

About Filing a Claim for Disability Benefits: Part 2

Insurers have many ways to avoid payment on claims.

By Jason Newfield, Esq.

What Happens Once The Claim For Disability Benefits Is Filed

In part 1 (February 2005), the process of filing a claim for disability benefits, the issues that sometimes arise in the claim process, and potential problems that must be avoided in order to successfully maintain a claim for disability benefits were addressed. This article addresses some of the common reasons insurers deny claims, additional techniques utilized by the insurers in the course of "investigating" the claim, and advice on how to protect yourself during this critical time, where you are in both a health and financial crisis.

In my disability insurance practice, I see a variety of claim issues that can destroy a claim or dramatically alter a claimant's rights. This article will highlight some of these issues and advise claimants on how to recognize when the insurer is not acting fairly.

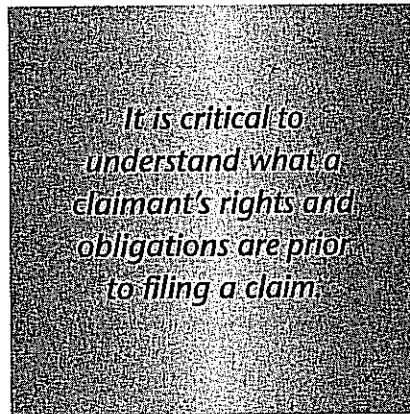
I Need to File a Claim—What Next?

Each claim for disability benefits under the terms of a policy of insurance is guided by the actual terms of the policy. Each insurer has policy language on a myriad of issues that can vary, from the definition of "own occupation," to the incontestability clause, to partial or residual disability provisions.

We previously cautioned claimants to review and analyze (or have a professional review and analyze) the policy prior to filing a claim, in order to strategize the claim issues pre-filing. For many claimants who

can perform some of the duties of their occupation, the only available claim might be a residual claim. Thus, it is critical to understand what a claimant's rights and obligations are prior to filing a claim.

It is also vital to address your impending claim with your treating doctor. The treating physician is an important player in the claim, because the insurer will seek to access the doctor, whether through records or otherwise, and an unresponsive doctor has the potential to hurt a claim. Thus, the importance



of working with your treating physician, and having the physician appreciate the contractual issues and how they integrate with the medical issues cannot be overstated. The treating physician must be able to relate not only symptoms but restrictions and limitations that one faces due to the symptoms or conditions.

Now That I Filed the Claim, What Should I Expect?

Once the insurer is notified of a claim, the insurer will make contact with the claimant, and will provide

the claimant forms to have completed, which usually include a claimant statement, attending physician statement, and an authorization form to be returned to the insurer. There is legal significance to each item that the insurer seeks, and consequences relating to the information supplied, provided, or withheld. Thus, a claimant must approach the response cautiously and methodically.

The information sought by the insurer with the claimant statement relates to the claimant's condition(s), the onset of the condition(s), the restrictions and limitations resulting from the condition(s), and work information, including occupational duties. A claimant must be conscious of how to respond to this information request, from the perspective of integrating the relevant policy definitions into the responses.

For example, a claimant may be asked to provide a list of job duties, listed in order of importance, or defined by the amount of time dedicated to each task or duty. Innocently, a claimant responds that as part of the work day, he/she handles certain functions like opening the mail, or dealing with vendors. It is quite likely that the insurer will take this information and seek to argue that the claimant is only partially disabled, if he/she retains the functional capacity to perform even these limited administrative functions.

Unless the physician is supportive and a strong advocate, many times the physician statement fails to properly document the disability sufficiently to qualify for benefits. It is best to secure a physician narrative to address areas that the

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physician statement may not cover unless properly prompted by a claimant or his/her representative.

Access to Your Information

As part of the claim, the insurer is entitled to access information from the claimant. The authorization is used by the insurer to access information about the claimant from third-parties. Quite often, the authorization provided by the insurer is an over-reaching authorization, allowing the insurer access to financial information and other information that is often irrelevant to the claim (in residual or partial disability claims, the financials are relevant). Claimants must be aware of their rights to substantially

restrict access to such materials, and to modify the scope of any authorization. An insurer will often complain that it unreasonably restricts their ability to render a claim decision. If faced with this issue, it is appropriate to request that the insurer articulate its basis for claiming entitlement to such a broad authorization.

Our prior article discussed the insurers' use of IME's (independent medical examinations), FCE's (functional capacity evaluations), peer reviews, field investigations, and/or surveillance. There are other tools the insurer relies upon to investigate the claim—some of which are clandestine and several of which often result in the development of material used by the insurer to deny or terminate a claim. Each of these "tools" pose potential problems for claimants.

