FRANKEL & NEWFIELD, PC
DISABILITY INSURANCE ATTORNEYS

A Leading National Disability Insurance Law Firm



# FILING A DISABILITY INSURANCE CLAIM

## Secrets the Disability Insurance Companies Don't Want You to Know!

By Jason Newfield, Esq. and Justin Frankel, Esq.

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## Disclaimer

The following eBook and the information contained therein is provided for general informational purposes only and is not a substitute for professional legal advice based on individual circumstances. Laws change frequently, disability insurance contracts are all different, and the authors cannot warrant that any and all of the information in this eBook is relevant to any one specific instance.

Individuals must always consult with a qualified attorney directly before making any legal decisions concerning their own situation.

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An attorney/client relationship with this firm is only formed with the execution of a written contract with Jason Newfield, Justin Frankel and/or the firm that is signed by the client and one of the partners of the firm.

*Filing a Disability Insurance Claim*


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# MEET THE AUTHORS

## Jason Newfield, Esq., Partner

Jason A. Newfield has spent many years aggressively representing claimants in long term disability insurance and other insurance claims and litigation. He has extensive experience in both Federal and State courts. For the majority of his legal career, he has represented doctors, dentists, accountants, lawyers and other professionals in various capacities. Mr. Newfield litigates cases throughout the country on behalf of aggrieved claimants.

Martindale-Hubbell® has rated Mr. Newfield an AV® Preeminent Peer Review Rated, the highest possible designation from Martindale-Hubbell. Super Lawyers has named Mr. Newfield to its select list of attorneys for the 2013 New York Metro listings.

Mr. Newfield served a four year term on the Chronic Fatigue Syndrome Advisory Committee, a federal committee that advises the United States Department of Health and Human Services regarding Chronic Fatigue Syndrome, a medical condition of particular concern to him. He is also a frequent lecturer to medical organizations about the disability process and is a Physician Educator concerning the documentation of support for claimants with Chronic Fatigue Syndrome. Mr. Newfield is a Member of the American Conference Institute, and a regular lecturer at their annual conference on Litigating Disability Insurance Claims, where he interacts with claim representatives, and attorneys for the insurance companies, throughout the country. He has also been on the faculty of ALI-ABA (American Law Institute, American Bar Association), providing lectures on ERISA disability insurance claims.

He received his B.A. from the State University of New York at Albany and his J.D. from Hofstra University School of Law, where he was a Member and Associate Editor of the Hofstra Law Review, an editor of the student newspaper and an advocate for employee benefits. He is admitted to practice law in the states of New York, Pennsylvania and Connecticut, the Federal courts of the Southern and Eastern Districts of New York, District of Connecticut, Eastern District of Pennsylvania, the Second and Fourth Circuit Court of Appeals, and the United States Supreme Court.





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## Justin C. Frankel, Esq., Partner

Justin C. Frankel has devoted most of his legal career to representing long term disability insurance policyholders, and also has experience in general litigation, complex commercial cases and class action litigation. Mr. Frankel also has extensive experience representing doctors and other health care providers in medical malpractice actions.

Martindale-Hubbell® has rated Mr. Frankel an AV® Preeminent Peer Review Rated, the highest possible designation from Martindale-Hubbell. Super Lawyers has named Mr. Frankel to its select list of attorneys for the 2011 and 2013 New York Metro listings.

Prior to forming Frankel & Newfield, Mr. Frankel worked tirelessly representing policyholders in all types of insurance matters, primarily long term disability insurance litigation and complex civil litigation. Previously, he spent many years at a major law firm representing individuals whose rights had been violated through class action litigation throughout the country.

Mr. Frankel is a regular speaker before bar associations and medical organizations regarding disability claims, and has published several articles on Disability Insurance. He received his B.A. from Stony Brook University and his J.D. from CUNY School of Law. Mr. Frankel is admitted to practice in the states of New York, Pennsylvania and Connecticut, as well as the United States District Courts for the Southern and Eastern Districts of New York, District of Connecticut, Eastern District of Pennsylvania, the United States Court of Appeals for the Second, Third and Fourth Circuits, and the United States Supreme Court. He is a member of the Association of Trial Lawyers of America.





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# INTRODUCTION

In the years that we have been in practice, we have seen countless times the hardship and emotional distress created when ill and injured men and women are denied benefits from long term disability insurance policies. The stress that results from the financial burdens caused directly by the insurance company's refusal to pay benefits has a cumulative impact that often leads to larger problems. Our practice was founded with the philosophy that our clients deserved better.

We have continued this dedication to our clients, deliberately keeping our practice small so that clients work directly with a partner. Similarly, we have maintained a practice of building strong working relationships with our adversaries, including those working directly in the insurance business, in-house attorneys, claim managers, investigators and outside law firms. They know us, and respect our professionalism as much as our tenacious and effective representation.

