

Long Term Disability Claims

An Overview of the Claims Process and Practical Considerations

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Disability Claims

I. Types of Disability Claims

A. Short Term Disability (STD)

1. Usually provides coverage for periods of 3 – 6 months.
2. Usually does not have many exclusions, such as pre-existing condition or mental/nervous disorder exclusions, due to the relatively short period that benefits are paid.

B. Long Term Disability (LTD)

1. Usually provides payment of a monthly benefit, so long as the employee is unable to perform the material duties of her/his regular occupation, for a limited period of time, i.e., 2 years.
2. After that period of time expires, employee is usually entitled to receive a monthly benefit so long as she/he is unable to perform the material duties of any occupation she/he is reasonably qualified by reason of her/his age, education and experience.
3. Usually subject to more substantial limitations and exclusions such as limited period of time benefits payable for certain conditions (i.e., mental/nervous disorders, CFS, FMS, etc.) or pre-existing conditions.
4. Benefits are usually subject to an offset for other income benefits such as SSDI and workers' compensation.
5. Accepted or approved claims are subject to periodic review to determine ongoing disability status and entitlement to benefits.

C. Social Security Disability (SSDI)

1. Administered by the United States Social Security Administration.
2. Subject to less frequent periodic review.

II. Governing Law for STD and LTD Claims ¹

¹ SSDI claims are governed by the United States Social Security Act and its implementing regulations. This presentation focuses on STD and LTD claims and only discusses SSDI claims generally.

A. The Employee Retirement Security Act of 1974, as amended (ERISA)

1. Disability coverage provided by an employer through its employee benefit plans are governed by ERISA.
2. Congress has established an administrative process for the initial handling and appeal of claims.
3. ERISA provides procedural protections to claimants.
4. Substantive rights are governed by LTD Plan (usually the LTD insurance policy).
5. **Exception:** governmental plans providing disability coverage for government employees (federal, state and local including school systems) are exempted from coverage under ERISA. These claims are governed by the laws of the state where the policy was issued.

B. State Law

1. Claims brought by government employees and by individuals who purchased individual disability policies are governed by the applicable laws (statutes and insurance regulations) of the state where the policy was issued. This is usually, although not always, the state in which the employer is located.
2. Policy governs substantive rights to benefits while state law governs claims administration and procedural protections.

III. ERISA Claims

A. ERISA provides procedural protections to the claimant in an attempt to guarantee fairness in the decision making process. These protections include:

- Time limits for claims decisions (45 days although an additional 45 days may be taken if substantial need exists in order to make a decision)
- A written explanation of the reasons for any claim denial including identification of all policy provisions that the denial is based upon.
- The right to a full and fair review by a different decision maker.

- The right to obtain copies of all documents relied upon in reaching the decision. This usually means a copy of the disability policy and your claim file.
- B. The LTD policy identifies your substantive rights to benefits. These include:
- The benefits provided by the Plan.
 - How benefits are calculated.
 - The timing of payment of benefits.
 - Identifying any offsets or reductions to benefits.
 - How long benefits may be paid.
 - The definition of the terms of the Plan.
 - The standard of disability that you must meet in order to receive benefits. Usually LTD plans require that due to Injury or Sickness, an employee must be unable to perform the material duties of her/his regular occupation in order to be eligible to receive benefits.
 - Identifies all exclusions or limitations to benefits under the policy, such as pre-existing conditions, mental/nervous disorders, and other restrictions on your entitlement to benefits.

IV. Administrators

- A. Self administered plan.
- B. Third Party Administrators.
- C. Insured plans administered by the disability insurance carrier.

V. Claims Practices

- A. ERISA provides that an Administrator is a fiduciary who is charged with administering the Plan in accordance with its terms, and in the best interests of the participant (claimant/employee) and the Plan.
- B. In other words, the insurance company is supposed to be neutral, unbiased and to make impartial decisions based upon
 1. the evidence submitted by the employee in support of her/his claim, and
 2. apply that evidence in accordance with the terms of the Plan in order to make a determine whether or not the employee is entitled to benefits.

- a. the insurance company should not consider its own financial interests in reaching its decision, and
- b. the insurance company should not impose terms or conditions on the receipt of benefits that are not included in the Plan.

