DRN-5846767

The complaint

Ms K complains that Legal and General Assurance Society Limited (L&G) has stopped paying benefit for an incapacity claim she made on a group income insurance policy.

What happened

The background to this complaint is well known to both parties. So I've simply set out a summary of what I consider to be the main events.

Ms K was insured under her former employer's group income protection insurance contract. The policy provided cover if Ms K was incapacitated from working in her own occupation due to accident or illness.

Unfortunately, in 2009, Ms K was signed-off work due to mental health conditions. L&G initially accepted Ms K's claim because it was satisfied she met the 'own occupation' definition of incapacity. After Ms K left her employment, L&G switched to paying benefit directly to Ms K and to assessing and paying the claim in line with the 'suited occupation' definition of incapacity. Ms K subsequently developed other medical conditions, including a cardiac condition.

In January 2025, following a further review of the claim, L&G decided to terminate the claim because it was no longer satisfied that Ms K's claim met the suited occupation definition of incapacity. In making this decision, it had taken into account reports from a lead vocational clinical specialist (LVCS), Ms K's cardiologist, a transferrable skills analysis (TSA) and a report by an independent medical examiner (IME), which concluded that Ms K was able to return to work in a suited occupation, with adjustments and a phased return.

So L&G told Ms K that it would stop paying benefit in mid-April 2025. It also offered Ms K the option to be referred to third-party providers of psychological and rehabilitation services.

Ms K was very unhappy with L&G's position and she asked us to look into her complaint. In brief, she felt L&G hadn't taken into account the combined impact of several medical conditions she had when it concluded that she no longer met the policy definition of incapacity.

Our investigator didn't think L&G had treated Ms K unfairly. She considered the available medical evidence and she thought it had been reasonable for L&G to rely on that evidence to decide that Ms K no longer met the policy definition of incapacity.

Ms K disagreed and so the complaint's 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.

Having done so, whilst I'm very sorry to disappoint Ms K, I don't think it was unfair or unreasonable for L&G to terminate her claim and I'll explain why.

First, it's clear that Ms K has suffered many years of very worrying and distressing diagnoses and symptoms. I was sorry to hear about the circumstances that led to her claim and her continued poor health. I don't doubt what a worrying time this must have been for her.

This claim was in payment for some years. This means that there is extensive medical and other evidence and both parties have provided detailed submissions. I'd like to reassure both parties that I've read and carefully thought about all they've said and sent us. In reaching my decision though, I haven't commented on each point that's been raised and nor do our rules require me to.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, amongst other relevant considerations, such as regulatory principles, the policy terms and the available medical evidence, to decide whether I think L&G treated Ms K fairly.

I've first considered the policy terms and conditions, as these form the basis of the income protection insurance contract. There's no dispute that following Ms K's claim in 2009, L&G accepted that she was incapacitated in line with the 'own occupation' definition of incapacity and that it paid benefit on this basis. However, both parties accept that Ms K's employment with her employer ended. It seems that at that point, L&G agreed to pay the claim on a pay direct basis, switching to assessing and paying Ms K's claim in line with the 'suited occupation' definition of incapacity. The policy says:

'Suited occupation means the insured member is incapacitated by an illness or injury so that he is unable to undertake any occupation which we consider appropriate to his experience, training or education.

For the purposes of this definition an occupation will not be considered to be inappropriate to an insured member's experience, training or education on the grounds that:

(i) the pay from such occupation may be lower than that paid to the insured member prior to the deferred period in relation to his own job or lower than the amount of members benefit, or
(ii) such occupation lacks the status or seniority associated with the insured members own job.

For this definition, own job means the essential duties required of the insured member in his occupation immediately before the start of the deferred period.'

The contract states that L&G will stop paying benefit if it considers an insured member is no longer a 'disabled member' – in other words, if it believes that they no longer meet the definition of incapacity.

In my view, L&G's terms indicate that subject to other conditions, it will continue to pay benefit, for as long as it's satisfied that an insured member remains incapacitated. It's clear that whilst L&G's accepted that Ms K was entitled to policy benefit for many years, it now considers that she's no longer incapacitated and is able to return to work in a suited occupation. So I've thought about whether I consider this was a fair conclusion for L&G to draw.

