DRN-5625593

## The complaint

Miss D is unhappy that Aviva Life & Pensions UK Limited (Aviva) declined her income protection claim.

Miss D is being represented on this complaint. However, I will refer to Miss D throughout this decision as she's the complainant.

## What happened

The background to this complaint is well-known to both parties. So, I've simply set out a summary of what I think are the key events.

Miss D is a member of her employer's group income protection policy. The policy pays a benefit under certain circumstances if Miss D is unable to carry out her employment, after a deferred period of 13 weeks. Aviva is the underwriter of the policy.

Miss D was first absent from work on 26 January 2024. Her symptoms on her claim form were noted as stress, anxiety, low self-esteem and depression. Miss D submitted a claim to Aviva. It reviewed Miss D's medical information and declined her claim. Aviva said it was unable to conclude that Miss D met the policy definition of incapacity. She appealed and provided further medical information. Aviva maintained its decision to decline the claim.

Unhappy Miss D brought her complaint to this service. Our investigator didn't uphold the claim. He didn't think Aviva had acted unfairly in declining Miss D's claim.

Miss D disagreed and asked for the complaint to be referred to an ombudsman. 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.

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 Miss D's claim, to decide whether I think Aviva 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 Miss D. 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. This defines incapacity for switched occupation as:

*'Means either own, suited or switched below as specified in the policy schedule (if none specified, own will apply).*

*'Switched'. For the first 24 months after the deferred period has been completed – the member's inability to perform on a full and part time basis the duties of their job role resulting from their illness or injury.*

*After 24 months – the member's inability to perform on a full and part time basis the duties of their job role and any other occupation for which they are suited by reason of education, training or experience, resulting from their illness or injury.*

Generally, in insurance, it's for the consumer to show their claim is valid. In this case, Miss D is required to provide medical evidence to show she is unable to work and cannot perform the duties of her employment due to injury or illness. And for the claim to be accepted, the medical evidence needs to show that Miss D was incapacitated for the 13-week deferred period and beyond.

For the avoidance of doubt, I'm not medically qualified so it's not for me to reach any determinations about Miss D'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 Aviva acted fairly and reasonably in declining Miss D's claim. This is the test I have to consider.

I note there's a dispute about what the primary reason for the absence was. I can see based on the GP note of 26 January 2024 that there is a possible primary reason for the absence. Aviva says this is the reason for Miss D's absence and the claim would be assessed against this medical condition. However, Miss D doesn't agree and said she didn't want this information to be disclosed to her employer. Aviva said it was unable to assess the claim based on this primary reason for absence or without her employer being made aware of the medical condition. As this was a group income protection policy, Aviva needed to be transparent with Miss D's employer who was the policyholder. I think Aviva's reasons for not assessing the claim further for this medical condition (which it considers is the primary reason for the absence) is fair. I'm not persuaded that Miss D has been treated unfairly in the circumstances.

Putting aside the above issue, Aviva also reviewed the medical evidence in line with the terms and conditions of the policy and the definition of incapacity. Based on the notes made by Miss D's GP on 10 January 2024 (telephone appointment) and 26 January 2024 (face to face appointment), there were work-related issues and changes happening at work which resulted in Miss D being unhappy and her mental health worsening. Miss D was referred to the mental health team and she was seeing a psychologist. Miss D requested sick notes online from her GP. The GP spoke to Miss D in September 2024 by telephone and she confirmed she has had depression and anxiety for over 20 years and the symptoms were made worse when a colleague passed away 18 months ago and due to work-related matters.

The policy also states:

'*Absence caused by workplace matters, such as a relationship breakdown, workplace demands or failure to make reasonable adjustments are not covered.'*

Based on the notes and Miss D's own submissions, it's clear that there were issues at work, and this was one of the reasons for her absence.

I've considered the further information provided by Miss D's clinical psychologist and from

her GP as part of her appeal. Having reviewed these, I don't think they provide anything new or different. They give additional details of the events that happened in Miss D's life and how she struggled as a result. They both note that Miss D made progress and there was a treatment pathway. And they both again noted the struggles related to work and changes to the employer's business. They refer to a history of mental health for a number of years that Miss D has struggled with. I understand the whole situation has been difficult for her, but she continued to work during those years whilst also having therapy sessions.

All of the medical information was referred to Aviva's mental health clinician and its medical team for review. The clinician said Miss D could have worked with reasonable workplace adjustments allowing for her treatment to take place also.

Having carefully considered all the information provided, I'm not persuaded that Aviva has declined Miss D's claim unfairly. The medical evidence isn't sufficient to demonstrate total incapacity as required in line with the policy terms and conditions. I don't doubt that Miss D is unwell, But the medical evidence doesn't support this to the extent that she is wholly incapacitated. And even if the primary reason for the absence was not taken into account, it's clear that there were work-place issues for which there is no cover under the policy.

Based on the available evidence, I'm sorry to disappoint Miss D. But I don't think Aviva has declined her claim unfairly or outside the policy terms and conditions. It follows therefore that I don't require Aviva to do anything further.

**My final decision**

For the reasons given above, I don't uphold Miss D's complaint about Aviva Life & Pensions UK Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss D to accept or reject my decision before 22 July 2025.

Nimisha Radia
**Ombudsman**