

ELEVEN WAYS TO ASSURE THE SUCCESS OF A DISABILITY CLAIM

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Many of the leading disability insurance companies have engaged in systematic strategies to deny valid applications (“claims”) by policyholders for disability benefits.¹ Aided by a federal law known as ERISA, (Employee Retirement Income Security Act of 1974), they have been given procedural advantages and have means at their disposal to intimidate and oppress even the most well-informed “claimants.”²

"Decisions whether and how to ensure that disability does not lead to poverty are obviously of great societal importance..."³ Since Social Security provides only a small portion of earnings replacement, we depend on private insurance to protect against the loss of one’s earning capacity, however as one court noted: “An individual claimant who encounters an insurance company that is disposed to deny valid claims must struggle to vindicate his rights at a time when he is at his most vulnerable. Often a newly disabled

¹ Early in J. Harold Chandler’s tenure as CEO of a predecessor entity of Unum/Provident Corporation, claims representatives were pressured to deny valid claims. For example, Unum instituted a “Hungry Vulture” award for employees who were especially adept at denying claims. The prize bore the motto, “Patience my foot, I’m gonna kill something.” Dean, Frost, Disability Claim Denied! Business Week, Dec.22, 2003. By 2002 some of these claims practices gained national attention as a result of investigative reporting of lawsuits brought by former Unum claims processing employees who had target numbers for claim denials. Dateline (NBC television broadcast, Oct. 13, 2002); 60 Minutes (CBS television broadcast, Nov. 17,2002). Unum and other insurer’s practices have become notorious in the courtrooms of America. *Bennett v. Unum Life Ins. Co.*, 321 F.Supp. 2d 925, 934-935 (E.D. Tenn. 2004), *Radford Trust v. First Unum Life Ins. Co.*, 321 F.Supp. 2d 226, 247 n.20 (D. Mass. 2004).

² Langbein, “Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials under ERISA” at 12 (Draft June 26, 2006 available at <http://www.law.yale.edu/faculty/2940.asp> (Accepted for publication in Northwestern University Law Review); Langbein, “The Supreme Court Flunks Trusts, [1990] Supreme Court Review 207 (1991); DeBofsky, “Disability Insurance Under the ERISA Law- Economic Security or Litigation Nightmare?” (Accepted for publication in the Journal of Insurance Regulation (Winter 2007)).

³ *Radford Trust v. Unum Life Insur. Co. of America*, 321 F.Supp.2d 226, 240 (D. Mass. 2004).

person will simultaneously confront increased medical bills and either termination of employment or diminished pay.”⁴

If you are considering a claim for disability insurance through a group plan provided by an employer, if you have purchased a private disability policy, or if you are presently receiving benefits, you must have a strategy to deal with the company. **Due to idiosyncrasies in this area of the law, if you wait until benefits are denied or terminated, more often than not, it is too late.**

This article is addressed to those who may be covered by group, ERISA plans, however, privately negotiated policies have also been shown to be the subject of unscrupulous claims practices; most recently and notably in the Unum/Provident scandals.⁵ So, whether the insurance is “general” or “occupational,”⁶ you must know your rights and most importantly, your limitations.

1. [Read and understand the summary plan description or policy.](#)
2. [Calendar dates and deadlines contained in the summary plan description.](#)
3. [Maintain absolute control of your medical records and reports.](#)
4. [Compare the medical information with the definitions and standards for disability as written in the plan summary or policy.](#)
5. [Be aware of video surveillance.](#)
6. [Apply for Social Security Disability benefits.](#)

⁴ *Id.*

⁵ The Unum/Provident scandal and subsequent settlements with state regulators prompted California’s Commissioner to remark: “Unum/Provident is an outlaw company. It is a company that for years has operated in an illegal fashion.” L.A. Times, “State Fines Insurer, Orders Reform in Disability Cases” October 3, 2005, available at <http://www.insurance.ca.gov/0400-news/0100-press-releases/0080-2005/> also available at <http://www.micethatroar.com>

⁶ There are two types of disability insurance, “general” and “occupational.” Under a general disability policy, like Social Security, the insured must establish incapacity from all forms of employment. Occupational coverage requires incapacity from one’s own occupation.

