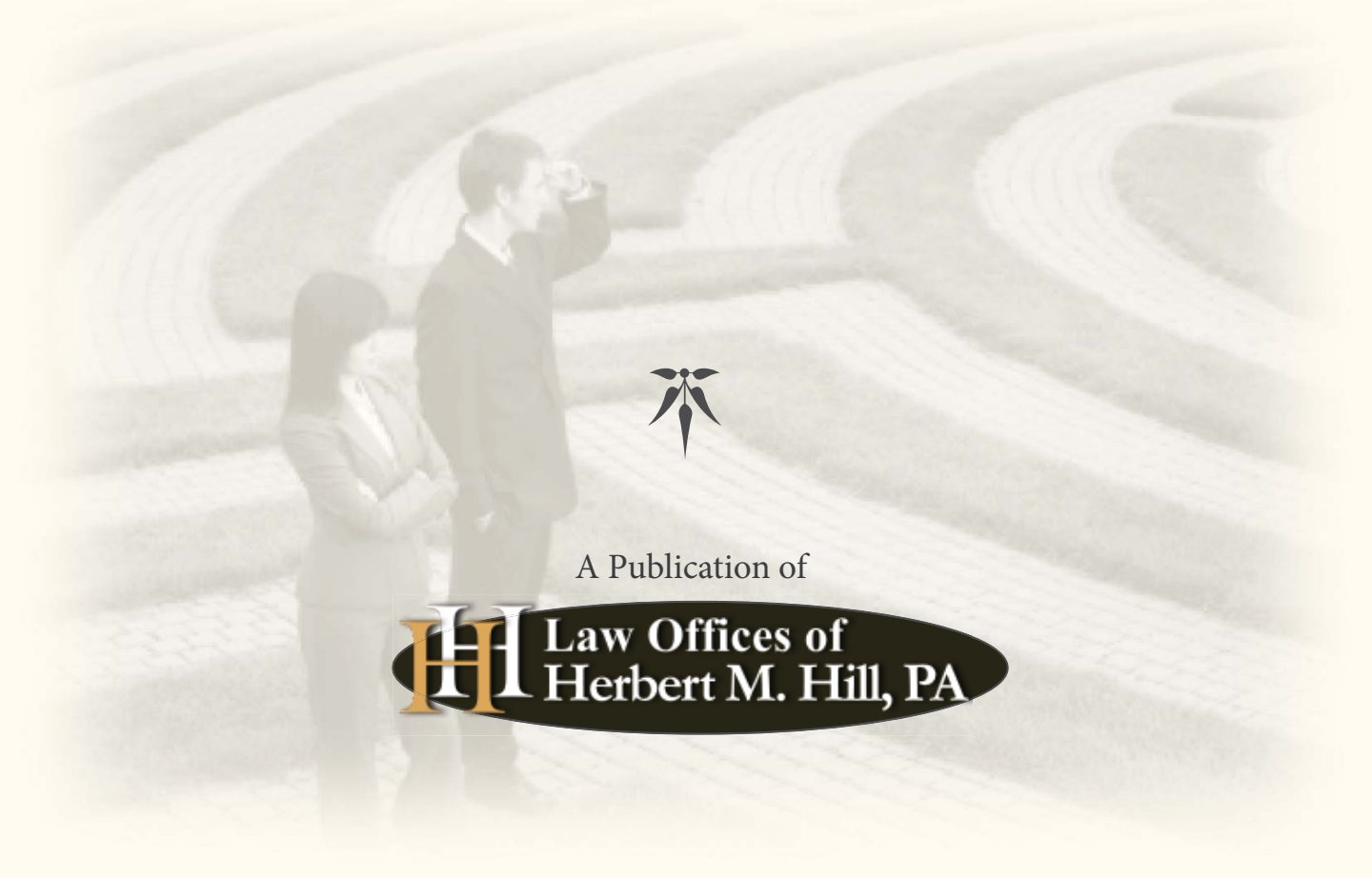
A GUIDE TO

Navigating Your Group Disability Insurance Claim

An introductory guide to give you helpful information about your Disability Claim and how to successfully navigate the filing process.



A Publication of

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Making A Claim

Making A Claim

Plan Documents

Let me take this opportunity to note that if you do not have a copy of the **Plan Documents**, you are entitled to receive a copy, **free of charge**, from the "Plan Administrator" which is usually the Employer, or some committee or division thereof.

