An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0360
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 was employed with her former Employer from May 2011 to February 2017. This Employer was the policyholder of a Group Income Protection Policy with the Provider and the Complainant, during her time as an employee, was an insured person under this policy.

The Complainant's Case

The Complainant was certified as unfit for work in May 2016 *"as a result of workplace stress and anxiety owing to an employment workplace matter".* Dr D. G., a Specialist in Occupational Health with the occupational healthcare practice engaged by the Complainant's Employer, advised in her Report dated 6 July 2016 that the Complainant *"is unfit for work for the next 6 to 8 weeks"* and in a later Report dated 10 November 2016 that the Complainant *"remains unfit for work and I anticipate that she will be on sick leave for another 2-3 months"*.

In this regard, the Complainant submits, as follows:

> *"During the period, the 19th May 2016 until the 19th November* [2016]*, my employer paid my Illness benefit entitlement subject to the* [Provider]*'s illness benefit policy. From the 20th November 2016 until my termination date of the 28th February 2017,*

> *the subject period of this complaint, I believe I was entitled to the terms of my employer's Income Protection Scheme as a member of their scheme with* [the Provider]. *Having checked the terms of the Income Protection Group Scheme Policy, Workplace Stress & Anxiety is not one of the exemptions noted"*.

In assessing her income protection claim, the Provider arranged for the Complainant to attend a medical examination with Dr P. W., Consultant in General Adult Psychiatry and based on the contents of his Report dated 18 January 2017, the Provider declined the Complainant's income protection claim on 6 February 2017 as it concluded that she was *"not currently totally disabled from following your normal occupation as required by the policy and you are fit to return to work"*.

The Complainant appealed this decision and submitted a Report from Dr S. O'D., Consultant Psychiatrist, dated 21 November 2017, in support of her appeal.

In this regard, in its correspondence dated 26 February 2018, the Provider advised the Complainant's Solicitor, as follows:

> *"We had obtained a contemporaneous opinion from a very experienced psychiatrist* [Dr P. W., Consultant in General Adult Psychiatry, dated 18 January 2017] *who formed the view at the time that* [the Complainant] *was medically fit to resume her normal occupation. It is our view that this opinion carried more weight than that of a psychiatrist who had assessed* [the Complainant] *a year later and was providing a retrospective opinion on her fitness or otherwise to work. However we advised* [by email dated 6 December 2017] *we would be prepared to arrange a further independent medical examination in respect of* [the Complainant] *or alternatively we would be prepared to make a without prejudice offer of €4,000 gross in full and final settlement of this matter. We also confirmed we would be prepared to reimburse* [the Complainant] *for the cost of the appeal report* [from Dr S. O'D.]*"*.

The Complainant does not accept the Provider's declinature of her claim and sets out her complaint, as follows:

> *"Although* [Dr P. W.]*'s report was capable of giving an opinion prospectively from the date he examined me and completed his report, the report failed to give an opinion retrospectively prior to the issuing of his report.*
>
> [Dr P. W.]*'s report failed to include the Medical Reports* [from Dr D. G.] *as part of his source of information for consideration which was available to him.*
>
> [Dr P. W.]*'s report failed to set out a clear and unambiguous return to work date for me.*
>
> [The Provider] *put me through two some [sic] incredible onerous processes. The first being the application for Income Protection* [that is, the claim] *and the second, the appeal.*

/Cont'd…

a) *With regard to the application for income protection, I had to depend* [on] *family support for income while* [the Provider] *processed my application. I believe this product, 'Income Protection' is not fit for purpose it was designed for.*

My application was submitted on the 14th November 2016, ahead of the commencement date of the 20th November 2016, but the decision regarding my application was not communicated until the 6th February 2017…I understand my timing period between application and decision is a common factor with [the Provider] *for similar type applications.*

b) *I note from* [the Provider's] *internal process that* [Mr N. H.] *Claims Assessor, Income Protection Claims was a party to my Income Protection Application decision and also a party to the decision of my appeal. I believe this is a flawed process by having the same person making the initial decision and again involving themselves in the appeal limb of the process.*

c) [Mr N. H.] *in his decision subjected me to an onerous appeal by requesting further specialist evidence from me at my own cost to support my appeal. As noted, my appeal was pre-determined to fail without such evidence. Again, I had to depend on family support to provide the financial means to allow me to comply with this request.*

d) *I find it incredulous and extraordinary that* [the Provider] *were prepared to subject me again to a further independent medical examination as part of an extended appeal process, or in the alternative, I was offered €4,000 in full and final settlement. I refused both"*.