Our decision to write this book came about because we feel we have important information to provide to our clients and potential clients and the disabled community more broadly, along with spouses and family members of those impaired, to help those in need. We hope this book answers some of your questions. We are available to answer others you may have. Contact us at jan@frankelnewfield.com or jcf@frankelnewfield.com. We welcome your questions, and look forward to hearing from you, and hope you find this book helpful, insightful and thinking more pro-actively about your claim issues.





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## DISABILITY INSURANCE CLAIMS

It's widely recognized and statistically proven that the chances of someone becoming disabled - unable to work during their working lives - because of an illness or accident are far higher than of them dying at an early age.[1]

According to the Council for Disability Awareness, a typical healthy female working in an office job has a 24% chance of becoming disabled for three months or longer during her working career, and a 38% chance of a disability lasting five years or longer. A typical male in an office job has a 21% chance of becoming disabled for three months or longer during his working career, and a 38% chance of becoming disabled for five years or longer.[2]

Every year, millions of Americans become disabled as a result of becoming ill with a chronic or life-threatening disease or because of an accident. The financial burdens of being unable to work add up quickly. Health insurance is rarely adequate to cover large medical bills and the cost of on-going care and savings are exhausted quickly. Most of us don't want to consider the hard economic facts of becoming disabled, but generally speaking, 60% of a person's income is barely enough to maintain a pre-disabled lifestyle. Many policies offer less than that amount and most group policies provide taxable benefits – at least a portion – if not the entire benefit. When even that amount of income is not available, costs snowball, and debt mounts. Your best defense: a strong legal team that will fight for your rights, and protect your interests throughout this difficult process.





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# TOP TEN QUESTIONS ABOUT DISABILITY INSURANCE

1 – *I have a legitimate claim. Why wouldn't they pay me?* Most disability insurance coverage is issued by public companies. Thus, disability insurance companies' first priority is their bottom line. They control costs by carefully managing claims – often through the denial or termination of legitimate claims.

2 – *My doctor says he filled out the forms, but the insurance adjuster says they can't find the paperwork.* Any materials that you send to the insurance company should go by certified registered mail or express mail that requires a signature. We also advise claimants to keep a copy of everything they send. Emailing or faxing will also work, so long as you are able to document that the communication was received.

3 – *Why do I have to attend an IME? What IS an IME?* In most cases, the claimant is contractually obligated to attend an Independent Medical Exam, or IME. However, these are not truly independent, and we often call them DMS's, or Defense Medical Examination. The doctors are selected by the insurance companies, and are paid by the insurance companies. The doctors hope for any repeat business will be from issuing a report that the insurance company is happy with; and thus is in stark contrast to being "independent". We often advise our clients to bring a friend or family member to the exam, and take careful notes of the process and interaction with the doctor. We also consider whether videotaping the examination will be valuable.

4 – *The woman on the phone was very nice – but she still said no. What did I do wrong?* You didn't do anything wrong. This is a business decision for the insurance company, and, while it feels very personal, it's about the insurance company trying to maintain its reserves. Very often, insurers try to get a claimant to feel comfortable and act pleasant, but the goal is to develop information which can be utilized to deny or terminate a claim.

5 – *Why can't I manage this claim by myself? After all, I handle my auto and home owner's insurance claims by myself.* Disability insurance claims are complicated contractual transactions, governed by equally complex federal law (in most cases). Some of our clients are attorneys who thought they could manage their own claims, and they learned the hard way that they could not. The issues involved are not simple like an auto claim. There are many more steps in the process, and many more variables to whether you will get paid.





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6 – *Do I have to stop working before I can file a claim?* It depends upon the specific language in your contract. This might involve a partial or residual disability claim, something we will discuss later. Not all policies provide for such coverage, but where they do, it can be very helpful to a claimant.

7 – *I can't afford to stop working completely, but I am concerned about the impact my disability is having on my performance. What should I do?* If there is any chance that your disability may cause you to harm someone, stop working. Next, call an experienced attorney to find out your options. One must also consider whether to advise the employer of an impairment and a potential need for accommodations.

8 – *Shouldn't I retain a local lawyer?* Disability law is complex and disability contracts are complicated. Unless your neighborhood lawyer has practiced in this field, you need a disability insurance lawyer first and foremost. Their location doesn't matter nearly as much as their knowledge does. Having said that, it is a very personal decision to engage a lawyer on these types of claims, and for some, the ability to have someone to sit with may trump the knowledge of the out of town lawyer.

9 – *How long will it take to resolve my case?* This depends on the facts and the contract. Our goal is always to resolve cases as efficiently and advantageously as possible. An experienced attorney will not make promises about the amount of time it will take, as there are numerous variables within each claim which will alter the timeframes involved.

