DRN-5626504

The complaint

Mrs M complains about the way that Legal and General Assurance Society Limited (L&G) has handled an incapacity claim she made on her employer's group income protection insurance policy.

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.

Mrs M was insured under her employer's group income protection insurance policy. The policy provided cover if Mrs M became incapacitated due to illness or injury. The deferred period was 26 weeks.

In April 2023, she was signed-off work due to suffering a number of symptoms. She was under the care of a rheumatologist and neurologist, amongst other specialists. She was ultimately diagnosed with chronic fatigue syndrome and fibromyalgia, along with other conditions.

In July 2023, Mrs M's employer made an incapacity claim on the policy. L&G asked for evidence to allow it to assess Mrs M's claim – including a member statement and medical evidence. Mrs M's completed member statement referred to the fact that she was intending to do paid coaching work. Mrs M's treating doctors provided some information, although this didn't specifically explain how or why her symptoms would incapacitate her from work. Occupational Health (OH) deemed Mrs M unfit for work in September 2023. And L&G's Vocational Clinical Specialist (VCS) assessed Mrs M as not fit for work in October and November 2023, although they suggested that L&G should obtain more objective medical evidence surrounding Mrs M's symptoms.

Subsequently, in December 2023, Mrs M's employer gave her notice of redundancy, with Mrs M leaving the company in April 2024.

L&G asked some of Mrs M's treating doctors for more targeted information about her condition in January 2024. In brief, they responded to say that Mrs M's symptoms had improved and that she was now fit to return to work on a phased basis.

In the meantime, L&G had arranged for Mrs M to undergo a Chronic Pain Abilities Determination (CPAD) assessment. Mrs M undertook the CPAD in January 2024, which concluded, in summary, that Mrs M had exaggerated her symptoms. L&G also arranged for surveillance to be undertaken and carried out additional investigations.

Based on the CPAD and its investigations, L&G turned down Mrs M's claim in April 2024. It said it didn't think she'd shown she met the policy definition of incapacity and it also said it had identified fraud by false representation.

Mrs M was very unhappy with L&G's decision and she appealed. In July 2024, L&G reviewed Mrs M's claim. It said that it hadn't known that Mrs M had been given notice of redundancy in December 2023 and that if it had, it wouldn't have arranged the CPAD or

carried out additional investigations. It agreed to accept the claim without admission of liability and paid benefit from the end of the deferred period until 31 December 2023.

Remaining unhappy with L&G's handling of the claim and its allegation of fraud, Mrs M asked us to look into her complaint.

Our investigator didn't think L&G had handled Mrs M's claim fairly. In brief, he thought L&G had had enough medical evidence to show Mrs M was incapacitated in January 2024. So he thought it should have accepted the claim from that point. He considered L&G should pay Mrs M any benefit due from the end of the deferred period, together with interest of 8% simple on any amount due. He felt that L&G's actions had caused Mrs M unnecessary trouble and upset and so he recommended it pay her £600 compensation. And he also recommended that L&G should write Mrs M a letter retracting its allegation of fraud by misrepresentation.

L&G agreed to pay Mrs M £600 compensation and it also agreed to write a letter apologising for its allegation and withdrawing the statement. But it didn't agree that it should have accepted Mrs M's incapacity claim any sooner than it had. So it didn't agree that any further benefit payment or interest was due.

The complaint was passed to me to decide.

I issued a provisional decision on 30 May 2025, which explained the reasons why I didn't think L&G had treated Mrs M fairly. I said:

'First, I'd like to reassure both parties that while I've summarised the background to this complaint and their detailed submissions to us, I've carefully considered all that's been said and sent. In this decision though, I haven't commented on each point that's been made and nor do our rules require me to. Instead, I've focused on what I think are the key issues.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, amongst other relevant considerations, such as regulatory principles, the policy terms and the medical evidence, to decide whether I think L&G treated Mrs M fairly.

I've first considered the policy terms and conditions, as these form the basis of the contract between Mrs M's employer and L&G. Mrs M made a claim for incapacity, given she was unfit to work. So I think it was reasonable and appropriate for L&G to consider whether Mrs M's claim met the relevant policy definition of incapacity. This says incapacity means:

'the insured member is incapacitated by illness or injury that prevents him from carrying out the essential duties of his occupation before the start of the deferred period.'

