

## The complaint

Mr W complains that Aviva Life & Pensions UK Limited declined a claim under an income protection policy.

## What happened

Mr W is covered by an income protection policy through his employer, which is provided by Aviva. The policy pays a benefit if Mr W is unable to work due to an illness or injury. The deferred period is 13 weeks, and the policy covers Mr W's own occupation.

Mr W says his symptoms first started on 1 March 2023, and he became unable to work from 5 June 2023 onwards. He made a claim to Aviva on 18 August 2023 due to anxiety caused by stress at work. Aviva declined the claim as it said Mr W didn't meet the policy definition of incapacity, and the policy also didn't cover absences due to workplace matters.

Mr W appealed the decision and explained that his absence was caused by anxiety and depression, rather than workplace issues. But Aviva maintained its position and said the evidence showed the trigger for Mr W's absence was due to workplace matters. Unhappy with this, Mr W brought a complaint to this Service. He said that Aviva should have arranged an Independent Medical Examination ("IME") to be carried out, as it at one point suggested, but then decided this wasn't needed.

One of our investigators considered the complaint. Having done so, she thought that Aviva had acted fairly and reasonably when it said the evidence didn't support that Mr W met the definition of incapacity during the deferred period. But she thought that the later medical evidence showed Mr W's condition had deteriorated. Overall, she recommended that Aviva should consider the claim based on a later deferred period starting in March 2024. She also thought Aviva should arrange an IME to allow it to fairly assess the claim.

Aviva disagreed with the investigator's recommendation. It maintained that Mr W hadn't met the policy definition of incapacity during the deferred period. And it didn't think it would be fair or reasonable to consider a later deferred period, as the policy requires members to be actively at work immediately before the deferred period, and Mr W wasn't.

As no agreement was reached, the complaint was passed to me to decide. I issued my provisional decision in August 2025. Here's what I said:

*"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 Mr W's complaint."*

*The policy covers Mr W's own occupation, and the incapacity is defined as follows, along with the relevant exclusion:*

*"The member's inability to perform on a full and part time basis the duties of their job role as a result of their illness or injury."*

*[...]*

*Absence caused by workplace matters, such as a relationship breakdown, workplace demands or failure to make reasonable adjustments are not covered."*

*The policy definition of incapacity for own occupation doesn't mean Mr W's role with his employer – it means his occupation in general with any employer. It's my understanding that Mr W's role involves responsibilities such as managing stakeholders, creating budgets and plans, and providing support and training. Overall, Mr W's role requires high-level cognitive function.*

*It's for an insured person to show they have a valid claim. So, it's for Mr W to show that he was incapacitated as per the policy terms for the duration of the deferred period (13 weeks from 5 June 2023) and beyond.*

*I've reviewed Mr W's medical records. All the fit notes between 12 June 2023 and 17 January 2024 refer to a stress related problem or stress at work. And Mr W himself said the cause of incapacity was "anxiety caused by stress at work" when he made the claim in August 2023.*

*The first GP notes on 12 June 2023 focus on issues at work, and the impact these have on Mr W. The next relevant review is on 17 October 2023 when Mr W is prescribed an antidepressant, but the notes still refer to a stressful issue with work. There are further notes on 31 October and 1 November 2023 referring to a deterioration in Mr W's condition, but there is no formal diagnosis of a medical condition, and the cause is noted to be largely due to his employer.*

*There was an occupational health assessment carried out on 15 November 2023. Whilst this report refers to a diagnosis of depression and anxiety, the report concludes that Mr W's mental health issues are work-related, and "once the trigger is removed or mitigated then there is a strong possibility his symptoms would improve to the point where he could work again".*

*Considering the contemporaneous medical evidence, I don't think Aviva acted unfairly or unreasonably when it declined the claim at this point, for the reasons it did. I can't see that Mr W had a formal diagnosis of a mental health condition by a doctor during the deferred period, and all of his symptoms appeared to be caused by workplace issues. So, I think Aviva acted fairly and reasonably when it didn't think Mr W met the policy definition of incapacity for the duration of the deferred period.*

*But there are situations where it may be fair and reasonable for an insurer to accept a claim based on a later deferred period. For example, where an insured person's health deteriorates to a point where they do meet the policy definition of incapacity during their absence. So, I've considered if this applies in Mr W's circumstances.*

*Mr W had a detailed review of his mental health with a GP on 25 January 2024, and these notes refer to longstanding underlying issues, including personal trauma and bereavement. And I can see that one of these issues is already referred to in the GP notes on 12 Jun 2023. The notes in January 2024 explain that issues at work pushed Mr W over the edge. The fit note that was issued following this appointment was for "depressed mood, trauma and bereavement".*