10- *Will the insurance company keep trying to stop paying me?* Unfortunately, as long as someone is on claim, the possibility exists that the insurance company will try to terminate or reduce their payments. In some instances, a lump-sum settlement is the best option for claimants. Each situation is unique and careful thought she be provided on such issues.





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## LONG TERM DISABILITY INSURANCE COMPANIES

Major insurance companies like CIGNA, MetLife, Liberty and Hartford, were created centuries ago, growing over decades into the global corporations that we know today. Most of these companies are publicly traded companies, and no matter how heartwarming or entertaining their commercials are, they are in business to make money for shareholders. During the Great Recession that started in 2008, these companies began to dig in even deeper, as their losses in equities markets were substantial, and reserves had to be protected.

It should be noted that the insurance industry is second only to the pharmaceutical industry in flooding Washington with vast amounts of money to influence legislation and public policy. In 2013, the insurance industry spent $153,116,559 in lobbying.[3] Big Pharma spent a total of $2.6 billion in lobbying from 1998 – 2012. The Insurance industry spent $1.8 billion during the same time period.[4] That's a lot of lobbying muscle.

In other words, the insurance industry is large and powerful, with lawyers and lobbyists and tens of millions of dollars to spend. A lone individual fighting a denied or delayed disability claim is up against a large opponent. When that individual is also battling the effects of an illness or injury that has made him/her unable to go to work, the fight becomes even harder. If being on claim for disability feels like a job, it should not.

When the insurance company claims you have no claim, we say this is one battle you don't want to take on by yourself.





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## BEFORE YOU FILE A CLAIM

Getting the right advice BEFORE filing a claim can prevent many problems. For instance, medical records from a primary care physician must clearly indicate the specific tasks of the occupation or what are the functional difficulties that the claimant can no longer perform as a result of their disability. If the physician form is not completed properly, the medical record will be used against the claimant to deny the claim. Nothing hurts a claim more than an unsupportive treating doctor.

Without experienced guidance, it is not likely that you or your physician will know how to correctly prepare your medical records for a disability claim.

If your disability insurance policy was purchased through your employer, it is governed by a federal law known as ERISA (The Employee Retirement Security Act), which was originally passed to protect employee retirement benefits and is used today to tightly control the appeals process for disability insurance claims. ERISA rules are very strict. Every single document, from the initial claim form to the medical records, must be considered evidence that may be used in an administrative appeal or a lawsuit. The only information that an administrative hearing can consider must be contained within the claim file.

There are strict time limits for applying for disability benefits. Read the policy carefully to make sure that you are within the time-frame of applying for benefits. A recent court decision has made the time element for bringing a lawsuit even more challenging for claimants. In *Heimeshoff v. Hartford Life & Accident Insurance Co.*, the U.S. Supreme Court held unanimously that the time limit contained within ERISA plans is enforceable - and the clock starts ticking from the date that the plaintiff's "proof of loss" is due - even before a lawsuit is filed, and possibly, even while a claimant is still receiving benefits, or has not yet "exhausted" their administrative remedies, a predicate to even being permitted to bring litigation.

This decision is not good for claimants, as it adds yet another layer of difficulty for those whose policies are part of their employee benefits package. As a result of this decision, plaintiffs may be faced with a dilemma as to how to proceed, as they may be subjected to a clock starting on their time to pursue relief, even while engaging in an administrative process with their insurer.





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Privately owned disability policies present their own challenges. For one thing, they usually are purchased by high income individuals, and the benefit payments are higher than group policy benefits. This means they cost more to the insurance company, which has a greater stake in denying a claim and protecting its assets. There are no damages or penalties for the insurance company if it refuses to pay a claim, except that it has to pay the claimant the monies that were owed in the first place – if the claimant wins. Meanwhile, the claimant has had to cover the costs that they expected the disability insurance benefits to pay, and experience the financial and emotional hardship of having their claim denied.

We know from experience that claimants who prepare their claims with the help of experienced professionals are more likely to avoid some of the common pitfalls that occur during the claims process. If a claim is complex or the situation is not straightforward, retaining an experienced disability attorney is critical to protecting your benefits. There is simply too much at stake to treat this as a do-it-yourself project.





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# PRIVATE OR INDIVIDUAL DISABILTY INSURANCE POLICIES

Private or individual disability insurance policies are usually purchased by high income professionals, business owners or savvy individuals who understand that the disability policy they get through their employer is just not enough to cover their living costs if they were to become disabled. While these are most expensive, the coverage is very often of significantly greater value, with rights superior to those afforded under many group policies, and with often greater coverage available, with less restrictions upon payment. Often, when premiums are paid by policyholders with post-tax dollars, the benefits are tax free.

