DRN-4715939

The complaint

Mr K complains that Vitality Life Limited has unfairly declined his claim under his income protection insurance.

What happened

Mr K holds two income protection policies, one starting in October 2019 and another January 2023. These are both underwritten by Vitality. These policies are designed to provide a regular benefit in the event that Mr K is incapacitated due to injury or illness and therefore unable to work.

In July 2023, Mr K made an income protection claim to Vitality. He explained he consulted with his GP in June 2023 and had been signed off work with depressed mood. He provided Vitality with the certificates issued by the GP to support his position. Vitality requested further medical records from Mr K's GP in order to consider the claim. Mr K complained about the delays in handling his complaint and Vitality offered £50 compensation.

Vitality declined the claim in September 2023. It queried whether Mr K's claim met the standard definition of incapacity or if, due to his employment status, his claim would be considered under the daily living definition. Notwithstanding this, Vitality said that there wasn't evidence of a pervasive mental health condition which would impact Mr K's ability to work. It said that in order to consider a claim he had to be experiencing an illness or injury that met the policy definitions. Vitality said Mr K was experiencing symptoms but as a mental health diagnosis hadn't been made, the claim wasn't covered.

Mr K was unhappy with this outcome and complained to Vitality about the rejection of the claim. It reviewed the case and provided its final response to his complaint in November 2023. Vitality said that the medical evidence supplied didn't support that Mr K's claim met the definition of incapacity. Vitality also said that the claim wasn't supported as at the date of incapacity Mr K had left his previous employment to become self-employed, but no income was being generated from the business. So, it said there was no objective confirmation of the loss of income.

As he disagreed with this response, Mr K brought his complaint to our service. Whilst the case was waiting to be allocated to an investigator, Vitality responded to Mr K's complaint about its service again and offered to increase the compensation to £200.

When our investigator looked into the matter, he didn't think the complaint should be upheld. He found that the dispute over Mr K's employment status and the definition under which his complaint should be considered didn't matter as he didn't think Mr K's claim met either definition. He said that Mr K needs to evidence he meets the definition of incapacity and that requires him to show he cannot complete daily work tasks. And he found that the GP notes provided didn't confirm this. When asked, the GP had said this wasn't information that they could provide. So, he didn't think it was unreasonable for Vitality to decline the claim based on the evidence supplied. And in relation to the service provided by Vitality, our investigator thought the offer of compensation was fair.

Mr K disagreed with our investigator's opinion. He provided documentation to support when he left his employment and said this shows his claim should be considered under the standard definition of incapacity. And he said that his GP confirms incapacity from a holistic point of view and that the mental health nurse he saw confirmed he was struggling to perform work tasks. Mr K said he didn't think Vitality treated him fairly and that it wasn't acting in accordance with the Consumer Duty – the standard set out by the Financial Conduct Authority ("FCA") to ensure that businesses put their customers' needs first.
As no agreement could be reached, the matter has 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.

The above is intended to provide a summary of the situation. I'm aware that Mr K feels very strongly about this matter and has provided lengthy correspondence in support of his complaint. It is important to point out that we're an informal dispute resolution service, set up as a free alternative to the courts for consumers. In deciding this complaint I've focused on what I consider to be the heart of the matter rather than commenting on every issue or point made in turn. This isn't intended as a discourtesy to Mr K. Rather it reflects the informal nature of our service, its remit, and my role in it.

The insurance industry regulator, the FCA, has set out rules and guidance for insurers in the 'Insurance: Conduct of Business Sourcebook' ("ICOBS"). ICOBS says that insurers should act honestly, fairly, and professionally in accordance with the best interests of their customers. It states that insurers must handle claims fairly and shouldn't unreasonably reject a claim. I've taken these rules into account along with The Principles set out by the FCA, including Consumer Duty, when deciding what I think is fair and reasonable in the circumstances of his complaint.