*You need only send a letter, preferably by "Certified Mail, Return Receipt Requested," and they have **30 days** within which to respond. If they do not respond, there are penalties which may apply. I would suggest you not rely on oral requests.*

I would also suggest that this should be done at the commencement of your claim so you can see the direction your claim might be headed. Those documents include not only the **"Plan Documents"** but also any **"Summary Plan Description."**

The import of this is that there have been cases in which these documents differed from the ones being used by the Insurance Company to render its benefits determination. If there is a difference, there is very specific case law which determines which documents governs the claim.

Your communications with the Insurance Company

> It is important that all communications with representatives of the Insurance Company are handled in a very precise manner.

The first subject is written communications.

I do not want to suggest the letters you send the insurance company end up in the trash can but I have had numerous complaints from clients that the insurance company has denied receipt of documentation or correspondence which they have sent. **All written communications should be sent in a way in which delivery can be verified.** This can be by Certified Mail, Return Receipt Requested or by way of courier service. Ensure that you keep a copy of what was sent as well as the document which evidences delivery.

Facsimile transmittal can be used as long as there is a cover sheet indicating the number of pages sent . When using facsimile also ensure you keep copy of the **"transmission report"** which every facsimile machine can generate. This will evidence the telephone number to which the document was sent, as well as the date and time. If your doctor or anyone else on your behalf sends documentation directly to the insurance company, get a copy of what was sent and then send it again yourself.

Regarding **written communications** from the insurance company, please keep not only the letter or documents received but also keep the envelope and mark on the face of the envelope the date you received it. More often than not, the insurance company's letters are not mailed on the date found on the face of the letter. The postmark on the envelope evidences the date of mailing. The reason it is important to know the date you received some letters is because some time frames commence from the date of receipt.

Keep a copy of all documents to and from the insurance company in a file in one place, in a chronological order.

The second subject is oral communications.

These should be handled with your personal "case diary" before you. Note the date and time of the conversation.

Before you engage in the substance of the conversation, ensure that you get the representative's full name ("Bob" is not enough).

If they will not give it, either get their employee number or refuse to talk to them. They know your full name. You must be able to get back in touch with them or at least be able to identify with whom you spoke. Along these lines, get a return telephone number with a direct extension. Again, if they will not give this, refuse to talk to them. They know how to get in touch with you easily. You should not be forced to work your way through the impenetrable telephone maze which many insurance companies have in place. Only after you are on a level playing field should you talk with them. Again, these things should be done at the beginning of the conversation.

During the conversation, keep notes on what was said, letting them know you are doing so. One good way to do this is to get them to repeat something they said *"just so I make sure I understand."* Also, make sure your questions **(the ones you have noted in your case diary)** get answered.

Oral communications are problematic because at the beginning of the claim, the claims representative will try to be your **"buddy,"** as if they are on your side. This is especially so when benefits have been approved. In fact, when a new claims representative later calls you, please ask why the change. What has probably happened is that a adverse decision has already been made and now you will deal with the "hatchet" man (or woman). **They will not remember all the fair weather representations made by your "buddy."**

> “Insurance companies are not really in the business of paying benefits. That costs them money. They are in the business of collecting premiums and keeping pay outs to a minimum, to the point of a lawsuit, if necessary.”

Indeed, insurance companies are as much in the litigation business as are attorneys. Their representatives are highly trained to this end, even the **“buddies.”** Remember that insurance companies already have attorneys on staff who direct the claims handling process. When your case becomes too expensive or looks like there may be a long pay out, efforts will be made by the insurance company to reduce its exposure.

Therefore, always keep in mind with whom you are really dealing, because this may make or break your claim.

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Another tactic is for the insurance company to have its **hired gun** -- **"medical records reviewers"** -- call up and impose upon an alleged professional courtesy with your treating doctor, insisting that the phone call be taken immediately. The number of times the I have seen these medical records reviewers make comments about treating doctor's findings totally inapposite to the actual opinions expressed by the treating doctor would be considered astonishing if it were not the actual routine practice employed by these insurance company **hired guns**.

