DRN-4294878

## The complaint

Mr K complains Aviva Life & Pensions UK Limited applied an unfair end date to his claim and refused to consider an earlier period of absence.

## What happened

Mr K worked in a technical role, mostly from home. And he was a beneficiary of his employer's income protection policy, underwritten by Aviva. The policy was designed to pay a benefit in the event of incapacity, after a 26 week deferred period.

The policy cover is based on Mr K's own occupation and defines incapacity as follows:

> *"The member's inability to perform on a full and part time basis the duties of his or her job role as a result of their illness or injury.".*

Mr K became absent from work due to illness in May 2019, and a claim was made against the policy in July 2019.
Aviva was presented with medical reports from the doctors who had conducted and assessed Mr K's scans. And based on this, said it thought Mr K met the policy terms of incapacity during the deferred period, so benefit payments would be paid from the end of that period. However, Aviva said the payments would be made up until 30 April 2020 only.

Mr K became absent from work in May 2019 due to symptoms including headaches, dizziness, tinnitus and other sensory symptoms. He underwent investigations with a specialist and following a brain scan, a lesion was found which his treating doctor - Dr H - thought was a 'low grade glioma'. In August 2019, Dr H recommended another scan to be done in a further six months.

Aviva referred the medical evidence to its Chief Medical Officer (CMO) for an opinion. They said Mr K would be fit to return to work around October 2019. And noted Mr K's anxiety about the finding on his scan was likely causing more symptoms than the issue itself.

Following this, Aviva arranged an Independent Medical Exam (IME) with Dr B – an occupational health consultant - to find out more about Mr K's condition. Dr B was provided with the medical evidence and met with Mr K.

The outcome of Dr B's report was that Mr K was medically fit to return to work. And recommended a gradual return starting at 50% of his hours for four weeks. Dr B noted Mr K was still experiencing some symptoms of discomfort when concentrating and recommended taking brief breaks. They said "*I expect that he would quickly learn to tolerate this discomfort if he returned to work regularly*" and commented on the possibility of medication for this if needed.

Dr B also noted Mr K's tinnitus had reduced and said this and his neck pain symptoms were not a current barrier to work. And they said his dizziness symptoms had resolved. The IME report was issued in early December 2019 and stated Mr K was fit to return to work at that time, although Dr B said Mr K had wanted to wait until his next scan in January 2020.

In February 2020, an occupational health report was arranged by Mr K's employer. The outcome of this report was that Mr K was anticipated to be fit to return to work within three months, on a phased return basis. One of the examples being a return on 50% of his hours for two weeks.

Aviva accepted the claim and began making payments with effect from 8 November 2019, after the deferred period had ended. And said these would end on 30 April 2020 as it said it thought the evidence showed Mr K would be able to return to work after that time.

Mr K complained to Aviva. In summary, Aviva said it wasn't able to pay the claim from any date earlier than November 2019, as the deferred period had not started until May 2019. It said any absences prior to May 2019 were not covered, as the policy was not in place before that time.

Aviva said it didn't agree to reinstate the claim beyond the end of April 2020, because it thought the medical evidence hadn't supported that Mr K was totally unable to work in his insured occupation, beyond this time, which was when it had ceased benefit payments.

Unhappy with the response, Mr K brought his complaint to this service. An investigator here looked into what had happened and said they didn't think Aviva had assessed the claim unfairly.

Aviva accepted the investigator's view. However, Mr K disagreed and asked for a decision from an ombudsman. So, the case has been passed to me to decide.

Mr K provided this service with additional medical evidence including letters from his treating specialists. An investigator sent this to Aviva and asked it for its comments. Aviva said it'd reviewed the evidence and this didn't change its decision. It said the letters didn't provide any information which wasn't already available in the medical reports. And it said it couldn't consider evidence related to Mr K's more recent condition and symptoms, as this didn't relate to the claim period.

**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.

And I've looked at the relevant rules and industry guidelines, which say insurers have a responsibility to handle claims promptly and fairly and shouldn't reject a claim unreasonably.

Mr K has provided detailed commentary and evidence in support of his case. If I haven't commented on a particular point in my decision, this doesn't mean I haven't considered it. I'm not required to comment on each and every point, but instead I'm concentrating on the main issues in the complaint. No discourtesy is intended by this; it simply reflects the informal nature of the ombudsman service and my role in it.

I've reviewed all of the medical evidence supplied in relation to this complaint. Having done so, I don't think Aviva has acted unfairly in its assessment of Mr K's claim. And I'll explain why.

