Decision Ref: 2021-0536

Sector: Insurance

Product / Service: Income Protection and Permanent Health

Conduct(s) complained of: Disagreement regarding Medical evidence submitted

Outcome: Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant became a member of an **Income Continuance Scheme** on **1 December 2017**, when she commenced employment with her Employer, the Policyholder of the Scheme. The Policyholder engages the services of a financial services firm to act as Scheme Administrator.

The Provider is the Insurer of the Scheme, responsible for the underwriting of applications for cover and assessing claims. This complaint concerns the Provider's decision to withdraw the Complainant's income continuance claim due to lack of medical evidence in support of the claim.

The Complainant's Case

The Complainant, a [occupation] was certified as unfit to work from **13 April 2018**. The Complainant completed an **Employee Claim Form** to the Provider on **13 August 2018** wherein she detailed the exact nature of the incapacity with which she was suffering from as *"Anxiety"*.

The Complainant furnished the Provider with the following medical records relating to her illness:

- Report from her employer's occupational health provider dated **13 April 2018**
- Medical Certificates from Medical Centre 1 dated **30 April** and **21 May 2018**

- Report from her employer's occupational health provider dated **27 July 2018**
- Medical Certificates from Medical Centre 2 dated **7 August** and **15 August 2018.**

The Complainant says the Provider did not accept this medical evidence and that in its **Final Response Letter** to her dated **19 February 2020**, the Provider confirmed to her that it had withdrawn her income continuance claim due to a lack of medical evidence.

The Complainant sets out her complaint in the **Complaint Form** she completed, as follows:

> *"I joined the* [**Income Continuance Scheme**] *as part of the compulsory requirement of the university. We are deducted the tariff from our salary. I was assessed as unfit for work by* [my employer's occupational health provider] *in April 2018. I was signed off. I could not recover from the condition when I reached the maximum permissible time-off by* [my employer's] *regulations (six months). After discussing with the human resources department, we reach a decision that I should resign from my position (in August 2018). I was referred by the human resources to submit a claim with the income continuation plan in July 2018.* [The Provider] *considered my claim as bogus, because they considered that I resigned quickly after the claim.* [The Provider] *did not consider that I was ill for nearly half-year. One of* [the Provider's] *argument is that they do not consider the assessment of the doctors from* [my employer's occupational health provider] *as medical evidence … I feel that my claim was unfairly dismissed"*.

The Complainant acknowledges that at the time she was absent from work she did not have a regular GP as she had only recently moved to Ireland to take up her job, nor had she attended a specialist in relation to her illness.

Nevertheless, the Complainant questions why the Provider will not accept the medical reports provided by her employer's occupational health provider and the medical certificates provided by Medical Centre 1 and Medical Centre 2, as sufficient evidence in support of her income continuance claim. In that regard, in her email to this Office on **23 March 2020**, the Complainant submits:

> *"I was assessed by* [my employer's occupational health provider] *from April to July a few times. I was a newly* [immigrant] *to Ireland. I could not think properly during that time. I could only follow the instruction of the human resources. For me, it is totally incomprehensible. The doctors who signed me off are not the doctors who have legal status. I did not see the GP for a few weeks, because I did not find him useful. I was seeing a* [counsellor]. *I decided to see another doctor in July* [2018], *because I had a panic attack".*

The Complainant seeks for the Provider to admit her income continuance claim and in that regard, in the **Complaint Form** she completed, the Complainant says:

> *"*[The Provider] *should consider the evidence of* [my employer's occupational health provider] *and compensate me to accord with the policy"*.

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The Provider's Case

The Provider says that the Complainant became a member of a voluntary **Income Continuance Scheme** on **1 December 2017**, when she commenced employment with the Policyholder.

On **26 July 2018**, the Scheme Administrator submitted a completed **Employer Claim Form** to the Provider detailing that the Complainant had been absent from work owing to being sick since **13 April 2018**, she had been placed on half pay on **12 July 2018** and would be off pay from **11 September 2018**. Enclosed was a post-doctoral researcher job description, setting out the work activities of the Complainant.

On **21 August 2018**, the Administrator submitted a completed **Employee Claim Form** to the Provider in which the Complainant detailed the exact nature of the incapacity from which she was suffering as *"Anxiety"* and listed her employer's occupational health provider as her usual medical attendant.

