An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0018
Sector:	Insurance
Product / Service:	Income Protection and Permanent Health
Conduct(s) complained of:	Rejection of claim - fit to return to work
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint arises following the Provider's cessation of payments made under an income protection policy held by the Complainant.

The complaint is that the Provider wrongfully terminated the Complainant's income protection policy claim in January 2017, and subsequently did not take into consideration the Complainant's main employment duties during a review process.

The Complainant's Case

The Complainant's income protection policy held with the Provider was incepted on **22 July 2014** and the Complainant was employed as a medical secretary. The Complainant submitted a claim form dated **3 March 2016** and the Provider made payments to the Complainant under the policy from **5 March 2016 to 6 January 2017.** The Provider ceased payment of the Complainant's claim on **6 January 2017**.

The Complainant states that the Provider has,

> *"refused to reinstate my benefit because my job description was mostly sitting down action".*

The Complainant agrees her role was mostly sitting, but states that this refers to keyboard duties,

> *"keyboard duties represented 95% of my working day and is the predominant source of my ongoing disability".*

The Complainant states that her continuing difficulties were corroborated by an Orthopaedic Surgeon's report which states that her ongoing issues and pain are aggravated particularly by sitting and using a computer. That surgeon, Dr KK, wrote on the 10th June 2016, "That a prognosis is difficult to give with certainty. I would hope that [the Complainant] will be able to return to work ultimately."

The Complainant states that she requested early retirement on the grounds of ill-health but was told that this would not be an option unless she was prepared to undergo surgery on her shoulder. The Complainant was advised by her orthopaedic surgeon that her degenerative disc disease, "Could be managed non-operatively."

The Complainant states that the Provider has wrongfully terminated her income protection policy claim without taking into account the Complainant's main work responsibilities, which consisted of keyboard duties, and instead has listed a series of tasks, which an assessor during the course of a Functional Capacity Evaluation (FCE) deemed she was capable of, but which the Complainant states did not reflect her working day.

The Complainant had been assessed by a doctor at a medical examination on the **19 May 2016**. Dr FG stated:

> *"She is predominantly engaged with typing up letters and reports…. She reports that 95% of her role is keyboard data input and mouse use; seven hours of regular typing daily.*
>
> *Occupational Plan states, 'she could never return to the same amount of typing and PC work she did previously.' 'She has the use of an orthopaedic chair at work and has had ergonomic assessments of her station carried out.'*
>
> *Impression: 'In my opinion she is not fit for work currently as her neck and upper limb symptoms are too active. I do not believe she could tolerate the duties involved as yet.' 'It is possible that she could resume work if her neck symptoms improve perhaps in a modified form with a reduction in static typing and a change to a more flexible role…."*

The Complainant states that the assessor was not aware of the contents of the job description provided by the employer and she rejects the Provider's decision to cancel benefit payments, based on her being fit for her job.

The Complainant states she received a letter dated **3 January 2017** from the Provider advising that her benefit had been terminated following a review of the medical evidence.

The Complainant wrote to the Provider on **4 January 2017** stating that she had received a notification from her Consultant Orthopaedic Surgeon advising that the Provider had

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requested that she attend the Orthopaedic Surgeon to obtain an updated report on her current symptoms.

The Complainant states that due to ill health this appointment was re-scheduled to **10 January 2017**. In her letter, the Complainant sought further information from the Provider on its decision to terminate her benefit without first receiving an updated report from the Orthopaedic Surgeon.

The Complainant received a letter in response dated **10 January 2017** whereby the Provider set out its reasons for terminating payment of benefit.

> *"As we had not received an update from the Consultant Orthopaedic Surgeon at that time, our Chief Medical Officer reviewed all the medical evidence we had received to date and felt we had sufficient information to make a decision".*
>
> *"… As is our usual practice, should you wish to submit a report from the Consultant Orthopaedic Surgeon, which might support your claim, we would be happy to review the matter".*

The Complainant wrote to the Provider on **11 January 2017** in relation to the termination of her benefit. The Complainant sought clarification in relation to the decision to terminate her benefit without obtaining an updated report from her Consultant Orthopaedic Surgeon.