The Provider has advised that its potential liability to the Complainant under her Employer's Group Income Protection Policy, which would be from 20 November 2016, when the deferred period expired, to 28 February 2017, when the Complainant ceased to be an employee and thus an insured person under the policy, would amount to €12,329.66.

The Complainant seeks for the Provider to admit her income protection claim and to pay *"compensation for stress as a result of* [its] *unnecessary delay in having my application process*[ed] *and being subject to an oppressive appeals process…*[and] *reimbursement of my legal fees to date...*[and] *my Consultant Psychiatrist fees"*. In this regard, the Complainant's Solicitor advised the Provider in its correspondence dated 11 January 2018 that it would be prepared to accept, strictly on a without prejudice basis, an offer of €15,000 gross, in full and final settlement of this matter.

The Complaint for Adjudication

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

/Cont'd…

The Provider's Case

Provider records indicate that the Complainant completed an income protection claim notification form on 14 November 2016, wherein she listed the exact nature of her condition as *"work related stress + anxiety"* and the date she had ceased working as *"19/05/2016"*.

In this regard, an income protection claim is paid where the policyholder meets the Group Income Protection Policy definition of disablement, as follows:

> *"Total disablement shall be deemed to exist where (a) the Insured Person is unable to carry out 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 on a full-time or part-time basis in any other occupation (whether or not for profit or reward or remuneration, including benefit in kind)"*.

The Provider states that it can only pay an income protection claim where this policy definition of disablement is met. As part of its assessment of her claim and in order to determine whether or not she met this policy definition of disablement, the Provider arranged for the Complainant to attend for an independent medical examination with Dr P. W., Consultant in General Adult Psychiatry, on 4 January 2017.

The ensuing report from Dr P. W. dated 4 January 2017 advised, among other things, that *"In* [the Complainant's] *case, legal and HR issues outweigh disabling psychiatric symptoms in preventing her returning to work"*. When commenting on her suitability for work from a medical perspective, Dr P. W. advised that the Complainant *"is fit to carry out all aspects of her role. She met with her Employer to try and resolve the matter as advised by her Occupational Health Department but this was unsuccessful. She felt she had no option but to pursue a legal case and has done so. A Court date has been set for the 30th January, to attempt to resolve her work problems"*. In relation to the question on her fitness for work, Dr P. W. stated, *"I feel* [the Complainant] *is fit to carry out her normal occupation"*.

In relation to her future prognosis, Dr P. W. commented that the Complainant's prognosis *"is related to her ability to resolve her work problems. If these are not resolved to her satisfaction she will need to let go and set new goals and plans for the future. These should include a return to work…She has placed things on hold until the outcome of her court case on the 30th January, but I feel it is in her interest to make future plans prior to then. Legal proceedings are often long processes and there is no guarantee that the matter will be resolved on 30th January. It is naturally disappointing for her the way in which she has been treated and even compensation or an apology at this stage is unlikely to repair the breach in trust with her employer"*.

The Provider states that it is satisfied that it was clear from Dr P. W.'s detailed assessment and report that the Complainant did not meet the policy definition of disablement and that she was medically fit to resume her normal occupation.

/Cont'd…

As a result, the Provider advised the Complainant by way of correspondence dated 6 February 2017 that it had declined her income protection claim as it had concluded that she was *"not currently totally disabled from following your normal occupation as required by the policy and you are fit to return to work"*. The Complainant was not in a position to resume work at that time as she was in dispute with her Employer with a court case pending, and her employment then ceased on 28 February 2017.

