

## The complaint

Miss G complains Liverpool Victoria Financial Services Limited (LV) unfairly declined her claim when she was too unwell to work.

## What happened

Miss G worked as a manufacturing operative and holds an income protection policy underwritten by LV. The policy is designed to pay benefits in the event that Miss G is unable to work due to illness or injury, after a waiting period of 4 weeks.

The relevant policy terms in this case are as follows:

*“If you’re unable to work because you’re ill or have had an accident*

*We’ll pay you if you’re too unwell to work in your own occupation (due to illness or injury only) and you aren’t doing any other paid or unpaid work – for example, voluntary work.”*

*“Unable to work means that due to illness or injury you cannot carry out the main tasks of your occupation, and you aren’t doing any other type of work whether this is paid or voluntary (unpaid) work. The main tasks are the parts of the job you do which can’t reasonably be left out or changed”*

In May 2024, Miss G became unwell and visited her GP who signed her off as unfit for work due to anxiety and depression. And Miss G raised a claim with LV in June 2024. Miss G continued to be absent from work for several months, and her employer later terminated her contract.

After review, LV declined the claim in November 2024. It said it didn’t think Miss G’s circumstances met the policy terms of incapacity. Miss G provided more medical evidence and LV reviewed this. However it didn’t change its outcome on the claim.

Miss G complained to LV. The insurer responded in January 2026 and said it thought the claim had been correctly declined, but it was willing to review any further evidence which could be supplied and wrote to Miss G’s GP. After receiving more information from the GP in June 2025, LV advised Miss G her claim was still declined.

Unhappy with the response, Miss G brought her complaint to this service.

An investigator here looked into what had happened and said he didn’t think the claim had been unfairly declined or unreasonably delayed.

LV acknowledged the investigator’s view and made no comments. However Miss G disagreed. In summary she said:

- the claim was unfairly declined and the evidence shows her illness;

- the occupational health report shows she was unable to perform her job role and no alternative roles could be found;
- the level of detail provided by the GP was beyond her control;
- LV continued to collect premiums when it was aware Miss G was not working; and
- LV did not request a full medical report or letter previously.

As Miss G disagreed and asked for a decision from an ombudsman, the case 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.

The relevant rules and industry guidelines say LV has a responsibility to handle claims promptly and fairly, and shouldn't reject a claim unreasonably.

First, I'd like to reassure Miss G that while I've summarised the background to this complaint, I've carefully considered all that's been said and sent. In my decision I haven't commented on each point that's been raised, and our rules don't require me to do so. Instead I've focused on what I think are the key issues. Having done so, I'm not upholding this complaint and I'll go on to explain why.

I'm sorry to hear of Miss G's circumstances, and don't doubt that she's been unwell. I hope her health is now improving. But, being unwell doesn't automatically mean an income protection claim should be paid. I've considered the policy terms and conditions as these form the basis of Miss G's contract with LV. And it's a general principle of insurance that it's for the policyholder to show they have a valid claim. This means Miss G needed to demonstrate through objective medical evidence, that an illness caused her to be unable to carry out the main tasks of her occupation during the deferred period and after.

I'm not a medical expert, so it's not for me to reach my own medical conclusions. Instead my role is to weigh up the available medical evidence in order to decide whether LV has acted fairly and reasonably when assessing Miss G's claim.

Miss G's GP provided her with fit notes stating she was unable to work due to depression and anxiety. GP statements of fitness are mostly based on self-reported symptoms and don't generally contain commentary on functional ability. And the criteria for a GP to deem a patient unfit for work are unlikely to be the same as the policy terms of incapacity.

Miss G has also referenced her claim with the Department for Work and Pensions (DWP). But similar to the above, the DWP will operate under its own assessment criteria, which will likely differ from the terms and conditions of Miss G's income protection policy.

LV said it didn't think Miss G was suffering with a mental health condition of a severity which would mean she was unable to work, and it noted there was no evidence of abnormal mental state examinations or diagnostic tests undertaken. I don't think this was an unreasonable stance for the insurer to take. The GP notes state Miss G was unfit for work due to anxiety and depression, and she was prescribed anti-depressant medication. However I'm not persuaded that the medical notes or later medical letters sufficiently demonstrate that Miss G was unable to carry out the main tasks of her occupation due to her illness.

I think LV has reasonably concluded that Miss G was absent from work due to work and life stressors. I say that because it's consistent with the occupational therapist's report referencing Miss G's struggles with life and family pressures, and the initial GP consultation

where comments on her family circumstances were also recorded. Although the occupational health reports conclude Miss G was unfit for work, these are largely based on Miss G's self-reporting, so I don't consider them to constitute objective medical evidence.

I've taken into account Miss G's comments to this service about the accuracy of the occupational health report. She's said references to family circumstances and transport to work are incorrect. She said her health breakdown was caused by the way she was treated by her manager at work. I think it's reasonable for LV to have relied on the content of the occupational health reports when it assessed the claim. And whilst I've noted what Miss G has said, I don't think it makes a difference here, because issues with her manager are still evidence of work stressors.

I think it's important to explain that income protection policies don't usually cover claims for absences from work caused by stress. This is because stress caused by situational circumstances generally isn't considered to be the same as suffering from a clinically impairing mental health condition.

### *Delays*

I've also considered whether LV unnecessarily delayed the assessment of the claim. And I don't think that it did. I've noted that there were delays in the GP responding to requests and chasers for information, but this is not something the insurer can reasonably be held responsible for. And while Miss G may have liked LV to write to her GP for a further letter sooner, I think the insurer had enough medical evidence available in order to make a decision on her claim. And I'm satisfied that when Miss G appealed the decision, LV said it would review any further evidence and wrote to the GP directly to ask if anything more could be supplied. I think LV appropriately considered whether the new evidence had any impact on its decision on the claim, and fairly agreed to review anything further Miss G could supply.

### *Policy premiums*

Miss G has said she thinks it is unfair that she was still required to pay her policy premiums whilst not working. Although Miss G's policy includes 'waiver of premium' cover, the policy explains that premiums must continue to be paid until a claim has been agreed. So as LV did not agree Miss G's claim, I don't find it unreasonable that it continued to require her to pay her policy premiums.

### **My final decision**

For the reasons I've given, it's my final decision that I do not uphold this complaint and make no award against Liverpool Victoria Financial Services Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss G to accept or reject my decision before 9 April 2026.

Gemma Warner  
**Ombudsman**