The Complainant received a letter from the Provider dated **20 January 2017.** The Provider advised the Complainant that:

> *"We note from the medical evidence received that you had not attended for a consultation with the Consultant Orthopaedic Surgeon since February 2016…"*
>
> *"Our Chief Medical Officer reviewed all the medical evidence we had received to date and felt we had sufficient information to make a decision on your claim…"*
>
> *"Following this review, he has confirmed, that based on the medical evidence available, that he is unable to consider that you are continuing to suffer a Period of Disability, which requires you to be totally unable to follow your normal occupation".*

The Complainant seeks for the Provider to reinstate payments of benefits in respect of her income protection policy.

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

The Provider states that the income protection policy held by the Complainant is a voluntary group protection scheme and the Complainant is a member of that scheme.

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A claim form dated **3 March 2016** was submitted by the Complainant. The Provider states that it paid an income protection claim from **5 March 2016 to 6 January 2017.** The Provider states that upon review of the claim, it stopped paying the benefit from **6 January 2017**.

The Provider states that the Complainant has not worked since **December 2015** and she took early retirement from her employer in 2016.

The Provider states that it ceased paying the claim based upon the medical file which included reports from a General Practitioner, an Occupational Health Specialist and an Orthopaedic Surgeon.

Following its decision to terminate the Complainant's benefit, the Provider agreed to review the claim at the request of the Complainant. As the Provider had not received an updated report from the Complainant's Consultant Orthopaedic Surgeon, it wrote a letter to the Surgeon dated **12 April 2017** which states among other things:

> *"Benefit is payable for as long as she is determined to be: 'Totally unable by reason of sickness or accident to follow the occupation of Medical Secretary".*
>
> *"…We are reviewing the file and our Chief Medical Officer would appreciate as comprehensive a report as possible at our expense, to provide the details of the Complainant's illness..."*

In response, the Provider received a report from the Consultant Orthopaedic Surgeon dated **13 June 2017**. In it, the Doctor stated,

> *"The prognosis is difficult to give, the Complainant has ongoing problems and they relate mainly to the cervical spine at this stage. I would not advise any surgical intervention for this but whether it can be resolved non-operatively is difficult to say as the symptoms are ongoing for some time now."*

This report does not state whether or not the Complainant is able to work in any capacity as a consequence of her condition. The Provider states that the criteria for a valid claim under the group policy scheme are set out in the policy definition of *'Period of Disability'.* The definition under 1.2.11 Period of Disability is:

> *"A period throughout which the Member is totally unable to carry out his/her Normal Occupation due to a recognised illness or accident and…"*

Section 3.6 *'Identifiable and Recognised Medical Cause'* states that benefit will not be payable where an identifiable and recognised medical cause does not exist.

Section 4.1 *'Disability Benefit'* states:

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"Disability Benefit will be payable from the end of the Deferred Period if, in Our opinion, having regard to all the information available to it, the Member is suffering for a Period of Disability, as defined in these Conditions.

We will continue to pay benefit until:

1) *The Member, in Our Opinion, having regard to all of the information available to it, is no longer suffering a Period of Disability".*

The Provider states that the medical file did not support a proportionate benefit claim under Section 4.2 as the Complainant was deemed fit to return to normal duties, as set out in the subsequent CMO case review dated **7 September 2018.**

The Provider states that the Complainant does not meet the policy criteria for a valid claim based upon the medical file provided when assessed under the group policy terms and conditions.

The Complaints for Adjudication

The complaint is that the Provider wrongfully terminated the Complainant's income protection policy claim and subsequently did not take into consideration the Complainant's main employment duties during the review process.

