

## **The complaint**

Mr V complains about how MetLife Europe d.a.c. handled a claim under an income protection policy.

## **What happened**

Mr V was covered by an income protection policy through his employer, which was provided by MetLife. The policy paid a benefit if Mr V was unable to work due to an illness or injury in his own occupation. The deferred period was 13 weeks.

Mr V was signed off work from 28 May 2024 onwards due to back pain caused by disc degeneration. He didn't return to work before his employment ended in December 2024 following his resignation. He made a claim, through his employer, for an income benefit.

MetLife declined the claim on 6 November 2024 based on the medical evidence it had, as well as a Functional Capacity Evaluation ("FCE") which was carried out on 18 October 2024 by a third party. MetLife said the medical reports didn't give enough detail about Mr V's ability to work in his occupation. It also said the FCE report noted significant inconsistencies and discrepancies in Mr V's test results. And it concluded that the levels of disability reported by Mr V couldn't be viewed as barriers preventing him from returning to work.

Mr V appealed the decision. He sent further medical reports, as well as other evidence, for MetLife to consider. MetLife then instructed a Functional Capacity and Cognition Evaluation ("FCCE") which was carried out on 4 February 2025. Following this report, MetLife accepted and paid Mr V's claim.

Mr V says MetLife unfairly declined his claim originally, it didn't fairly consider the evidence, and it caused delays in the process. He says the impact of these has been significant on him.

One of our investigators reviewed the complaint. Having done so, he didn't think MetLife had acted unfairly or unreasonably when it declined Mr V's claim in November 2024, for the reasons it did. And he thought MetLife acted fairly and reasonably in how it handled Mr V's appeal, which then led to it accepting the claim. But the investigator thought there were some delays and occasions when MetLife could've handled things better. Overall, he thought MetLife should pay Mr V £250 in compensation for the distress and inconvenience caused.

MetLife agreed with the investigator's recommendation. Mr V didn't think the compensation fairly reflected the impact on him, and he still didn't think MetLife acted reasonably when it declined the claim originally. As no agreement was reached, the complaint has been passed to me 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.

Industry rules set out by the regulator (the Financial Conduct Authority) say insurers must handle claims fairly and shouldn't unreasonably reject a claim. I've taken these rules, and other industry guidance, into account when deciding what I think is fair and reasonable in the circumstances of this complaint.

### Claim decision

The policy terms define incapacity as follows:

*"[U]nable 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 [...] are not following any other occupation."*

It was for Mr V to show that he met the definition of incapacity for the duration of the deferred period, and beyond. The deferred period was between 28 May and 27 August 2024.

I don't think MetLife acted unfairly or unreasonably when it declined Mr V's claim on 6 November 2024, for the reasons it did. As the investigator explained in detail, none of the medical reports provided detail on how Mr V's symptoms impacted his ability to work, or to what extent. Rather, they only confirmed the physical condition Mr V had, and that this was causing him pain. One of the reports said that his *"day-to-day activities are moderately affected due to pain"*. But as I explained, this still doesn't give detail how the pain is impacting Mr V's ability to work, or to what extent.

So, I don't think MetLife acted unfairly or unreasonably when it didn't think that the medical evidence showed that Mr V met the policy definition of incapacity for the duration of the deferred period. The claim was made due to Mr V's back pain, and how this was impacting his physical ability to work. So, I think MetLife acted fairly and reasonably by referring Mr V for an FCE to assess his functional capacity and ability to work.

The FCE was carried out by an independent third party who assessed Mr V in person. I think it was reasonable for MetLife to rely on the results of this evaluation, along with all the other evidence it had, when considering the claim. The FCE report noted inconsistencies and discrepancies in Mr V's test results, and it concluded that the levels of disability reported by Mr V couldn't be viewed as barriers preventing him from returning to work. I don't think MetLife acted unfairly or unreasonably when it declined Mr V's claim following this report. This is because there still wasn't any medical evidence which showed that he had met the policy definition of incapacity for the duration of the deferred period.

Mr V appealed the decision and sent further evidence for MetLife to consider. Following this, MetLife arranged an FCCE which took place on 4 February 2025. Mr V says MetLife should have accepted his claim based on the further medical, and other, evidence he sent. This included proof that he was approved for Employment Support Allowance ("ESA") in December 2024 (which was updated in March 2025), and for Disabled Students' Allowance ("DSA") in March 2025. He was also granted a Blue Badge in February 2025. He says these confirmed his limited capability for work.