7. [Maintain an excellent relationship with your treating physicians and other health care providers.](#)
8. [Pack your claim file With medical records, reports and other proof of disability.](#)
9. [Consider Hiring a vocational counselor.](#)
10. [Beware the dreaded IME and "records review."](#)
11. [Consider a settlement or buyout of your claim for continuing benefits.](#)

1. Read and understand the summary plan description or policy.

If the employer is the sponsor of a disability plan, or if the plan is "self-funded," you have been given or should receive upon request a "summary plan description."⁷ If you have purchased private disability insurance, you have been given a policy and presumably you have worked with someone, an agent or other specialist, to determine your particular needs for coverage in the event you lose the ability to engage in your own occupation.

The policy or plan is a contract or agreement between you and the insurer or employer; it defines the rights and responsibilities of the parties. You are bound by its language and the company is bound by its language. This document must be read thoroughly and understood. As lawyers say: "It is the law of the case." Unlike most agreements that we make in life, the language of insurance policies is generally non-negotiable. The insurer, armed with superior knowledge and experience, has defined the terms and designed the procedures, limitations and exclusions in coverage.

Normally, when a dispute arises concerning ambiguous terms in an insurance policy, the courts, under state law, use an equitable rule that ambiguities are decided against

⁷ The term "plan" is often confusing. The word is derived from the ERISA law which describes employee benefits as "employee welfare benefit plans" and includes pension plans. Disability benefits, however, are usually secured through the payment of insurance premiums or they are "self-funded" by payment directly from the employer or an employer group. When insurance is purchased, the "plan" is usually the insurance policy.

the drafter of the document.⁸ In ERISA plans, however, many state laws do not apply. Important, hard-fought state laws meant for the protection of the consumer are “pre-empted” by federal law.⁹ Unfortunately, federal ERISA law provides little or no protection for the consumer. If the insurer uses certain language providing itself, a plan administrator or agent the “discretion” to determine the meaning of the language and its application, then a court generally will not question the insurer’s interpretation unless it is shown to be an “arbitrary or capricious” interpretation or decision.¹⁰ If the insurer’s decision is reasonable, based on the information it had at the time of the decision, the court, in most jurisdictions will affirm the insurer’s decision. It will look at no other evidence. In an application for disability insurance governed by ERISA, you basically get one chance to prevail in the claim. If you lose, the deck is stacked against you on appeal.

Unlike other types of insurance contracts, such as motor vehicle or homeowners insurance, there is no uniform or “standard” disability insurance policy. The policies differ from insurer to insurer and often differ in response to a particular employer’s needs or the demands of a collective bargaining unit or the interests of a public employer. Read your policy thoroughly, then read it again thoroughly, write notes and understand the respective rights and obligations as stated in the document.

⁸ This equitable legal doctrine is known as *contra proferentum*.

⁹ The Supreme Court of the United States, which has made a mess of Employee Benefits law, has held that state “bad faith” laws designed to protect the consumer against deceptive insurance practices are pre-empted and therefore not available to consumers in cases governed by ERISA. *Pilot Life Ins. Co. v Dedeaux*, 481 U.S. 41(1987), *Aetna Health Inc. v Davila*, 542 U.S. 200, 124 S.Ct. 2488 (2004).

¹⁰ Several states, in response to insurer abuse and deceptive practices have passed laws, and the insurance commissioners of other states have adopted rules, prohibiting the use of these “discretionary clauses” in insurance policies. It remains to be seen however as to whether these laws and regulations will also be pre-empted. See Henry Quillen, State Prohibition of Discretionary Clauses in ERISA-Covered Benefit Plans, 32 J.Pension Planning & Compliance, Summer 2006. Donald T. Bogen, ERISA: State Regulation of Insured Plans after *Davila*, 38 J.Marshall L.Rev. 693 (2005).

