

The complaint

Mrs D complains that Aviva Life & Pensions UK Limited initially turned down a claim she made on a group income protection insurance policy. She's also unhappy that Aviva treated her claim appeal as a complaint and considers this has disadvantaged her.

What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I think are the main events.

Mrs D is insured under her employer's group income protection insurance policy. Unfortunately, Mrs D became unwell and was signed off from work. In June 2023, her employer made an incapacity claim on the policy.

Aviva obtained medical evidence to allow it to assess Mrs D's claim and it spoke with Mrs D. Based on the available evidence - and having sought the opinion of clinical members of staff - it concluded that Mrs D's absence was caused by work-related stress, caring responsibilities and insomnia. Aviva wasn't persuaded that Mrs D's absence was down to an illness which prevented her from working part time throughout the period of her absence. And it didn't think her claim met the policy definition of incapacity. Therefore, in November 2023, it turned down Mrs D's claim.

Around a year later, Mrs D appealed. She also sent Aviva further medical evidence in support of her claim.

Given the content of the appeal letter, Aviva considered that it should be treated as a complaint in line with the regulator's - the Financial Conduct Authority (FCA) - rules. Aviva reviewed Mrs D's claim in line with the new medical evidence and the policy terms and it concluded that Mrs D had now provided enough evidence to show her claim met the policy definition of incapacity. On that basis, it agreed to accept and backdate her claim, paying Mrs D benefit from the end of the deferred period.

Aviva issued a final response to Mrs D's complaint which outlined its recent acceptance of the claim, but which set out why it thought its initial decision had been fair.

Mrs D was very unhappy with Aviva's handling of the claim and she asked us to look into her complaint. In brief, she was unhappy that Aviva had treated her appeal as a claim; she felt that Aviva hadn't given her claim fair consideration; it hadn't properly considered the impact of her medical conditions on her; it hadn't undertaken sufficient investigation into her diagnoses or sought specialist opinion; it hadn't complied with its regulatory obligations and she felt it had caused her significant avoidable harm.

Our investigator didn't think Aviva had treated Mrs D unfairly. In summary, he felt it had shown it had acted reasonably when it turned down Mrs D's claim in November 2023.

Mrs D disagreed and so the complaint's 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.

Having done so, whilst I'm very sorry to disappoint Mrs D, I don't think Aviva has treated her unfairly and I'll explain why.

First, I was sorry to hear about Mrs D's ill-health and the impact this has had on her. I'd like to reassure Mrs D that while I've summarised the background to her complaint and her very detailed submissions to us, I've carefully considered all she's said and sent us. I understand Mrs D would like me to address a number of specific points she's raised. But, I haven't addressed each point Mrs D's made and I'm not required to by our rules. That's in line with our statutory remit as a quick and informal alternative to the courts. Instead, I've focused on what I find to be the key issues in reaching what I consider to be a fair and reasonable decision.

I must also make the parameters of this decision clear. Mrs D has asked us to look into points which she hasn't previously raised with Aviva. Namely, that Mrs D says Aviva's delay in dealing with a Data Subject Access Request (DSAR) delayed her being able to draft her appeal and return to work – therefore impacting on her potential earnings. And secondly, Mrs D considers that Aviva failed to provide promised support with her recovery and return to work. In line with our rules, a financial business must be given an opportunity to consider a complaint before we can potentially look into it. As neither of these issues have previously been raised with Aviva, I'm satisfied it wouldn't be appropriate for me to consider them within this decision. It's open to Mrs D to make a new complaint to Aviva about those specific points should she wish to do so.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, amongst other relevant considerations, such as the regulator's principles and standards, the available evidence, the policy terms and what I consider to be good industry practice, to decide whether I think Aviva treated Mrs D fairly.

The policy terms and conditions

I've first considered the policy terms and conditions, as these form the basis of Mrs D's employer's contract with Aviva. Mrs D made an incapacity claim on the policy, given she wasn't fit for work. So I think it was reasonable and appropriate for Aviva to consider whether Mrs D's claim met the policy definition of 'own occupation' incapacity, which says:

'The member's inability to perform on a full and part time basis the duties of his or her job role as a result of their illness or injury.'

This means that in order for Aviva to pay Mrs D incapacity benefit, it needed to be satisfied that she had an illness or injury which prevented her from carrying out her own occupation either on a full or part time basis for the entire 52-week deferred period and afterwards.

It's a general principle of insurance that it's for a policyholder to show they have a valid claim on their policy. This means it was Mrs D's responsibility to provide Aviva with enough medical evidence to demonstrate that an illness had led to her being incapacitated from carrying out her role. While in some circumstances an insurer may choose to ask for more evidence from the specialists providing a claimant's care, there's no obligation for it to do so.

As I've set out above, following Mrs D's appeal and provision of new medical evidence in

November 2024, Aviva agreed that she'd shown she had a valid claim and that the definition of incapacity had been met. Mrs D's complaint centres, in my view, on Aviva's initial decision to turn down her claim in November 2023.

In 2023, Aviva assessed the evidence Mrs D provided in support of her claim, including seeking the opinion of its clinical staff. And it wasn't persuaded that she'd shown she met the policy definition of incapacity at that point. So I've next looked at the available medical (and other) evidence to assess whether I think this was a fair conclusion for Aviva to draw.

I've first looked at the absence notification Mrs D's employer sent Aviva in June 2023. This stated that Mrs D was absent due to anxiety and insomnia. It stated she was awaiting a neurodiversity assessment. And it also noted that in January 2023, Mrs D had suffered stress at work.

