An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0107
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

The Complainant holds an income protection policy which was offered by her employer and administered by the Provider.

The Complainant's Case

The Complainant states that in [Date Redacted]she had eye surgery which resulted in complications causing her visual difficulties and in particular difficulties working in an office environment. The Complainant states that her employer was unsupportive of the position she found herself in, leading her to developing stress and taking extended sick leave.

The Complainant states that she has been on sick leave since [date redacted]and that in [date redacted] her employer ceased to pay her wages and referred her to the Provider to claim from its employee **Income Protection Policy**. The Complainant contends that the Provider incorrectly denied her claim for Income Protection payment despite supporting medical reports.

The Complainant submits that:

> *"In [date redacted] I had bilateral cataract surgery and developed complications. These impacted on my work causing issues with screens and bright lights and triggered visual vertigo.*

> *My employer, [company] where I worked since 2000, were unsupportive in making accommodation and this combined with substantial loss of employee resources, led to me developing severe mental stress issues which has resulted in prolonged sick leave. I have been out on sick leave since* ***[date redacted]****. In October 2018 [Employer] ceased to pay me and referred me to [Provider] to claim under the firm's Income Protection policy. I made this claim and have been unsuccessful despite submitting reports from [Reports D and E] it appears that the [Provider] doctors can override these opinions and so prevent any claim. I am still ill and am unable to carry out the duties pertaining to my normal occupation*. "

The Complainant contends by letter, dated **1 March 2021**, that:

> "*[Report D] is independent. He is a highly respected eye surgeon consultant and while confirming my eye test results were within normal limits, outlined that I was significantly symptomatic, and these symptoms were likely to persist. He also outlined that while they may abate over time it was unlikely that they would allow me function as a [job title]. I am still struggling with these symptoms which can also trigger vertigo*."

The Complainant submits that "*it seems unfair and inequitable that the insurers do not accept my reports*." The Complainant wants the Provider to admit her claim and make payment of benefits under the Policy.

The Provider's Case

The Provider says that the Complainant stopped working on [Date redacted].

The Provider issued a **Final Response Letter,** dated **25 March 2020**, which noted that the Complainant had appealed its decision to decline payment of her income protection claim. The Provider states that claims are paid when claimants met the definition of disablement as defined under the policy. The Provider relies on an independent Consultant's medical report which stated that:

> "*her eye examination is normal and she achieves normal levels of vision with her present glasses correction. Her field of vision are full and there is no evidence of any field defect .. .In my opinion, there is no ophthalmic reason preventing her from carrying out her work as a [Job Role]*."

The Provider states that as a result of the medical evidence it received, it is satisfied that the Complainant "*does not meet the definition of disablement, as required by the policy, and her medical complaints do not render her unfit to carry out the duties of her normal occupation*."

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The Provider says that the Complainant's submission that her employer was unsupportive, is not relevant to an assessment of the claim, which is centred on whether or not she is "disabled" within the meaning of the policy. The Provider notes that "*there are issues of [type redacted] nature which appear to be a barrier preventing [Complainant's] return to work*." The Provider maintains "*that she did not satisfy the definition of disablement under the policy*" and that "*this decision was taken, based on the weight of the objective medical evidence received*."

The Provider submits that "*I am therefore satisfied that both of [Complainant's] medical complaints of work-related stress and her eye condition were fully considered as part of our assessment of her claim*."

The Provider submits, by letter dated **16 March 2021**, that:

> "*[Complainant] suggests that, in declining her claim, [Provider] put undue weight on the fact that [Report E] was not her treating doctor. This, however, is not the case, and this was not the basis for our decision on [Complainant's] claim. … I can confirm that we do not place any emphasis on one particular medical report over another. All reports are carefully considered as part of our claims assessment process, however, we are not necessarily bound by these opinions and we are entitled to form our own view on fitness or otherwise for work, based on our review of all of the medical evidence received.*"

The Provider further asserts, that:

> "*We note [Complainant's] comments in relation to [Report D]. We do not doubt the diagnosis he has made nor the treatment he has provided to her. However, the diagnosis of a condition does not automatically equate to disablement and we are satisfied, based on the weight of the medical evidence received, that [Complainant] does not meet the definition of disablement, as required by the policy, and her medical complaints do not render her unfit to carry out the duties of her normal occupation.*"

The Provider submits that it offered to arrange and pay for counselling sessions for the Complainant, in order to facilitate her return to work.

