How to Unravel the Mystery and
Prove Your Claim

Disability Insurance Policies

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The following eBook is authored by Marc Whitehead, an attorney, whose principal office is located in Houston, Texas.

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Marc Whitehead Biography

Marc Stanley Whitehead is the founding partner of Marc Whitehead & Associates, Attorneys at Law, LLP which was established in 1992 in Houston, Texas. Marc was born on November 24, 1966 in Memphis, Tennessee and was raised in Normangee, Texas. He graduated in 1985 from Normangee High School as class valedictorian. Marc attended Texas A&M University where he graduated in 1989 with a Bachelor of Business Administration in Finance. Marc attended the University of Houston Law Center and received his law degree (J.D.) in 1992, graduating in the top quarter of his class. He was admitted to the State Bar of Texas in 1992. He is also admitted to practice before all U.S. Federal District Courts in Texas, the U.S. Court of Appeals-Fifth Circuit and the U.S. Court of Appeals for Veterans Claims.

Marc's areas of practice include personal injury and wrongful death, social security disability, long-term disability insurance denials, employee benefit denials, ERISA litigation and insurance claims.

He is also a former adjunct professor of Law at the University of Houston Law Center teaching Civil Trial Advocacy. He has also been an instructor for the National Institute of Trial Advocacy teaching Civil Trial Advocacy and an instructor for the National Business Institute teaching Social Security Disability Law.

Marc is double board certified in both Personal Injury Trial Law by the Texas Board of Legal Specialization and in Social Security Disability Law by the National Board of Trial Advocates.

Marc Whitehead was the 2009-2010 President of the Houston Trial Lawyers Association, a current member of the Board of Directors of the Texas Trial Lawyers Association, a former member of the Texas Trial Lawyers Board of Advocates, and a

member of the American Association of Justice. He is a former HBA Social Security Section Chairman (2004-2005) and is a current member of the governing council. He is a member of the following organizations: Association of Civil Trial and Appellate Specialists, National Organization of Social Security Claims Representatives, Texas Aggie Bar Association, Houston Volunteer Lawyers Association, College of the State Bar of Texas, and the Houston Bar Association. Marc is married and has four daughters.

Mr. Whitehead authored the following articles:

- *Tort Reform As It Relates to Strict Products Liability;*
- *A Lawyer's Guide for Determining Eligibility of Social Security Disability Claimants;*
- *Nuts & Bolts of Social Security Disability Law;*
- *The Five Step Sequential Evaluation Process Used in Determining Disability For Social Security Claimants;*
- *The Social Security Disability Puzzle-How to Fit the Pieces Together and Win Your Claim;*
- *Disability Insurance Policies-Solving the Mystery and Proving Your Case*

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Disability Insurance Policies – How to Solve the Mystery and Win Your Claim

The Disability Insurance Industry

The Major Carriers
The largest and most infamous disability carrier is **Unum**. Unum came into being from a merger of Unum of Portland, Maine and Provident Life and Accident Insurance Company, which had previously acquired Paul Revere Insurance. Other major companies include MetLife, The Standard, Aetna, Liberty Mutual, John Hancock, New York Life, Prudential, Penn Mutual, The Hartford, Cigna, Colonial Life Insurance Company, and Guardian Insurance among others.

The lucrative cash cow became a financial nightmare for disability insurance carriers.

A Notorious History
In the 1980s many insurance companies recognized that there was a lucrative market in selling disability insurance policies to young healthy individuals. These policies were designed to insure an individual in the event that they became disabled and could not perform the duties of their own occupation. These non-cancelable policies often had relatively generous terms with regard to the definition of disability, a life time payout and a built in cost of living adjustment.

Eventually, the lucrative cash cow became a financial nightmare for disability insurance carriers such as Unum, Paul Revere, Provident Life and others. Poor underwriting policies and under pricing in a competitive market lead to a massive number of these policies being written on the expectation of substantial investment returns based on the high interest rates at the time. By the 1990s claims on these disability policies began to increase at the same time interest rates and investment returns began to drop.

Provident Life publicly admitted to the Securities and Exchange Commission that one of its principle solutions to its losses was to "improve its claims handling procedures," a thinly veiled euphemism for increased claims terminations and denials. Since insurance carriers could not control investment returns or the fact that their policy holders were aging and filing more claims, they did the only thing that was in their control, refuse to pay claims.

The industry devised a series of measures designed to control claims costs. These included systematically searching for "misrepresentations" in the policy holders initial applications, requiring "objective" evidence of disability even though the policy didn't require it, redefining a claimant's "own occupation," using Employee Retirement Income Security Act (ERISA) preemption offensively, use of biased insurance medical evaluations and an increased use of video surveillance.

The result of these "cost control" measures is that to this day thousands of individuals that had paid their disability premiums for years have been left in financial ruin because of their own insurance company's broken promises.

This book is designed to inform you about your disability policy and hopefully guide you in giving yourself the best chance to prevail against the deck that has been stacked against you.

Congressional Hearings

On September 28, 2010 the Senate Finance Committee convened a hearing to examine the disability insurance industry and the difficulty that policy holders have in winning benefits under the terms of their policy. The hearing was entitled "Do Private Long-Term Disability Policies Provide the Protection They Promise?" The hearing focused on whether claimants are being unfairly denied or terminated by their own insurance company because of aggressive use of ERISA. The hearing also examined claims handling practices and the individual's appellate rights.