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 12 August 2019, outlining my preliminary determination 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

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

1. Letter from the Provider to this Office dated 30 August 2019.
2. Letter from the Complainant to this Office dated 11 September 2019.
3. Letter from the Provider to this Office dated 27 September 2019.
4. Letter from the Complainant to this Office dated 9 October 2019.
5. Letter from the Provider to this Office dated 14 October 2019.
6. Letter from the Complainant to this Office dated 18 October 2019.
7. Letter from the Provider to this Office dated 1 November 2019.
8. Letter from the Complainant to this Office dated 5 November 2019.

Copies of the above submissions were exchanged between the parties.

Having considered these additional submissions and all of the submissions and evidence furnished to this Office, I set out below my final determination.

The Complainant notes in her post Preliminary Decision submissions that the incorrect email address has been used by the Provider multiple times. The Provider has stated that this has since been brought to the Data Protection Commissioner's attention.

This is not a matter on which this Office can adjudicate.

The Complainant submitted a claim under her income protection policy in **March 2016** as she was unable to attend work due to a disc degenerative disease. The Complainant had received a weekly benefit payment under the policy of €179.52.

In **October 2016**, the Provider commenced a review of the Complainant's benefit payments. The Provider spoke to the Complainant who advised that she did not qualify for Ill-Health Early Retirement "IHER".

The Complainant took early retirement. I note from the documentary evidence, taken from the [internal notes] dated **17 October 2016**, that the Provider thought that this

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"…seems a bit strange that she has retired but didn't qualify for IHER obviously her condition is not of such severity that she satisfies the definition for IHER".

I believe this comment to be inappropriate since the role of the provider is to assess whether or not the complaint meets the criteria set out in its policy. Any other assessment is not relevant.

The Provider arranged for the Complainant to attend a Medical Evaluation. I note from the report of the Medical Evaluation dated **18 November 2016**, it is the opinion of the doctor that:

"Overall there appears to be both subjective and objective evidence of improvement in her wellbeing. She still has persistent residual pain affecting her neck, upper back and across her shoulders. The pain is exacerbated by prolonged static postures such as on a computer or laptop…….She has been discharged from physiotherapy. She was last with her GP availing of medical input for her symptoms in August 2016.

The doctor [FG] goes on to list daily activities such as driving and managing the household or walking the dog which the Complainant could undertake.

"She was involved in a community based project contributing her time and some PC work. She can tolerate up to one hour on the laptop before her symptoms might emerge."

The Complainant is no longer totally disabled from working life and no longer meets the definition of total disablement".

The review by the Chief Medical Officer of the Provider, dated **20 December 2016**, states that the Complainant was:

"No longer in the care of her consultant and has not been seen by her GP in relation to this condition since August 2016. Sent her for an IME which has advised that [she] has improved in terms of her symptom profile. She has some residual pain after prolonged static neck postures and expect this would be overcome in context of working life in low risk office based role with ergonomic support simple modifications to her working practice and regular micro break to stretch mobilise and exercise.

Doctor feels no longer totally disabled from working life and no longer meets the definition of total disablement. Based on evidence I feel no longer satisfies our definition of being totally disabled. Recommend paying one further months benefit and ceasing claim".

Following this report, the Provider took the decision to terminate the claim on **January 6** 2017 although it had indicated its intention to pay a final month's benefit in its letter of **3 January**, "*We are willing to pay a further months benefit in order to finalise the claim*".

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It would appear that decision was based on the three separate assessments by Dr KK, the Consultant Orthopaedic Surgeon, on **18 January** and **23 February** and also **10 June 2016** as well as reports by Doctor FG who was retained to complete a medical examination by the Provider on the **26 May 2016** and to review its findings on **18 November 2016**.

There is also a report from the Complainant's GP, doctor GC, dated **14 November 2016**. I note that this was the only medical report which deemed the Complainant to be totally unable to work,

> "*She remains total [sic.] disabled*."