> "One of the first steps taken by **Herbert M. Hill, P.A.** when hired for representation on a disability benefits claim, whether on a private policy or on a group policy governed by ERISA, in which benefits have been denied is to advise the insurance that there is to be no further contact with my client treating doctors without our prior knowledge."

When handling a case on your own, my suggestion is to do the same. All such communications have to be in writing and given to you or your attorney as well such that you can ensure the doctor is given adequate time to respond and fully consider the opinion he is being asked to render. Every effort is made to tightly control such contact. This is necessary because you are never given the chance to speak with the physicians hired by the insurance company about the predetermined opinions for which they routinely pay.

CHAPTER

2

What Benefits Are Denied

What Benefits Are Denied

Denial Letter

Receipt of the Insurance Denial Letter- a Fateful Day

One of the most distressing letters you can receive is a letter from an insurance company denying your claim for benefits. **The letter will carefully go through and discount without good reason all the evidence you have submitted demonstrating your right to receive the benefits which the insurance company agreed to pay.** You paid good money to be secure against the economic and very personal calamity now before you and now they seem to be taking that good money and making every effort to refuse to pay. Then, as if to rub salt in the wound, the suggestion is made that you can file an appeal with them if you have any other evidence you want to submit. Submit an appeal to the very company which just denied benefits on clear evidence demonstrating the obligation to pay? *How would any other evidence get them to reconsider when they have proven they will ignore just about anything?*

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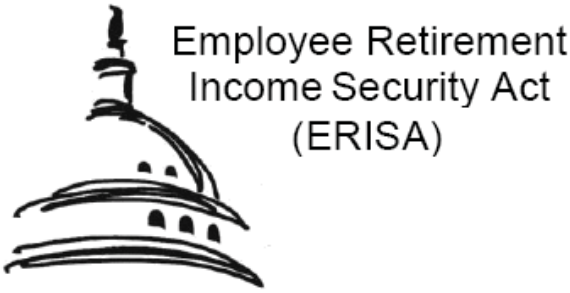

Unfortunately, submitting that appeal is required in just about every case. If your case is governed by the federal statute commonly referred to as **ERISA** (Employee Retirement Income Security Act), **it is absolutely required before you can file a lawsuit to enforce your rights.** ERISA is a statute which governs just about every employment fringe benefit you have, from medical benefits to disability benefits, pension benefits, 401k benefits, life insurance, dental, vision and any other provided by your employer. The obligation to appeal may even be important in private disability, medical or life insurance policies as it may be necessary **to protect your rights** to all benefits.

CHAPTER

3

Surveillance

Communications between the Insurance Company and Your Doctors

> Communications between your insurance company and health care providers can also work to the detriment of your claim.

Too often this is handled in a fashion designed to discount or even change the clear opinions of your doctors regarding their medical findings and related physical restrictions. Let me identify some of the tactics employed by Insurance Companies to this end.

The first tactic involves a letter sent to your treating doctor asking him to sign off on some statement allegedly made during a telephone conference with either the doctor or one of his staff.

This is coupled with a demand for an immediate response. Then, when the artificial deadline is not met, the suggestion is made that the doctor is uncooperative. Usually, that deadline is the result of the insurance company sitting on the claim for so long that it does, in fact, need something immediately but only because it wants to **"look busy"** in the face of its own inactivity and hopefully place the blame elsewhere for its own failure to act. Of course, your doctor is running a real world medical practice with in office and out of the office appointments and schedules which have been pre-set and must be met. Also, the doctor has a reasonable expectation of being compensated for his or her work, something almost never offered by the insurance companies. Indeed, if the offer to pay was made, the doctor would likely take the time to fully consider the matter, something the insurance company does not want when it's end goal may be to put words in the doctor's mouth.

I love to call insurance companies "it" because, in fact, that is what they are. Despite the commercials about being on your side, insurance companies are heartless and soulless legal fictions with no purpose other than to make money. You are the one at whose expense the effort is now being made to make that money by saving on the payment of a legitimate claim for benefits which they agreed to pay, at least when the premiums were being paid.

Surveillance

Who's Watching You?

Insurance Companies routinely use **surveillance investigators** to tail and videotape the activities of claimants. About the only thing which is off limits is filming activities inside the home.

> "My advice to my clients is to live your life as if the insurance company has someone watching you at all times."

