

## The complaint

Mr R complains that Legal and General Assurance Society Limited ('L&G') has unfairly ceased paying benefit for a claim he made under his income protection policy. To resolve his complaint, Mr R wants L&G to reinstate his benefit, backdate any missing benefit and provide compensation along with an apology for cancelling the benefit in the first place.

## What happened

Mr R took out his Income Protection Benefit policy in February 2023. It provides monthly benefit for Mr R if, by reason of illness or injury, he is unable to perform the material and substantial duties of his own occupation. The benefit is payable after a deferred period of four weeks.

Mr R sadly became unwell with abdominal pain in July 2023, for which he was admitted to hospital. He was thereafter treated for bilateral adrenal vein thrombosis and haemorrhage. However, he continued to suffer with multiple medical issues including adrenal insufficiency, chronic lung inflammation, a mediastinal mass, blood discrepancies, and chronic fatigue with cognitive impairment. This led to Mr R being referred to several different specialists and included investigations to establish the cause of his symptoms and to rule out malignancy. Mr R ceased working altogether on 22 December 2023.

In February 2024, L&G accepted a claim for income protection benefit from Mr R, backdating it to the end of the deferred period on 19 January 2024.

In 2025, L&G reviewed the claim. It sought medical evidence from Mr R's GP, and it undertook a clinical assessment with Mr R in March 2025. After a review of the medical evidence, L&G wrote to Mr R on 3 June 2025 to confirm that the payment of benefit would cease with immediate effect. It said its chief medical officer ('CMO') had noted how any malignant cause had been excluded and Mr R's adrenal insufficiency was being appropriately managed with treatment. L&G explained that it did not therefore believe Mr R remained totally incapacitated and prevented from undertaking his own occupation.

Mr R appealed the decision and lodged a complaint. He referenced a number of letters, including letters from:

- A haematologist dated 19 June 2024.
- A consultant in diabetes and endocrinology (Dr T) dated 9 April 2024, 7 May 2025, and 4 June 2025.
- A consultant in respiratory medicine (Dr M) dated 16 June 2025.
- A multidisciplinary lung cancer team meeting dated 21 May 2025.
- His GP dated 3 June 2025.

Mr R also made a subject access request to obtain all of the information L&G held concerning his claim.

On 4 July 2025, L&G rejected the complaint. It said none of the information Mr R had supplied showed how his symptoms would prevent him from undertaking his role; and the

previous evidence showed how Mr R had recovered from some symptoms, and his other persisting symptoms were well managed by medication. It did otherwise note that Mr R had since sent more medical evidence, and it said it would review this in due course.

On 24 July 2025, L&G rejected Mr R's appeal and told him its decision was unchanged. It reiterated that his adrenal insufficiency was being managed with medication and assessment of the obstructive defect in his lung showed no malignancy with normal oxygen saturation readings. Since it no longer had evidence to support that Mr R couldn't carry out the material duties of his own occupation, it could not continue to pay the claim.

Mr R thereafter lodged his complaint at this service. He explained that he felt L&G had behaved unfairly. He said:

- L&G implied that he was exaggerating his medical symptoms.
- It also used an internal occupational therapy review which was not reasonably conducted against his own employment nor was it undertaken by a suitably qualified medical professional.
- L&G was relying on Mr R undertaking a primarily sedentary role as a means to refuse his claim – but it knew what his job was when it agreed to insure him.
- L&G failed to provide advanced notice of the cessation of benefit.
- It also disregarded the comprehensive medical evidence showing he had been under investigation for potential cancer, he required numerous treatments, he had suffered from oxygen desaturation, and he remained at risk of adrenal crisis.

One of our investigators reviewed the complaint but she did not think it ought to succeed. She said she thought L&G was reasonable to terminate the claim. She noted though the medical evidence did demonstrate that Mr R was under monitoring by several consultants, the content of the letters from those consultants suggested that his symptoms had stabilised. Furthermore, in January 2025, Mr R had been discharged from the lymphoma clinic.