The other medical assessments available at the time of the review did not support the GP's view. The surgeon's reports suggested the Complainant was improving and the medical examination by Doctor FG, an occupational health specialist, on **19 May, 2016** stated:

> *'Her MRI confirmed multi-level degenerative disc disease with C4/5, C5/6 and C6/7 levels being the most affected. Occupational Plans states, 'she could never return to the same amount of typing and PC work she did previously.' 'She has the use of an orthopaedic chair at work and has had ergonomic assessments of her station carried out.' Impression: 'In my opinion she is not fit for work currently as her neck and upper limb symptoms are too active. I do not believe she could tolerate the duties involved as yet' 'It is possible that she could resume work if her neck symptoms improve perhaps in a modified role with a reduction in static typing and a change to a more flexible role.'*

The second examination by Doctor FG on the **15 November 2016**, stated:

> *'Review to offer updated opinion on her current health status and fitness for work, to ascertain if the claimant remains totally unable by reason of sickness or illness to carry out their occupation.' '[The Complainant] tells me she has retired from working life on a reduced pension. She sought but did not meet the medical criteria for early retirement on the grounds of ill-health'.*
>
> *Opinion; 'In my opinion [the Complainant] is no longer totally disabled from working life and no longer meets the definition of total disablement.'*

The CMO review from the **20 December 2016** stated:

> *'Claimant has taken early retirement however did not satisfy the IHER criteria so took reduced pension. No longer in care of her consultant and has not been seen by her GP in relation to this condition since August 2016. Sent her for IME which has advised that has improved in terms of her symptom profile.*

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She has some residual pain after prolonged static neck postures and expect this would be overcome in context of working life in low risk office based role with ergonomic support simple modifications to her working practice and regular micro break to stretch mobilise and exercise.'

Doctor feels no longer totally disabled from working life and no longer meets the definition of total disablement. Based on evidence I feel no longer satisfies our definition of being totally disabled. Recommend paying one further months benefit and ceasing claim'.

I note from the documentary evidence that the Complainant wrote to the Provider to query why the Provider had terminated the claim without having received an updated report from the Consultant Orthopaedic Surgeon. The Provider agreed that it would review its decision if it received an updated report from the Consultant.

I note from the submissions that the Provider had requested that the Complainant be re-assessed by the orthopaedic surgeon following its review. The scheduled appointment was cancelled on the **22 November 2016** by the consultant. The postponed appointment was then cancelled by the Complainant as she had a chest infection on **13 December 2016**. In the absence of any input from the orthopaedic surgeon, the Chief Medical Officer conducted a review on the **20 December**. At that time a third appointment had been made for **10 January 2017**.

I accept that the Provider was unaware of the planned appointment for the **10 January** at the time of the review and the subsequent discontinuation of the claim. The Complainant then cancelled the appointment set for the **10 January** after receiving the termination of claim letter.

On the **16 June 2017**, the Complainant's GP, Doctor GC, wrote:

'[The Complainant] continues to experience unacceptable degrees of chronic pain and remains unfit to go back to work as a secretary. She has received an up to date expert opinion from Dr KK, consultant orthopaedic surgeon, which confirms this.'

I note that the report from the consultant does not say that she was unfit to work in any capacity.

On **17 June 2017**, the orthopaedic surgeon, Dr KK, submitted an updated report to the Provider, based on an assessment conducted on the 13th June. The report states:

"She tells me she has been involved in a community group locally and has developed severe and what she describes as excruciating pain in using a computer or keyboard while doing that voluntary work. She tells me she could not function at a medical centre and this is the reason for her inability to do her work."

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> *"The prognosis is difficult to give. The Complainant has ongoing problems and relate mainly to the cervical spine at this stage. I would not advise any surgical intervention for this but whether it can be resolved non-operatively is difficult to say as the symptoms are ongoing for some time now".*

Following receipt of this updated report, the Provider, through a recommendation from its Chief Medical Officer dated **17 July 2017**, decided to obtain an objective assessment of capacity/ability from a functional capacity evaluation (FCE). I note that the purpose of such an assessment is to obtain an objective perspective on what an individual can or cannot safely do, with reference to the essential components of their job.