This is not intended as a direction to curtail your activities. It is just a reminder that on the one day in the month on which your condition has allowed you to go out and run those long overdue errands, or take the garbage can down to the end of the driveway or lean over and pick that one weed, the insurance company may have someone right there filming you. **In fact, the insurance company may have someone follow you around the grocery store with a camera hidden in the kiddie seat of the grocery cart.** Another trick is to schedule a doctor's appointment or Functional Capacity Evaluation. For some reason, the provider will be at some distance from your house. You can rest assured you will filmed during that trip. **On the other hand, no one will film you the next three (3) days while you lay in bed trying to recover from the over-exertion.**

Having an investigator follow you is not the only type of surveillance which insurance companies use. If the insurance company sends you to a doctor for an Independent Medical Examination or for a Functional Capacity Evaluation, the office staff will be asked to watch and see if your physical actions are consistent with your effort during the evaluation.

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It is my opinion that the insurance company cannot rightfully ask the evaluator's office to go above and beyond the evaluation itself. This would make the medical evaluator also a fact witness. This is something to which the claimant did not agree by cooperating with the request for the evaluation.

There is an additional problem with surveillance in cases governed by the federal statute commonly referred to as the Employee Retirement Income Security Act ("ERISA"), found at 29 U.S.C. §10101 et seq. As discussed earlier in this E-Book, there is case law which may limit the evidence which a claimant can present in Court to support the claim for benefits under ERISA. **There may never be the opportunity to cross examine the fact witness who provides surveillance evidence.** For example, the investigator whose only training consists of being taught how turn on and point a camera will routinely make medical opinion statements in the "reports" he files even though he is grossly unqualified to do so. The same is true of the medical staff which suggests that claimant's actions were different in the parking lot than in the office.

These unsubstantiated statements are not subject to cross examination yet there they are in the documents submitted by the insurance company to the Judge in support of the benefit denial.

There are the highly publicized situations in which an insurance company has discovered, through surveillance, a claimant who is performing in a manner grossly inconsistent with the reports to the treating physician. Those cases do exist but in the vast majority of cases involving surveillance shows nothing of significance. In fact**, "nothing of significance"** should indicate that surveillance supports the claim for benefits. Insurance companies rarely see it that way. Insurance companies routinely uses surveillance to support a predetermined conclusion not actually supported thereby.

CHAPTER

4

Administrative Exhaustion

Administrative Exhaustion

Exhaustion of Administration Remedies

One **quirk** of claims governed by ERISA is the requirement that ***"administrative remedies"*** be exhausted prior to the filing of a lawsuit to enforce rights to the claimed benefit entitlement. ***"Quirk"*** is a polite term because the requirement is, quite frankly, another one of the numerous mechanisms provided in the ERISA statute which slants the provisions thereof unfairly in the favor of the Employers and Insurance Companies. The Plan Administrator (usually the insurance company) is given discretionary authority in rendering its benefits determination which must be given deference by the reviewing Court of Law.

The exhaustion of administrative remedies requirement basically forces the claimant to engage in the administrative appeal process set up by the Plan Administrator. While there are federal regulations governing the process, the end result is typically untoward delay in addressing the issue of entitlement. The process is supposed to one in which the Plan Administrator is required to consider all of the evidence but typically the process is just one which allows them to gather further evidence in their favor and fill in those places where mistakes were made in past handling of the claim. The merits of the case are not the primary concern but instead there are policy decisions made about certain claims and no amount of supportive evidence will change whatever policy decision has been made regarding an adverse benefit denial.

In any event, the administrative appeal process set up by the Plan Administrator must be followed. **The governing federal regulations allow a claimant 180 days to appeal the initial denial of claims involving disability benefits.** Other time frames may apply for other appeals or types of benefits. See, generally, 29 C.F.R. §2560. The claimant must be careful to comply with these deadlines as the failure to appeal within these deadlines could be the death knell to the claim. One must, under no circumstance, allow the deadline to pass without affirmatively placing some form of document in the possession of the Plan Administrator claiming the right to appeal. Sending the document with some proof of delivery is imperative.

