By George Thompson, Attorney-at-law, specialist in Long-Term Disability Insurance

1. What is Disability Insurance?

Disability insurance is privately owned insurance that pays a monthly benefit to an insured who is either disabled by an injury or sickness in his/her "own occupation," "any occupation," or a modified definition of his/her occupation. The insurance can be acquired in the form of an individual policy where the policyholder usually pays the premium or group insurance offered by an employer which insures an individual usually in their capacity as an employee. "Own occupation" insurance insures an individual against his/her ability to perform the substantial and material duties of his/her occupation, i.e. a salesman, surgeon, accountant. An individual can be disabled in his/her own occupation and still collect benefits if s/he is capable of working in a different occupation.

"Any occupation" coverage, on the other hand, pays a disability benefit if the insured is unable to work in any occupation for which s/he is suited by age, education, status in life, income and experience. The standard is similar to that utilized by the Social Security Administration and generally requires a greater degree of impairment.

A policy with a modified occupation language generally pays a disability benefit if one is disabled in his/her own occupation and not engaged in another occupation.

Finally, some policies have a Change in Definition feature ("CID") which states that after a passage of time (12, 24, 36 or 48 months), the disability standard changes from "own occupation" to "any occupation." This is a typical feature of a Group Disability Insurance policy. The impact of the CID is to elevate the degree of disability if one is to remain disabled and eligible for benefits after the "own occupation" period passes. In short, benefits will only continue if the insured is disabled in the "any occupation" period that follows the "own occupation" period.

Difference Between Regulated Insurance Policies and Self Funded Plans
2. What is ERISA?

The Employee Retirement Income Security Act ("ERISA") is federal legislation enacted by Congress in 1974. The public policy concern underlying ERISA was a concern that too many employers were abusing their responsibilities for administering benefit plans for their employees. It was also believed that the passage of exclusive federal legislation regulating employee benefits would simplify and expand employee benefit offerings since employers would be accountable to the federal government as opposed to 50 different state insurance departments.

ERISA reserves to the federal government the exclusive right to regulate the vast majority of employee benefit plans, which typically include either pension, life, health, or disability insurance or a combination of the four. ERISA is a complicated statute that details when an employee benefit plan is or is not subject to ERISA, claim processes, claim review standards, claim administration timelines, and exclusive and limited litigation remedies available only in Federal Court. Unfortunately when ERISA was enacted into law there were a number of substantive areas of the legislation where Congress provided little or no guidance. Consequently the Federal Courts, including the Supreme Court, had to weigh in to "fill in the blanks." Not surprisingly, there is a lack of uniformity among the various federal circuits on the significance of certain issues, many of which have yet to be addressed by the Supreme Court. Given the legal and technical nature of ERISA and the variance of its application from federal circuit to federal circuit, it is critical that you give serious thought to consulting an attorney who has significant disability and ERISA significance.

3. What type of information should I bring to my first meeting with an advocate?

- A copy of the insurance policy;
- Any forms and letters you have received from the insurance company or your employer's HR Department;
- The names and addresses of your healthcare providers treating you for your disability condition;
- A timeline outlining the start of the disability and your treatment dates;
- The name and address of your employer and your supervisor/manager; names of co-workers who can verify what your job was and perhaps corroborate your decline in performance because of your disability;
- The names of any individuals you believe could provide information in support of your claim.

4. If I am receiving Disability Insurance due to a workplace injury, can I also get Social Security Disability and/or Workman's Compensation Insurance?

Yes, but depending upon the language of the disability policy, the benefit amount paid under the disability policy might be offset by the amount of benefit you receive from either Social Security or Workman's Compensation. The offset feature is a typical feature of a Group Disability policy and not as typical with an Individual Disability policy. Even when allowing offsets, the policies generally guarantee a minimum amount of monthly benefit that cannot be offset. Workman's Compensation insurance, Social Security disability and private disability insurance are not mutually exclusive. They can be collected at the same time with or without offsets.

Finally, private disability insurers may require you to sign a reimbursement agreement if your policy has an offset feature that would allow for them to collect retroactively a percentage of benefits paid to you in the past and present that may be subject to a future retroactive offset such as a delayed Social Security Disability Award.

5. Can Private Disability Insurance drop my coverage after I receive Social Security Disability?

It depends upon the language in the insurance policy or insurance plan. This is not a typical feature of private insurance policies regulated by the state and sold to the general public. It might be a provision in a self-insured plan. The "dropping of coverage" differs from the offsetting of a disability benefit because of the receipt of Social Security benefits, discussed in #3 above.