This means that in order for L&G to pay Mrs M incapacity benefit, it needed to be satisfied that she had an illness or injury which prevented her from carrying out her own occupation for the entire 26-week deferred period and afterwards.

It's a general principle of insurance that it's for a policyholder to show they have a valid claim on their policy. This means it was Mrs M's responsibility to provide L&G with enough medical evidence to demonstrate that an illness had led to her being incapacitated from carrying out the essential duties of her role.

L&G assessed the evidence Mrs M provided in support of her claim, including seeking the opinion of its clinical staff. And it wasn't persuaded that she'd shown she met the policy definition of incapacity. Based on the CPAD and other investigations, it also concluded that

Mrs M's activities could be perceived as fraud by false representation. So I've next looked at the available medical evidence to decide whether I think these were fair conclusions for L&G to draw.

Both parties agree that Mrs M's claim wasn't progressed until September 2023. It seems that's because L&G hadn't been aware of Mrs M's correct address and so she hadn't received the paperwork earlier. I think it was reasonable and appropriate for L&G to write to the specialists Mrs M referred to on her member statement – a consultant neurologist I'll call Mr C and a rheumatologist who I'll call Mr G - to ask for medical evidence.

Based on the information the doctors initially provided, I don't think it was unreasonable for L&G to conclude that Mrs M hadn't shown she met the policy definition of incapacity. While the evidence explained Mrs M's ongoing symptoms and treatment, neither letter explained in any depth how or why her symptoms incapacitated her from carrying out her insured role.

I'm mindful that in September 2023, OH had concluded that Mrs M wasn't fit for work. And L&G's VCS concluded in October and November 2023 that Mrs M wasn't clinically fit for work. But I also note that the VCS felt that it would be beneficial for L&G to obtain more objective medical evidence to gain a better understanding of Mrs M's symptoms, how they affected her function and fitness to work. Taken together with the lack of detail in Mr C and Mr G's original evidence, I don't think it was unfair for L&G to decide to ask for more targeted medical evidence from the treating doctors.

Mr C sent L&G a detailed response to its request, dated 19 January 2024. He explained in some detail how Mrs M's symptoms would have likely affected her ability to carry out her insured role and why. He also said:

'During our last two reviews in mid-November, and again more recently in January, it was felt that Ms M had made sufficient improvements in her conditions to consider a phased (graded) return to work by the start of this year.'

Based on the medical evidence provided at that point, I note L&G's Chief Medical Officer (CMO) concluded:

'My opinion is there is insufficient objective evidence of an illness or injury of sufficient severity to result in total incapacity for the member relative to the demands of her own occupation at any employer from 26/01/2024 onwards.'

I accept the CMO's opinion later changed following a review of the CPAD and surveillance evidence L&G had gone on to carry out.

It's important I make clear that I'm not a medical expert. It isn't my role to interpret medical evidence to make a clinical finding and it would be inappropriate for me to do so. Instead, my role is to weigh-up the available expert evidence and decide whether I think it was fair for L&G to conclude that Ms M hadn't shown she met the policy definition of incapacity.

In the round, I don't think it was. I've carefully considered the opinions of Mr C - Mrs M's treating neurologist who'd had the opportunity to examine and treat her over a period of months, L&G's VCS and the OH. Both the VCS and OH hold some expertise in occupational medicine. All three parties found Mrs M hadn't been fit to work and Mr C stated clearly that he believed Mrs M wouldn't have been fit to begin a graded return to work until the start of 2024. This opinion also originally appears to have been shared by L&G's CMO – who is also an expert in occupational medicine. In my view, L&G had enough evidence to show Mrs M met the policy definition of incapacity at the point it received Mr C's report of 19 January 2024. And therefore, I currently think it should have accepted the claim at that point.

L&G now accepts that had it known Mrs M had been given notice of redundancy in December 2023; it wouldn't have arranged the CPAD or other investigations. Setting that issue aside though, as I've said, I think it had enough medical evidence to have accepted the claim from the date it received Mr C's report of 19 January 2024. This means I think it ought to have paid benefit in line with the policy terms from that point onwards. I understand L&G has now paid ex-gratia benefit covering the period from 18 October 2023 until 31 December 2023. This benefit period appears to match Mrs M's redundancy entitlements, as it seems she was paid a monthly salary by her employer in January, February and March 2024. So it doesn't seem any further benefit is due.