What Type of Disability Policy Do You Have?

The long term disability policy is the contract between a claimant's employer and the insurance company. The language and provisions in the contract varies from policy to policy, so it is essential that a claimant get a copy of the policy from Human Resources.

Short Term Disability

Short Term Disability benefits ("STD") are paid for a limited amount of time, anywhere from one week to six months, depending on your policy. Generally, STD is sometimes paid for by your employer and is usually 100 percent of your salary. Because STD is usually paid by the employer and is

for a limited amount of time, it can be easier to get approved for STD than LTD.

Long Term Disability
Most Long Term Disability ("LTD") policies have an "elimination" or waiting period. This means a claimant must first apply for and receive all of the STD benefits available under their policy or satisfy a waiting period by being disabled for up to six months, before a claimant can even apply for LTD benefits. LTD benefits are generally paid for 24 months, if a person cannot work their own job. After this "own occupation" period (described in detail in 5.5) a claimant can potentially receive LTD benefits until age 65, if they continue to prove disability.

Catastrophic
A catastrophic policy is one that pays benefits only if a claimant is so severely impaired by accident or disease, that the claimant cannot do even the most basic activities of daily living such as feeding, getting dressed or showering without assistance. The insurance company will often send a home health nurse to the claimant's home to confirm that the claimant is disabled under this type of policy.

What Type of Benefits Can You Get?

Salary Percentage
The majority of policies pay 60 percent of a claimant's salary. If a claimant works on a commission or other non-salaried basis, the insurance company will use a calculation described in the policy to arrive at a benefit amount.

Partial or Residual Disability
Some policies allow a claimant to work part time or work at a lighter duty job because the claimant is unable to work full time due to their medical impairment. A partial or residual disability benefit is payable if an impairment causes a claimant's income to fall more than a certain percentage, usually 20 percent below their regular income. Generally, the claimant will be making less money than if they worked full time or full duty. The policy will require the claimant to make a certain percentage less than their regular salary.

The Social Security Offset
Most policies have a Social Security offset. This means if a claimant receives a monthly Social Security Disability (SSD) benefit, the amount of the SSD check is "subtracted" from the monthly LTD check. For example, if a claimant receives a LTD check for $2,000 a month and then begins to receive a SSD check for $1,000, the insurance carrier will reduce the amount of the LTD check to $1,000. The claimant still receives a total of $2,000 a month, but $1,000 from SSD and $1,000 from LTD. Some policies even allow the SSD benefit paid to a claimant for his or her minor children to be taken as an offset.

Other Possible Offsets
Every policy is different, but other possible offsets are worker's compensation benefits, certain retirement or retirement disability benefits, settlements from lawsuits, and state disability benefits. In the event that the total of the offsets is higher than the monthly LTD benefit amount, most policies have a minimum payment of at least $100 per month or in some cases, 10 percent of the monthly LTD benefit.

The Problem of Overpayments
Many claimants apply for SSD benefits around the same time they apply for LTD benefits. Included in the paperwork for the LTD application, claimants will find a form that the claimant must sign that tells the insurance company how they will "pay back" the SSD offset. A claimant can choose to have the carrier estimate how much their SSD benefit will be. The insurance carrier will then "deduct" that estimate from the claimant's monthly LTD benefit.

Most claimants choose another option, which is to pay back the SSD offset in a lump sum, so that the claimant will receive the full LTD monthly benefit. Because it can take as long as 18-24 months to receive an SSD award, a claimant's SSD back benefits can add up to several thousand dollars. Once the claimant receives the SSD award and back benefits, the insurance company will want to recover the full amount of back benefits. Because the claimant has been unable to work and has been getting only 60 percent of their former salary, many claimants spend their SSD back benefits to pay bills.

If a claimant cannot pay back the full amount in a lump sum, sometimes the insurance company will hold back the entire LTD monthly benefit towards the amount of SSD offsets that the claimant "owes." This problem is compounded when the SSD award arrives just as a claimant hits the "any occ" definition of disability at 24 months (discussed in "Occupations

Standard" section), because the insurance company may cut-off benefits when the policy changes, leaving the claimant owing a large overpayment.

Does Your Policy Cover Your Condition?

Preexisting Condition Exclusion
Most policies have a preexisting condition exclusion. These exclusions usually kick in when a claimant has been eligible for benefits for less than a year, but sometimes the stated period is two years. Besides the preexisting condition exclusion time period of a year, there is also a "look back" period, usually the three months prior. In a nutshell, if a claimant applies for LTD benefits less than a year after the claimant signs up for the benefit, the insurance company will look at all medical records and pharmacy records for the entire year plus the look back period.

These exclusions are very, very broad. For example, a claimant may have been prescribed a medication for the treatment of anxiety during the look back period. Later, the claimant develops a back problem with muscle spasms. The same medication that was prescribed to the claimant to treat anxiety is now being prescribed to treat muscle spasms. The insurance company will get the claimant's pharmacy records and claim that the claimant was being treated for muscle spasms because they took the medication. The insurance company will then refuse to pay benefits based on the preexisting condition exclusion.

Mental Health Limitation
Most policies have a 24 month mental health limitation. This means that benefits for mental health conditions such as depression, anxiety or bipolar disorder will only be paid for 24 months.