2. Calendar the dates and deadlines contained in the summary plan description.

Dates and deadlines for things such as the submission of medical information or in an ERISA plan, requesting an “administrative appeal” should be strictly observed. If you are having trouble meeting a time-line, make sure you write the company a letter explaining the circumstances and make clear that the “record” is incomplete without such information. A decision should not be made without a complete record. Remember, the insurer has to be “reasonable” in its methods.

Generally you will not get complete information concerning your medical condition from existing medical records and reports. Your care and treatment is probably ongoing. Certain tests have not been performed or may not be available. Your condition may deteriorate or change. **The disability often involves a combination of impairments. You may soon realize there is a psychiatric component to your incapacity.**

Everyone faced with a life-changing illness or injury also faces challenging psychological issues. The effects of certain medications are not well documented. Other details, important for a full and fair determination of your claim, require documentation. The insurer may want to rush the process. For financial reasons, you want a speedy decision. Slow down! Unless your case is exceedingly clear, it is in your best interest to keep the “administrative record” open until the insurer receives all important information.

It is also essential to keep track of dates and deadlines because in many jurisdictions the insurer or plan administrator has the ability to shorten certain state law statutes of limitation.¹¹ Generally and historically a

¹¹ The ERISA law does not provide a limitation period within which a claim for benefits must be brought, therefore the courts look to comparable state law statutes, notably the typical six year period within which to bring a breach of contract claim. Many states laws however, also allow contracting parties including parties to insurance contracts to “agree” on shorter periods of limitation. Such “agreements” invariably appear in disability insurance policies. It

consumer will have as many as six years within which to bring a "cause of action" or "lawsuit" based on a contract dispute, into court. Most disability policies, however, contain language shortening this period to one or two years. Certain policies not only shorten the limitations period but also state that the time "begins to run" when "proof of loss" is required to be submitted, rather than when a "breach of contract" occurs, which is the time-honored common law trigger for commencement of the counting. Such limitation on the time within which you must bring a matter to court must be observed in states which allow an insurer to modify by contract certain statutes of limitation.

3. Maintain absolute control of your medical records and reports.

Nothing is more important to assure a successful claim than the quality of your medical records and reports. Your records should provide a legible and comprehensive account of your symptoms. The records must provide a medical foundation for your symptoms and changes in symptoms over time. The profound degree that your daily activities have been affected should be clear from existing records. It is most likely, however, that records prepared in the ordinary course of treatment will be entirely inadequate. They will contain mistakes and inaccuracies. They will be incomplete and partially illegible.

Doctors, nurses, therapists and other health care professionals obtain information sufficient to make diagnoses and select proper and effective treatment. They certainly do not record information to address issues that can arise in disability policies or to meet Social Security guidelines or to

follows that if state insurance law prohibits unreasonably short periods of limitation, such laws would be "saved" from preemption. For example see, M.G.L. c.175 §22 which prohibits limiting the time for commencement of actions in insurance policies to a period of less than two years from the time when the cause of action accrues.

support causal relationship issues. The records invariably must be supplemented by narrative reports, answers to specific questions or short clarifications. Many claimants, understandably absorbed in major life changes, provide authorizations to the insurer and don't even look at their own records, trusting that the records will contain the facts. **This is a recipe for disaster.**

Let the insurer know that you will take responsibility for providing the medical records, reports and opinions. Unless the claim is clearly and overwhelmingly in your favor, you should not provide authorization to the insurer or plan administrator to obtain medical information. At the very least you must restrict and limit the authorization.