Our investigator also looked at the further medical evidence referenced by Mr R when he appealed to L&G. However, though some of the content of that evidence referenced the symptoms he continued to suffer from, she did not believe that having symptoms or being under the care of medical professionals meant Mr R was totally unable to work in his insured role. Rather, our investigator was persuaded that L&G had been fair to conclude that Mr R could work, with adjustments as required. She also believed it had not reached this conclusion because of any suggestion Mr R could have been exaggerating his symptoms.

Mr R disagreed. He sent further detailed submissions split into eight sections. In summary, Mr R set out that:

1. L&G alleges Mr R has 'recovered' but he remains under the care of multiple consultants for several lifelong conditions – and the consultants disagree with L&G.
2. At no time had L&G engaged with Mr R's treating consultants, and it instead reached a decision without their input which Mr R says was contrary to fair practice as required by the Financial Conduct Authority ('FCA').
3. L&G was selective as to which medical evidence it relied upon – despite the most recent evidence from May and June 2025 having no suggestion that he could work.
4. L&G mistakenly relied on its own – flawed – occupational review which failed to assess him in person and used generalisations about the nature of his job role.
5. L&G did not assess the significant mental health impact caused by his chronic illness.

6. Discussion was had with L&G's underwriter about functional limitations - this misapplied the policy definition. His policy wording required a measure of his 'own occupation', not 'activities of daily living'.
7. L&G's actions have breached multiple regulatory standards.
8. He wants an ombudsman's decision. The resolution he seeks is that his claim is reinstated with interest, any internal notes by L&G implying fraud or exaggeration should be removed and he ought to be given a formal apology for the distressing impact of L&G's procedural mishandling.

Mr R also provided additional submissions to our investigator, all of which I have reviewed though I do not intend to repeat them verbatim here. Within those comments, he set out that when he met with his various consultants, the clinical objective had not been to make a capacity-to-work determination but rather to assess how his illness was progressing, monitor organ function, and manage his treatment plan. However, when the question of his ability to work has been raised directly, each treating specialist has consistently concluded that his symptoms and treatment effects were materially impairing his capacity to perform his role. Mr R concluded that the medical views ought to be sufficient to continue to meet the policy definition and maintain his claim payment. And if not, he was otherwise prepared for L&G to set up an independent medical examination to reaffirm the views of his treating consultants.

A series of further correspondence continued between our investigator and both parties, after Mr R supplied two pieces of contemporaneous medical evidence. These comprised private GP consultation notes from 6 August 2025 and a Functional Capacity and Work Capability Assessment from a physiotherapist dated 14 August 2025.

L&G issued a second final response letter dated 9 September 2025. Some of the issues in that complaint related to the ongoing refusal by L&G to reinstate Mr R's claim and so form part of this complaint. The remaining issues relating to customer service and subject access, which L&G agreed was insufficient, but it didn't otherwise feel Mr R had been disadvantaged.

Mr R thereafter supplied a further set of written submissions – again, which I have read in their entirety – to accompany escalation of his complaint to an ombudsman.

L&G wrote to Mr R on 19 September 2025 regarding the additional evidence, but it wasn't able to consider reinstating Mr R's benefit. It said neither letter clarified that Mr R had no capacity to work in his own occupation. Rather, L&G believed that the evidence showed that Mr R would be functionally capable from a medical perspective, with reasonable adjustments in place.

Our investigator then reassessed the complaint in light of the additional medical evidence, along with L&G's response. In her view, the additional medical information did not provide any objective evidence that L&G had reached an unfair conclusion on the claim. And she was satisfied that the CMO had properly considered the new medical evidence with an explanation as to why this did not alter its view that Mr R wasn't totally prevented from working by the impact of his various symptoms.

Mr R supplied an extensive written executive summary of his complaint, including a skeleton argument which gave reasons as to why he believed the investigator's outcome contained material errors of fact and reasoning. Within this summary, he said that the investigator had wrongly classed his occupation as sedentary, that the medical evidence hadn't been properly considered, that unfair weighting had been given to L&G's CMO and it had not complied with procedural fairness including processing his subject access request within the required timescale.

Whilst the matter was awaiting referral to an ombudsman, Mr R continued ongoing correspondence with L&G regarding his concerns about his subject access request. He also told our investigator that his review of the claims file L&G had disclosed showed the CMO to have acted in a biased manner by unfairly overruling one of its claim assessors. He felt the CMO's opinion was the sole basis for the refusal of his ongoing claim, without appropriate medical evidence to justify a reversal, and such actions must fail a reasonableness test.