Depression Secondary to Chronic Pain
Many claimants develop depression secondary to chronic pain. The insurance company will try to classify the claimant's impairment as mental, so that benefits will be paid for only 24 months. The insurance company may also try to classify a cognitive problem or side effects from narcotic pain medications as a mental impairment.

It is very important to make sure the insurance carrier does not mischaracterize a claimant's physical disability as mental.

Self Reported Symptoms Limitation
Disability insurance companies are always looking for ways to reduce their liability and one way is to continually ask for "objective evidence." Objective evidence usually refers to diagnostic tests like MRIs or X-rays. Unfortunately, some symptoms, like pain, and some diseases, like fibromyalgia and chronic fatigue syndrome, do not show up on any "objective" tests. These symptoms and diseases are diagnosed by the doctor based on examination and patient reports. Examples of these conditions include Chronic Pain, Fibromyalgia, and Chronic Fatigue Syndrome

Non-Exertional Limitations
Non-exertional limitations are also largely self-reported and therefore, ignored for the most part by the insurance company. Examples include fatigue, intellectual and cognitive limitations, headache, memory loss and medication side effects.

What Do You Have To Prove?

The Definition of Disability
There is no one legal definition of disability. Every insurance company, the Social Security Administration and the Veterans Administration all have different definitions.

The definition of disability is explained in the policy. Usually, it is something along the lines of "due to sickness or injury the employee is unable to perform the material and substantial duties of his or her own occupation." The insurance company defines disability, interprets the terms in their definition and decides whether a claimant is disabled or not. The insurance company decides whether or not a claimant will receive benefits. This creates an inherent financial conflict of interest.

Your Doctor Says You Are Disabled! Why Doesn't It Matter to Them
The insurance company decides whether or not a claimant is disabled. They use their own employees, either a nurse or an in-house doctor, to review a claimant's medical records. Many times, these in house consultants will have an opinion that is different than a claimant's doctor. The insurance company will state that the claimant's doctor's opinion is not supported by the medical records. The Supreme Court has looked at this issue and decided that the "treating physician rule" used by the Social Security Administration, does not apply in LTD determinations.

The treating physician rules says if a treating doctor says a claimant is disabled, that opinion is entitled to "great weight." In private disability plans, the Supreme Court has held that a claimant's doctor's opinion that the claimant is disabled should be taken into account as a "factor" in the insurance company's determination of disability.

Social Security Says You Are Disabled! Isn't That Enough?
For a person under 50 years old, Social Security's definition of disability is actually a tougher standard than an LTD definition because a claimant must be unable to work at any occupation available in the national economy. But because Social Security has slightly different rules for disability, the insurance company will ignore an award of benefits by Social Security by stating that the rules are different.

But the Insurance Company Helped Me Get Social Security Disability
The insurance company is more than happy to help a claimant get Social Security benefits because it helps them financially. The insurance company contracts with another company that represents claimants before the Social Security Administration. The insurance company will reduce a claimant's LTD monthly benefit by the amount that claimant receives from Social Security and will demand that the claimant "pay back" the insurance company the back benefits received from Social Security.

Vocational Review by the Insurance Company
If the insurance company finds a claimant "not disabled," they will often perform a cursory "vocational review." The vocational analyst will take the restrictions the insurance company decides the claimant has and the skills the vocational analyst derives from a claimant's past work history and come up with a list of jobs that the claimant can perform. The vocational analyst will state that these jobs are available in the claimant's home region and that the job will pay usually, at least 80 percent of the claimant's pre-disability earnings. These reviews are often flawed and make unreasonable suggestions for occupations.

Your Residual Functional Capacity (RFC)
A claimant's RFC is based on what physical level work a person can perform. The Dictionary of Occupational Titles and Social Security define work as sedentary, light, medium, heavy and very heavy. A sedentary job is like an office job, where a claimant sits up to six hours a day, stands or walks up to

two hours a day and lifts and carries up to 10 pounds, like files or small objects. A light job, for example a cashier or security guard, requires that a person be able to stand or walk up to six hours per day and frequently lift and carry 10 pounds and occasionally lift and carry 20 pounds. A medium job, like a nurse or commercial truck driver, requires the ability to lift 50 pounds; heavy, like construction, requires the ability to lift 100 pounds; and very heavy requires the ability to lift more than 100 pounds.

Your Skill Level
Skill levels are also defined by the Dictionary of Occupational Titles, based somewhat on how long it takes a person to learn a skill. Unskilled or semi-skilled jobs, rated at skill level 1, 2, or 3, take less than 30 days to learn. Skilled jobs are rated at 4, 5 and 6 and very skilled jobs are 7, 8 and 9.

"Own Occupation" Standard – Usually Limited to the first 24 Months
For the first 24 months or as defined in the policy, a claimant only has to be unable to perform their "own occupation." For example, as noted in Salary Percentage Requirement section, a nurse is a medium occupation. If the claimant was working as a nurse, but has a medical impairment, for example, a back problem, and is restricted to only lifting 20 pounds because of that impairment, the claimant would not be able to perform his or her own occupation.

The definition of own occupation is found in the policy. Often it will state that the definition is based on how the job is performed in the national economy as defined by the Dictionary Occupational Titles, not how the claimant actually performs his or her own occupation.

"Any Occupation" Standard
After 24 months, a claimant must prove that he or she cannot perform "any occupation." Usually the definition includes "any occupation" that the claimant can perform based on his or her education, background and skills.