6. Can I receive Disability Insurance Benefits when I am unemployed?

It is possible to receive benefits under an individual disability policy if one becomes disabled while unemployed. These claims are complicated given the general rule that a disability must be measured against an occupation one is engaged in at the start of disability. There are times, however, when an individual may be laid off and job hunting or perhaps left the workforce temporarily to care for a sick loved one. In these situations, the disability insurer should look for evidence as to whether the policyholder intended to return to the occupation or had they abandoned the occupation (i.e. retired). If the circumstances reveal that the insured intended to return to the occupation, the insurer will likely measure the disability against that occupation.

Please note that some individual disability policies may have a termination of coverage feature that provides that after a certain age, such as 65, the coverage ends if the insured is not working a specified number of hours per week.

Finally, the issue of unemployment will likely have a more dramatic effect in the context of group disability coverage since generally group disability insurance for employees ends once they are

no longer employed by the employer who provides the group coverage. This may not be applicable, however, if the group disability coverage offers a conversion benefit allowing the departing employee to convert the group coverage into individual coverage.

7. How long will Private Disability Insurance pay if I am disabled for life?

The policy language will state whether the benefit term is for a fixed duration, i.e. 48 months or to age 65, or whether it is lifetime benefits. If you qualify for lifetime benefits, you will be paid for the remainder of your life whether that is 34 days, 34 weeks, 34 months or 34 years. Individual disability policies sometimes have a death or survivor benefit as well, which can be paid to your spouse or estate if you die while on claim.

8. Would I need a lawyer or advocate to handle my claim?

That is a personal decision unique to each person seeking disability benefits. The advantage of a lawyer/advocate at the outset of the claim process is that s/he can minimize your time interacting with the insurer and obtaining all the relevant information needed to assess your claim for benefits. If s/he is well versed in insurance law, the lawyer can help you better understand your rights under the policy. An example would be the lawyer's familiarity with ERISA and expertise in knowing that you are timely submitting a complete packet of information in support of your claim. The downside to a lawyer/advocate at the claim stage is that you will have to pay the lawyer/advocate.

9. What public benefits may I be eligible for?

Depending upon the significance of your disability and your residence, you may qualify for Social Security disability benefits and Medicare Health coverage from the Federal government. Some states, such as California, have a state disability insurance program as well.

10. Can I sue the Insurer when I receive a denial or must I exhaust the Administration Remedies offered by the Plan or Insurance Policy?

Generally you must exhaust the administrative remedies under a Group Insurance claim unless it is apparent that an appeal would be futile given the content of the denial letter.

11. What type of information should I expect in a Denial Letter?

A thorough and balanced explanation of the relevant insurance policy provisions and applicable evidence in the claim file that led to the denial conclusion. If the claim was denied because there was certain information that should have been submitted with the initial claim submissions, the insurer should describe the type of information that would be helpful in

perfecting the claim that would allow for its payment.

If it is a group disability insurance claim, there must be ERISA Appeal rights and timeframes contained in the language. Some state insurer departments, such as California and New Hampshire, require the insured, who is a resident of that state, to receive language advising of his/her rights to contact his/her state insurer department if s/he believes s/he has been mistreated.

Generally there is no mandated legislative right to a claim denial appeal for individual disability policies, although individual disability insurance carriers often offer an appeal.

12. What are my rights during the Administration Appeal Process?

This question addresses the rights of an insured under an ERISA-governed group disability insurance policy or plan. Generally, you have the right to receive all pertinent documents or the complete administrative record (claim file) if you ask before you submit your appeal. You have the right to a full and fair review by a different claim examiner.

13. What initial steps should I take if I receive a Denial of Benefits?

Make sure to read and understand the letter. Call the author of the letter if any part of it is confusing or incorrect. Calculate your ERISA deadlines. Request in writing that you wish to appeal the denial and you would like the insurer to send you all pertinent documents.

14. What are common reasons given for denials?

They really do vary depending on the circumstances of the claim, but ultimately the insurer has concluded that the claimant is no longer eligible for benefits.

15. What should I send with my appeal?

All the information that you believe will assist in getting the decision reversed.

