DRN-5610541

The complaint

Mr E is unhappy that Legal and General Assurance Society Limited (L&G) declined a claim on his income protection policy.

What happened

Mr E is a director of a company. He is the beneficiary of his company's executive income protection policy. The policy was taken out in August 2023 with L&G.

The policy provides cover where an employee becomes incapacitated due to illness or injury and is unable to work as a result. The policy is designed to protect the business so a claim would be reviewed on both medical and financial grounds. If a valid claim is agreed, a settlement would be paid to the business.

The deferred period on Mr E's policy is 4 weeks. Any payments start after the 4-week deferred period and Mr E must show that he was incapacitated for the whole of the deferred period and beyond.

On 25 March 2024, Mr E notified L&G that he had a groin and hamstring injury since 20 March 2024. He raised a claim under the policy for his loss of earnings. L&G reviewed the information provided by Mr E and his GP and declined the claim. Mr E appealed. Further information was reviewed by L&G, but it maintained its decision to decline the claim as it wasn't medically and financially valid.

Mr E brought his complaint to this service. Our investigator initially upheld the complaint but after having received further information, it wasn't upheld.

Mr E disagreed and asked for the complaint to be referred to an ombudsman. So, it's been passed to me 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.

I'm sorry to hear that Mr E has had a difficult time recently. Mr E has raised a number of points in response to our investigator's opinion. I have carefully reviewed each of these, but I won't address all of them in my decision. I'll focus on the points I think are central to the outcome of the complaint.

I'm not upholding this complaint for the reasons I'll go on to explain.

How was L&G required to consider the claim?

Under the relevant rules and appropriate industry guidelines L&G was required to consider Mr E's claim promptly and fairly. And it shouldn't decline it unreasonably.

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

Incapacity is defined on page 3 in the policy booklet as:

> *'We will assess any claim to establish if the life insured lacks the capacity to perform the material and substantial duties of their own occupation, as a direct result of their illness or injury.'*

And on page 9 as:

> *'The inability due to illness or injury of the life insured to carry out the material and substantial duties of their own occupation.*
>
> *'We will not pay a claim if the life insured is performing any occupation during the deferred period or benefit period.'*

In light of the above, it isn't enough for the medical evidence to show Mr E was unwell during the deferred period or that he was signed off work by his GP. There needs to be evidence his injury prevented him from being able to work throughout the deferred period and beyond.

Did L&G decline the claim unfairly?

Medical evidence

I've considered the medical evidence that's been provided to me. Mr E's GP records and a further letter dated 14 June 2024 confirmed Mr E had consulted with the GP on 26 March 2024 because of an injury that happened on 20 March 2024. He'd requested a sick note, and they discussed amended duties versus time off. It was noted Mr E preferred time off. My understanding is that Mr E was signed off work.

There's evidence that Mr E received physiotherapy in August 2023 related to his hamstring. The treatment plan shows no medication was prescribed and home exercises and self-management were recommended.

I've considered notes from the physiotherapy sessions from 20 March 2025 to 14 May 2024. Discussions included managing the injury through home exercises, pain control and health principles. A description of the injury suggested that the pain had gradually progressed over the last two years and had been on and off since onset. There was no evidence of a sudden and specific episode of when the injury happened – the evidence shows the injury was progressive. Mr E wasn't prescribed any medication. The session on 25 March reports that Mr E had no pain and that his hip movement was 5/5. In the session on 14 May, the therapist reports there are no concerns, and Mr E has improved by 60% since the physiotherapy started and he was able to do light duties.

The medical evidence, in summary, recommends rest and to do home exercises to help regain strength. Mr E said he could walk, but not run, jump, pass the ball or shoot. He was advised a six-to-eight-week recovery by his physiotherapist. Mr E initially took some painkillers, but he stopped and was no longer taking any medication – off the counter or prescribed. There were no scans recommended and there was no onward referral to a specialist. The approximate date of onset for the injury is shown to be around March 2022.

Mr E told the Vocational Clinical Specialist (VCS) on 16 April 2024 that he was working two hours in the library to do some administration work. He said he was driving and had been walking without issues and without a time restriction. I think the VCS notes were contemporaneous and were written from what Mr E had self-reported. I understand that Mr E later said he went to the library to watch some videos, so it avoided being in the house all the time. But I find the notes from the VCS to be more persuasive.

The VCS initially said Mr E was unfit to complete his coaching sessions, However in the later session it states that it's unclear whether Mr E was fit to work as his level of fitness was unclear from what he had self-reported. This was because of the frequency of his gym sessions and the lack of medical evidence to support the severity of his injury as it didn't require surgical intervention. The VCS said as a result no further reviews were booked.

I've considered also that Mr E has had issues with his hamstring previously before the policy was taken out. In his claim form he states that was why he took the policy out. I can't see that Mr E took time off work previously for the condition and the evidence is insufficient to show how that same condition now prevented him from working and carrying out the material and substantial duties of his own occupation. From the information available, the issues were of a similar nature, and I can't see what changed on this occasion. I understand Mr E's occupation as a sports coach is a physical one. He reported though that he could walk and was able to go to the library and to the gym. The evidence provided isn't sufficient to the extent that he was completely precluded from carrying out his duties.

L&G's Chief Medical Officer (CMO) was asked to review the medical information in relation to the definition of incapacity in the policy terms. His opinion was that the evidence didn't show the injury would completely prevent Mr E from working in his own occupation. The CMO said the evidence points to the condition being progressive rather than being acute.

Financial evidence

I've also been provided with Mr E's financial information for consideration.

Mr E's accounts show evidence of payments being made to him by a payroll service in April 2024 and May 2024 but there's no explanation for these as far as I can see. They appear to be payments for work from a payroll and accountancy service to temporary contractors and small businesses.

Mr E has also received director's loan payments. His accountant said this was money taken as a loan. I'd expect to see further evidence confirming a loan agreement showing such details as the loan amount and when it would be repaid. The payments are being made into Mr E's personal account which likely suggests they were a form of income for Mr E.

There are also payments for one-to-one sessions. However, whilst these were made during the deferred period, I can' be certain these can be taken into account as they could be for work carried out prior to the injury.

The test here is whether the business has suffered a loss from the incapacity. And based on the information available, I'm currently not persuaded the business has suffered a financial loss. The business needs to suffer a financial loss in Mr E's absence. In this case, the evidence doesn't sufficiently show the business has been affected.

What I've decided

For the reasons given above, taking all of the evidence into account, I'm not persuaded that L&G has declined Mr E's claim unfairly or outside the terms and conditions of the policy.

I fully appreciate Mr E's comments that he's provided everything he possibly could. And as he's paying a premium on the policy, L&G should pay the claim. However, that's not how an insurance policy works. Whilst Mr E has provided evidence, the ultimate test is whether he met the definition of incapacity as required by the policy terms. In the circumstances here, on balance, I don't think he has met this definition. I don't doubt that Mr E suffered an injury, but the medical and financial evidence doesn't sufficiently support that he was incapacitated to the level that he couldn't carry out the material and substantial duties of his own role. I'm sorry to disappoint Mr E but it follows that I don't require L&G to do anything further.

My final decision

My final decision is that I don't uphold this complaint

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

Nimisha Radia
Ombudsman