Individual Disability Law Update, or How Hamilton Lyrics Will Help You Remember This Year’s Most Interesting Cases

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ERISA may dominate the world of disability law the way Hamilton has dominated Broadway, but there are always some interesting individual disability cases to be found in the eye of the hurricane. Highlights include a case upholding an expansive definition of “earnings” for purposes of calculating a monthly benefit; several seemingly logical claims determinations brought down by ambiguity in policy language; a pair of decisions rejecting the bad faith claims of unsatisfied insureds; a case of a doctor who threw away his shot at residual disability benefits by ignoring his policies’ notice provisions; and a cautionary tale about settlement with a tax-dodging claimant. Your author hopes you will enjoy this year’s crop of notable individual disability decisions. Feel free to sing along.

I. “The Man Is Non-Stop”—Are You Really Disabled from Your Own Occupation?

In Duda v. Standard Insurance Co., 649 F. App’x 230, 232 (3d Cir. 2016), the court held the claimant was not entitled to LTD benefits under his personal policies. The claimant was an orthopedic surgeon who earned his income from several related sources, including participating in an orthopedic practice with his own treating physician and conducting independent medical evaluations. Id. at 231. After the claimant fell and injured his wrist, he sought disability benefits claiming he was unable to perform the material duties of his own occupation because he could not perform surgery. Id. While the claimant maintained he could not perform surgery due to his injury, the Third Circuit found that surgery was only a small portion of his duties and, therefore, not “the exclusive ‘main duty’ of his regular occupation.” Id. at 232.

The court was presented with a slightly different issue, but used a similar analysis, in Nefsky v. Unum Life Insurance Co., No. 1:15-cv-2119, 2017 WL 621269, at *1 (N.D. Ga. Feb. 2, 2017). The disability policy at issue, like many, paid benefits only to age 65. But it also included a “Lifetime Sickness Benefit Rider,” which provided continued coverage for total disability. Id. at *1. The rider did not apply to residual disability, which the policy defined as an injury or sickness that did not prevent the insured from performing the duties of his occupation, but did “restrict his ability to perform” those duties. Id. The plaintiff was a dealer in watches, jewelry, and precious metals, with wholesale, retail, and online sales. He claimed a retinal vein occlusion impaired his vision; he could no longer spend as much time examining watches due to blurred vision. He argued he was totally disabled and entitled to lifetime benefits as a result. Id. at *4. Pointing to the extensive activities the plaintiff was still able to perform despite his vision loss (buying and selling items, advertising, purchasing wholesale, and attending trade shows), the court found he was residually disabled and thus not entitled to the rider’s continued benefits. In so ruling, the court focused on the insured’s “meaningful engagement” with the duties of his occupation. Id. at *7.

II. “Wait for It”—A Four Year Delay Can Doom Your Claim

The court in Duquette v. National Life Ins. Co., No. 2:15-cv-0316-RDP, 2016 WL 4247791, at *1 (N.D. Ala. Aug. 11, 2016), upheld the notice provisions in several disability policies insuring a plastic surgeon. Two of the doctor’s six policies required notice within “20 days after the commencement of any disability;” while the remaining four policies required such notice within 30 days. Id. The plaintiff began experiencing neck pain and stiffness in 1996; his worsening condition led to surgery. Id. at *2. After surgery, the plaintiff contin-
ued to work full-time until April of 2009. At that point, his increased pain and loss of range of motion led him to begin reducing his medical practice because of difficulties in performing surgery. \textit{Id}. According to the opinion, the “plaintiff did not inform defendant that he was partially disabled because he did not want to be forced to end his practice.” \textit{Id}. (The opinion is silent on any risk to patients this strategy may have posed). After an automobile accident, the plaintiff’s symptoms continued to worsen, and he closed his practice on June 28, 2013. \textit{Id}.

The plaintiff provided National Life with notice of his claim on July 20, 2013, seeking both residual disability benefits from January 1, 2009 until June 28, 2013 and total disability benefits thereafter. National Life concluded that plaintiff’s four and half year delay in reporting his residual disability claim was not supported by a reasonable explanation. \textit{Id}. Quoting Alabama law, the court agreed, noting that the physician’s four-year delay in notifying his insurer was “virtually unprecedented” and explaining “the court has no hesitation in concluding that seeking to avoid ending (or affecting) one’s practice (by not informing his patients of his decreasing ability to perform plastic surgery) is simply not a reason that is sufficient to justify the lengthy delay in informing an insurer of such a condition involved here.” \textit{Id}. at *5. The court also evaluated whether the plaintiff’s total disability (which the insurer did not contest) was due to sickness or accident, because the policy provided for a reduced benefit after age 65 for disabilities resulting from sickness. On that issue, however, questions of fact precluded summary judgment in favor of either party. \textit{Id}. at *4.