The policy terms and conditions

I've looked at Mr K's policy wording and considered the relevant parts to his case. In the wording it states that income protection cover is provided as per below:

> *"We will pay if you become ill, injured, or disabled, and your incapacity meets one of the following definitions:*
>
> *A standard definition means that illness or injury makes you unable to perform the material and substantial duties of your own occupation. These are the duties that are normally needed to do your own occupation and that cannot reasonably be omitted or modified by you or your employer. To meet this definition, you must also not be working in any other occupation for payment or profit.*
>
> *An activities of daily living definition means that we assess your incapacity according to a specific set of everyday physical activities. These are designed to help show how able someone is to look after themselves. We list these activities in provision D5.4. We use this definition to assess houseperson claims. For more about this, see provision B3.6.*
>
> ***How we will assess your claim***
>
> *We will assess any claims you make according to the occupation you were in immediately before you claimed.*

When we will start paying your claim

Your benefit will be due at the end of your deferred period."

The policy goes on to describe which definition will be used as follows:

"If you become unemployed – or take a career break – and claim under Income Protection Cover within a month of leaving work, we will assess your claim against your previous own occupation.

If you claim more than one month after leaving work, we will assess you as a houseperson.

Houseperson claims

We will use the houseperson category to assess claims for anyone who is:

- *A houseperson*
- *A student*
- *Retired*
- *Working less than 16 hours a week*
- *Unemployed – and has been for at least one month"*

For a claim to be payable, Mr K needed to show that he was unable to perform the main duties of his occupation, or a set of everyday physical activities if considered under the daily living definition, due to an injury or illness he suffered throughout the deferred period. In Mr K's case the deferred period was four weeks which would have started from when he first contacted his doctor and was signed off work.

The definition of incapacity

Mr K first consulted with his GP on 28 June 2023. He told Vitality that he had left his previous employment on 31 May 2023 to become self-employed. He told them that he had set up his own company but that he hadn't created a business banking account as yet nor had he held any client meetings. Vitality said that as there wasn't enough evidence to show when he left his employment it couldn't confirm that he met the standard definition of incapacity. Vitality also questioned if there is a loss of income to be considered. It therefore considered his claim under both definitions.

I can understand Vitality's concern here. It isn't clear if Mr K was unemployed at the point of being certified as unfit for work or self-employed. From what he told Vitality it would appear Mr K was just starting up his new business but wasn't taking any wage.

Mr K has provided a copy of his P45 which shows that he left his old employer at the end of May 2023, so I don't think it is in question when he stopped work as an employee. And this was within one month of the date he was signed off work so it would appear the claim could be considered under the standard definition. But the difficulty arises in relation to whether he is to be considered unemployed or self-employed but not earning a wage.

However, whilst this issue would likely need further evidence from Mr K to demonstrate exactly what he had been doing during the time since he left his employers, I don't think that the choice of definition used ultimately makes a difference here. Vitality has considered the claim under both definitions. And it has said that the evidence supplied doesn't support the claim for either definition. Therefore, I'm not persuaded Vitality has acted unfairly here.

Has Vitality fairly declined the claim?

The main reason for Vitality declining Mr K's claim is that it doesn't think the medical evidence he has provided supports that he meets either of the incapacity definitions. Mr K provided to Vitality the certificates from his GP which state he was unfit for work as a result of depressed mood. Vitality requested Mr K's medical records following receipt of his claim submission. And the notes of the consultation in June 2023 refer to such symptoms as feeling flat, demotivated, disturbed sleep and appetite, along with feeling he has been more irritable and socially isolating himself. The notes also refer to Mr K talking about a family member's physical health issues along with the anniversary of a bereavement. It was noted that Mr K had put himself forward for counselling but was aware there was a waiting list of several months. The notes also show that Mr K declined medication.

The only other consultation note on the medical records refers to a conversation Mr K had with a mental health nurse on 1 August 2023. In this note it refers to Mr K suffering a number of bereavements in a short space of time and personal relationship issues too. The symptoms reported previously were reiterated but in addition it was noted that Mr K had been studying within his job role and had been struggling to write reports. But he had been completing household tasks and working through a 'to do' list. Mr K also reported reading self-help books which he found helpful.

