

The complaint

Miss T is unhappy with MetLife Europe d.a.c's decision to decline her income protection claim.

What happened

Miss T has income protection with MetLife, through her employer's group policy. In August 2023, Miss T became too unwell to work, suffering with symptoms of fatigue. Miss T made a claim on her policy however it was declined by MetLife in June 2024 and again a few months later in September 2024. Miss T said MetLife has relied on an unsuitable test, the chronic pain abilities determination test (CPAD) to rationalise its decision. Miss T said she was diagnosed with functional neurological disorder (FND) and that a CPAD assessment isn't suitably designed to determine her readiness to return to work because of her related symptoms.

MetLife said there was little in the way of objective or persuasive medical evidence to explain why Miss T is unable to fulfil the duties of her insured occupation. It said most of Miss T's medical evidence is based on self-reported symptoms and so it decided to refer her for a CPAD assessment. MetLife said the assessment doesn't just measure pain, but also cognitive function, which Miss T has reported is one of the main reasons she's unable to work.

MetLife said the CPAD report highlighted Miss T had exaggerated her symptoms during the cognitive testing and the results were consistent with someone suffering with dementia or a traumatic brain injury. It said this showed she was able to cognitively function at a greater level than she was prepared to demonstrate on formal testing. It maintained its decision to decline her claim.

Our investigator didn't uphold Miss T's complaint. She said MetLife's reliance on the CPAD assessment was fair. She noted MetLife had previously said it would contact Miss T's consultant neurologist and that it didn't do that. She said whilst that was unhelpful, it was for Miss T to evidence she has a valid claim and not MetLife. Our investigator also recognised MetLife considered all available medical evidence for the relevant deferred period and beyond, to better understand the reasons behind Miss T's absence from work before maintaining its decision to decline her claim.

Miss T, unhappy with this, asked for an ombudsman to review her complaint. In summary, she said, MetLife said it would follow up with her consultant and by not doing so, meant it'd failed to clarify key evidence that was crucial to the outcome of her claim. The results of the CPAD assessment were deemed to be invalid, so it therefore follows that it's unfair of MetLife to rely on that evidence to determine her ability to return to work. MetLife's poor handling of her claim meant she lost out on over £20,000 of benefit that would have otherwise been payable. She'd like this to be paid and compensation for the distress and inconvenience caused.

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 decided not to uphold it and mainly for the same conclusions reached by our investigator. I know this'll come as a disappointment to Miss T and I'd like to be clear that I'm not minimising her FND or the symptoms she's experienced. The issue here is that in order to receive benefit under her income protection policy, the presence of an illness isn't enough to satisfy the policy criteria. Miss T must show, through persuasive medical evidence, that her condition fully incapacitates her, as described by the policy.

The medical evidence I've seen doesn't go far enough to persuasively explain why Miss T is unable to fulfil the duties of her insured occupation. In addition, the CPAD assessment is perhaps the most persuasive piece of evidence as it's not only detailed, but its recommendations are based on cognitive and functional testing that are relevant to determine Miss T's capacity to return to work. Therefore, I'm persuaded MetLife is able to rely on it to decline Miss T's claim as it shows a greater level of function than she'd previously reported. I'll explain why.

I may not respond to every point raised by Miss T or MetLife. I don't want either side to think I've not considered everything that's been presented, because I have. But the rules that govern the ombudsman service allow me to focus on what I consider to be the crux of the complaint and the arguments relevant to that outcome.

The relevant rule in this case comes from the Insurance Conduct of Business Sourcebook (ICOBS) and says MetLife must handle claims promptly and fairly and must not reject a claim unreasonably. I've considered MetLife's obligations under ICOBS whilst assessing Miss T's complaint.

The policy terms describe incapacity as;

“Unable to perform their own occupation - an insured member, eligible employee or eligible partner, is incapacitated if:

- they are unable to perform, due to illness or injury, the material and substantial duties required of them in their own occupation which they were performing immediately prior to being incapacitated; and

- are not following any other occupation”

Was it fair for MetLife to refer Miss T for a CPAD assessment?

I think it was. I say that because the symptoms of Miss T's FND that prevented her from working were largely cognitive. I accept Miss T said she didn't suffer with pain, but the assessment doesn't focus solely on that. It also considers physical and cognitive barriers preventing a return to work, including chronic fatigue.

The evidence shows she reported suffering with fatigue and symptoms of intermittent seizures when she initially saw her GP in July just before her absence in August. The medical evidence shows Miss T was reducing one of her prescribed medications as it was thought this was potentially contributing to her symptoms.

Her GP also suggested the extreme fatigue Miss T was experiencing could have been caused by post-acute withdrawal syndrome from her medication, particularly as she was titrating off her medication. And so, given the perceived barriers at the time preventing Miss T being able to work were both cognitive and functional, I'm persuaded that MetLife's

decision to refer her for a CPAD assessment was fair. I say that because the assessment puts users through a range of physical and neuropsychological tests to evaluate their functional and cognitive status.

