DRN-4332541

The complaint

Mr W complains that Legal and General Assurance Society Limited (L&G) has turned down an incapacity claim he made on a personal income protection insurance policy.

What happened

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

Mr W is insured under a personal income protection insurance policy, which he took out in 2017 to cover his occupation as a self-employed contractor. In July 2019, Mr W decided to take a break from his contract at the time, as he'd been experiencing some symptoms of work-related stress and anxiety. He wanted some time to recover.

However, Mr W's symptoms didn't get better. In February 2020, he was diagnosed with anxiety and depression. He was prescribed anti-depressants and referred for counselling. In March 2020, Mr W made an incapacity claim on the policy.

Having investigated the claim, L&G turned it down. As Mr W hadn't been working at the time he made the claim, it hadn't assessed the claim in line with the 'own occupation' policy definition of incapacity. Instead, it had assessed the claim in line with the 'activities of daily living' definition of incapacity. L&G didn't think that Mr W had met the policy definition of incapacity and so it declined to pay his claim.

Mr W complained to us about L&G's decision to turn down his claim. I issued a final decision on Mr W's complaint in March 2022, which explained why I felt it had been fair for L&G to turn down the claim. Briefly, I didn't find that Mr W had provided medical evidence to show he'd been incapacitated in July 2019, or that he met the definition of incapacity in 2020.

Subsequently, Mr W obtained further evidence from his GP practice which he asked L&G to consider. This consisted of a letter, from a GP, dated 14 June 2022, which said that Mr W had consulted at the surgery in June 2019, complaining of symptoms of tiredness and low energy and that the symptoms had been queried as being post-viral fatigue. The GP noted that these symptoms were also associated with depression, which seemed more likely due to Mr W's personal circumstances.

And Mr W also sent L&G a backdated fit note, dated 7 December 2022. The fit note covered the period 11 June 2019 until 4 February 2020. The note stated that Mr W was not fit for work due to anxiety with depression.

L&G considered the new medical evidence but maintained its decision to decline the claim. It didn't think the new information changed the fact that Mr W hadn't been signed-off as unfit to work until February 2020.

Unhappy with L&G's further decline of his claim, Mr W asked us to look into a further complaint. He considered that the new medical evidence showed he had become incapacitated while he was actively working. And therefore, he considered that L&G should

accept and pay his claim under the 'own occupation' contractual definition of incapacity.

Our investigator explained that he could only assess whether he felt L&G had appropriately considered the new medical evidence. And he was persuaded that it had. He noted that the GP's letter indicated that Mr W had had an appointment in June 2019, when he'd been experiencing symptoms which were more likely to have been down to depression, rather than post-viral fatigue. But he didn't think the letter showed that Mr W was experiencing such severe symptoms that he'd been incapacitated in line with the policy definition. The investigator accepted that Mr W had retrospectively been issued with a backdated sick-note, covering the period June 2019 until February 2020. But he noted that Mr W hadn't been signed-off work in either June 2019, or at a later appointment in December 2019 either. He considered that the contemporaneous medical notes from the time of those appointments were more reliable evidence that retrospective medical evidence.

On that basis, the investigator felt it had been fair for L&G to turn down the claim again.

Mr W disagreed and he sent us a further letter from a third GP, dated 27 July 2023, in support of his claim, along with supporting evidence from his financial adviser. The GP said that Mr W's records clearly showed he was suffering from migraines and fatigue which made it difficult for him to focus. The GP said that Mr W's symptoms would have affected his ability to work and the rationale in his decision-making.

The investigator asked L&G for its comments on the GP's further evidence. L&G concluded that the evidence wasn't compatible with the medical records from the relevant time. There was no reference to Mr W having been referred for specialist support or receiving on-going treatment in July or December 2019. Therefore, it maintained its decision.

Our investigator reconsidered the complaint and still didn't think it had been unfair for L&G to rely on evidence from across the whole period to conclude that Mr W hadn't shown he met the policy definition of incapacity.