- Benefits Usually Paid Up to Retirement Age: If a claimant can continue to prove ongoing disability, benefits are usually paid through age 65, depending on the policy.

- Special Rules if Disability Occurs After Age 60: If a claimant's disability begins after age 60, benefits are paid according to a schedule in the policy. Depending on the age of the claimant benefits will be paid for a

maximum number of months. For example, a claimant who becomes disabled at age 63 would get 36 months; age 64, 30 months.

Salary Percentage Requirement
The "any occupation" standard usually includes a salary percentage requirement. In other words, the insurance company must find occupations that will pay the claimant usually at least 80 percent of their pre-disability income.

Why You Shouldn't Use the Insurance Company's Recommended Social Security Representative

Frequently your insurance company will recommend one of several different companies that will represent you on your social security disability claim. This is not done out of the goodness of their heart. They have a financial motive for you to win social security disability benefits AND they have an incentive to keep tabs on you and your social security case. They accomplish both of these agenda's if they can control who you choose to represent you before the Social Security Administration. Many people don't realize it, but the disability insurance plan not only gives the insurance company the right to offset (subtract) your Social Security benefits from what the insurance company owes you now, but the insurance company also wants to recover your past benefits for their own use.

Don't be fooled!

Get your own lawyer that answers to no one but you.

Using their recommended attorneys (sometimes they aren't even attorneys) allows them to track your progress with the SSA and swoop in and take any back benefits you recover. Sometimes you owe it, sometimes you don't. In any event, it creates an obvious conflict of interest between yourself and their recommended representative. One of the most notorious suspects brags on its Web site about how much money it recovers for the insurance company, not what it recovers for you.

How to Begin Your Claim

A claimant must request the forms for disability benefits from the Human Resources department of the employer. The claimant must also take an Attending Physicians Statement form to a physician who will indicate that

the claimant is disabled or that the physician is keeping the claimant off work. Once the forms are completed, they are sent to the insurance carrier along with a list of all medical providers the claimant sees for treatment. Once the carrier receives all the medical records, it will begin investigating the claim.

What If They Deny Your Disability Claim-The Administrative Appeal

The Denial Letter
After the claim is filed, the insurance carrier will either grant the claim or deny the claim. If the claim is granted, the insurance company will begin to pay monthly benefits. If the claim is denied, the claimant will receive a "denial letter." This letter is very important because it will list what evidence the insurance company reviewed when making its decision, who reviewed the evidence, for example, an in-house Nurse Case Manager, a doctor hired as a consultant or only non-medical reviewers such as a Senior Claims Adjuster. The denial letter should state the reasons the claim was denied and what medical evidence the carrier needs to prove disability. The denial letter also gives important information for an appeal, including where and when the appeal must be received.

The Time Limits for Filing Your Appeal
The denial letter will give the time limits for filing the appeal. If the policy is governed by ERISA, the appeal deadline is 180 days. Most non-ERISA policies also give the claimant 180 days to appeal, but it is very important to read the denial letter carefully, so no deadlines are missed. If an appeal deadline is missed, the claimant is unable to appeal. If the claimant does not "exhaust" or use all appeals available, the claimant will not be able to file a lawsuit.

Mistakes That Even Lawyers Make
Lawyers who are not familiar with disability issues do not always understand what has to be proved. These lawyers may argue that because the claimant's doctor or Social Security has found the claimant disabled, the insurance carrier "must" find the claimant disabled. Although these are factors to consider and do support disability, these two factors alone do not prove disability to the insurance carrier. Some lawyers may not understand the difference between "own occ" and "any occ," or the subtle differences in each carrier's definition of "disabled." Inexperienced lawyers may argue the medical diagnosis, which does nothing to help prove disability.

Are "Independent Medical Exams" Really Independent?
Often the insurance company will send the record out for an Independent Medical Review. However, these reviews are anything but independent. The insurance companies contract with other companies that have many doctors working for them who perform these reviews. Most of these doctors do not see patients anymore because they receive a large income from doing these file reviews. The medical review companies advertise on their Web sites that they can help disability insurers who keep costs down. That is because these doctors rarely find a clamant disabled.

What Happens if I Refuse to Be Examined?
Because the disability policy is a contract, all contractual obligations must be followed. If the policy indicates that the insurer has a right to have the claimant examined, that is a contractual obligation. If the claimant refuses to be examined, benefits can be terminated.

What Happens If You Win Your Administrative Appeal?
If the claimant wins the administrative appeal, he or she will receive back benefits (monthly benefits from the date the claimant was cut-off benefits) and be put "back on plan." The claimant will begin to receive monthly disability benefit payments. The claimant will still need to adhere to all contractual obligations and will need to continue to send in updated medical records and Attending Physician Statements to prove on-going disability.

Do You Need an Attorney to Help With the Administrative Appeal?

The Importance of Representation During the Administrative Appeal
Many claimants decide to appeal the insurance carrier's denial on their own. Often, a claimant will write a one-paragraph appeal stating "I appeal your decision. Please reconsider." This approach rarely succeeds. An experienced attorney will perform many tasks on appeal, including writing an appeal letter that addresses each of the carrier's allegations, contacting and

Strategies experienced attorney use to improve your chances of winning your claim:

1. Loading the Record
2. Using Obtaining Vocational Expert Opinions
3. Obtaining Medical Expert Opinions
4. Rebutting Insurance Company Distortions and Mischaracterizing of the Evidence
5. Rebutting In House Medical Reviews

obtaining expert opinions, sending a claimant out for a functional capacity exam or other medical exam, obtaining updated medical records, and carefully going through the claims file to see if the insurance carrier followed the proper procedures in its handling of the claim.

