DRN-4558898

The complaint

Ms D is unhappy with Assicurazioni Generali SpA's decision to decline her claim.

What happened

The background to this decision was set out as part of my provisional findings. To summarise, Ms D became unwell and was unable to work from 9 February 2022 having contracted COVID-19. She had a 13-week deferred period on her policy and a claim was made in May 2022 upon its completion as Ms D said she was suffering with the effects of long-COVID.Ms D contracted COVID-19 a second time in June 2022 which further impacted her recovery and exacerbated her long-COVID symptoms. Ms D said this was the reason she was unable to return to work.

Generali declined Ms D's claim in December 2022 and also her appeal in February 2023. On both occasions, Generali said there wasn't enough medical evidence to show that Ms D was suffering with an illness that would preclude her from working as a software engineer. It noted the majority of Ms D's symptoms were self-reported and that there wasn't enough objective medical evidence to support her position. Generali also drew attention to its discovery that Ms D had been working on projects which required similar technical ability as her occupation during the time she reported to be too unwell to work. And so, it maintained its declinature.

I'd provisionally agreed with Generali. I said there was enough evidence to persuasively determine that Ms D had been working on other, personal projects that were indicative her functional capacity was greater than she'd previously described. I highlighted the ceramics project she'd published in February 2023 and the almost daily contribution she'd made to it during the months prior to its release, where she'd previously explained she was too unwell to work. I also noted other activities she's been involved with, such as attending a conference for her jewellery business and her ability to participate in a planned holiday abroad for the Grand Prix.

I gave both Ms D and Generali the opportunity to respond to my provisional decision, prior to making a final one. Generali accepted my provisional findings. However, Ms D didn't. I granted Ms D an extension in which to respond. Ms D made several arguments in response to my provisional findings. I've not listed them all, rather, I've distilled what I consider to be the relevant key points. In summary, Ms D said;

- She had completed the majority of work on her ceramics coding project prior to becoming unwell. Although she accepted she also contributed to the project during the time she was signed off sick from work;

- The contribution log she'd previously provided as evidence hadn't been properly explained and therefore had been misinterpreted;

- Generali took too long to assess her claim which left her without money to live and pay her bills. Ms D said she had no choice but to undertake work for which she was renumerated as a result of Generali causing unnecessary delays handling her claim

and;

- She remains too unwell to work due to suffering with several symptoms of long-covid.

And so, it's now for me to make a final decision.

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. My reasons for doing so are the same as those set out in my provisional decision. However, there were some additional arguments made by Ms D that I thought helpful to address. In short, I think Generali assessed Ms D's claim fairly because it based its decision not to accept liability on the available medical evidence, which I'm satisfied doesn't fulfil the policy definition of incapacity. Further, there was sufficient and persuasive evidence to suggest Ms D was able to contribute to other projects during the period she was signed off sick. It's for these reasons I don't uphold her complaint.

The relevant rule that applies here is from the Insurance Code of Business Sourcebook (ICOBS) which says Generali must handle claims promptly and fairly and not reject a claim unreasonably. I'm satisfied Generali has fulfilled its obligations here. I'll explain why.

In my provisional decision, I explained that Ms D had undertaken additional work closely linked to her insured occupation as software engineer. Having carefully considered Ms D's job description, her testimony and that of Generali, I'm satisfied she contributed to the project during the time she'd previously reported to be too unwell to work in any capacity. I say that because the project was released in February 2023 and in the run up to the release date, she'd regularly contributed to it in some way. Her exact contribution remains unknown as previously, Ms D had denied completing any work towards it – having previously explained she'd completed the vast majority prior to becoming signed off work in February 2022. However, I don't think that makes a material difference here because the policy terms are clear how they describe incapacity.

"As a result of illness or injury, the Member is incapable of performing the Material and Substantial duties of their occupation, and they are not carrying out any other work or occupation"

It defines *work* as;

"Means on the part of a Member, any employment, self-employment or consultancy or engaging in any work or physical activity which gives rise, or is capable of giving rise, to any remuneration, income, fees, profits, capital or other gains, whether or not they are taxable and whether or not they are paid to, or to the order of, or enjoyed, whether directly or indirectly, by the Member or any person with whom he lives or to whom he is related or who is dependent on him"

In my provisional decision, I'd highlighted a work activity log she'd produced, which suggested she'd worked on that project almost daily for several months. However, since then, Ms D made further arguments explaining that the daily activity logged was automated and not a true representation of her involvement. She's since provided an updated version of the activity log, however, I find that less persuasive in the circumstances as it's self-reported and appears to be at odds with the original submission. In any event, even if I were to take that evidence on face value, it still shows Ms D was able to contribute, exercising similar

skills required for her insured occupation, at a time she'd previously said she was too unwell to work.

Fundamentally, Generali's role here was to consider the available evidence to determine the outcome of Ms D's claim and I'm satisfied it did that fairly, based on the information provided by Ms D.

I'd previously highlighted Ms D had attended other events, including a day's seminar and other personal events which I'm satisfied show a greater level of functionality than previously described. I accept Ms D's rationale for attending these events and I accept she needed a walking aid and the option to sit down. However, that's not the test being applied here. Generali's assertion that she could return to work in some capacity seems reasonable given she could complete these commitments albeit with adjustments.

Ms D works from home and her employer previously indicated it would consider reasonable adjustments to help facilitate her return to work and on a graded return. And so, I think Generali has assessed this appropriately and fairly, based on Ms D appearing to have greater functionality than she'd previously described. I also noted the comments made by the vocational rehabilitation team that assessed Ms D in August 2022. It explained Ms D could sit for short periods, with breaks and build up her tolerance overtime. It felt she could discuss a return to work with adjustments.

In her reply to my provisional findings, Ms D referred to the letter she provided from her neurologist as support that she's too unwell to work. But I find that less persuasive given the events I've just explained. In addition, the neurologist doesn't go into any detail about Ms D's limitations or explain why she'd be unable to fulfil the responsibilities of her insured role. Generali reached the same conclusion with that piece of evidence – which for the reasons I've explained, I find reasonable. It said it would've expected a more detailed account of Ms D's function, treatment plan and prognosis and that without that, it was unable to interpret the medical evidence in the way Ms D had hoped. I think it's also worth highlighting that the vast majority of symptoms described were self-reported by Ms D. And this becomes less persuasive when considered in the wider context of the particular circumstances of this case.

I've thought about Ms D's arguments about the delays she experienced with Generali handling her claim and that being the reason she had to work during the time she was unwell. I'm not persuaded Generali need to take any action here because but for those delays, there was still no claim to be paid. Generali explained it didn't consider Ms D to have satisfied the incapacity term – which I thought fair given the lack of objective and detailed medical evidence to support her position. I also note there was activity on her claim throughout most of that time, including having to collect medical evidence from Ms D's GP. I note Ms D's comments that Generali did this in two parts, but I thought that was the fair thing to do in the circumstances.

Generali explained that after reviewing Ms D's claim form, it decided it wanted to gather further medical evidence from her GP. Generali didn't do anything wrong in doing that and I note this was explained to her at the time.

My final decision

For the reasons I've explained, I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms D to accept or reject my decision before 12 February 2024.

Scott Slade
Ombudsman