The Complaint for Adjudication

The complaint is that the Provider wrongfully rejected the Complainant's claim for Income Protection Benefit Payment.

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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 **1 March 2022**, 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 is covered under the terms of a **Policy Document** which provides:

> "*Insured Person*
> *means each Eligible Employee in respect of whom an application for insurance under this Policy has been received by and accepted by the Company*
> *Provided That a person shall cease to be an Insured Person*
> (i) *subject to Provisions 15 and 19, upon ceasing to be in the permanent employment of the Grantees*."

The **Policy Document** says, under *Provisions, Conditions and Privileges* that:

> "*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 the duties pertaining to his normal occupation by reason of disablement arising from bodily injury sustained or sickness or illness contracted and*

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(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).

And

(ii) partial disablement shall be deemed to exist where

(a) following a period of total disablement as in Sub-Provision 1 (i), which period is to be decided by the Company, an Insured Person is unable to carry out the duties pertaining to his normal occupation by reason of disablement arising from bodily injury sustained or sickness or illness contracted and
(b) the Insured Person, with the written consent of the Company, either re-engages in his normal occupation with a loss of earnings as a result or engages in some other occupation on a full-time or part-time basis (whether or not for profit or reward or remuneration, including benefit in kind)."

I note that the **Policy Document** says, under *Provision of Evidence Tests and Information* that:

"*…*
(iii) 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 note the contents of the **Employment Information Form** dated **2 October 2018**, and the **Claim Notification Form** dated **26 September 2018**. I also note that this **Claim Notification Form** records the date symptoms began as [date redacted], with the nature of symptoms noted as "*physical and psychological associated with stress*." I note that this form includes an acceptance that medical information will be shared amongst medical professionals, and is signed by the Complainant.

The Provider submits that the **Claim Notification Form** lists the reason for the Complainant's absence from work as *"work related stress"* and that she informed a specialist nurse during a telephone interview arranged by the Provider, that her absence was due to *"work related stress."*

The Provider says it considered the interview with the Specialist Nurse, a report dated **17 October 2018** from the Complainant's employer outlining her role and a report from an Independent Medical Examination, conducted by a Consultant Psychiatrist, dated **13 November 2018 ("Report A")**.

Report A noted that:

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> "*her symptoms are quite mild and nonspecific and do not represent a specific psychiatric illness… The reason [the Complainant] is absent from work is her workplace difficulties. She is not absent from work because of an inability to perform that work due to any psychiatric symptoms or illness. [The Complainant] is not unable by reason of psychiatric illness or injury to carry out the duties of her normal occupation.*"

The Provider commissioned a further report from an Independent Medical Examination, conducted by a Consultant Psychiatrist, dated **8 May 2019 ("Report B")**. Report B recorded as follows:

> "*The diagnosis is [illness redacted] related to [cause of redacted]... She is on no treatment for a psychiatric disorder. She has no goals with regard to a] return to work… It is my opinion that [Complainant] is currently fit to carry out her occupation on a full-time basis*."

The Provider commissioned a further report from an Independent Medical Examination, conducted by a Consultant Ophthalmologist, dated **20 January 2020 ("Report C")**. Report C noted as follows:

> *"Her eye examination is normal and she achieves normal levels of vision with her present glasses correction. Her field of vision are full and there is no evidence of any field defect. During my eye examination I did not notice any light sensitivity. In my opinion, there is no ophthalmic reason preventing her from carrying out her work as a [job title]*."

The Complainant submitted a number of complaints about this Consultant Ophthalmologist including that she was abrupt, wore a facemask, that she was prevented from giving fulsome answers and that whole experience was "*bizarre*."