Loading the Record
During the administrative appeal process, medical records, medical literature and articles, doctor's opinions, letters from friends or employers, photographs and all other types of evidence that document a claimant's impairments can be submitted and made part of the "record." Once all appeals that are allowed under the policy (usually two), the "record" is closed. There is case law that indicates that more material can be added to the record before a lawsuit is filed, but usually once all appeals are "exhausted," the carrier will send any newly submitted evidence back. After a lawsuit is filed, nothing else can be added to the record. That is why it is so important to fully load the record during the appeals process. An experienced attorney will understand the importance and ensure that the record is loaded.

Obtaining Vocational Expert Opinions
Vocational experts are sometimes called "jobs experts" or "VEs" for short. VEs usually have a master's degree or a Ph.D in a field such as Vocational Rehabilitation or Vocational Counseling. Using a claimant's RFC, taking into consideration all of a claimant's restrictions and limitations caused by their medical impairments, and the claimant's age, education, background, work experience and skills, the VE can form an expert opinion on what jobs a claimant may be able to perform. The VE could also come to the conclusion that there are no jobs available in the national or regional economy that the claimant can perform.

Some policy's definition of disabled include that the claimant is disabled if he or she cannot find work that pays a certain percentage of their pre-disability income, usually around 80 percent. A VE researches the local job market and wages and is able to form an opinion on whether or not there are jobs that the claimant can perform and still meet the salary percentage. An example would be a claimant who performed heavy manual labor, like construction, and now can only do sedentary work. If the claimant does not have the background to do skilled sedentary work, an unskilled sedentary job may not pay enough to reach the salary requirement. That claimant would meet the policy definition of disabled because the VE found that there are no jobs that the claimant could perform that pay 80 percent of his or her salary.

Obtaining Medical Expert Opinions
In the same way that the VE reviews the record and forms an expert opinion, an independent medical expert can review all the medical records and form an opinion about a claimant's RFC. Sometimes the medical expert will also examine the claimant and include those findings in the report. A claimant may need a medical expert opinion if there are not very many records or if the records don't accurately reflect the claimant's condition.

Rebutting Insurance Company Distortions and Mischaracterizing of the Evidence
The insurance companies claim adjusters focus only on the evidence that supports a denial and ignores evidence that supports disability. This is called "cherry-picking" the record. For example, a claimant's physician may write a letter that states that their patient is disabled due to pain and can no longer work, but on another form may indicate that their patient could sit for eight hours a day. The insurance company will ignore the "disabled" letter and state that the physician has released the claimant to work in a sedentary position because the claimant can sit for eight hours.

Insurance Company Tactics

The insurance companies have tactics of their own. These can include:

- Separating Impairments During the Review
- Video Surveillance
- Functional Capacity Exam
- Malingering Because of "Grip Strength" Test
- Non-Compliance
- Non-Medical Problems at Work

Rebutting In-House Medical Reviews
The insurance company often has nurses and doctors on staff who review medical records.

Separating Impairments During the Review
Many claimants have more than one medical impairment. It may be the combination of a claimant's impairments that renders the claimant disabled. However, during a file review, the hired doctors will focus on each impairment individually and find that the claimant is not disabled based on that one impairment. It is not unusual for the insurance company to send the file out to several doctors, each with a different "specialty." When a claimant's impairments are separated out, the reviews do not reflect a true picture of the claimant's condition.

Video Surveillance
Some insurance companies make a habit of videotaping claimants after they have received

benefits for a year or two. The insurance company will claim that there are "red flags" that indicate a claimant may be working, so an "investigation" is necessary. Often, the only activity that that is "caught on tape," is a claimant going to a doctor's appointment, going to the pharmacy or driving through a fast food chain. The insurance company will always claim that the claimant is capable of more activity that originally reported because the claimant was "able to enter and exit a motor vehicle unaided," "use a cell phone," and "walk about in a non-guarded fashion." Later, a representative of the insurance company will visit the claimant for an "interview" and show the claimant the footage. This can be intimidating to a claimant. Then the insurance company will use the video surveillance as evidence to terminate benefits even when the record as a whole supports a finding of disabled.

Functional Capacity Exam

A Functional Capacity Exam ("FCE") is a series of physical tests given to determine a claimant's RFC. These are standardized tests given by a physical therapist over about a 3-4 hour period in a gym-like setting. The claimant walks on a treadmill, lifts and carries cardboard boxes and goes through a series of different postures, like squatting and crawling. The physical therapist observes and analyzes the claimant's physical abilities to sit, stand, walk, lift and carry. These tests are designed to surmise the claimant's maximum RFC in the work environment. However, 3-4 hours of activity can't really reflect how well a claimant would do eight hours a day, day after day, week after week.

What Is Malingering?

Malingering means that a person deliberately pretends to have a disability in order to gain financial benefits. Another term used by insurance companies is "symptom exaggeration." The insurance company will state that the claimant's symptoms do not correlate to "objective evidence," so the claimant must be exaggerating their pain or other symptoms.