The appeal should include all evidence which supports the **claimed entitlement** together with a rebuttal of the points made in the letter of denial. Remember that doctor's records generally address medical issues, not the specific issues governing the entitlement to the legal claims made the subject of the benefit entitlement to be enforced. Some specific input from your doctor would be appropriate. **Please keep in mind that the appeal will likely be your last chance to get evidence before the Plan Administrator and, ultimately, the Judge. It must been done with thoroughness.**

CHAPTER

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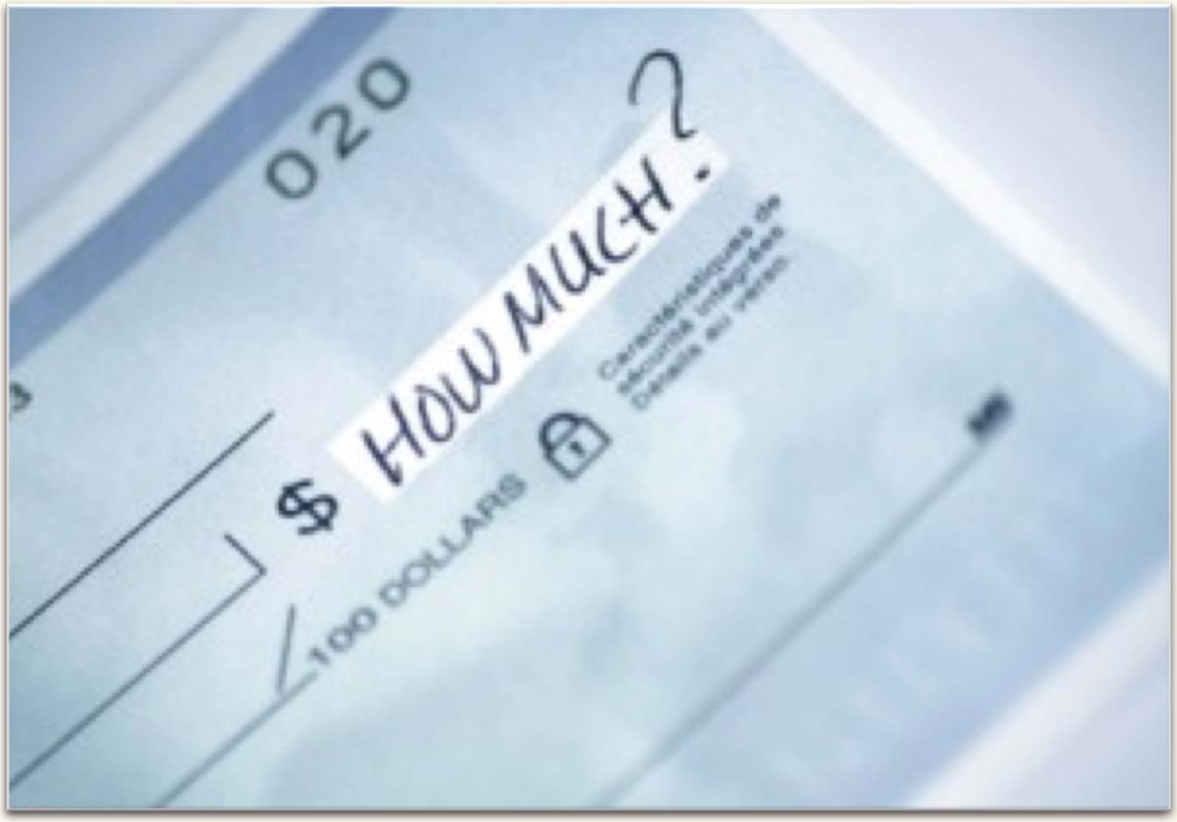
Social Security Ramifications



Social Security Ramifications

Social Security Reimbursement Agreement

Of the many documents which an Insurance Company may submit to you in connection with commencement of either your claim or the later payment of benefits, is one typically entitled ***"Social Security Reimbursement Agreement,"*** or words to that effect. Many inquiries have been received about whether this document should be signed. This is one instance in which the answer is a rather simple "yes" but let me explain the reasoning..

The Insurance Company is typically entitled to an offset of at least part of the benefits you receive from the Social Security Administration. I say "typically" because this is often the case; however, the Plan Documents governing your benefit entitlement should be examined to determine whether the Insurance Company can rightfully claim this offset. The Plan Documents and securing a copy thereof is also a topic addressed earlier in this E-book.

