

The complaint

Ms F is unhappy that Legal and General Assurance Society Limited ('L&G') declined a claim made under a group income protection insurance policy ('the policy') and with the way in which the claim was handled. That includes the time taken to assess the claim.

What happened

Ms F was signed off work by her GP in October 2024 with post-traumatic stress disorder ('PTSD').

She had the benefit of the policy through her employer – the policyholder. Subject to the remaining terms of the policy, the policy can pay out a portion of her income each month after she'd been off work for 26 weeks due to illness ('the deferred period'). The deferred period started in mid-October 2024 and was due to end in April 2025.

Due to Ms F's absence from work, a claim was made on the policy for the monthly benefit. L&G considered the medical evidence and by way of letter dated early April 2025, it declined the claim. It concluded that Ms F's absence from work was primarily due to work-related issues. L&G didn't think Ms F had established that she met the policy definition of incapacity for the monthly benefit to be paid.

Unhappy, Ms F appealed the decision. And by way of a letter dated June 2025, L&G maintained its decision to decline the claim.

Ms F brought a complaint to the Financial Ombudsman Service. One of our investigators looked at what happened and didn't uphold Ms F's complaint. Ms F didn't agree and raised further points in reply. These didn't change our investigator's opinion. So, this complaint has now 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.

That includes all submissions made by Ms F to the Financial Ombudsman Service, for which I'm thankful. Whilst I've considered these in detail (along with all the other evidence) I won't be responding to each point made.

I hope Ms F understands that no discourtesy is intended by this. Instead, I've focussed on what I think are the key issues here. The rules that govern the Financial Ombudsman Service allow me to do this as we are an informal dispute resolution service. If there's something I've not mentioned, it isn't because I've overlooked it. I haven't. I'm satisfied I don't need to comment on every point to fulfil my statutory remit.

I understand Ms F's strength of feeling that L&G has acted unfairly in the way it handled the claim made under the policy (and its decision to decline the claim). I know that its decision

has greatly impacted her. I have a lot of empathy for her situation and what she's going through.

However, for reasons I'll go on to explain, 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 Ms F's experienced (and continues to experience). I can see that she's been through a very difficult and worrying time over the last few years.

The relevant policy terms

Subject to the remaining terms of the policy, L&G will pay the monthly benefit provided that the member of the policy is a 'disabled member'. That has a specific definition under the policy which is:

An insured member who at any time:

- i. Is incapacitated by an illness or injury; and
- ii. Meets the incapacity definition; and
- iii. Is not engaged in any other occupation...

It goes on to say:

For the avoidance of doubt, an insured member is not a disabled member if they are absent because of:

- i. Workplace issues, including an employer's failure to make reasonable adjustments, disputes between the insured member and their employer, or employer demands...

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

The insured member is incapacitated by illness or injury that prevents them from performing the essential duties of their occupation immediately before the start of the deferred period.

So, the focus is very much on whether Ms F could perform the role she was doing (as opposed to the role for her particular employer) because of illness.

The decision to decline the claim

L&G has a regulatory obligation to not unreasonably decline an insurance claim.

I'm not a medical expert so I've relied on the medical evidence available to me when considering whether L&G has fairly and reasonably declined the claim.

I've also taken into account that it's for Ms F, 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 Ms F doesn't meet the incapacity definition.

Ms F's member statement, completed in support of the claim, (completed by her in February 2025) asked 'what symptoms stop you from working?'.

She answered:

extreme insomnia, nightmares, panic attacks, dissociative episodes, flashbacks, intrusive thoughts, physical chest and stomach pain, nausea/vomiting, extreme fatigue, thoughts of suicide and self-harm

It isn't disputed that Ms F had been diagnosed with PTSD. Further, Ms F had been medically signed off from work, been prescribed medication, was accessing therapy and the medical records reflect that she was displaying a range of symptoms. She is also in receipt of disability related welfare benefits.

However, as set out above there's a specific definition that needs to be met under the policy and being signed off from work – or declared as being too unwell to work - by the medical professionals involved in her care doesn't automatically mean that she was a disabled member as defined by the policy.

Having considered the overall medical evidence, I'm satisfied that L&G has fairly and reasonably concluded that it was work related issues which were the main barrier for her returning to work during the deferred period. And she didn't meet the incapacity definition, nor the definition of a disabled member. I use the term 'work related issues' not to trivialise the seriousness and range of the issues at work Ms F reported and the impact they had on her. But, rather, as a generic term to encompass all the work issues she's reported which I appreciate would've been very distressing.

- Ms F's consultant psychiatrist provided a report which sets out her symptoms and history in detail. It's reflected that there were work-related issues and Ms F had a previous period of extended sick leave during which she'd first been diagnosed with PTSD but returned to work several months later. The report says that after she returned from sick leave, there were continued issues within the team and the behaviours that she'd previously expressed concerns about continued. She was subsequently signed off work.
- There's an entry from early November 2024 in her GP records reflecting that Ms F requested a letter to her employer to say they needed to accommodate the recommendations made by occupational health about her PTSD so she can keep working.
- There are further entries during the deferred period, reflecting her employer ignoring the recommendations made by occupational health and being unwilling to create an environment that's safe for someone with her condition to work in. And her symptoms worsening due to her working environment.
- Occupational health reports reflect that in September 2024 (shortly before her period of sick leave in October 2024) Ms F was anxious (especially around the work environment) but she was working full time and feeling more positive. But by November 2024, she'd been signed off work and Ms F attributed the deterioration to difficulties from a work perspective.

