

## The complaint

Mrs B is unhappy with Legal and General Assurance Society Limited's decision to decline her income protection claim.

## What happened

Mrs B has a group income protection policy with L&G provided by her employer. In March 2024, she became absent from work owing to her symptoms of stress and anxiety, which led to her suffering from burnout. This was further compounded by the sad passing of her husband the following month. Mrs B said she then began suffering with executive dysfunction, stress headaches, invasive thoughts, fatigue, flashbacks, insomnia and a reduced ability to manage her symptoms of autism and ADHD.

Mrs B said even though she was experiencing these issues, L&G decided to decline her claim as it focused predominantly on her challenges with bereavement, rather than her symptoms of anxiety and her other medical conditions. She'd like L&G to pay her claim.

L&G said it declined Mrs B's claim because there wasn't enough medical evidence to support that she was totally incapacitated and unable to fulfil the demands of her insured occupation. It also said Mrs B's barriers to returning to work appeared to be of a non-medical nature and so maintained its decision to decline her claim.

Our investigator partially upheld this complaint. She said that whilst she agreed with L&G's position on the claim's liability, it should have offered Mrs B more support throughout the claims process. She highlighted Mrs B was under the care of a private psychotherapist and that it could have better explained the significance of obtaining and providing evidence from that specialist. Our investigator also noted L&G's communication could have been better as there were some elements Mrs B found offensive. She recommended L&G pay £150 compensation for the distress and inconvenience caused.

L&G responded accepting her recommendation, although highlighted it obtained Mrs B's GP medical records so it could better understand her situation. L&G said this would usually contain relevant medical information gathered by psychotherapists as the GP is responsible for Mrs B's primary care. L&G also said it told Mrs B it would consider any additional medical evidence she wanted to provide, but on balance, said the occupational physician's report and the assessment provided by its chief medical officer (CMO) was conclusive that Mrs B wasn't suffering with a medical condition severe enough to fully incapacitate her.

Mrs B asked for an ombudsman to consider her case. In summary, she said this was a difficult time for her and that her executive dysfunction made it even harder to comprehend what evidence she needed to gather in order to persuasively challenge L&G's position on her claim. She said that despite her obvious vulnerability at that time, L&G didn't provide her with enough support, or explain what else she needed to provide beyond her FIT notes issued by her GP.

Mrs B also said L&G's decision to decline her claim was based on her not being referred for secondary mental health care. She explained her GP had referred her, only to be told that

she didn't qualify as she was receiving support from a private psychotherapist. And so, it's now for me to make 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've also decided to partially uphold it for the same reasons explained by our investigator. I agree L&G's communication could have been better in the way our investigator described, and I think £150 compensation for the distress and inconvenience caused is a fair acknowledgement of that. But I'm not persuaded L&G should pay her claim because I don't think there's enough medical evidence to show Mrs B was totally incapacitated from fulfilling the requirements of her insured occupation. I'll explain why.

I should say that whilst I've not commented on everything Mrs B has raised, I have reviewed everything she's provided. I'm pleased to hear she's made more of a recovery and returned back to work in November 2024. I'll only be focusing on events that took place within the deferred period. I know she's provided more information about the recent diagnoses she's received of complex PTSD and alexithymia and I wanted to acknowledge that. But like our investigator explained, that falls outside of the scope of my investigation and so I won't refer to these events in the body of my final decision.

The relevant rule that applies in this case comes from the Insurance Conduct of Business Sourcebook (ICOBS). In summary, ICOBS says L&G must handle claims promptly and fairly and must not reject a claim unreasonably. I've kept this in mind whilst assessing Mrs B's complaint.

L&G's policy terms are also an important consideration as they define what it means by incapacity. The terms say;

*"PART 3. Disablement of insured members*

#### *1 BENEFIT PAYABLE*

*Subject to the terms of this policy, the benefit will be paid in respect of an insured member from the benefit start date provided he is a disabled member."*

The policy defines a disabled member as:

*"Means an insured member who at any time,*

*i. meets the incapacity definition, and*

*ii. is not engaged in any other occupation, other than one which causes payment of a partial benefit in accordance with Part 3, Section 7 of this policy."*

The policy schedule sets out that Mrs B must meet the 'own occupation' definition of incapacity:

*"Means the insured member is incapacitated by illness or injury that prevents him from performing the essential duties of his occupation immediately before the start of the deferred period. The insured members capacity to perform the essential duties of his own occupation will be determined whether or not that occupation remains available to him."*

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."*

I think it's important to acknowledge Mrs B's medical records show that she'd been suffering with symptoms of anxiety prior to her absence from work in March 2024. She took a mental health break from work in September 2023 and was managing her symptoms through psychotherapy. Mrs B's also been under the care of her psychotherapist since 2020 to help her cope with other significant life events. In the run up to her absence in March 2024, Mrs B was caring for her terminally ill husband, whilst balancing her commitments with work and family. She was in regular contact with her GP practice and there are records to show she was struggling to maintain her symptoms with everything on her plate.