Insurance companies used to target medical professionals; as a group, they tended to work long after most people retire, and rarely filed a claim for disability as they earned substantially more than most. For a long time, expensive policies sold to medical professionals were very profitable for the insurance companies. However, changes in how medicine is practiced – the passing of the family doctor, the rise of the large medical practices that are run like small businesses – led to a change in the number of physicians and dentists who filed claims. Companies began losing significant money with the rise in claims on these claimant favorable policies. Something had to be done. Insurers began to deny and terminate legitimate claims. Different than the group policies, disputes concerning private policies can be addressed in State civil court, and are generally resolved faster than those subject to ERISA rules. Moreover, a claimant with these policies have a broader array of rights, and are not limited in pursuing litigation following a denial or termination of their claim.





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# ERISA, OR GROUP, DISABILTY INSURANCE POLICIES

Group disability policies are part of many worker's benefits package, cost far less than private disability policies, and are the most difficult to fight when claims are denied or terminated. The claims process is definitely weighed in favor of the insurance companies. They are almost always governed by a federal law known as ERISA – The Employment Retirement Income Security Act of 1974, which was originally created to protect employee retirement funds.

Under ERISA, a claimant with a denied or terminated claim must exhaust administrative appeals before it can be brought to the court system, and all litigation must take place in Federal court. What this means is that a claimant is compelled to seek redress first with the same entity which mis-treated them before, seeking to have them change their own minds.

In litigation, evidence rules are strict – and quite often, only the materials contained within the claim file can be considered during the Court process. The insurance company itself is in charge of the claims appeal – serving as judge and jury to a dispute that it has an interest in. They get the final word, and they often control what is contained in the record.

This conflict is one reason we advise claimants against handling their appeals themselves – the deck is stacked and your adversary is skilled and experienced. Our formula for success on appeal is to address each aspect of the claim determination, treating the decision as the foundation of a house, and needing to make the house crumble, but taking away each piece of the foundation on appeal.





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# THE CLAIMS PROCESS

Once you have come to the undeniable conclusion that you can no longer continue to work, or no longer continue to work full time, the claims process begins. The first step is to locate your policy and any related documents. Do not rely on the insurance company to find the policy. The nature of disability insurance purchased more than five or ten years ago, or even twenty years ago, has changed dramatically. The policy is not just an insurance policy – it is a legal, binding contract between you and the insurance company, and the specific language it contains will govern the entire process, from the initial claim to the years of receiving benefits or negotiating a lump sum payment. If the policy is one through your employer, very often, you can access it through the employer benefits portal, but if not, you should be able to secure it from the employer.

For privately owned policies, contact the insurance agent who sold you the policy and request the necessary documents to file a claim. For a group policy, the Human Resources department at your company should be able to provide you with the forms you will need to prepare.

The moment you file your claim, be aware that two things begin. One, the clock starts ticking on your ability to potentially pursue litigation and two, the insurance company will begin gathering information about you, your lifestyle and your activities. This includes everything you do, from how often you leave the house to what you post on any social media platform. We will explore this in more detail in the Investigative Methods chapter.

Speak with your primary care physician and all other medical professionals. Their cooperation and support will be a critical part of your medical record, which is the heart of your legal defense when and if a problem arises. We wish all doctors knew how important their notes and reports are to their patients during this process.

The claims adjuster must see that not only are you not able to perform the material duties and tasks of your occupation (or potentially any occupation), but why you are not able to perform work functions. Details matter. The specific tasks or abilities required to perform your occupation must be included. Any mention of anxiety or nervousness will raise a red flag, which may lead the insurance company to attempt to re-classify your claim as a "mental/nervous" claim, which may carry a limited pay period. Many group policies pay a maximum benefit of 24 months for claims arising from or caused or contributed to a mental or nervous disorder, which is often very broadly defined.





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Test reports and clinical findings are very important, particularly for conditions like Chronic Fatigue Syndrome and Fibromyalgia. Our firm works with many doctors to educate them about the appropriate language that will best support claims for their patients. We have to stop the aggressive efforts by the insurance company to claim that there is no evidence of the impairment.

