DRN-4533993

The complaint

Miss D complains that Legal and General Assurance Society Limited (L&G) has stopped paying benefit for an incapacity claim she made on a group income protection insurance policy.

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.

Miss D was a member of her employer's group income protection insurance policy. The policy included a deferred period of 39 weeks. Miss D unfortunately became very unwell in June 2017 and therefore, her employer subsequently made an incapacity claim on her behalf.

L&G accepted Miss D's claim. Miss D had had related periods of absence from work during 2016 and so it linked her previous periods of absence when it calculated when the deferred period should start and end. L&G therefore began to pay benefit from November 2017.

In November 2022, L&G stopped paying Miss D's claim. That's because it said the policy included a limited benefit period of five years. As Miss D had been paid monthly benefit for a five-year period, L&G said no further payment was due.

Miss D's employer provided her with a policy schedule dated January 2017, which stated that benefit would be paid until state pension age. So Miss D felt L&G had acted in error when it terminated her claim and she complained.

L&G maintained that Miss D's claim was subject to a limited benefit period of five years. It considered that Miss D's employer had sent her the 2017 schedule in error. As L&G had started Miss D's deferred period during 2016, it concluded that the claim was subject to the 2016 policy terms. The 2016 policy schedule was silent as to the relevant benefit period. But L&G sent Miss D a copy of the insurance broker's 'confirmation of placement' (COP) which set out the cover terms agreed between L&G and Miss D's employer. This showed that L&G had agreed to provide a cover with a limited benefit period of five years. And therefore, it concluded that it had correctly ended the claim in November 2022.

Miss D was unhappy with L&G's position and she asked us to look into her complaint.

Our investigator didn't think Miss D's complaint should be upheld. He thought it had been immaterial whether L&G assessed Miss D's claim in line with the 2016 policy, as she'd been paid benefit for a five-year period. He accepted that the 2016 policy schedule didn't set out a limited benefit period. However, he felt that the COP made clear the terms upon which L&G had agreed to provide cover. And he felt this showed that the policy was subject to a limited benefit period of five years. He'd also seen a copy of an email from Miss D's employer to L&G. The email agreed that L&G could share the COP showing the five-year period with Miss D. Therefore, he felt it had been fair for L&G to terminate the claim after the five-year benefit period had ended.

Miss D disagreed and I've summarised her responses to our investigator. She felt that the deferred period should begin from 2017 and that it had been unfair for L&G to start the deferred period from 2016. She considered that if the deferred period had begun in 2017, she'd have been entitled to an extended benefit period. She didn't think the COP represented an actual contract of insurance. And she felt that the omission of the limited benefit period from the 2016 schedule showed that both L&G and her employer had acted negligently and without due care and diligence. She thought that L&G was working with her employer to provide evasive answers. She maintained that L&G had entered into a contract with her employer which stated that the benefit end date was state pension age.

I issued a provisional decision on 1 December 2023. In my provisional decision, I explained the reasons why I thought it had been fair for L&G to stop paying Miss D's claim. I said:

'First, I'd like to reassure Miss D that while I've summarised the background to her complaint and her submissions to us, I've carefully considered all she's said and sent us. I was sorry to hear how unwell Miss D has been and I understand she's been through a very upsetting time. Within this decision though, I haven't commented on every point that Miss D has made and nor do our rules require me to. Instead, I've focused on what I think are the key issues.

I must make it clear that this decision will only consider whether I think L&G acted fairly and reasonably when it terminated Miss D's claim. I won't be considering any concerns Miss D may have about her employer or any involvement she believes it may have had with her claim. That's because we have no power to look into employment disputes.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And the relevant regulator's principles say that firms must act in the best interests of their customers and treat them fairly. So I've considered, amongst other relevant considerations, the terms of this policy and the available evidence, to decide whether I think L&G has treated Miss D fairly.

