



GOLDBERG SEGALLA ^{LLP}

Life, Health, Disability and ERISA Quarterly

April 25, 2011 • Vol. 1, No. 4

Editors: [Sarah J. Delaney](#), [Daniel W. Gerber](#) and [Matthew C. Van Vesse](#)

Life, Health, Disability and ERISA Quarterly provides a summary of decisions from across the country concerning life, health and disability policies, including those governed by ERISA. The publication is distributed quarterly via e-mail. Cases are organized by Circuits, plus a section mentioning federal district court and state court decisions. Hyperlinks are included providing recipients with direct access to the full decision. In addition, we provide the latest information regarding news in regarding life, health and disability coverage and ERISA plans. We appreciate your interest in our publication, and welcome your feedback. We also encourage you to share the publication with your colleagues. If others in your organization are interested in receiving the publication, if you wish to receive it by regular mail, or if you would like to be removed from the distribution list, please contact [Sarah J. Delaney](#).

Goldberg Segalla's **Global Insurance Services** team encourages you to check out daily case updates on its blog: *The Insurance and Reinsurance Report* and follow us on Twitter at **InsureReReport**. You may also be interested in subscribing to *CaseWatch: Insurance*, a bi-weekly digest of insurance law decisions and legislation, *Reinsurance Review*, a monthly publication concerning reinsurance law developments worldwide, and *The Professional Liability Monthly* a monthly publication which provides the latest information regarding news in the professional liability industry

In this Edition

I. Circuit Court Decisions	2
A. Second Circuit.....	2
B. Third Circuit	3
C. Sixth Circuit	4
D. Seventh Circuit	4
E. Eighth Circuit	5
F. Ninth Circuit	6
G. Eleventh Circuit	7
II. District Court Decisions	8
III. State Court Decisions	8

CIRCUIT CASES

A. SECOND CIRCUIT

[LIN V. METROPOLITAN LIFE INSURANCE COMPANY](#)

(2nd Cir. (NY) February 22, 2011)

Insured's Misrepresentation of Medical History Voids Policy, Even if Subject Matter of Misrepresentation Did Not Adversely Affect Insured's Health

The underlying insured, Bang Lin, acquired a \$1 million life insurance policy from the defendant, but failed to disclose that he had been treated for Hepatitis B. Less than two years later (and within the contestability period), he passed away from other causes (stomach cancer). The insurer discovered the discrepancy in the application, and denied coverage on the basis of material misrepresentation.

Mr. Lin had previously treated for Hepatitis B, but it was effectively managed and “had no impact on [Mr. Lin's] longevity or survival.” In essence, the insured was advised he was “cured” of Hepatitis B. Subsequently, he applied for a \$1 million life insurance policy. Although Mr. Lin's native language was not English, there was evidence that he had the application translated by the insurer's agents, and replied negatively to a question asking whether he had ever had any liver ailments, including hepatitis.

Following Mr. Lin's death and after the claim was denied, his widow argued that the failure to disclose the Hepatitis was excusable because (1) the insurer's agents never asked him the question; (2) that the Hepatitis B did not materially affect the risk.

Applying California law, the court held that the insurer had met its burden for rescission. With regard to the claim that the insurer's agents did not ask the question, the court rejected plaintiff's claims noting that there was no basis to contest the agent's testimony that she had asked the insured the questions. Second, the court noted that even if the insured was “cured,” it was his treatment history that was sought on the application. Finally, the mere fact that the question was present on the application was sufficient to establish materiality under California law.

Impact: Even if “cured,” a life insurance application is required to disclose past illnesses.

[DORMER v. NORTHWESTERN MUT. LIFE INS. CO.](#)

(2nd Cir. (N.Y.) Feb. 2, 2011)

Court Upholds Rescission of Disability Policy Based on Material Misrepresentation

The insured appealed from a judgment dismissing her complaint against her disability insurer and rescinding her insurance policies. The court found that the record supported the district court's factual finding that the insured intended to defraud her disability insurer. In this regard, the court noted that in applying for disability insurance, the insured routinely denied suffering from illnesses that she later admitted to having. She also denied in her applications any muscle

weakness or having received any disability payments in the past, even though she had been diagnosed with chronic fatigue syndrome, Bell's palsy, and back pain and had received disability payments for six months before applying for disability insurance. The court held that the insured's lack of candor supported the inference created by the factual record that the insured acted with fraudulent intent.