Finally, we cannot stress enough the importance of the medical records that will be presented in your claim. If your treating physician sees this as a burden and delegates it to a staffer who does not know the process at hand, your claim may be at risk. An experienced disability attorney must review medical records and interface with the doctor to ensure the records amply address the nature and scope of impairment, before they are submitted to the insurance company to ensure that your claim is presented. While your claim is being processed, a few pointers:

- **Make a note of every conversation you have with the insurance company representatives. Note the time and date of the call, the topics discussed and the action items. If you are unable to do this, ask a trusted and responsible family member or friend to help you.**

- **Send any documents by express mail or registered mail so that you have a signature and can prove that the documents were sent.**

- **Make a copy of EVERYTHING you send to the insurance company. Lost documents can cost you precious time.**

- **If you receive correspondence from the insurance company, do not delay opening the envelope. There are many time constraints and any unnecessary delay can put your claim at risk.**

- **Often the insurance companies will follow up a telephone conversation with a letter that purports to memorialize the conversation, and includes items that you may not remember, did not agree to, or that otherwise distorts the conversation. These follow up letters usually include language to the effect that if you do not dispute the letter by a certain date, that you are agreeing to its contents. You must respond in a timely manner in a way that can be recognized by the court to protect your interests, no matter how infuriating the letter may be.**





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# IF YOUR CLAIM IS DENIED OR TERMINATED

Most claimants tell us that when they receive the phone call or letter notifying them that their disability claim has been denied, they are at first stunned, then become convinced some kind of bureaucratic error has occurred. They call their HR department, their insurance agent, or the insurance company itself, their emotions ricocheting from stunned to bewildered to angry to furious.

We advise you not to contact the insurance company in an emotional state. A denial or termination of benefits when you are already battling the effects of an illness or injury that has caused you so much loss already can feel like the last straw. You know that you can't work, your doctor knows that you can't work, your boss knows that you can't work. How on earth can the insurance company refuse your claim?

No matter how many times we have heard from claimants about their being denied or terminated, we still share our client's sense of frustration and outrage. Perhaps that is what fuels our aggressive and relentless representation. Having an experienced disability insurance firm handling your claim allows you to focus less on the injustice and more on the healing that you need to do. As with most things, acting out emotionally will be detrimental to your claim.





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## CLAIM INVESTIGATION & SURVEILLANCE TOOLS

As stated earlier, once your claim is filed, the insurance company begins to gather information to evaluate your claim. However, the information is being collected with a second purpose: to be used as evidence for an administrative hearing or legal proceedings, if the insurance company decides to deny or terminate your claim in the near or distant future.

If you are active on social media websites, we recommend that you immediately stop posting, tweeting, blogging, etc. Insurance companies are very attuned to social media, and social media activities are accepted by the courts as evidence. We have seen numerous instances where claimants' discussions of activities on Facebook, Twitter, Linked In, or other social networks have served to undercut their claims.

Do not be surprised if you are placed under surveillance. Video surveillance is relatively inexpensive and easy to do for an insurer. If you leave the house often, keep a record of when you leave and where you go. We have seen clients who leave the house only for doctor's appointments who are accused of leading an active life. Be careful not to say you cannot do something, and then be captured on surveillance engaging in that activity. Nothing undercuts a disability claim worse than major inconsistencies between what a claimant says he/she can or cannot do and what is observed.

Field visits are another intrusive and nerve wracking tactic. Claimants are vulnerable, and field visits take advantage of this. An unexpected knock on the door from someone claiming to be from the insurance company is startling for most claimants. We advise clients to call an attorney immediately if this takes place. You have no obligation to meet with an insurance company on an unannounced visit. If at all. Depending on your contract, you may be required to have such a visit, but you also have the right to protect yourself. Get a name and phone number for the field investigator when they arrive unannounced. Tell them you are not well enough for an interview and will call to make an appointment. Have a trusted and responsible adult with you when the meeting does take place, and record it with a video camera or tape recorder of your own. If you do meet at your home, be mindful that your home is also then under scrutiny. Is the house neat? Does it look like you spend time maintaining it? Observations during a field visit are not just limited to those of the claimant.





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The conversations can become confrontational and upsetting. Typically, after an extensive interview and an overly long conversation, when the claimant is tired and overwhelmed, the investigator opens a laptop and the claimant is presented with video footage of them leaving the house and potentially engaged in a higher level of activity than previously articulated. The investigator asks pointed and inflammatory questions – "Why can't you go to work? We have videotaped you leaving your house."

If you call the insurance company from a phone that is not in your home, or from another location, expect to be asked why you are able to be away from home if you are disabled.

It is possible that neighbors, friends and family members may be contacted and interviewed. They are under no legal obligation to respond, although the investigator may imply that their cooperation is in your best interest. Make them aware that their answers, however innocent and well-meaning, may be distorted, or misrepresented and used against you. You have a right to ask them not to speak with the insurance company investigators – and they have the right to refuse to do so.

The disability insurance company will use investigative methods that present no-win situations. Knowing what to expect will not prevent the investigation from happening, but it may help prevent some of the more obvious pitfalls.





