

The complaint

Mr C complains that Legal and General Assurance Society Limited (L&G) terminated an incapacity claim he made on an income protection insurance policy. He's also unhappy that it didn't offer to pay proportionate benefit after he returned to work in a lower-paid role.

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 key events.

Mr C holds a personal income protection insurance policy, which pays benefit if he's incapacitated from working in his own occupation due to illness or injury.

Unfortunately, in 2019, Mr C was signed off from work suffering from depression. He made an incapacity claim on the policy.

L&G accepted the claim and began to pay Mr C monthly benefit. It also paid for Mr C to have treatment with a psychologist, who I'll call Mr D. L&G continued to keep the claim under review, including arranging for Mr C to speak with one of its Rehabilitation Specialists.

In May 2020, Mr C spoke with the Rehabilitation Specialist, who concluded that Mr C was ready to return to work. L&G also took into account a report from Mr D which showed Mr C's depression and anxiety scores had improved. So L&G concluded that Mr D no longer met the policy definition of incapacity and it decided to terminate his claim. It paid final benefit in June 2020.

Independently, Mr C arranged with his employer to begin a period of paid leave in June 2020 and he then returned to work in a different, lower paid role in July 2020.

Subsequently, in October 2024, Mr C got in touch with L&G regarding an administration point. And around the same time, he complained about L&G's decision to end his claim in June 2020 and questioned why it hadn't paid him proportionate benefit following his return

L&G maintained its decision to terminate benefit had been fair. It said Mr C hadn't let it know in 2020 that he was returning to a different role or that his pay had reduced. It agreed to consider a claim for proportionate benefit if Mr C provided it with evidence in support of his claim. However, having considered the information Mr C sent it, L&G concluded that Mr C hadn't shown proportionate benefit was due.

Unhappy with L&G's decision, Mr C asked us to look into his complaint.

Our investigator didn't think L&G had unfairly terminated Mr C's claim in June 2020 and he didn't think it had been unreasonable for L&G to conclude that there wasn't enough evidence to show proportionate benefit was due. So he didn't think L&G needed to do anything more.

Mr C disagreed. In summary, he didn't think L&G had acted in line with its regulatory obligations. He didn't think it had asked for enough medical evidence to show he no longer met the policy definition of incapacity and he believed it had effectively forced him to return

to work prematurely. He also felt L&G had overlooked indicators that his redeployment had been driven by Occupational Health (OH).

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 Mr C, I don't think L&G has treated him unfairly and I'll explain why.

First, I'd like to reassure Mr C that while I've summarised the background to his complaint and his detailed submissions to us, I've carefully considered all he's said and sent us. In this decision though, I haven't commented on each point that's been made and nor do our rules require us to. Instead, I've focused on what I think are the key issues.

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 regulatory principles, the policy terms and the available medical evidence, to decide whether I think L&G treated Mr C fairly.

It seems there are two key issues for me to decide. First whether I think L&G fairly terminated benefit in 2020. And second, whether it reasonably concluded that there wasn't enough evidence to show proportionate benefit should be paid. I've considered each point in turn. I note L&G's final response letter dealt with administrative concerns and offered Mr C some compensation for those. But as Mr C didn't ask us to comment on those issues, I haven't considered them as part of this complaint.

Was it fair for L&G to terminate benefit?

I've first considered the policy terms and conditions, as these form the basis of the contract between Mr C and L&G. Mr C made a claim on the policy after he became incapacitated by depression. So it's clear that when it accepted the claim in 2019, L&G was satisfied that Mr C met the following 'own occupation' policy definition of incapacity:

'If you are in gainful employment or gainful self-employment at the time of incapacity we will consider you to be incapacitated once we have assessed your claim as set out in section 8.2 and are satisfied that you have no capacity for working in your own occupation, on any basis, as a direct result of your injury or illness.'

The contract also explains:

'The claim will be reviewed on both medical and financial grounds on a regular basis...