Blanket authority, allowing the insurer or plan administrator to obtain medical information, opens the door to abuse and manipulation. This is the subject of many horror stories: An insurance representation will often make an early assessment to deny your claim. From that point forward the insurer will manipulate the information to support the denial. Phone calls will be made to the treating physician. If unsatisfied with existing records the insurer will request phone interviews with your doctors, and without you being present, misleading questions will be asked, recorded and made a part of the claim file. The insurer will use all legal, or often illegal means at its disposal to support the denial of your claim.¹² If phone interviews are unproductive, forms are sent with biased questions. If your treating physician's statements support your claim, the insurer will hire so-called "Independent Medical Examiners." If they cannot get a doctor, they'll settle for nurses or therapists. Often they use their own nurse or physician

¹² For a compendium of unfair, deceptive and blatantly illegal claims practices proven to have occurred in actual cases tried in federal court see, *Radford Trust v. Unum Life Insurance Co. of America*, 321 F.Supp.2d 226, (D.Mass.2004).

employees to provide “record reviews.”¹³ Do not underestimate the power, willingness or capacity of an insurer to deceive you.

If you have a very good claim that would be difficult to deny and you decide to give some authorization, limit the authorization to existing records relating to the nature of the disability. As a privacy matter, an insurer has no business inquiring at length into your medical history, particularly if it involves matters unrelated to the nature of your incapacity from work. It goes without saying that they should not be allowed phone communications with your doctors.

When you have control of your medical records you then have some influence on the compiling of medical information in your claim file. After reviewing the existing records, ask your doctors for reports and letters clarifying the nature of your medical problem and outlining the symptoms that prevent you from doing your job. The responses should be sent to you and then to the insurer/administrator.

4. Compare the medical information with the definitions and standards for disability as written in the plan summary.

Unum Provident is the largest underwriter of disability insurance in the United States. The company sells policies through subsidiary companies such as: Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, The Paul Revere Life Insurance Company, Colonial Life & Accident Insurance Company,

¹³ In an attempt to level the playing field, some courts, including the Court of Appeals for The Ninth Circuit, attempted to apply the so-called “treating physician rule” to disability insurance claims. Such rule was adopted by the Social Security Administration in disability benefit claims and requires that the treating physician’s opinion be accorded special weight as against opinions from other sources. The Supreme Court in *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003) reversed the Ninth Circuit Court of Appeals, holding that under ERISA, plan administrators/insurers are not obliged to give special weight or “deference” to opinions of treating physicians.

Genex and Duncanson & Holt. They are also an agent handling claims under MetLife (Metropolitan Life), John Hancock, New England Life and Equitable Insurance policies.

The definitions of “disability” differ from policy to policy and differ for short term v. long-term disability. Typically you will be disabled from work under a “short term” plan if you cannot do all the “material and significant” duties of your job. The definitions often change for long-term disability or change after two years of “own occupation” coverage and may require proof that you are unable to perform any work.¹⁴

In making your initial application and when submitting medical records, compare the definition of disability with what your doctors say in records, reports and supplemental reports. If the restrictions and limitations contained in the records or supplements appear to satisfy the short-term definition of disability but not the long-term definition, assess your situation and consider supplementing the record further with proof of total disability from all forms of employment for which you are reasonably suited.

Short-term disability benefits usually last for 6 months, after which another application for long-term benefits needs to be presented. Typically you must qualify for and exhaust benefits for short-term disability before being able to get long-term benefits. This is called the “elimination period.”

But the definitions for disability are often different in short-term and long-term plans! Without taking care in the submission of medical proof in the short-term claim, you may unwittingly have boxed yourself out of the long-term claim. Again the horror stories abound: A seemingly cooperative insurer willingly begins payment under the short-term plan and with your cooperation develops a medical file. Opinions are obtained from your doctors about limitations and restrictions. The records overwhelmingly support your claim for 6 months of short-term disability benefits. Then when you apply for long-term benefits, that same proof may ultimately preclude you from long-term benefits. You end up scrambling for more records, more information and additional opinions.

¹⁴ For more information see Terry Low, Anatomy of a Disability Insurance Policy: What Physicians Need to Know About Disability Insurance. Available on-line at <http://www.TerryALow.com>.

You've been "sand-bagged." If you think you are going to be unable to work in the long term, set up the long-term claim in the short-term application.

