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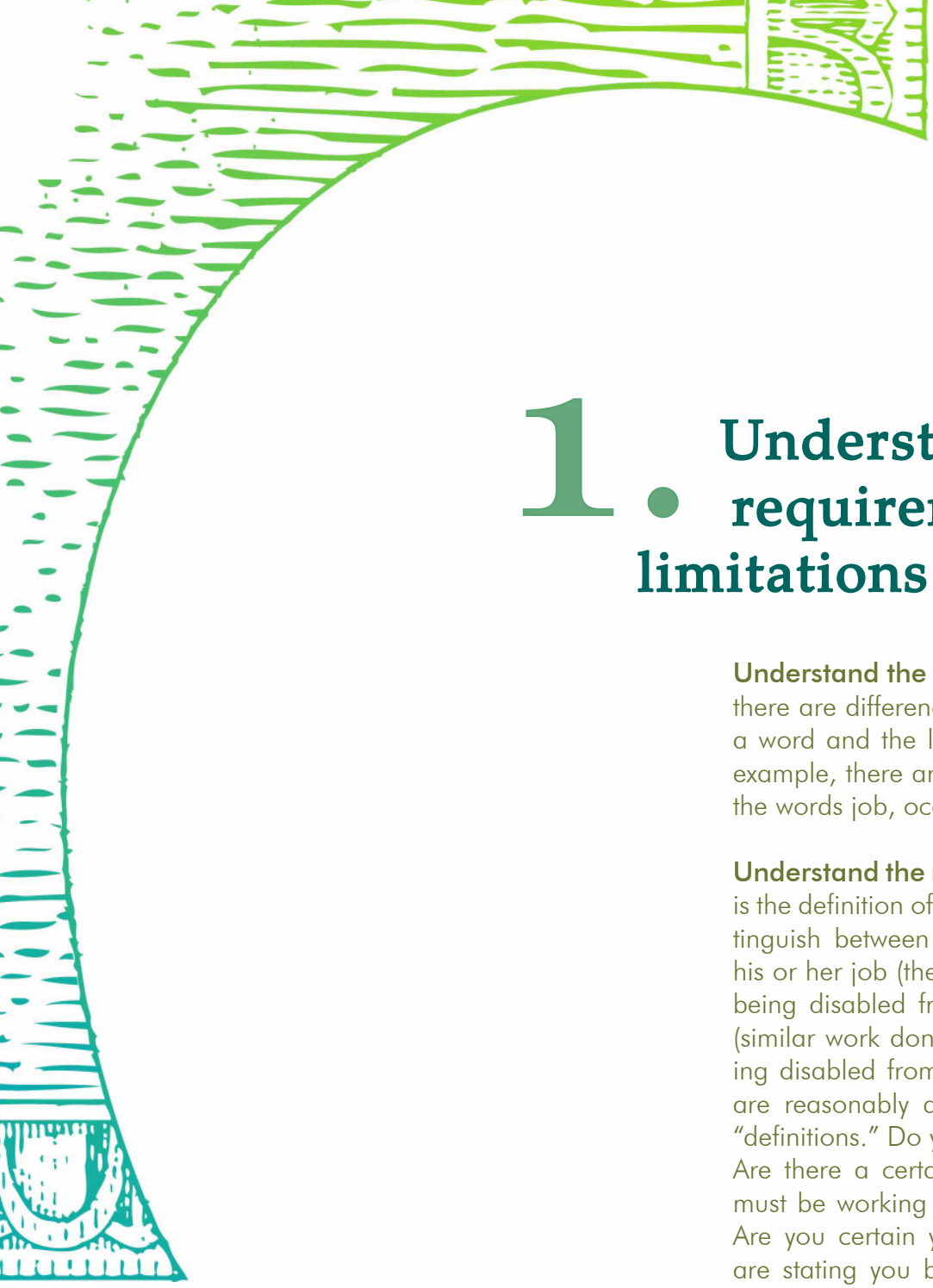
# Suggestions for Long Term Disability Claimants



# 1. Understand the terms, requirements, and the limitations in your policy

**Understand the terms used in your policy.** Often there are differences between the plain meaning of a word and the legal implication of the word. For example, there are significant legal issues involving the words job, occupation, any occupation.

**Understand the requirements in the policy.** What is the definition of disability? Insurers sometimes distinguish between a claimant being disabled from his or her job (the position held with the employer); being disabled from his or her "own occupation" (similar work done for another employer); and being disabled from "any occupation" for which you are reasonably qualified. Read the insurer's own "definitions." Do you have a pre-existing condition? Are there a certain number of hours a week you must be working prior to disability to be covered? Are you certain you are insured on the date you are stating you became disabled? Are you totally or partially disabled? Do you need to be totally disabled throughout the elimination period or longer to be eligible? What is the definition of disability? What onset of disability do you need to maximize benefits? Did you change or modify you usual job prior to application because you were having difficulty performing your regular employment? Were you dually employed; could it be argued you were performing two functions or occupations (e.g. surgeon and real estate investor; surgeon and CEO of medical group)? There are many questions you need to answer in order to proceed with caution.