But given I think L&G ought reasonably to have accepted the claim once it received Mr C's letter of 19 January 2024, and it didn't pay that benefit until July 2024, I think Mrs M has been deprived of access to benefit and the use of that money. She's also told us she had to dip into savings to cover costs at that time, so I think she's likely lost out on potential growth on her savings through interest. Therefore, I currently intend to find that L&G must pay interest on the settlement at an annual rate of 8% simple from the date it received Mr C's report until the date it paid the benefit.

Compensation

It seems to me that both L&G and Mrs M broadly accepted the investigator's findings in regard to both compensation and the recommendation to write a letter retracting L&G's allegation of fraud by false representation. So I don't think I need to explore either point in particular detail.

I do think though that L&G caused Mrs M unnecessary trouble and upset both by organising further investigations and by the allegation that she'd effectively sought to obtain benefit she wasn't entitled to. Mrs M's member statement clearly stated that she planned to do some coaching and the amount she expected to be paid for that – coaching was an entirely different role to the occupation which was insured under the policy. L&G was therefore aware from the start that Mrs M planned to do other work. And the CPAD report didn't take into account the clear improvement Mr C had noted in Mrs M's symptoms since she'd been taking medication and undergoing treatment. Indeed, by the time the CPAD and surveillance took place, Mrs M had already been deemed fit to return to work.

It's clear how important Mrs M's reputation is to her and I think L&G made clear errors in suggesting that Mrs M's actions could be perceived as fraudulent. I'm satisfied this caused her trouble and upset at a time when she was trying to recover. I think it's appropriate that L&G should pay compensation to reflect this. On the other hand, while I know Mrs M feels that but for L&G's actions, she may not have proceeded with taking redundancy, I think the contemporaneous evidence from the time indicates that redundancy was Mrs M's preferred option. So I don't think I could fairly find that any error on L&G's part caused Mrs M to accept her employer's redundancy package when she wouldn't otherwise have done.

As such, I find the £600 compensation the investigator recommended is fair, reasonable and proportionate to reflect the impact of L&G's errors on Mrs M. I was pleased to note L&G has agreed to pay this amount. And I also find that it would be fair and reasonable for L&G to write a letter to Mrs M which apologises for its allegation and which withdraws it. Again, I was pleased to note L&G has also agreed to take this action.

Putting things right

I currently intend to direct Legal and General Assurance Society Limited to:

- *Pay interest on the total benefit payment it paid Mrs M at an annual rate of 8% simple, from the date it received Mr C's report of 19 January 2024 until the date it paid benefit;*
- *Pay Mrs M £600 compensation; and*
- *Write a letter to Mrs M apologising for the fraud allegation and withdrawing the statement.'*

I asked both parties to send me any additional evidence or comments they wanted me to consider. I've summarised both parties' responses below.

Mrs M asked me to address some points she believed I hadn't set out in my provisional findings. She didn't think L&G had been proactive in obtaining the evidence it needed to establish the validity of her claim. She considered it ought to have arranged in-person reviews rather than telephone reviews. She said that once it had determined her specialists' initial evidence was inadequate, it hadn't done anything further – instead it had waited for the CPAD. She told us that she'd had to chase up information with the specialists, etc. And she felt that if L&G had been more proactive, the claim could have been accepted some months earlier. She asked me to decide whether I felt L&G had followed a fair process. She said she'd like her complaint to serve as an example for L&G to evaluate its processes and she asked me to request that L&G make such changes to its policies. She also considered it would be fairer for me to award interest from October/November 2023, when L&G first received the clinical letters and decided to do nothing more to progress her claim.

L&G didn't agree it was fair for me to direct it to pay interest. It stated that Dr C's letter of January 2024 referred to the fact that during earlier reviews, it had been felt that Mrs M had made sufficient improvements in her condition to attempt a phased return to work. It therefore said it would have expected Mrs M to have attempted a return to work, but to the best of its knowledge, this hadn't happened. So it didn't agree the claim could have been accepted on full benefit in January 2024, as Mrs M didn't meet the full definition of incapacity. It maintained that it had only been in a position to accept the claim once it received Mrs M's appeal correspondence. It felt it had been disadvantaged in the matter because it hadn't known Mrs M's employment had come to an end.