One reason the Insurance Company requests the Social Security Reimbursement Agreement is to ensure that you understand the offset (presuming it exists). Also, it is not unusual for group Long Term Disability benefits to be paid prior to an award and payment of Social Security benefits. The Insurance Company will agree to pay the gross or full amount (before the offset) of group Long Term Disability as long as the Social Security Reimbursement Agreement is signed evidencing an understanding of the entitlement to an offset and, more importantly, **the potential obligation to "reimburse" the Insurance Company for any overpayment resulting from a subsequent award of Social Security benefits.**

There are couple of points to keep in mind. First, there typically is no offset against Short Term Disability benefits because the Social Security Administration does not pay benefits from the date of disability. Second, the amount of the offset which the Insurance Company can claim is limited to the ***"Primary Insurance Amount"*** which, for present purposes, can be described as the amount of Social Security benefits due in the first month of entitlement thereto. The effect of this is that the Insurance Company is not entitled to offset any subsequent ***"Cost of Living Adjustments"*** paid by the Social Security Administration.

One point which must be kept in mind is the hiring of an attorney for purposes of pursuing your Social Security claim. If you get to the point of needing to do so, it is suggested that you do not use the attorney recommended by the Insurance Company even though they suggest they will pay the attorney's fee. It is disingenuous for them to make this suggestion.

First, you should have your own attorney represent you rather than one of the nationwide, impersonal Social Security attorney firms.

Second, any fee you incur as a result of representation will ordinarily be deducted from any amount you are required to reimburse the Insurance Company from any overpayment resulting from receipt of Social Security benefits.

Social Security Ramifications

Overpayment

How does an overpayment occur in a Disability claim?

> "It is unfortunate that so many people do not realize that the disability insurance company is allowed to offset benefits you receive from other sources, thereby dramatically reducing or even, in some cases, eliminating the benefit entitlement."

Just about every person who comes to me is surprised to learn that the disability benefits they paid for are not over and above **"other benefits"** to which they are also entitled. Those **"other benefits"** which your disability insurance company might claim as an offset against (or, reduction of) your disability benefits might include Social Security Disability benefits, workers' compensation benefits, claims against third parties who cause the disabling medical condition, retirement benefits and others. The governing Plan Documents, "Summary Plan Description" and insurance policy need to be reviewed in detail to determine which **"other benefits"** can be used to offset benefits. Also, the method by which the deduction can be taken needs to be considered. Issues concerning receipt of lump sums of **"other benefits"** routinely arise as well.

The strange phenomena I have experienced is that when these other benefits are received, the disability insurance company will simultaneously claim the **overpayment** and then soon after find a reason to deny the benefits they owe. This may seem somewhat astonishing but that is only because it is. The point being that when you receive **"other benefits"** from other sources, you need to proceed with caution. **The first issue is the correct amount of the overpayment.** This is one area in which an experienced attorney can provide particular assistance.

CLOSING

There are many subtle issues which must be successfully dealt with during the claims process. These issues are going while you are experiencing medical and economic issues, both of which are stressful all by themselves. This s a time during which you should seriously consider securing professional help to protect an income stream which is probably one of your most valuable assets.

Please keep in mind that the foregoing is not intended as legal advice applicable to any individual person's unique legal situation. Its sole purpose is to give a general idea of the existing status of the law as it applies to the point of law addressed above. You cannot rely on the foregoing as legal advice. You cannot make legal decisions based on its contents. If you have questions arising out of this point of law, you should contact an attorney who routinely handles claims involving policies of disability insurance.

The law offices of **Herbert M. Hill, P.A.** handles such cases and would welcome the opportunity to discuss your case with you, at no charge. You can contact me at **407-839-0005** or at **hmh@herbertmhill.com**.

FOR A FREE

CONSULTATION

If you would like, after discussing your case, we can set a conference. That conference would be free of charge and you would be under no obligation to hire me nor would you feel any pressure from me to do so.

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Herbert M. Hill, P.A. *is a law firm located in Orlando, Florida with a practice extending throughout the state of Florida and the southeastern part of the United States, including Georgia and Alabama. Areas of practice include disability and employee benefit claims of all sorts. The firm handles any claims arising under the Employee Retirement Income Security Act (known and referred to as "ERISA") for disability benefits, medical benefits, retirement benefits of any sort, including pension, 401k, termination agreements or the like as well as claims arising under private disability policies.*

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