Malingering Because of "Grip Strength" Test

One of the tests performed at a FCE is a grip strength test where the claimant squeezes a handle rapidly, alternating hands. In claimants with normal or weak grips, the test results produce a bell shaped curve. The thought behind this test is that it is difficult to consciously control how hard a person grips the handle in a rapidly alternating exchange. If the results are not bell-shaped, the claimant will be accused of faking their hand strength. Most importantly, the insurance company will then claim that the claimant was malingering on all the tests and therefore, even if the FCE shows that the claimant has a very low RFC, the insurance company will say the FCE results are not valid. However, scientific study of these tests on people with

carpel tunnel syndrome show that these tests are really not reliable to distinguish true or faked hand weakness.

What is Non-Compliance?
If a claimant refuses treatment or does not take medication as directed by their doctor, a claimant is "non-compliant." There is a difference between not having a surgery because of possible adverse outcomes or not being able to pay for medication and non-compliance.

Non-Medical Problems at Work
Insurance companies sometimes make the claim that a claimant is not really ill and that the claimant "just wants a lifestyle change." The insurance company will ask the claimant if they ever had any problems at work with their supervisor or co-workers. This is an attempt by the company to characterize symptoms as "job stress."

The Importance of Attorney Representation During Your Lawsuit

An experienced attorney is well aware of all the tactics an insurance company uses during the administrative appeal process to turn down a claim. Many of these tactics have been litigated in prior lawsuits. An attorney researches case law in a claimant's jurisdiction and uses that law to support legal argument to persuade the judge that the insurance company made the wrong decision in finding the claimant not disabled. Because most long term disability lawsuits are under ERISA, there is no jury trial, only a trial before a judge, called a bench trial. The judge reviews written legal argument, called a Motion for Summary Judgment, to make a decision. It is important to have an attorney knowledgeable in the appropriate case law during the lawsuit. An attorney understands the strengths and weaknesses of a case and may be able to negotiate a cash settlement on behalf of the claimant before it is necessary to present argument to a judge.

What Does An Attorney Do to Help With Your Claim?

Every client is different and has different needs, but below are just some of the things our attorneys may do to help you with your Disability insurance claim:

- Aid you in filing out all insurance company forms;
- Evaluate your insurance claim and advise you on the law and your options;

- Review your medical records and make suggestions for any additional testing required to prove your case;
- Supplement your claim file with additional medical records;
- Obtain your complete claim file from the Insurance Company pursuant to Federal ERISA statutes;
- Obtain medical reports and opinion evidence regarding your disability;
- Consult with qualified Vocational Experts to get opinion evidence rebutting an insurance company's denial;
- Obtain and develop evidence regarding you "Residual Functional Capacity" that is the key to your disability claim;
- Quickly and effectively file your administrative appeal when necessary;
- Correctly Calculate your benefits;
- File a legal brief arguing the legal, medical and vocational issues in your case;
- File a lawsuit in Federal Court if necessary;
- Conduct discovery in the Federal Court case such as filing interrogatories and requests for production, as needed, as well as taking all necessary depositions;
- Responding to Motions for Summary Judgment and trying your lawsuit.

How Does Your Attorney Get Paid?

There are a number of ways to hire an attorney. They range from a traditional hourly basis to a pure contingency fee arraignment, or some combination of both. The difference is generally boils down to who is taking the risk of whether a recovery is made, the client or their attorney. If a claimant hires an attorney on an hourly basis, the claimant is taking all the risk of an unfavorable outcome. In other words the claimant has to pay attorney fees whether they win or not. Under a contingency fee arraignment, the risk of not getting paid shifts to the claimant's attorney. In other words, the attorney will not get paid if the claim is not successful. Generally speaking, an attorney expects to get compensated more for doing contingency fee work because the attorney is assuming a risk that they will not get paid at all. For a discussion of the prospects of getting reimbursed for your attorney fees from the LTD Insurance Company.

Is Your Case Governed by Federal ERISA Law?

What is ERISA?
ERISA stands for the Employee Retirement Income Security Act of 1974. ERISA is a federal law that regulates the handling of Employee Benefit Plans

and the remedies of the beneficiaries of these Plans. ERISA applies to all employees benefit plans established or maintained by an employer engaged in commerce or by an employee organization representing employees engaged in commerce. Practically all long-term disability plans offered by a private employer are governed by ERISA. A claimant challenging a disability denial under an ERISA governed plan or policy must bring the claim pursuant to ERISA regulations and procedures. All state law remedies are preempted, meaning they do not apply to an ERISA claim.

ERISA Does Not Apply to Privately Purchased Insurance

If you purchase your own private individual or family disability policy, then ERISA does not apply. To be clear, it must not be a policy obtained through your employer sponsored group benefits plan. If you do purchase your own private policy, you are entitled to all procedural rights and remedies available to you in your state just like you would under your privately purchased homeowner's or life insurance policies. Good for you if you have a private disability plan. You will be treated much better by your insurance company. Later in the book, we'll discuss remedies if benefits are denied under your private plan.

Possible Exceptions to ERISA

- Government employees: Government plans are excluded from ERISA coverage. This generally includes federal, state and local governments including school districts and public universities.

- Church Plans: Employees of qualifying religious institutions such as a church, synagogue or mosque are generally exempt from ERISA.

- Self Employed Individuals: Self employed individuals are not governed by ERISA if only the individual and their family are covered.

- Some Partnerships: Similarly, partners in a partnership with a plan that only covers partners, but no employees is not an ERISA governed plan.