L&G had no further comments to add.

### **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 thank both parties for their patience whilst this matter has awaited an ombudsman's decision. I was sorry to hear of the difficulties affecting Mr R since the onset of his symptoms. I also appreciate that Mr R has taken considerable effort in seeking evidence to satisfy his claim at what continues to be a challenging time for him and I thank him for this.

I realise Mr R feels very strongly that what has gone on is unfair. However, I won't be making findings on every submission made or undertake any forensic analysis of the complaint history. That is because this service's role is to investigate disputes and resolve complaints informally, including taking into account relevant laws, regulations, and industry guidance, where necessary. My remit is to decide what I deem to be a fair and reasonable outcome based on everything I've seen.

I've set out the background to this complaint using my own words, citing what I find relevant. And, in reaching my conclusions, I've focused solely on what I consider are the key issues in the complaint. Our rules allow me to take this approach; it simply reflects the nature of our service as a free alternative to the courts, and no discourtesy is intended by it. If there's something I haven't mentioned, it isn't because I've ignored it. I appreciate the various detailed written submissions supplied to this service, but I don't need to comment on each individual argument to be able to reach what I consider is the right outcome in the circumstances.

I also note Mr R has referred to various regulatory provisions that he feels have been reached by L&G within the FCA's Treating Customers Fairly Principles including those set out at Principle 12, the Consumer Duty. I've carefully considered the detail of those obligations, but I haven't seen objective evidence that L&G has acted contrary to its regulatory requirements, nor do I consider it has otherwise treated Mr R unfairly.

My role isn't to substitute my view for that of a business but instead, to determine if a business has acted fairly in all the circumstances of a complaint. Regulatory rules require L&G to handle claims promptly and fairly and to not unreasonably reject a claim. I have therefore considered the evidence provided by the parties alongside the terms and conditions for Mr R's insurance policy to determine whether I believe L&G treated him fairly and reasonably in ending the policy benefit. Though I realise Mr R will be disappointed, my decision is that I won't be asking L&G to do anything further to resolve the complaint.

L&G terminated Mr R's claim which had been in payment. It is therefore for it to show that Mr R no longer met the policy's definition of a disabled member, which says:

*"If you are in gainful employment or gainful self-employment at the time of incapacity we will consider you to be incapacitated once we have assessed your claim as set out in the section headed 'Assessing your claim' and are satisfied that you have **no***

**capacity** [my emphasis] for working in your own occupation, on any basis, as a direct result of your injury or illness.”

And “own occupation incapacitated” is defined in the policy as:

*“We’ll recognise you as incapacitated if, because of your illness or injury, you are unable to carry out the material and substantial duties of the occupation you are following at the point of incapacity.”*

It isn’t in dispute by either party that Mr R was originally deemed to meet the policy definitions when the claim was accepted in February 2024. However, in this decision I’m considering the medical evidence that led to the review of the claim, since the policy wording goes on to permit L&G to terminate benefit in circumstances where it no longer has sufficient evidence of an insured member being disabled under the terms of the policy.

Prior to ceasing benefit payment in June 2025, L&G referred all of the information it held regarding Mr R on file to its CMO to reach a decision – and I find that fair in the circumstances. They are a specialist in their field and on balance, I find their view persuasive. The CMO gave clear reasoning as to why Mr R no longer met the policy definition of incapacity since the available objective medical evidence did not demonstrate that Mr R could not perform the duties of his occupation. Rather, the medical evidence showed that Mr R was now feeling well; there was no clear suggestion that any debilitating symptoms prevented him from working.

Mr R provided additional medical evidence by way of appeal, and I’ve considered this carefully. Though his GP did agree with all of Mr R’s reported symptoms (severe fatigue, dizziness, cognitive issues, weight fluctuation), there was no assessment of his ability to work in any capacity – but rather, the GP said that the persistence and severity of the symptoms significantly impaired Mr R’s ability to work.