Vitality referred back to the GP to request further information on how Mr K's depressed mood was affecting his ability to do the material and substantial duties of his occupation. A response was received in which the GP stated that they weren't qualified as an occupational health doctor, so it wasn't their area of expertise to advise on how Mr K's illness prevented him from working, nor whether his condition precluded him from performing his duties in work.

I'm sorry to read about the difficulties Mr K was facing. And I'm in no doubt that this was a very challenging time for him and why this may cause him to suffer from depressed mood. However, I don't think it is unreasonable of Vitality to find that the medical evidence provided doesn't demonstrate incapacity in line with the policy terms.

It is important to state at this point I'm not a medical professional and so, in order to reach any decision on Mr K's medical situation at the time, it is necessary for me to rely on the information provided from those medical experts he has consulted with.

The GP certificates, Mr K's medical record and the further letter from his GP lack detail about the impact of Mr K's health on his ability to perform the essential duties of his occupation. While I note there is mention that Mr K was struggling to write reports, this doesn't explain the actual impact this would have on his role. And from the explanation of the types of things Mr K had been able to do, such as working through a list of tasks, it would appear likely he may have been able to perform some aspects of his role. But there isn't any medical evidence to explain whether this meant he couldn't do the substantive duties of his occupation.

Mr K has said that the guidance provided to GPs by the NHS shows that they had to consider whether he was fit to work before issuing the certificate. I appreciate his perspective and understand why he feels that, as a medical professional has issued a certificate stating he should refrain from work, this should be suitable evidence. I've thought about this point carefully. I've noted that Mr K's GP has said that they don't go into details about a person's role as it isn't their area of expertise. So, while they may have issued the note to say Mr K was unfit to work, this doesn't confirm that Mr K was incapacitated in the sense that he was unable to do the material or substantive duties of his occupation as required by the policy terms.

To be considered under the daily living definition of incapacity, this required Mr K to be unable to do every day physical tasks, such as getting out of bed or washing and feeding himself. From reading the information provided by the GP, it doesn't appear that Mr K's condition was such that he was limited in his ability to perform these types of tasks. So, I'm not persuaded that Mr K would meet this definition either.

Mr K has questioned why, if Vitality didn't feel there was enough medical evidence, it didn't arrange for him to see a medical expert to obtain these details. The policy does state that Vitality may ask a policyholder to see a medical expert. However, it is up to an insurer if it wants a medical expert's opinion on a policyholder's illness, and this will depend on the individual circumstances of each claim. Ultimately, it is the insured person's responsibility to show they have a valid claim under the policy, not for Vitality to do this for them. Vitality did request medical information so it could fairly assess the claim, which I think was reasonable. However, I'm satisfied that this didn't show that Mr K met the definition of incapacity under the policy definition, for the reasons that I've explained. So, I don't think it was unfair for Vitality to decline the claim, based on the evidence available.

Claims handling delays and service

Mr K has complained about the poor service he received from Vitality when making his claim. When he first submitted his claim, Vitality said it hadn't received the information and so he had to send it again. And I've also seen that there were some telephone calls where the quality was poor.

I can appreciate how frustrating this must have been for Mr K at this time. He was without funds due to not working and so he was understandably anxious for his claim to go through quickly. Any delays to getting an answer would have caused him inconvenience and stress. Vitality has accepted that there were delays initially when Mr K submitted his claim and this meant that the request for information to the GP was delayed by a couple of weeks. And it has also recognised that there were system issues which affected the call quality on some of Mr K's contact. Vitality has apologised and offered a total of £200 for these service issues. I've noted Mr K has accepted this offer. Having carefully considered this matter, I'm satisfied that this offer of compensation is reasonable based on what happened.

My final decision

As stated above, I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr K to accept or reject my decision before 12 June 2024.

Jenny Giles
Ombudsman