An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0202
Sector:	Insurance
Product / Service:	Income Protection and Permanent Health
Conduct(s) complained of:	Rejection of claim - fit to return to work
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant, a storage and delivery operations specialist, is a member of a Group Income Protection policy that his Employer is the grantee of and which is administered by the Employer's broker. The Provider is the Insurer of this group policy, responsible for underwriting the cover and assessing the claims.

The Complainant's Case

In **March 2014**, the Complainant *"contracted a virus which attacked my nervous system and left me with health complications … blackouts, headaches, fatigue, muscle and joint pain, nausea and a weakened immune system. The medical diagnoses I have been given are vasovagal syncope and post viral syndrome"*.

The Complainant completed an income protection claim notification on **29 November 2014** wherein he listed the nature of his symptoms as *"loss of consciousness / headaches / nausea / fatigue / muscle + joint pain"* and the date he ceased working as *"8 August 2014"*.

Following its assessment, the Provider notified the Complainant by way of correspondence dated **25 March 2015** that it had declined his income protection claim as it had concluded that *"based on the medical evidence received that* [he] *is not currently totally disabled from following his normal occupation as required by the policy and is fit to return to work".* The

Complainant appealed this decision, but the Provider upheld its declinature on **6 October 2015**.

In this regard, the Complainant sets out his complaint, as follows:

> *"The company I work for operate an income protection scheme in order to pay a percentage of an employee's wage should they develop a long term illness and be deemed unfit for work…*[The Provider] *have made the decision not to pay me under this policy and have rejected the appeal I submitted…The background to this is that in March 2014 I contracted a virus which attacked my nervous system and left me with health complications. As a result I now suffer from blackouts, headaches, fatigue, muscle and joint pain, nausea and a weakened immune system. The medical diagnoses I have been given are vasovagal syncope and post viral syndrome. A Consultant recently prescribed a course of medication for me to try to prevent the blackouts I experience but it has not worked. Since this all started I have returned to work twice and also attempted to work from home but have found it to be impossible so far"*.

In addition, in his correspondence to the Provider dated 27 January 2016, the Complainant submits, *inter alia*, as follows:

> *"I have submitted medical evidence form a number of different medical practitioners, including my GP, a Consultant Neurologist and a Consultant Cardiologist, each explaining my condition and why I was unable to work.* [The Provider] *has chosen to follow the advice of an Occupational Therapist who I met once for about fifteen minutes …*
>
> *I also found the following statement…from the Occupational Therapist you referred me to, to be flippant and insulting, "there was no evidence from today's assessment to suggest that* [the Complainant] *is not fit to return to his office based job". This remark highlights the ignorance and complete lack of understanding of a supposed medical expert who has no idea of what this illness is and what it has done to me or what the functions of my job requires, as if I sit in an office all day twiddling my thumbs".*

As a result, the Complainant seeks for the Provider to admit his income protection claim.

The Complainant's complaint is that the Provider has wrongly or unfairly declined his income protection claim.

<u>The Provider's Case</u>

Provider records indicate that the Complainant completed an income protection claim notification on 29 November 2014 wherein he listed the nature of his symptoms as *"loss of consciousness / headaches / nausea / fatigue / muscle + joint pain"* and the date he ceased working as *"8 August 2014"*. The Complainant's Employer completed an income protection

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employment information form on 17 December 2014 advising that his job was office based and involved walking for approximately 1 hour a day, with the rest of the day spent sitting and that he works 39 hours a week, providing operational support to customers.

The Provider can only pay an income protection claim where the claimant meets the Group Income Protection Policy definition of total disablement, as follows:

> *"Total disablement shall be deemed to exist where (a) the Insured Person is unable to carry out the duties pertaining to his normal occupation by reason of disablement arising from bodily injury sustained or sickness or illness contracted and (b) the Insured Person is not engaging in any other occupation for profit or reward or remuneration"*.

As the deferred period under the policy is *"the first 26 consecutive weeks in each period of disablement"*, the Provider notes that any liability it might have had in respect of the Complainant's claim would have been due to commence on **9 February 2015**.