**Understand the limitations in your policy.** Many policies contain special limitations for certain conditions. Be aware of 24 month change in definitions and limitations on certain conditions. Many policies contain two year limitations for mental illness and nervous conditions. Beware of "cause or contributed to by" language. The insurer may look for reasons to classify the claimant as mentally ill in order to limit benefits. If symptoms of depression or anxiety must be documented, be sure the doctor clarifies that they are secondary to the illness and did not exist before. Many new and renewal policies also include two year limitations for "chronic fatigue conditions," "allergies to chemicals or the environment" and "self-reported" symptoms such as "chronic fatigue" and "muscle pain" which can not be confirmed by objective laboratory testing. Many policies now require "objective evidence" of the impairment.

# 2.

# Work closely with your treating doctor(s) to provide the strongest possible evidence in support of your claim.

It is imperative you get regular and appropriate care from a licensed medical provider in the field of medicine related to the disabling impairment. Seek treatment on a regular basis. This is true even if your disability is not amenable to treatment. Make certain your provider is charting all your symptoms, restrictions and limitations at every visit. Keep a log of your severe symptoms and share it with your physician at every visit. Request to see your chart and make sure the medical records are detailed and readable. Medical reports submitted with the applications or appeals should include

(1) a strong statement confirming the diagnosis and your inability to work and the recommendation by the treating physician that you file for disability;

(2) a detailed application of current criteria and medical history to support the diagnosis;

(3) documentation of all physical signs, abnormal lab tests and other objective evidence of illness;

(4) a statement that you are disabled based on the policy definition of disability;

(5) a complete assessment of both your exertional and non-exertional limitations;

(6) a detailed explanation of how your specific symptoms [i.e. difficulty standing for more than 15 minutes at a time; only occasional use both hands; the need to elevate legs above heart level for 4-5 hours a day; need for bathroom use 3-4 times per hour; severe, unrelenting, daily fatigue, etc…] limit or preclude any work activity;

(7) results of functional capacity or exercise tolerance tests to support the inability to work; and

(8) objective evidence that all other possible causes for the symptoms have been carefully excluded (lab tests, reports from specialists, etc.).

Throughout the claim, be prepared to provide ongoing documentation of all signs and symptoms that support your diagnosis and inability to work. Every impairment you have has an impact so make sure you include information concerning impairments that my not be the primary cause of disability. For instance if you have always been blind in one eye but work until your unrelated Multiple Sclerosis prevented continued work activity, you should still provide documentation of the visual impairment.

# 3.

## Prepare your doctors for requests from your insurance company.

Your doctor may be asked to submit additional information, including office notes and written reports. Your doctor may also receive phone calls from the reviewing doctors at the insurance company. Make certain your doctor and the doctor's office personnel are aware that you want all their communications to be in writing not on the phone and that their failure to respond to requests may result in the denial of your claim. Peer to peer phone calls are often not properly documented by the insurance company and can be major hurdles during an appeal if the claim is denied.

# 4.

## Maintain a chronological file.

Maintain a chronological file of all documentation and correspondence related to the claim, including the initial application; information from the employer and physician's statement; all medical information submitted; all letters from you, the claimant, and the insurer; and any supplemental forms completed. Review this file frequently to catch and clarify any details you may have missed, and note patterns of delays or denials. You are legally entitled to copies of everything your insurer has in the file, including internal memos, reports from independent medical examinations required by the insurer and any surveillance videos the insurer has ordered from private investigators. If you have an issue on an individual policy, you can complain to the office of the insurance commissioner. If information is denied to you under a policy governed by ERISA, you can complain to the department of labor.

# 5.

## Buy out offers.

If the insurer offers a cash settlement in exchange for relinquishing your right to future benefits, insist on being allowed time to review the offer in written form to weigh its merits and obtain qualified advice before signing away your rights. Some insurers will pay for an attorney's time to assist you in evaluating the offer. Many offers are ridiculously low, some are never put in writing, or withdrawn after a short time. The entitlement to other employee benefits while you

are on LTD such as medical insurance and pension credits may be linked to receipt and entitlement of LTD benefits. If so, these related benefits may disappear if you settle the LTD claim—be careful. Many times they are more valuable than the actual LTD benefit. We have litigated cases were the actual monthly benefit was minimal but the pension and medical benefits were of great value. In one recent case the pension freeze and medical benefits were valued at over 350,000 while the LTD after offset was only $179.00 per month. The same holds true with an insurance company's offer to accelerate your claim and advance pay and close the claim a year or two before the claim is scheduled to be closed.

# 6.

## Be sure to appeal denials within the stated time limit.

Your appeal of any denial should address the strengths of the medical evidence, weaknesses in the insurer's denial and citing relevant sections of ERISA or other applicable laws and cases. Remember that insurers do not care about the pain and hardships you must endure – they are only interested in the relevant facts of the case. But write the appeal as if you are writing for the court later and be certain your appeal includes everything you would need to prove your case in court. **In an ERISA case, once the insurer declines to reverse the decision on your appeal, the record is CLOSED!**

# 7.

## Strengthen your case by providing additional evidence.

Second and third medical opinions, specialized testing at leading medical centers for the illness, and opinions from gurus in the specific impairment help support a treating doctor's opinion. Relevant articles published in peer reviewed, medical journals, and information from organizations for persons with your disability impairment can be used to support your case. Also consider obtaining functional capacity evaluations or vocational appraisals by persons trained to assess your ability to work based on the definition of disability.