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 and having considered the detailed additional submission of both parties, my final decision is the same as my provisional decision and for the same reasons. I'll now go on to address what I consider to be the key further points both Mrs M and L&G have made.

I must first make our role clear. We're not the industry regulator and so we have no power to tell a financial business to change its policies or procedures. Our role is to investigate individual complaints brought by consumers and to decide whether we think a financial business has acted fairly, based on the specific facts and circumstances of each complaint. So while I appreciate Mrs M would like me to direct L&G to evaluate its policies, procedures or processes, this simply isn't something I have the power to do.

It's clear Mrs M feels strongly that L&G didn't do enough to progress her claim. She considers it ought to have asked her specialists for more information once it had assessed their initial reports and that it ought to have arranged in-person assessments for her.

However, as I explained in my provisional decision, it's an insured person's responsibility to

provide their insurer with enough evidence to show they have a valid claim on their policy. So it was for Mrs M to provide L&G with sufficient evidence to show that her claim met the policy definition of incapacity throughout the whole of the deferred period and beyond. I don't think it was unfair or unreasonable for L&G to rely on the initial reports it was sent by Mrs M's treating doctors to decide that the evidence didn't indicate she met the definition of incapacity at that point. Nor do I think it had any obligation to ask the specialists for additional evidence which might support Mrs M's claim. And it isn't unusual for insurers to arrange telephone reviews with its VCS or other clinical assessors it might appoint during the course of a claim. So I don't find L&G acted unfairly when it didn't arrange an in-person assessment for Mrs M earlier in the claims process, given the evidence it had been sent.

And, taking the above into account, I still don't think L&G had enough evidence to accept Mrs M's claim prior to Dr C's letter of 19 January 2024.

Nonetheless, I'm still satisfied that L&G had enough evidence to accept Mrs M's claim from the date it received Mrs M's letter. I don't agree that it didn't have enough information to accept the claim until after it received and assessed Mrs M's appeal paperwork. That's because, as I said, Dr C, the VCS and OH all agreed that Mrs M wasn't fit to work – a view which appeared to have been shared originally by the CMO. While Dr C's report stated Mrs M would've likely been fit to begin a phased return to work in January 2024, I don't think this prevented L&G from accepting that Mrs M had met the policy definition of incapacity for the full deferred period and up until the end of December 2023.

It's on that basis that I'm still persuaded that it would be fair and reasonable for L&G to pay interest on the backdated settlement it paid Mrs M for the period 18 October 2023 until 31 December 2023. So I find that L&G must pay interest at an annual rate of 8% simple on the backdated benefit it paid Mrs M, from the date it received Dr C's letter until the date the settlement was paid.

I note L&G has accepted my proposed directions to write Mrs M a letter of apology for the fraud allegation and which withdraws its statement and to pay her £600 compensation. And I still find those to be fair and reasonable awards in all the circumstances.

Putting things right

I direct Legal and General Assurance Society Limited to:

- Pay interest on the total benefit payment it paid Mrs M (representing the period 18 October until 31 December 2023) at an annual rate of 8%
simple, from the date it received Mr C's report of 19 January 2024 until the date it paid benefit*;
- Pay Mrs M £600 compensation; and
- Write a letter to Mrs M apologising for the fraud allegation and withdrawing the statement.+

*If L&G considers that it's required by HM Revenue & Customs to deduct income tax from that interest, it should tell Mrs M how much it's taken off. It should also give Mrs M a tax deduction certificate if she asks for one, so she can reclaim the tax from HM Revenue & Customs if appropriate.

+ L&G must pay the compensation within 28 days of the date on which we tell it Mrs M accepts my final decision. If it pays later than this, it must also pay interest on the compensation from the deadline date for settlement to the date of payment at 8% a year.

My final decision

For the reasons I've given above and in my provisional decision, my final decision is that I uphold this complaint and I direct Legal & General Assurance Society Limited to put things right as I've outlined above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs M to accept or reject my decision before 16 July 2025.

Lisa Barham
Ombudsman