DRN-5918896

The complaint

Mrs B complains about how Legal and General Assurance Society Limited ("L&G") handled a claim under an income protection policy.

What happened

Mrs B is covered by an income protection policy through her employer. The policy pays a benefit if she is unable to work due to an illness or injury in her own occupation, and the deferred period is 26 weeks.

Mrs B was signed off work from 5 September 2023 onwards due to dizziness and headaches. L&G declined her claim as it said there was insufficient objective medical evidence to support that she met the policy definition of incapacity throughout the deferred period.

Mrs B made a complaint about several aspects of how L&G handled everything. In summary, she's unhappy with the following:

- The policy definition of "own occupation" for incapacity is ambiguous, and L&G didn't apply the definition fairly when it considered her claim.
- L&G unfairly declined her claim for an income protection benefit.
- L&G has been inconsistent in how it interprets stress and mental illness.
- L&G discriminated against Mrs B based on her age, sex and by association when it considered her claim.
- The vocational clinical services failed to offer meaningful assistance.
- L&G improperly requested, stored, processed and disclosed confidential medical information.
- L&G unfairly said she made a misrepresentation in relation to her history of mental illness when she applied for a top-up for the cover she held.

One of our investigators reviewed the complaint initially. He thought that L&G had acted reasonably when it requested Mrs B's medical records so it could assess her claim, as well as to ensure she had disclosed her medical conditions correctly when applying for a top-up on the policy. He also thought L&G had acted fairly and reasonably when it concluded that there was insufficient medical evidence to show Mrs B had met the policy definition of incapacity for the duration of the deferred period. The investigator said he hadn't seen any evidence which suggested it had declined the claim for any other reason.

The investigator also didn't think L&G had acted unfairly when it assessed the information contained in Mrs B's medical records as part of the claim. And he didn't see any reason to doubt L&G when it said the information about Mrs B's child contained in those records wasn't disclosed to a third party.

Another investigator reviewed Mrs B's complaint about misrepresentation. Having done so, she thought L&G had acted fairly and reasonably when it said that Mrs B had made a qualifying misrepresentation about her mental health, but she thought the misrepresentation was careless, rather than deliberate or reckless. So, the investigator thought L&G was entitled to apply an exclusion for mental health on the top-up, but it shouldn't have refused the top-up completely. And it should now ensure the top-up was still available for Mrs B on the revised terms.

L&G agreed, and it said it would waive any minimal premiums that would have been due on the top-up from 5 September 2023 (when Mrs B first went absent) until 1 November 2023. After that, the product was no longer available to Mrs B. So, from that point onwards, no exclusions applied on her policy, and she only held the standard policy without a top-up.

Mrs B didn't respond to the second investigator's findings. But as she hadn't agreed with the first investigator's findings about her claim, 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.

Firstly, Mrs B has set out her complaint in detail. However, my role is to decide what's the crux of her complaint and address the points that I consider to be material to the outcome. So, I've considered all the points she's raised, but I'm satisfied the crux of these are fairly summarised under the "what happened" heading of this decision. My findings are also a lot less detailed than how Mrs B has raised all her concerns. This isn't intended as a discourtesy, rather, it simply reflects the informal nature of this service.

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.

Policy terms

Mrs B isn't happy with how L&G has interpreted the policy definition of incapacity, and she says the term for "own occupation" is unfair and ambiguous. This is defined in the policy as follows:

> *"Means the insured member is incapacitated by illness or injury that that prevents him from performing the essential duties of his occupation immediately before the start of the deferred period."*

And "essential duties" are defined as:

> *"Means the duties that are normally required for the performance of the insured member's insured occupation and which cannot reasonably be omitted or amended."*

Firstly, Mrs B's employer is the policyholder, so the policy terms are part of a contract between the employer and L&G. Mrs B is a beneficiary under the policy, so the policy terms are relevant for her when considering her claim under the policy.

For completeness, the policy definition for "own occupation" is not an unusual one in these types of policies. It's for Mrs B to show that she has a valid claim under the policy. And it's for L&G to assess if the evidence supports that she has met the policy definition and therefore is entitled to a benefit under the policy. So, I don't think L&G has done anything wrong by considering if the evidence showed that Mrs B met the policy definition of incapacity, as above.

Claim decision

Mrs B doesn't think L&G assessed her claim fairly. She says, among other things, that it focused on activities that are not relevant to her role (and therefore it didn't apply the incapacity definition fairly), people without medical training assessed her claim, and it considered factors that she says shows it discriminated against her. Mrs B is also not happy with the personal information L&G collected, and how it handled confidential information.

