DRN-4411388

The complaint

Ms C complains that Legal and General Assurance Society Limited (L&G) has terminated benefit for an incapacity claim she made on her employer's income protection insurance policy.

What happened

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

Ms C is insured under her employer's group income protection insurance policy. The policy provides cover if Ms C became incapacitated due to sickness or injury. Ms C's employer chose to take out 'progressive' incapacity cover. That meant that for the first two years of a claim, L&G would assess a claim in line with the 'own occupation' policy definition of incapacity; for the following two years, it would assess a claim in line with the 'suited occupation' definition; and after that, it would assess a claim in line with 'activities of daily working' (ADW) criteria.

Unfortunately, in 2016, Ms C was diagnosed with myeloma and became unfit for work. She underwent chemotherapy treatment, which remains ongoing. And she was diagnosed with carpal tunnel syndrome and osteoarthritic changes, amongst other things. So Ms C's employer made an incapacity claim on her behalf.

L&G accepted Ms C's claim in 2017. The claim was assessed and paid in line with an 'own occupation' definition of incapacity for two years, and subsequently, the claim was assessed and paid in line with the 'suited occupation' definition. However, the relevant definition of incapacity switched to ADW. Therefore, L&G appointed a vocational clinical specialist (VCS) to carry out a face-to-face ADW assessment with Ms C. This assessment took place in May 2022.

The VCS didn't find that Ms C had shown she fulfilled the requisite number of L&G's ADW criteria. Based on the VCS' report, L&G concluded that Ms C no longer met the relevant definition of incapacity. And so it terminated her claim in July 2022.

Ms C was unhappy with L&G's decision and she appealed. She provided supporting evidence from one of her treating specialists.

However, L&G maintained its stance and so Ms C asked us to look into her complaint.

Our investigator didn't think Ms C's complaint should be upheld. Briefly, she felt that given the VCS assessment had been face-to-face, it was more persuasive evidence than the letter provided by Ms C's specialist. And she thought it was reasonable for L&G to rely on the VCS report to conclude that Ms C no longer met the policy definition of incapacity. Therefore she thought it was fair for L&G to terminate the claim.

Ms C disagreed and I've summarised her responses to our investigator. She explained her medical conditions and symptoms and had these conditions impacted on her day-to-day life

and her ADW. She explained the effect the chemotherapy had on her. She didn't think the VCS assessment of May 2022 reflected her current position or capabilities. And she also felt that she should be assessed under the 'own occupation' definition of incapacity.

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 Ms C, I don't think it was unfair for L&G to terminate her claim in July 2022 and I'll explain why.

First, I'd like to reassure Ms C that while I've summarised the background to this complaint and her detailed submissions, I've carefully considered all that's been said and sent to us. Within this decision though, I haven't commented on each point that's been made and nor do our rules require me to. Instead, I've focused on what I think are the key issues.

It's also important that I make the parameters of this decision clear. I will only be considering the evidence which was available to L&G in December 2022 – at the point it issued its final response to Ms C's complaint, endorsing its decision to terminate benefit in July 2022. Ms C has now provided us with new information and evidence about her health and I understand that she has also sent a copy of this evidence to L&G for assessment. It will be for L&G to let Ms C know the outcome of any further assessment of her claim, based on that new evidence. It wouldn't be appropriate for me to make any finding on that new evidence as part of this decision. If Ms C is unhappy with any new claims decision L&G makes, she may be able to bring a new complaint to us about that issue alone.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. So I've carefully considered, amongst other things, the policy terms and conditions and the available evidence, to decide whether I think L&G has handled Miss C's claim fairly.

It's a general principle of insurance that it's for a policyholder to provide enough evidence to show that they have a valid claim on their policy. This means that at the outset, it was Ms C's responsibility to provide L&G with enough medical and other evidence to demonstrate that she met the policy definition of incapacity. It's common ground that L&G was satisfied that Ms C was incapacitated in line with the policy terms and it accepted her claim in 2017. Once an insurer accepts an income protection insurance claim, the burden of proof switches. I generally take the view that in order for it to terminate Ms C's claim fairly and reasonably, L&G needs to provide enough evidence to show that Ms C no longer meets the definition of incapacity.

I've first considered the policy terms and conditions, as these form the basis of Ms C's employer's contract with L&G. L&G concluded that Ms C no longer met the policy definition of incapacity and so I've looked closely at the definition of incapacity which applied to Ms C's employer's scheme. The relevant policy schedule shows that Ms C's employer had selected a 'progressive' definition of incapacity. I appreciate Ms C feels this isn't the definition which should apply to her claim. However, I'm satisfied that it was fair and reasonable for L&G to consider Ms C's claim in line with the progressive definition. The contract defines this as follows:

'*Progressive*

Means for an insured member, payment of benefit under this policy is assessed against:

i. own occupation for a period of two years starting on the benefit start date, then
ii. suited occupation for the next two years, then
ii. activities of daily working thereafter.'

The evidence indicates that at the time of the VCS assessment, Ms C's claim had been in payment for over four years. So I find it was fair and reasonable for L&G to consider Ms C's claim in line with the ADW criteria at that point. I've set these out below:

'Activities of daily working

Means the insured member is incapacitated by an illness or injury so that he meets (with or without aids or adaptations) at least three of the criteria in Section A or one of the criteria in Section B below:

Section A

i. Walking: cannot walk more than 200 metres on a level surface without stopping due to breathlessness, angina or severe pain elsewhere in the body.
NOTE: a claim under this section should be supported by evidence that the insured member has been prescribed and is taking appropriate medication.
ii. Rising/Sitting: is unable to rise and sit using a raised chair with arms without the help of another person.
iii. Dexterity: is unable to write legibly with a pen or pencil or use a keyboard with either hand.
iv. Communication: cannot (a) clearly hear (with a hearing aid or other aid if normally used) conversational speech in a quiet room in his first language, or (b) understand simple messages in his first language; or (c) speak with sufficient clarity to be clearly understood in his first language.
v. Eyesight: visual ability is reduced to the extent that functional abilities are affected and independent functioning without physical assistance from another person in a workplace is impossible, even with the use of assistive devices.