Impact: Fraudulent intent can be inferred from behavior.

B. THIRD CIRCUIT

BICKNELL V. LOCKHEED MARTIN GROUP BENEFITS PLAN

(3rd Cir. (N.J.) February 10, 2011)

Written Terms of a Plan Document Supercede Oral Undertakings

Mr. Bicknell enrolled his son in his employer's term life and accidental death benefits plan. According to the plan, children were eligible up to age 25 for unmarried, full-time, dependent students. Mr. Bicknell's son was older than 25. Nonetheless, the online automated enrollment program allowed him to enroll his son without comment, and did not ask for the son's date of birth. It did advise him to "check the eligibility status" of persons enrolled online.

Subsequent to enrollment in the plan, Mr. Bicknell's son was killed in a car accident at the age of 27. Mr. Bicknell sought benefits for his son, arguing that the plan should be estopped from asserting the son was ineligible for coverage because he was allowed to enroll him online, and Lockheed employees assured him that if he was able to enroll a dependent online, the dependent was eligible. Noting that the terms of a plan supersede any oral representations made by an employer, the court held that the son was ineligible.

Mr. Bicknell then argued that because the plan allowed employees to convert dependent coverage to individual policies, he should be allowed to do so retroactively because the insurer failed to advise him of that right. The court held that the plan did not place a burden on the insurer to affirmatively advise participants of the right to conversion, and that plan participants have a duty to inform themselves of the details of their plans.

Accordingly, the court held that the plan fiduciaries did not breach any duties to Mr. Bicknell or his son, and confirmed the district court's award of summary judgment to the benefits administrator.

Impact: It is the plan participant's obligations to inform him or herself of a plan's benefits and eligibility and the administrator will not be charged with duties not set forth in the written plan.

C. FIFTH CIRCUIT

CROSBY v. LOUISIANA HEALTH SERV. & INDEM. CO.

(5th Cir. (La.) Dec. 29, 2010)

Claimant Permitted to Seek Discovery from Insurer Beyond Administrative Record

The Fifth Circuit reversed the ruling of a Magistrate Judge (and adopted by the District Court) that limited a claimant's discovery from her health insurer to the administrative record. The claimant sought extensive discovery concerning the compilation of the administrative record, the proceedings at the administrative level, and the insurer's past coverage determinations in similar situations. The Magistrate Judge previously denied the request on the ground that Fifth Circuit precedent restricted the scope of discovery to evidence of how the administrator had previously interpreted the plan and expert reports explaining scientific terms.

The Fifth Circuit overruled the lower court's decision, noting that while it has previously prohibited "the admission of evidence to resolve the merits of the coverage determination," its decisions do not "prohibit the admission of evidence to resolve other issues that may be raised in an ERISA action." The Fifth Circuit noted that plaintiff sought benefits under Section 502(a)(1)(B) and, therefore, could seek to introduce evidence concerning the completeness of the administrative record, whether the plan administrator complied with ERISA's procedural regulations or whether there existed a conflict of interest.

Impact: Broad discovery may be available to determine completeness of the administrative record.

D. SIXTH CIRCUIT

UNION SECURITY INSURANCE COMPANY V. BLAKELEY

(6th Cir. (Ohio) February 15, 2011)

Plan's Criteria for "Domestic Partner" Determines Beneficiary Status

The decedent died leaving three children, a fiancée with whom he lived and a life insurance policy with no beneficiary. The policy provided that in the absence of a beneficiary, the benefits would be distributed to the spouse, then to a domestic partner, then to the decedent's children or his domestic partner's children, then to his estate.

The policy did not define "domestic partner." The court found a definition in the common law, which it adopted, and found the fiancée to qualify as "domestic partner." The court held that even though the policy did not define "domestic partner," the text of the plan is a preferred source for identifying beneficiaries to common law. "If courts can identify a workable means of identifying beneficiaries in the plan document – whether it be in a general definition section or the plan as a whole – they need look no further."

Although the life insurance plan did not define "domestic partner," it provided criteria to determine who else qualified as "insurable" under the plan. Of the criteria listed, it was unclear

whether the fiancée met one: it was unknown whether the fiancée and the decedent had powers of attorney for each other. The court found that whether the fiancée was a “domestic partner,” hinged whether she possessed a power of attorney for the deceased.