### III. “We Have the Check Stubs from Separate Accounts”—Court Confirms an Expansive Definition of Earnings for Income Calculation

The court had no trouble finding that an insurer properly included a claimant’s “incentive pay” and “bonus loan payments” when performing its loss of earnings calculations in \textit{Lynn v. Provident Life and Casualty Co.}, No. 328321, 2016 WL 6638601, at *1 (Mich. Ct. App. Nov. 8, 2016). The plaintiff’s disability policy allowed for partial disability benefits only if the insured “incurred at least a 20% reduction in income because of a disabling condition.” \textit{Id}. In performing the loss of earnings calculations to determine whether the plaintiff met this standard, the insurer considered the plaintiff’s incentive pay and bonus loan payments from his employer. Relying on the policy’s definition of “earnings,” which included “your salary, wages, commissions, fees, bonuses, and any other income earned for the work you do...,” the court agreed with Provident that the bonus loan payments constituted earnings, given the fact that the payments were predicated entirely on the plaintiff’s continued employment. \textit{Id}. at *3. As the court observed, “this common sense notion is made clear by the fact that the … payments are included as wages on plaintiff’s W-2 forms.” \textit{Id}. Accordingly, the court upheld the trial court’s judgment in favor of Provident.

### IV. “The People Won’t Know What We Know”—Ambiguous Policy Provisions Trump Logical Claims Decisions

A clear policy provision can be made ambiguous when considered with other policy provisions, according to the court in \textit{Amanatullah v. U.S. Life Insurance Co.}, No. 4:15-CV-00056-EJL, 2017 WL 522 947, at *1 (D. Idaho, Feb. 8, 2017), which found that language reducing a policy’s monthly benefit after age 65 was ambiguous when read with the policy’s schedule page that set the monthly benefit at a fixed amount. The provision at issue, titled “Change in Amount of Insurance,” stated that the insured’s “Monthly Benefit for Total Disability will reduce on your certificate anniversary next following your attainment of age 65...” to an amount 25% less than the monthly benefit shown on the policy schedule page. \textit{Id}. The court noted that the
schedule page did not mention the reduction, and went on to find that the reduction provision did not necessarily put the insured on notice of the benefit change. The court also noted the title of the subject provision mentioned a change in insurance rather than a change in monthly benefit, which the court deemed “confusing.” For reasons it failed to explain, the court also found that the “Change in Amount of Insurance” section was ambiguous because it was not mentioned in the exclusions section of the policy either. Id. at *2.

Ambiguity in the policy language also worked in the plaintiff’s favor in Berg v. New York Life Insurance Co., 831 F.3d 426 (7th Cir. 2016). The plaintiff was a pit broker at the Chicago Mercantile Exchange who began experiencing a tremor in his arms and hands in 2005. By September of 2007, the tremor forced him to leave his job. Id. at 427. (The case is silent on the issue of whether, by 2007, a pit trader was still performing open outcry trading such that he could not perform the duties of his occupation via Globex or another applicable computerized trading platform). The plaintiff applied for disability benefits under his policies in 2010, after a neurologist diagnosed him with “essential tremor.” Id. at 428.

Noting that Illinois law governed the plaintiff’s claims, and that an ambiguous policy provision must be read in light of “the insured’s reasonable expectations and the policy’s intended coverage,” the court examined the insurer’s reliance on the policy’s definition of injury and sickness, which provided that “the injury or sickness must be one which requires and receives regular care by a physician.” Id. at 429. New York Life argued that because the plaintiff did not receive “care by a physician” until 2010, he did not have an illness or sickness until that date, such he was not totally disabled for policy purposes until February 3, 2010. The Seventh Circuit rejected this argument, noting that the policy’s provisions did not contain any “temporal elements.” Id. The court went on to offer the “absurd results” that stemmed from New York Life’s position:

