule, which says:

> "*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*".
>
> *The insured members capacity to perform the essential duties of his own occupation will be determined whether or not that occupation remains available to him*."

And deferred period is set out as:

> "*Deferred period*
>
> *Means for each insured member the period of consecutive weeks shown for the relevant category in the schedule starting with the first day that he was:*
>
> - *unable to work;*
> - *only able to work reduced hours; or*
> - *only able to work in a reduced capacity;*
>
> *because of an injury or illness that resulted in him becoming a disabled member.*"

Whilst I have no doubt that Mrs M suffers from a set of genuine and debilitating conditions, whereby these have combined progressively such that Mrs M felt she was no longer able to perform the material duties of her employment. Thereafter, Mrs M was diagnosed with fibromyalgia. However, L&G has decided that the medical evidence she has supplied does not support the conclusion that she was prevented from carrying out her own occupation during the deferred period or after 5 August 2024 (the first date the claim could be accepted). And the burden of proof does rest with the claimant; so, it is for Mrs M to show sufficient evidence to satisfy the claim.

I appreciate Mrs M feels that both tribunal case law and her disability benefits assessment provide persuasive evidence that she is disabled for the purposes of the group policy. But those are not comparable tests as they use different criteria of disability. The requirement here is incapacity as defined by the policy wording for the deferred period and beyond.

I also recognise that Mrs M feels that L&G originally operated on an incorrect basis to refuse her claim, by focusing on her initial presentation of stress and anxiety, which had increased after her myriad symptoms of unexplained poor health. However, I do not find L&G's approach to be unreasonable.

Mrs M had self-referred for talking therapy because of stress. And in the assessment with the Vocational Clinical Specialist ('*VCS*') in August 2024, it was set out that Mrs M "*stated that her symptoms of anxiety were triggered by multiple stressors including physical health problems and feeling overwhelmed at work*". Further, Mrs M's fitness for work certificates had listed the reason for her absence as "stress and anxiety", and this was also the listed cause for absence on Mrs M's signed member's statement to L&G from July 2024.

Thereafter, Mrs M appealed the decision on the basis that her position had now changed; primarily because her fibromyalgia diagnosis has, understandably, explained the various issues she suffered for the many months preceding the diagnosis.

Mrs M feels L&G hasn't fairly considered that diagnosis and its numerous symptoms that impact her from being able to work, but I believe it has done so. In the appeal outcome, the relevant evidence surrounding the diagnosis was reviewed by L&G and its CMO.

The letter from Mrs M's consultant rheumatologist from February 2025 said:

> "*You have been struggling with back pain particularly in your thoracic areas, but you also get aches in your hips, stiffness in the shoulders, and pain in your elbows, fingers and toes. You suffer from insignificant sleep, and you only get a few hours at night. You struggle with fatigue as well as brain fog. You have history of anxiety and low mood as well. You have tenderness over Fibromyalgia pressure points today but there is no evidence of inflammation in your joints and no stigmata of Connective Tissue Disease.*
>
> *I have provided you with prescription for Amitriptyline to trial at night which may help with the sleep and some of the pains. It would be good that you have a look body reprogramming website for information on self-management techniques. The symptoms are clearly affecting your day-to-day activities and your work. You have also had a lot of stress in your private life separating from your partner. You clearly need additional help, and I will ask Pain Team to see you, who can provide further input in helping you manage your symptoms. In the long run, it would be best to try to reduce and come off opioids.*
>
> *On the MRI scan of your thoracic spine there was no nerve root compression. There were some early degenerative changes in form of early osteophytes in mid spine. You certainly have mechanical sounding back pain and for that you should have continuing input from Physiotherapy*."

From this assessment, and the wider additional information supplied by Mrs M in her appeal, L&G concluded that Mrs M's fibromyalgia (aside from non-work related factors) prevented her entirely from undertaking the essential duties of her own occupation. Rather, the CMO concluded that the medical advice was reassuring, provided steps to resuming work and that it "*does not point toward a condition inherently precluding work*".

I am persuaded that L&G has made a reasonable conclusion on the information it received in conjunction with the further evidence Mrs M has supplied relating to her claim. It isn't my role to substitute my view for that of L&G; instead, I have assessed if I think it reached a fair and reasonable outcome based on the information available – which I find it did.

At the time of the appeal, Mrs M had yet to explore the impact of awaited pain management, body conditioning treatment, as well as medicines on her newly diagnosed condition – and there hadn't been a vocational assessment or other examination to show how the various duties of the role could no longer be completed (and that this had been the case throughout the deferred period given the cause for her original absence had changed).

I recognise that it has taken Mrs M some time to receive the diagnosis that she feels is fundamental in preventing her from working, but L&G hasn't seen any objective evidence of that incapacity beyond Mrs M's account of her limitations and the management plan given by the treating rheumatologist in February 2025 – one month before the appeal outcome was issued.

It follows that I do not believe that this complaint should succeed in respect of L&G's decision to decline Mrs M's income protection claim. I don't agree that L&G has treated Mrs M unreasonably in concluding that she hadn't met the policy definition of incapacity during the deferred period and beyond or that it has otherwise behaved unfairly in how it processed

her claim, beyond the apology it already gave for the delay in December 2024.

I'm sorry that my decision won't bring Mrs M welcome news, but overall, I don't think L&G needs to do anything further to resolve this complaint.

Though I appreciate my decision will be disappointing for her, Mrs M is not prevented from submitting new medical evidence to L&G for its consideration (such as the information she referred to when replying to our investigator in May 2025). She can also pursue a further claim including consideration of a fresh vocational clinical assessment, if appropriate.

My final decision

I do not uphold this complaint or make any award.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs M to accept or reject my decision before 13 August 2025.

Jo Storey
Ombudsman