VI. Claims under ERISA

- A. Procedures are governed by U.S. Department of Labor Regulations and procedures implemented by the insurance company that usually closely follow federal regulations.
- B. Applications must be submitted by the employee along with supporting medical documentation and other evidence (i.e., wage information, job descriptions, statements of co-workers, etc.). This constitutes your “proof of claim.”
- C. Decisions on claims to be made within 45 days (an additional 45 days may be taken if necessary in order to make a decision).
- D. Approved benefits are paid in accordance with the terms of the Plan. Usually, benefits are paid at a rate set by the Plan (often 60% of the employee’s average monthly salary) on a monthly basis. Offsets (deductions) for Other Income Benefits (SSDI, workers’ compensation, etc.) may be taken by the insurance company at this time although if the employee provides proof of application for these other income benefits and that benefits have either not been awarded yet or have been denied but are being pursued through the appeal process by the employee, the insurance carrier may pay the full LTD benefit. Usually, they will require the employee to sign a reimbursement agreement promising to repay these amounts to the insurance carrier upon receipt by the employee.
- E. Approved claims are subject to periodic review by the insurance carrier to determine the employee’s continuing disability status and entitlement to LTD benefits.
- F. Decisions **denying claims or terminating benefits** of approved claims must
 - 1. be in writing,
 - 2. identify the provisions of the Plan that were relied upon in arriving at the decision,
 - 3. must identify the documents that were relied upon in reaching the decision, and
 - 4. must notify the employee of her/his rights to appeal the decision.

VII. Appeal Rights

- A. ERISA and its regulations govern appeals of the denial of claims or the termination of benefits.
- B. Written appeals must be submitted within 180 days of the **receipt** of the notice of denying the claim or terminating benefits.
- C. Accompanying the written appeal, the employee should provide all additional evidence that she/he has to support the LTD claim. This should include some or all of the following:
 - 1. all additional medical records supporting disability including office notes, reports, test results, pharmacy records and other medical records of the employee's treating and/or consulting physicians;
 - 2. reports and/or affidavits of claimant's physicians attesting to disability and addressing any prior mistakes, misunderstandings, disputes or other issues that the insurance company made concerning the claimant's medical condition, disability status or the physician's opinions or records;
 - 3. statements or affidavits of co-workers, supervisors, friends, family members or other fact witnesses;
 - 4. diaries;
 - 5. wage records;
 - 6. photographs;
 - 7. receipts;
 - 8. any other documents that are relevant and support your claim.

VIII. State Law Disability Claims

- A. Like ERISA claims, the employee's substantive rights are governed by the LTD Policy.
- B. Procedural protections are provided through either state insurance regulations (that vary from state to state) or policy procedures drafted by the insurance company (and usually subject to state review and/or approval).

IX. Trial

- A. ERISA claims are usually brought in the local United States District Court. Suits filed in the local state court can be transferred by the insurance company to federal court. Insurance companies usually do seek to transfer these claims to federal court.

1. Damages recoverable in ERISA actions include unpaid, past due benefits, interest and attorney's fees that may be awarded in the discretion of the court.
 2. Compensatory damages (i.e., pain and suffering, monetary damages other than benefits, interest and legal fees) are not allowable.
- B. State Law claims are usually brought in the local state/county trial court. If the amount of unpaid benefits exceed \$100,000 and the employee and insurance company are citizens of different states, the insurance company has the right to seek removal of the suit to the local federal court.
1. Damages recoverable in state law claims include unpaid, past due benefits, interest and punitive damages. Punitive damages awards are rare and difficult to prove. You must show malice in many states which means the insurance company intended to injure you and its actions were motivated by such intention.
 2. Legal fees are not recoverable.
 3. Compensatory damages are generally not recoverable although it varies from state to state.

X. PRACTICAL CONSIDERATIONS

A. During the Claims process:

1. be cooperative;
2. be responsive and act in a timely manner;
3. treat the claims personnel civilly. Do not yell, belittle them or use profanity. Try to act professionally and treat them as you would like to be treated if you were in their position.
4. do not take things personally. The insurance company and its claims people are not taking actions against you personally. They are most likely making decisions based upon their own financial interests or upon their interpretation of the information you supplied to them. Just like the government you are a (claim) number to them and their decisions are not personal in nature although you may strongly disagree with them.
5. it is better to produce too much evidence than too little support for your claim.

