DRN-5908060

The complaint

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

What happened

Mrs C holds income protection cover through her employer. The policy pays a benefit if she's unable to work due to an illness or injury, and the deferred period is 26 weeks.

Mrs C went off sick on 5 August 2024. So, the deferred period ran until 3 February 2025. She was first signed off due to mechanical back pain, but the fit notes changed to back pain, stress and anxiety on 27 August 2024, and to stress and anxiety on 7 April 2025. Mrs C's family member, who had provided primary childcare for her children, was sadly diagnosed with a terminal illness. Mrs C says the emotional impact of this was overwhelming and devastating.

Mrs C's employer made a claim to Aviva for an income benefit, but it declined the claim as it didn't think the medical evidence showed Mrs C met the definition of incapacity for the duration of the deferred period. But it offered £100 compensation for the impact its Consultant Medical Adviser's ("CMA") comments had on Mrs C.

Mrs C doesn't think Aviva considered her claim fairly, or in line with regulatory guidance, and she says declining the claim has resulted in her mental health deteriorating further. Mrs C wants Aviva to accept and pay her claim. She also wants Aviva to pay her more compensation than the £100 it offered. In short, Mrs C said Aviva's CMA misrepresented and distorted medical evidence, it failed to consider material medical evidence, and it didn't consider the policy terms fairly.

One of our investigators reviewed the complaint. Having done so, she didn't think Aviva had acted unfairly or unreasonably when it declined the claim, for the reasons it did. Overall, the investigator thought the medical evidence didn't provide sufficient detail why Mrs C was unable to perform the substantial duties of her role due to an illness. And she thought the compensation Aviva had offered for the unnecessary distress and inconvenience caused by its CMA's comments was fair and reasonable in the circumstances. So, the investigator didn't think there was anything else Aviva needed to do, to put things right.

Mrs C didn't agree with the investigator's findings. She sent further evidence, including a letter from her GP, a therapist letter and further Occupational Health ("OH") reports in support of her complaint. She said she was incapacitated due to severe anxiety and depression, as well as the resulting physical symptoms, and the medical evidence showed she was unable to perform her job role from August 2024 onwards.

The investigator asked Aviva for its comments on the new evidence. In short, it said the OH reports and therapist letter didn't provide clinical observations or enough detail about Mrs C's symptoms, and they didn't support a claim from August 2024 onwards. And Aviva said the GP's comments in the further letter weren't reflected in the contemporaneous medical evidence. So, Aviva said these didn't change its position on the claim for Mrs C being incapacitated throughout the deferred period.

The investigator reviewed the further evidence and comments from both parties. Having done so, she didn't think Aviva had acted unfairly when it said the evidence didn't change its claim decision. And as Mrs C had already asked for an ombudsman's review and no agreement was reached, 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.

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 this complaint.

The policy covers Mrs C's "own occupation" for incapacity, which is defined in the policy terms as follows:

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

And the policy terms define "duties" as follows:

> *"The material and substantial duties that:*
> - *are normally required to perform the job role for the policyholder; and*
> - *perform a significant and integral part of the performance of the job role for the policyholder; and*
> - *cannot be reasonably omitted or modified by the member of the policyholder.*
>
> *Duties do not include the journey to and from work."*

It's for Mrs C to show that she has a valid claim under the policy. So, she needs to show that she was unable to perform her job role for her employer due to an illness for the duration of the deferred period (between 5 August 2024 and 3 February 2025) and beyond. I've reviewed the medical evidence to decide if Aviva acted fairly and reasonably when it declined her claim.

Mrs C was first signed off due to mechanical back pain, but from 27 August 2024 onwards due to back pain, stress and anxiety. I appreciate her GP considered her not fit for work. However, the fit notes alone don't show that she met the policy definition of incapacity. This is because there's nothing in the fit notes to explain why Mrs C's symptoms prevented her from performing her job role.

I've reviewed the contemporaneous GP notes. When Mrs C was first signed off, the notes said the following:

"lots of stress, family issues
[family members] dx with cancer recently
no child care available
back spasming
needs time away from work"

And the doctor prescribed medication for muscular back pain. There was a medication review over the phone on 20 August 2024, and it was noted Mrs C had stopped taking the medication *"as back pain has improved"*. It was noted that the medication was stopped as it was no longer needed.

There are no GP review notes for the remaining fit notes that were issued during the deferred period. But I can see that Mrs C had a consultation about neck pain on 7 November 2024. The notes said the following:

"Pt reported in neck and upper and mid back pain and spasm since many years, recently got worse due to ongoing stress at home, [family member] got diagnosed with Ca.
[…]
Postural pain sec to stressleading[sic] to muscle spasms?"

The notes show medication was discussed, as well as exercises for the back pain with a follow up to be booked in four weeks. When describing Mrs C's symptoms, it was noted that *"sleep is affected sometimes"*.

It looks like the follow up was discussed on 14 December 2024, when the following was noted:

"She has been doing the exercises as advised and it is helping her. She is doing better now. Offered another appt but she is going away […] Work on Upper, mid and lower back and neck Mobs and progress with the exercises if better."