Consequently, the CMO reviewed the new evidence but didn’t alter the view that Mr R would be able to undertake some sedentary work. And I don’t find this to be an unreasonable stance to have taken. Though the letters from Dr M and Dr T confirmed Mr R remained symptomatic, Dr T noted the symptoms arose from a reduction in medicine for Mr R’s adrenal insufficiency, and Dr M confirmed how Mr R continued to suffer breathlessness. However, neither specialist put forward that this would entail Mr R having no capacity to work whatsoever.

I realise Mr R says some of his insured role comprised travelling. However, he also reported as working from home in a sedentary role, so I do not feel it is unreasonable to include that when assessing if he has any capacity to work, with adjustments.

The CMO continued to feel that Mr R could undertake some work with reasonable adjustments after reviewing the two new pieces of medical evidence from August 2025. And again, I am not persuaded that the CMO has reached an unfair or unreasonable conclusion about that. I say this noting how the physiotherapist assessed Mr R’s functionality from a cognitive and physical perspective – but he is suitably qualified for the latter. In his letter, the physiotherapist said:

*“The following functional limitations are present and ongoing:*

- *Sitting tolerance: limited to approximately 20–30 minutes before requiring position change due to musculoskeletal pain, fatigue, and breathlessness.*
- *Standing tolerance: limited to approximately 5–10 minutes before onset of dizziness, instability, and worsening fatigue.*

- *Walking tolerance: limited to short distances (<100m) without significant breathlessness and oxygen desaturation risk.*
- *Postural changes & mobility: requires frequent rest breaks; difficulty with sustained posture required for computer-based work.*

*...these physical and cognitive limitations mean he cannot reliably or safely perform his essential occupational duties on a consistent basis.”*

Though the physiotherapist notes Mr R’s limitations preventing him from *consistent* working, the policy wording is not based on regularity of working but rather a total incapacity from performing the material and substantial duties of the insured occupation, on any basis. I believe L&G was reasonable when it concluded that this evidence doesn’t show Mr R has no capacity to work in his own role. It shows, on balance, notable reported restrictions but not a total incapacity. For example, the CMO concluded how postural changes are typically advised for all sedentary workers and form part of reasonable workplace adjustments.

And the private GP relied on Mr R’s reporting of his current health circumstances in relation to his functionality, but there was no objective assessment undertaken as to Mr R’s capacity to work in his insured role – instead, the GP referred Mr R for pain management with a physiotherapist and counselling.

Mr R says the content of the updated evidence along with the previous specialist letters shows that the decision to cease his benefits was unfair, but I disagree. I realise Mr R feels that he simply cannot undertake any work at all, due to the ongoing impact of his symptoms. However, the correct assessment for L&G to apply is to determine whether or not illness or injury prevents Mr R from carrying out his insured occupation.

In all the circumstances – and having reviewed the evidence and Mr R’s comments - I’m satisfied that L&G fairly reviewed Mr R’s medical information and subsequent appeal; I’m also satisfied it reached a fair conclusion that he no longer met the policy definition of incapacity. It follows that I don’t require L&G to reinstate Mr R’s claim.

I note that in the latest claim outcome letter of 19 September 2025, L&G told Mr R if he wished to consider a further appeal, it may ask him to undertake an independent medical examination – and this is something Mr R has mentioned to this service that he would be willing to undergo. Mr R can therefore liaise with L&G about this if he requires.

As an aside, I also note that Mr R has raised some further concerns about the manner in which L&G has handled his subject access request. If Mr R continues to hold concerns about that issue or the General Data Protection Regulation (‘GDPR’), that is a matter which can be pursued with the Information Commissioner’s Office.

Overall, despite my natural sympathy with Mr R’s position, I think that L&G has provided enough evidence to show, on balance, that he no longer met the policy definition of incapacity. And so while I appreciate that my decision is likely to be upsetting for him, I find it was fair and reasonable for L&G to terminate Mr R’s incapacity claim as of June 2025.

### **My final decision**

For the reasons I’ve set out above, my final decision is that I do not uphold this complaint.

Under the rules of the Financial Ombudsman Service, I’m required to ask Mr R to accept or reject my decision before 24 February 2026.

Jo Storey  
**Ombudsman**