Financial Ombudsman Service

consumer factsheet on ...

complaints about income protection insurance

This is a factsheet for consumers with income protection insurance who are complaining about their insurance company:

- **rejecting a new claim;**
- **stopping an existing claim;**
- **handling a claim incorrectly, poorly or unfairly; *or***
- **mis-selling a policy.**

what is income protection insurance?

Income protection insurance – sometimes known as permanent health insurance (or PHI) – is a long-term insurance-contract, designed to provide a replacement income if the consumer becomes unable to work due to "total disability".

These policies can provide up to 75% of the income that the consumer was earning before their disability (after any state benefits, or other insurance benefits, have been deducted).

An income protection policy will generally start to pay out after a "deferral period" – which can range from 4 weeks from the time of the consumer's disability to 104 weeks.

Most income protection complaints we deal with are disputes as to whether or not a consumer meets the definition –set out in the insurance policy – of being disabled or incapable of working. We explain in this factsheet what this means and how we approach disputes about the consumer's ability to work.

This factsheet also includes case studies involving the definition of "total disability".

what if I'm unhappy with my insurance company's decision to reject or stop my claim?

You should first raise your complaint directly with the insurance company – and give them the opportunity to review your case. By law it has to investigate your complaint thoroughly – and it has up to eight weeks to do this.

If you are unhappy with your insurance company's explanation at this stage, we may then be able to get involved. We will ask you to complete our complaint form with your details.

If you are complaining about your claim being rejected, without any benefit paid to you, you will need to provide us with the medical evidence that you sent to the insurance company – to show that you met the definition of disability set out in the policy.

But if your insurance company initially accepted your claim and then stopped it, they will need to show why you no longer meet the policy's definition of disability.

are insurance companies allowed to review a claim they're already paying – and stop benefits?

Insurance companies have the right to review claims from time to time, to make sure that consumers claiming benefits continue to meet the terms of the policy. But before an insurance company stops paying a claim, it should explain clearly why it believes that the consumer's condition has improved – to the extent that they no longer meet the definition of "total disability".

The insurance company may seek updated medical opinion, or ask the consumer to attend a medical examination. It may also ask the consumer to complete a "continuing claim form", outlining their ongoing symptoms.

Sometimes insurance companies obtain surveillance evidence showing the consumer carrying out their daily activities. But unless the consumer's activities – recorded "under cover" this way – are markedly inconsistent with their reported abilities, we are unlikely to place much weight on this type of evidence.

We also expect the insurance company to give the consumer an opportunity to comment on any evidence it obtains to back up its decision to stop paying the claim.

what if the definition of "total disability" wasn't explained when I took out the policy?

If a consumer complains that the way the insurance cover worked wasn't adequately explained to them when they applied for the policy, we will ask them for information or evidence as to what they were told at the point of sale – and what information was provided when they agreed to purchase the policy.

For example, defining disability as being incapable of carrying out "any occupation whatsoever" – a definition which sometimes appears in this type of insurance policy (see page 5) – is a very strict test.

So we say that someone who sold a policy like this should have made the consumer fully aware of the definition that they would need to meet, to make a successful claim.

We say the same about the definitions of "activities of daily living" (see page 5) that appear in some insurance policies. Because these definitions limit the insurance cover available, we expect the person who sold the policy to have made the consumer fully aware of these criteria.

The person who sold the insurance should also have explained how the benefit under the policy is calculated – and the limits to the amount of benefit payable under the "limitation of benefit" clause.

what type of evidence do I need, to back up my complaint?

The best evidence is medical evidence from the consumer's own treating consultant (or other specialist involved in their care) – where the specialist comments on the consumer's condition at the dates relevant to the claim.

Other medical evidence could come from the consumer's GP, an occupational physician or an independent specialist. It is helpful if a doctor or specialist can give an opinion on how any condition prevents the consumer from working in their existing occupation or in any other role.

We will look at this evidence carefully, taking into consideration the qualifications of the medical practitioner who provided it and the extent of their involvement in the consumer's care.

what do "total disability" and "total incapacity" mean?

The term "total disability" means that the consumer has to be totally unable to carry out their occupation, before benefits can be paid under their income protection policy. This is also sometimes referred to as "total incapacity".

We take the view that the words "total" or "totally" are a very strict test in this context.

This means the focus of our investigation in a case like this is on whether the consumer is totally unable to carry out the *essential* or *substantial* duties of their occupation – not on whether they are totally unable to carry out *all* the duties required by their occupation.

what if I get further evidence after I have referred a complaint to the ombudsman?

Our role is to look at the insurance company's decision on your claim, taking into account the evidence it had at the time of that decision.

So any new evidence obtained by the consumer after they have received their insurance company's final response to their complaint should be sent in the first place directly to the insurance company for it to look at – with a copy sent to us.

We will not make a decision on a complaint on the basis of evidence that one side in the dispute has not yet seen. But we may look at whether the insurance company's subsequent assessment of any new evidence is fair.

what can the ombudsman do, if the complaint about my claim is upheld?

If we agree that the consumer has a valid complaint and that the insurance company's decision on the claim was wrong, we can tell the insurance company to:

- pay all benefits owing – with interest on the backdated benefits; *and*
- continue paying the claim until it can show that the consumer no longer meets the definition of incapacity under the policy.

should I continue to pay my premiums?

A consumer should continue to pay their premiums while their claim is being considered.

However, once a claim is being paid, the premiums are normally waived – and any premiums paid during a period of incapacity should usually be refunded by the insurance company.