Say, for instance, that an insured fell down the stairs to his basement, severing his spinal cord and rendering him a paraplegic. He happens also to be a doomsday prepper and thus has ample food and water for an extended period of time. He survives in the basement for six months until he is discovered. Finally, he is taken to a physician and his care begins. According to the insurers, his injury did not exist, and he was not totally disabled, for those six months. Or suppose that an insured’s hands were amputated in an industrial accident. She would need immediate care from a physician, but eventually, when there is nothing more that a doctor could do for her, she would cease receiving care from a physician. Would she not be totally disabled after that point? Or what about a woman who discovers a lump in her breast, but who cannot see a doctor for several months, and only then is told she has Stage 4 cancer? In each of these cases, it is plain that the person was either disabled or ill without regard to the timing of the visit to the physician. Id. at 430-31. Using these admittedly “absurd” hypotheticals and applying them to the facts before it, the court concluded that the provision’s “temporal effect is at least ambiguous” and therefore construed it against New York Life, holding that “if Berg can prove that the essential tremor prevented him from performing his pit broker duties in September of 2007, then he was disabled under the policies starting at the time. The facts in the light most favorable to Berg show just that.” Id. at 431.

Ambiguity also worked in favor of the claimant in Slice-Sadler v. Principal Life Insurance Co., No. 1:15-cv-216, 2016 WL 5724824, at *1 (M.D.N.C. Oct. 6, 2016), where the court found that the insured was entitled to additional benefits under a Future Benefits Increase Rider. The rider at issue, which allowed the insured to elect increases in the total monthly benefit, incorporated a limitation which applied the increase only to “new disabilities” starting after the increase was elected and barred any increase option while an insured was disabled. Id. at *3. Principal offered and the insured accepted five increases in her monthly benefit between 2010 and 2014. Id. at *1. In May of 2012, however, the insured made a claim for residual and total disability. Principal denied her claim, the plaintiff filed suit, and after extensive discovery Principal agreed
that the insured was residually disabled. Id. at *2. With respect to the benefit amount, however, Principal claimed that the monthly benefit should reflect only the last benefit increase before the plaintiff filed her claim in 2012.

Construing ambiguous policy language in favor of the insured under North Carolina law, the court disagreed with Principal and found the provisions at issue ambiguous. The court noted that “new disability” was undefined and could refer to either the date a disability claim was filed or the date a disability determination was made. Id. at *3. The court also found that Principal’s actions in offering increases after the disability claim was filed supported the plaintiff’s policy interpretation. Id.

V. “What Did I Miss?”—Clear Policy Provisions Defeat Claims

Courts have has not found all policy provisions ambiguous in the past year. In Hopkins v. Ameritas Life Insurance Co., No. 1:15-CV-00051-GNF-HBB, 2016 WL 3748518, at *1 (W.D. Ky. July 8, 2016), for example, the court examined whether the disability policy at issue was a “non-occupational” or “occupational” policy. Id. at *2. While it recognized that Kentucky law construes ambiguous policy provisions against the insurer, the court found no need to resort to such a rule of construction here. The provision at issue provided that an insured would be considered totally disabled if prevented from “performing the material and substantial duties of your occupation.” The same provision went on, however, to define occupation to mean: “your occupation or occupations at the time the disability began” for only the first 60 months of benefits. Id. at *3. Thereafter, the definition of “your occupation” changed to mean “any reasonable occupation.” Id. Describing this provision as creating a “hybrid policy,” the court granted partial summary judgment in favor of Ameritas on the issue of construction of that provision.

The court in Lasner v. Massachusetts Mutual Life Insurance Co., 34 N.Y.3d 142 (N.Y. App. Div. 2016), also found the disputed policy provision at issue clear and unambiguous. The subject provision, another lifetime total disability benefits rider, allowed for lifetime disability benefits (beyond age 65) if the insured was prevented by sickness or injury from performing not only the duties of the insured's occupation, but from “working at any other job or business.” Id. at 144. In other words, the policy was an “own occupation” policy until age 65, and “any occupation” policy thereafter. The plaintiff was a dentist at the time of his disability and received total disability benefits under the policy beginning in 1989. He then obtained employment as a surgical supply salesman, a job in which he continued to work after his 65th birthday. Id. MassMutual concluded the plaintiff was not eligible for continued benefits under the lifetime benefits rider. Id. The appellate court upheld summary judgment in favor of MassMutual on plaintiff’s breach of contract claim. In so finding, it expressly stated that the terms of the policy, and in particular the lifetime total disability benefits rider, were “clear and unambiguous” such that the plaintiff could not be considered totally disabled under the rider. Id. at 145.

