DRN-5873933

The complaint

Mr F complains because Legal and General Assurance Society Limited ('L&G') hasn't paid his claim under an income protection insurance policy.

What happened

Mr F was insured under a group income protection insurance policy provided via his now former employer and underwritten by L&G.

Unfortunately, Mr F was signed off work due to depression and work-related stress. He made a claim under the policy, but L&G said the claim wasn't covered because Mr F's illness didn't meet the policy definition of 'incapacity'. Mr F appealed and provided additional medical evidence, which L&G considered, but said its position remained unchanged.

Unhappy, Mr F brought a complaint to the attention of our Service.

One of our Investigators looked into what had happened and said she didn't think L&G had acted unfairly or unreasonably by declining Mr F's claim. Mr F didn't agree with our Investigator's opinion, so the complaint has now been referred to me to make a decision as the final stage in our process.

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'm sorry to hear about the circumstances which led to this complaint and it's clear Mr F has been through a very difficult time. I don't dispute that Mr F has been ill, or that he has been deemed unfit to work but this doesn't automatically mean that L&G must pay his income protection insurance claim. The terms and conditions of the policy which Mr F's former employer holds with L&G determine in what circumstances a claim is payable. I appreciate Mr F views this as semantics, but my remit requires me to reach an independent and impartial outcome which is fair and reasonable to both parties to the complaint and my starting point in considering this case is the contract between the parties.

Industry rules set out by the regulator say an insurer must handle claims fairly and shouldn't unreasonably reject a claim. I've taken these rules, alongside other relevant considerations, into account when making this final decision.

This policy pays a benefit if Mr F meets the policy definition of incapacity throughout, and beyond, the applicable deferred period. Mr F was insured on an 'own occupation' basis. This means, in order to receive a benefit under the policy, Mr F must provide medical evidence to show he is incapacitated by an illness or injury which prevents him from performing the essential duties of his occupation for *any* (so, not just his own) employer.

I wouldn't generally expect an income protection insurance policy to pay a benefit for absence from work caused by workplace or lifestyle stresses. This is because such stresses

which impact a person's ability to do their job aren't the same as being unable to perform their occupation entirely due to illness more generally. When such stresses are removed or reduced, an insured person can often return to work.

I'm not medically qualified and it's not my role to reach my own medical conclusions or to substitute expert medical opinion with my own. It's also not for me to make any assumptions based on the medical evidence provided, or to draw any inferences into what the medical evidence says. Instead, I've weighed up the information I've seen to decide whether I think L&G acted fairly and reasonably when declining Mr F's claim.

Mr F has provided a number of 'Statements of Fitness for Work' from his GP as well as letters from a remote GP saying he wasn't fit for work. The reasons stated include 'depression and anxiety', 'depression/stress at work' and 'depression and work-related stress'. While certificates completed by a GP do carry evidential weight, the certificates contain limited information and are based on symptoms which were self-reported by Mr F. As such, I wouldn't generally consider that GP medical certificates are sufficient evidence to demonstrate that a person is unable to perform their own occupation. The threshold for a GP to issue such certificates is not necessarily the same as the policy requirements for a claim to be paid.

I've taken into account a letter from Mr F's psychotherapist dated 6 June 2024 in which she said her professional opinion was for Mr F to take sick leave for at least a 6-month period. This was stated to be to *'help him cope with all the changes, finalize his divorce issues, organize and settle into his new home, and adjust to all the changes in his life.'* While there's no doubt this letter demonstrates that Mr F was advised to take sick leave, I don't think this letter demonstrates that he meets the policy definition of 'incapacity'.

L&G arranged for a Vocational Clinical Specialist Report to be carried out, and I think this was reasonable action for L&G to take when making enquiries into the claim. The report is dated 29 August 2024 and lists some perceived work stressors which Mr F outlined. The report concluded that Mr F's absence from work was linked to personal stressors and workplace issues and, so, was non-clinical in nature. I've also carefully considered the Occupational Health Report dated 25 October 2024. While this clearly states Mr F was unfit for work, it outlines what I think is a clear perception that personal issues and work-related factors triggered stress related symptoms. This doesn't therefore support that Mr F meets the policy definition of 'incapacity' either.

I've taken into account the other medical evidence which Mr F provided to and was considered by L&G. This includes letters dated 15 November 2024, 22 November 2024, 5 December 2024, 31 December 2024, 1 January 2025 and 6 January 2025. Overall, there's limited-to-no commentary in these letters about Mr F's ability to work so I don't think these letters are persuasive evidence in support of Ms F's claim.

L&G has provided comments from its Chief Medical Officer based on the medical evidence which I've mentioned. The Chief Medical Officer's conclusion was that Mr F didn't meet the policy definition of 'incapacity'. While this isn't necessarily determinative evidence of whether I think L&G acted fairly and reasonably in the circumstances, the opinion from the Chief Medical Officer does carry persuasive weight.
We wouldn't generally contact medical professionals directly for further information about a policyholder's medical condition. This is because our Service generally considers complaints based on the medical evidence which has been presented to us.

Overall, on balance, I don't think the totality of the medical evidence which I've seen demonstrates it's more likely than not that Mr F met the policy definition of incapacity at the relevant time. So, I don't think Mr F has demonstrated that he had a valid claim which L&G

ought to have paid.

After this complaint was brought to our Service, Mr F provided us with additional medical evidence dated February and March 2025. Within this final decision, I can only consider events up until the date of L&G's second final response letter. This is because, under the rules that govern our Service, we have no power to comment on evidence which the insurer hasn't been given the opportunity to consider first. So, if Mr F wants this new evidence taken into account, then he'd need to first send it to L&G before our Service could comment on it. However, I would point out that the policy terms and conditions require a policyholder to demonstrate incapacity throughout and beyond the deferred period. While I may sometimes consider it appropriate to direct an insurer to consider a deferred period as starting from a later date, Mr F's entitlement to a benefit under this policy will only have lasted for the duration of his employment anyway.

I understand Mr F has been severely impacted as a result of his claim being declined. While I'm wholly sympathetic to the situation Mr F found himself in through no fault of his own, I don't think L&G acted unfairly or unreasonably in the circumstances. I wish Mr F well for the future, but I won't be directing L&G to do anything more.

My final decision

My final decision is that I don't uphold Mr F's complaint.

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

Leah Nagle
Ombudsman