When a claim is stopped by an insurance company because a consumer returns to work, the consumer should continue to pay the premiums – if they want to keep the policy in force, in case they need to make a claim at a later date.

case studies: definitions of "total disability"

When we investigate complaints about income protection insurance, we look at how the insurance policy describes the level of disability or incapacity that is required for a claim to be paid. There are four common definitions of "total disability".

1. "own occupation"

Where the definition of "total disability" relates to "own occupation", our approach is that the consumer must be totally unable to carry out their *own* occupation due to illness or injury – and they are not carrying out *any other* occupation.

This requirement is not normally *job* specific. The consumer has to be unable to carry out the general duties of the *occupation* they were following before their disability.

This means that a total inability to carry out the essential duties of *the occupation in general* (say, book-keeping) is necessary, to make a claim possible under the policy – rather than being totally unable to carry out the essential duties of, for example, *the specific post* of head book-keeper at the consumer's actual employer.

case study 1

Mr N worked as a petrol and oil-tanker filler. He had stopped work after developing a skin condition which was aggravated by any contact with oil or petrol, which often spilt onto his skin. His skin condition also prevented him wearing protective gloves.

His insurance company rejected his claim, saying that the medical and other evidence it had obtained suggested Mr N could still carry out his occupation.

We agreed that Mr N could not continue his occupation for his present employer. But we took the view that he could carry out the same occupation for another employer transporting less harmful liquids – for example, a dairy transporting milk – where his skin would not be affected by the liquid involved, and where gloves were not required. We were therefore unable to uphold Mr N's complaint.

case study 2

Mrs D was employed as a nurse but she could no longer work due to a post-traumatic stress disorder. Her insurance company rejected her claim, as it believed she was capable of returning to work on a gradual basis with reasonable adjustments to her daily routine – including regular breaks – and by passing some of her more complex work to colleagues.

We did not agree that Mrs D was able to return to her own occupation, as the balance of medical evidence suggested that the material and substantial tasks involved were too much for her to cope with, given her illness.

We also considered that the complex work she did was a material and substantial part of her occupation. So as the insurance company had already agreed she was unable to deal with this type of work, she was therefore unable to carry out her own occupation.

We told the insurance company to accept the claim and pay benefits from the end of the "deferral period" to the present date – including interest.

2. "suited occupation" or "any occupation"

Where the definition of "total disability" relates to "suited occupation" *or* "any occupation", we take the approach that the consumer must be totally unable – due to illness or injury – to follow their *own* occupation or *any other* occupation to which they are suited by education, training or experience.

We take the view that professional qualifications, skills and previous experience all need to be taken into account for this definition to be applied fairly. We treat the term "any occupation" as essentially meaning any "suited" occupation.

case study 3

After accepting and paying Mr J's claim for three years, the insurance company re-assessed and stopped his claim – on the grounds that his condition no longer prevented him from returning to work in a suited occupation.

Mr J, who had multiple sclerosis, had previously worked as a commercial salesman. He had reduced his hours, and finally stopped working, because he could no longer manage the large amount of driving required to visit his clients, or carry his computer equipment.

As the insurance company had stopped a claim that it had previously been paying, the onus was on them to show why the consumer no longer met the necessary criteria.

We did not agree that the insurance company had adequately proved its case. In our view the balance of medical evidence did *not* indicate that Mr J was capable of carrying out his own or any suited role – such as another less demanding job using his skills and qualifications (say, working as a sales representative in a shop or other fixed location).

We decided that the evidence showed Mr J's progressive condition had deteriorated – and that he was unable to concentrate for any length of time because of the pain.

We concluded that this prevented a return to any paid work. We told the insurance company to reinstate the claim, and to backdate the benefits, including interest.

case study 4

Mr G was a painter and decorator who worked on ladders. After he fractured his shoulder and suffered reduced shoulder movement, he complained to us about his insurance company's decision to reject his claim.

The insurance company had declined the claim on the grounds that – though Mr G was unable to return to his normal occupation – it considered him capable of doing an alternative job involving "light duties". We reviewed all the medical evidence available, including a report from Mr G's treating consultant who confirmed that he was able to carry out light tasks with little movement.

We agreed with the insurance company that the medical evidence showed Mr G was capable of "light duties" – for example, working in a DIY outlet or builders' merchants, where he could use his painting and decorating experience to advise customers. We were therefore satisfied that Mr G's disability did not meet the "any occupation" definition of incapacity.

3. "any occupation whatsoever"

The requirement for a consumer to be totally unable – due to illness or injury – to carry out *any* occupation *at all* before a policy pays out is a very strict test to meet. But for some occupations it is only possible to obtain cover on this basis.

In these circumstances, the restrictive nature of the cover should be clearly set out to the consumer at the point of sale. So we are likely to want to investigate what the consumer was actually told at the time the policy was taken out.

4. "activities of daily living (ADLs)"

Where the definition of "total disability" relates to "activities of daily living" (ADLs), the consumer has to be unable to perform a certain number of defined activities – such as eating, dressing and undressing, reading a newspaper, walking, bending *etc* – before the policy will pay out.

These activities should be clearly set out in the insurance policy. Where a complaint involves a dispute about "activities of daily living", we will consider carefully how the relevant activities have been assessed.

further information

This is only a very general guide. The rules we have to follow can be complex.

If you ask us to look into your complaint, we will explain any particular rules or restrictions that may apply in your own individual case. We will always give you the chance to query anything you don't understand or agree with. If you have any questions, please contact the person handling your case in the first instance.

If you'd like information in Braille, large print or on audiotape/CD – or in a different language – just let us know.