It's not for this Service to decide if a business has breached the Equality Act 2010 – that's a matter for the Courts. But as it's relevant here, I have taken this law into consideration when deciding what's fair and reasonable in all the circumstances of this complaint.

It's also not for this Service to decide if a business has breached any data protection laws – that's a matter for the Information Commissioner's Office ("ICO"). But as Mrs B's concerns relate to how L&G managed her claim, I've considered what's fair and reasonable in all the circumstances of this complaint.

As I explained, it's for Mrs B to show that she has a valid claim under the policy. To do so, she needs to show that she was incapacitated in line with the policy terms for the duration of the deferred period, and beyond. The deferred period ran from 5 September 2023 until 5 March 2024.

L&G requested Mrs B's medical records from her GP, and I can see that she consented for it to do so. L&G said it requested medical records dating back to 12 July 2021 to assess the top-up benefit application Mrs B made on 12 July 2023 to ensure the information provided on the medical underwriting questionnaire was accurate, as well as to gather medical evidence to help understand Mrs B's absence. I think this was fair and reasonable, and not unlike what any insurer would have done in a similar situation.

Mrs B's GP issued fit notes for dizziness and headache throughout the deferred period. But I don't think L&G acted unfairly when it didn't consider these to be enough to show Mrs B met the policy definition of incapacity. This is because these didn't provide any further detail of the illness Mrs B had, or how these symptoms prevented her from performing the essential duties of her own occupation.

Mrs B had a phone appointment with a GP on 15 August 2023, a few weeks before she went absent, and it was noted she had been *"dizzy all of the time and had a lot of headaches"*. The suspected diagnosis was sinusitis, and the GP prescribed a nasal spray.

Mrs B had another phone appointment on 4 September 2023. She had continued to feel dizzy and have headaches, and the GP wanted to review Mrs B face-to-face and carry out some tests. The GP issued a fit note for a week.

Mrs B saw the GP on 6 September 2023. The notes from this appointment include the following:

"Mild frontal headache behind eyes […]
Lightheaded feeling eg on forced expiration blowing bubbles for kids. Never on head movement. Does not sound like a vertigo sx […]
Quite stressful at home with [children], doesn't feel able to keep working and doing this at present with how she is feeling […]"

The GP concluded that it was likely related to sinuses, and Mrs B should continue with the steroid nasal spray. They also wanted Mrs B to undergo some blood tests and an optician check.

Mrs B saw a GP again later in September 2023 to discuss the results of the blood tests. It was noted that her headaches were ongoing, and the GP notes included the following:

"Has got a bit better with resting and doing less, but she has two young children. Concerned she still can't work due to headache when looking at a computer screen."

The GP noted the diagnosis as sinusitis, advised Mrs B to continue using steroid nasal spray, as well as regular painkillers. They agreed to extend the sick note for another week, and the notes said the GP discussed ways to adapt Mrs B's work.

It looks like the next appointment Mrs G had with the GP was over the phone as she had requested a further fit note, and the following was noted on 9 November 2023:

"initially signed off re some episodes of dizziness, (and headache)
occurs still though not as often,
initially occured [sic] when blowing up birthday balloons for her son,
asked her to describe the sx – vague – possibly light headed just wants to lay down,
stiff neck for several weeks,
cares for two children […]
can get a tingling in L arm […]"

Mrs B also said she had a neck lump she wanted checked. So, she had a face-to-face appointment on 20 November 2023. It was noted Mrs B had had a neck lump present for ten years but it had increased in size, and that she had *"generalised neck ache and headaches"*. The GP suspected a cervical rib, but also issued a fast-track referral for suspected head and neck cancer. She was seen at an ear, nose and throat ("ENT") clinic on 24 November 2023, and Mrs B was referred for a CT scan. The notes from this appointment include the following:

"She generally is in good health but has been more tired of late and described occasional light-headedness. This does not appear to be related to neck movements. She has no otology symptoms and is not describing true vertigo."

Mrs B also received a musculoskeletal referral on 7 March 2024, and a referral for neurology on 11 March 2024, which were just after the deferred period had ended. Although Mrs B says these were done on 1 March 2024, and I can see a GP review on the records on that date. However, no medical evidence has been provided to show what happened following these referrals, or the results of any tests or investigations into Mrs B's symptoms.

Overall, the medical records outline Mrs B's symptoms. But they don't give detail of how these prevented Mrs B from working, or if she could have returned to work with adjustments. In fact, the GP mentioned adjustments during an appointment in September 2023. And the GP notes in November 2023 suggested that Mrs B's symptoms weren't as frequent as previously. The notes from the ENT appointment also didn't suggest Mrs B's symptoms were severe.