That assessment was done over two days, **24 and 25 July**. The Complainant provided her job description at the evaluation as the Provider was waiting for an official job description from the Complainant's employer.

A summary of the FCE report is as follows,

> *"[The Complainant] is not fit for the reaching and turning aspects of her job at this time. She is fit for all other aspects of her job. She is reluctant to use her left hand in any capacity….She would benefit from rehabilitation at this point to get her to start using her arm again. This could see her quickly fit to return to work."*

The Provider sought clarification from the FCE on the **22 August, 2017**. It questioned the implications of the statement that '[The Complainant] is not fit for reaching and turning aspects of her job at this time.' The Provider refers to the medical report by Dr FG that [The Complainant]'s role involves 'seven hours of typing daily'.

> *"Can you please clarify what are the turning and reaching aspects of [The Complainant's] job as … a secretary?"*

On the **26 October 2017,** the Complainant's employer provided a job description of her role to the Provider. I note that it states her role was clerical support to a team in the [Employer]. The main activities were described as Dictaphone typing with foot pedals and sitting while using a keyboard, standing, bending and lifting.

I note that following receipt of the job description from the Complainant's employer, the Functional Capacity Evaluator wrote to the Provider on **10 January 2018** as follows:

> *"…this would suggest the Complainant's job was mostly sitting. There is occasional standing, bending and lifting of files (weight negligible), the building is 2 storey but the Complainant worked on the ground floor, so no climbing of stairs. There is no overhead lifting, kneeling, crawling, climbing ladders, balancing or crouching…*
>
> *…Based on this job description the Complainant is fit for her job".*

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On **12 December 2017** the Chief Medical Officer, Dr PH, for the Provider, wrote that the Complainant was:

> *"Fit for essential job components', 'Not totally disabled by virtue of identified restrictions'* and that the Provider should *'Maintain [the] decision."*

The Complainant's GP supported the view that her disability precluded her working, the orthopaedic surgeon's reports were optimistic about a long term recovery but did not state that she was totally disabled from working. The report from the Medical Examination on **16th June, 2017** stated that she was, "*Not fit for work currently*". The Examination from **November** stated she was. "*No longer totally disabled from working life*".

The review by the Provider's Chief Medical Officer concluded that she was:

> *"Fit for essential job components', 'Not totally disabled by virtue of identified restrictions'* and that the Provider should *'Maintain [the] decision."*

The medical evidence I have been presented with includes conflicting opinions. It is not the function of this Office to adjudicate on or second guess any medical evidence or opinion. Nor is it the role of this Office to offer an opinion as to the Complainant's ability to work or otherwise. My role is to decide if the Provider's conduct in assessing the claim and its decisions were fair and reasonable given the information it had available when it made the decision to cease paying benefits under the policy.

I note the unfortunate circumstances of the two cancelled appointments in November and December 2016, with the Consultant Orthopaedic Surgeon, Dr KK. I note that the Provider was unaware of the re-scheduled appointment in January when it made the decision to cancel the benefit. I believe it was unreasonable that the Provider did not clarify the reason for the lack of a recent report form Dr KK, before terminating the benefits of the policy. The Complainant had been directed to re-attend the orthopaedic surgeon by the Provider. The termination of the benefit when, from the Complainant's perspective, the appointment was imminent, could have been avoided.

As I have stated above, my role is to decide whether the conduct of the provider, in deciding to terminate the benefit under the policy was reasonable. Having considered all the evidence and submissions I believe the Provider's decision to terminate the benefit was not reasonable in all the circumstances.

In arriving at this conclusion I have taken note in particular of the following: On **19 May 2016,** Dr FG stated, " *it is possible that she could resume work if her neck symptoms improve perhaps in a modified role with a reduction in static typing and a change to a more flexible role."*

I am particularly concerned by the reasons given by the Provider for terminating the payment of benefit in the absence of the orthopaedic surgeon's opinion which it had sought.