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# FILING AN ADMINISTRATIVE APPEAL

The administrative appeal of a denied disability claim is not a simple matter. We have seen many appeals fail, even in cases where the denial seems outrageous, and even when the individuals preparing the appeal are smart and sophisticated in their own fields. This is an area where professional representation makes a big difference, for a number of reasons:

- **The insurance companies respond differently when an attorney, especially an attorney they know from previous matters, is handling the claim or appeal.**

- **Laws change. A recent case changed how deadlines are treated, and made timeframes for the appeals process even more restrictive.**

- **Do you know what evidence to prepare? When you are presenting an appeal, you are creating a body of evidence that will be used by the administrative official reviewing your case. Once the file is complete, no new evidence can be added. If you lose the appeal and the case goes to Federal court, you cannot add any new materials.**

- **Filing an administrative appeal is not an easy process, and can become overwhelming. Tackling a legal battle with a large insurance company when you are disabled may not be the best path to success.**





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# MEDICAL RECORDS FOR DISABILITY INSURANCE CLAIMS

Medical records for any insurance claim are challenging, but for a disability insurance claim, medical records can make the difference between a claim that is paid and one that is the subject of a long and drawn out denial and appeals process.

First and foremost, it is necessary for anyone considering a disability claim to have a history of medical treatment that is consistent with their disability.

While our firm has won appeals for individuals with inconsistent treatment records, it is not an easy defect to overcome. Every doctor's visit, every test and study, becomes a piece of evidence supporting the claim. The best scenario is to have a primary treating physician who coordinates care with a series of other medical professionals or medical care centers.

We cannot stress this enough: just having a condition or an injury noted in your medical records is not enough to support a claim, even though it seems as if that would be enough. Your medical records must include a detailed assessment of what physical and/or mental tasks are associated with your occupation, and why your illness or injury has left you unable to perform these specific tasks.

For example: a highly compensated financial executive responsible for complex and rapidly made calculations on buying and selling equities who suffers from Multiple Sclerosis (MS) no longer has the high level cognitive abilities that are required to succeed in his occupation. He cannot make multi-million dollar decisions in a split second anymore, and that ability was the specific task that his occupation required.

The medical record must fully document the nature of the tasks of his occupation and the effect his disability has on his ability to perform these specific tasks. We repeat this because it is so important. A doctor who has not worked with an experienced disability insurance lawyer will not be likely to understand how medical records support a claim. It's not their focus, and we understand that, so we work with the physician and the claimant together.





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## SPECIFIC ISSUES OFTEN SEEN

## RESIDUAL OR PARTIAL DISABILITY - BACKDATING A CLAIM

Can an insured with a disabling condition who suffered a decline in income from his physician practice for a year or 18 months (or perhaps even longer), file a claim for disability *back dated* to the time in which the income declined? How will the insurance company deal with such a claim?

The answer is largely dependent upon the policy language, but the better question is not if the claim can be back dated, but *how far back* can it be back dated? Most policies require an insured to provide "proof of loss" - with time periods for such proof as short as 30 days or as long as 6 months after the commencement of the disability.

One important policy provision that would be important to analyze is the Notice of Claim provision. This is the time period in which a claimant is typically obligated to provide the insurance company with notification that a claim has occurred. These are often time frames that are shortly after the claim occurred.

Moreover, ordinarily, these policies will have language with a "proof of loss" provision, the time to be provided shortly after a claim occurs (typically 30 to 60 days). While those are requested time-frames, these policies also usually contain language stating that proof is to be provided as soon as reasonably possible, but in no event should that be more than one year after the period in claim.





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Does this mean that a claimant can file a claim more than one year prior to the date of disability? Technically yes, but will you receive benefits for these subject periods? One strategy is to utilize some of these otherwise "disqualified" periods to accrue the elimination period - that period of time which must be satisfied before benefits are payable. By using this period to satisfy the elimination, your benefits become compensable within the notice period.

Be aware that residual disability claims present a complex challenge for claimants because they involve financial evaluations in addition to the usual occupational and medical issues. Careful consideration must be given to best strategize such a claim prior to filing.

Residual or partial disability claims often permit an insured to utilize different time frames for considering what their "Pre-Disability" income was, which is compared to their "current" income for purposes of evaluating whether an insured suffered a compensable loss of income under the policy. We work with clients often on developing the highest Pre-Disability income to maximize their recovery under these policy provisions and then counsel claimants with regard to their ongoing monthly residual claims. Often, an insured can use their highest two consecutive years of earnings in the five (5) years prior to the claim, or may use their last year's earnings. We evaluate these issues with our clients.





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# INJURY OR SICKNESS: LIFETIME OR AGE 65?

We are seeing an increase in the number of medical professionals who are facing the issue of whether their disability is due to a sickness or an injury. The difference in the total amount of benefits is potentially significant, and that's why insurance companies have dug their heels in on this issue.