The Provider notes that in order for a valid income continuance claim to arise, a member must satisfy the **Income Continuance Scheme** definition of *"Disabled"*, set out in the **Policy Document** as follows:

> *""Disabled" in respect of a Member means that he is totally incapable by reason of illness or injury of following his normal occupation and is not following any other occupation".*

The Provider says that a valid claim can be considered when the disability continues past the end of the deferred period. For members deemed "Non-Critically Ill", a benefit of 25% of salary becomes payable after 13 weeks (66 working days) of absence due to sick leave, in a rolling 12 month period, increasing to 75% of salary after 26 weeks (65 more working days) of absence in any 4 year rolling period, in accordance with the *"Deferred Period"* definition set out in the **Policy Document**.

The Provider says that on **29 August 2018**, it wrote to the Complainant's employer's occupational health provider requesting a medical report in respect of her disability and absence from work because she had listed this health provider as her usual medical attendant in her **Employee Claim Form**. The Provider says this occupational health provider telephoned on **6 September 2018** to confirm that it did not act as the Complainant's GP or hold any medical records in respect of her, and that it had only seen her from the outset, when the Policyholder offered the policy.

The Provider says that on **13 September 2018**, the Scheme Administrator confirmed by email that the Complainant had resigned from her employment with effect from **31 August 2018**.

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On **17 September 2018**, the Provider emailed the Administrator to advise that because the Complainant had only joined the **Income Continuance Scheme** on **1 December 2017**, a 26 week deferred period applied. The Provider noted that she had resigned on **31 August 2018**, prior to the end of the deferred period on **11 October 2018**, 26 weeks after her absence commenced on **13 April 2018**, and accordingly, no benefit payment could be considered.

The Provider says that on **20 September 2018**, the Administrator advised by email that the Complainant was classed as a 'Non-Critically ill' member and thus a 13 week deferred period applied, resulting in a potential short-term claim to be considered for the period from **12 July 2018**, the date the Complainant had been placed on half pay, 13 weeks after her absence commenced, until **31 August 2018**, the date of resignation.

The Provider notes that should a valid claim then have arisen, benefit would be payable beyond the resignation date in accordance with Provision 4.4, 'Cessation of Insurance', of the **Policy Document**, as follows:

> *"The insurance of any Member shall immediately terminate upon the happening of any one of the following events:- …*
>
> *(c) the date on which the Member ceases to work for the Policyowner unless that Member is in receipt of Benefit or has submitted a request for Benefit which is being considered by the Company".*

The Provider says that on **1 October 2018**, it emailed the Administrator to confirm that a claim could be considered and in order to progress the assessment of that claim, it would require details of the doctor who the Complainant was attending, specifically in respect of her medical condition.

On **8 October 2018**, the Administrator forwarded a copy of medical records provided by the Complainant, as follows:

- Report from her employer's occupational health provider dated **13 April 2018**
- Medical Certificates from Medical Centre 1 dated **30 April** and **21 May 2018**
- Report from her employer's occupational health provider dated **27 July 2018**
- Medical Certificates from Medical Centre 2 dated **7 August** and **15 August 2018**.

The Provider says that on **17 October 2018**, it wrote to both Medical Centre 1 and Medical Centre 2 requesting medical reports in respect of the Complainant's disability and her absence from work. It says that on **4 January 2018**, it issued reminders to both Medical Centre 1 and Medical Centre 2 for the medical reports requested.

The Provider says that on **9 January 2019**, it received a letter from Medical Centre 2 dated **7 January 2019** advising that it was unable to complete the request for a medical report

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because the Complainant was a new patient to its practice, and it had been unable to contact her.
The Provider says that on **17 January 2019**, it emailed the Administrator to advise of the response from Medical Centre 2. This email also advised of the delay in obtaining a response from Medical Centre 1 and asked that the Complainant make contact to urge a response.

On **24 January 2019**, the Administrator confirmed by email that it would follow-up on this matter with the Complainant.

The Provider says that on **5 March 2019**, it emailed the Administrator querying if contact had been made with the Complainant in relation to the outstanding medical report.

The Provider says that on **8 April 2019**, as it had received no response, it emailed the Administrator to advise that the claim was being withdrawn as it had received no medical evidence indicating total incapacity, due to the presence of an underlying illness or injury, though it confirmed it would consider the claim if medical evidence were to be submitted.