Mr W disagreed and I've summarised his responses to our investigator:

- He has provided sufficient medical evidence to show that he wasn't fit to work from July 2019 onwards, at which point he'd still been working. It wasn't fair for L&G to continue to decline the claim. And there wasn't a policy exclusion for mental illness;
- He felt he had no choice but to take legal action and he considered that our service's involvement had delayed legal action;
- His financial adviser felt L&G were a disgrace and referred to errors on Mr W's claim form which it hadn't picked-up upon review;
- He considered that our service had misunderstood the complaint and hadn't appropriately engaged with employment-related contractual disputes or compassion. He felt it was easier for us to decide not to uphold his complaint to avoid ramifications from a large company like L&G;
- He had visited his GP a number of times and it had been based on his symptoms in February 2020 that he GP had diagnosed him with anxiety and depression. L&G didn't offer any support, such as counselling and it had only offered a review seven months after he made the claim, which was traumatic for him.

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 W, I don't think it was unfair for L&G to turn down his claim and I'll explain why.

First, I must make it clear that this decision will consider whether L&G has fairly assessed the new medical evidence Mr W has provided to it since I issued my final decision in March 2022; and whether I think its decision to maintain the decline of the claim is fair and reasonable. I *won't* be commenting on any issues I decided previously. I'd also like to reassure Mr W that although I've summarised his complaint and the detailed communications he's made; I have read and considered all of his submissions in detail. My findings though will be focused on what I think are the key issues. I'm confident that I have fully understood the issues Mr W has complained about and the terms of the insurance contract he held with L&G. I was sorry to hear about Mr W's illness; the impact on him and his family and I was pleased to read that he's now making a recovery.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't unreasonably reject a claim. Accordingly, I've taken into account these rules, amongst other relevant considerations, such as the policy terms and the available medical evidence, when deciding whether I think L&G has treated Mr W fairly.

Mr W made an incapacity claim on the policy. It's a general principle of insurance that it's for a policyholder to provide enough evidence to show, on balance, that they have a valid claim on their policy. As such, it was Mr W's responsibility to provide L&G with sufficient evidence to show that he was incapacitated in line with relevant policy definition of incapacity. The first definition is for a policyholder's 'own occupation' and says:

'Incapacity definition: Own occupation

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 the section headed "Assessing your claim" 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.'

If L&G considers that a policyholder isn't in gainful employment or self-employment at the time of the incapacity, then the following definition will apply:

'*Incapacity definition: Activities of Daily Living*

If you are a houseperson at the time of incapacity we will consider you to be incapacitated once we have assessed your claim as set out in the section headed "Assessing your claim" and are satisfied that you are unable to undertake at least three of the tasks from the activities listed below for a sustained period and as a direct result of your incapacity.'

Mr W considers that while he didn't receive a formal diagnosis of anxiety and depression until February 2020 - and he didn't make a claim until the following month – the new medical evidence shows he was incapacitated from July 2019 onwards. At this point, he'd been actively working and therefore, he'd been in gainful employment. L&G assessed the new medical evidence, but it wasn't persuaded that it showed that Mr W had been incapacitated since July 2019. So I've carefully considered the new medical evidence to decide whether I think this was a fair conclusion for L&G to reach. I must make it clear that I'm not a medical expert, so my decision has necessarily been based on an assessment of the evidence provided and the comments of L&G's Chief Medical Officer.

The first piece of new evidence is a letter from a GP at Mr W's GP practice, dated 14 June 2022. This says:

'I am writing to confirm that (Mr W) has been attending since the 10th December 2019 with symptoms of anxiety. He was diagnosed on the 5th February 2020 with anxiety and depression, and commenced on anti-depressants. I do note however that Mr W had consulted on 11 June 2019 complaining of symptoms of being tired all the time and low energy levels, at the time he was queried as suffering from ?post viral fatigue, but these symptoms are also associated with depression, which seems more likely due to his current work stress, personal family issues and dealing with the emotions and support needed for (a terminally ill relative) *who died of …cancer later that year.'*

The GP notes which were sent to L&G only date back to July 2019 – so there's no evidence of an appointment which took place in June 2019. It seems clear though that Mr W did see a GP at that point with symptoms of tiredness and low-energy. The GP has linked those symptoms to Mr W's subsequent diagnosis with depression and anxiety. But I don't think it was unreasonable for L&G to conclude that this letter didn't show that Mr W's symptoms were severe enough to mean he was incapacitated in line with the policy terms and conditions. And it's clear that Mr W wasn't signed-off work at that time.

