DRN-5776964

The complaint

Miss R complains MetLife Europe d.a.c (MetLife) has declined the claim she made under an income protection insurance policy.

Miss R is being represented in this complaint, but for ease I've referred to Miss R throughout.

What happened

The circumstances of this complaint will be well known to both parties and so I've summarised events.

Miss R was covered under a group income protection policy through her employer. The policy was provided by MetLife. In January 2023 Miss R became absent from work and subsequently submitted a claim to MetLife.

MetLife reviewed Miss R's claim but in October 2023 it declined it. It said the evidence didn't confirm the presence of a consistent or sustained loss of function due to a pervasive mental health condition throughout the deferred period. It said the available evidence showed there was a sufficient improvement in Miss R's symptoms and function to enable a return to work during the deferred period.

Miss R appealed MetLife's decision and provided further information, however in November 2023 MetLife maintained its decision to decline Miss R's claim. It said the new evidence hadn't changed its understanding of Miss R's absence from work and the barriers preventing Miss R from returning to work were non-medical in nature. Miss R didn't agree and so raised a complaint. She also raised several service related complaint points.

On 3 December 2024 MetLife issued Miss R with a final response to her complaint. It said it had reviewed the additional evidence Miss R had provided but this evidence wasn't contemporaneous as it covered visits after the deferred period. It said the evidence didn't change it's understanding of any functional impairments Miss R was experiencing around the material time of the claim and so it wouldn't be changing its decision on her claim. It also responded to the service related issues Miss R had raised and offered Miss R £100 compensation. Miss R referred her complaint to this Service.

Our investigator looked into things. He said he thought Metlife had acted fairly when it declined Miss R's claim. Miss R didn't agree with our investigator. She provided a detailed response but in summary she said:

- She has provided evidence she says show the non-medical issues mentioned were not the cause of her depression but rather a symptom of it.
- Enjoyment experienced in her personal life doesn't relate to whether she can carry out her occupation.
- The witness statements she had provided should be considered as evidence of her

inability to work and MetLife was unreasonable to dismiss them.

As Miss R didn't agree with our investigator 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.

I want to acknowledge I've summarised Miss R's complaint in less detail than she's presented it. I've not commented on every point she has raised. Instead, I've focussed on what I consider to be the key points I need to think about. I mean no discourtesy by this, but it simply reflects the informal nature of this Service. I assure Miss R and MetLife I've read and considered everything that's been provided.

Miss R has said she is happy for my decision to focus solely on MetLife's decision to decline her claim. So, this is what I've considered. I won't be commenting on any of the service related issues Miss R has previously raised and which MetLife responded to in its final response of 3 December 2024.

The relevant rules and industry guidelines explain MetLife shouldn't unreasonably reject a claim.

The policy terms define incapacity as:

- *'Unable to perform their own occupation – an insured member, eligible employee or eligible partner is incapacitated if:*
    - *They are 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*
    - *Are not following any other occupation.'*

The policy also includes a 26 week deferred period. This means Miss R would need to be continuously incapacitated for 26 weeks before any benefit would be paid.

The onus is on Miss R to prove her claim. So, this means Miss R needs to show, through medical evidence, she met the policy definition of incapacity throughout the deferred period and beyond.

MetLife considered the evidence Miss R provided in support of her claim, but it wasn't persuaded Miss R had shown she met the policy definition of incapacity. I've considered the relevant available medical evidence which I'll summarise here:

- In January 2023 Miss R's GP diagnosed her with depression and prescribed her medication.
- The GP notes over the coming months show Miss R's prescribed medication was increased, but her symptoms were improving. She had discussions with her GP about returning to work.
- In August 2023 Miss R told her GP her concentration was non-existent and so she was unable to return to work.

- In October 2023 Miss R's GP wrote a letter in which they explained there had been improvement in Miss R's mood throughout the year, but Miss R had still reported a loss of function in her cognition and concentration.

- Miss R's psychologist also wrote a letter in October 2023. They explained they had seen Miss R for weekly therapy sessions since September 2022. They detailed the symptoms Miss R had presented with and explained her low mood had been consistent.

- In January 2024 Miss R attended a clinic with a consultant psychiatrist. They've written a letter summarising Miss R's condition and outlined a plan moving forward.

- In July 2024 Miss R attended another clinic with a consultant psychiatrist. They said Miss R felt her mood was somewhat better but work would be very difficult as she has periods of low mood, poor concentration and feeling overwhelmed.

- In August 2025 Miss R's GP who treated her in 2023 wrote a letter confirming they diagnosed her with depression. They said she had reported hating her job, but that this was an indicator of her illness and not the cause of it. They said Miss R was struggling with the typical symptoms of depression which meant she was unable to carry out the duties of her job during that period.

I've thought carefully about the evidence that's been provided. It's important to make clear I'm not a medical expert. In reaching a decision I must consider the evidence provided by medical professionals to decide what evidence I find most persuasive. It isn't my role to interpret medical evidence to reach a clinical finding – or substitute an expert medical opinion with my own.

I think it's clear from the medical evidence Miss R was diagnosed with an illness and has been suffering from symptoms relating to this. However, being diagnosed with a medical condition alone doesn't mean the policy definition of incapacity has been met. The medical evidence during the deferred period shows Miss R's symptoms were improving. And I don't think the medical evidence during this period explain how Miss R's symptoms meant she was unable to carry out the material and substantial duties of her role. I acknowledge in the GP's letter from October 2023 they've said Miss R had reported a loss in function. However, this loss in function is self-reported and the letter doesn't go into detail about Miss R's symptoms or how it was impacting her ability to carry out her job role.

Similarly, whilst the letter from Miss R's psychologist provides detail around Miss R's symptoms, it doesn't go into detail about how her symptoms meant she was unable to carry out the material and substantial duties of her job role.

In July 2024 the consultant psychiatrist has said work would be difficult for Miss R as she has periods of low mood and poor concentration. However this was a number of months after the deferred period, which is the period relevant to Miss R's claim.

Miss R has provided three witness statements written by her sister, friend and employer respectively. And whilst I acknowledge their content, I don't consider this to be more persuasive than the objective medical evidence written by the medical professionals treating Miss R.

Taking into consideration all of the available evidence, I don't think it was unreasonable for MetLife to decline Miss R's claim. I don't doubt Miss R has been suffering from an illness. However, I'm not persuaded Miss R has shown through the medical evidence provided that

her symptoms meant she was unable to carry out the material and substantial duties of her job role during the deferred period.

I naturally empathise with Miss R given what has happened, but for the reasons I've explained I don't require MetLife to take any further action in relation to her claim.

My final decision

For the reasons I've outlined above I don't uphold Miss R's complaint about MetLife Europe d.a.c.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss R to accept or reject my decision before 24 November 2025.

Andrew Clarke
Ombudsman