The Provider first received the Report from Dr D. G., a Specialist in Occupational Health with the occupational healthcare practice engaged by the Complainant's Employer dated 6 July 2016 wherein she concluded that the Complainant *"is unfit for work for the next 6 to 8 weeks"* and a later Report dated 10 November 2016 wherein she concluded that the Complainant *"remains unfit for work and I anticipate that she will be on sick leave for another 2-3 months"* in April 2017. The Provider was, around this time, in detailed correspondence with the Complainant's Solicitor, who was of the view that greater emphasis should be placed on these occupational health reports than the opinion of Dr P. W. but the Provider wrote to the Complainant's Solicitor in June 2017 confirming that it did not accept this view, particularly when one of these Reports was in relation to a consultation in June 2016 and the other from November 2016, some two months prior to Dr P. W.'s examination.

The Provider was notified in August 2017 that the Complainant would be appealing the claim declinature and submitting further evidence to support her appeal. The Provider agreed to extend the appeals deadline in order to allow for this additional medical information to be submitted. In this regard, the Complainant's Solicitor submitted a Report in November 2017 from Dr S. O'D., Consultant Psychiatrist, dated 21 November 2017, in support of her appeal. The Provider noted that despite Dr P. W.'s contemporaneous assessment of the Complainant on 4 January 2017, it was the opinion of Dr S. O'D. that the Complainant was unfit for work up until the date her employment ceased on 28 February 2017. Dr S. O'D. also provided some commentary on Dr P. W.'s detailed medical report and in arriving at his conclusion, seemed prepared to set aside Dr P. W.'s opinion in favour of an earlier occupational health report from Dr D. G., dated 10 November 2016.

In this regard, the Provider notes that Dr D. G. saw the Complainant before the expiry date of the policy deferred period, that is, on 20 November 2017. Dr D.G. recommended a further review in a couple of months' time, however no such further review took place. Instead, the only contemporaneous medical report available is that of Dr P. W. dated 4 January 2017, which concluded that the Complainant was at that time medically fit to resume her normal occupation. The Provider states that it therefore could not accept that this detailed, independent and contemporaneous report and opinion from a very experienced consultant psychiatrist should be set aside in a favour of a short occupational health report commissioned a few months earlier and before the Provider had any liability.

/Cont'd…

However, in light of Dr S. O'D's report and in order to give full consideration to her appeal, the Provider emailed the Complainant's Solicitor on 6 December 2017, as follows:

> *"I can confirm that we have now reviewed the report* [from Dr S. O'D.] *submitted in respect of* [the Complainant's] *appeal and note the opinion.*
>
> *However we have a contemporaneous opinion from a very experienced psychiatrist who formed the view at the time that* [the Complainant] *was medically fit to resume her normal occupation and that it was the ongoing work issues which were preventing a return to work.*
>
> *We therefore believe the opinion of* [Dr P. W.] *carries more weight than that of a psychiatrist who has assessed her a year later and is providing a retrospective opinion on her fitness or otherwise to work. However in the circumstances we are happy to arrange a further independent assessment to consider the position in full and we'll confirm the appointment details shortly.*
>
> *Alternatively and in order to resolve this matter, we would be prepared to make a without prejudice offer of €4,000 gross to* [the Complainant] *in full and final settlement of this claim. This payment would be subject to Tax/USC in the normal manner"*.

The Complainant declined both the offer to attend for a further independent assessment and the alternative offer of a settlement of €4,000 gross, subject to Tax, PRSI and USC.

As noted previously, the Provider was only first provided with the occupational health reports from Dr D. G. dated 6 July and 10 November 2016 in April 2017. It would not be standard practice some months after a decision is made on a claim to send copies of medical reports that pre-date the date the claimant attended for their independent assessment to that independent examiner for review. Instead, as it was still in the appeals process and as the Complainant had provided additional evidence in support of her appeal, the Provider offered to arrange for her to attend for a further independent medical examination. Had the Complainant been willing to attend for this further assessment, the Provider would have made available copies of all the medical reports, including those from Dr D. G., Dr P. W. and Dr S. O'D., to the new independent examiner for review.

The Provider states that the offer of a further independent examination remains open to the Complainant. In this regard, should she agree to attend and if the ensuing report was to also overrule the report of Dr P. W. and conclude that the Complainant was most likely unfit for work for the period in question, the Provider would admit her claim from the expiry of the deferred period, 20 November 2016, to the date her employment ceased on 28 February 2017.

