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FRANKEL & NEWFIELD, P.C. is a boutique law firm focusing on assisting individuals with long term disability claims, and individuals whose long term disability claims have been wrongfully denied or terminated. Our experience in recognizing issues before they become problems has helped guide many claimants through this difficult process at a time in their lives when they most need the benefits of the protections they purchased.

Welcome to "LTD Management," Frankel & Newfield, P.C.'s quarterly newsletter for the Firm's clients and professionals who routinely consult with the Firm, updating them on our practice, as well as important new developments in the law of disability insurance.

Firm Updates

The firm is proud to welcome its associate, Kimberly Fass-Marcus, Esq., to the firm. She handles claims and appeals for claimants with long term disability claims and claims that have been denied or terminated.

The firm is launching its new web site, still found on the web at www.longtermdisabilityclaim.com. The new site offers greater navigation and links to other helpful sources of information concerning disability news and medical information.

Frankel & Newfield continues to contribute to Podiatry Management magazine, with three articles published, the most recent a helpful Q&A about the disability claim process and potential problems seen by claimants.

We are also publishing an article in an upcoming issue of Chiropractic Economics concerning disability insurance claim issues.

Practical Concerns-A Case Study

An issue being seen with greater regularity in disability claims is the situation where anxiety or depression is suffered by a claimant that is secondary to a physical condition, which causes a claimant to become unable to work in their profession. This is often seen in cases where the claimant has had a cardiac event, and returned to work after a period of recovery.

The claimant finds that upon return to work, it has brought back the stressors which perhaps contributed to the cardiac event in the first instance. The claimant becomes anxious, fearful of another event - and loses the ability to concentrate and focus as well as before. Unfortunately, the insurer is likely to take the position that the disability insurance covers the inability to work at the job, and not the fear of dying from working in that job. Thus, where a claimant also has anxiety or depression which impacts on their ability to focus or concentrate, the claim may be developed and supported through a mental health provider. The insurer is likely to fiercely contest the mental aspects, but such claims can be well supported and testing data can also support that aspect of the claim.

Thus, a claimant who has sustained a disabling event and returned to work, but feels that they are unable to continue without jeopardizing their

continued recovery can strengthen a potential claim by having the emotional aspects of their condition explored and treated. Be mindful, however, that failing to receive treatment for such a condition will prevent a claimant from pursuing this aspect of the claim, since policies require that a claimant be under the care of a physician, other than themselves, for the disabling condition.

Success Story

Frankel & Newfield was able to secure the reinstatement of benefits for a client whose benefits were terminated improperly. The insurer had argued that he could perform the duties of his job, having sent him for a Functional Capacity Evaluation. We successfully argued that the client's physical limitations substantially prevented him from performing his own occupational duties on a regular basis. The client is now receiving his full monthly benefit and received his arrears.

For more success stories, go to our web site, at www.longtermdisabilityclaim.com, and click to success stories.

Time for a Check Up on your Coverages

There are a myriad of disability coverages available to professionals, offered by a number of insurers, and everyone who currently has disability insurance coverage should take the time to appreciate the scope of their coverage, and understand just what they are paying for. There are essentially three (3) types of disability coverages; individual, association and group. We will outline each below, and discuss the benefits and drawbacks that exist.

Individual DI coverage is where a policyholder contracts directly with an insurer - much like one does for auto or homeowners insurance. This is a contract between two parties - and the coverage afforded is negotiated, with potential riders offered. These riders might include lifetime benefits, rather

than payable until age 65, or a cost of living adjustment (COLA). Extra premiums are usually required for these riders, but provide enhanced benefits to disabled claimants. This coverage offers the greatest array of benefits and the best coverage, at a greater cost than the others.

Another type of disability insurance coverage is an association policy, usually offered through one of several professional organizations, such as the American College of Surgeons. These coverages are a different form of individual coverage than a pure DI policy, and usually offer lower quality of coverage, at a reduced premium. For example, while many DI policies have "own occupation" coverage for the duration of the policy, many association coverages have an "own occupation" for a period (60 months) switching to a modified definition of disability that is less generous to the claimant. Thus, a professional holding this coverage may operate under the mistaken belief that their coverage is adequate, only to learn when a claim develops that coverage will not last as long as needed, or as long as thought when purchased.

The final type of disability coverage is group disability insurance, usually provided through an employer, such as a hospital or medical practice. This coverage is less generous than DI or association coverages. There are many reasons why the coverage is inferior, from the fact that the individual is not the insured, but only a beneficiary of the policy, to the fact that the employer can modify coverage without input from the individual. Group coverage usually has a limited pay period for certain types of claims, whether Mental and Nervous ("M&N") or self reported symptoms without objective support.

These coverages never adequately protect the financial concerns of a professional - offering a percentage of their earnings, and often deducting benefits received from many other sources as an offset against the potential payments. This coverage is always less expensive and may be totally paid by the employer - causing benefits to be taxable.

The following chart highlights some of the common differences between and among the various coverages.

	IDI	Association	Group
Lifetime Coverage?	Yes	No	No
Limited Pay on Mental Claims?	No	No	Yes
Self Report Claim Limited Pay?	No	No	Yes
Offset for Other Benefits?	No	Possibly	Yes
COLA?	Yes	Possibly	No
Occupation Specific?	Yes	Often for limited time (60 months)	Limited time (24 months)

Recent Decisions on Disability Cases

There have been a number of interesting decisions from the Courts that decide these claims. There are also a few trends that we have noticed from the recent cases that have been decided.

From the perspective of the claimant, it is clear that the courts are moving toward an appreciation of the improper conduct of insurers, and are more receptive to arguments by claimants of biased conduct. Nonetheless, many decisions still favor insurers, particularly those where a claimant can be shown to have inconsistencies between statements made to the insurers and information gathered from the investigation performed by insurers.

One court recently found that the insurer acted in an arbitrary and capricious manner when it failed to have a medical doctor review the claimant's medical documentation, relying instead upon a nurse to review the materials. This was an important factor supporting the court's decision.

Another court found that an insurer acts in an arbitrary matter where the claim review was focused skepticism rather than reasoned decision-making. The insurer essentially minimized or refused to acknowledge the severity of the claimant's conditions, and the court was not satisfied that the conduct of the insurer was appropriate.

Regarding the issue of focus of this issue in our case study, one court recently found that a claimant, with a history of serious cardiac problems, which required medical intervention over a long time period, was disabled, even without immediate and current heart symptoms. The court found that the claimant should not be forced to "take the risk that continuing to work could generate" and was found to meet the definition of disability. This case is of significance to claimants in similar situations, since we can utilize the rationale of the court to persuade courts and insurers in other matters.

Another court found that the insurer's conduct was improper where the decision relied upon the results of a Functional Capacity Evaluation. The court held that the bias of the evaluating company who performed the testing was readily apparent from the report, and from information gleaned from its web site, which led the court to conclude the company was an extension of the insurer.

Courts have been ruling against claimants whose alleged conditions have been refuted or called into question by other materials developed during the insurer's investigation. Where the insurer captured surveillance of the claimant engaging in certain activity, or where the claimant advised his treating physician as to certain activities which were inconsistent with the claimed restrictions or limitations, the insurers have succeeded in terminating the claims, and having the courts uphold these claim determinations.

The information provided in this publication is intended to be for informational purposes only. It is not intended, nor should it be used, as a substitute for legal advice or opinion which can only be rendered when related to a specific fact situation, and on an individual basis.