I've carefully considered the available policy terms and conditions, as these form the basis of the contract between Miss D's employer and L&G. The contract terms were agreed by Miss D's employer and L&G. Miss D's employer is the policyholder – Miss D didn't enter into a direct contract of insurance with L&G.

The deferred period start date

It's clear that Miss D feels that it was unfair for L&G to begin her deferred period from the date of her first absence in 2016. By doing so, L&G assessed and accepted the claim in line with the terms of the 2016 insurance contract. However, Miss D believes that the deferred period should have begun in 2017 and would therefore have been subject to the 2017 contract terms.

I've thought about this carefully. The terms of the group policy state:

'If a disabled member returns work for during the deferred period, but becomes unable to work again because of their injury or illness, we'll link the separate periods of absence together as long as:

• each absence is for at least five consecutive working days;

• each absence is because of the same or a related injury or illness; and

• all the absences we link have been within the last 52 weeks.'

Based on the evidence I've seen, Miss D's employer asked L&G whether it would be prepared to link Miss D's previous periods of absence - which had begun in June 2016 – to her 2017 absence. The evidence indicates that these absences were related to the cause of Miss D's June 2017 absence. It's clear that at least two of those periods of absence were for longer than five consecutive working days and that they took place within a 52-week period.

As such then, I currently don't think it was unfair for L&G to link Miss D's earlier periods of absence to her June 2017 absence and to start the 39-week deferred period from June 2016. That means I think it was fair and reasonable for L&G to assess Miss D's claim in line with the 2016 policy terms and conditions.

The relevant benefit period

I've seen a copy of the 2016 policy schedule, which sets out the main policy benefits and limits. It's clear that the 'benefit termination date' has been left blank. It's unfortunate that this information wasn't included on the documentation issued between L&G and Miss D's employer. However, that doesn't mean that L&G is required to pay benefit indefinitely or in line with the cover terms which it seems to have agreed with Miss D's employer at renewal in 2017 – even though I appreciate applying a 2017 benefit period limit period may have been more beneficial to Miss D.

Miss D has been provided with a copy of the COP issued by the relevant broker, setting out the cover terms which were agreed by L&G and Miss D's employer. Her employer agreed to the sharing of this evidence with her by L&G, to demonstrate that a five-year benefit period applied. I've considered the terms of the signed COP document very carefully because it shows the insurance contract terms both parties agreed to enter into and be bound by. The COP was produced in December 2015, ahead of policy renewal and was intended to apply from 1 January 2016 onwards.

Page four of the COP includes a heading titled: 'Limited Payment Period.' Immediately adjacent to this heading, the document states:

'Benefits are limited to a maximum 5 year period for all employees.'

At the end of the document is an insurer declaration. It states:

'I agree to place this Scheme on risk based on the information contained in the above schedule.'

A representative of L&G signed and dated the declaration.

In my view, this is persuasive evidence that L&G agreed to cover beneficiaries under Miss D's employer's scheme for a maximum benefit period of five years. I'm also persuaded that this benefit period was taken into account when L&G considered the total risk of claim posed

by this particular policy and when it calculated the premium it charged the policyholder. So I'm satisfied, on balance, that the terms of the contract between L&G and Miss D's employer included a maximum benefit period of five-years – even if that information isn't set-out on the post-sale schedule.

It's unfortunate that Miss D's employer sent her a copy of the 2017 schedule. It's clear that the 2017 schedule refers to benefit being paid up until state pension age. So I can understand why Miss D is concerned that the wrong benefit period has been applied to her claim. However, L&G isn't responsible for any error on the part of Miss D's employer.

And as I've explained above, I'm persuaded that L&G entered into a contract with L&G's employer to provide cover in line with the COP. This means that I think L&G acted fairly when it concluded that under the terms of the 2016 policy which apply to the circumstances of this claim, payments were subject to the five-year benefit period limit. So I currently find that L&G was reasonably entitled to stop paying Miss D benefit once the claim had been in payment for a five-year period. The benefit period ended in November 2022.

