

The complaint

Mr W is unhappy that Zurich Assurance Ltd ('Zurich') only paid his claim for a limited period of time.

What happened

Mr W has a group income protection insurance policy through his employer, underwritten by Zurich. This pays a benefit if Mr W is unable to work due to illness or injury throughout the deferred (waiting) period of 52 weeks and beyond.

Unfortunately, Mr W became unwell and absent from work in July 2022. He continued to remain off work until the end of the deferred period in 2023 and made a claim.

Zurich reviewed the claim and accepted that Mr W was unable to work until August 2023 after which he was discharged from the mental health services as he had reported a significant improvement. So it paid benefit from the commencement date plus some weeks for a phased return.

Mr W appealed and complained and unhappy with Zurich's response, referred his complaint to the Financial Ombudsman Service.

Our investigator looked into the complaint but didn't think Zurich had done anything wrong. Mr W disagreed and asked for an Ombudsman's review. In summary he said his GP didn't see how bad he was but he was really struggling with his mental health.

And so the case has been passed to me for a final decision.

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, I don't think this complaint should be upheld. I'll explain why.

The relevant rules and industry guidelines say an insurer should handle claims promptly and fairly. And shouldn't unreasonably reject a claim.

The background to this matter has already been set out by the investigator. So I won't repeat the facts here again. Instead I will focus on what I consider to be key to my conclusions.

The starting point is the policy terms and conditions which make up the contract of insurance.

The policy confirms the definition of incapacity as: *"an illness or injury that causes the Member to be unable to work and is applicable under this policy. The Incapacity definition that applies is in your policy schedule. The Member must be under the regular supervision and treatment of a Medical Practitioner."*

The incapacity definition that applies is: *“The Member cannot perform the Material and Substantial Duties of their employment and they are not doing any paid work.”*

Material and Substantial Duties are defined as: *“...the duties that are the essential activities for which a Member is employed that take up a significant proportion of their time. They are also activities that you or the Member cannot reasonably change or stop.”*

So this means Mr W would need to show that he is unable to perform his job as a result of an illness or injury and this would need to be supported by objective medical evidence. I would expect the medical evidence to show that Mr W was unable to perform his job as a result of illness and why. It wouldn't be enough for Mr W to simply be diagnosed with an illness. The onus is on him to prove his claim and show, through the medical evidence, that he is unable to carry out the essential activities of his job as a result of his illness.

I have carefully reviewed the medical evidence and Zurich's reasons for its decision to pay benefit for a limited amount. Although Mr W continued to be absent from work, Zurich relied on a letter from Mr W's mental health support services practitioner who confirmed Mr W had reported an overall significant improvement and he was discharged from the service in August 2023. There is no further medical evidence after this date to show that Mr W's condition had deteriorated again. And Zurich paid benefit to allow for a phased return. This means Zurich fairly accepted the claim up to the point Mr W reported he was better.

Zurich paid the full benefit for a phased return following advice from its chief medical officer. In the absence of any contrary medical evidence to show that this wasn't appropriate for Mr W, I can't say Zurich has acted unfairly or unreasonably so I won't be directing it to do anything further.

Mr W has provided a number of fit notes from his GP and a letter but apart from confirming Mr W's diagnosis, there is no evidence to explain why Mr W is unable to work following his discharge from the mental health support service. Although Mr W is continuing to take medication, this doesn't automatically mean that he is unable to perform the material and substantial duties of his role. A GP note by itself isn't enough to demonstrate that Mr W meets the definition of incapacity as this is based on self-reporting.

I am really sorry to disappoint Mr W but I don't think Zurich has treated him unfairly or unreasonably assessed and paid his claim for a limited period.

My final decision

For the reasons set out above, I don't uphold this complaint.

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

Shamaila Hussain
Ombudsman