

The complaint

Mrs J is unhappy with the way MetLife Europe d.a.c. handled a claim made under a group income protection insurance policy, through her (then) employer.

What happened

Mrs J had the benefit of a group income protection insurance policy ('the policy'). Subject to the remaining terms, and after the end of the deferred period, the policy can pay out a monthly benefit if Mrs J was too ill to work.

MetLife accepted the claim in early August 2023, and backdated the benefit to the end of the deferred period. It also said it would arrange a chronic pain abilities determination (CPAD).

The CPAD took place at the end of January 2024. And in light of the CPAD report, MetLife decided to terminate the claim in February 2024 - paying the benefit to mid-March 2024. Unhappy, Mrs J appealed and provided further medical evidence.

In light of this, MetLife decided to reinstate the claim and backdated the benefit to the date the claim was terminated. It said it would review the claim again in November 2024.

MetLife was in the process of reviewing the claim again at the end of 2024 when it became aware that Mrs J had ended her employment with the policyholder. As she was no longer employed, MetLife stopped paying the benefit.

Mrs J is very unhappy with the way the claim was handled including but limited to the arrangements made in relation to the CPAD, the contents of the CPAD report, MetLife's decision to rely on the CPAD report to terminate the claim (only for it to be later reinstated on appeal) and the communications she received whilst on medical leave. She brought a complaint to the Financial Ombudsman Service.

Our investigator looked into what happened and didn't uphold Mrs J's complaint. Mrs J disagreed and raised further points in reply. These didn't change our investigator's opinion. So, her 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.

That includes all submissions made by Mrs J to the Financial Ombudsman Service. Whilst I've considered these in detail (along with all other evidence) I won't be responding to each point made. I hope Mrs J 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 Mrs J's strength of feeling that MetLife has handled her claim unfairly. I have a lot of empathy for her situation and the health issues she's experienced. However, overall and for reasons I'll go on to explain, I'm satisfied that MetLife has acted fairly and reasonably here.

The decision to end the claim, the CPAD report and decision to reinstate the claim

The insurance industry regulator, the Financial Conduct Authority ('FCA'), sets out rules and guidance for insurers in the 'Insurance: Conduct of Business Sourcebook' ('ICOBS'). ICOBS says insurers should act honestly, fairly and professionally in accordance with the best interests of its customers. It also says insurers should handle insurance claims promptly and fairly - and shouldn't unreasonably reject a claim.

Under the policy terms, and relevant to this complaint, an insured member is incapacitated if they're:

- unable to perform, due to illness or injury, the material and substantial duties required of them in their own occupation which they were performing immediately prior to being incapacitated; and
- not following any other occupation.

When making a claim, it's for Mrs J to establish that she was incapacitated. She did that and the claim was accepted and monthly benefit paid under the policy. When MetLife ended the claim in February 2024, it was for it to show (on the balance of probabilities) that Mrs J no longer met the definition of incapacity.

When first accepting the claim, I'm satisfied that MetLife fairly did so on the basis that Mrs J would be required to have a CPAD in the foreseeable future. I think it fairly concluded in around August 2024 that it wasn't clear from the medical evidence how her condition was impacting her ability to carry out the material and substantial duties of her role more recently.

Mrs J says that MetLife could've set out what medical information it required in relation to the claim which would've avoided the need for a CPAD. However, it's not unusual for an insurer to request a CPAD when assessing or reviewing a claim under an income protection policy, particularly in the context of considering the definition of incapacity. It's an objective review of the insured member's functionality. In the circumstances of this case, I'm satisfied it was fair and reasonable to want to arrange a CPAD when looking to review the claim.

Even though there was medical opinion that a CPAD wasn't appropriate for those with symptoms of long-Covid-19, from what I've seen this was provided after the CPAD took place and in support of Mrs J's appeal. So, MetLife didn't have an opportunity to consider this when arranging the CPAD.

I know Mrs J is unhappy with the contents of the CPAD report. I appreciate that it only gives a snapshot of her capabilities over a two-day period. However, MetLife isn't responsible for the way in which the CPAD was carried out by the assessor or their conclusions based on the testing.

The report sets out that there were inconsistencies and discrepancies between Mrs J's reported capabilities and the results of the objective tests. The assessor concluded that Mrs J "attempted to simulate disability during formal testing, and therefore her demonstrated cognitive workday tolerances during formal testing cannot be viewed as barriers preventing her from returning to her normal role". I think it's fair and reasonable for MetLife to place

weight on the results and conclusions detailed in the CPAD report when taking the decision to end the claim.

