DRN-5626340

The complaint

Mr J says that Liverpool Victoria Financial Services Limited ('*LV*') has unfairly refused an income protection claim he made under his LV Flexible Protection Plan. He says that LV has accepted claims under the policy in the past, but now it has used unfair tactics to delay and reject the claim. To resolve his complaint, Mr J wants the claim backdated and paid in full.

What happened

Mr J's policy has been in force since May 2012. It offers him life assurance cover and waiver of premium benefit. It also provides income protection benefit for Mr J if, by reason of illness or injury, he is unable to perform the material and substantial duties of his own occupation. The benefit is payable after a deferred period of one month.

Mr J had claims paid for income protection benefit previously in 2014 to 2015, 2015 to 2016, 2018 to 2019 and 2023 to 2024. For the latter two claims, the cause of his incapacity was mental health issues, including stress, anxiety and depression. Mr J's fourth claim was terminated by LV in January 2024 at which time he had been discharged by a medical provider of cognitive behavioural therapy ('*CBT*'). The premiums for income protection became due from March 2024. The previous claims are not the subject of this complaint.

In May 2024, Mr J made another income protection claim. A claim call took place with LV on 5 June 2024, where Mr J explained that he had suffered another decline in his mental health causing insomnia, lack of concentration and shortness of breath. Mr J would not complete an employer consent form, as he explained he had ceased working on a zero-hours contract that had only begun in May 2024. However, Mr J supplied a statement of fitness for work ('fit note') dated 18 June 2024 to 22 July 2024 to LV. His GP also noted he had suffered a deterioration in his mental health.

Mr J complained to LV about the time it was taking to decide his most recent claim. LV thereafter treated those concerns as a complaint.

By September 2024, LV had received some medical evidence from Mr J along with his GP and so, it completed its assessment of his claim. It said Mr J had met with his GP once in June 2024, but there was no objective evidence as to how Mr J was unable to complete the substantive duties of his previous employment.

On 26 September 2024, LV rejected the complaint. It apologised to Mr J for the time that assessing his claim had taken. However, it believed it had fairly explained why delays occurred. In respect of the claim, it maintained that it hadn't seen sufficient medical evidence to establish why Mr J's symptoms prevented him from working. Without this and due to Mr J's refusal to complete the employer consent information, it couldn't accept his claim.

In October 2024, LV received further medical information relating to Mr J's GP records, which it considered. However, it said that its position remained unchanged. It closed his claim that month.

Mr J remained unhappy with LV's decision and lodged his complaint with this service, where it was thereafter reviewed by one of our investigators.

Mr J said he felt that his claim was continued from 2023, and both LV and this service ought to be assessing his medical history from that time as a whole.

Our investigator didn't think the complaint ought to succeed. She firstly noted that LV had considered the medical evidence relevant to Mr J's period of incapacity from May 2024, and she was satisfied that this was a fair approach for a new, separate claim. She also didn't think it was unreasonable for LV to have concluded that there was little clinical evidence to explain how a medical illness was preventing Mr J from working as it hadn't seen any objective view on Mr J's functional capabilities regarding his inability to complete his job.

Whilst she noted LV had apologised to Mr J for how long the claim process had taken, our investigator believed that it had acted fairly in progressing the claim at all material times.

LV accepted the investigator's view. But Mr J disagreed. He said, in summary:

- He feels he has presented sufficient medical evidence for a claim to be paid.
- He also asked LV to refer him to an occupational health professional to further support his claim, but it refused to do so.
- He feels the claim was upheld on the same basis previously, and nothing has changed now.
- His mental health is affected in many ways – and Mr J provided a comprehensive list of his cognitive, emotional, physical, social and stress-based effects.
- When he previously met with an assessor from LV, it agreed with the various effects on him from his condition(s).
- LV cannot simply change how it decides to assess claims; its actions must be unfair.

Our investigator considered the additional points Mr J had made carefully. However, she was not persuaded to change her view that the complaint shouldn't succeed.

LV said it didn't have anything else to add for an ombudsman's review. Mr J asked for the complaint to be referred to an ombudsman. He said he had feedback relating to his previous claim from LV, but he didn't have any other comments to make in relation to this complaint.

The complaint has now 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.

I've fully reviewed all the information before me, including the representations Mr J made following our investigator's view. However, in reaching my findings, I've focused on what I consider to be the central issues. I don't need to comment on every argument in order to reach what I believe is the right outcome in the circumstances. No discourtesy is intended by this, but rather, our rules allow me to take this approach; it reflects the informal nature of our service as a free alternative to the courts.