I don't doubt this must have been a very difficult time for Mrs B and I can see why she was unable to focus on work during that time. I've considered her medical records, the occupational health reports and the opinion of L&G's CMO and I'm persuaded there's not enough evidence to show the symptoms of her medical conditions were severe enough to fully incapacitate her from work. In order to satisfy L&G's incapacity term, the presence of a medical condition isn't enough to say the policy should pay out. There needs to be more detailed medical rationale from a suitably qualified professional that explains the severity of symptoms and why Mrs B was unable to fulfil the specific duties of her insured occupation.

After careful review, I agree with L&G that there isn't enough detailed medical justification to persuasively demonstrate Mrs B was fully incapacitated during the deferred period. I've reviewed the vocational clinical specialist report from July 2024 which detailed the reasons for Mrs B's absence as being stress and anxiety, burnout and bereavement. It also noted her executive dysfunction was the main reason preventing a return to work at that time as Mrs B was worried about feeling overwhelmed and controlling her emotions and anxiety. PHQ-9 and GAD-7 scores also indicated she was suffering with symptoms of moderate anxiety and depression and was taking a low dosage antidepressant medication to alleviate her symptoms.

It was the specialists view that based on that assessment, Mrs B's absence from work appeared to be non-clinical in nature. L&G interpreted this to mean although Mrs B's suffered with anxiety, there wasn't a medical barrier preventing her from returning to work. I can see why it reached that conclusion given the clinician's comments. That doesn't mean to say Mrs B was ready to return to work as it's clear she was also suffering with symptoms of stress, bereavement and executive dysfunction, but these aren't considered medical conditions by the NHS. And for L&G's policy to look to offer cover, there needs to be a medical incapacity that prevents her from working.

This was similarly captured in August 2024 when Mrs B attended an occupational health assessment with an occupational health nurse. It was determined she was unable to return to work at that time because she was suffering with severe levels of stress and grief. It was noted this would undoubtedly impact Mrs B's functional capacity, but for the same reasons I've explained previously, these aren't considered medical conditions.

In September 2024, L&G's CMO reviewed Mrs B's claim and also agreed there was no mental state examination or other clinical findings to suggest persuasive and persistent symptoms of illness or injury of sufficient severity to totally preclude work. He explained Mrs B's dosage of medication at the time to treat her panic disorder was inconsistent with medical guidelines as it was below the recognised clinical dosage to treat her condition. I've considered his comments about that and I find them persuasive. I know Mrs B's testimony is that she was reluctant to take medication and that's supported by the notes from her GP practice. But L&G has interpreted that to mean her symptoms of anxiety weren't severe enough to render her totally incapacitated as defined by the policy. I think it's a reasonable summation to make in the absence of any other persuasive and objective medical evidence to say otherwise.

Mrs B provided a report from her psychotherapist in support of her claim in October 2024. This fell beyond the deferred period – which ended in September – but as L&G considered it, so too have I. It's the psychotherapist's clinical opinion that Mrs B had been unfit for work for over a year at that point in time, owing to her increasing symptoms of anxiety and the effect this was having on her autism and executive function levels. But it stops short of explaining why Mrs B would have been unable to fulfil the duties of her insured occupation – which means I find it less persuasive in these circumstances.

The report suggested Mrs B was unfit to work for over a year at that point. However, other than a short mental health break she had from work in September 2023 for around three weeks, she'd been actively at work until March 2024 albeit on lighter duties. So, I think that indicates Mrs B was not totally incapacitated during the period mentioned in the report. It's for these reasons I've placed less weight on Mrs B's psychotherapist's report as it not only appears inconsistent with the other medical opinions presented as part of this case, it's also inconsistent with Mrs B's ability to go to work prior to her absence in March 2024.

Mrs B's argued her symptoms of autism have made it difficult for her to articulate her symptoms and, at times, absorb information about her claim. She said L&G should have supported her more because of her vulnerabilities and had it done that, her claim may have been payable. I understand the point she's making here, and I sympathise with what she says about that. Mrs B asked whether I could make a finding in response to her argument, but I'm unable to do that due to its speculative nature. However, I can say based on the information I've reviewed, I think L&G's declination of her claim is fair because the medical evidence doesn't support she suffered with a totally incapacitating medical condition that precluded her from work. I think it persuasively shows she was unfit to work, but the reasons for that weren't of a medical nature.

I agree L&G could have supported Mrs B more, particularly as she had told it she was under the care of a private psychotherapist. ICOBS say L&G should give Mrs B reasonable guidance when making a claim and I think it could have advised her to obtain that information from the outset. I know L&G responded to that point saying it told Mrs B it would consider any medical evidence she provided – and it has – but given Mrs B's vulnerabilities, it could have been clearer with her about what it needed from the start. But I still think the £150 compensation awarded by our investigator is a fair acknowledgement of the distress and inconvenience caused and so I make no further award for those reasons.

### **My final decision**

For the reasons I've explained, I'm partially upholding Mrs B's complaint. I think Legal and General Assurance Society Limited declined her claim fairly. But its communication with Mrs B fell short. It must now pay her £150 compensation for the distress and inconvenience caused.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs B to accept or reject my decision before 3 February 2026.

Scott Slade  
**Ombudsman**