Impact: Definitions for undefined terms may be crafted from plan documents. Also, fiancées may qualify as “domestic partner” and entitled to beneficiary status above the named insured’s own children.

E. SEVENTH CIRCUIT

PROTECTIVE LIFE INSURANCE COMPANY V. HANSEN

(7th Cir. (Ill.) January 19, 2011)

Court Rejects Double-Reformation Bid in Keyman Policy.

The named insured was insured under a \$1 million key man policy, naming his LLC as owner of the policy. Sadly for the LLC, however, the business went poorly and the other member of the LLC suspected the named insured was mismanaging the company. It turned out those suspicions were correct. The “key man,” Richard McDonald, had mis-appropriated \$48,351.85 in funds, and spent some of those funds on his girlfriend, who happened to be a friend of his ex-wife’s daughter. He was removed from his post in the LLC, but it was too late to save the company. The company went into liquidation.

The LLC decided to let the policy lapse. For some reason, however, the liquidator submitted a change of ownership form to the insurer, asking it to change the ownership of the policy to McDonald. Under the insurer’s protocols, only one signature was required to transfer ownership on a policy owned by an LLC. Two signatures were required to transfer policies owned by corporations. The insurer mistakenly listed the policy as a corporation, causing the insurer to reject the change of ownership form. The liquidator took no further action to change ownership of the policy. Meanwhile, McDonald, believing himself to be the new owner of the policy, submitted a change of beneficiary form to his now ex-girlfriend. He then committed suicide.

When the ex-girlfriend sought to collect under the policy, she was blocked because only the owner, who was still listed as the LLC, could change the beneficiary. In order to collect, she had to demonstrate both that the policy should be reformed to change the owner from a corporation to an LLC, and then to change the owner to McDonald. The court rejected the argument, noting that the record did not conclusively establish that the transferring of a policy owned by an LLC was a simple ministerial task. Rather, the signature was shown to be just one requirement.

The court characterized the ex-girlfriend’s argument as “what should have happened,” and noted it was not a legal theory. Instead, it focused on what did happen: the insurer rejected the change of ownership form. Further, the court held that there was no mutual mistake entitling the ex-girlfriend to reformation to name McDonald. This was due to the fact that the policy was originally designed to name the LLC as owner and beneficiary.

Finally, the court noted that even if a legal basis for reformation existed, the court would still consider reformation improper because the equities did not lie with the ex-girlfriend. The LLC

purchased and paid premiums on a policy for a dishonest employee. He also attempted to obtain the LLC's last asset to which he had access, the policy, to benefit his ex-girlfriend. The ex-girlfriend was trying to benefit from a policy which was purchased to protect creditors. The creditors had remained unpaid. Since the ex-girlfriend apparently paid no premiums nor had any connection with the business, the court held the equities favored the creditors and granted judgment in their favor.

Impact: Reformation is an equitable relief and equities may weigh heavily in life insurance disputes.

F. NINTH CIRCUIT

[FIER V. UNUM LIFE INSURANCE CO. OF AMERICA](#)

(9th Cir. (Cal.) January 4, 2011)

“Loss” of Hands and Feet Requires Physical Removal of Limbs to Qualify for Accidental Death and Dismemberment Benefits

The insured was shot in the neck by a drunk person and rendered a quadriplegic. The Accidental Death and Dismemberment policy defined “loss” as “dismemberment by severance at or above the wrist or ankle joint.”

The insured argued that although his hands and feet remain attached to his body, he has lost them from a functional standpoint due to the severance of his spinal cord. The court adopted an interpretation of “severance” which required the actual, physical separation of the limbs. Thus, no accidental death and dismemberment benefits were owed to the quadriplegic claimant.

Impact: Policy definitions are to be read literally when referencing “severance” of a limb.

[MUNIZ v. AMEC CONSTR. MGMT.](#)

(9th Cir. (Cal.) Oct. 27, 2010)

Burden of Proof Remains With Claimant Under De Novo Standard

In *Muniz v. Amec Constr. Mgmt. Inc.*, the plaintiff, Dierro Muniz, was diagnosed with HIV in 1989 and stopped working in 1991. Muniz applied for and received benefits under a disability policy issued by CGLIC. CGLIC terminated Muniz's disability benefits in 2006 even though there was no evidence of material medical improvement and Muniz's treating doctor continue to certify his disability. CGLIC demanded that Muniz undergo a functional capacity evaluation (FCE), which Muniz's treating doctor refused to authorize given Muniz's fatigue and overall condition. CGLIC terminated Muniz's benefits based on a file review by an in-house medical director. Muniz's appeals were denied and litigation ensued.