The Provider says that subsequently, on **26 January 2020**, the Complainant emailed the Provider with a letter of the same date requesting it to issue her with a final response letter, so that she could proceed with her complaint to the Financial Services and Pensions Ombudsman.

On **27 January 2020**, the Provider emailed the Complainant to acknowledge her letter and advise that it would respond once it had looked into the matter. On **19 February 2020**, the Provider issued the Complainant with its **Final Response Letter**, which concluded, as follows:

> *"There is no evidence suggesting that you were under the ongoing care of a doctor for a medical condition. Had your condition been so severe at the time of ceasing work/end of the 13 week deferred period that you could have met the policy definition of disability that is, that you were 'totally incapable by reason of illness of injury of following his normal Occupation',* [the Provider] *would have expected you to be under the care and treatment of a GP at the very least, if not the care of a Specialist.*
>
> *To assess a claim for Income Continuance benefit,* [the Provider] *would require medical reports from your treating GP and Specialist(s) in order to substantiate that you were totally incapable of working, due to illness or injury, in line with the policy terms and conditions.*
>
> *Unfortunately,* [the Provider] *have been unable to obtain any reports form your treating doctors and it is not clear whether you did actually attend any doctor for treatment and management of your condition, other than attending various doctors for medical sick certificates. On the basis of the information provided it is clear that your symptoms were attributable to workplace issues and on this basis a valid claim*

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for Income Continuance benefit would not arise. In the circumstances I wish to advise [the Provider's] *decision to withdraw your claim remains unchanged"*.

The Provider confirms it did not request the Complainant to attend for an independent medical assessment. The Provider says that the reason for this, was because the employer's occupational health provider's **Medical Assessment Reports** submitted by the Complainant, by way of the Administrator, noted that the Complainant was complaining of anxiety and stress which she attributed to her workplace and perceived workplace issues including lack of support from her Line Manager and the ergonomic set-up of her office (the lack of a window). In that regard, the Provider says that stress is not a medical diagnosis but is a result of perception of one's own environment.

The Provider says the purpose of the **Income Continuance Scheme** is to provide an income benefit to members who demonstrate that they are totally incapable of performing their occupational duties directly as the result of ongoing illness or injury and that this is supported by objective medical evidence. On the basis of the information received in support of this claim, the Provider says there was no indication that the Complainant was under the care of a doctor in respect of treatment of symptoms. Furthermore, the medical evidence provided confirmed that the symptoms were attributable to workplace issues.

The Provider notes that Provision 5.8.1 of the **Policy Document** provides that:

> *"The Member shall furnish to the Company all such data, information and evidence as the Company shall reasonably require with regard to the happening of any event affecting or relating to the insurance of any Member under this policy".*

The Provider says that the Complainant's claim is under a disability policy and as a result, it is reasonable that it has requested medical reports in respect of her disability and absence from work.

The Provider says that, at all stages throughout its assessment and review of the Complainant's claim, it had stated that medical reports from her treating doctor would be required in order to substantiate the claim. This medical evidence has not been submitted, however the Provider confirms that it is happy to review this claim, and the Complainant's eligibility for benefit, if the Complainant can submit medical evidence in support of her claim that she was totally incapable of working, due to illness or injury, during the stated timeframe.

The Provider says that the Complainant submitted **Medical Assessment Reports** from her employer's occupational health provider dated **13 April** and **27 July 2018** respectively, who she attended on behalf of her employer, rather than in the capacity of a treating doctor. The Provider says that the information contained within these reports noted symptoms of anxiety and stress, which were attributed to the workplace, and perceived workplace issues. The Provider notes that in the **Report** dated **27 July 2018**, the Complainant specifically requested the examining doctor to make reference to the fact there was no window in her office which she believed to be contributing to her stress.

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In addition, the Provider notes that in the **Report** dated **27 July 2018,** the examining doctor advised that the Complainant was fit to engage with management, but that she was unwilling to meet with her Line Manager.
The Provider says that the fact that the employer's occupational health provider deemed the Complainant unfit to work, does not automatically mean that a claim for income continuance benefit is valid. In that regard, the Provider says the occupational assessments by the occupational health provider, carried out on behalf of the Policyholder, the Complainant's employer, may take into account several factors such as attendance record, performance and subjective symptoms, in addition to the nature of the illness and specific workplace and role.