Mrs C had an appointment on 5 February 2025, which was shortly after the deferred period ended. The notes from this appointment said the following:

"Been signed off since 2/8/2024, last yr both [family members] were diagnosed with cancer, c/o poor sleep, lives with hub and children, picking at skin, irritable, nil dsh expressed, adv iapt, med3, rev after"

Mrs C says the primary reason for her absence was depression and anxiety. And her stress symptoms also impacted her physically, as she suffered from back pain, and she had a jaw surgery in February 2025. However, the contemporaneous GP notes don't give much detail of Mrs C's symptoms, and how these prevented her from working throughout this period. The notes from August 2024 also said that Mrs C's back pain had improved, and again that she was doing better in December 2024. And the notes from November 2024 said her sleep was affected sometimes.

One of Mrs C's GPs wrote a letter on 19 May 2025. The letter said the following:

"This is to confirm that [Mrs C] has been diagnosed and treated for stress & anxiety; she has not been able to perform her role in any capacity during the time of August 2024 to the present day due to the on-going impact of her stress and anxiety.

[Mrs C] has struggled with performing basic daily tasks at home even with the support of her husband, so undertaking her work duties during this time she has not felt is possible.

She has not seen me face to face each time because of her anxieties but has kept me informed of her progress and continued impact that her symptoms have and are presently causing her."

I've reviewed Mrs C's fit notes during the deferred period and the GP who wrote the letter signed these on 27 August 2024 and 29 October 2024. Aviva has said that the GP letter doesn't describe Mrs C's symptoms in detail, and that her symptoms aren't reflected in the contemporaneous notes in detail either.

I've considered the contemporaneous GP notes during the deferred period, and the GP's letter, carefully. Having done so, I don't think Aviva acted unfairly or unreasonably when it said these didn't show enough detail of Mrs C's symptoms and how these prevented her from performing her job role consistently throughout the deferred period, and therefore that she met the policy definition of incapacity. Additionally, this GP only signed the fit notes on two occasions during the deferred period.

Mrs C had an OH review carried out on 17 February 2025, which was a few weeks after the deferred period ended. I appreciate this report concluded Mrs C wasn't fit for work. But the report only refers to Mrs C's reporting of her symptoms during the assessment, and there's no mention of a review of her medical records throughout the deferred period. And during the assessment, Mrs C said her symptoms had worsened in recent weeks. The report concluded that Mrs C was suffering from mood related symptoms that had developed in the context of personal stressors. Overall, I don't think this report gives enough detail about Mrs C's symptoms during the deferred period, and how these prevented her from performing her job role throughout that period.

Mrs C has submitted further evidence from after the deferred period. I've reviewed these, but I don't think these provide any further detail of her symptoms during the deferred period that's supported by the contemporaneous medical evidence. Firstly, the OH reports don't refer to any review of Mrs C's medical records. Rather, the reports refer to a phone assessment carried out, along with reference to previous OH reports. So, whilst these reports provide an assessment of Mrs C's symptoms at the time of the review, these don't provide a medical review of her symptoms during the deferred period based on contemporaneous medical evidence.

Additionally, another GP wrote a letter on 14 October 2025 and described Mrs C experiencing significant symptoms. But these aren't reflected in the contemporaneous GP notes during the deferred period. The GP also referred to psychometric test scores in March 2025 indicating moderately severe symptoms of depression, and severe symptoms of anxiety. But the scores for anxiety indicated moderate anxiety in March 2025, with the scores not indicating severe symptoms until a later test in June 2025. The GP also said Mrs C was offered intensive Cognitive Behavioural Therapy ("CBT") in March 2025, however, she was offered low-intensity CBT first, and high-intensity CBT in June 2025.

So, there also seems to be some inconsistency in the GP's comments about the severity of Mrs C's symptoms, and when these started. Overall, I don't think Aviva acted unfairly or unreasonably when it said the GP's comments in this letter don't reflect Mrs C's symptoms during the deferred period, as set out in the contemporaneous medical notes.

However, it does look like Mrs C's symptoms became more severe after the deferred period ended – based on her medical records, the GP's comments and the OH reports. But I haven't seen the full medical records for that time period, and neither has Aviva. If Mrs C thinks that the severity of her symptoms, and illness(es), meant that she met the policy definition of incapacity later on, she can ask Aviva to consider a claim for a later deferred period in line with the remaining terms and conditions of the policy. If she's not happy with Aviva's decision, she can then raise a new complaint about this with Aviva in the first instance.

I appreciate Mrs C isn't happy with how Aviva's CMA assessed and commented on her claim, and how upsetting she found those comments. But overall, an insurer is entitled to assess and interpret the evidence it has. This then allows the customer to challenge that assessment and interpretation, as appropriate. That said, Aviva has offered to pay Mrs C £100 for the distress and inconvenience those comments caused. I think this is fair and reasonable in the circumstances.

My final decision

My final decision is that the offer Aviva Life & Pensions UK Limited has made is fair and reasonable, so it should now pay Mrs C £100 compensation for the distress and inconvenience caused.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs C to accept or reject my decision before 2 March 2026.

Renja Anderson
Ombudsman