The Provider received a report from a Consultant Eye Surgeon, dated **19 September 2018 ("Report D")** which said that:

> "*it has gotten to the stage where she is finding it impossible to function in a working environment because of the bright light. This has gone on for some time and therefore is unlikely to resolve. There is no known cause for this. It is one of those undetermined factors that can happen after intraocular surgery and of course it has the effect particularly in [Complainant's] case because of her working environment that it profoundly affects her... changing the lighting environment in [Complainant's] office, changing the computer terminal, making sure she has a proper screen, measures to cut down the light environment are things which may or may not help... The only suggestion that I have made to her is to go and get photochromic lenses, these grade the light going into the eye...*
> "

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The Provider submits in relation to Report D that:

> *"the report does not provide any objective evidence as to [Complainant's] continued ocular difficulties, other than her own self reported complaints*."

The Provider also received a report from Consultant Psychiatrist, dated **20 March 2019, ("Report E")** which said that:

> *"She does not believe that she would be able to return to work with [Company] and explained this as being down to the environment and anxiety in the workplace but also because she has lost trust in the company and remains angry about how she feels that she was treated…My opinion regarding [Complainant's] diagnosis is that she has experienced a [nature of illness redacted] …In my opinion the factors relevant to [Complainant's] Diagnosis are the visual symptoms that she developed following her cataract surgery and in particular the impact that these had on her in her workplace. A significant factor here is that she felt that her employer did not … help in addressing this problem. She felt unsupported,. unvalued and rejected, which undermined her confidence in her work. In my opinion the increased workload associated with the loss of key staff significantly added to her distress and anxiety at the time…[Complainant] feels a complete lack of trust in her employer and this is a cause of significant psychological distress to her at the current time. In my view it is unlikely to be in her best interests to return to work with this company in the future…She would like to return to work in an environment that doesn't exacerbate her visual symptoms. The fact that she has no plans to do so at present is symptomatic of her current [illness redacted]. In my opinion once this episode is effectively treated she would benefit from a return to work*."

By letter, dated **16 September 2018**, the Consultant Eye Surgeon said as follows:

> *"the eye examination is satisfactory and there are no problems that I can detect from the cataract operation…it is very likely in my opinion that [Complainant's] symptoms will persist.*"

I note that Report A recorded that the Complainant *"is not absent from work because of an inability to perform that work due to any psychiatric symptoms or illness*." I note that Report B says that "*[Complainant[is currently fit to carry out her occupation on a full-time basis*."

Report C notes that "*there is no ophthalmic reason preventing her from carrying out her work as a [job titl*e]" and I am not satisfied that the Complainant's review of her experience with the Consultant Ophthalmologist takes away from Report C's findings.

Report D notes that the Complainant's symptoms arise from no identified cause and is *one of those undetermined factors*. Report E notes that the complainant suffers

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from [illness redacted] and *"once this episode is effectively treated she would benefit from a return to work."* I note the Complainant has what is referred to as a "high powered" and stressful desk job and that the Consultant Ophthalmologist carried out a thorough review of the Complainant's eyesight and noted no abnormalities.

On the basis of the medical evidence which was available to the Provider at the time when it assessed the Complainant's claim for income protection benefits, and her subsequent appeals, I am satisfied that the Provider was entitled to maintain the position that it did, that the Complainant did not meet the policy definition of being

> "*unable to carry out the duties pertaining to her normal occupation, by reason of disablement arising from bodily injury sustained or sickness or illness contracted.*"

There is no doubt that the Complainant had an optical difficulty and underwent a procedure from which it appears she subsequently recovered, but I am satisfied on the basis of the medical reports which were available to the Provider at the time when it assessed her claim for benefits, that it was entitled to take the view that the Complainant did not meet the definition of disablement as laid down within the policy document.

Accordingly, I am satisfied that the Provider was entitled to decline the Complainant's claim for benefit and for that reason, this complaint is not upheld.

Conclusion

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

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

MARYROSE MCGOVERN
Financial Services and Pensions Ombudsman (Acting)

25 March 2022

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PUBLICATION

Complaints about the conduct of financial service providers

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.

Complaints about the conduct of pension providers

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will **publish case studies** in relation to complaints concerning pension 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.