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I note that having ceased paying benefits on **6 January 2017,** it stated in correspondence dated **10 January 2017,**

> *"As we had not received an update from the Consultant Orthopaedic Surgeon at that time, our Chief Medical Officer reviewed all the medical evidence we had received to date and felt we had sufficient information to make a decision".*

In a further letter from the Provider to the Complainant dated **20 January 2017** the Provider stated,

> *"We note from the medical evidence received that you had not attended for a consultation with the Consultant Orthopaedic Surgeon since February 2016…"*
>
> *"Our Chief Medical Officer reviewed all the medical evidence we had received to date and felt we had sufficient information to make a decision on your claim…"*
>
> *"Following this review, he has confirmed, that based on the medical evidence available, that he is unable to consider that you are continuing to suffer a Period of Disability, which requires you to be totally unable to follow your normal occupation".*

It is most unfortunate and unreasonable that the Provider took this course of action when a re-scheduled appointment had been made for the Complainant to attend the orthopaedic surgeon on **10 January 2017.**

While the report of the Medical Evaluation carried out on **18 November** states,

> *"The Complainant is no longer totally disabled from working life and no longer meets the definition of total disablement".*

It also states,

> *"The pain is exacerbated by prolonged static postures such as on a computer or laptop".*

It is not disputed that the Complainant's role was mainly static involving the use of a computer. In an assessment from **15 November 2016** Doctor FG wrote,

> *"She has some residual pain after prolonged static neck postures and expect this could be overcome and managed in the context of working life in a low risk office based desk role with ergonomic support simple modifications to her working practice and regular micro break to stretch mobilise and exercise and alternative duties to allow for versatility."*

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The Chief Medical Officer of the Provider quoted that assessment on **20 December 2016** and went on to state;

> *"Based on evidence I feel [sic] no longer satisfies our definition of being totally disabled. Recommend paying one further months benefit and ceasing claim".*

Dr FG in a report dated **26 May 2016** in relation to an assessment undertaken on **19 May 2016** wrote:

> *"Occupational Plan states, 'she could never return to the same amount of typing and PC work she did previously.' "*

This report goes on to state,

> *"It is possible that she could resume work if her neck symptoms improve perhaps in a modified form with a reduction in static typing and a change to a more flexible role."*
>
> *'In my opinion [the Complainant] is no longer totally disabled from working life and no longer meets the definition of total disablement.'*

I note the CMO referral form dated **20 December 2016,**

> "*Claimant has taken early retirement however did not satisfy the IHER criteria so took reduced pension."*
>
> *No longer in care of her consultant and hasn't been seen by her GP in relation to this condition since August 2016.*
>
> *Sent her for IME which advised that [sic] has improved her symptom profile. She has some residual pain after prolonged static neck postures and expect this would be overcome and managed in context of working life in low risk office based role with ergonomic support simple modifications to her working practice and regular micro break to stretch mobilise and exercise.*
>
> *Dr feels no longer totally disabled from working life and no longer meets the definition of total disablement.*
>
> *Based on evidence, I feel no longer satisfies our definition of being totally disabled. Recommend paying one further month's benefit and ceasing claim."*

Having considered all of the evidence it is my view that sufficient consideration was not given to the various reports and aspects of reports which indicated that the Complainant would have difficulty performing certain tasks which made up part of her work.

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The Provider advised the Complainant's GP on **11 March 2016**, that it, "*recognised the grey area between total disability and full recovery in that benefit does not cease if a return to work is attempted*." By June of that year, the Complainant had applied for ill-health early retirement but was ineligible. Since she took early retirement, a return to work was not attempted and therefore a period of proportionate benefit could not be offered. The Provider's Chief Medical Officer states, in the review of **7 August 2018**, that it was considered at the claim and review stages but that without an attempt to return to work it was not an option.