For background, many of the policies issued in the 1980s and early 1990s contained lifetime benefit provisions, which meant that an insured who became disabled potentially had the ability to collect benefits for their lifetime, as opposed to collecting benefits until Age 65, when many other policies cease providing benefits.

Many private insurance policies differentiate on the maximum benefit period between sickness and injury. Disabilities resulting from a sickness are often limited to a benefits period until age 65, while many policies afford lifetime benefits for a disability that is the result of an injury. Several conditions fall into a gray area, which has led to disputes with the insurance companies on the maximum benefit period for which they will provide benefits.

A typical example is where an insured suffers from carpal tunnel syndrome, seen often among dental professionals due to the repetitive nature of their work and the importance of maintaining fine motor skills. Insurers will often argue that this condition is a sickness, because the disability happens over a period of time, or because no single incident led to the disability and it could arguably be considered an "occupational disease" process that is akin to traditional sicknesses. We take the position that it is an injury - the result of repeated injuries and thus, is an unintended result of intentional behavior (accidental), and thereby entitling our clients to lifetime benefits, where applicable.

Several courts throughout the country have addressed the issues and have utilized a variety of legal concepts to reach decisions. The driving force behind the courts' decisions, however, has been the "reasonable expectations" of the insured. Thus, if a claim should arise from a repetitive type condition, careful thought must be given to how to respond to the insurer on the claim forms, because the insurer will likely look to develop claim responses that could lead to finding an insured disabled from sickness, rather than injury, and greatly shortchange benefit payments. This is a great example of where an insured, unrepresented by counsel, can cost themselves several hundred thousand dollars unwittingly.





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# LEGAL VS. FACTUAL DISABILITY

When a professional, whether a doctor, dentist, chiropractor, podiatrist, or lawyer, is faced with disciplinary action from the governmental agency charged with overseeing such conduct, and seeks to file a claim for disability benefits, the insurance company often attempt to use this as a means of blocking payment of claims.

There are times when claimants with disabling conditions engage in conduct which subjects them to disciplinary action, or have suffered disabling conditions relating to such conduct. Insurers will often seek to deny or terminate benefits to claimants who lose their license to practice their profession, or have disciplinary action taken against their license, even where the disabling condition preceded any action against the professional's license.

The issue is characterized by the courts as "legal disability" versus "factual disability." A legal disability will not permit recovery of disability benefits, while a factual disability will entitle a claimant to recover benefits. A legal disability arises from the situation where the claimant can no longer practice their profession as a result of the loss of a license, or other disciplinary activity.

A factual disability is where the claimant has a disabling condition (whether physical, mental, emotional, addiction) that causes the claimant to become unable to perform the duties of the occupation, and thereafter suffers disciplinary action against the license. So long as the disabling condition precedes the loss of the license, a claimant should be permitted to recover benefits under his or her policy.

For example, a dentist with a drug addiction may engage in conduct that causes a state agency to investigate and take action against the license. However, the dentist is actually unable to effectively (and safely) perform the duties of dentistry because of this addiction. That claimant should be considered factually disabled and entitled to benefits, even if their license to practice dentistry in the future is revoked.





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# PHYSICAL AND MENTAL DISABILITY AS CO-MORBID CONDITIONS

An issue being seen with greater regularity in disability claims is where there is anxiety or depression 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. Unfortunately, the insurer is likely to take the position that the insurance covers the inability to work at the job, not the fear of dying from working in that job. Thus, where a claimant also has anxiety or depression that impacts on their ability to focus or concentrate, the claim may be developed and supported through a mental health provider.

Often, the anxiety and depression can be the condition supporting payment of the claim, even if the insurer rejects the claimant's contention of being subjected to inappropriate risk of a future cardiac event. 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 continued without jeopardizing their continued recovery can strengthen a potential claim by having the emotional aspects of their condition explored and treated. Failing to receive appropriate 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. Thus, coming under the care of a mental health provider would be critical to supporting the claim.





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# FREQUENTLY USED TERMS IN POLICIES

## Elimination Period

The elimination period is the number of months for which the insurance company will not pay benefits at the start of your claim; and you must be disabled from the same cause or a different cause for this entire period. The days within this period do not have to be consecutive but they must occur within the accumulation period. Each month of continuous disability will be calculated from the date your disability began to the same date in each subsequent month. For periods of disability that are less than one month, the insurance company will consider each day of disability to be 1/30 of a month. The elimination period is the length of time you must wait between when your disability starts and when you start receiving benefits.

## Accumulation Period

The period of consecutive months that begins on the first day that you are disabled and during which the elimination period must be satisfied is the accumulation period. This is the amount of time in which you collect enough days, weeks or months in order to receive disability benefits.

## Care and Treatment Provisions

The *medical care requirement* is when the insurance company will not pay benefits under the policy for any period of disability during which you are not under the care of a physician. Many policies also include that such care must be appropriate, according to generally accepted medical standards, for the conditions which is causing the disability, and must be provided by a physician whose specialty is appropriate for your sickness or injury.