5. Be aware of video surveillance.

If your claim has been targeted for denial, an insurer will often hire a private investigator or someone "in-house" to do video surveillance. Video in the hands of an insurer, where there is no opportunity for judicial oversight, is a powerful tool. Pictures can be biased and misleading. A snap shot of you doing something in everyday life, perhaps on a "good day," can be made to look inconsistent with medical restrictions and limitations. Suddenly something you are doing occasionally as a part of everyday life is being used to make you look like you are exaggerating your disability. Even the suggestion through videotape that you may be able to perform tasks outside those prescribed in the medical records taints and poisons your file.

During the application process is not the time to test your restrictions and limitations. Know what they are, and do not do anything inconsistent with those limitations.

6. Apply for Social Security Disability benefits.

If you are not going to be able to work for 12 months or more, apply for Social Security Disability Insurance benefits ("SSDI"). Remember, Social Security is a trust fund that you have paid into week after week, year after year from payroll deductions or self-employment taxes. It's not a gift; it's your money. If you become disabled from work, you are entitled to be paid from the fund. If applied for early, the Social Security process can help support the private disability claim or a claim for continuing benefits, just as it can be used to support a workers' compensation claim.

In order to qualify for Social Security, the medical, vocational and other evidence must show an inability to engage in any "substantial gainful employment" that exists "in significant numbers in the national or local economy". An elaborate and complex system has been built to make this determination. An early application, with aggressive

submission of evidence, can result in a favorable determination, often within one year and without a hearing. Since the standards for Social Security Disability are more rigorous than standards for short-term disability, and usually as rigorous as standards for long-term disability, a finding of entitlement is persuasive and can pave the way to uninterrupted long-term benefits.

Most long-term disability policies require an application for Social Security, so there is no reason to delay the process. Although a final decision in your Social Security application may not be made until long after your private disability claim has been decided, a record is being compiled and this record can be plundered and poached to support your claim.

Your Social Security file will contain material useful to your initial long-term disability application and/or useful to prove continuing eligibility for long-term benefits. Since there are no rules of evidence or other formalities to observe in submitting information to the insurer/plan administrator, if you have them, submit the Social Security materials: record reviews by physicians, affidavits concerning prescription medications, vocational rehabilitation assessments and your disability questionnaires. Since you have control of these materials, you can select and submit those, which supports your claim. The Social Security process is used to assist in your private policy claim, and your private policy claim can assist your Social Security Disability claim.

Since the standards of disability differ between Social Security and a private policy, winning the Social Security case does not insure the success of the other. It is, however, persuasive.

7. Maintain an excellent relationship with your treating physicians and other health care providers.

The disability application process runs on medical information and doctor's opinions. Invariably, existing medical records, those records that are prepared in the ordinary course of medical treatment are inadequate and insufficient to support a disability claim.

This is not a failure of the medical professional. Doctors, nurses, therapists, chiropractors gather information and order tests in order to make diagnoses and prescribe effective treatment. "Disability" is a term that requires medical-legal-vocational analysis. Your physicians are not vocational experts. For example, when asked if a patient could perform "sedentary" work, a doctor will often answer "yes". When questioned further, however, it is clear that he or she has only a superficial understanding of what "sedentary" means. In a legal proceeding such a vocational question to a doctor is objectionable and would have to be sustained by a judge. In ERISA cases, however, there is no "legal proceeding"; there is, in most cases, a claim review process conducted by the same entity that denied the claim and judicial review of the most superficial nature.

A claim for disability benefits is not governed by rules of evidence. It's basically a "free-for-all" and you must get the full support of your treating physicians. They must be involved in the claim even though they prefer not to be involved. If a treating physician tells you that he or she does not get involved in claims, consider changing doctors. You are not asking them to testify in court. You are simply asking them to provide information.

Let each of your doctors and providers know up front that you are going to need his or her assistance in providing information to support your claim of inability to work. It is the physician's duty to record your history. But providing a detailed opinion regarding each physical/mental restriction and limitation you have may go beyond a duty of care. You should be prepared to offer payment for such opinions. (Needless to say, this is not covered by any insurance policy). This burden can be lessened by the use of forms, but nothing is more persuasive than a narrative report.