As part of its assessment of his claim and in order to determine whether or not he met this policy definition of total disablement, the Provider arranged for the Complainant to attend for an independent medical examination with Dr J., Specialist in Occupational Physician, on 6 March 2015. It also requested a medical questionnaire from the Complainant's Consultant Neurologist, Dr D. and from his GP, Dr A.

The Provider received reports from both of the Complainant's treating doctors prior to him appointment with Dr J. and in this regard it notes that his Consultant Neurologist, Dr D. confirmed that all neurological exams were normal and that the Complainant was fit for fulltime work from 1 January 2015. Both of these reports were sent to Dr J. for his consideration in advance of his examination of the Complainant on 6 March 2015.

In his ensuing report dated 10 March 2015, Dr J. concluded that *"It is my opinion, based on the assessment of this gentleman, that he is currently fit to return to work. In my view his current symptoms are not of such severity that these would prevent him from performing his usual office-based duties"*.

Based on the medical evidence received, the Provider concluded that the Complainant was fit to carry out his normal occupation and thus did not meet the policy definition of total disablement. As a result, the Provider wrote to the policyholder's broker on 25 March 2015 to advise, as follows:

> *"We have recently received the results of the Independent Medical Examination with* [Dr J.] *Occupational Physician. We have also received a report from* [the Complainant's] *own specialist,* [Dr D.]. *It is our opinion based on the medical evidence received that* [the Complainant] *is not currently totally disabled from following his normal occupation as required by the policy and is fit to return to work. I must advise therefore that we are unable to admit this claim"*.

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The Provider received correspondence from the Complainant on 23 June 2015 enclosing a letter from Dr S., Consultant Neurologist dated 11 May 2015 and also a report from his GP, Dr A. dated 18 June 2016 in support of his appeal. Having reviewed this additional evidence, the Provider wrote to Dr S. on 7 July 2015 requesting some further information. On receipt of this additional information, and in order to fully consider his appeal, the Provider arranged for the Complainant to attend for a further independent medical examination with Dr X, Specialist in Occupational Health, on 31 August 2015. In his ensuing report dated 1 September 2015, Dr advised, *inter alia*, as follows:

> *"While* [the Complainant] *reported ongoing symptoms affecting his daily activities, there was no objective evidence from the medical reports provided (noting the normal extensive tests apart from the tilt test indication vasovagal episodes) or clinical finding from today's assessment to suggest that he is not fit to return to his office based job. Therefore based on the objective clinical grounds, my view is that* [the Complainant] *is fit for work"*.

As a result, the Provider advised the Complainant by way of correspondence dated 6 October 2015 that it had reviewed all aspects of his file and that his appeal was unsuccessful.

The Complainant furnished the Provider by email on 16 December 2015 with a report from Consultant Cardiologist, Dr G. dated 17 November 2015. The Complainant himself acknowledged in his email that this report did not contain any new information. The Provider reviewed this report but as it contained no new information the Provider confirmed to the Complainant in its correspondence of 7 January 2016 that its decision to decline his income protection claim remained.

No further evidence was submitted by or on behalf of the Complainant until 22 November 2016, some 12 months later, when he furnished the Provider with a report from Prof M. dated 10 November 2016, wherein she confirmed that the Complainant was fit to return to work from 1 January 2017. However, the Provider could not consider a further appeal at that late stage as it had no way of establishing whether or not the Complainant met the policy definition of total disablement in the intervening period and had no way to retrospectively assess his fitness for work. As a result, this report did not alter its position and the Provider wrote to the Complainant on 25 November 2016 confirming this. The Provider later received a report from the Complainant's GP, Dr Q. dated 28 March 2017, but this too did not provide any new objective evidence.

The Provider notes that in his appeal correspondence dated 23 June 2015, the Complainant advised that he had attempted to work from home, however he did not provide any details such as whether this was a structured return to work in agreement with his employer, or for how many hours or days he attempted this return to work. In any event, the Provider's decision was based on all of the medical evidence obtained during the course of the claim assessment, including the opinion of the Complainant's own specialist.