/Cont'd…

Despite the fact that any such additional examination would be even further removed from this period, the Provider believes that in view of Dr S. O'D.'s commentary and in order to be fair to all parties, it would be appropriate to arrange a further independent medical examination to establish if it was appropriate as indicated by Dr S. O'D., that Dr P. W.'s contemporaneous opinion should be ignored for the purposes of determining fitness or otherwise for work during this period of absence. If this additional report was to express similar concerns in relation to Dr P. W.'s report as those voiced by Dr S. O'D. and was also of the view that it was likely that the Complainant was unfit for work during this period of absence, then the Provider would be happy to overturn its original decision and admit the Complainant's income protection claim for the full period in question.

The Provider does not accept the Complainant's contention that it delayed in assessing her claim. Section 12 of the Group Income Protection Policy states, *"Fully completed claim forms must be returned to the Company not later than 2 months prior to the end of the Deferred Period"*.

This allows for detailed investigations to be carried out before any payment may fall due. In this case, the completed claim forms were submitted on 14 November 2016, just 5 days before the expiry of the deferred period, as opposed to two months. The Provider wrote to the Complainant on 5 December 2016 confirming that a telephone consultation interview would take place the following week. It took place on 15 December 2016. The Complainant telephoned the Provider on 9 December 2016 enquiring as to the timeframe as she was hoping her claim would be sorted before Christmas. The Agent informed her that she was to have a telephone consultation interview the following week and that she would then likely have to attend for an independent examination thereafter, which would realistically be in January 2017. This took place on 4 January 2017. The Complainant was further advised that the Provider would have to await the results of this examination and then assess it. In this regard, the Complainant submitted her income protection claim on 14 November 2016 and was notified of the Provider's decision on 6 February 2017, some 12 weeks later.

In addition, the Provider does not accept the Complainant's contention that she was put through an onerous process during the assessment of her claim. As part of this assessment, the Complainant underwent a telephone interview and attended for an independent medical assessment, both of which would be considered very reasonable, standard investigations that an insurer needs to undertake to determine if an income protection claim can be paid in accordance with the policy definition of disablement. The Provider also does not accept that the appeals process was onerous. As part of her appeal assessment, the Provider offered to arrange for the Complainant to attend for a further independent medical assessment, but she declined to do so. It would be standard practice to arrange such assessment where the claimant has submitted further medical evidence in support of their appeal that disagrees with the independent medical evidence relied upon by the Provider in declining the claim.

Furthermore, the Provider does not accept the Complainant's contention that assigning a different Claims Assessor to her appeal from the one assigned to her initial claims assessment would be fairer.

/Cont'd…

The Provider states that it has robust processes in place for dealing with the declinature or appeal of a decision on a claim. Any decision to decline a claim is not made by the Claims Assessor handling the claim. In the Complainant's case, the Provider states that her claim was reviewed by a very experienced Senior Technical Specialist and the final decision not to admit her claim was made by a Technical Manager. Similarly, during an appeal, all decisions in terms of the handling of the appeal and the final decision on whether or not the appeal is upheld are not made by the Claims Assessor assigned to the claim. Again the Provider states that all such decisions are made by a very experienced Technical Specialist and/or a Technical Manager.

The Provider made a number of offers, on the record in an attempt to resolve the complaint.

As noted above, following receipt of the Report from Dr S. O'D., the Provider emailed the Complainant's Solicitor on 6 December 2017 offering to arrange for the Complainant to attend for a further independent assessment or the alternative offer of a settlement of €4,000 gross, subject to Tax, PRSI and USC.

The Complainant's Solicitor responded by email on 11 January 2018 advising that *"our instructions are that* [the Complainant] *will, on a strictly without prejudice basis accept a sum of €15,000.00 in full and final settlement"*. The Provider noted that this amount exceeds its total potential liability of €12,329.66.

An offer of €12, 690.48 which would be subject to Tax and USC in the normal way, plus €1,400 for the cost of the Appeal Report and an *ex gratia* payment of €750 was proposed to the Complainant. All of these offers were rejected by the Complainant.