Quality opinions from your doctors in treatment records and notes or in the form of narrative reports cannot be expected unless you inform them in detail of your physical and mental symptoms. Include in your history such things as reactions to medications, sleep disturbances, limitations on lifting, standing, sitting, walking, if applicable. All

factors that impact your ability to work, such as the need to rest and lie down on an as needed basis, should be noted in your medical history.

If your medical history is complete, the process simply requires a comparison between job descriptions and restrictions. If the history is incomplete, the medical records need supplementation. This requires cooperation. No doctor likes to be told what to do and physicians generally do not react well to demands outside what is required to fulfill a standard of care.

Use all of your finest relationship skills when dealing with your health care providers and their staff. You will need their assistance and cooperation.

8. Pack your claim file with medical records, reports and other proof of disability.

In most instances you will have only one chance to qualify for benefits in a disability claim under the ERISA laws. Unless you return to work and again become disabled, this will be your first and only chance to qualify. Determinations are often made quickly. Appeals to federal court are generally limited to a review of “the record”. In most jurisdictions there are no rights to a trial or “de novo” hearing.¹⁵ You must, therefore, pack the “claim file” with information and medical opinions to support the claim. Once a plan administrator declares that a final review has been made, in most jurisdictions you will not be able to add any more information to the record. In the First Circuit, for example, the court will only review the record, as it existed at the time that the decision was made by the administrator/insurer. Generally, no additional “evidence” will be allowed.¹⁶ Claimants and their counsel must therefore insist upon complete information.

¹⁵ This anomaly in the law is the result of what a leading scholar has called “doctrinal hash” and “a crude piece of work” by the U.S. Supreme Court in *Firestone Tire & Rubber Co. v. Bruch*, 109 S.Ct. 948 (1989); Langbein, *The Supreme Court Flunks Trusts*, [1990] *Supreme Court Review* 207,228 (1991).

¹⁶ Most jurisdictions will allow additional evidence where there is a “conflict of interest” affecting the decision-making process, however there is no consensus on what constitutes a “conflict” nor is there consensus as to how to show a conflict. For example, in the First Circuit, the appealing claimant who has been denied benefits has the burden to show evidence of a conflict of interest beyond a mere “structural conflict of interest” (which is invariably

If complete information is not present in the insurer's file before a final determination on the claim such fact should be asserted in writing so it becomes a part of the record. As a practical matter it may be difficult for anyone to see what is missing in a claim file that has been carefully and systematically compiled by an insurer. In an ERISA claim for benefits the absence of information must be pointed out in writing and made a part of the record before the claim has been denied.

9. Consider hiring a vocational counselor

Consider the services of an expert in the field of Vocational Rehabilitation. If there has been a hearing in the Social Security claim, there will often be an expert in this field testifying for the Administration. If this testimony is favorable, it can be used in the initial disability claim or in a claim for continuing long-term benefits. It is more likely, however, that you may need this evidence before a hearing on the Social Security claim is scheduled. A vocational expert will compare the restrictions and limitations contained in the medical records and reports with actual job descriptions. He or she will then provide an opinion as to whether there is any job that can be performed on a regular and sustained basis. This opinion, unlike an opinion by a physician, has a solid medical/vocational foundation. It would be unreasonable for an insurer to ignore such proof.

10. Beware the dreaded IME and "record review."

Another notorious and often dishonest method to support the denial of a claim is the dreaded IME or "Independent Medical Examination". An insurer has a right to have you

present when an insurer is also the plan administrator/insurer and payer of the claim), however, that same claimant may be denied the ability to conduct Discovery and review is limited to the insurer's claim file, as it existed at the time the claim was denied. The appealing claimant may be stripped of the tools to show evidence of a sufficient conflict, such that a more "heightened" standard of review is appropriate. *Doyle v. Paul Revere Life Insurance Co.*, 144 F.3d 181, 184 (1st Cir. 1998); *Doe v. Travelers Insurance Co.*, 167 F.3d 53, 57 (1st Cir. 1999). See, Debofsky, "Conflicted over conflicts of interest," Chicago Daily Law Bulletin, May 15, 2006.