6. although you can usually handle or represent yourself in the initial claims process, it is worthwhile
 - a. to consult with an attorney concerning your legal rights, the meaning of the insurance policy and the evidence that should be submitted in support of your claim (you may not need to retain an attorney at this time but consultation can help you avoid delay in receipt of your benefits and providing relevant and responsive information in support of your claim);
 - b. speak with other members of your support group;
 - c. speak with other individuals that you know have filed disability claims.
7. REMEMBER – the insurance company is usually looking out for its own interests and they are FINANCIAL AND NOT PERSONAL.

B. Claims Representatives are taught:

1. to be brief in the information they provide to you or put in your claim file;
2. want to draw you out so that you will say things against your own interest;
3. they will record what you say to use your own words against you in defeating your claim;
4. construe your evidence narrowly and the insurance company's evidence broadly; and
5. put you on the defensive.

C. During the Appeal Process:

1. hire an attorney to represent you. There are numerous procedural pitfalls (i.e., timeframes) and evidentiary issues that must be addressed properly at this state of the process otherwise, if your appeal is denied and you file suit, you may lose your case because of inadequacies in the administrative record below.
2. Also, attorneys are trained to be objective and do not have the emotional investment in your case that you have. Thus, their vision is not clouded

and they can identify the issues and best decide how to overcome them.²

3. Appeals must be filed within 180 days of receipt of the notice of denial of the claim or termination of benefits.
4. Decisions on appeal are to be made within 45 days of submission although an additional 45 day period may be allowed.
5. Appeals that have been denied may be appealed administratively again, in certain circumstances, rather than filing suit.

XI. OTHER MISCELLANEOUS MATTERS

- A. Buy a fax/copier/scanner. They are relatively inexpensive (This equipment usually costs between \$100 - \$200). They provide you with easy access to copies, limit your trips to the copy center, and generally pay for themselves over time by eliminating the .15 per page copying cost, gas and parking meter fees.
- B. At the end of each office visit with your doctor, request a copy of the doctor's office notes, lab tests, etc. for that visit. If they are not available at that time, request they be sent to you by either mail or fax. Once you receive the copy, immediately fax or scan/email it to your attorney and then file it in a simple manila folder, placing the document on top of the last document. That way, you have a chronological medical record, have filed it and provided it to your attorney. This takes only a few minutes to do and then you are "caught up" and can avoid the easy pitfall of "not being able to get around to it." Try it, it works.
- C. Make arrangements with your attorney on the best way to communicate between the two of you. Email allows you to provide the information right away before it is forgotten. Fax allows you to provide information immediately without the need to make copies, get stamps or run to the post office. Telephone can be used to discuss matters in more detail. Discussions early on in the relationship can set the agreed manners of communication in action and allow for the most efficient representation.

² Also applicable is the old maxim, "The lawyer who represents himself has a fool for a client." Although the U.S. Court of Appeals for the Fourth Circuit, which had jurisdiction of federal cases in Virginia and Maryland, among other states, has held that attorney's fees incurred during the administrative appeal process cannot be recovered by the successful employee litigant, it may still be in your best interest to retain an attorney for the reasons set forth above.

- D. Only open mail received from the insurance company during business hours in case you need to discuss its contents with your attorney. Although your symptoms are usually unpredictable, determine the time of your mail delivery and the time of day that you function best between 9 a.m. and 5 p.m. and then open these items only during that time period. You can also immediately fax the document to your attorney and then immediately file it in a manila folder that contains all of your correspondence with the insurance company. Just place it on the top of the last document to maintain a chronological file. Again, this takes only a few minutes unless you have to speak with your attorney by telephone.
- E. COBRA payments should be sent before the due date in a manner that is traceable, such as certified or registered mail, overnight mail, or by electronic payment if allowed. Many employers require the employee to execute a document at the same time attesting that they are not covered by another group insurance plan. Find out if this can be faxed or emailed. If financially possible, try to send your COBRA payments in quarterly, prepaying for 3 months at a time instead of making monthly payments. This cuts down on the mailing and the possibility of forgetting to make the payment. Put the due dates on a paper calendar as well as your computer calendar so you will have a backup reminder.
- F. Surveillance happens more frequently than you think. Do not do things that you shouldn't be doing. It is not good for you medically and it could hurt your disability claim. Follow your doctor's instructions on your physical activity and restrictions. If your doctor recommends that you follow an exercise regimen, have her/him put it in writing and make sure it is in your medical records. That way, if the insurance company videotapes you exercising, it can be explained by the fact that you are following your doctor's orders in an attempt to get better.
- Have a general awareness of who is around you. Private investigators often drive vans or SUVs so that they can set up their videotape equipment in their vehicles to tape you. If you see such a vehicle following you when you are driving or parked in your neighborhood, advise your attorney and your family or friends. Someone (not you) could walk by to see if there is someone sitting in the van. One of my clients actually saw a van that had been following her parked down the street from her house and called the police, advising that she thought it was a stalker. The police reported back to her that