I've considered the retrospective fit note Mr W's GP has completed too. This is dated December 2022 and says that Mr W was unfit to work between 11 June 2019 and 4 February 2020. I'm mindful that this is medical evidence which shows that upon a backdated review, a GP concluded that Mr W hadn't been fit to work during this period. However, there's no detailed explanation as to how or why Mr W's symptoms would have prevented him from working during this time.

And I don't think it's unfair or unreasonable for L&G to find the contemporaneous medical notes spanning July 2019 until May 2020 to be more persuasive evidence of Mr W's health at the time. It's clear that Mr W did discuss suffering some anxiety and depression over a period of a few months with his GP in December 2019. However, the GP didn't suggest any onward referral for counselling or psychiatric treatment at that time and neither did they prescribe any form of treatment. It's clear too that the GP didn't sign Mr W off at this point either. I'd add that it isn't clear whether the fit note was completed by a doctor who'd been responsible for Mr W's care during this period, or that they were familiar with Mr W's health in July 2019. As such then, I don't think L&G acted unfairly when it placed more weight upon the contemporaneous GP notes recording what was discussed at the time of Mr W's appointments, than a fit note issued over two and a half years after Mr W was ultimately signed-off as unfit to work.

A third GP provided another letter, dated 27 July 2023, which stated:

'Mental health affects a patient's physical health as well as emotionally. In Mr W's case, it clearly shows from the records he was suffering from fatigue and migraines which made it difficult for him to focus. His symptoms would have affected his ability to work and the rationale in his decision making.'

The investigator asked L&G for its comments. It said:

'I can confirm our position remains unchanged. While we note that (the GP) has referenced fatigue and migraines as symptoms that would have affected his ability to work in 2019, contemporaneous evidence from around the period in question is not compatible with this assertion. Whilst we do not have an entry available from June 2019, entries available to us from July and December 2019 make no reference to on-going treatment or referral to specialist support. We would expect this to be the case if mental illness of sufficient severity to make him unable to work was diagnosed in the preceding months. We also note references to cycling (of considerable distance) in 2019 which would suggest that his fatigue and inability to focus were not of a level that rendered him incapacitated.

It is important to note that our Chief Medical Officer also wrote to (the GP who issued the June 2022 letter) *in March 2023 with a detailed explanation of the reasons why they were of the view that Mr W's absence, and the retrospective medical certificate provided in relation to it, did not relate to mental illness of sufficient severity to preclude him from working in his own occupation on any basis…the GP has not challenged any of these points in the letter they were asked to provide by the claimant.*

As we do not agree there is any credible evidence of incapacity at the time the customer was working, we remain of the view that the claim has been correctly assessed against the "activities of daily living" definition outlined in his policy from the point he was certified unfit for work by his doctor in February 2020.'

Like the investigator, I've weighed-up the evidence from across the whole period – from the original GP records from July 2019 onwards and up to and including the letter of 27 July 2023. I don't doubt that Mr W was suffering from symptoms of migraine and fatigue in June 2019. But I don't think there's sufficient medical evidence which shows that Mr W's symptoms were severe enough, in June or July 2019, to mean he was medically incapacitated from carrying out his role on any basis. Again, he wasn't signed-off at this point and he wasn't prescribed medication or referred for treatment. So I can't fairly find that it was unreasonable for L&G to conclude that this letter wasn't enough evidence to show Mr W was incapacitated in July 2019 either.

I do understand that Mr W chose to take a break from work in July 2019 to try and recover. I've thought carefully about the explanation he and his financial adviser have given to explain why he took a break, rather than being signed-off work and I do sympathise with Mr W's position. But I think L&G is reasonably entitled to be satisfied that a policyholder meets the policy terms before it agrees to accept and settle a claim. And in this case, I don't think it's acted unfairly by concluding that the new medical evidence isn't enough to demonstrate that Mr W was incapacitated in line with the policy terms. Therefore, it follows that I don't find it was unfair or unreasonable for L&G to turn down Mr W's claim.

My final decision

For the reasons I've given enough 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 W to accept or reject my decision before 16 October 2023.

Lisa Barham
Ombudsman