DRN-4236184

## The complaint

Mr M is unhappy with Assicurazioni Generali SpA's decision to decline his income protection claim.

## What happened

Mr M has income protection with Generali. In November 2021, Mr M was admitted to hospital having contracted the COVID-19 virus. He spent 14 days in hospital and was admitted to the intensive care unit (ICU) for half that time. He was discharged at the end of November, although continued to suffer with several symptoms, including breathlessness and coughing, owing to blood clots having formed on his lungs.

Mr M said he's still too unwell to return to work. He also explained he had arterial fibrillation (AF) in March 2022 which further compounded his recovery and overall health. Mr M would like Generali to pay his claim.

Generali said Mr M's policy has a 26-week deferred period. It also explained the policy is for any other suited occupation. Generali's position is that the medical evidence doesn't support that Mr M was incapacitated for the whole of the deferred period. It highlighted reports from specialists showing Mr M was recovering well during that time and that his lung capacity had vastly improved. It acknowledged the AF and said this was an isolated episode for which he'd been prescribed medication to help manage those symptoms. Generali said Mr M could potentially return to work with reasonable adjustments and so it declined his claim.

Our investigator said Generali had declined Mr M's claim fairly. She said that it relied on medical evidence to do so. She explained that where there were differences of medical opinion, it'd rationalised its decision-making and relied on the medical opinions of the most suitably qualified specialists.

Mr M disagreed with her view. In summary, he said that he's continued to suffer with many other symptoms commonly associated with long COVID, such as, breathlessness on exertion, memory fog, fatigue, changes in mood and difficulty maintaining concentration. Mr M's also unhappy with the investigator's synopsis of his physical capabilities and referred to her comments about his gym frequency and other physical activities, such as dog walking.

Mr M explained these are all prescribed and recommended forms of rehabilitation suggested by medical professionals responsible for his care. And that to perceive this as his readiness to return to work, or that he has an increased physical capacity, would be artificial. So, it's now for me to make a final decision on whether Generali declined Mr M's claim fairly.

## 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 similar to those already explained by our investigator. I'm satisfied Generali relied on appropriate medical

evidence to decline Mr M's claim. I'll explain why.

I should start by saying the test here isn't simply whether Mr M is unwell. To be clear, I'm satisfied Mr M was very unwell for a period and this is supported by his admission to ICU. I also don't doubt that Mr M continued to suffer with symptoms of long COVID. I think the contemporaneous medical evidence is consistent about that. But the real test in the circumstances of this complaint is whether Mr M was incapacitated as defined by the policy terms, and whether Generali declined his claim fairly. The Insurance Conduct of Business Sourcebook (ICOBS) says an insurer must handle claims promptly and fairly and not reject a claim unreasonably. And so, I've also considered Generali's responsibility in that regard.

The policy terms say;

The Definition of Incapacity

*"As a result of illness or injury, the member is incapable of performing the material and substantial duties of their occupation, or any occupation to which they are suited by education, training or experience, and they are not carrying out any other work or occupation"*

Definition of Deferred Period

*"Means the period of Incapacity which must elapse before Benefit may become payable. If the Member is on statutory leave or granted leave of absence, the Deferred Period will start from the date of Incapacity and Benefit payments will start from either the end of the Deferred Period or the agreed return to work date whichever is the later"*

Material and substantial:

*"Means duties that are normally required for the performance of a member's occupation and cannot reasonably be omitted or modified by their employer"*

The suited to any other occupation part of the policy is important because it means that Mr M must also demonstrate that he's unable to fulfil the responsibilities and demands of other occupations that he's suited by way of education and experience, like a sedentary home-based role.

I'm satisfied the medical evidence shows that Mr M, although initially incapacitated in November 2021, didn't satisfy the 26-week deferred period. I say that because I note the improvements with his health described by his doctor. To be clear, the deferred period expired on 12 May 2022. On 25 March, some seven weeks prior to the end of the deferred period, Mr M's consultant explained his lungs had recovered excellently and Mr M even noted his function was between 65 – 70% of their original capacity prior to his COVID admission to hospital. For clarity, Mr M's claim was borne from his contraction of COVID-19 and the complications with his recovery.

I think this adequately demonstrates Mr M's recovery was going well. And for Mr M to satisfy the policy's incapacity criteria, such a vast improvement on his original reason for absence, would make it difficult to explain why he continued to be incapacitated and unable to return to work in his current, or a suited occupation. I'm satisfied Generali interpreted and relied on this piece of medical evidence fairly for these reasons.

I've considered the other arguments made by Mr M about his impaired cognitive function and although I don't doubt he's experienced the symptoms he's explained, it's difficult for me to rely on this because he's not produced any medical evidence to support his perceived

impaired function by a suitably qualified professional. In addition, when I consider it in conjunction with medical opinions that are consistent that Mr M's health had vastly improved, I find that argument less persuasive.

I understand the challenge Mr M's put forward here and the reference to the large numbers of people that suffer from long COVID and their collective reporting of similar symptoms. But Generali is entitled to make its claims decision based on medical evidence related directly to Mr M. And other than his self-reported symptoms inhibiting his functional capacity, I've not seen anything persuasive that's explored this, or produced any tangibly persuasive medical evidence explaining the extent of Mr M's cognitive symptoms in detail, or how this prevented him returning to work from March 2022.

Mr M explained the FIT notes issued by his GP are evidence that he was too unwell to work and to be clear, that's not in dispute. But it's also not the test he needs to meet. He must be able to demonstrate his incapacity as defined by the policy to receive benefit. So, although the FIT notes are an important piece of medical evidence, they're not the full story. That's why our investigator and Generali referred to other pieces of medical evidence that better explain Mr M's illness and functional capacity.

I'm not persuaded Generali 'cherry picked' evidence to simply decline his claim. I'm satisfied it placed more emphasis on available evidence from the specialists, that reviewed Mr M and provided detailed assessment notes, rather than relying on FIT notes which were significantly less detailed. I should say it's for Mr M to show he has a valid claim and I'm not persuaded he's done that because the medical evidence available shows he'd made an excellent recovery by March 2022. I'm not at all saying he was fully recovered, but I'm satisfied with Generali's interpretation that he was well enough to consider a phased return to work, with reasonable adjustments because that's what the consultant said.

The cardiac issue

Mr M's explained he feels this was a subsidiary issue and that Generali's reference to his AF is perhaps another way to decline his claim. I have to say I don't agree with that. I think it important that Generali demonstrate it'd considered this issue as this could have significantly impaired Mr M's functional capacity as this happened at the end of March. As things stand, this was an acute issue, meaning there's no on-going treatment needed.

I note the consultant cardiologist's comments that this episode was likely arterial fibrillation and that a change in medication was needed. He made no further comments about Mr M's ability to return to work and so I'm less persuaded that his heart problems were an on-going issue that would preclude a phased return to work.

I think Generali considered all the medical evidence related to this issue fairly. I say that because the cardiologist recommended that Mr M not drive for three months after the issue. And I noted Generali, when considering Mr M's readiness for work, considered the travel-element of his role. Generali said Mr M could likely return to work, provided he didn't have to travel to see clients.

I've considered Mr M's role and it was estimated he had to travel around 30% of the time. And so, it recommended that he should not have to fulfil those obligations as a reasonable adjustment – which I thought was fair. It's also important to highlight the suited occupation part of the policy as the medical evidence doesn't support that Mr M would not have been able to fulfil the remaining deferred period working from home.

## My final decision

My final decision is that I don't uphold this complaint for the reasons I've explained.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr M to accept or reject my decision before 31 August 2023.

Scott Slade
**Ombudsman**