When assessing income protection claims, the Provider must be guided by the weight of the medical evidence available. Having reviewed all of the medical evidence, it remained the Provider's opinion, based on the independent medical examination as well as the reports

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from his own specialists, that the Complainant was not totally disabled from following his normal occupation and therefore it concluded that he did not meet the definition of total disablement as required by the policy.

Accordingly, the Provider is satisfied that it declined the Complainant's income protection claim in accordance with the terms and conditions of the Group Income Protection Policy.

The Complaint for Adjudication

The complaint is that the Provider wrongfully declined the Complainant's income protection claim in March 2015, and also in October 2015, wrongfully declined the Complainant's appeal of that decision to refuse benefit payments to him on foot of his claim in November 2014.

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainant was given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint.

Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on 13 June 2019, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

Following the consideration of an additional submission from the Complainant, the final determination of this office is set out below.

The complaint at hand is that the Provider wrongly or unfairly declined the Complainant's income protection claim. In this regard, the Complainant is a member of a Group Income

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Protection policy and the Provider is the Insurer, responsible for, *inter alia*, assessing any income protection claims.

I note that the Complainant completed an income protection claim notification on 29 November 2014 wherein he listed the nature of his symptoms as *"loss of consciousness / headaches / nausea / fatigue / muscle + joint pain"* and the date he ceased working as *"8 August 2014"*. Following its assessment, the Provider notified the Complainant by way of correspondence dated 25 March 2015 that it had declined his income protection claim as it had concluded that *"based on the medical evidence received that* [he] *is not currently totally disabled from following his normal occupation as required by the policy and is fit to return to work".* The Complainant appealed this decision, but the Provider upheld its declinature on 6 October 2015.

Income protection policies, like all insurance policies, do not provide cover for every eventuality; rather the cover with be subject to the terms, conditions, endorsements and exclusions set out in the policy documentation. In this regard, **Section 1**, '**Disablement**', of the applicable Provisions, Conditions and Privileges of the applicable Group Income Protection Policy booklet provides, *inter alia*, as follows:

> *"**Disablement** – For the purpose of the Policy*
>
> *(i) total disablement shall be deemed to exist where (a) the Insured Person is unable to carry out the duties pertaining to his normal occupation by reason of disablement arising from bodily injury sustained or sickness or illness contracted and (b) the Insured Person is not engaging in any other occupation for profit or reward or remuneration*
>
> *and*
>
> *(ii) partial disablement shall be deemed to exist where (a) following a period of total disablement as in Provision 1(i), which period is to be decided by the Company, an Insured Person is unable to carry out the duties pertaining to his normal occupation by reason of disablement arising from bodily injury sustained or sickness or illness contracted and (b) the Insured Person with the written consent of the Company re-engages in his normal occupation with loss of earnings as a result or engages in some other occupation for profit or reward or remuneration"*.

As a result, the Provider will only pay an income protection claim where the claimant satisfies this policy definition of total disablement.

As part of its assessment of his claim, I note that the Provider send a Medical Questionnaire to the Complainant's Consultant Neurologist, Dr D. on 14 February 2015 to complete. In his completed Questionnaire dated 4 March 2015, Dr D. advised, *inter alia*, as follows:

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*"**What are the current symptoms?***

Recurrent syncopal events.
… moderately well controlled.

Please provide details of all current treatment.
Lifestyle measures – avoid fasting – avoid dehydration – fluid intake

Is the treatment providing any relief of symptoms?
Yes – syncopal events less frequent …

In your opinion, is* [the Complainant] *currently fit to carry out the duties of his normal occupation?
Yes – from 01.01.2015

If you feel that* [the Complainant] *is not currently fit to work on a full-time basis, in your opinion is he currently capable of carrying out such duties on a part-time basis?
I believe that [the Complainant] *can work on a fulltime basis. He may need occasional rest days if/when he experiences a syncopal event"*.

In a recent submission to this office, since the Preliminary Decision was issued to the parties on 13 June 2019, the Complainant says that Dr. D's. answers represented "*an error of judgment*", and that Dr. D. should have referred him to another specialist, or for further testing at that time.