However, the further medical reports still didn't provide detail about how Mr V's symptoms impacted his ability to work, or to what extent. For example, one of the reports was with a consultant in pain management who said that *"I would certainly recommend that you continue to work but you may need certain adaptations for you to continue to work"*. So, this still doesn't show that Mr V met the policy definition of incapacity for the duration of the deferred period.

Additionally, considering the inconsistencies and discrepancies in the FCE results, I don't think it was unreasonable for MetLife to arrange another FCE to be carried out. I also think it was reasonable to change this to FCCE, as Mr V had explained his mental health and cognition had been impacted because of the back pain and this was also referred to in the medical reports. The GP also added "mixed anxiety and depression" as a reason for Mr V being signed off work, in addition to back pain, on 31 December 2024. For completeness, some of the evidence Mr V sent was only available after the FCCE assessment which took place on 4 February 2025.

Following the FCCE report, MetLife accepted and paid the claim. So, I make no further findings on MetLife's claim decisions.

### Claim-handling

MetLife received the claim on 10 July 2024. Following this, it requested Mr V's medical records from his GP on 17 July 2024. However, due to a typo, it didn't use the correct email address until 22 August 2024. The GP practice sent the medical records to MetLife the same day, with some additional information provided on 27 August 2024. It's clear that MetLife caused some delays here by not using the correct email address. But I'm also mindful that it needed Mr V's medical records for the duration of the deferred period to fully assess the claim, so it would have always needed information up until 27 August 2024.

MetLife reviewed the records on 12 September 2024, and it referred Mr V for an FCE on 30 September 2024. This was carried out on 18 October 2024, and MetLife received the report on 30 October 2024. Following this, MetLife declined Mr V's claim on 6 November 2024. I accept MetLife could have been more prompt in arranging the FCE. But I think the timing of the FCE and when it received the report were outside of its control. And I think MetLife assessed the claim following the receipt of the report within a reasonable time.

Mr V appealed the decision on 16 November 2024, and he sent further evidence on 7 December 2024 for MetLife to consider. MetLife said on 23 December 2024 that considering the significant inconsistencies and discrepancies in the FCE results, it would refer Mr V for another FCE, which was booked for 4 February 2025. I do think MetLife could've arranged the FCE more promptly following Mr V's appeal. But again, I think the timing of the FCE and when it received the report were outside of MetLife's control.

As Mr V had also raised concerns about the impact of his mental health, and this was referred to in the medical reports, the FCE was changed to an FCCE. I think as the further medical reports Mr V sent MetLife still didn't provide the detail MetLife needed to accept the claim, along with the inconsistencies and discrepancies in the first FCE report, I think it was reasonable that MetLife wanted to carry out another evaluation to assess the appeal. So, I don't think it caused any unreasonable delays in doing so. Following the FCCE report, MetLife accepted Mr V's claim, and it paid the benefit to his employer in May 2025.

I appreciate there were some delays between MetLife receiving the FCCE report and until it paid Mr V's claim to his employer. But I'm satisfied it paid the claim as soon as it reasonably could, and the delays were largely due to circumstances outside its control.

I appreciate Mr V considers the impact on him warrants more compensation. But as I've explained in this decision, I don't think MetLife acted unfairly or unreasonably when it declined his claim first in November 2024. And whilst it didn't handle everything as well as it should have done up until this point, I don't think the delays it caused were significant.

I also think that whilst MetLife could have acted more promptly at times, it acted fairly and reasonably in how it handled Mr V's appeal overall. And I'm satisfied that it paid his claim as soon as it reasonably could in the circumstances. So, I don't think the issue Mr V now needs to sort out in relation to tax is something I could fairly hold MetLife responsible for.

For completeness, I'm also mindful that the policyholder here was Mr V's former employer. So, Mr V needed to approach his employer for any updates on the claim. I'm not persuaded that further updates from MetLife to his employer would have had a significant impact on the claim or its progress.

Overall, I think MetLife should pay Mr V £250 in compensation for the distress and inconvenience it caused in all the circumstances of his complaint.

### **My final decision**

My final decision is that I uphold Mr V's complaint in part and direct MetLife Europe d.a.c. to pay him £250 in compensation for the distress and inconvenience caused.

MetLife must pay the compensation within 28 days of the date on which we tell it Mr V accepts my final decision. If it pays later than this, it must also pay interest on the compensation from the deadline date for settlement to the date of payment at 8% simple per annum.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr V to accept or reject my decision before 12 December 2025.

Renja Anderson  
**Ombudsman**