The CPAD was carried out by a specialist independent of the parties and based on objective tests (although also considered against Mrs J's subjective reporting of her symptoms). So, given the available information at the time, I'm satisfied that MetLife fairly and reasonably declined the claim on the basis that the (objective) medical evidence no longer supported that Mrs J's ability to function was impaired to the extent that she'd reported. And so, she wasn't incapacitated as defined by the policy.

However, Mrs J did provide further medical evidence in support of her claim when appealing the decision to end her claim. I'm satisfied that MetLife promptly considered the appeal and medical evidence in support. I think its decision to reinstate the claim, backdating the benefit, based on that further information was fair and reasonable. However, I don't think that means MetLife's initial decision to end the claim was unfair. The medical evidence provided with the appeal is dated after the CPAD. So, it wouldn't have been available for MetLife to review before it took the decision to end the claim.

Claim handling issues

Overall, having considered the other concerns raised by Mrs J, I'm satisfied MetLife handled the claim fairly. I'll explain why.

- I'm satisfied that MetLife fairly and promptly assessed the claim made under the policy after it was submitted in April 2023. I appreciate Mrs J's point that it took several months for MetLife to accept the claim. However, I'm satisfied that the assessment was proactively progressed by MetLife. It requested medical records and evidence relevant to the claim, as I would reasonably expect. This was to consider whether incapacity had been established in line with the policy definition.
- Further, during this time, Mrs J had returned to work for a period on a phased return. So, I think it was reasonable for MetLife to want to understand more about that and how this impacted the claim, if at all. Mrs J also had the benefit of another income protection policy which could've had an impact on the benefit entitlement under the policy. So, I think it was reasonable for MetLife to want to explore this and get further information when assessing the claim.
- I'm satisfied that MetLife said when accepting the claim that it would want to arrange for Mrs J to attend a CPAD. She says she was told about this shortly after travelling abroad to stay with relatives for support and to receive further medical treatment. I can understand why this would've been stressful for Mrs J as she'd intended to remain abroad for several months and the flight time was several hours long. However, based on the information I've seen, I don't think it would be fair and reasonable to hold MetLife responsible for the manner and timing in which this was communicated.
- I'm satisfied that it was fair and reasonable for MetLife to arrange for the CPAD in person rather than virtually (given the nature of the CPAD and objective tests to be carried out).
- Ultimately, MetLife agreed to wait for Mrs J to return to the UK before arranging the CPAD and carried on paying the claim during this period, lasting several months. I think that was fair and reasonable. And the CPAD was arranged for around ten days after she returned to the UK to give her time to recover from travelling.
- I know Mrs J says that MetLife has discriminated against her because of her disability and it should've made reasonable adjustments. In other words, MetLife has acted in

breach of the Equality Act 2010 ('the Act').

- For the purpose of this decision, I've assumed that a court is likely to find that Mrs J meets the definition of being disabled under the Act. However, I don't have any power to determine whether the Act has been breached. Only a court can do that. When considering whether MetLife acted fairly and reasonably, I've taken the Act into account (along with relevant regulations, rules and good industry practice) as it's relevant law.
- I can't see that Mrs J specifically raised with MetLife what adjustments she needed. Having considered the contents of MetLife's communications, I'm satisfied that they were clear overall. And I don't think its processes were excess or unreasonable. I'm satisfied that MetLife was entitled to obtain medical evidence when initially assessing whether Mrs J could establish that she was incapacitated under the policy terms. And then to review the claim once it had been originally accepted. I think they acted fairly when doing so.
- Mrs J has also raised concerns that MetLife has been deliberately deceptive. I've taken into account the points she's raised but I'm not persuaded that it was. And for the reasons explained, I'm satisfied it's acted fairly and reasonably overall when handling her claim.
- I know Mrs J is unhappy that MetLife's internal communications reflect that it raised the issue of Mrs J's ability to travel abroad for family support and medical treatment to indicate a level of function. I don't think it was unreasonable for MetLife to note this as it's potentially relevant to Mrs J's abilities, and therefore relevant to the incapacity definition. But MetLife ultimately accepted the claim even though it was aware of her travel plans. So, I don't think its internal note was unfair or detrimental.
- Mrs J says that MetLife's actions have hindered her recovery and caused a deterioration in her health. I'm very sorry to read that her symptoms worsened. However, for reasons set out above, I'm satisfied MetLife acted fairly and reasonably here. So, if there has been a deterioration in her health, I don't think it would be fair and reasonable for me to hold MetLife responsible for this.

My final decision

I don't uphold this complaint. Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs J to accept or reject my decision before 5 November 2025.

David Curtis-Johnson
Ombudsman