DRN-5692805

The complaint

Miss T is unhappy that Legal & General Assurance Society Limited ('L&G') declined a claim made on her income protection policy ('the policy'). She's also unhappy about the way in which the claim was handled.

What happened

Miss T claimed on her income protection policy after was signed off work with anxiety due to work related issues.

L&G declined the claim on the basis that the policy definition of incapacity wasn't met.

Miss T raised concerns with that decision, but L&G maintained that it had correctly declined her claim.

Unhappy, Miss T complained to the Financial Ombudsman Service. Our investigator looked into what happened and didn't uphold Miss T's complaint.

Miss T disagreed. So, this complaint has been passed to me to consider everything afresh 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.

Subject to the remaining terms of the policy, L&G will pay the monthly benefit following the deferred period if Miss T met the definition of incapacity.

The relevant definition of incapacity is 'own occupation' which is defined by the policy terms as:

> You will be considered to be incapacitated if after a review of all medical and associated evidence, and as a direct result of your injury or illness, we agree that you have no capacity for working in your own occupation on any basis; and
>
> a) you were in gainful employment or gainful self employment at the time of the incapacity;
>
> and
>
> b) you are not working in any other occupation

Occupation is defined as:

> Any trade, profession or type of work and receiving a salary or wage if employed, or for profit or reward if self employed. It is not specific to any particular employer or job description.

So, the focus is very much on whether Miss T could perform the role she was doing (as opposed to the role for a particular employer) because of illness or injury.

L&G has a regulatory obligation to handle insurance claims promptly and fairly. And it mustn't decline a claim unreasonably.

And it's for Miss T, when making a claim, to establish that she met the definition of incapacity as defined by the policy terms, and throughout the deferred period. It's not for L&G to show she didn't meet the incapacity definition.

The decision to decline the claim

I understand Miss T's strength of feeling that L&G has unfairly declined her claim. This decision has financially impacted her, and I appreciate that she has paid for the policy over a number of years. I have a lot of empathy for what's happened.

However, based on the evidence I've seen, I'm satisfied that L&G has acted fairly and reasonably here. My decision is in no way intended to be dismissive of the health issues Miss T experienced, but I'm satisfied L&G has fairly and reasonably declined her claim. I'll explain why.

- I'm satisfied that L&G reasonably concluded there was limited evidence to support that Miss T was incapacitated as defined by the policy terms and that it was work-related issues which were the main barrier for her returning to work, rather than illness.

- It isn't disputed that Miss T was signed off work by her GP and was considered unfit to work by occupational health during the deferred period. However, that doesn't automatically mean that she was incapacitated as defined by the policy terms. The policy has a specific definition which needs to be met. And the available medical evidence gives little meaningful insight, from a medical perspective, into why Miss T couldn't carry out her role because of illness throughout the deferred period.

- I'm satisfied that the overall evidence during the deferred period supports that it was reported work-related issues which were the main cause of her symptoms and the main barrier for Miss T returning to work during the deferred period. Had the underlying work issues not been present, I'm satisfied L&G has fairly concluded that she is likely to have been able to work.

They way the claim was handled

I'm satisfied that L&G acted fairly by relying on the information it had when initially making the decision to decline the claim. I'm satisfied that the available evidence – including Miss T's claim form and a report prepared by L&G's vocational clinical specialist – supported that it was work related stress which was the primary cause of her symptoms.

I'm also satisfied that L&G promptly assessed and provided an outcome to her claim after receiving her GP records (which I'm satisfied it proactively chased for).

L&G didn't take into account the GP report when declining the claim as it hadn't been received by that time. But it did have other evidence including the GP records. It looks like the report was provided after the GP notes were sent. I think it was reasonable for L&G to provide an outcome without waiting for the GP report, given the other evidence it had.

I'm satisfied that the GP report was considered by L&G after Miss T raised concerns about the claim outcome. And ultimately, I'm satisfied L&G has fairly and reasonably concluded

that the GP report doesn't add much to the overall evidence it had. Or that it was unfair to maintain its decision to decline the claim after considering the GP report.

My final decision

I don't uphold Miss T's complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss T to accept or reject my decision before 20 October 2025.

David Curtis-Johnson
Ombudsman