# 8.

## Be prepared for insurer medical examinations (IMEs) by doctors paid by the insurer to evaluate the disability.

Some insurers go out of their way to schedule IMEs with cynics who do not recognize the disability as a valid diagnosis and many times IMEs are purposely scheduled

with doctors through third party vendors who do volumes of this type of work and may not have experience in the specialty for the type of impairment alleged. Try to find out about an IME examiner's experience and attitudes toward disability and how much of their work is for insurance companies. Bring an observer or record the examination. Make certain you avoid appearing antagonistic, but document any irregularities in the examination or indications of obvious bias by the examiner.

# 9.

## Expect difficulties after the first two years of the claim.

Many insurers try to limit their liability to a maximum of two years of benefits. After two years, depending on the policy/plan you may need to prove disability from any occupation to be eligible for further benefits. Also be prepared for increased frequency of IMEs, home visits, or surveillance.

# 10.

## Document everything.

Remember, the insurer's profits are related to the amount of premiums taken in relative to claims paid out. Companies bank on "meltdown" and you do not have to see "The Rainmaker" to understand that the unstated culture of every insurance company encourages the earliest possible resolution of every claim. Case workers will say "no and bye, bye" wherever they can. Do not give up.

# 11.

## Be aware of Offsets.

Under most group polices, as compared to individual disability policies, the LTD benefit is the maximum amount the claimant can receive from all employment related sources. For example, any additional income you receive from part time work, short term disability, state disability, workers' compensation, Social Security and some retirement plans may be deducted from the benefit amount. If you receive back payments from SSDI while receiving LTD payments, you may owe all or part of this to the LTD carrier. If other family members receive benefits due to your illness, depending upon the provisions in the LTD contract, the carrier may seek to include all dependent's benefits in the offset calculation.

# 12.

## Taxability of Benefits.

Determine what percentage of the premiums (if any) were paid by you with after tax dollars and the same percentage of the benefits will be considered tax-free income by the IRS. There are some additional rules if there were recent changes in the premium payments just prior to disability.

# 13.

## Social Security Disability and LTD.

While it is generally the case that you are better off applying for Social Security, many circumstances may prove to be an exception to the general rule. Health insurance coverage and tax consequences must be examined. Furthermore, a Social Security application can be both a sword and a shield to both the claimant and the insurance company. An integrated plan must be made regarding when and how to apply for SSDI benefits and what information to make certain goes into to your LTD claim file. Even though most group LTD contracts provides for a Social Security offset, it is generally to your advantage to apply and seek approval for Social Security disability for the following reasons:

Most LTD policies do not offset Social Security's annual cost of living increases (COLA). In addition, some policies only offset only individual Social Security benefits and not family's Social Security benefits and many policies have a minimum benefit payment that is not offset by Social Security.

Receipt of Social Security disability benefits for all years prior to retirement age "freezes" those years for the purpose of calculating the retirement benefits amount. Therefore, lack of earnings covered by Social Security during the period of disability will not adversely affect the amount of the claimant's retirement check. In this way, Social Security retirement and survivor's benefits are usually protected, so the claimant is not penalized for lost work due to his/her disability if the claimant applies and is awarded a period of disability from Social Security.

If the LTD carrier terminates benefits for any reason, however wrong, you will have a Social Security benefit to fall back on until you can obtain reinstatement of the LTD benefits. Many LTD policies limit benefits to 24 months or less. For example, some policies limit payment of benefits to 24 months if your disability is due to mental health problems, whereas Social Security does not discriminate between mental or physical limitations.

Many LTD policies require the claimant to apply for Social Security Disability and appeal any denials. Some LTD policies even require the claimant to obtain Social Security within a certain time frame or lose entitlement to LTD benefits. In this case, winning a Social Security claim is very important.

Medicare entitlement commences after 24 months of Social Security Disability benefits. If you are uninsurable, this entitlement sometimes is more important than the monthly benefit amount from Social Security. In addition, if you are receiving insurance under COBRA, the COBRA benefits will only last, at most, for 29 months following the COBRA entitlement. Therefore, after 29 months of COBRA, Medicare might be the only medical coverage you can obtain.

Entitlement to Social Security disability within the claimant's original eighteen (18) months of coverage under a COBRA insurance plan finding the individual disabled within the first 60 days of COBRA entitlement will allow the claimant to extend his/her COBRA coverage to twenty-nine (29) months.

Social Security payments may be tax free depending on your other income, whereas, LTD benefits may be taxable, partially taxable or not taxable depending on how & by whom the premiums were paid; whether they were paid with after tax dollars by the recipient of the benefits.

The application for Social Security raises some important considerations to be carefully evaluated with a competent attorney.

I hope you found my suggestions helpful. More disability information may be found on my website.

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