The monthly benefit will be paid one month in arrears following the end of the deferred period and at monthly intervals until the earliest of:

- *the end of your incapacity.'*

In summary, I think the policy terms make it sufficiently clear that L&G will regularly review a claim it's paying to check whether a policyholder remains incapacitated in line with the policy terms. And that if L&G thinks the evidence shows a policyholder is no longer incapacitated, it will stop paying the claim. In my experience, neither of these terms are unusual in income

protection insurance policies. And generally, I think an insurer is entitled to periodically review a claim to ensure a policyholder still meets the policy definition of incapacity.

As part of L&G's regular reviews of Mr C's claim, it considered various pieces of evidence. These included OH reports, Mr C's medical records, evidence from Mr D and the clinical opinion of its Rehabilitation Specialist – a qualified nurse. In May 2020, L&G concluded that Mr D no longer met the policy definition of incapacity. So I've carefully considered the available evidence to decide whether I think this was a fair decision for it to reach.

It's clear from Mr C's medical records that he had a diagnosis of depression and that he was receiving support from OH, as well as his GP. L&G also agreed to pay for Mr C to undergo treatment with Mr D.

During mid-March 2020, Mr C spoke with the Rehabilitation Specialist, who noted that in their opinion, Mr C was improving and that he would be work ready within the following eight weeks. The report stated that Mr C hadn't had any further OH reviews.

In April 2020, Mr D drafted a progress report. In that report, Mr D stated that Mr C's generalised anxiety score and depression score had both markedly reduced from moderately severe levels to Mr C having mild anxiety and depression. He also noted that Mr C's motivation to do things around the house and enjoy them had improved, although he noted Mr C's work situation remained unclear and that Mr C wouldn't be returning to work in his previous role.

On 12 May 2020, Mr C spoke with the Rehabilitation Specialist again. They noted that Mr C had completed his psychological therapy, *'which he had found helpful and generally his symptoms had improved.'* The report noted Mr C hadn't spoken with his GP since February 2020 and that he remained on antidepressant medication. The report also said that Mr C had seen OH in March 2020, where they'd considered he was working towards a return to work and that he was waiting for an OH review.

The report stated:

'(Mr C) had a...meeting with his employers...he has been told where to access information on alternative roles within the company, as he does not wish to return to his pre-absence role.

...

In my opinion, I consider the customer is 'work ready' at this juncture as he is improving and is able to carry out daily living activities.'

Additionally, Mr C spoke with L&G a few days later, when he told the claims team that he was returning to work and that he *'felt he needed to get on with it.'* He also said he would no longer be obtaining fit notes from his GP citing that he wasn't fit for work.

I've carefully considered the medical evidence that was available to L&G when it decided to terminate benefit. It's important I make it clear that I'm not a medical expert. It's not my role to interpret medical evidence to reach a clinical judgment and it would be inappropriate for me to do so. Instead, I've focused on whether I think L&G has shown it was fair to rely on the evidence it had available to terminate benefit.

Mr D – an expert in psychology – had concluded that Mr C's depression and anxiety had improved and that both now fell in the mild range. It seems Mr C told the Rehabilitation Specialist – a nurse and therefore clinical member of L&G's team – that his symptoms had

improved. It also seems that while he remained on medication, Mr C hadn't spoken to his GP for some months. I note too that it appears Mr C indicated that he didn't *want* to return to his previous role. I'm also mindful that Mr C told L&G's claims team that he was returning to work.

In the round, I think it was reasonable for L&G to rely on the expert opinion of Mr D and the clinical opinion of the Rehabilitation Specialist when deciding that Mr C no longer met the policy definition of incapacity. I also find it was entitled to take into account Mr C's call with it a few days after the May 2020 call with the Rehabilitation Specialist. I don't think - based on the individual circumstances of this case - that L&G was obliged to ask for further evidence from Mr C's GP or that it needed to carry out further investigations. Nor do I think there's any persuasive evidence to show that L&G effectively prevented Mr C from appealing its decision at this point or obtaining more evidence of his incapacity if he'd wished to do so.