However in her review she states, "*We supported an additional one month benefit from when the claim was ceased to encourage a phased return to work but this did not happen*". I have not been presented with any evidence which demonstrates that the Provider made any effort to support the Complainant with a phased return to work.

The Provider has stated that the medical file did not support a proportionate benefit claim as the Complainant was fit to return to normal duties. I am not satisfied that the evidence supports this assertion.

I stated in my Preliminary Decision that:

> "*It appears to me that the Provider placed far too much emphasis and consideration on the fact that the Complainant had retired from her job for ill-health reasons but had not been approved for early retirement on the grounds of that ill-health. I believe this should not have played any part in the assessment or in any way influenced the decision of the Provider*".

The Provider, in its post Preliminary Decision submission dated 30 August 2019, has stated that: *"from a review of the Provider's file that [sic] there is no evidence to support the contention that the Provider placed too great an emphasis on the fact that the Complainant had not been approved for ill health retirement in deciding to decline the claim."*

I remain of the view that it was inappropriate for the Provider to comment or make reference to the fact that the Complainant could not qualify for Ill-Health Early Retirement.

The fact that the Complainant is the party that informed it that she could not qualify for Ill-Health Retirement unless she opted for surgery, does not mitigate that it was inappropriate to state:

> *"…seems a bit strange that she has retired but didn't qualify for IHER obviously her condition is not of such severity that she satisfies the definition for IHER".*

I also believe it is significant that this fact was mentioned in the Provider's Chief Medical Officers referral.

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The Provider asserts in its post Preliminary Decision submission that it was mentioned at the start solely as background information and was not used in an assessment. I believe the results of the IHER were not relevant to the Provider's assessment yet it was still mentioned by the Provider on two occasions.

The Provider, in its post Preliminary Decision submission dated 30 August 2019 argues that I made an error in fact and law in my Preliminary Decision by interpreting the medical evidence in the complaint.

The Provider has stated throughout its submission that I have:

"…made an adjudication on the medical evidence..."

And that it is:

> *"Respectfully submitted that the Ombudsman has, in error, sought to second guess the medical evidence available to the Provider as of January 2017 in directing the reinstatement of benefit".*

The Provider has stated that:

> *"The Ombudsman has made an assessment of the medical evidence in order to establish the position that it was not reasonable for the Provider to form the opinion that the Complainant was no longer totally unable to carry out her normal occupation".*

The Provider ends its submission dated 30 August 2019 with the statement:

> *"In all circumstances it is submitted that the Decision does not provide a legal basis for the reinstatement of the claim. The Ombudsman is respectfully requested to consider this submission prior to issuing a Legally Binding Decision".*

I have considered tis submission and all the submissions and evidence in arriving at my Decision.

In coming to the conclusion that *"the Provider's decision to terminate the benefit was not reasonable…"* I did not adjudicate on or make an assessment on the medical evidence "*in order to establish the position…"* as the Provider has asserted.

In my Preliminary Decision and in the Legally Binding Decision I have stated that:

> *"The medical evidence I have been presented with includes conflicting opinions. It is not the function of this Office to adjudicate on or second guess any medical evidence or opinion. Nor is it the role of this Office to offer an opinion as to the Complainant's ability to work or otherwise.*

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My role is to decide if the Provider's conduct is assessing the claim and its decisions were fair and reasonable given the information it had available when it made the decision to cease paying benefits under the policy".

For the reasons set out above I do not believe it was reasonable for the Provider to cease payment of benefit to the Complainant when it did.

I uphold this complaint and direct the Provider to admit the claim in the usual manner and pay it from **6 January 2017.** It is open to the Provider to re-assess the claim at any future date in line with the policy terms and conditions.

Conclusion

My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is upheld, on the grounds prescribed in ***Section 60(2) (b) and (g).***

Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to rectify the conduct complained of by admitting the claim in the usual manner and paying it from **6 January 2017**.

The Provider is also required to comply with ***Section 60(8)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.***

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

10 January 2020

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—

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(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.