It's for an insured member to provide enough evidence to show that they have a valid claim under their policy. However, once a claim is in payment, it becomes the insurer's responsibility to show that an insured member no longer meets the policy terms. Generally, I think it's fair and reasonable for an insurer to periodically review income protection claims

and request medical evidence to determine whether a claim remains payable. So I think L&G was reasonably entitled to commission expert reports and request medical evidence during the life of the claim.

I've carefully considered the available medical evidence. Firstly, I've looked closely at a mental health provider's initial assessment report dated July 2022. This stated that Ms K did not work due to a 'serious heart problem'. This was echoed in a further report from the same mental health provider in April 2023, which said that '*a return to work was unlikely because Ms K has a heart condition which has a significant impact on daily functioning.'* The report noted that Ms K had undergone recent cardiac surgery.

In December 2023, as part of its claim review, L&G wrote to Ms K's treating cardiologist to ask for some further information. The cardiologist stated that Ms K was waiting for further tests and review. But they also added:

'Your second question was whether I had any specific concerns that would preclude her from working in a less demanding, sedentary, low stress, high autonomy home working role with reasonable adjustments. I do not have any such concerns.'

L&G also wrote to Ms K's GP surgery to ask for some further information about her health. It responded as follows in February 2024:

Is there any significant medical intervention pending, from your perspective?

Upon review of Ms Ks records, I can confirm there is no significant medical intervention currently pending. She is due a cardiology follow up this month to review her medication and her latest cardiac (surgery) *undertaken…in early 2023.*

2: Are you aware of any concerns as her GP that would preclude Ms K from working in a less demanding, sedentary, low stress, high autonomy homeworking role, such as data entry clerk, with reasonable adjustments? If so, can you please elaborate on your concerns?

Ms K has not seen a GP since (July) 2023. Given that there has been no further contact with the patient since this time, and she is still under the care of cardiology, I do not feel her GP is best placed to comment on her ability to work.'

Subsequently, L&G arranged for Ms K to be assessed by a LVCS. The LVCS' report of April 2024 stated:

'*Based on my observations during the face to face appointment and most recent GP correspondence (documenting in February that there is there is no significant medical intervention currently pending, I am of the opinion that the member would be able to undertake a suited occupation.'*

Following the LVCS' assessment of Ms K's health, L&G asked for a TSA to be carried out, based on the available evidence. The TSA was carried out by an occupational therapist/vocational rehabilitation specialist and the report was dated July 2024. I've set out below what I think were the key findings:

'*Ms K will benefit from adjustments which are detailed in the job role options. It is also noted that Ms K is returning to work after a long absence and as such is expected to have experienced some deconditioning, as such Ms K is encouraged to consider engaging with her local Jobcentre to access any support available locally for work preparation support. Jobs with adjustments that could be made – phased return.*

I have reviewed the evidence provided, considering skills and capacity for work with the current function of Ms K. I have matched Ms K's strengths and skills against any suited occupation, in any industry, irrespective of location, availability or salary. I am confident that Ms K has appropriate transferable skills to return to the workplace in a suited role with adjustments. It is my clinical opinion that Ms K has the skill set to work in the following occupations…

(List of occupations)

Noting the length of absence, Ms K may now wish to engage with her local Jobcentre to explore locally available resources to help with returning to employment. It is noted that during this long absence, that flexibility from employers to home-work, work flexibly and bulk work has increased hugely and homeworking could be a good option for Ms K to manage any health issues around work.'

And in September 2024, L&G arranged for Ms K to be assessed by an IME – an occupational health physician. Again, I've set out below what I believe to be the IME's key findings:

'*To summarise the position: Ms K is experiencing reported dizziness for some five years, is concerned regarding palpitations but has not experienced loss of consciousness, has had appropriate treatment, and although waiting further investigations, there is no objective evidence indicating that a return to work would be inadvisable for her current cardiac profile.*

Ms K does have deeply entrenched fixed beliefs regarding the risk of returning to work, but this is subjective, and in my view unbalanced.

In answer to the question, there is no objective medical evidence to suggest that Ms K could not be supported to return to a suited role.'