*The GP has written two further letters for clarification, one in January 2025 and the other in June 2025. In the latter, the GP confirms the following:*

*"[Y]our primary diagnosis is anxiety and depression secondary to life stress events, namely underlying unresolved and unprocessed grief symptoms due to several traumatic losses and this is what has made you unable to work. This mental health condition impacts your ability to focus, process information and communicate effectively with others and this therefore has direct impact on your ability to work and undertake your current job role."*

Mr W had an appointment with a mental health nurse on 31 January 2024, and he was arranging talking therapy through work. The GP notes on 20 March 2024 include the following:

*"He presented as quite depressed and tearful throughout the apt. He describes struggling significantly with daily activities and feels detached from his life [...] Thinks about death daily as does not want to live like this but not suicidal."*

After this, Mr W's antidepressant medication was changed as his previous medication wasn't thought to be working for him.

There is a report from a therapist on 4 October 2024 which refers to "Anxiety and depression leading to anhedonia and suicidal ideation. Feels that work related issues and pressures have 'tipped him over the edge'. Underlying unresolved and unprocessed grief." And Mr W was awarded an Adult Disability Payment effective from 31 January 2024 onwards for the Daily Living component.

Having considered the further medical notes, I think these show a deterioration in Mr W's mental health, leading to a diagnosis of depression and anxiety. I think it's reasonable to consider the date of diagnosis to be 25 January 2024 based on the GP notes that day along with the GP's later letters. This was also the date when the underlying issues impacting Mr W were uncovered, and I think the medical evidence shows the absence wasn't caused by workplace issues from this point onwards.

Shortly after this, Mr W also qualified for a disability payment. And it's clear that Mr W's symptoms continued as his antidepressant medication was changed in March 2024.

I don't think the medical evidence shows that this was a new absence. Rather, Mr W's symptoms worsened over time, and a more detailed review of his mental health uncovered an underlying illness. And considering Mr W's job and the GP's comments about the impact his illness has on him, I think it's more likely than not that Mr W met the policy definition of incapacity from 25 January 2024 and potentially onwards. So, I think a fair and reasonable outcome for this complaint is for Aviva to reassess the claim based on the deferred period starting from this date.

I appreciate that this means that I'm asking Aviva to depart from the strict interpretation of the policy terms, as the contemporaneous medical evidence doesn't show that Mr W met the policy definition of incapacity for the duration of the deferred period set out by the policy terms. But for the reasons I explained above, I think applying a later deferred period is fair and reasonable in the circumstances of this complaint.

Aviva doesn't think this would be fair because Mr W wasn't actively at work as per the policy terms immediately before the start date of incapacity (as I'm saying it should consider a later start date of incapacity). Overall, I don't think it's fair for Aviva to rely on the actively at work term as the evidence shows Mr W has been continuously absent from work as a result of the same symptoms, and he was actively at work before the absence. And the further medical evidence shows that Mr W had an underlying condition which was diagnosed after Mr W's symptoms hadn't improved – rather, these had worsened over time.

*The investigator recommended that Aviva should arrange an IME to assess the claim. But I don't think this would be fair in the circumstances. Firstly, it's for Mr W to show he has a valid claim. And I think an independent medical professional would struggle to now assess Mr W's mental health and symptoms as of 2024. I think it's for Mr W to submit any reasonable evidence Aviva requires to allow it to fairly assess the claim, likely from the medical professionals who treated him during the time. That said, if Aviva considers an IME would be appropriate in the circumstances, it can arrange this if it wishes to do so.*

*For completeness, I appreciate Mr W wanted Aviva to instruct an IME already in 2024. But at this point, the medical evidence during the official deferred period didn't support Mr W met the policy definition of incapacity – rather, the medical evidence showed the absence was caused by workplace issues. So, I don't think Aviva acted unfairly or unreasonably when it didn't arrange this at the time."*

Aviva said it accepted the provisional outcome. Mr W didn't have any further comments. As the deadline to respond has now expired, I'm issuing my final decision

### **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.

As neither party has provided me with any new information to consider, I see no reason to depart from the findings I reached in my provisional decision. So, I've reached the same decision, and for the same reasons.

Overall, I think a fair and reasonable outcome is for Aviva to reassess the claim based on a later deferred period, for the reasons I explained in my provisional findings. But I don't think Aviva needs to instruct an IME, unless it wishes to do so – again, for the reasons set out in my provisional decision.

### **My final decision**

My final decision is that I uphold Mr W's complaint in part, and I direct Aviva Life & Pensions UK Limited to reassess the claim based on the deferred period starting on 25 January 2024.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr W to accept or reject my decision before 13 October 2025.

Renja Anderson  
**Ombudsman**