seen by a doctor of their choosing. More often than not, however, the doctor is not “independent”, nor is there much of a medical examination. Here’s another horror story: A patient with a combination of impairments is sent to a retired orthopedic surgeon for an IME. (There’s no doctor/patient relationship, therefore no need for much in the way of professional liability insurance.) The doctor does an orthopedic physical examination and writes a report that includes the statement: “based on physical examination and available test results, there is no objective evidence of disability”. The patient is advised to return to work without restrictions. The patient, however, has a neurological disease, which can be accelerated so as to require immediate surgery! This was an intellectually dishonest IME report. There may not have been “objective” evidence of disability based on orthopedic examination. And there was no “objective evidence” because the patient had only “subjective” signs and symptoms such as pain. Furthermore, the root cause was not orthopedic.

The insurer has a right to have you seen by a health care professional and should have such a right. They do not however have a right to send you to an abusive or dishonest examiner. Most communities will have these types of examiners available, but they will also be well known. If you suspect the examiner has such a reputation, ask for another examiner. Always request a copy of the report. If the report is unfair and misleading provide copies to your treating physicians for comment and provide these comments to the insurer.

More often than not, the plan administrator/insurer will conduct “record reviews.” Often there will be two such reviews, once during the initial determination process and a second review during the appeal process. If the claim has been targeted for denial, **the record review is an ambush**. Physicians who derive substantial income from the insurer are retained to review the records contained in the insurer’s file. Based on the records, an opinion is provided that the employee/claimant can return to his or her former occupation or a “sedentary” occupation or an occupation within the treating physician’s restrictions.¹⁷ Often a skilled examiner (with written authorization from the

¹⁷ “IME” and “record review” abuses are notorious and prompted one court to express the following:

claimant) will phone the treating physician and ask self-serving, misleading questions. A letter will follow the phone interview purporting to record the full content of the communication. The treating physician will be asked to sign the letter and return it to the examiner or insurer. The questions and subject matter will combine medical, vocational and legal analysis that the doctor is not qualified to answer. Of course the physician will not admit he or she is not qualified. Answers are provided, often without a clue as to the legal effect. To a busy practitioner it may appear to be merely another insurance form that is completed with some degree of haste.

11. Consider a settlement or buyout of your claim for continuing benefits.

A successful case may result in a reinstatement of benefits or a lump sum payment from the insurance company. Settlement discussions are possible in cases where benefits are being received and where benefits may be received. Settlements are also possible in difficult and questionable cases.

Settlement discussions involve a calculation of the present value of benefits, an assessment of risks, and the structure and timing of payments. Related health insurance coverage issues can also impact discussions, as can reduced life expectancy. Settlements can be an excellent option. When all or nothing risks are high, we are wise to compromise. This aspect of a claim must be approached with extreme care. Suggesting a settlement may trigger suspicion. Why do you want to settle your claim? Are you expecting to die sooner than what appears in the records? Is there some weakness in the claim that the insurer suspects it is not aware of? Has there been an

Caveat Emptor! This case attests to a promise bought and a promise broken. The vendor of disability insurance now tells us, with some legal support furnished by the United States Supreme Court, that a woman determined disabled by the Social Security Administration because of multiple disabilities which prevent any kind of work cannot be paid on the disability insurance she purchased through her employment. The plan and insurance language did not say, but the world should take notice, that when you buy insurance like this you are purchasing an invitation to a legal ritual in which you will be perfunctorily examined by expert physicians whose objective it is to find you not disabled, you will be determined not disabled by the insurance company principally because of the opinions of the unfriendly experts, and you will be denied benefits.

Loucks v. Liberty Life Assur. Co. of Boston, 337 F.Supp.2d 990 (W.D.Mich. 2004) (vacated following settlement)."

improvement in your condition that disqualifies you for future benefits? Not surprisingly, many of these suspicions disappear when a lawyer gets involved. To your benefit, the suspicion is transferred to the lawyer who must be primarily interested in financial gain!

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