Ms K has provided evidence that during the relevant period, she was referred for investigations for other conditions and underwent non-cardiac related surgery in January 2025 for a separate issue. She feels a combination of all of these factors, as well as taking into account her mental health conditions and pending cardiology review, mean that L&G unfairly terminated her claim.

I've thought very carefully about the evidence that was available to L&G at the time it terminated Ms K's claim and when it issued its final response to the complaint. It's important I make it clear that I'm not a medical expert. In reaching a decision, I must consider the evidence provided by both medical professionals and other experts to decide whether I think it was reasonable for L&G to rely on that evidence to stop paying Ms K's claim. It isn't my role to interfere with expert clinical opinion and it would be inappropriate for me to do so.

It's clear that Ms K has suffered a number of conditions and worrying symptoms over a number of years – and that in particular, her mental health conditions and cardiac condition have been the main reasons for her incapacity during that time.
However, I don't think it was unfair or unreasonable for L&G to place significant weight on the independent and expert clinical evidence it obtained as part of this claim assessment. It seems that in 2023, the main factor preventing Ms K from carrying out a suited occupation was her heart condition. However, by December 2023, her treating cardiologist had informed L&G that they didn't have any concerns about Ms K carrying out a low stress, sedentary, home-based occupation. So I don't think it was unreasonable for L&G to have relied on that evidence to conclude that Ms K's cardiac condition didn't prevent her from carrying out a suited occupation, even if she did need further review.

Nor did Ms K's GP specify any concerns they had about her fitness to work. And it doesn't appear that she saw the GP after mid-2023, so there's little evidence from the GP to show how or why Ms K would have been incapacitated in line with the policy terms.

Both the LVCS and the TSA occupational therapist are clinical experts. I'm satisfied the LVCS' report show they engaged with Ms K to understand her health situation and how it affected her. I'm also satisfied they explained clearly why they thought Ms K would be fit to work in a suited occupation. I find too that the TSA report showed that the occupational therapist concerned had clearly taken into account the available evidence when carrying out their analysis. And they set out the jobs they felt would be suitable for Ms K and why. On that basis, I think it was reasonable for L&G to take those reports into account.

Similarly, the IME is an expert in occupational medicine. I think they were well-placed to assess Ms K and whether she was fit to work in a suited occupation. So I'm satisfied it was reasonable for L&G to rely on this evidence when it weighed-up whether the claim should remain in payment.

I'm mindful that Ms K did have other health concerns and that she underwent surgery in January 2025. But I don't think the medical evidence Ms K's provided about those conditions explains how or why they would prevent Ms K from carrying out a suited occupation – and there's nothing to indicate that the surgery Ms K underwent would incapacitate her beyond mid-April 2025. Therefore, I don't think there's sufficiently persuasive medical evidence to show that it was unfair for L&G to conclude that Ms K was no longer incapacitated in line with the policy terms.

Overall, despite my natural sympathy with Ms K's position, I don't think L&G acted unreasonably when it relied on the medical evidence it gathered from independent clinical experts and Ms K's treating cardiologist to conclude that Ms K no longer met the policy definition of incapacity. That means that I don't find L&G acted unfairly when it terminated Ms K's claim in January 2025. And nor do I think Ms K has since provided sufficient evidence to support her position.

I appreciate Ms K feels L&G should have arranged for her to undergo third party referrals and treatment prior to terminating benefit, to give the treatment a better chance of working. However, I can see that while L&G let Ms K know it would be terminating the claim in early January 2025, benefit was paid until April 2025 – meaning a further three months of benefit was paid. In my view, this gave Ms K a fair chance to engage with the third-party providers ahead of benefit payments ceasing. This means I don't think L&G unfairly terminated the claim earlier than it should have done.

It's open to Ms K to provide L&G with further, new evidence to support her claim, which post-dates its final response letter, should she wish to do so. I'd expect L&G to review any such new evidence in line with its regulatory obligations and the policy terms. If Ms K's unhappy with the outcome of any assessment of new medical evidence she may send to L&G, she may be able to bring a new complaint to us about that issue alone.

My final decision

For the reasons I've given above, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms K to accept or reject my decision before 6 November 2025.

Lisa Barham

Ombudsman