The assessment was able to provide MetLife with the necessary insight into Miss T's symptoms that were preventing her returning to work, such as her extreme levels of fatigue and speech disturbance. Had the test results supported what Miss T had said about being unable to work because of her symptoms, MetLife would have likely relied on this evidence to accept and pay her claim.

Is it fair that MetLife rely on the CPAD assessment to decline the claim?

The short answer is yes. But it's important that the insurer also considers all available medical evidence. It's for MetLife to decide how much weight to place on that evidence and so simply because an occupational health report says Miss T is unable to work, doesn't mean MetLife should accept the claim based solely on that report. MetLife must consider all evidence in the round and decide what's most persuasive.

In this case, I think the CPAD assessment is the most persuasive piece of evidence. I say that because it's not based solely on Miss T's self-reporting, but also on objective cognitive and functional testing. In other words, Miss T was being observed the whole time and was being assessed by a suitably qualified medical professional. I accept Miss T will likely disagree, particularly as she said the examiner was unaware of her FND condition. But I find that argument less persuasive as the examiner assessed Miss T on what she reported her symptoms to be. And it's those symptoms that Miss T said are the main cause for her not returning to work.

It was noted in the assessment that Miss T described being unable to perform any aspects of her role due to her extreme fatigue levels, difficulty concentrating and difficulties speaking. She also reported that when she tries to use her brain, it makes her ill. However, none of these symptoms were observed as part of the two days' worth of testing. The examiner noted Miss T was able to converse normally and extensively throughout the assessment, including at the conclusion of testing. It was also noted there was no evidence of any word finding difficulties, or the need to have instructions or questions repeated.

Miss T also reported her fatigue to be severe, scoring herself 11/11 as part of the relevant questionnaire. However, the examiner noted this was inconsistent with her presentation and reported ability to undertake most activities of daily living and to even attend the assessment. It was determined Miss T reported a higher level of disability in these questionnaires than is the case.

In addition, the report said there was evidence to suggest Miss T exaggerated her symptoms during the cognitive tests and her scores were comparable with individuals that were suffering with dementia, a significant brain injury or even a stroke. Typically, someone with Miss T's score in this area of testing would require support to perform everyday self-care and routine functions and that cognitive function challenges are often clearly evident within general communication and interaction with such individuals. The examiner concluded this is not the case with Miss T.

The assessment concluded that Miss T's inconsistent reporting should therefore be ignored and indicative of her ability to function at a greater level than she was prepared to demonstrate. I think, therefore, MetLife can fairly rely on this to decline her claim. The other medical evidence from Miss T's treating specialists doesn't explain why Miss T is unable to fulfil the duties of her insured occupation. And the evidence that does support her claim is based on her self-reported symptoms, which given the findings of the CPAD assessment, I

find less persuasive in the circumstances.

Invalid test results

Miss T argued that part of the CPAD assessment results were determined to be invalid and therefore questioned whether it was fair for MetLife to rely on them to decline her claim. I've carefully considered this and I'm still persuaded it can. I think there's some confusion about what the CPAD assessment reported. I should say that whilst it said Miss T's results for cognitive function were invalid, it doesn't support her claim in the way she thinks.

It was the examiner's opinion that Miss T exaggerated her symptoms based on the inconsistencies identified during testing. They noted she appeared to struggle unnecessarily with certain cognitive tests than others that were more complex and said this should not have been the case in reality. It was therefore determined Miss T had a greater level of function than she was prepared to demonstrate during the tests. Or, in other words, Miss T didn't authentically engage with the tests. It's for those reasons, the examiner classified her results as invalid. And where there's evidence of symptom exaggeration, the examiner concluded this meant Miss T was capable of more than she showed throughout the relevant testing.

It was also noted that where Miss T described extreme fatigue, this was unsupported by her vital signs, including heart rate and other key observations related to fatigue. And so, because the evidence doesn't support Miss T's self-reported symptoms, MetLife is fairly entitled to rely on it to decline her claim.

Miss T said MetLife ought to have contacted her consultant neurologist for more information about her condition and her ability to work. I note MetLife said it mistakenly agreed to do that in June 2024 when it first declined her claim. MetLife said this was an error. It also said that it had enough information to reach a decision on her claim as it'd already reviewed the two letters from Miss T's neurologist from September and December 2023.

MetLife said this, alongside the CPAD assessment and Miss T's GP notes was enough for it to determine liability on her claim and I'm in agreement with that. It said it'd potentially consider more information that becomes available later, but as things currently stand, there's not enough persuasive medical evidence to support her claim. It's also worth highlighting that it's for Miss T to show, through medical evidence, that she meets the policy's definition of incapacity and not MetLife.

My final decision

For the reasons I've explained, I don't uphold Miss T's complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss T to accept or reject my decision before 10 March 2026.

Scott Slade
Ombudsman