16. What should I do if my disability insurer offers me a lump sum settlement?

It would be wise to consult an attorney experienced in these matters. A lump sum settlement is not a contractual benefit. From time to time, however, an insurer may offer a lump sum to pay

you to give up your claim (but keep your policy) or to give up your claim and policy. Here are some of the possible issues, by no means exclusive, that you should address when considering a lump sun:

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The "upside" of a lump sum settlement is that you can collect a greater amount of money now as opposed to collecting a benefit monthly for a specified period of time. You can generally return to any form of work, assuming your health permits it and there is a satisfying job awaiting you, without the need to continue to complete monthly claim forms for the insurer.

- The "downside" is that you may be forfeiting significant contractual rights to continue your current claim or a future claim. Once you surrender your policy, you no longer have a policy to protect you in the event you are disabled again. Similarly, once you have submitted a claim and collected disability benefits with Insurance Company AA and later take a lump sum settlement from Insurance Company AA, you may not be able to satisfy the underwriting requirements to get a new disability policy with insurance Company BB or you might be at risk for having a future claim of the same nature denied by a different insurer if it is deemed to be a pre-existing condition.
- You should ask the insurer how they calculated the lump sum. Is it based on an expectation that you'll recover your health in short order? Do they expect to deny the claim in the near future? Ask them what is their calculation of the Present Day Value of future benefits? What interest rate did they use? Did they discount the present day value? What type of discount did they use? What is the amount of the disability claim reserve they are holding on the claim? If you have been collecting disability benefits because of a cognitive or psychological impairment associated with a brain injury, ask the insurer if they'll agree to pay a fixed some (perhaps $2000) towards your retention of counsel to review the proposal?

Accepting a lump sum settlement is a very significant decision and must be carefully evaluated in light of your current and expected future health, your future employability, your future insurability, and the fairness of the lump sum amount.

17. What should I do if my insurer asks me if I am interested in a rehabilitation program?

Insurers view the successful participation of those they insure in a rehabilitation program as a "win-win" for both the insured and the insurer. Its a "win" for the insured to the extent the details

of the rehabilitation agreement and program allow an insured to return to a productive and satisfying career. Its a "win" for the insurer if the insured's return to work helps the insurer to reduce or eliminate the cost of paying a claim. The ultimate decision that you make, however, will be unique to your particular circumstances. You may want to consult with an attorney or advocate experienced in disability claims. Here are some of the issues you should consider.

a. Does your policy provide an optional rehabilitation benefit? Confirm this with your insurer. Ask them why they are approaching you "now" with an invitation to participate in a rehabilitation program?

b. What consideration is the Insurer Company offering you to participate in the program? For example, will they continue to pay your disability benefits if you successfully complete the program? Will they pay an amount of money that helps you transition into a new career upon completing the program. In other words, would they be willing to pay you a lump sum upon successful completion, assuming you needed some "seed" money to pursue a new occupation or career?

c. Ask your insurer if there will be any negative consequence to the handling of your claim if you simply decline the invitation? Ask your insurer if they will be responsible for any injury or further exacerbation of your disability in the event you are injured during the program?

d. If you are genuinely interested, speak with your attending physician or the medical specialist treating you for your disability to see if there is any medical risk to your participation.

e. Rehabilitation programs are only limited by one's imagination if both the insurer and insured are both motivated to make it work. Aside from traditional work-hardening programs or specific vocational/career counseling, the insured may be able to negotiate for assistance pursuing a college or graduate degree that would redirect their career currently stymied by a disability.

18. What should I send with my appeal?

Assuming your initial denial involved an ERISA-governed disability policy, it is absolutely critical that you use the opportunity to appeal to submit a complete record (any and all documentation) supporting your claim. The reason it is especially important to "get it right" is that under ERISA, if your denial is upheld on appeal and you still disagree with the decision, the administrative

record/claim file is "closed" and you are not allowed to submit new information except in rare circumstances. Consequently, any Court that reviews the claim decision will typically be limited only to the claim file in front of the appeals examiner. ERISA does not allow for witnesses to testify at trial and generally, new information is not allowed to be added to the claim file after an appeal has been upheld.

What you actually submit will in part be determined with the reasons provided to you as part of your denial and the information in your claim file. This is why it is critical that upon learning of your denial you ask the insurer for a copy of your claim file and all pertinent documents as discussed earlier. After you review the denial letter, you may want to consider calling the claim examiner and asking him or her "What type of information was missing from my claim that would allow you to approve benefits?"

Assuming your claim was denied under a policy not governed by ERISA, I'd still suggest asking the insurer for the same information.

Because of the seriousness of getting the record right on appeal, you may want to seriously consider consulting an attorney or advocate experienced with disability matters.