The parties stipulated that the plan did not contain discretionary language and a de novo standard of review applied. The court held that the administrative record was insufficient to determine whether Muniz was “totally disabled” under the terms of the plan. The District Court

instructed Muniz to undergo an FCE, the results of which supported a finding that he was not “totally disabled.” Muniz appealed to the Ninth Circuit.

The Ninth Circuit upheld the District Court’s determination. The court ruled the burden of proof remained on the plaintiff under the de novo standard: “[t]hat benefits had previously been awarded and paid may be evidence relevant to the issue of whether the claimant was disabled and entitled to benefits at a later date, but that fact should not itself shift the burden of proof.” The court held that Muniz failed to provide “sufficient evidence” to overcome the district court’s ruling. In this regard, the Ninth Circuit ruled that the District Court was not required to give deference to the treating doctor’s opinion.

The court also upheld the District Court’s finding that the treating physician's records “were inconsistent, incomplete and did not ultimately support Muniz’s claim that he met the definition of total disability under the CGLIC plan.” The Ninth Circuit also rejected Muniz’s argument that an FCE performed in 2009 was irrelevant to Muniz’s condition when benefits were terminated in 2006. The court pointed to other 9th Circuit cases permitting the admission of additional evidence in order to conduct an adequate de novo review of the benefit denial decision: “while not conclusive, the 2009 FCE potentially provided insight as to Muniz's previous condition, for Muniz had many of the same symptoms and same activity levels as he did in 2006, and Muniz does not contend that his underlying condition changed substantially.”

Impact: Under a de novo standard, the burden of proof lies with the claimant.

G. ELEVENTH CIRCUIT

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY V. CAIN

(11th Cir. (Tenn.) February 23, 2011)

Termination of Child Support Obligation Terminates Obligation to Name Ex-Wife as Life Insurance Beneficiary

The appellant had been married to the decedent, but the two divorced. As part of the divorce decree, the ex-wife was given child support and the decedent was required to maintain life insurance naming his ex-wife as a beneficiary “so long as he is liable for child support.”

Sometime after the divorce, the ex-wife, two of his sons and the ex-wife’s boyfriend conspired to kill the decedent. He survived, but the conspirators were charged with attempted murder. The child support awarded to the ex-wife was vacated, and redirected to a non-conspirator son who had custody of the couple’s one remaining minor child.

After the wife pled guilty to conspiracy to commit murder, the decedent removed her as the beneficiary of the life insurance policy, naming his non-conspirator son instead. Five years later, the decedent died. The ex-wife, *pro se*, claimed the insurance proceeds, asserting that because the divorce decree stated that the decedent should designate the ex-wife as beneficiary “for so long as he is liable for child support,” and the decedent was liable for child support (albeit not to her), she was the beneficiary.

The court held that because the child support award in favor of the ex-wife was vacated on a permanent basis, the order requiring the decedent to designate her as beneficiary was also vacated. “[I]t would make no sense to ensure continued payments of child support payments with a life insurance policy payable to a woman who no longer had any role in those payments.”

Impact: The court read practical considerations into the life insurance beneficiary designation, and linked beneficiary status to the existence of a financial obligation from the insured to the beneficiary.

DISTRICT COURT CASES

[SADEL v. BERKSHIRE LIFE INS. CO.](#)

(E.D. Pa. Jan. 31, 2011)

Fraud Exception to Incontestability Period

The insured, a pharmacist, failed to disclose in his application for disability insurance that he sought regular and continued treatment for use of unprescribed narcotics. Two years after procuring disability insurance, the insured submitted a claim for benefits for injuries sustained during an armed robbery at his drugstore. The insurer denied the claim after it became apparent that the insured misrepresented on his insurance application that he never used drugs. The court granted the insurer’s motion for summary judgment and rescinded the policies, finding that the insured’s representations were false, made in bad faith, and were material to the risk. In addition, the court held that the insurer was not precluded from rescinding the policy based on the incontestability provision. To this end, the court noted that the incontestability provision contained a fraud exception that permitted the insurer to rescind the policy based on fraud after a two year period.

