DRN-5660791

The complaint

Ms B complains that Legal and General Assurance Society Limited ('*L&G*') unfairly refused a claim she made under a group income protection policy.

What happened

Ms B was a member of her employer's income protection policy, underwritten by L&G. The policy was designed to pay monthly benefit of two-thirds of Ms B's salary should she be incapacitated due to an illness or injury preventing her from completing the essential duties of her own occupation throughout a deferred period of 26 weeks and beyond.

Ms B suffers from a number of longstanding chronic health conditions including ulcerative colitis, sciatica and fibromyalgia. Prior to going off sick in February 2024, she worked part-time in a type of home-based clerical role. Based on Ms B's first absence from work, the policy's deferred period ran up to 5 August 2024.

In May 2024, Ms B supplied a claim form to L&G for income protection benefit. Within her claim she said she was suffering with nerve pain, muscular pain, fatigue and confusion as a result of her fibromyalgia. Ms B explained she had been undergoing a neurodiversity assessment since January 2024 (that continued up to a confirmed diagnosis in July 2024) which was extremely stressful. She said this had further exacerbated her existing fibromyalgia symptoms.

In July 2024, Ms B underwent an assessment with a Vocational Clinical Specialist ('*VCS*'), which was arranged by L&G. The specialist set out that Ms B could not return to work due to pain and a flare up of her fibromyalgia.

In October 2024, L&G rejected the claim. It said its chief medical officer ('*CMO*') believed that the reasons Ms B was absent from work related to employer-specific concerns about the impact of her recent neurodiversity diagnosis, changes to home-based working and the employer's occupational health team's view on Ms B's prescription medication.

L&G therefore could not agree the policy definition of incapacity had been met, because it felt Ms B could perform the role at a different employer – and the reasons preventing her return related to issues with her current employer.

Ms B sent L&G further emails appealing the claim outcome, alongside a report from her GP dated 7 November 2024 which related to her fibromyalgia.

On 18 November 2024, L&G rejected the appeal. It said that it remained of the view that Ms B had been able to work previously in her occupation with workplace adjustments for her disabilities, including her recent neurodiversity diagnosis. It felt that the reason Ms B could not work was due to workplace stressors – and these would not prevent her from undertaking her insured role elsewhere.

Ms B complained, noting that she felt L&G had focused solely on her employment, rather than her incapacity. In December 2024, L&G rejected the complaint. It maintained its view

that the barrier to Ms B returning to work was due to issues with her employer, rather than any objective medical evidence of an illness causing incapacity.

Ms B's employment was later terminated on capability grounds, with effect from March 2025.

Ms B brought her complaint to this service, where it was reviewed by one of our investigators. She believed the complaint should succeed on the basis that L&G hadn't properly considered all of the available medical evidence from the outset in respect of Ms B's fibromyalgia; rather, it had focused on her neurodiversity diagnosis. She proposed that L&G reassess the claim to include consideration of the impact of fibromyalgia symptoms as Ms B's primary reason for incapacity. She also thought it should pay Ms B £250 as a consequence of the delay.

L&G said it did not accept the investigator's view and it asked for the complaint to be referred to an ombudsman. It nonetheless supplied a new assessment from its CMO dated 23 June 2025 which specifically addressed Ms B's full history of fibromyalgia. It also provided a further VCS report in which the specialist explained that had she been privy to GP evidence of fibromyalgia when she undertook her previous assessment in July 2024, her conclusion that Ms B could not return to work would have been the same.

L&G also said:

- It had considered Ms B's GP records when it refused the claim, and those records said – in August 2024 - that her fibromyalgia symptoms had improved.
- It is clear from the evidence that Ms B's reason for absence from work was because of work-related stress.
- During the deferred period – in May 2024 – it was noted that Ms B's focus was on her neurodiversity assessment and her mental health.
- It takes the view that Ms B's primary concerns were focused on her mental health and the impact of the neurodiversity assessment, rather than her fibromyalgia symptoms.
- It did consider the claim holistically.
- Both the claim refusal letter and the final response letter refer to Ms B's GP noting her fibromyalgia symptoms had improved, as per the telephone call she had with the GP on 21 August 2024.
- The CMO's further opinion was not based on new evidence.
- It maintains that the original decision was fair and taken reasonably at the time, and that did not include it discounting Ms B's fibromyalgia.

Ms B didn't have any further comments to make. 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'd like to thank the parties for their patience whilst this matter has awaited an ombudsman's decision. I've reviewed all the information before me, including the representations L&G made following our investigator's view. In reaching my findings, I've set out the background to this complaint in less detail than the parties and I've done so using my own words.

I've also focused on what I consider to be the central issues in the complaint. If there's something I haven't mentioned, it isn't because I've ignored it - rather, it's because I don't

need to comment on every argument in order to reach what I believe is the right outcome in the circumstances. 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 Ms B's medical or employment circumstances, though I've carefully considered everything I've seen when reaching my decision.

I agree with our investigator that this complaint should be upheld. I'll summarise my reasons for reaching this view below:

- Regulatory rules require L&G to handle claims promptly and fairly and to not unreasonably reject a claim. I've therefore considered the evidence provided by the parties alongside the terms and conditions for Ms B's employer's group policy to determine whether I believe L&G treated her fairly and reasonably by refusing her claim and subsequent appeal.