it was an investigator and there was a police record generated for the call.

- G. Although you have a legal right to obtain a copy of your Summary Plan Description (SPD), it is just that, a brief summary of the disability plan. The SPD does not contain the information necessary to determine your substantive rights under the LTD Plan. Always try to obtain a copy of the LTD policy issued by the insurance company. That is the best document defining your substantive rights.
- H. Pre-planning your LTD Claim. Although this is not always possible in light of the sudden onset of an illness, for a number of medical conditions, including CFS and FMS, planning for your disability claim can be done. Whenever it is possible, the employee should try to do the following:
- Obtain a copy of the LTD policy and claim forms;
 - Find a doctor with expertise and experience in treating patients with your illness;
 - Speak with your doctor about your symptoms and the difficulty you are having in being able to perform your job duties;
 - Set aside whatever monies you can to help you with your bills after you stop working;
 - Investigate financial matters including refinancing your mortgage, obtaining a home equity line of credit, paying off your credit cards and otherwise consolidating your debt so that you can live as inexpensively as possible in the event you have to survive without benefits for an extended period of time;
 - Talk to an attorney, support group, other people you know who have filed disability claims about their experiences and suggestions for you;
 - Document your problems. Keep a diary. Advise trustworthy co-workers of your problems and difficulties;
 - Start getting your medical records and open files for medical records, financial records, insurance company records so you have a system started and in place before you are unable to tackle this monumental task after going out on disability.
 - **MOST IMPORTANTLY** – acknowledge that you have a medical problem that is making it very difficult (or impossible) for you to perform your job duties.

I. “Under the medical care and treatment of a physician” means, in some fashion, continuous care from a licensed physician. Every policy requires a claimant to be under the medical care and treatment of a physician but does not usually define what constitutes medical care and treatment. This term usually encompasses office visits (as necessary for your medical condition), lab tests (again as necessary), and prescriptions and could include telephone discussions with your physician and possibly emails where your doctor is providing treatment options and opinions. However, there must be some form of “regularity” or continuous treatment in order to meet the requirements of most policies.

- Diaries, conversations with co-workers, diet or lifestyle changes usually do not constitute medical care and treatment. Rather, they can be viewed as supplementary evidence in support of your claim.
- You should continue with your regular treatment after you have submitted your claim. LTD claims are subject to periodic review and you will need the evidence to prove your entitlement to ongoing benefits.

J. Medical testing should be left to your doctor to determine although for conditions such as CFS, at a minimum, basic tests to rule out other causes should be run.

- Neuropsychological testing is often useful and helps to serve as objective evidence of a disability
- Testing for Orthostatic Intolerance can also be helpful, including a tilt table test or other form of testing
- Sleep studies

K. SSDI Reimbursement is a universal provision in LTD policies. I usually recommend agreeing to reimburse the insurance for future SSDI you may be awarded because:

- You receive your full LTD benefit now, which helps with current financial needs;
- Receipt of SSDI is not guaranteed in the future and therefore you will have been substantially underpaid your LTD benefits;
- The insurance company does not charge you interest on the offset amount so it equals an interest free loan in the event

you do obtain SSDI benefits and have to repay the insurance company.

- HOWEVER, you must be careful about the reimbursement agreement you sign. Do not agree to pay attorney's fees to the insurance company in the event they have to file suit to collect your reimbursement unless the LTD plan specifically provides for payment of such legal fees. Put a line through that provision and initial it. Only agree to pay legal fees "if they are awarded by the court."