I sympathise with Miss D's position because I appreciate she remains very unwell and because she's distressed by this situation. But, on balance, I think L&G has settled her claim fairly and in line with the policy terms. I've seen no persuasive evidence that L&G has acted unreasonably or that it has been evasive in the way it's handled Miss D's claim.

Overall, I currently intend to find that L&G's liability for this claim ended in November 2022. So it follows that I'm not planning to tell L&G to pay anything more.'

I asked both parties to send me any further evidence or comments they wanted to me to consider.

L&G explained that it had never offered to pay claims up to state pension age under this scheme. It said the 2017 schedule was erroneous on this point. And it said the 2017 schedule had never applied to Miss D's claim anyway.

Miss D provided further information in support of her claim. This included a copy of the 2017 COP between Miss D's employer and L&G, and her payslips from 2017. I've also summarised Miss D's responses to my provisional decision below:

- The 2017 COP was identical to the 2016 COP and showed that the benefit period was limited to five years. This showed that I shouldn't automatically assume that the 2016 COP would tie-in with the 2016 schedule;

- She maintained that her sick leave began in 2017 and so the deferred period shouldn't have begun in 2016;

- She'd asked her employer to provide copies of earlier contracts, but it had refused to do so. She questioned why this was the case unless it was being deliberately obstructive or it damaged its case. She felt we should investigate the matter to get to the bottom of things.

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 Miss D, I still think it was fair for L&G to terminate her claim in November 2022 and I'll explain why.

As I set out in my provisional decision, Miss D's employer asked L&G to link her 2016 and 2017 periods of absence. Based on the evidence I've seen, I still think it was fair for L&G to conclude that Miss D's periods of absence were linked and therefore, I don't think L&G acted unreasonably when it concluded that Miss D's deferred period should begin in 2016. While I've looked carefully at the payslips Miss D has provided, I don't think they're persuasive evidence which would lead me to change my findings on this point. As such, I still think it was fair for L&G to assess Miss D's claim under the terms of the 2016 contract.

Miss D has provided me with a copy of the 2017 COP between L&G and her employer. This

indicates that the benefit payment period for that policy year was also limited to five years. I appreciate this differs from the benefit period which was stated on the 2017 schedule Miss D was sent. So I can understand why Miss D has concerns about my reliance on the 2016 COP when deciding what I think the benefit term was most likely to have been during the 2016 policy year.

However, I've seen copies of the 2013 and 2014 policy quotations too. These also show that the benefit payment term in each of those years was limited to five years. I'm afraid I can't share these quotations with Miss D because it's confidential information between Miss D's employer and L&G. But I hope it reassures her to know that I've considered this evidence carefully.

In my view, the totality of the available evidence points to Miss D's employer having agreed a limited benefit payment period of five years during its contract negotiations with L&G in 2013, 2014 and in 2016. The 2017 COP would also suggest a limited benefit period of five years was agreed between Miss D's employer and L&G, although I accept this is at odds with the 2017 schedule. So, I find it's more likely than not that in 2016 (and earlier) L&G agreed to provide a group income protection insurance policy to Miss D's employer, based on a limited benefit period of five years. And I find it's most likely that the 2016 policy was underwritten and issued in line with the terms of the COP. I'd add too that as I've decided L&G was reasonably entitled to assess Miss D's claim in line with the 2016 contract, I don't think any discrepancy in the policy documentation for the 2017 policy year materially affects the outcome of this claim.

I do sympathise with Miss D's position, as I appreciate how unwell she's been. I'm sorry to add to her disappointment at an already difficult time. But based on all I've seen; I'm satisfied L&G has accepted and settled her claim fairly and in line with the policy terms. And it remains the case that L&G isn't responsible for any actions on the part of Miss D's employer. So I'm not telling it to pay anything more.

My final decision

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

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss D to accept or reject my decision before 5 February 2024.

Lisa Barham
Ombudsman