On that basis, I haven't set out the complete details of Mr J's medical circumstances, though I have carefully considered all of the evidence when reaching my decision. I also send Mr J my best wishes, as I realise how difficult things have been – and continue to be – for him.

It's also important that I make the parameters of this decision clear. I will only be considering the evidence which was available to LV up to the point it issued its final response to Mr J's complaint in May 2024, endorsing its decision to refuse his claim for income protection benefit.

I realise Mr J believed the matter is ongoing, as his previous period of incapacity was also for reasons relating to his mental health. However, his policy wording makes clear that whilst 'linked claims' made within six months of a previous claim can be considered if the cause of the inability to work is the same issue, the policy wording also requires that "*your occupation is the same as it was when you were first unable to work.*". That doesn't apply to Mr J since his previous insured occupation ended, and the inability to work now stems from the new zero-hours employment he commenced – and ceased – in May 2024.

Regulatory rules require LV to handle claims promptly and fairly and to not unreasonably reject a claim. I've therefore considered the terms and conditions for Mr J's policy alongside the evidence to determine whether I believe LV treated him fairly.

Having done so, I agree with our investigator that this complaint should not be upheld. That means I won't be asking LV to pay the claim retrospectively. I know this will be a disappointment for Mr J, 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 one month deferred period and beyond, as follows:

> "*In this section, the words 'unable to work' and 'inability to work' mean that we will pay a claim if, following your waiting period, because of sickness or accident, you are totally unable to carry out all the main duties of your occupation and aren't doing any other paid or unpaid work. The words 'able to work' and 'ability to work' mean that you can work.*
>
> *By main duties, we mean the duties that can't reasonably be left out without affecting your ability to do your occupation. When assessing your ability to carry out those duties, we will consider whether there are any changes that you or your employer can reasonably make that would allow you to continue in your occupation.*"

I've thought carefully about everything Mr J has said. LV has concluded that it hasn't seen enough medical evidence to ascertain that Mr J was continuously incapacitated for the one month deferred period and beyond. And I find LV's decision fair in these circumstances.

I know Mr J feels strongly that his fitness certificate - alongside his GP records – ought to provide sufficient evidence that he was unable to work. This shows a period (from June to July 2024) that Mr J's GP concluded he wasn't fit for work based on Mr J's reporting of the symptoms he suffered. However, the fitness certificate defined unfit for work as "*your health condition means that you **may** [my emphasis] not be able to work for the period shown. You can go back to work as soon as you feel able to and, with your employer's agreement, this may be before your fit note runs out*".

I consider that the fitness certificate, of itself, isn't objective medical evidence of incapacity as defined by Mr J's policy wording. I must be fair to both parties in a complaint. Having looked at Mr J's full medical records, I don't think that LV was unreasonable to conclude there was no clear evidence to demonstrate how the effects of depression prevented Mr J from completing the material and substantial duties of his role from 8 May 2024 to 7 June 2024 (the deferred period) and beyond.

I say that noting how Mr J was recorded as considering CBT, but he hadn't pursued this. And the GP did not make any assessment of Mr J's functional capacity whatsoever.

Mr J has agreed with LV that he would consider an occupational health assessment, but he wouldn't complete the information it required about his previous employment to enable that. I don't find LV to have behaved unfairly in not carrying out the referral, as its occupational health assessment for work capacity required information about the occupation he was completing immediately before his period of sickness. Consequently, there is no impartial evidence of Mr J's functionality and whether he could undertake wok in any capacity.

It is clear Mr J has been through a difficult period, and I do understand why he may not have felt able to carry out his occupation, notwithstanding any adjustments the employer may have offered before he stopped working. Unfortunately, this doesn't mean the above policy definition was met, as that definition requires him to be prevented from working due to being incapacitated by illness.

It follows that I do not believe that this complaint should succeed in respect of LV's decision to decline Mr J's income protection claim. I cannot therefore agree that LV has treated Mr J unfairly or unreasonably in concluding that he hadn't met the policy definition of incapacity during the deferred period and beyond. Though I appreciate my decision will be disappointing for him, Mr J is not prevented from submitting new medical evidence to LV for its consideration or from pursuing legal action, if he so requires.

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 Mr J to accept or reject my decision before 25 July 2025.

Jo Storey
Ombudsman