DRN-4718970

Financial Ombudsman Service

The complaint

Mr B complains that Legal and General Assurance Society Limited (L&G) has turned down an incapacity claim he made on a personal income protection insurance policy. He's also unhappy that L&G cancelled the policy because it considers he breached the policy fraud condition.

What happened

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

Mr B was insured under personal income protection insurance policy. The policy provided cover for Mr B's own occupation and had a deferred period of 13 weeks.

In August 2022, Mr B was signed-off from work due to stress at home, as a result of the serious illness of a family member. So he made a claim on the policy.

L&G asked for medical evidence to support Mr B's claim. And it also arranged for Mr B to speak with one of its vocational clinical specialists (VCS). The VCS concluded that Mr B was fit to return to work. And the available medical evidence was reviewed by L&G's Chief Medical Officer (CMO) who didn't think that Mr B had shown he met the policy definition of incapacity. Additionally, L&G considered that Mr B had carelessly misrepresented his occupation, as it appeared he carried out some manual work. L&G turned down Mr B's claim.

Mr B was unhappy with L&G's position and he appealed.

L&G reviewed the claim again. It obtained further evidence which it said indicated that Mr B had been working in a different profession during September, October, November and December 2022 and in January 2023. So it concluded that Mr B had a level of functional capacity which contradicted his reporting to it and that he hadn't disclosed a second job. It stated that it believed Mr B had exaggerated his circumstances in order to claim on the policy. And therefore, in May 2023, it invoked the policy fraud condition and cancelled Mr B's policy, retaining the premiums he'd paid.

Remaining unhappy with L&G's stance, Mr B asked us to look into his complaint. He also complained that despite having confirmed his policy had been cancelled, L&G had continued to debit premiums from his bank account.

Our investigator didn't think Mr B's complaint should be upheld. She didn't think it had been unfair for L&G to conclude that Mr B hadn't shown he met the policy definition of incapacity. And she didn't think it had been unreasonable for L&G to invoke the fraud condition. Nor did she think there was evidence that L&G had continued to debit premiums from Mr B's bank account.

Mr B disagreed and so 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 Mr B, I don't think L&G has treated him unfairly and I'll explain why.

First, I'd like to reassure Mr B that while I've summarised the background to his complaint and his detailed submissions to us, I've carefully considered all he's said and sent us. I'm very sorry to hear about the circumstances that led to Mr B needing to make a claim and I don't doubt how upsetting and worrying his family member's serious illness has been for him and his family.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. So I've considered, amongst other things, the terms of the policy and the available medical evidence, to decide whether I think L&G handled Mr B's claim fairly.

It seems to me that there are two key issues for me to decide. Firstly, was it fair for L&G to conclude that Mr B hadn't met the policy definition of incapacity? And second, was it fair for L&G to invoke and rely on the policy fraud condition and cancel the policy? I'll consider each issue in turn.

Was it fair for L&G to conclude that Mr B hadn't met the definition of incapacity?

I've first considered the terms and conditions of the policy, as these form the basis of Mr B's contract with L&G. Mr B made a claim for incapacity benefit, given his doctor felt he wasn't fit for work. So I think it was reasonable and appropriate for L&G to consider whether Mr B's claim met the policy definition of incapacity. This says incapacity means:

'Your inability, caused by illness or injury, to carry out your gainful employment or gainful self-employment.'

This means that in order for L&G to pay incapacity benefit, it needed to be satisfied that Mr B was suffering from an illness which prevented him from carrying out his own occupation, for the entirety of the deferred period and afterwards.

It's a general principle of insurance that it's for a policyholder to show they have a valid claim on their policy. This means it was Mr B's responsibility to provide L&G with enough evidence to demonstrate that an illness had led to him being unable to carry out the duties of his own occupation for the full 13-week deferred period between August and November 2022 and afterwards.

L&G assessed the evidence Mr B provided in support of his claim, including with clinical members of its staff, and concluded that it didn't indicate he had the persistent and pervasive symptoms compatible with more severe depression or that he met the policy definition of incapacity. So I've next looked at the available medical evidence to decide whether I think this was a fair conclusion for L&G to draw.

I've taken into account Mr B's medical records for the duration of the deferred period. In mid-August 2022, Mr B spoke with a GP due to low mood. He explained that a family member was seriously ill in hospital and that he was under considerable stress as a result of that and because of caring responsibilities for other family members. He was signed-off work with stress at home.

A further fit note was issued at the end of August 2022, which stated that Mr B was unfit for work due to stress at home. Again, it seems he reported low mood due to his family situation. At the end of September 2022, Mr B spoke with the GP again. He reported ongoing stress and worries due to his family member's illness. It seems at this point, Mr B agreed to contact talking therapies and was prescribed anti-depressant medication. Another fit note was issued citing Mr B was unfit for work, due to stress at home.

It's clear that in October 2022, Mr B's GP began to issue fit notes which stated that Mr B was off sick with 'depressed mood'. His anti-depressant medication was subsequently increased and he began to attend talking therapy. And I can see that Mr B was found to have symptoms of depression and anxiety, amongst others.

On 11 November 2022, Mr B spoke with L&G's VCS. I've set out below what I consider to have been the VCS' key conclusions:

The VCS was asked what perceived barriers prevented Mr B from returning to work. The VCS said:

'He is very stressed out and he is not in the right frame of mind to return. He needs to be present for his family and he needs to prioritise them at the moment.'

The VCS was also asked about Mr B's ability to undertake his insured role. The VCS said:

'Although the customer reported ongoing symptoms of stress, anxiety and low mood, he is functioning relatively well from day-to-day. His absence seems to have been triggered by his personal circumstances…and subsequent family stressors and is therefore not primarily medical.