L&G also arranged a Vocational Clinical Specialist ("VCS") to review Mrs B in November and December 2023, to allow it to better understand the absence. The VCS thought Mrs B could return to work with adjustments, and they made a return-to-work plan with reduced hours. The VCS also recommended an occupational health referral, a display screen equipment and workstation assessments, breaks for posture changes, home working, as well as flexible hours. It's not clear if this plan was shared with Mrs B at the time, as the VCS noted she didn't feel able to return to work. But overall, the VCS thought Mrs B could return to work, with adjustments.

Mrs B says that the vocational clinical services failed to offer meaningful assistance. But the role of the VCS review was to help L&G assess the claim by assessing Mrs B's ability to work. The VCS did also recommend additional assessments, a phased return to work as well as adjustments for Mrs B. So, I can't see that L&G did anything wrong in how it handled the VCS referral, or the results of this review.

L&G's Chief Medical Officer ("CMO") reviewed the information and concluded that there was insufficient objective evidence of an illness of sufficient severity to result in Mrs B being incapacitated as per the policy terms for the duration of the deferred period, and beyond.

Mrs B also had an occupational health ("OH") review on 24 April 2024. The report said Mrs B's symptoms, particularly the neck pain and headaches, *"could hinder her ability to concentrate and perform her duties effectively"*. So, the report concluded that based on the information obtained at the assessment, Mrs B was currently unfit to return to work. It was recommended this would be reviewed after six weeks and consider any adjustments that may be necessary for Mrs B to return to work.

Having considered everything, I don't think L&G acted unfairly or unreasonably when it declined Mrs B's claim, for the reasons it did. As I explained previously, Mrs B's medical records don't give detail of how her symptoms prevented her from working. And whilst Mrs B received some referrals for further tests and treatment in November 2023 and March 2024, there's no further detail of any tests, investigations, or treatment done following these. If Mrs B has further evidence following those referrals, she can send these to L&G and ask it to reconsider her claim in light of those.

Mrs B has also recently told us that she's now received diagnoses which explain her symptoms throughout the deferred period. However, this isn't information L&G had when it considered her claim. So, Mrs B can share the relevant evidence with L&G and ask it to reconsider her claim in light of her diagnoses, and all the relevant medical evidence.

I've only considered the evidence L&G had when it considered her claim initially, along with the OH report it has since had the opportunity to review. The medical records during the deferred period suggested her symptoms weren't as frequent later in September 2023, and her symptoms weren't described to be severe in the ENT appointment in November 2023.

The VCS and OH reports appear to contradict each other. The former concluding Mrs B could return to work with adjustments, and the OH report concluding she was unfit to work at the time. Overall, I don't think L&G acted unfairly or unreasonably by relying on the VCS reports. This is because they were carried out during the deferred period, and the symptoms described in Mrs B's medical records during that time period didn't show that she was incapacitated as per the policy terms. I also can't see anything in the OH report to suggest that the conclusion was reached based on a review of Mrs B's medical records from the deferred period. Rather, it said it was based on the information obtained at the assessment.

I appreciate Mrs B is unhappy that when L&G declined the claim, it referred to her family situation, and her ability to function during daily life. I agree that this isn't the test required to meet the policy definition of incapacity. But I don't think L&G acted inappropriately by considering Mrs B's overall circumstances and function when it considered her claim and outlined these in its claim decision letter.

An insurer relies on medical reports and medical opinions when considering claims for incapacity. Whilst a claim handler may not have medical training, the information was ultimately reviewed by L&G's CMO. So overall, I think L&G considered her claim fairly.

Mrs B says L&G discriminated against her based on her sex, age and by association when it considered her child's condition. But for the reasons I've explained, L&G ultimately declined the claim due to insufficient medical evidence. As I already explained, I don't think L&G acted unfairly when it considered Mrs B's overall circumstances, including her family situation and daily life, when it assessed the claim. And I can't see that Mrs B's age, or the length of any potential benefit payment, was mentioned as a reason to decline her claim. Overall, I don't think L&G acted unfairly and unreasonably in how it considered Mrs B's claim.

L&G deleted Mrs B's child's birth records after she asked it to, and it also let the GP know about this. I appreciate there was a delay in doing so, but I can't see that this delay led to the information being disclosed to any unauthorised parties. And otherwise, the information L&G had was assessed in the context of her claim, and entitlement to a benefit, which Mrs B had consented it to do. The information was ultimately part of Mrs B's medical records of conversations she had with medical professionals. Mrs B also consented to us investigating her complaint, and L&G sent us the evidence it had considered so we could consider the complaint.