However, for a valid income continuance claim to arise, the Provider reiterates that the medical evidence must confirm that the individual is rendered totally incapable of performing their occupational duties, directly as a result of illness or injury. In this instance, the Provider says the criteria for a valid claim are based on the Complainant's ability to carry out the role of a post-doctoral researcher, irrespective of where this role is carried out, or with which employer. The Provider says It is clear from the information provided that the Complainant attributed many of her symptoms to issues in her workplace.

The Provider notes that the Complainant has provided no information to suggest that she was under the ongoing care of a doctor for a medical condition, despite requests. It says that if her condition had been of sufficient severity at the end of the 13 week deferred period as to qualify as a valid disability claim, the Provider would have expected the Complainant to be under the care of a Specialist.

The Provider notes that the Complainant confirmed on the **Employee Claim Form** which she completed on **13 August 2018** that she resided in Ireland. The Provider understands that the Complainant shortly thereafter left the country. In that regard, the Provider says it was not advised of a change of address, though it was noted in correspondence received from the Complainant in **January 2020** that an address in [European City] was provided on headed paper. In any event, the Provider says all its communication and correspondence in relation to this claim was with the **Income Continuance Scheme** Administrator and that it had no direct communication or dealings with the Complainant during the claims process other than her request in January 2020 for a **Final Response Letter** and a subsequent confirmatory email.

In conclusion, the Provider says it has been unable to obtain any reports from the Complainant's treating doctors, and that it is not clear whether she did actually attend any doctor for treatment and management of her condition, other than attending various doctors to obtain medical sick certificates. The Provider says that while it is satisfied that it withdrew her claim due to lack of supporting evidence, it remains the Provider's position that it would be happy to review the claim, if the Complainant confirms the name of her attending doctor at the time of disability or provides medical reports to support her claim for total disability during that time.

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The Complaint for Adjudication

The complaint is that the Provider wrongfully or unfairly withdrew the Complainant's income continuance claim for policy benefit payment, due to lack of medical evidence in support of the claim, notwithstanding that the Complainant furnished the Provider with medical reports and certificates relating to her absence.

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 **25 November 2021**, 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. In the absence of additional submissions from the parties, within the period permitted, the final determination of this office is set out below.

I note that the Complainant, having been certified as unfit for work from **13 April 2018**, completed and submitted an **Employee Claim Form** to the Provider on **13 August 2018,** detailing the exact nature of the incapacity from which she was suffering from as *"Anxiety"*. The Complainant resigned from her post some 4 months later, on **31 August 2018.**

The Complainant supplied the Provider with (i) two **Medical Assessment Reports** from her employer's occupational health provider dated **13 April** and **27 July 2018** respectively, (ii) two **Medical Certificates** from Medical Centre 1 dated **30 April** and **21 May 2018** and (iii)

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two further **Medical Certificates** from Medical Centre 2 dated **7 August** and **15 August 2018**.

Following its consideration of this medical evidence, and having requested further medical information from the employer's occupational health provider and from Medical Centre 1 and Medical Centre 2 but to no avail, the Provider advised the Scheme Administrator in its email of **8 April 2019,** and advised the Complainant in its **Final Response Letter** dated **19 February 2020** that it had withdrawn her income continuance claim, due to a lack of medical evidence.

The Complainant questions why the Provider will not accept the medical reports supplied by her employer's occupational health provider and the medical certificates provided by Medical Centre 1 and Medical Centre 2 as sufficient evidence in support of her income continuance claim. In that regard, I note that on **8 October 2018**, the Scheme Administrator forwarded a copy of medical records provided by the Complainant, to the Provider.

In its **Medical Assessment Report** dated **13 April 2018**, I note the employer's occupational health provider advised:

> *"**Reason for Referral:*** [The Complainant] *is complaining of Stress and Anxiety at present, and is partly attributing them to the workplace.*
>
> ***Recommendation:*** [The Complainant] *is currently unfit for work. I have recommended and given the contact details of a GP Service, for which she has agreed to attend today. As you are aware* [the Complainant] *has a poor support system in Ireland. I have advised her to attend the GP Referral Centre today, for possible further management, and treatment, as required. She is unfit for work at present, and I would be keen to see her back in two week's* (sic) *time".*

I note the **Medical Certificate** from Medical Centre 1 dated **30 April 2018** advising that the Complainant was suffering from *"unfit"* and was unable to attend work from **13 April** to **20 May 2018**. A second **Medical Certificate** from Medical Centre 1 dated **21 May 2018** again advised that the Complainant was suffering from *"unfit"* and was unable to attend work from **21 May** to **27 May 2018**.