In the round then, I'm not satisfied that L&G unfairly or unreasonably terminated Mr C's claim in 2020.

Following Mr C's complaint to L&G some years later, his GP provided further evidence. One letter, dated May 2025, says: '*On the consultation of 27 January 2020 the consultation was a general discussion about the improvement of your mental health. "Feeling improving, getting into place where feeling more positive, spoken to work." On 19 June 2020, you mentioned that you had decided to do (self-employed role) and was [sic] feeling enthusiastic and motivated.*' In another letter of May 2025, the GP stated that Mr C had stopped taking medication in early 2023.

L&G reviewed the GP's letters but didn't think they were detailed enough to change its understanding of Mr C's claim. I don't think that was unreasonable. That's because it seems to me that the GP's letters support that around four months before L&G terminated the claim, Mr C had been improving and that in the weeks after the last benefit payment was paid, Mr C was enthusiastic and motivated to do a new, self-employed role.

This means that despite my natural sympathy with Mr C's position, I don't think L&G acted unfairly when it stopped paying him benefit in June 2020.

Did L&G unfairly conclude that there wasn't enough evidence to show Mr C had a valid proportionate benefit claim?

The contract says:

'If you return to gainful employment or gainful self-employment on a lower level of earnings than you received immediately before your incapacity, directly as a result of your incapacity, the proportionate monthly benefit will be payable.'

In my view, the contract terms make it clear that proportionate benefit will be payable if a policyholder returns to work on lower pay *directly as a result of their incapacity*. This is a standard term in income protection insurance policies.

It's clear Mr C feels that L&G failed to tell him about the option to potentially claim for this benefit when his claim was originally terminated. I've considered this point carefully.

I accept that the evidence shows L&G was aware that Mr C was looking to return to work in an alternative role rather than his own occupation. From Mr C's complaint form though, this seems to have followed a January 2020 OH review and following his employer telling him it couldn't keep his role open indefinitely. As above, I've noted the Rehabilitation Specialist reported that Mr C didn't want to return to his previous role. So it isn't clear, on balance, that

Mr C's return to alternative lower-paid employment was caused directly by his incapacity or that he was medically unable to return to his previous role. It seems instead, based on the available evidence, that this may have been a personal choice Mr C made following discussions with his employer about its operational needs.

Additionally, during the call with L&G's claims team in mid-May 2020, Mr C didn't explain that he was returning to work in a lower-paid role or suggest that this was down to incapacity. So I don't think L&G would've been or ought reasonably to have been aware that Mr C's return to work was subject to a significant drop in pay.

Taking those factors together, I don't think I could fairly say that L&G unreasonably concluded that there isn't enough evidence to show Mr C is entitled to retrospective proportionate benefit.

I do appreciate that given the years that have passed, there may be practical difficulties in Mr C obtaining medical evidence that his return to work on lower pay was directly related to his incapacity. But it does remain open to him to obtain new medical evidence should he wish to do so and to send this to L&G for it to consider. I would expect L&G to review any new evidence in line with its regulatory obligations.

Finally, I understand Mr C has concerns about the way proportionate benefit is presented and that the cover is misleading. I don't agree that the policy is worded unclearly or that it's misleading. I would add though that as we're not the industry regulator, I have no power to tell an insurer to revise its terms or to review its policies or procedures.

Summary

As I've explained above, I do sympathise with Mr C's position. It's clear he went through a difficult time and his income substantially reduced. But I'm not persuaded that L&G treated him unfairly or that it breached any of its regulatory obligations or the regulator's rules and principles when it dealt with his claim. And for that reason, 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 Mr C to accept or reject my decision before 28 April 2026.

Lisa Barham
Ombudsman