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.

/Cont'd…

A Preliminary Decision was issued to the parties 20 August 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 receipt of my Preliminary Decision, the Provider pointed out under cover of its e-mail to this Office dated 21 August 2019 that there was a typographical error on Page 16 of my Preliminary Decision insofar as the figure quoted for the cost of the Appeal Report should have read **€1,400** (and not €14,000). The Complainant was notified accordingly and this figure has now been corrected in my Legally Binding Decision.

Following the issue of my Preliminary Decision, the parties made the following submissions:

1. Letter from the Provider to this Office dated 22 August 2019.

2. Letter from the Complainant's appointed solicitors to this Office dated 10 September 2019.

3. Letter from the Provider to this Office dated 18 September 2019.

4. Letter from the Complainant's solicitors to this Office dated 26 September 2019.

Copies of these additional submissions were exchanged between the parties.

The complaint at hand is that the Provider wrongly or unfairly declined the Complainant's income protection claim. In this regard, the Complainant was employed with her former Employer from May 2011 to February 2017. This Employer was the policyholder of a Group Income Protection Policy with the Provider and the Complainant, during her time as an employee, was an insured person under this policy.

Income protection claims, like all insurance policies, do not provide cover for every eventuality; rather the cover will be subject to the terms, conditions, endorsements and exclusions set out in the policy documentation. As a result, the Complainant must satisfy the policy definition of disablement in order to have a valid income protection claim.

In this regard, section 1, 'Disablement' of the Provisions, Conditions and Privileges document of the applicable Income Protection Plan provides, among other things, as follows:

> *"**1. Disablement** - For the purpose of this Policy*
>
> *(i) total disablement shall be deemed to exist where (a) the Insured Person is unable to carry out duties pertaining to his normal occupation by reason of disablement arising from bodily injury sustained or sickness or illness contracted and*

/Cont'd…

(b) the Insured Person is not engaging on a full-time or part-time basis in any other occupation (whether or not for profit or reward or remuneration, including benefit in kind)".

As a result, in order for an income protection claim to be payable, the claimant must satisfy this policy definition of disablement. In this instance, the Complainant must be unable to carry out her duties as a manager by reason of bodily injury or sickness or illness contracted.

I note from the documentary evidence before me that the Complainant completed an income protection claim notification form on 14 November 2016, wherein she listed the exact nature of her condition as *"work related stress + anxiety"* and the date that she had ceased working as *"19/05/2016"*.

I also note that the Complainant met with Dr D. G., a Specialist in Occupational Health with the occupational healthcare practice engaged by the Complainant's Employer, on 5 July 2016 and in her ensuing Report dated 6 July 2016 Dr D. G. advised, among other things, as follows:

"4.1 Diagnosis:

[The Complainant] *presents with a stress reaction. She outlines issues in the workplace. There is no evidence of additional personal stressors.*
[The Complainant] *does not have any major underlying mental or physical health problems. She demonstrates good insight and understanding of her symptoms and is engaged with appropriate treatment to ensure a good recovery. I believe she has a good prognosis for making a full recovery over the next 6 to 8 weeks.*

I agree with her doctor that [the Complainant] *would benefit from counselling. Please advise her if the employer is willing to sponsor the cost of 4 to 6 sessions of counselling as part of an employee assistance programme.*

4.2 Fitness for work:

In my opinion [the Complainant] *is unfit for work for next 6 to 8 weeks. In the interim* [the Complainant] *is fit to meet with her managers to address and resolve any work issues.*

Remaining on long term sick leave will not be good for [the Complainant's] *mental or physical health and hopefully matters can be resolved quickly to enable her to move forward and return to work.*

I am happy to review [the Complainant] *in 6-8 weeks' time or at any stage at your request to monitor her progress and give further advice on her fitness for work. Alternatively,* [the Complainant] *should submit a "fit note" from her GP confirming her fitness to resume work"*.

