DRN-5589124

The complaint

Mr A is unhappy that Legal and General Assurance Society Limited (L&G) declined a claim made on his employer's group income protection scheme.

What happened

Mr A is a beneficiary of his employer's group income protection scheme ('the policy'). He claimed on the policy after he was signed off work by his GP with anxiety and depression (and later, anxiety disorder).

L&G declined the claim on the basis that the policy definition of incapacity wasn't met. And after Mr A appealed this decision, L&G maintained its position.

Unhappy, Mr A complained to the Financial Ombudsman Service. Our investigator looked into what happened and didn't uphold the complaint. Mr A didn't agree. So, this complaint has been passed to me to consider everything afresh to decide.

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.

Subject to the remaining terms of the policy, L&G will pay the monthly benefit so long as the member of the policy is a 'disabled member'.

This has a specific definition under the policy which is:

> An insured member who at any time:
>
> i. Is incapacitated by an illness or injury; and
>
> ii. Meets the incapacity definition; and
>
> iii. Is not engaged in any other occupation…

It goes on to say:

> For the avoidance of doubt, an insured member is not a disabled member if they are absent because of:
>
> i. Workplace issues, including an employer's failure to make reasonable adjustments, disputes between the insured member and their employer, or employer demands…

The relevant definition of incapacity is 'own occupation' which is defined by the policy terms as:

> The insured member is incapacitated by illness or injury that prevents them from performing the essential duties of their occupation immediately before the start of the deferred period.

So, the focus is very much on whether Mr A could perform the role he was doing (as opposed to the role for his particular employer) because of illness.

L&G has a regulatory obligation to handle insurance claims promptly and fairly. And it mustn't decline a claim unreasonably.

I've also taken into account that it's for Mr A, when making a claim, to establish that he met the definition of incapacity as defined by the policy terms, and throughout the deferred period (of 26 weeks). It's not for L&G to show Mr A didn't meet the incapacity definition.

I understand Mr A's strength of feeling that L&G has unfairly declined the claim made under the policy. I know its decision has financially impacted him and I have a lot of empathy for his situation.

However, based on the evidence I've seen, I'm satisfied that L&G has acted fairly and reasonably here. My decision is in no way intended to be dismissive of the health issues Mr A's experienced, but I do think L&G has fairly and reasonably declined the claim. I'll explain why.

- I'm satisfied that L&G reasonably concluded there was limited medical evidence to support that Mr A was incapacitated as defined by the policy terms. And that the reported work-related issues were the main barrier for him returning to work, rather than illness

- The available medical evidence provides limited insight into Mr A's condition, how it impacted his ability to perform the duties of his job role during the deferred period and how it affected his functionality in the workplace. Further, many of Mr A's symptoms were self-reported.

- I appreciate that Mr A was signed off work by his GP, was prescribed anti-depressant medication and was considered as unfit to work by occupational health. So, I can understand why he thinks the claim should be paid. However, those things don't automatically mean that he was a disabled member as defined by the policy. The policy has a specific definition which needs to be met. As I've outlined above, the available medical evidence gives little meaningful insight, from a medical perspective, into why Mr A couldn't do the essential duties of his job because of illness throughout the deferred period.

- I'm also satisfied that the overall evidence during the deferred period supports that it was reported work-related issues which were the main cause of his symptoms and were the main barrier for Mr A returning to work during the deferred period. And had the underlying work issues not existed Mr A is likely to have been able to continue working/returned to work during the deferred period.

I know Mr A will be very disappointed, but I hope it reassures him to know that his complaint has been impartially considered by someone independent of the parties.

My final decision

I don't uphold Mr A's complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr A to accept or reject my decision before 17 October 2025.

David Curtis-Johnson
Ombudsman