- Pass Through Plans: Voluntary Plans where the employer contributed nothing to the plan and merely acted as a "pass-through" are exempted from ERISA if all requirements are met. These are extremely rare as the LTD carriers generally require employer contributions to set up the plan for the express purpose of receiving ERISA protection.

Why Is ERISA Favorable to the Insurance Company?

- No State Law Claims: As stated above, all state law procedures and remedies are preempted by ERISA. Put bluntly, you are prevented from pursuing state law remedies such as mental anguish and consequential damage claims, loss of credit claims, punitive damage claims, statutory insurance violation claims, deceptive trade practice claims, bad faith and mandatory attorney fee reimbursement.

- Limited ERISA Remedies: Under ERISA you can only sue for what the insurance carrier should have paid you in the first place and your ability to recover attorney fee reimbursement is difficult at best. As you might imagine, under a system in which the worst that could happen to the insurance company is that they have to pay the original claim and nothing else, the insurance companies are emboldened and do not fear denying claims as they see fit.

- No Right to Jury Trial: Also, you have no right to a jury trial to decide your claim. Juries are the great equalizer in the civil justice system. Insurance companies are wary of them. In an ERISA case, the insurance company doesn't have to worry about a jury holding them accountable.

- No Treating Physician Rule: Unlike a Social Security Disability claim where the SSA must respect the opinions of your own doctor, in an ERISA disability insurance claim, the insurance company can ignore your own doctor's opinions and rely on their own doctor's opinions as they see fit.

- Little Government Regulation: There is little guidance in the law as to how the insurance policy must be written. As a result the insurance carriers are free to write the policy as they wish. Competition from other companies is their greatest incentive to write any provisions favorable to the claimant.

- Plaintiff Must Prove Insurance Company "Abused Its Discretion": In a disability insurance claim brought under state law, the disabled claimant only has to prove it is "more likely than not" that they are disabled. However, in most claims brought under ERISA, the claimant must prove that the insurance carrier "Abused Its Discretion" when it

denied your claim. This is a tough standard requiring you to show the insurance company had "No Reasonable Basis" for denying your claim. An example might be if you had three doctors that said you were disabled and the insurance company only had one that said you were not. The insurance company would argue that they had a "reasonable basis" to deny your claim based on their one doctor, in spite of your three.

Filing an ERISA Law Suit If My Administrative Appeal is Denied

Who Can Sue?
Any Plan beneficiary or participant may bring suit to enforce their rights under the plan or policy. This generally means the disabled individual but in some cases could be a spouse, an estate or an heir.

Who Do You Sue?
Typically in a disability claim, the suit is brought against the Plan or the Plan Fiduciaries, often called the Plan Administrator. Frequently, the plan administrator is the underwriting insurance company. Hence, the reason we generally refer to the insurance company throughout this eBook when we are speaking about the Plan. Occasionally, but not often, the proper defendant is the claimant's employer. The test is who had the authority under the plan to grant or deny the disability claim.

Where Can I File My Lawsuit?
ERISA states you may file your lawsuit in one of four places:

1. Where the Plan is administered;
2. Where the breach occurred;
3. Where the defendant resides; or
4. Where a defendant may be found.

The plaintiff's choice of venue is given great deference by the courts. In benefit denial cases, the courts generally conclude that the breach of contract occurs where the benefits are to be received. Practically speaking, this means you may file your lawsuit where you live or expect your benefit checks to be delivered. You may file an ERISA case in either state or federal court, but invariably the defendant will remove (transfer) your case to federal court based on federal issue jurisdiction.

What Remedies Can I Sue For?
Under ERISA, you may sue to "recover benefits due under the terms of the plan, to enforce rights under the terms of the plan, or to clarify rights to

future benefits under the terms of the plan." The only relief available is to require the plan to pay what it was required to pay in the first place, including an award for retroactive benefits. No extra contractual compensatory damages or punitive damages are allowed. You may also seek a declaration of a right to future benefits or an injunction preventing a future denial of benefits.

How Long Do I Have to Sue?
All potential claims for which a lawsuit could be filed have deadlines for filing suit. These deadlines are known as the "Statute of Limitations." Your lawsuit must be filed prior to the expiration of the appropriate statute of limitations or your claim is lost forever. This is an absolute. One day late and your claim is gone, PERMANENTLY. Oddly, ERISA provides for no statute of limitations directly, so instead you must look to each individual state for the appropriate deadline. Most courts apply a breach of contract statute of limitations to a benefit denial claim under ERISA. In Texas, for example, the deadline would be four years from the date of breach or denial. This varies from state to state. However, the insurance plan or policy may shorten the deadline pursuant to the terms of the plan. It is vital that you check your plan documents for any pending deadlines. Many plans shorten the deadline to three years from the date proof of disability must be provided. Some plans have much shorter deadlines.

Do not skip this step!

Do I Have To Exhaust My Administrative Appeals Before I Can Sue?
In a word, Yes! ERISA regulations require that all Employee Benefit Plans have an Internal Administrative Appeal or claims procedure. The courts have interpreted this to mean that it is mandatory that you go through with an Administrative Appeal and "Exhaust" your administrative remedies before you have a right to file a lawsuit. You cannot skip this step! If you do you will lose your right to file your lawsuit. The denial of a disability claim must be done in writing. Generally the last paragraph or two of the denial letter spells out the deadline for filing the administrative appeal. Usually the deadline is 180 days from the date of the denial letter. Remember, only the evidence submitted during your administrative appeal can be used during your federal lawsuit. If you don't do an excellent job developing your evidence at this point, you probably won't have much of a chance in Court!