/Cont'd…

In addition, I note that the Complainant met again with Dr D. G. on 11 November 2016 and in her ensuing Report dated 16 November 2019 Dr D. G. advised, among other things, as follows:

> *"**1. Medical progress:***
>
> [The Complainant] *remains on sick leave certified by her doctor with work related stress and anxiety.*
>
> [The Complainant] *reports subjective symptoms which are not improving. Her medication has been increased. She availed of counselling as arranged by her GP and found this helpful.*
>
> [The Complainant] *is disappointed that the work situation has not resolved. Matters have been referred to The Work Relations Commission.*
>
> *Objectively* [the Complainant] *remains unwell and appears to have deteriorated.*
>
> ***2. Recommendations:***
>
> [The Complainant] *is unwell with stress related condition. She is under the care of her doctor and receiving appropriate medical care. I expect her to recover in due course.*
>
> *In my opinion* [the Complainant] *remains unfit for work and I anticipate that she will remain on sick leave for another 2-3 months.*
>
> *Realistically, I do not expect* [the Complainant] *to become fit for work until there is some resolution to the work situation. Returning to work is likely to provoke symptoms of acute stress and a mediated return to work may be appropriate in due course.*
>
> [The Complainant] *is medically fit to engage with her employee and other parties to address and resolve the work issues.*
>
> *I would like to review* [the Complainant] *in 2-3 months' time. Please arrange a follow up appointment".*

As part of its claim assessment, the Provider arranged for the Complainant to attend for an independent psychiatric assessment with Dr P. W., Consultant in General Adult Psychiatry, on 4 January 2017 and I note that in his ensuing Report dated 4 January 2017, Dr P. W. advises, among other things, as follows:

> *"**3.*** ***Symptoms that caused* [the Complainant] *to go off work***
>
> *3.1* [The Complainant] *was appointed CEO of* [the branch office] *in May 2011. In 2015, her* [business location] *merged with* [business location].

/Cont'd…

She felt this was a good move and had worked hard for the merger to take place…As part of the merger, she was to become the Deputy CEO of the new [business location] *based out of her office in [location].*

3.2 *Following the merger, the position of Deputy CEO never materialised. She felt unwanted and was excluded from Management Meetings. She found it difficult to meet with her CEO to discuss her position. In the end, she was offered in effect a demotion. At a meeting with her CEO in March 2016, she was told that the job as Deputy CEO was not going to be created.*

3.3 *By the time she took sick leave, she felt "stressed". She felt 'let down…lack of trust…I was not part of the organisation". She could not get a job description and said her job seemed to be "disappearing".*

Her sleep was poor. She felt "exhausted" during the day. She was ruminating constantly on the merger and blamed herself for her work situation.

3.4 *At home she was irritable. Her concentration was poor. Her family said she was "obsessed" with her job situation. In the end she found work "too stressful" and took sick leave. She has since passed her case on to a Solicitor who has initiated legal proceedings.*

4. Treatment

4.1 [The Complainant] *attended her G.P. prior to going on sick leave. She said "I knew I was in trouble" and her GP advised stress management techniques. She was also prescribed the anti-anxiety and anti-depressant medication Escitalopram.*

4.2 *She attended a Counsellor on one occasion. She did not find it helpful as she felt relaying her story did not help her address her problem.*

4.3 *Following an Occupational Health Assessment, further counselling was advised. It was also recommended that she engage with her Employer to resolve her work problems. She attempted this but was unsuccessful.*

4.4 *Her current medications are Escitalopram (she is unsure of her current dose) and a sleeping tablet which she takes three times a week.*

5. Current Symptoms

5.1 [The Complainant] *said she is "tired of it all". She would like to see an end to her legal case and wants to go back to work. Her sleep is poor and she frequently ruminates about her work situation. She blames herself for pushing through the merger and feels responsible, to a degree, for her work problems, She has feelings of guilt …*

/Cont'd…

5.2 …Her mood is low and anxious especially when she talks about work. She said "I am just obsessed with it (work)". Her energy is low.