In addition, I also note that the Provider arranged for the Complainant to attend for an independent medical examination with Dr J., Specialist in Occupational Physician, on 6 March 2015. In his ensuing report dated 10 March 2015, Dr J. advises, *inter alia*, as follows:

*"**OCCUPATIONAL HISTORY:*** [The Complainant] *has been employed by* [his Employer] *since 1999. He holds the position of storage operations specialist and tells me that his duties are computer and office based. His tasks involve the backing up and recovery of data and he usually works 39 hours per week but with an occasional requirement for overtime and on-call duties.*

HISTORY OF PRESENTING COMPLAINT: [The Complainant] *was last at work on the 8th of August 2014. He tells me that he has been suffering from syncope since March 2014. He says that he experienced flu-like symptoms at the time and as a result was out from work for a period of one week. After his return to work, he suffered his first blackout and another two weeks later. He says that after that, the blackouts occurred on average once a week.*

He has since that time been investigated under the care of [Dr D.] *consultant neurologist, whom he last attended in October 2014 and with whom he has another appointment in May 2015.* [The Complainant] *tells me that he underwent an EEG, CT brain, holter monitor, ECG, echocardiogram, synacthen test, routine blood screening, as well as an MRI brain. He says that these tests were fortunately all normal.*

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> *According to* [the Complainant]*, the biggest problem at present is experiencing fatigue which has been ongoing since around May 2014. He says that the fatigue is aggravated by physical exertion and improved by rest. He says that, overall, there has been no improvement in the fatigue over the past 9 months. On further inquiry* [the Complainant] *tells me that the blackouts now occur less frequently and around once a month at present. He says that his last blackout occurred more than a month ago and that the blackouts are accompanied by nausea.*
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> [The Complainant] *also complains of headaches and pain in his eyes, especially in his right eye, which also started around May 2014. He says that his headaches are aggravated by reading and improved by using paracetamol. He says that he experiences the headaches around 3 times per week and that they could last for a few hours to a whole day at a time.*
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> [The Complainant] *tells me that he has also been experiencing joint pains since around May 2014, mostly affecting his shoulders, hips and back. He tells me that he attended a physiotherapist for his back in November 2014 and availed of 3 or 4 sessions of physiotherapy …*
>
> ***DISCUSSION:*** *This 40-year-old gentleman has been out from work for the past 7 months after experiencing blackouts with a diagnosis of syncope. He currently has complaints of fatigue, headaches and joint pains. He says that he is hopeful that once the headaches and fatigue subside that he will be able to return to work.*
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> *It is my opinion, based on assessment of this gentleman, that he is currently fit to return to work. In my view his current symptoms are not of such severity that these would prevent him from performing his usual office-based duties".*

As a result, the Provider notified the Complainant by way of correspondence dated 25 March 2015 that it had declined his income protection claim, as follows:

> *"We have recently received the results of the Independent Medical Examination with* [Dr J.] *Occupational Physician. We have also received a report from* [the Complainant's] *own specialist,* [Dr D.]. *It is our opinion based on the medical evidence received that* [he] *is not currently totally disabled from following his normal occupation as required by the policy and is fit to return to work. I must advise therefore that we are unable to admit this claim".*

I note from the documentary evidence before me that the Provider then received the following undated letter from the Complainant on 23 June 2015:

> *"Following a tilt table test recently I was informed that the reason I have been suffering from episodes of loss of consciousness for the past 15 months is that I have vasovagal syncope.*

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Along with those episodes of loss of consciousness I have also been suffering from fatigue and headaches on a daily basis. Other symptoms I have been experiencing since I contracted a virus in March of last year include pain in my joints and in my muscles and nausea and grogginess.

I have had numerous medical tests done to date to try to find out the cause of my illness and am scheduled for more in the coming months.

I still have not been given a definitive diagnosis for my illness but my GP and the consultants I have been attending, believe it may be caused by some kind of post viral syndrome.

After not being able to carry out my work duties in the office I attempted to work from home instead but found it impossible to get anything done because of an inability to apply myself or concentrate because of a combination of fatigue, headaches, muscle and joint pain and nausea.

I am hopeful that sooner rather than later my symptoms will alleviate or that I will be given a diagnosis and or a treatment which will enable me to return to my normal life".