In its **Medical Assessment Report** dated **27 July 2018**, the employer's occupational health provider advised:

> *"**Diagnosis:*** [The Complainant] *continues to complain of symptoms of Anxiety and Stress, which she attributes to her workplace. She also admits to some social stressors, but attributes the majority of her symptoms to her work, and her perceived workplace issues. She reports to me that she feels unsupported by her Line Manager. She requested that I state in my report that she also finds the fact that there is no window in her office, contributes to her stress.*

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> ***Treatment:*** [The Complainant] *is currently attending counselling with the Employee Assistance Programme, and plans to continue with counselling, when she has completed her sessions with the Employment Assistance Programme. She is not currently under the care of a GP, but is actively looking for a new GP. I have given her some advice today, on the best management of her symptoms.*
>
> ***Recommendation:*** *In my opinion* [the Complainant] *is unfit for work currently. She is in my opinion fit to engage with management, and stated to me today that she is happy to meet with* [name redacted] *again, but not her Line Manager".*

I note that the **Medical Certificate** from Medical Centre 2 dated **7 August 2018** advised that the Complainant was suffering from *"Stress/Anxiety"* and was unable to attend work from **9 August** to **16 August 2018**. A second **Medical Certificate** from Medical Centre 2 dated **15 August 2018** again advised that the Complainant was suffering from *"Stress/Anxiety"* and was unable to attend work from **16 August** to **23 August 2018**.

I note from the documentary evidence before me that the Provider wrote to the Complainant's employer's occupational health provider on **29 August 2018** and to Medical Centre 1 and Medical Centre 2 on **17 October 2018**, and again on **4 January 2019**, requesting medical reports in respect of the Complainant's disability and absence from work. I note the employer's occupational health provider and Medical Centre 2 responded that they were not in a position to provide any such information to the Provider as they were not the Complainant's GP. Medical Centre 1 did not respond to the Provider.

I note also that the Provider emailed the Administrator on **1 October 2018** to confirm that in order to progress the assessment of her claim, it would require details of the doctor who the Complainant was attending, specifically in respect of her medical condition.

I acknowledge that the Complainant says she did not at the time of her absence from work have a regular GP, as she had only recently moved to Ireland to take up her job, nor had she attended a specialist in relation to her illness and as a result, she was not in a position to supply the Provider with any additional medical information at that time.

In that regard, however, I accept the Provider's position that if the Complainant's condition had been of sufficient severity at that time as to qualify as a valid disability claim, then it is reasonable to expect that the Complainant would have been referred to and would have been under the care of an appropriate Medical Specialist. Indeed, I note that in April 2018, the Complainant's employer's occupational health provider gave the Complainant details for a GP service, so that she could progress her medical care.

There is no evidence however, that the Complainant sought medical treatment or advice from any general practitioner, as her employer's occupational health provider's report in July 2018, noted that she was then "*actively looking for a new GP*".

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Having examined the documentation before me, I am of the opinion that there is no evidence to support the Complainant's contention in her **Complaint Form** that the Provider does *"not consider the assessment of the doctors from* [my employer's occupational health provider] *as medical evidence"*. Instead, I take the view that having considered the Complainant's employer's occupational health provider's two **Medical Assessment Reports** dated **13 April** and **27 July 2018**, that it was reasonable for the Provider to conclude from the contents of those reports (and in the absence of any further medical information) that the stated reasons for her continued absence did not support a claim that the Complainant was totally incapable by illness or injury of following her normal occupation, and that there were instead a number of workplace issues contributing to her absence from work.