5.3 …She is future orientated and not suicidal. She would like to return to work in the job she was promised as Deputy CEO. She felt better over the Christmas period when she had no contact from her legal term and was not ruminating about her work problems …

7. Work Issues

7.1 [The Complainant] *wants to return to work. She said "I am embarrassed by this, I don't want to be out sick".*

She would like to return to the job that was promised to her in the merger…She feels there has been a breach of trust with her employer and while she did not say she wanted financial compensation, she has engaged a Solicitor to try and resolve her work problems. A Court date has been set for [date] 2017.

7.2 On the advice of her Occupational Health Department, she arranged a meeting with her employer in October 2016. She was told again that the position of Deputy CEO would not be created. Her sick leave pay and her holiday leave have expired and she is not in receipt of pay from her Employer at present.

7.3 In terms of her legal case, she would like recognition that she did not do anything wrong in the merger…She is worried that friends and neighbours suspect her of a wrongdoing given that she is out of work. She would like her name cleared and said "I know they have wronged me and I want them to tell me that".

7.4 …Given how she feels she has been treated lately, she resents giving up family time for work reasons and has a degree of anger towards her Employer. Her back to work plan includes receiving an apology from her Employer and being offered the job she was promised.

Having said that, she would consider moving to a different [location] *given the breach of trust she feels has occurred …*

Conclusion

Q1 What is the exact diagnosis of the condition?

[The Complainant] *experienced anxiety and depressive symptoms in the context of work related problems.*

/Cont'd…

Her symptoms have persisted as her work problems remain unresolved. Her diagnosis is a Prolonger Adjustment Disorder …

Q4 ***Work issues appear to be a major contributor to the on-going absence. If these were resolved could*** **[the Complainant]** ***return to work and could she have returned before now?***

In [the Complainant]*'s case, legal and IR issues outweigh disabling psychiatric symptoms in preventing her returning to work. She would like acknowledgement from her Employer that she was wronged and would be able to return to work if the position she was promised was made available to her. She has a Court date set for the [date] 2017 to attempt to resolve the matter. From what* [the Complainant] *tells me, it would appear that her entire sick leave could have been avoided if the merger…had been conducted as agreed.*

If she had been appointed to the position that was promised to her as part of the merger then, I feel, she would not have taken sick leave in the first place.

Q5 ***From a medical perspective, what aspects of*** **[the Complainant]*'s role could she not perform and why? What goals are set around a return and what is being done to achieve this?***

[The Complainant] *is fit to carry out all aspects of her role. Her confidence has suffered as a result of her work situation but I feel this is something she will regain quickly upon he return to work. Similarly, her concentration has been affected as she is easily distracted by work problems. Again, this should improve quickly upon a return to work. She met with her Employer to try and resolve the matter as advised by her Occupational Health Department but this was unsuccessful. She felt she had no option but to pursue a legal case and has done so. A Court date has been set for [date], to attempt to resolve her work problems".*

Q6 ***In your opinion, is*** **[the Complainant]** ***currently fit to carry out her normal occupation?***

I feel [the Complainant] *is fit to carry out her normal occupation …*

Q8 ***What is the future prognosis of the condition?***

[The Complainant]*'s prognosis is related to her ability to resolve her work problems. If these are not resolved to her satisfaction she will need to let go and set new goals and plans for the future. These should include a return to work…She has placed things on hold until the outcome of her court case on [date], but I feel it is in her interest to make future plans prior to then.*

/Cont'd…

> *Legal proceedings are often long processes and there is no guarantee that the matter will be resolved on [date]. It is naturally disappointing for her the way in which she has been treated and even compensation or an apology at this stage is unlikely to repair the breach in trust with her employer"*.

I note that having assessed her claim, the Provider wrote to the Complainant on 6 February 2017, as follows:

> *"It is our opinion, based on the medical evidence received that you are not currently totally disabled from following your normal occupation as required by the policy and you are fit to return to work. I must advise therefore that we are unable to admit this claim.*
>
> *It is clear from the evidence that the issues between you and your employer are a major reason for the ongoing absence. I'm afraid that these issues cannot be a factor for us when considering a claim such as this"*.

I accept that it was not unreasonable for the Provider to conclude from the evidence before it that the Complainant did not satisfy the policy definition of disablement. As a result, I also accept that the Provider declined the Complainant's income protection claim in accordance with the terms and conditions of the Group Income Protection Policy.