Section B

Severe mental illness means the diagnosis by a Specialist Consultant Psychiatrist of one of the following

i. *• Schizophrenia, Bipolar Affective Disorder, Paranoid (delusional) psychosis, schizo affective disorder or*
• Severe depressive illness which:
- has chronic unremitting symptoms; and
- has not responded to comprehensive management and treatment and which the individual has complied with for a period of greater than 12 months; and
- has resulted in an inpatient admission to a psychiatric ward for more than seven consecutive nights.

The insured member's ability to think, communicate and behave appropriately must be so impaired as to significantly interfere with his ability to deal with the ordinary demands of life.

ii. Organic brain disease or injury: suffers from chronic organic brain disease or brain injury (confirmed by neurological investigation or imaging techniques) affecting the insured member's ability to reason and understand to the extent that they require continual supervision by another person 24 hours a day.'

I've gone on to consider then whether I think L&G has provided enough evidence to show that Ms C no longer met the policy definition of incapacity. I've considered the available medical reports and VCS notes, amongst other things. There is little available objective medical evidence from between 2021 and early 2022 to support that Ms C couldn't complete the ADW. I note that in a letter dated February 2022, Ms C's haematologist stated:

'I do not think your daily activities, such as personal care and household chores are affected by these symptoms, although I understand if your vulnerability to infection does affect your social activities.'

Based on the haematologist's letter, I don't think it was unreasonable for L&G to require further evidence to allow it to consider whether Ms C still met the ADW definition of incapacity. It isn't unusual for income protection insurers to require claimants to undergo medical assessment while a claim is in payment. And so I don't think it was unfair for L&G to ask the VCS to carry out a face-to-face assessment to determine whether Ms C met the ADW criteria.

The VCS provided a report of their findings and I've summarised what I think are their key conclusions. They were satisfied that, based on their observations of Ms C, she *had* shown she couldn't walk more than 200 metres on the flat. But they didn't think she'd shown she met the rising/sitting criteria. The report stated:

'The member was observed to stand up independently, at least three times, from an armchair located in the kitchen/dining room.'

Nor did the VCS think Ms C had shown she met the dexterity criteria. They noted:

'The member was not observed to write or use a keyboard at the time of the visit, however she reported that she will use her desktop computer on a daily basis to read and respond to emails. Additionally, she described that she uses (an app) on her mobile phone to communicate with her family... The member also reported that although her husband predominantly drives, she continues to drive locally to shops; this activity requires good dexterity of both hands for control and operation of the car.

In my opinion the member has the ability to write legibly with a pen or pencil or use a keyboard with either hand.'

Additionally, the VCS didn't think Ms C met any of the remaining criteria under Section A of the ADW, or any of the Section B criteria. This would appear to tie-in with the haematologist's view in February 2022. On that basis, L&G didn't think Ms C had met the ADW criteria overall. Given the nature of the assessment and the expert opinion of the VCS, I don't find this to have been an unfair conclusion for L&G to draw. And so I think it was fair for L&G to conclude that Ms C no longer met the policy definition of incapacity and to terminate benefit.

Following its decision, Ms C appealed and provided L&G with evidence from her orthopaedic specialist. In October 2022, the specialist stated:
'(*Ms C) has difficulty putting on her shoes and socks. She also has great difficulty rising from a seated position and needs assistance. Her walking distance is limited to approximately 100 metres, after which she has to stop and rest. She has great difficulty managing the stairs and can climb approximately 10 steps before she has to rest holding onto the handrail as the hip locks in that position. She is due to have a hip replacement, however given her myeloma diagnosis this will need to be co- ordinated with her myeloma treatment.'*

I've thought very carefully about all of the medical evidence that was available to L&G when it issued its response to Ms C's complaint in December 2022. I'm not a medical expert and so my decision is necessarily based on a weighing-up of the available expert evidence to decide which I find most persuasive. In the circumstances of this complaint, I'm more persuaded by the findings of the VCS during the face-to-face assessment than the orthopaedic surgeon's evidence. That's because the VCS had the opportunity to observe Ms C, at first hand, during the assessment. It isn't clear whether the specialist's evidence is based on observed symptoms, or Ms C's self-reported symptoms. And I've also borne in mind that the VCS report appears to correlate with the haematologist's letter of February 2022 in regard to Ms C's ability to carry out ADW.

Overall then, despite my natural sympathy with Ms C's position, I think that L&G has provided enough evidence to show, on balance, that Ms C no longer meets the policy definition of incapacity. And so while I appreciate that my decision is likely to be upsetting for her, I find it was fair and reasonable for L&G to terminate her incapacity claim in July 2022.

Ms C has also referred to a potential claim for Permanent Total Disability. However, this isn't a benefit of the group income protection insurance policy she holds. It appears to be a benefit of a different group insurance scheme. So I can't comment any further on that issue here.

My final decision

For the reasons I've given 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 Ms C to accept or reject my decision before 30 November 2023.

Lisa Barham
Ombudsman