I can see that L&G has explained to Mrs B its contractual, regulatory and legal needs to retain her personal information. And I haven't seen anything to suggest that L&G disclosed any confidential information to any unauthorised third party. Overall, I don't think L&G has acted unfairly or unreasonably in the circumstances.

Misrepresentation on the top-up

The key considerations here are the principles set out in the Consumer Insurance (Disclosure and Representations) Act 2012 ("CIDRA"). This is designed to make sure that consumers and insurers get an appropriate remedy if a policyholder makes what is called a "qualifying misrepresentation" under the Act.

A misrepresentation is a "qualifying misrepresentation" when 1) a consumer fails to take reasonable care not to misrepresent facts which the insurer has asked about, and 2) the insurer shows that without the misrepresentation it would not have entered into the contract at all or would have done so only on different terms. If there is no qualifying misrepresentation, the insurer cannot take any action.

I've considered if Mrs B failed to take reasonable care. The standard of care required is that of a reasonable consumer. And one of the factors to be considered when deciding if a consumer has taken reasonable care is how clear and specific the questions asked by the insurer were. The question in dispute asked the following:

> *"any mental illness that's required treatment or counselling, or chronic fatigue syndrome?"*

It's not clear what time period the question applied to. It looks like one of the previous questions started with "During the last 5 years". But as L&G hasn't been able to show what time period the question applied to, I've considered Mrs B's medical records, along with what she's explained, to decide if she took reasonable care to answer the question in dispute.

Mrs B had a GP appointment in September 2021, and it was noted she felt anxious, and thought her mood may have worsened around April. The GP also noted Mrs B was given medication for anxiety previously, and she was interested in arranging talking therapy. The GP signed Mrs B off until maternity leave due to anxiety and issued a fit note saying Mrs B wasn't fit for work. The diagnosis was noted as anxiety. The GP sent Mrs B information for self-referral to the wellbeing service to be assessed for counselling/therapy.

Mrs B had a check-up in April 2022. The GP noted a diagnosis of a mood disorder and suggested a mental health review when Mrs B returned from abroad.

Mrs B had an assessment through the wellbeing service on 13 June 2023. A letter about this assessment (dated 19 June 2023) outlined that the tests Mrs B had undertaken for depression and anxiety suggested she was both severely depressed and severely anxious. The treatment plan was to refer Mrs B for online cognitive behavioural therapy ("CBT"). The letter said that Mrs B had reported struggling with symptoms of anxiety and low mood. I can see that Mrs B engaged with the treatment, but as she didn't think this was the right treatment for her, she was discharged on 22 August 2023 back to the care of her GP.

Mrs B applied for the top-up on 12 July 2023. She says that she answered the question correctly as "no", as the treatment had been for stress, rather than a mental illness. But Mrs B's GP had noted two mental health diagnoses in the two years preceding the top-up – namely, anxiety and mood disorder. And the assessment Mrs B had carried out in June 2023 indicated she was severely depressed and anxious. I appreciate these weren't formal diagnoses. But considering the diagnoses leading up to this assessment, and the severity of her symptoms that resulted in treatment just a month before the top-up application, I think Mrs B failed to take reasonable care when she answered the question as "no".

L&G has explained that had Mrs B answered the question as "yes", it would have applied an exclusion on the policy for mental health. So, I'm satisfied the misrepresentation Mrs B made was a qualifying one. And L&G has now accepted the misrepresentation was careless.

This means that L&G can apply the exclusion on the top-up. However, it has since confirmed that the product Mrs B had applied for was no longer available from 1 November 2023 onwards. So, L&G said it would waive any minimal premiums that would have been due between 5 September 2023 (when Mrs B first went absent) and 1 November 2023. After this point onwards, Mrs B's policy would have continued as standard, without a top-up and without any exclusions applied. I think this is fair and reasonable in the circumstances.

My final decision

My final decision is that I uphold the complaint in part as Legal and General Assurance Society Limited hadn't reached a fair outcome on the misrepresentation on the top-up. To put things right, it should:

- accept the top-up application, but it can apply the relevant exclusion on the top-up,
- apply the top-up on the policy for the time period this was available for Mrs B, and
- waive any premiums that would have been due between 5 September and 1 November 2023.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs B to accept or reject my decision before 27 February 2026.

Renja Anderson
Ombudsman