Enclosed with this correspondence was a letter from the Complainant's GP, Dr A. dated 18 June 2015, wherein she advised, as follows:

"[The Complainant] *has been certified unfit for work since late March 2014 due to recurrent blackouts with attendant headaches, muscle and joint pains and episodes of profound fatigue. This has greatly reduced his powers of concentration. Due to the recurrent blackouts, he has been advised not to drive. These symptoms came on after a severe flu-like illness in March 2014.*

[He] *was investigated by* [Dr D.] *Neurologist…His tests there were normal including brain scan, EEG, 24 hour heart tracing and cardiac ultrasound. Blood tests likewise were normal. He sought a second opinion and was seen by* [Dr S.] *Neurologist. He referred him for a tilt table text. This was done by* [Dr B.] *Consultant Physician. This confirmed that his episodes of weakness were vasovagal in nature. He was seen by* [Dr G.] *Cardiologist. He has referred him for repeat cardia tests namely, 24 BP monitor, 3 Day Holter Monitor and an ECG.*

In the last six months there has been a reduction in the frequency of the blackouts which were occurring previously once a week and are now occurring just monthly. He gets bouts of joint pains affecting his hips, his shoulders and his back. These can last for three to four days and occur every three weeks or so. In the last six months the muscle and joint pains have also eased in severity. However, on a daily basis he is still getting phases of profound fatigue where he just has to lie down. He regularly gets a headache with this out his right eye. The fatigue can last for a few days to a week at a time.

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In summary, [the Complainant] *remains unfit for work due* [to] *this debilitating illness which seems to have stemmed from a viral infection in March 2014"*.

In addition, also enclosed was correspondence from Consultant Neurologist Dr S. dated 11 May 2015 which stated that the Complainant had attended for consultation on 21 April 2015. As a result, and as part of its appeal process, I note that the Provider then sent a Medical Questionnaire to Dr S., Consultant Neurologist on 7 July 2015 to complete. In his completed Questionnaire dated 21 July 2015, Dr S. advised, *inter alia*, as follows:

*"**What is the current diagnosis?***
Episodes of loss of consciousness – likely syncopal/vasovagal recurrences

When was the condition first diagnosed?
21/4/15

What is the exact nature of the current condition?
Recurrent episodes of loss of consciousness – approximately 15-20 times between April 2014 – April 2015

What are the current symptoms?
Unpredictable loss of consciousness with quick recovery …

We received a report from* [Dr D.] *who advised that it was his opinion that* [the Complainant] *was fit to return to work from 1st January 2015. Can you please advise if there has been any change in* [the Complainant's] *symptoms since then or do you agree with* [Dr D.]*'s opinion on fitness for work?
There has been no change in symptoms between January 2015 and 21/4/2015

What is the prognosis of the condition
a) In the short term?
[The Complainant] *will have recurrent losses of consciousness but hopefully with preventative treatments these will reduce in frequency*
b) In the long term?
Difficult to predict, but episodes should become less frequent with preventative management

In your opinion, is* [the Complainant] *currently fit to carry out the duties of his normal occupation on a full-time basis?
No …

If you feel that* [the Complainant] *is not currently fit to work on a full-time basis, in your opinion is he currently capable of carrying out such duties on a phased basis increasing his hours to full-time work?
… Yes, starting 10 hours per week, and increasing by 10 hours per week every month – i.e. up to full time work in 4 -5 months".

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On receipt of this additional information, and in order to fully consider his appeal, the Provider then arranged for the Complainant to attend for a further independent medical examination with Dr X, Specialist in Occupational Health, on 31 August 2015. In his ensuing report dated 1 September 2015, I note that Dr X advised, *inter alia*, as follows:

> *"*[The Complainant] *informed me that he has been absent from work for more than 1yr. He said he was absent from work for a week in March 2014 due to flu-like symptoms. He said he returned to work after 1 week.*
>
> *He told me that in late March, while he was at home, he blacked out and collapsed without warning. He was unsure of the duration of his collapse and he said he had no other associated symptoms. He said he came around and went to ask his wife to bring him to hospital. He said he attended the A&E in* [named] *Hospital but he said he did not wait to be seen and he left. 2 weeks later, he said he had another similar episode and was assessed in A&E. He said he was referred to neurologist* [Dr D.] *in* [the hospital]*. He said he was fully investigated but no abnormality (or diagnosis) was detected in the tests which he said included brain scan, EEG & cardiac tests. At that stage, he also had headaches.*
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> *He said* [Dr D.] *was meant to review him but he had not received any appointment, he said that while he was waiting for the appointment, he attended another neurologist* [Dr S.] *at [named] Clinic. He said he was also referred for full cardiology review and had cardiac investigations and tilt table testing. He said all the tests turned out to be normal although he was apparently "verbally told" his tilt table testing in May was "positive" and that he has "vasovagal syncope". He said he is due to see the cardiologist and* [Dr S.] *in Oct but he has yet to receive another appointment to see* [Dr D.] *…*
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> *He said he is still getting 1-2 syncopal episodes a week (lasting approx. 20 sec) and he lost consciousness in ½ of these episodes. He said he sometimes gets warning symptoms of nausea and feeling detached and he would get onto the floor. He had had no injuries from his faints.*
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> *He said he had headaches "all the time". He described these headaches as varying in severity from 5/10 to 10/10. He also said the pain can be at different sites – retro-orbital, side of his head, back of his head etc. He said ibuprofen or paracetamol helps. In addition, he also complained of fatigue and general aches/pains. He said he can get down but he denied being depressed …*
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> ***Opinion:***
> [The Complainant] *was referred for an independent medical assessment. He has been absent from work since mid-Aug 2014. He reported having flu-like illness in March and since then he has been getting syncopal episodes. He had attended different specialists…I believe there was no abnormality detected to date and I believe he was told his near-faints/fainting episodes were vasovagal in nature. He reported having frequent on-going symptoms of faint/near faint every 1-2 weeks along with headaches, general aches & fatigue …*

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> *While* [the Complainant] *reported ongoing symptoms affecting his daily activities, there was no objective evidence from the medical reports provided (noting the normal extensive tests apart from the tilt test indication vasovagal episodes) or clinical finding from today's assessment to suggest that he is not fit to return to his office based job. Therefore based on the objective clinical grounds, my view is that* [the Complainant] *is fit for work. Phasing is recommended e.g. doing ½ his usual weekly hours for the 1st 2 weeks & gradually increasing over a further 2 weeks to his normal work hours"*.

As a result, I note that the Provider notified the Complainant by way of correspondence dated 6 October 2015 that his appeal had been unsuccessful and that it was upholding its initial decision to decline his income protection claim.

I note from the documentary evidence before me that the Complainant emailed the Provider on 16 December 2015, as follows:

> *"I have attached a letter from one of my Consultants as I believe it is the only one you have not yet received. However it does not contain anything that you haven't already been made aware of at this stage"*.

Attached to this email was correspondence from Consultant Cardiologist, Dr G. dated 17 November 2015, wherein he stated, as follows:

> *"This is to say that* [the Complainant] *suffers from vasovagal syncope and is treated with midodrine 5 mgs three times a day. He gets occasional episodes of dizziness, but is generally feeling better than he did earlier on this year. He was unable to work earlier on this year because of frequent episodes of near syncope and syncope"*.

In this regard, the Provider emailed the Complainant on 7 January 2018 to advise that *"we have reviewed* [Dr G.]*'s medical report…unfortunately the medical evidence does not alter our position and we are standing over our decision to cease your claim"*. (I note in that regard that the claim had never been placed in payment, and therefore in fact the claim was not one which was to be "ceased").

I also note from the documentary evidence before me that the Complainant later furnished the Provider with two further medical reports. The first was a letter from Consultant Physician Prof M. to the Complainant's Employer, dated 10 November 2016, which advised, as follows:

> *"I am glad to report* [the Complainant] *is making a slow but steady improvement. He does have ongoing symptoms of fatigue and headaches but thankfully these seem to be improving. I have instructed him on getting assistance with returning to the activities of daily living, which we plan over the next 6 weeks. Following this time I believe he will be fit to resume work from 1st January 2017. I would request that* [the Complainant] *be met with consideration that a new position within the organisation may offset relapse of his symptoms"*.