I note that the Complainant ceased her employment with her Employer in February 2017 and thus from that date was no longer an insured person under the Group Income Protection Policy.

The Complainant appealed the Provider's decision to decline her income protection claim and in this regard her Solicitor submitted a Report in November 2017 from Dr S. O'D., Consultant Psychiatrist, dated 21 November 2017, in support of her appeal. As would be typical as part of an income protection appeals process, I note that the Provider offered to arrange for the Complainant to attend for a further independent medical assessment, but the Complainant declined this offer. In this regard, section 11, 'Provision of Evidence Tests and information - Claims' of the Provisions, Conditions and Privileges document of the applicable Income Protection Plan provides, among other things, as follows:

> *"(ii) The Insured Person as often as is required by the Company shall submit to medical examination, psychiatric assessment, assessment by an occupational therapist or any other medical or other assessment or tests to include the taking and testing of blood, urine or other samples"*.

I believe it was not helpful that the Complainant declined to attend for this assessment.

By declining to attend for a further independent medical assessment, the Complainant failed to engage fully in the appeals process.

/Cont'd…

In this regard, I note that the Complainant submits that *"*[the Provider] *put me through two some (sic) incredible onerous processes. The first being the application for Income Protection* [that is, the claim] *and the second, the appeal"*.

I have not been supplied with any evidence that demonstrates that the Provider's income protection claim application process was onerous and I accept that in arranging for the Complainant to attend for an independent medical examination as part of its claim assessment that the Provider was assessing her income protection claim in accordance with the terms and conditions of the Group Income Protection Policy. Similarly, I have not been provided with evidence that the Provider's claim appeals process was onerous and I accept that in offering to arrange for the Complainant to attend for a medical examination as part of her appeal assessment that the Provider was seeking to assess her appeal in accordance with the terms and conditions of the Group Income Protection Policy.

In addition, I note that the Complainant considers that there was significant delay in the Provider assessing her claim insofar that she states, *"My application was submitted on the 14th November 2016, ahead of the commencement date of the 20th November 2016, but the decision regarding my application was not communicated until the 6th February 2017"*.

In this regard, I note that Section 12, 'Claim Procedure', of the Group Income Protection Policy states, among other things, as follows:

> *"Fully completed claim forms must be returned to the Company not later than 2 months prior to the end of the Deferred Period"*.

I accept that this two month timeframe allows the Provider the time necessary to carry out claim assessments before any payments may fall due. In this instance, I note from the documentary evidence before me that the completed claim forms were submitted on 14 November 2016, just 5 days before the expiry of the deferred period, as opposed to two months. As a result, in declining her claim on 6 February 2017, I do not consider that the Provider unduly delayed in assessing the Complainant's income protection claim.

The Complainant has stated that *"*[Mr N. H.] *Claims Assessor, Income Protection Claims was party to my Income Protection Application decision and also a party to the decision of my appeal. I believe this is a flawed process by having the same person making the initial decision and again involving themselves in the appeal limb of the process"*. In this regard, I note the Provider's position that any decision to decline a claim in the first instance or a subsequent appeal is not made by the Claims Assessor handling the claim, rather it would appear that the Claims Assessor performs a more administrative function in the processing the claim. In this regard, the Provider has advised that all such claim and appeal decisions are made by an expert Technical Specialist and/or a Technical Manager.

A number of offers were made by the Provider in an attempt to resolve the complaint. All of these offers were rejected by the Complainant. The latest offer was made by the Provider on 28 May 2019. When this offer was rejected by the Complainant, the Provider withdrew it and left its offer of 17 January 2019 available to the Complainant.

/Cont'd…

This offer comprises €12,690.48 which would be subject to Tax and USC in the normal way, €1,400 for the cost of the Appeal Report, together with an additional *ex gratia* payment of €750.

Given that I accept that the Provider assessed and declined the Complainant's income protection claim in accordance with the terms and conditions of the Group Income Protection Policy of which she was an insured person, I consider this offer to be reasonable in the circumstances.

On the basis that the offer remains available to the Complainant and for the reasons set out above, I do not uphold this complaint.

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.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

23 October 2019

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.**