What Do I Have To Prove?
Winning your lawsuit requires much more than simply proving you are disabled. You must prove that the insurance company that denied your disability claim "abused their discretion" in denying your claim based on the evidence available to them at the time they made their final decision to deny the claim. That is why it is so important that your case is properly developed during the administrative appeal.

Experienced ERISA attorneys know that it is critical to the litigation to prove both a structural conflict of interest and an individual conflict of interest that is present with the insurance company and its decision makers. The odd procedure set up under ERISA allows the insurance company to decide if they have to pay the claim, assuming that their financial self interest won't out weight their fiduciary duty to do the right thing. In previously litigated cases, it has also been discovered that insurance carriers sometimes create financial incentives for their own doctors, vocational experts and decision makers to keep claims cost down. These inherent conflicts of interest must be demonstrated to the court when litigating these cases. Doing so can cause the court to use a more favorable "sliding scale" when deciding these cases.

ERISA disability claim outcomes:

- Settlement
- Motion for Summary Judgment
- Bench Trail
- Remand for Another Administrative Appeal

What are the Possible Outcomes?
When litigating an ERISA disability claim, the mostly likely outcomes, depending on the strength of your case are:

- Settlement: It may be possible to negotiate a "buy out" with the insurance carrier to settle the claim and surrender the policy;
- Motion for Summary Judgment: The case could be decided for or against you based on a Motion for Summary Judgment filed either by yourself (through your attorney) or by the insurance carrier. A motion for summary judgment is filed by either party when they believe the case could be decided by the judge "as a matter of law" without the need for a trial. Remember, there is no opportunity to submit new evidence to the court, therefore the only thing the judge needs to consider to decide the motion for summary judgment is the evidence already submitted (referred to as the administrative record).
- Bench Trial: The judge could decide to have a bench trial. Since there is no right to a jury trial, the case would be tried to the judge at the "bench." The judge would indicate what issues were not decided on the

motions for summary judgment and that would dictate what live testimony may be needed for the judge to decide the remaining issues.

- Remand for Another Administrative Appeal: The judge could order the case remanded back for another administrative appeal to develop the case further.

One thing to remember is that if a judge rules in your favor, he or she only has the power to order the insurance company to pay you the back benefits you are owed and to start your monthly benefits from this point forward. The insurance company has the right to require you to continue to demonstrate that you are disabled per the policy definition and could conceivably cut you off again in the future. The judge may award you some attorney fees as well.

Can I get My Attorney Fees Paid?
Maybe, but it is difficult. Generally speaking, attorney fees are not recoverable in most causes of action without an explicit statute authorizing it. ERISA does allow for recovery of attorney fees, but only at the "discretion" of the judge. In other words, it is not mandatory that the judge award attorney fees and the judge also has the discretion to award what he thinks is reasonable, not necessarily what you have to pay. This is especially evident given that most claimants hire their attorney on a contingent fee basis, but the judge can only award fees based on a reasonable hourly rate. Also, the judge will not award attorney fees based on work done during the administrative appeal even though the claimant still has to pay them. In short, ERISA strikes again. Call your Congressman! Seriously, only they can fix this!

Filing a Lawsuit on a Private or Non-ERISA Disability Insurance Claim

As stated previously, most disability insurance claims are ERISA preempted because most people obtain their policy from their Employee Benefit plans. As you have noticed most of this book has been devoted to ERISA claims for the same reason. The other reason is that since ERISA claims are based on federal law, the law and procedures are generally the same in all 50 states, allowing for a uniform explanation of the issue.

The same cannot be said for private or non-ERISA based claims. Since these cases are based on the individual state law that applies to the particular

policy, we would have to write 50 different books to cover the topic. As such, we only discuss the topic generally.

In cases where an insurance carrier has denial a claim, most states have multiple remedies available if litigation is necessary. What applies to all state law claims is that you should endeavor to give your insurance company every opportunity to do the right thing and put it in writing.

Many states require that you put your grievances in writing and establish a certain amount of time that must be given for the insurance company to comply. If the insurance company fails to comply with your requests by the statutory deadlines, you probably have many extra contractual remedies available to you that you would not be available if your case was ERISA preempted. These include causes of action for breach of contract, bad faith, punitive damages, mental anguish or consequential damages, loss of credit, deceptive trade practice act damages, insurance code statutory damages and attorney fees.

If you have such a claim, bringing in an experienced attorney early will help you "set up" your case for a good result down the road.

Conclusion

Disability Insurance claims are governed by a complex set of laws and procedures. These laws are full of traps for the unwary, even attorneys not experienced in ERISA law. Most people make the mistake of thinking they can handle the administrative appeal themselves and then hire a lawyer if they lose and have to file a lawsuit. This is totally backwards thinking.

Recently, I had a client come to me with such a claim. He said, "don't worry about the administrative appeal, I filed it myself. I just need you to file my lawsuit." It turns out he filed a one page letter asking the insurance company to reconsider because he "really was disabled." He was astonished to learn that this one page letter was the only evidence the judge could consider in his case other than what the insurance company chose to include when they denied him. In other words, he had blown any chance to present his case in court. Don't let this happen to you. If you don't call us, call someone.