



FRANKEL & NEWFIELD, P.C.

585 Stewart Avenue
Suite 301
Garden City, New York 11530

Telephone: (516) 222-1600
Facsimile: (516) 222-0513
www.frankelnewfield.com

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FRANKEL & NEWFIELD, P.C. is a boutique law firm focusing on assisting individuals with long term disability claims, and individuals whose long term disability claims have been wrongfully denied or terminated. Our experience in recognizing issues before they become problems has helped guide many claimants through this difficult process at a time in their lives when they most need the benefits of the protections they purchased.

Welcome to "*LTD Management*," Frankel & Newfield, P.C.'s quarterly newsletter for the Firm's clients and professionals who routinely consult with the Firm, updating them on our practice, as well as important new developments in the law of disability insurance.

Firm Updates

Frankel & Newfield has completed its move into new office space. Our new address is 585 Stewart Avenue, Suite 301, Garden City, New York 11530, and our new fax number is (516) 222-0513. Our telephone number remains (516) 222-1600.

In other news, the firm has been featured in the Fall 2004 issue of *The CFIDS Chronicle* with an article entitled "Finding Success in the Disability Wars". To read this article, please visit our web site at www.longtermdisabilityclaim.com and link to the article from our home page.

Frankel & Newfield has also been featured in the February 2005 edition of *Podiatry Management* magazine, in the first of a series of articles about the disability claim process and potential problems seen by claimants.

The Firm is also proud to be a Founding Member of a web site dedicated to helping victims of bad faith insurance tactics.

Practical Concerns-A Case Study

One hotly contested issue that arises in certain disability cases is where a professional, whether a doctor, dentist, chiropractor, podiatrist, or lawyer, is faced with disciplinary action from the governmental agency charged with overseeing such conduct. Claimants often have disabling conditions that either have caused them to engage in conduct which subjects them to disciplinary action, or have suffered disabling conditions relating to such conduct. Insurers will seek to deny or terminate benefits to claimants who lose their license to practice their profession, 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 benefits and 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. In contrast, 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.

Recent Decisions on Disability Cases

Court Takes Insurer to Task for Failing to Consider Opinions of Treating Physician

Although insurers consistently argue that they are not required to accept the opinions of a claimant's treating physician in a disability case (as is the rule in the Social Security disability context), one court has recently determined that even in the wake of the United States Supreme Court decision on this issue, it was improper for the insurer to simply ignore a claimant's treating physician's opinion on the claimant's inability to work. Guiding the court on this issue was the fact that the treating physician had a lengthy history treating the claimant and the fact that the insurer never had the claimant examined, but simply relied upon a paper review of the medical records.

Court Chastises Insurer for Reliance Upon Surveillance and Activity Logs

A court recently determined that the insurer acted improperly where it terminated a claim based upon surveillance evidence, where it failed to consider the significant medication regimen that the claimant required to combat the effects of severe and chronic pain suffered by the claimant. The court was also troubled by the insurer's reliance upon a nurse's review of the medical evidence rather than a medical doctor, where the policy language requires the claimant to be under the care of a physician.

Court Reverses Insurer's Claim Decision Where Claim Supervisor Overruled Claim Examiner

A judge recently determined that it was improper for the insurer to terminate a claim where the claim supervisor dictated the claim determination contrary to the position taken by a subordinate that the claim should be continued. The supervisor improperly determined that the claimant failed to sufficiently document impairment and thus failed to meet eligibility for benefits.

Problems In Subjective Complaint Claims

Where a claimant suffers from a condition that is not readily diagnosed by objective testing, there is often great difficulty in having the insurers accept liability of the claim. Some of the more common symptoms faced with these problems include claims of fibromyalgia, chronic fatigue syndrome, depression, and even cases of rheumatoid arthritis or back injuries. Even in cases where herniated discs appear on MRI, insurers will often challenge the claim for disability, arguing that there is no impingement upon nerves or that the condition is simply degenerative.

The key to succeeding on claims with subjective complaints is in having the treating physician strongly advocate for the claimant, providing well documented clinical findings, restrictions and limitations. Where the treating physician lacks zeal for the claimant, the claim is often doomed to be denied. Thus, working with the doctor is imperative in such claims.

While some disability policies contain language requiring objective medical evidence in support of a claim, the majority of policies do not contain such provisions. Nonetheless, many insurers inject the requirement into the claim process unilaterally, knowing that such a requirement will be impossible for the claimant to satisfy. Symptoms such as fatigue, pain, energy, focus and concentration are difficult to demonstrate objectively. The medical personnel for these insurers are likely to opine that the claimed restrictions and limitations are not supported or are self-limited.

Many courts, however, have required insurers to take into consideration a claimant's subjective complaints when deciding upon the validity of the claim, if the claimant's credibility is not challenged.

Policy Definitions at a Glance

In our prior newsletters, we have discussed certain governing definitions in disability insurance policies. Since these definitions are vital to appreciating your rights and obligations under these policies, we have provided further insight to educate our readers before a claim arises.

Contestability Clauses: Disability policies generally have clauses that permit the insurer to challenge the application responses which induced the insurer to issue the policy, or to challenge the claimant's pre-insurance insurability. Many policies have a two year limitation, which restricts the insurers' ability to 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 policies 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.

Offsets: Some policies contain provisions which allow the insurer to reduce or offset the amount of benefits they are required to pay by analyzing your receipt of other types of benefits. Typically, these other benefits consist of workers compensation benefits, social security disability benefits, other disability insurance benefits, or pension or retirement benefits. Most private disability policies purchased by professionals will not be subject to these offset provisions. On the other hand, group policies provided as an employee benefit through an employer will usually be subject to many or all of these offset provisions.

Examinations: Disability policies contain clauses which permit the insurer to require claimant's to be examined as part of their proof of loss obligations under the policy. Issues that arise under these provisions include the frequency in which 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.

Proof of Loss: As addressed above in the section regarding subjective complaints, there are specific proof of loss requirements in each disability policy. It is imperative to ascertain what requirements exist for a claim for benefits. Moreover, just because the insurer asks for certain materials in support of a claim does not mean that such material is required by a claimant in its proof of loss, and caution should be used in supplying unnecessary material.

In addition, while in a claim for total disability benefits, tax returns are not ordinarily required, in a claim for business overhead expenses, or residual or partial disability, tax returns will be required under the proof of loss provisions. In many of those situations, a client will have the ability to select which years of tax returns provide the claimant with the highest prior earnings for purposes of calculating loss of income in a residual or partial benefits claim.

The information provided in this publication is intended to be for informational purposes only. It is not intended, nor should it be used, as a substitute for legal advice or opinion which can only be rendered when related to a specific fact situation, and on an individual basis.