DRN-5697527

The complaint

Mrs G is unhappy that Zurich Assurance Ltd (Zurich) stopped her income protection benefit payments.

Mrs G is being represented on this complaint.

What happened

Mrs G has a group income protection policy with her employer. This provides a benefit in certain circumstances after a deferred period of 26 weeks on an own occupation basis. Zurich is the underwriter.

Mrs G was first absent from work in November 2020 suffering from nerve pain and fatigue. She hasn't returned to work and was later diagnosed with Post Viral Fatigue Syndrome (PVFS).

She submitted her claim for income protection benefit. Zurich accepted the claim and following the deferred period, benefit payments started in May 2021.

As part of the claim review process, Zurich requested medical information from her GP and referred the information to its Chief Medical Officer (CMO). A Chronic Pain Abilities Determination (CPAD) test was arranged. As a result of the recommendations made, Zurich declined to continue the income protection benefit payments. The report said Mrs G was capable of returning to work in her role. Mrs G appealed the claim and provided Zurich with further information. It maintained its position to stop the claim. The benefit payments stopped from 1 March 2024.

Unhappy, Mrs G brought her complaint to this service. Our investigator didn't uphold the complaint. He didn't think Zurich had unfairly stopped the benefit payments under the policy.

Mrs G 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.

At the outset, I wanted to acknowledge that the whole situation has been very difficult for Mrs G. My role is to reach an independent and impartial outcome that's fair and reasonable, based on the information available to me. I don't doubt that Mrs G is unwell, but this doesn't automatically mean that Zurich must continue to pay her claim.

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 Mrs G's claim, to decide whether I think Zurich 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 Mrs G. 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, as it forms the basis of the contract between Mrs G's employer and Zurich.

The policy states for a claim to paid, the definition of incapacity must be met. Incapacity is defined on page 4 as:

> *'**Incapacity or Incapacitated** means an illness or injury that causes the member to be unable to work and applicable under this policy.'*

And on page 5:

> ***Standard** The member cannot perform the Material and Substantial Duties of their employment and they are not doing paid work.'*

In a situation like this, where an insurer has accepted a claim and subsequently terminates that claim, it's for the insurer to show that the claimant no longer meets the definition of incapacity.

For the avoidance of doubt, I'm not medically qualified so it's not for me to reach any determinations about Mrs G'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 Zurich acted fairly and reasonably in terminating Mrs G's claim.

I've been provided with detailed medical evidence relating to Mrs G's condition. It's not in dispute that Mrs G met the policy definition of incapacity from May 2021 to March 2024. Zurich was paying the claim during the time. The issue for me to determine is whether I think the medical evidence supports Zurich's decision that Mrs G no longer meets the policy definition of incapacity.

Zurich requested medical information from Mrs G's GP who completed a Claims Medical Report (CMR) in May 2023. This confirmed that Mrs G continued to be signed off work for post viral fatigue. There was no treatment plan in place, and her condition appeared to be static. The GP medical records show that Mrs G self-managed her symptoms through online sessions with the chronic fatigue syndrome (ME/CFS) service but I note Mrs G hadn't been reviewed face to face.

On 14 November 2023 and 16 November 2023, Mrs G had a CPAD test. The assessor was a registered chartered physiotherapist and an accredited functional capacity assessor. It was a two-day assessment to explore Mrs G's physical and cognitive abilities compared to the functional requirements of her own occupation. The report concluded that Mrs G's actual abilities were greater than she was willing to perform. Its conclusion was based on a number of inconsistencies and discrepancies demonstrated by Mrs G throughout the testing. I note the report states that Mrs G was unable to complete the cognitive tests on day 1 but did so on day 2. She scored 30/30 and the conclusion was that she didn't demonstrate any level of cognitive impairment during this test. And upon the testing that took place on day 2, the report states there weren't any barriers preventing Mrs G from returning to her normal role. The report goes into detail about the tests that were carried out on Mrs G's capability.

Mrs G's representative instructed a GP whose specialist interest is ME/CFS to prepare a

report. The report concluded that Mrs G is not capable of returning to work. I've thought carefully about this, and I appreciate the information she's provided for us to consider. However, I have to look at the medical evidence in its totality. The letter from this GP predominantly relates to self-reported symptoms. I've considered that the assessment with this doctor was an hour-long video call and not face to face. Mrs G's medical records were reviewed by the GP, but I note they are not her treating GP. And the information the GP relied on to review was provided by Mrs G. As such, it's highly unlikely this GP would have had access to all of Mrs G's medical information. Whilst I don't doubt the GP's specialist interest, I have to weigh up all the evidence available. I don't think this report provides an objective or independent assessment of Mrs G's condition. A recommendation made by the GP that Mrs G isn't fit to return to work doesn't automatically mean that she continues to meet the policy definition of incapacity. I've also considered that there was no physical or cognitive assessment carried out on Mrs G.

In contrast, the CPAD is independent and objective. The assessment was carried out by a chartered physiotherapist and qualified functional capacity assessor over two days and face to face. A number of tests were carried out against Mrs G's cognitive and functional capabilities against her own occupation. So, I think the report does, on balance, carry more persuasive weight.

Zurich referred all of Mrs G's medical information from her GP, the CPAD test and the further letter from the GP, to its CMO. The opinion was that Mrs G was capable of returning to work on a phased basis over 12 weeks. It's not up to Zurich to provide further instructions to Mrs G's employer. It's usual practice for the employer and Mrs G to arrange this between themselves. I note that Mrs G didn't engage in this recommendation. Zurich confirmed that it would provide support to Mrs G of its in-house rehabilitation team and pay the full benefit to allow for Mrs G's return to work.

Ultimately, the test here is whether Mrs G continues to meet the definition of incapacity as per the terms and conditions of the policy. And having reviewed everything, I don't think it's likely she does. There isn't sufficient evidence to say that Mrs G is incapable to carry out the material and substantial duties of her own occupation.

Mrs G says the CPAD is invalid, and Zurich was put on notice that the actual testing procedure was flawed. I don't agree the test was invalid and I've provided above my reasons why I'm not persuaded it was flawed. Whilst I appreciate that Zurich has the burden of proving the validity of the test, in the circumstances, an independent assessment took place. The evidence is sufficient to show that Mrs G no longer met the definition of incapacity as required by the policy terms and conditions.

Overall, based on all the evidence available, I don't think Zurich stopped Mrs G's claim unfairly or outside the terms and conditions of the policy. I don't find there are any reasonable grounds upon which I could direct Zurich to reinstate Mrs G's claim. I'm sorry to disappoint Mrs G. But it follows that I don't require Zurich to do anything further.

My final decision

For the reasons given above, I don't uphold Mrs G's complaint about Zurich Assurance Ltd.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs G to accept or reject my decision before 28 October 2025.

Nimisha Radia
Ombudsman