- Mr K disputes the claim end date, so I've considered Aviva's reasons for ending the benefit payments when it did. Aviva said it would pay the claim up until the end of April 2020. This means Aviva accepted Mr K met the policy definition of incapacity up

until that time. So, in other words, that he was unable to perform the duties of his job role as a result of his illness.

- In August 2019, Mr K's scans showed what the doctor referred to as a "possible low grade glioma' and recommended a further scan in six months. There was no further information in this report about Mr K's ability to work. So Aviva referred the report to it's CMO for an opinion, and then appointed an IME. I think this was reasonable and is what I would expect an insurer to do in these circumstances.

- Both the IME arranged by Aviva and the Employer's Occupational Health reports concluded Mr K was able to begin a phased return to work and I note Mr K was able to work remotely from his home. Dr B thought the return could begin sooner, however, both reports suggested similar phased returns starting at 50% of Mr K's hours. Dr B thought Mr K was fit to return to work in December 2020, and the occupational health report said "*within the coming three months*" of the assessment in early February 2020. So, I think it was reasonable that Aviva concluded Mr K would no longer meet the policy terms of incapacity after the end of April 2020. And I think this allowed sufficient time for Mr K to try out a gradual return to work as recommended in the reports.

  Had Mr K attempted to return to work and been unsuccessful, I would have expected Aviva to investigate this further through additional medical evidence. However I note Mr K did not start a phased return as recommended in the reports.

- Mr K has since provided further medical evidence and letters from his treating doctors including Dr H and Dr T, and these have been shared with Aviva. However, Aviva has said these do not change its position on the claim. And I think that's fair, as the content of these letters is mostly a summary of the medical evidence which was already available, and I've not found that they contain evidence of Mr K's inability to undertake his job role, which contradicts that of the reports in December 2019 and February 2020.

  I've been unable to consider more recent medical evidence Mr K has provided about his condition, as this relates to the time after the claim period and was not available at the time Aviva made its assessment.

- I've also noted Mr K's partner's comments on the IME report. Mr K commented on the report at the time of issue in 2020, and I've noted Dr B reviewed these comments and responded to say that these did not alter their opinion. And they commented that although Mr K was still experiencing neck pain, he had previously coped with this for many years while remaining in work.

  Mr K's partner has commented on Mr K's cycling detailed in the report and has said this was a reference to the past and Mr K was unable to cycle regularly at the time of the consultation. However, this was not raised within Mr K's comments when the report was originally issued in 2020, so this wasn't something Dr B was able to consider at the time. And I would have expected Mr K would have raised this with his other contemporaneous comments on the report, had it been inaccurate.

  I've noted the comments about the discrepancy with regards to medication, but I don't think this was significant enough to have made a difference to Dr B's overall opinion on Mr K's ability to return to work. So, I've not been persuaded that it was unfair for Aviva to rely on the report at the time it made its claim decision.

- Whilst I don't dispute Mr K was still experiencing symptoms such as discomfort with his head and neck, the medical evidence shows these were not of a severity which would have prevented him from beginning a return to work at reduced hours. And so I'm persuaded Mr K no longer met the policy definition of incapacity by the end of April 2020, and as such, I think it was reasonable that Aviva said it would not pay benefits beyond that time.

*Linked absences prior to May 2019 and the claim payment date*

Whilst there is cover under the policy for linked claims and linked periods of absence, I'm satisfied Aviva was not on risk in relation to any claims prior to when the policy started. The policy schedule shows the cover underwritten by Aviva started on 1 May 2019. And there is no reference within the terms to Aviva being required to honour any claims relating to events prior to that date.

It's my understanding Mr K's employer had an earlier income protection policy in place with a different insurer, prior to the Aviva policy. So, it would seem a different insurer was on risk at the time of Mr K's earlier sickness absences. So, any claims related to that period would have needed to be directed to the relevant insurer.

*The claim payment start date*

The deferred period for the policy is 26 weeks. This means that policy benefit payments will not be paid until 26 weeks have passed from the date of first absence. Mr K's absence started in May 2019, and Aviva started the payments 26 weeks later in November 2019, which is in line with the policy terms. So I'm satisfied Aviva calculated the benefit start date correctly.

**My final decision**

For the reasons I've given, it's my final decision that I do not uphold this complaint. And I make no award against Aviva Life & Pensions UK Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr K to accept or reject my decision before 5 January 2024.

Gemma Warner
**Ombudsman**