DRN-5582407

The complaint

Mr G is unhappy with Aviva Life & Pensions UK Limited's decision to decline his income protection claim.

What happened

Mr G has income protection cover through his employer's group policy. In April 2024, Mr G began suffering with symptoms of depression, anxiety and dizziness and took sick leave from work. Mr G's work involved physical activity, packing boxes in a factory setting. Mr G claimed on the policy in November 2024, however, his claim was declined in January 2025. Mr G said Aviva ignored the medical evidence he provided to support his claim. He also said Aviva didn't reach out to his GP to discuss his illnesses or his claim to better understand why he's unable to work. He'd like Aviva to review his claim with the view to accepting liability for it.

Aviva said that Mr G's medical evidence doesn't sufficiently explain why his symptoms prevent him from working, not only in his current role, but in any other suited occupation. Aviva said Mr G was suited to working as a painter and decorator, a builder and a van driver as these were occupations he'd previously undertaken and was therefore suited to by way of experience. It also noted Mr G could still work in a similar setting to his current role, but with some adjustments. Aviva said, therefore, Mr G hasn't satisfied the policy's definition of incapacity and maintained its declinature of his claim.

Our investigator didn't uphold this case. She explained that although Mr G provided FIT notes and letters from his GP and psychotherapist, this ultimately didn't satisfy the policy terms for the reasons Aviva explained. She also said the letters didn't explain how Mr G's functional capability was impacted to such a degree, he couldn't perform any other suitable occupation. She noted Mr G was yet to see an ENT specialist for his symptoms of dizziness, however, that hadn't yet happened and so she couldn't consider the outcome of that as part of this investigation.

Mr G disagreed with her findings. In summary, he explained that he'd been assessed by the DWP which determined he had a limited capability for work and work-related activity. He also said the assessment was carried out by suitably qualified professionals and that this is evidence that he's unable to carry out his current or any suited occupation. Mr G also submitted further medical evidence from his GP and psychotherapist, providing more detail about his conditions and why his symptoms are preventing his return to work. And so, it's for me to make a final decision.

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, I've decided not to uphold it. I say that because the contemporaneous medical evidence, although indicated Mr G suffered from his illnesses, doesn't explain in enough detail the reason why he's unable to work in any suited occupation. I'm therefore

persuaded that Aviva has declined his claim fairly. I'll explain why.

The relevant rule that applies in this case is from the Insurance Conduct of Business Sourcebook (ICOBS). This says Aviva must handle Mr G's claim promptly and fairly and mustn't unreasonably reject a claim. I've thought about Aviva's obligations under ICOBS whilst I've considered this case.

The policy terms say about incapacity;

"1 What benefits are covered

1.1 Total benefit
We will pay total benefit if immediately before the start of incapacity the member was actively at work and following their job role and, after the start of incapacity they are not following any other occupation, and the deferred period has finished.

Incapacity
'Suited''. The member's inability to perform on a full and part time basis the duties of their job role and other occupations for which they are suited by reason of education, training or experience, as a result of their illness or injury."

Mr G's policy has a 26-week deferred period which he must demonstrate, through medical evidence, that he was incapacitated, as defined by the policy, throughout that time. Mr G's absence began in April 2024 and so the deferred period ended in October 2024. I've carefully considered the medical evidence provided by Mr G to Aviva during that period and I'm satisfied it doesn't meet the threshold of evidence required to satisfy the policy terms.

I say that because the evidence consisted of GP FIT notes, with limited information other than to say Mr G was suffering with depression, anxiety and dizziness; a brief letter from the GP saying Mr G was unfit to return to work; and a letter from his psychotherapist which said Mr G was suffering with some physical difficulties which may require him to take some time off work and potentially has the power to affect his mental health also. And so, whilst this is evidence that Mr G was suffering with illnesses, it didn't explain why he'd be unable to work in other occupations he was suited to.

Mr G argued Aviva should have contacted the medical professionals responsible for his care, but I disagree. I say that because it's Mr G's responsibility to gather and provide evidence to support that he has a valid claim and not Aviva's. I should say, however, that Aviva did reach out to Mr G's GP and requested his medical records in January 2025, following Mr G's escalation of its answer to his claim. Upon receipt, Aviva reviewed the GP records and maintained its position to decline cover in February 2025.

Having reviewed the GP records, I can see why Aviva maintained its position because there's limited information about Mr G's conditions and symptoms and how this prevented him working in any occupation. They simply log the FIT notes that were issued and the repeat prescriptions medications. There's some discussion about Mr G's symptoms of dizziness, however, I note these only lasted for a few seconds and a few times each day. Aviva, therefore, said Mr G was capable of working in some capacity although suggested he could perhaps have a chair to sit on, or even move to an area where he was able to handle smaller, less heavy items. And so, I'm satisfied Aviva conducted a fair investigation and gathered medical evidence to better understand the issues Mr G was experiencing.

For Aviva to have accepted his claim, Mr G would have had to provide evidence that he was suffering with a medical condition of such severity that he was unable to work in any other occupation. For the reasons I've explained, I'm not persuaded the medical evidence from

that time met that test as FIT notes and limited GP records weren't detailed enough.

Even the subsequent GP letters sent in response to Aviva don't offer any explanation about why Mr G can't work in any capacity, full or part time, in his occupation, or any other occupation. They simply say Mr G's suffering from severe symptoms of depression, anxiety and dizziness and then go on to list the dates he was provided FIT notes – which doesn't go far enough to satisfy the criteria of the policy. I know Mr G has argued that Aviva simply ignored the GP letters, but I disagree. There wasn't enough detail, or any meaningful explanation, about why he was unable to perform any other occupation and therefore were unpersuasive in the circumstances.

Mr G explained the DWP assessed him personally and that he was awarded personal independence payments (PIP) and that this should be evidence in itself of his incapacity. To be clear, I understand the argument and the connection Mr G is attempting to make here, but I'm unpersuaded it means Aviva should have accepted his claim. I say that because these are two completely separate schemes with different criteria to satisfy. Income protection insurance, more often than not, is a much higher bar to meet and in Mr G's case, significantly higher, given he must demonstrate that he's unable to perform any other occupation.

The new medical evidence

Mr G provided additional medical evidence in response to our investigator's opinion on this case. This, a letter from his GP and a letter from his psychotherapist, was new evidence and therefore couldn't be considered as part of this complaint. Our investigator shared this with Aviva and asked whether it impacted the decision to decline cover. Aviva said that whilst it doesn't change its position to decline liability, it reviewed Mr G's case again and considered the new evidence. It said the evidence has provided more detail and clarity about the conditions Mr G's suffering and has decided to begin a new deferred period from December 2024 until June 2025.

I thought that was a fair position for Aviva to take in the circumstances. Aviva said the new evidence shows there was a decline in Mr G's medical conditions in December 2024 and it felt there was enough evidence for it to consider a new deferred period as a result. I should highlight this wasn't available to Aviva when it assessed Mr G's claim initially, which is why I don't think it did anything wrong as part of the first assessment. I'm also aware that Mr G is undergoing diagnostic testing with an ENT specialist to try to determine the root cause of his dizziness. Aviva will also consider any evidence that may produce during that window of opportunity which I think is fair.

My final decision

For the reasons I've explained, I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr G to accept or reject my decision before 18 July 2025.

Scott Slade
Ombudsman