In late June 2023, Mrs D spoke with one of Aviva's claims handlers. During the call, it was noted that – in my words – Mrs D had had some concerns about meeting her targets, that she was having difficulty sleeping; that she'd been undergoing therapy; she was awaiting the outcome of an ADHD assessment and that she had some family caring responsibilities.

Mrs D's GP also provided copies of her medical records and I've considered entries relevant to the deferred period. In January 2023, Mrs D had a consultation with a doctor. The GP noted that Mrs D wasn't sleeping at all, that she worked through the night to hit deadlines, that she didn't want to let work down and that a close family member had serious diagnoses. She was signed off with insomnia and anxiety. A couple of weeks later, she was issued with a fit note which said she was unfit for work due to insomnia and stress at work.

Subsequently, in March 2023, Mrs D consulted with a medical practitioner. The notes state that Mrs D was stressed and wasn't sleeping and that her close relative had been in and out of hospital. Mrs D was again signed off with insomnia and work stress for four weeks and again, for a further four week period in April 2023.

Additionally, in April 2023, Mrs D's psychologist wrote a letter. This explained that Mrs D had been undergoing therapy since 2022, that she was *'currently booked off work due to stress and burn out and is experiencing severe insomnia.'* The letter also referred to Mrs D's caring responsibilities. The psychologist felt Mrs D would benefit from a formal diagnostic ADHD assessment.

In May 2023, Mrs D was referred to a sleep clinic. And in early June 2023, Mrs D was signed off with insomnia and ADHD. The notes show that Mrs D had reported insomnia, work stress and significant burnout from work and caring responsibilities. In July 2023, Mrs D was diagnosed with ADHD.

One of Aviva's medical team reviewed Mrs D's claim in November 2023, based on the available medical evidence. They said:

'Member suffers from chronic insomnia and work-related stress and appears member has a responsibility as a carer (for relative) who currently lives with member. Medical information confirms chronic insomnia for many years and more recent work-related stress factors noted by GP... There is no indication documented in the medical information to support extended absence from the workplace due to mental ill health... It does appear that work related stress is a primary issue linked to current absence so it would appear that working for an own or alt employer with supportive measures in place would be medically possible.'

I've thought very carefully about all of the evidence that's been provided and which was available to Aviva when it made its initial claims decision. It's important I make it clear that

I'm not a medical expert. In reaching a decision, I must consider the evidence provided by both medical professionals and other experts to decide what evidence I find most persuasive. It isn't my role to interpret medical evidence to reach a clinical finding – or to substitute expert medical opinion with my own.

It's clear from the evidence that Mrs D had been suffering from upsetting symptoms (and had been undergoing therapy for some time for c-PTSD). However, in my view, it wasn't unreasonable for Aviva to rely on the medical evidence provided by Mrs D's GP which indicated that at least part of the reason why Mrs D was signed off was due to work-related stress and caring responsibilities. And it does appear from the medical records that Mrs D had had insomnia for many years prior to the claim. I'm also mindful that the evidence was considered by Aviva's own clinical team, which has expertise in occupational medicine.

Therefore, based on the totality of the medical evidence which was available in November 2023, I don't think Aviva unfairly or unreasonably concluded that at that point, Mrs D hadn't shown she met the policy definition of incapacity. That's because there wasn't sufficient medical evidence to show Mrs D was prevented from working by a defined mental illness or a significant deterioration of a long-standing condition. The GP's fit notes don't indicate that Mrs D was signed off due to her existing c-PTSD. And so I don't find Aviva acted unfairly when it turned down Mrs D's claim.

Mrs D feels strongly that Aviva didn't fully or fairly assess her claim. But having considered everything, I think Aviva was entitled to make a claims decision based on the medical evidence it had available in November 2023. I haven't seen persuasive evidence that it deliberately 'cherry-picked' which evidence to place weight on or disregarded evidence which supported Mrs D's claim. And I don't think it was unreasonable for Aviva not to undertake further investigations or arrange an independent examination of Mrs D before it made its decision to turn down her claim.

Additionally, I don't find that Aviva's decision to treat Mrs D's appeal as a complaint was incorrect or that it prejudiced her position. Having considered the appeal letter, I agree that it met the FCA's definition of a complaint and so Aviva was accordingly required to handle it as such. Mrs D's appeal was still fully reviewed and her claim was accepted as a result of that appeal and the evidence. I think this indicates Aviva carried out the appeal in good faith and based on a full and fair review of the new evidence. Aviva also addressed Mrs D's main complaint point – that its initial claims decision had been unfair. And I think it was open to Mrs D to have raised the further issues she's since brought to us with Aviva, even after it had issued its final response to this particular complaint.

I'd add too that I'm satisfied the evidence shows Aviva complied with its regulatory obligations, responsibilities and duties when it initially assessed Mrs D's claim and when it reviewed her appeal. I think it communicated with Mrs D in a clear and fair way. Nor do I find that Aviva caused Mrs D any material distress and inconvenience when it responded to her initial request for the medical evidence it had relied on in reaching its decision for which I could reasonably award compensation. If, however, Mrs D believes Aviva breached data protection law when it handled her DSAR, she may wish to complain to the Information Commissioner's Office.

Overall, whilst I sympathise with Mrs D's position and I understand she's been through a very difficult time; I don't think Aviva acted unfairly when it turned down her claim in November 2023. And I'm not persuaded that Aviva handled Mrs D's claim unreasonably, either. So I'm not directing it to do anything more.

My final decision

For the reasons I've given above, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs D to accept or reject my decision before 5 March 2026.

Lisa Barham
Ombudsman