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The second was a letter from the Complainant's GP, Dr Q., dated 28 March 2017, which stated, as follows:

> *"*[The Complainant] *was recently informed that his application for disability allowance was declined he appears to be suffering from a post viral fatigue syndrome from March 2014. Although he has seen gradual improvements in his symptoms he still is quite symptomatic. He describes having 'good days and bad day'.*
>
> *His bad days which occur weekly will consist of headaches and profound weakness. He had not been able to return to his previous employment as yet"*.

Notwithstanding that it had declined the Complainant's income protection claim in the first instance on 25 March 2015 and on appeal on 6 October 2015, more than a year previously, I note that the Provider considered both of these reports and concluded that neither contained any new objective evidence.

A claimant must satisfy the policy definition of total disablement in order to have a valid income protection claim. In this regard, Section 1, 'Disablement', of the applicable Provisions, Conditions and Privileges of the applicable Group Income Protection Policy booklet provides, *inter alia*, as follows:

> *"**Disablement** – For the purpose of the Policy*
>
> *(i) total disablement shall be deemed to exist where (a) the Insured Person is unable to carry out the duties pertaining to his normal occupation by reason of disablement arising from bodily injury sustained or sickness or illness contracted and (b) the Insured Person is not engaging in any other occupation for profit or reward or remuneration*
>
> *and*
>
> *(ii) partial disablement shall be deemed to exist where (a) following a period of total disablement as in Provision 1(i), which period is to be decided by the Company, an Insured Person is unable to carry out the duties pertaining to his normal occupation by reason of disablement arising from bodily injury sustained or sickness or illness contracted and (b) the Insured Person with the written consent of the Company re-engages in his normal occupation with loss of earnings as a result or engages in some other occupation for profit or reward or remuneration"*.

Income protection insurance decisions are based on medical evidence available and the duties of the policyholder's occupation. It is necessary for the insurer to ascertain whether the claimant meets the policy definitions for a valid claim.

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Having considered the documentary evidence before me and which I had cited from at length, which includes the report from the Complainant's own Consultant Neurologist, Dr D. dated 4 March 2015, I am satisfied that it was reasonable for the Provider in March 2015, to conclude from the medical evidence that it received, that the Complainant was at that point, fit to carry out his normal occupation and thus that he did not meet the policy definition of total disablement. I am similarly satisfied that, in the course of the Complainant's appeal against that decision, the Provider was entitled to conclude in October 2015, on the basis of the medical evidence available to it, that the Complainant was not suffering from disablement within the meaning of the policy.

In this regard, I am also mindful that some of the medical reports indicated that the Complainant was fit to engage in a phased return to work whereby he return on a reduced working week and increase the hours over a short period, to achieve a fulltime return. The policy terms and conditions however do not provide benefit in respect of partial disablement, without the policyholder having first previously satisfied the policy definition of total disablement, for a time before such partial disablement.

I note indeed that the Complainant returned to work in October 2017 for a period, and has since had a number of medical problems. It is not the function of this office to assess the Complainant's current medical condition or to decide whether he now meets the definition of "*disablement*" within the meaning of the policy, at this point in time. Rather, the complaint which has been the subject of this investigation has required a determination as to whether the Provider in March 2015 and subsequently in October 2015 was entitled to reach the decision which it did that the Complainant, at those times, did not meet the policy definition of disablement and thus that the Complainant's claim should be declined.

Accordingly, on the basis of the evidence available, I am satisfied that the Provider declined the Complainant's income protection claim in strict accordance with the terms and conditions of the Group Income Protection policy in March and October 2015.

Conclusion

My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is rejected.

The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.

MARYROSE MCGOVERN
DIRECTOR OF INVESTIGATION, ADJUDICATION AND LEGAL SERVICES

12 July 2019

/Cont'd…

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will publish legally binding decisions in relation to complaints concerning financial service providers in such a manner that—

(a) ensures that—

(i) a complainant shall not be identified by name, address or otherwise,

(ii) a provider shall not be identified by name or address, and

(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.