## Contestability Clauses

Disability policies generally have clauses that permit the insurer to challenge the application responses or to challenge the claimant's pre-insurance insurability. Many policies have a two year limitation when the insurer can challenge the responses, while other policies contain only a "fraudulent misstatement" clause, which permits the insurers to challenge application statements only where they were made fraudulently. If an application response is false and induced the insurer to issue a policy, the insurer may seek and be granted relief known as rescission, which amounts to a cancellation of the policy as if it were never issued.

Other policy clauses address pre-existing conditions, and may not cover disabilities that occur within a specified period of policy issuance where the condition existed at the time the policy was placed.





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## Offsets

Some policies contain provisions which allow the insurer to reduce or offset the amount of benefits they are required to pay by analyzing other types of benefits received by the claimant. Typically, these other benefits include Worker's Compensation Benefits, Social Security Disability Benefits, other disability insurance benefits, and/or pension or retirement benefits. Often, the offset is also permitted for Social Security benefits paid for dependents. Between the primary and dependent Social Security offset, often claimants are left with a small remaining benefit.

Most private disability policies purchased by professionals are not subject to these offset provisions, however group policies provided as an employee benefit through an employer will usually be subject to many or all of these offset provisions.

## Recurrent Disability

This occurs after the elimination period has been satisfied. The insurance company will consider recurrent periods of disability to be one continuous period of disability if you result from the same cause or causes and are not separated by a recovery of more than 12 months if the benefit period is to age 65 or longer and recurrence occurs before age 60; or 6 months in all other instances including recurrence at or after age 60.

## Examinations

Disability policies contain clauses which require claimants to be examined as part of their proof of loss obligations. Issues that often arise under these provisions include how often the insurer is permitted to have the claimant examined, as well as what constitutes a reasonable examination. For example, it may not be reasonable to require a claimant to undergo invasive neurological testing or to undergo neuropsychological testing all day for two consecutive days. These issues lead to points of contention during the claim process, with the insurer boldly asserting broad contractual rights. Too often, the claimant is bullied into accepting the insurer's demands, without appreciating the implied covenant of good faith and fair dealing that exists in all contracts. An experienced attorney will protect the claimant from these and other intimidation tactics.





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## Proof of Loss

There are specific proof of loss requirements described in each disability policy. It is imperative to ascertain what requirements exist for a claim for benefits. Just because the insurer asks for certain materials does not mean that a claimant is required to provide the materials. A close review of the policy will provide details of the specific materials that the insurance company is entitled to. Do not provide any more material than is required by the contract.

Tax returns are not ordinarily required in a claim for total disability benefits, while in a claim for business overhead expenses, or residual or partial disability, tax returns may be required under the proof of loss provisions. Read carefully – you may be able to select which years of tax returns to provide. You want to opt to provide the years with the highest prior earnings for purposes of calculating loss of income in a residual or partial benefits claim.

## Pre-Existing Limitation

The *preexisting condition limitation* is common among many disability policies. Although the preexisting timeframe will vary from policy to policy, it is the period of time when the insurance company will not cover any loss that begins prior to the date you purchased the coverage. There is often a "look-back" period, typically three months prior to the effective date of coverage, whereby they will consider whether a claimant had received care or evaluation or treatment for the condition(s) causing impairment, and if so, will try to bar or limit coverage for such condition(s).

## Foreign residency limitation

This policy provision is when the insurance company will not pay benefits for more than a defined period, often twelve months, during the lifetime of the policy if you are not a resident of the United States of Canada. This often happens with people who have dual citizenship, or who wish to go to a different climate due to conditions, or wish to explore medical care somewhere outside of the US.





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## CONCLUSIONS

Disability insurance claims are complex matters that are difficult at best for the layperson to manage.

We represent individuals throughout the country, from all walks of life and occupations, and all parts of the economic spectrum. All of our clients have one thing in common – they have paid to have long term disability insurance coverage or have this coverage through their employment, and have had their claims denied, delayed or terminated. Each case is different and unique, but many have common features that we have likely seen many times in our years of practice.

If you have questions about your long term disability claim, whether you are just considering filing a claim or have been battling by yourself to get benefits paid or reinstated, call our office at 877-583-2524. When the insurance company claims that you have no claim, we are there to help.

## SOURCES


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2 Council for Disability Awareness, Personal Disability Quotient (PDQ) calculator
3 http://www.opensecrets.org/lobby/indusclient.php?id=F09 Open Secrets
4 http://www.publicintegrity.org/2013/02/11/12175/opinion-big-pharmas-stranglehold-washington The Center for Public Integrity






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