VI. “Say No to This”—Reason Defeats Bad Faith

They say that no good deed goes unpunished, but sometimes a court can intervene. In Oliver v. MONY Life Insurance Co., No. 2:15-cv-00905-AKK, 2016 WL 7384842, at *1 (N.D. Ala. Dec. 21, 2016), the court entered summary judgment in favor of MONY on all of the plaintiff’s claims, which included fraud, suppression of material facts, breach of contract, bad faith, and “negligence and wantonness.” Id. The plaintiff claimed MONY took too long to approve his claim and he suffered mental anguish as a result of the delay. Somewhat lost in the court's lengthy opinion is the fact that MONY decided to pay benefits even though the insured had stopped working in his regular occupation seven years before his disability began. Id. at *2. More-
over, the delay at issue was caused, in part, by the insured's refusal to drive about 100 miles to an IME. *Id.* at *3. The plaintiff also claimed MONY acted in bad faith by making him a settlement offer. Ultimately, however, the court concluded that the plaintiff had no evidence to support any of his claims, as plaintiff could point to no specific misrepresentations to support fraud, had no damages, and could not prove that MONY lacked a legitimate reason to investigate his claim before approving it. *Id.* at 8.

In *Coleman v. UNUM Group Corp.*, No. 15-0367-WFM, 2016 WL 4994553, at *1 (S.D. Ala. Sept. 16, 2016), the court granted summary judgment to UNUM on a bad faith claim, finding that UNUM had a reasonably legitimate basis to deny the underlying contested claim for disability benefits. The court specifically examined Alabama bad faith law, which it explained constitutes "a single tort 'with different options for proof.'" *Id.* at *2, citing *State Farm Fire & Cas. Co. v. Brechwill*, 144 So. 3d 248, 257-58 (Ala. 2013). Under either option, the absence of an arguable reason for an insurer's refusal to pay is required. The court specifically held that the "imperfections of the insurer's investigation" play no part in determining whether the insurer had a legitimate reason for denying the claim. *Id.* The court then outlined the extensive evidence on both sides of the issue of whether the plaintiff was disabled, including multiple medical opinions, diagnoses, and conflicting deposition testimony. Considering all of this, the court concluded that "the defendant had a debatable reason for terminating the plaintiff's disability benefits, since it was far from clear that the symptoms he reported were of such a character, severity, frequency and duration as to render him unable to perform the duties of his occupation." *Id.* at *7. The court therefore granted summary judgment to UNUM on the plaintiff's bad faith claim.

**VII. “He Will Never Be Satisfied”—Settlement With a Tax Dodger Aided by the IRS**

While the facts of *Eaton v. UNUM Group, et al.*, No. 7:15-CV-01204-LSC, 2016 WL 6804191, at *1 (N.D. Ala. Nov. 17, 2016), aren't necessarily specific disability law, it's an interesting enough case to close out this article. UNUM originally owed the plaintiff commission payments, but received a Notice of Levy from the IRS in 2006, as the plaintiff owed the IRS nearly $500,000 in back taxes. *Id.* In addition to sending commission payments due to the plaintiff to the IRS, UNUM also informed the IRS that the plaintiff "may hold disability insurance policies with its sister corporation, Provident Life." The IRS never sent a Notice of Levy to Provident Life. *Id.* Thereafter, the plaintiff made a claim for disability benefits to Provident Life. After his claim was denied, he filed suit and the parties eventually settled the dispute in 2009.

While the parties' written settlement agreement was never signed, the last version of that agreement contemplated that Provident Life would pay the agreed settlement amount only after receiving sufficient direction from the IRS as to how the funds should be paid. *Id.* at *2. The plaintiff's counsel called the agreement "fatally flawed" because it "falsely claimed that Provident Life had received a Notice of Levy from the IRS." *Id.* Provident Life stood firm, and after several additional letters demanding payment, the plaintiff filed suit. In essence, the plaintiff argued that his performance under the contract had "been completely foreclosed because Provident Life never provided him with a copy of the Levy." *Id.* at *3. Granting summary judgment to the insurers on the plaintiff's claims of breach of contract, breach of the covenant of good faith and fair dealing, negligent misrepresentation, fraudulent inducement, fraud, conspiracy, and unjust enrichment, the court concluded that the plaintiff failed to comply with a condition precedent for a payment by failing to provide the appropriate direction from the IRS that would allow Provident Life to pay the settlement amount without further IRS entanglement. *Id.* at *8. Provident was aided in its efforts by the IRS, which issued to the court a new Notice of Levy showing the amount of taxes the plaintiff still owed the IRS. *Id.* at *5. The court noted that this action showed that "Provident Life's concerns in 2009 [were] well founded." *Id.*