Based on the customer's reporting today, in my clinical opinion, he is fit to return to work.'

L&G also referred Mr B's claim to its CMO. Again, I've set out what I think were their key findings:

'*The member scores high on the screening tests, but from an occupational health physician perspective, he does not have persistent and pervasive symptoms compatible with 'more severe' depression…He is able to function well at home…which points away from persistent symptoms of low motivation, poor concentration and anhedonia. I note there is no reference to…consideration of Psychiatrist input…*

My view, based on the current evidence, is that stress at home has triggered some symptoms compatible with 'less severe' depression, which are being managed appropriately with low-dose (anti-depressants) and talking therapy, which would be considered compatible alongside work, noting the nature of his specific role. Noting his overall functional ability, his symptoms and activity are not compatible with someone totally incapacitated from work due to a mental or physical health condition, in my opinion.'

I've thought very carefully about all of the evidence that's been provided. It's important I make it clear that I'm not a medical expert. In reaching a decision, I must consider the evidence provided by both medical professionals and other experts to decide what evidence I find most persuasive. It's clear that Mr B was suffering from symptoms which can be indicative of a severe, impairing mental health condition. And it's clear too that his GP didn't think he was fit to work.

But, taking into account the totality of the medical and other evidence available to L&G, I

think it was reasonable for it to conclude that the evidence showed that Mr B was suffering from an understandable reaction to his home situation. And that the main reason for Mr B's absence from his workplace during the deferred period was
likely the home stress he was experiencing as opposed to a significant mental health condition. I think too that the medical evidence points to the cause of Mr B's symptoms being the stress caused by his family member's serious illness and the impact on his home-life.

This means I don't find that L&G acted unfairly when it relied on its VCS' and CMO's opinion to decide that Mr B wasn't suffering from a significant mental health condition, during the deferred period, which prevented him from carrying out his occupation. On this basis then, I don't think it was unfair for L&G to conclude that Mr B's absence wasn't due to incapacity in line with the policy definition. Instead, I think it fairly concluded that Mr B's absence during the deferred period was more likely due to home stress and a reaction to his circumstances. And so, I think L&G was reasonably entitled to turn down this claim.

Was it fair for L&G to rely on the fraud condition and cancel Mr B's policy?

The policy terms say:

'*You must not be working in any occupation during the deferred period and whilst the monthly benefit is being paid.'*

And the general conditions of the policy say:

'If you (or an agent acting on your behalf) deliberately or recklessly provide inaccurate information we are entitled to cancel this policy and refuse to pay the monthly benefit. In these circumstances we may not refund any premiums you have already paid.'

L&G considers that Mr B reported symptoms to it during the deferred period which weren't consistent with his activities and that he hadn't told it about a second occupation. So it believes he exaggerated his circumstances to gain a financial benefit under the policy. As such, it cancelled Mr B's income protection policy (amongst other policies).

I've considered this point carefully. L&G has provided me with evidence of the investigation it carried out, which we shared with Mr B. It's provided details of Mr B's company. The contact details match his name, email and telephone details. And L&G's provided detailed, photographic evidence, including from social media, which appears to show that Mr B was carrying out other work in an unrelated occupation during much of the deferred period and afterwards – both for his own company and another company.

Mr B says this role is carried out as a hobby, which contributes to maintaining his mental health and it isn't intended for financial gain. He said the information given in the report didn't imply he was earning an income from the activity. I've thought about what Mr B has told us. But I can understand why L&G had concerns, given a) Mr B said he wasn't fit to work due to anxiety and depression and b) because he hadn't disclosed this other role to it. So I don't think it was unfair for L&G to rely on the evidence set out in the investigation to conclude that Mr B was working in another occupation and that he was well enough to do so.
On that basis, I don't think it was unfair or unreasonable for L&G to rely on the evidence it gathered to conclude that Mr B had deliberately or recklessly provided it with inaccurate information. This also accords with the legal position set out in the Insurance Act 2015. And therefore, I don't think L&G acted unreasonably when it relied on the fraud condition to cancel Mr B's income protection policy and keep his premiums.

As a side point, I note that during the life of the claim, L&G considered that Mr B had carelessly misrepresented the nature of his role and that had it been aware of the type of

work he did, it would have classified his job differently. This would have resulted in a higher premium being charged and affected any benefit paid. However, given I find L&G was entitled to turn down the claim and cancel Mr B's policy, I don't think I need to make any finding on this particular point because I don't think it affects the outcome here.

Premiums

Mr B says that L&G has continued to collect premiums for his policies despite the policy cancellation. He's provided screenshots showing continued debits from his account to L&G after May 2023, when the income protection insurance policy was cancelled. Mr B had a number of payments debited to L&G each month prior to the cancellation representing different policies. There was a regular debit each month for £32.02, which was the premium shown on Mr B's policy documentation.

L&G has provided us with evidence which shows that the last income protection insurance premium of £32.02 was debited in May 2023. I can see from Mr B's statement that no further debits for this amount were debited from his account after May 2023. So it doesn't seem that the debits which continued from his account relate to this income protection insurance policy. I'm satisfied the policy was cancelled and no further premiums for this particular contract have been taken.

If Mr B believes he is being wrongly charged for other insurance policies he held with L&G or which are associated with his bank account, he should send evidence of those debits to L&G for its consideration. However, as this complaint relates to the way L&G has handled Mr B's income protection insurance policy and claim, I don't think it would be reasonable or appropriate for me to address potential other insurance contracts as part of this decision.

Summary

Overall, despite my natural sympathy with Mr B's position, I don't think L&G has treated him unfairly.

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 Mr B to accept or reject my decision before 2 August 2024.

Lisa Barham
Ombudsman