- My role isn't to substitute my view for that of a business but instead, to determine if a business has acted fairly in all the circumstances of a complaint. On that basis, while I have not seen any objective reason that L&G has unfairly processed the claim from an administrative perspective, I do agree with our investigator that the claim focused primarily on Ms B's issues at work alongside her mental health concerns during her neurodiversity assessment.

- And, despite receiving further GP evidence regarding fibromyalgia during Ms B's appeal, L&G did not provide a substantive response to the impact of fibromyalgia on Ms B's capacity to perform the essential duties of her own occupation when it rejected the claim.

- I recognise that Ms B's medical records (from March 2024) show she is concerned about changes at work. However, she sought medical attention for the symptoms of fibromyalgia and the statements of fitness for work were given on the basis of Ms B suffering with fibromyalgia.

- Further, when making her claim, Ms B was specifically asked which symptoms stopped her from working – and she particularised those under the heading of a "*fibromyalgia flare up*". It is for this reason that the VCS assessment of July 2024 focused on the impact of the fibromyalgia symptoms, with the specialist setting out that "*she does however, report worsening of fibromyalgia symptoms. She has had this condition for several years and has had restrictions in her physical function, however, has always managed a sedentary role working part time hours. Based solely on her reporting, due to the deterioration in her condition the history does suggest she would be unable to perform her role, due to the pain and fatigue*".

- I have seen the view of L&G's CMO from September 2024. Given L&G says it is commercially sensitive, I cannot repeat the precise content here. However, the view centres on the neurodiversity diagnosis and the employer's duty to make reasonable adjustments for Ms B. It does not consider the impact of the fibromyalgia flare up or undertake any review of her reported fibromyalgia symptoms whatsoever.

- And in the appeal outcome letter of 18 November 2024, L&G told Ms B how "*in summary, the claim was declined following an assessment by our Vocational Clinical Specialist, GP records being received and the Medical Officer assessment. It was noted that there were several perceived work-related issues and the stress of the diagnosis procedure for [Ms B's neurodiversity condition]… Therefore, it was deemed that your absence fell outside of the remit of this insurance policy, and this would be*

a matter for discussion with your employer rather than a Group Income Protection matter so that any work related barriers can be resolved to your expectations and bring about a return to work".

- Whilst L&G is entitled to reach an objective view on the medical evidence and the underlying cause of incapacity, it also must act reasonably in measuring Ms B's evidence against the policy wording for own occupation income protection benefit which "*means the insured member is incapacitated by illness or injury that prevents him from performing the essential duties of his occupation immediately before the start of the deferred period*".

- Ms B, the VCS specialist and the GP have all directly referred to the illness causing the inability to work as Ms B's fibromyalgia – even where the cause of that flare up may be workplace stress and/or the impact of the neurodiversity assessment. However, in its appeal outcome L&G told Ms B that "*although the report received from [the GP] is informative to an extent, it is clear that the work-related pressures and issues still remain present*".

- I am of the view that a fair and reasonable approach to the claim would include an assessment of the impact of Ms B's fibromyalgia symptoms on her ability to work during the deferred period and beyond. I am pleased to note that L&G has now provided such an assessment from both its CMO and from the VCS specialist dated 23 June 2025. However, I would expect this to have been provided to Ms B as part of the claim outcome or thereafter within the appeal process, given its focus on her fibromyalgia.

- Accordingly, I agree that this complaint should succeed on the basis that L&G could (and should) have provided a full claim outcome to Ms B sooner than it did; and that outcome should have taken account of the particulars of her fibromyalgia given this formed the basis of her claim.

- What this service does is decide if a business has treated a customer unfairly because of its actions or inactions. And if it has done so, we then go on to consider what ought to be done to put any mistake(s) right. In this case, L&G ought to have provided Ms B with a comprehensive outcome to her claim on the basis of her absence with fibromyalgia symptoms set out within the evidence she supplied. The error has not caused Ms B any identifiable financial loss (since L&G maintains that it cannot pay the claim), but it has delayed matters for Ms B and failed to give her full written reasons as to why the claim was refused.

- As well as putting right any financial losses in a complaint (though there are none in this circumstance), this service will also consider the emotional or practical impact of any errors on a complainant. In doing so, we do not fine or punish businesses; that regulatory role falls to the Financial Conduct Authority.

- Overall, I am satisfied that a £250 award is appropriate in the circumstances where an avoidable delay in providing a full response to Ms B's claim and appeal delayed matters by several months; it has also caused Ms B undue concern about the impact of the claim decision on her career, since her employment has now ended.

Putting things right

I believe this complaint ought to succeed, on the basis that the claim outcome has been unduly prolonged by L&G – and £250 compensation should be paid to Ms B to reflect the

impact of that delay.

I have also not seen any suggestion that L&G has provided Ms B with a written update as to its most recent assessment of the claim. I note L&G says the two reviews by the CMO and VCS specialist were not based on new evidence, but these are new events which post-date the issue raised to our service by Ms B as a complaint dated 3 April 2025. The review of June 2025 includes an extensive assessment from its CMO regarding the claim refusal based on Ms B's fibromyalgia. I therefore believe L&G ought to provide Ms B with a further outcome letter confirming its reasons for maintaining its view on the claim within one month of the date of my decision.

My final decision

For the reasons explained, I uphold this complaint. I direct Legal and General Assurance Society Limited to pay Ms B £250 and provide her with an updated outcome letter based on its renewed assessment of the claim dated 23 June 2025. I make no other award.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms B to accept or reject my decision before 20 November 2025.

Jo Storey
Ombudsman