In that regard, the **Income Continuance Scheme** under which the Complainant sought to claim, provides cover only for those claimants who satisfy the policy definition of *"Disabled"* at pg. 2 of **Policy Document**, as follows:

> *""Disabled" in respect of a Member means that he is totally incapable by reason of illness or injury of following his normal occupation and is not following any other occupation".*

I am also of the opinion that there is no evidence to support the Complainant's contention in her **Complaint Form** that *"*[the Provider] *considered my claim as bogus, because they considered that I resigned quickly after the claim"*. Instead, I take the view that the Provider withdrew the Complainant's income continuance claim, on what I am satisfied was a reasonable basis, that it had received no medical evidence indicating total incapacity due to the presence of an underlying illness or injury, which would have led it to proceed with an assessment of the claim. In that regard, I am mindful that the Provider did seek further medical information from the Complainant's employer's occupational health provider and also from Medical Centre 1 and Medical Centre 2, as well as from the Complainant herself, by way of the Scheme Administrator, but regrettably, no such information was forthcoming.

I note that Provision 5.8.1 of the **Policy Document** provides at pg. 9 that:

> *"The Member shall furnish to the Company all such data, information and evidence as the Company shall reasonably require with regard to the happening of any event affecting or relating to the insurance of any Member under this policy".*

In that regard, I am satisfied that it was reasonable and in accordance with the **Income Continuance Scheme** terms and conditions for the Provider to request medical reports in respect of the Complainant's illness from sources other than her employer's occupational health provider.

In addition, while the Complainant resigned from her position with effect from **31 August 2018**, there is no evidence to support her contention that this was a factor in the Provider's decision to withdraw her claim.

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Instead, I note that if a valid claim had arisen in respect of the Complainant's absence from **12 July 2018**, the date she had been placed on half pay, to **31 August 2018**, the date of resignation, regardless of whether that determination was made prior to or after the date she resigned, then benefit could have been payable beyond the resignation date in accordance with Provision 4.4, '**Cessation of Insurance**', at pg. 6 the **Policy Document**, as follows:

> *"The insurance of any Member shall immediately terminate upon the happening of any one of the following events:- …*
>
> *(c) the date on which the Member ceases to work for the Policyowner unless that Member is in receipt of Benefit or has submitted a request for Benefit which is being considered by the Company".*

In any event, I note the Provider continued to seek medical reports in respect of the Complainant's illness, beyond her date of resigning, in that the Provider wrote to Medical Centre 1 and Medical Centre 2 on **17 October 2018**, and again on **4 January 2019**, requesting medical reports in respect of the Complainant's disability and her absence from work.

I note the Provider has advised that it would be happy to review the Complainant's claim again, should she confirm the name of her attending doctor at the time of disability or provide medical reports to support her claim that she was totally incapable of working, due to illness or injury, during the stated timeframe. I am satisfied that this is a reasonable position for the Provider to take in this matter.

Further, I note in her email to this Office on **12 January 2021** the Complainant submitted:

> *"I would like to clarify the following:*
>
> 1. [My employer] *obliged us to join the Income Continuation Plan (ICP). It is not a voluntary scheme, as the insurer claimed. If I was not in the plan, why did they take money from my salary each month?*
>
> 2. *… The ICP was claimed to protect the insured from the unexpected loss of income. It did not say that we have to provide* [Electronic Health Records] *to prove my health status. Also, taking this long to process the claim will get the insured falling into destitute states. It is not an insurance plan by definition … We should have been given the right to opt out from the scheme … "*

I note in its email response to this Office of **31 January 2021**, the Provider advised, as follows:

> *"The Provider wishes to confirm the Complainant was a member of the Income Continuance Scheme. The Provider has never stated otherwise - at initial claims notification stage the Provider did not hold scheme member data as the*

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> *Complainant had joined following the renewal date, however scheme membership was subsequently confirmed following review with the Scheme administrator and this caused no delay on the claims assessment or had any adverse impact.*
>
> *Any concerns the Complainant has regarding her membership of this Scheme, or having the option not to join, should be addressed with her Employer and unfortunately does not fall within the remit of the Provider. The role of the Provider is to provide insurance cover to all registered scheme members".*

In this regard, I accept the Provider's position that it is a matter for the Complainant and her employer, the Policyholder, as to whether her membership of the **Income Continuance Scheme** was optional or formed part of her contract of employment when she joined in late 2017.

Having regard to all of the above, I am satisfied that the evidence does not support the Complainant's complaint that the Provider wrongfully or unfairly withdrew her income continuance claim, due to lack of medical evidence in support of the claim, notwithstanding that she supplied the Provider with medical reports and certificates relating to her absence.

<u>Conclusion</u>

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
Deputy Financial Services and Pensions Ombudsman

17 December 2021

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

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