So, I'm satisfied L&G has fairly concluded that the trigger for Ms F's deterioration in health in October 2024 was the reported breakdown in relations with her employer. And had the underlying work issues not existed (and the recommendations made by occupational health been in place at the outset) Ms F is likely to have been able to continue working. So, I'm satisfied L&G has reasonably concluded that Ms F hasn't established that she's 'incapacitated' throughout the deferred period and that the work-related issues were the main barrier for her returning to work.

When making this finding, I've taken into account another ombudsman's decision referred to by Ms F. However, each case is different. I've considered the individual circumstances of the

complaint I'm deciding. Further, having read the other ombudsman decision, I don't think it's similar to the circumstances of this complaint.

The way the claim was handled

I know Ms F says she's disabled as defined by the Equality Act 2010 ('the EqA') and L&G failed in its duty to make reasonable adjustments including delays in the process.

I have no power to decide whether L&G breached the EqA. Only a court or tribunal can do that. However, for the purpose of this decision, I accept that Ms F is disabled under the section 6 of the EqA so it's relevant law for me to take into account along with other considerations like relevant industry regulations and good industry practice. That also includes L&G's regulatory obligation to handle insurance claims fairly and promptly.

Having done so, whilst I acknowledge Ms F's very distressing circumstances and that she was clearly vulnerable, I think L&G has handled the claim made on the policy fairly and reasonably overall.

I'm satisfied that it promptly progressed the claim and provided its decision to decline the claim within a reasonable timeframe, and before the end of the deferred period.

After Ms F provided her completed member's statement which also contained her signed authority for L&G to access her medical records, I'm satisfied that L&G promptly took action to request these. It also arranged for L&G's vocational clinical specialist to speak with her in February 2025 and upon receipt of the medical evidence, reasonably promptly sought the advice of its chief medical officer.

I'm also satisfied that L&G reasonably promptly addressed the appeal against the decision to decline the claim and although the appeal outcome is dated almost two months after the date of the appeal, I don't think L&G acted unfairly by requesting updated medical evidence to see if this impacted its decision. Once this was received it promptly considered everything and sought its chief medical officer's opinion on whether the further evidence changed the original decision. I don't think that was unfair.

I also think L&G acted fairly by initially sending the policyholder the claim and appeals decision, rather than to Ms F directly. That isn't unusual when a claim is made under a group policy, where the employer is the policyholder. Although Ms F was a member (and so, a potential beneficiary) of the policy, the contract of insurance is between L&G and the policyholder.

Ms F is also very unhappy with some of the comments made by L&G in correspondence, including in its letter dated April 2025 declining the claim and the final response letter dated June 2025. She says she was being encouraged to end her employment at a time when she was extremely vulnerable. Had she done so, she says she would've lost access to her employment benefits including health insurance and the policy.

The April 2025 letter says:

We appreciate that the current situation reported appears untenable and our view is that this ongoing matter requires appropriate HR input, in the best interests of yourself and the business. Notwithstanding this fact, this is a matter which unfortunately falls outside the scope of the policy terms. As such, we are unable to support this application.

It is likely that you [sic] a sense of closure with your current employer, if possible, will be supportive to your overall psychological wellbeing, in our view.

The final response letter says:

The concerns and increasing symptoms relating to your absence are specifically related to workplace issues and your concerns around job security, which need to be addressed through greater collaboration between you and your employer.

The current situation with regards to your financial situation is now also compounding this further and contributing significantly to your mental wellbeing symptoms and has created further barriers to engaging in meaningful progress in addressing the original workplace concerns.

For this reason, we still strongly encourage collaboration with your employer, and we also remain of the view that there was insufficient evidence of incapacity throughout the deferred period.

The evidence shows a breakdown in an employee and employer relationship which falls outside of the scope of the policy. It would be for the parties involved to take any appropriate steps to reach a satisfactory resolution, as a sense of closure is likely to benefit your wellbeing and reported symptoms.

Having considered these comments in the overall context of both letters, I'm not persuaded that L&G has acted unfairly. I'm not persuaded that it was encouraging Ms F to end her employment. Rather, in the context of the reasons it relied on to decline the claim, L&G explained that for the situation to be resolved, Ms F and her employer may want to collaborate and involve HR to resolve issues between them.

I also note that Ms F wants to be sent the full policy terms and conditions and the details of L&G's chief medical officer. As she isn't the policyholder, I don't think L&G has acted unfairly by not providing her with the full terms which set out the basis of the insurance contract between it and the policyholder. Further, I don't think it's acted unfairly by not providing the identity and professional experience of its chief medical officer to her.

My final decision

I don't uphold this complaint. Under the rules of the Financial Ombudsman Service, I'm required to ask Miss F to accept or reject my decision before 13 October 2025.

David Curtis-Johnson
Ombudsman