Many insurers rely upon in-house medical staff, who contact a claimant's treating physician to discuss the claimant's condition, restrictions and limitations. In essence, the insurer's medical staff seeks to develop evidence from the treating physician to demonstrate that the claimant is not disabled,

notwithstanding the physician's certification of disability for the claimant. Often, the insurer sends a letter to the physician "confirming" the conversation and stating that absent a quick reply, they accept the statements in the letter.

The letter, however, may either distort the facts, or at a minimum, cast them in light least favorable to the claimant. Because the physician is often busy, or simply fails to respond to the letter for other reasons, the insurer deems the physi-

cian to agree with the statements and denies or terminates the claim.

To combat this potential problem, I counsel clients that the insurer should not have access to the treating physician by telephone; rather, all inquiries either flow through my office or are done

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in writing to the doctor. Then the insurer is prevented from attempting to miscast information, distort facts, or otherwise develop erroneous information, and knows that its conduct is being carefully scrutinized.

Rescission of the Policy

Another tool used by insurers that I have dealt with on several occasions is the claim by the insurer for rescission of the policy. This is an effort by the insurer to cancel the contract, return to the claimant any previously paid premiums and to cease any contractual relationship. The basis for such a claim is usually predicated upon a misstatement in the policy application, or some other claim of fraud in the inducement.

Essentially, the insurer states that it relied upon certain statements of the claimant in order to issue a policy and those statements were untrue. The law on this topic is generally favorable to the insurer and leaves many claimants without coverage that was paid for many years. Below is a true-to-life factual scenario that will highlight the issue.

A claimant files a claim based upon anxiety and depression. The

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claim is denied and the claimant proceeds to litigate his claim, bringing an action in Federal Court (most cases litigated in Federal Court proceed more quickly). During discovery in the litigation, defense counsel accessed documents from claimant's general physician (in addition to the treating physician for the condition). Those records indicated that during a routine office visit, he had complained to the general physician about feeling anxious. The physician prescribed medication, which the claimant did not recall even taking, and the issue was never again raised by the claimant to the physician.

Nonetheless, because the claimant did not report the information on his policy application, an argument existed that the application was falsely completed, and induced the company to issue a policy that it otherwise would not have issued in that form. Thus, a claim for rescission was developed. That issue led the claimant to resolve his litigation at a substantially reduced value from its real worth in the absence of the issue, because the possibility existed that the claimant would have lost the litigation and received nothing.

This example brings several issues up for discussion. First, as was addressed in earlier PM articles by Dr. Daniel Lefkowitz, the application process is crucial, and any misstatements could be fatal to a claim. Thus, working with a professional in the application process (whether broker or attorney), is important. Second, it is imperative to be honest at every stage of the process, whether on the initial application or when making a claim. A misstatement can ruin a claim, even where it was an innocent misstatement. Depending upon the jurisdiction, even innocent misstatements can be grounds for rescission of the policy.

What Basis Does the Insurer Have to Deny My Claim?

There are a number of common reasons provided by insurers when a claim is denied. These include issues relating to a lack of objective proof supporting the claim, filing a claim for secondary gain, or the po-

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tential loss of a professional license. Each of these reasons can serve as a plausible rationale for denial of a claim, but are often simply an excuse to justify the denial of a legitimate claim.

Where a claim is predicated upon conditions where there are no "objective" test results or other data to support a claim, it seems improper for the insurer to deny a claim on that ground.

Unfortunately, some of these conditions, including fibromyalgia, chronic fatigue, and depression, rely upon mostly clinical and/or subjective proof for diagnosis. These claims are among the most disputed types of claims for this reason. Involving an advocate at the outset can assist in marshalling claim support and improving the likelihood of an accepted claim.

Insurers often argue that the medical professionals claim disability for "secondary gain." In essence, they contend that the doctor has a financial incentive to become or remain disabled, particularly where the policy is an "own occupation" policy, where the professional could change careers and potentially collect substantial benefits. These issues are challenging to face, but can normally be overcome by developing claim support in a variety of ways.

Loss of License

The loss of a license to engage in one's profession can act as a bar to a claim in some cases; however, a claimant's

rights under the policy will normally vest at the time of the disability. Thus, a claimant who is disabled and thereafter loses his/her license should be considered disabled and entitled to benefits. Many insurers, however, view the loss of a license as a legal disability that does not allow recovery of benefits because the claimant is not "allowed" to engage in his/her occupation, as opposed to "unable" to engage in his/her occupation.

From the practical standpoint, the insurer believes that a litigated case involving a revoked or suspended license will not engender sympathy at trial. Thus, the insurers aggressively deny or terminate these claims.

While these are some of the issues faced by claimants

in the process of applying for and receiving disability benefits, there are a number of other issues that are seen as well. Each claim will have its own unique aspects to it. We welcome any questions about issues contained in our articles, or relating to the field of disability insurance in general. ■

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