STATE COURT DECISIONS

[BLUE SHIELD OF CALIFORNIA LIFE & HEALTH INSURANCE COMPANY V. THE SUPERIOR COURT OF LOS ANGELES COUNTY](#)

(Ct. App. Cal. February 9, 2011)

Insurer’s Failure to Use Statutory Limitation Language Expanded Limitations Period Regarding All Claims Related to the Policy

Blue Shield approved the claimant’s gastric bypass surgery. Subsequently, it learned that the claimant’s height and weight were incorrect on the policy application. It then rescinded the policy. Claimant sued for breach of contract and tortious breach of the implied covenant of good faith and fair dealing. Blue Shield sought to have the tortious bad faith cause of action dismissed, claiming it was subject to a two-year statute of limitation and thus, time barred. Section 10350.11 of the California Insurance Code requires that health insurance policies contain a provision stating that all actions on a policy must be brought within three years of the date on which written proofs of loss must be furnished. Blue Shield argued that the provision only applied to contractual claims, not tortious claims. Therefore, the tortious bad faith claim was subject to the statutory two year limitations.

Blue Shield's policy did not adopt the statutory language. The court found it was irrelevant whether a tortious bad faith claim fell outside the statute's requirements because Blue Shield's policy provided a limitation that was "far different" from what the statute required. Blue Shield's policy provided a three year statute of limitations for all claims and "any other matter arising out of this Plan." The court held because the statute allowed insurers to provide more favorable language to the insured, and the Plan's language broadly expressly referred to "any other matter," the policy's three year statute of limitations applied to the tortious bad faith claim.

Impact: A policy's language may create obligations for the insurer beyond what statutes require. When a policy's language is broader, a court will not allow the insurer to look to statutes to limit its obligations.

Goldberg Segalla LLP is a Best Practices law firm with offices in Philadelphia, New York, Pennsylvania, New Jersey and Connecticut. Our **Life, Health, Disability and ERISA** practice is encompassed within our **Global Insurance Services** Practice Group. We handle matters nationally on issues which include evolving concerns over ERISA preemption, contestability periods, fraud, foreign death schemes, unique beneficiary claims, benefits limitations due "own occupation" and "any occupation" periods, disputes over payor submissions deadlines and third-party billing, health insurance and provider audits, HIPPA compliance and litigation. For more information on Goldberg Segalla's **Global Insurance Services** Group, please contact either **Daniel W. Gerber** or **Richard J. Cohen**. Our **Global Insurance Services** team consists of the following attorneys:

Partners

Daniel W. Gerber
Thomas F. Segalla
Sean P. Beiter
Michael T. Glascott
Jeffrey L. Kingsley
Matthew S. Lerner
Colleen M. Murphy
Joanna M. Roberto
Joseph J. Welter

Richard J. Cohen
Sharon Angelino
Richard A. Braden
Anthony J. Golowski II
Jonathan M. Kuller
Brian W. McElhenny
Joseph A. Oliva
Matthew C. Van Vessem

Special Counsel

Mark R. Cramer
Sandra Snaden Kuwaye
Paul D. McCormick
Verne A. Pedro

Associates

Sarah J. Delaney
Carrie P. Appler
Melanie J. Beardsley
Brian R. Biggie
Jennaydra D. Clunis
Kimberlee L. Danieu
Sarah X. Fang
Toni L. Frain
Annmarie Giblin
Bryan D. Richmond
Paul C. Steck

PHILADELPHIA

1700 Market Street / Suite 1418, Philadelphia, Pennsylvania 19103-3907
Telephone: 267.519.6800 Fax: 267.519.6801

NEW YORK

1200 Avenue of the Americas / 3rd Floor, New York, New York 10036-1615
Telephone: 646.253.5400 Fax: 646.253.5500

PRINCETON

902 Carnegie Center / Suite 100, Princeton, New Jersey 08540-6530
Telephone: 609.986.1300 Fax: 609.986.1301

HARTFORD

100 Pearl Street / 7th Floor, Hartford, Connecticut 06103-4506
Telephone: 860.760.3300 Fax: 860.760.3301

BUFFALO

665 Main Street / Suite 400, Buffalo, New York 14203-1425
Telephone: 716.566.5400 Fax: 716.566.5401

ROCHESTER

2 State Street / Suite 805, Rochester, New York 14614-1342
Telephone: 585.295.5400 Fax: 585.295.8300

SYRACUSE

5786 Widewaters Parkway, Syracuse, New York 13214-1840
Telephone: 315.413.5400 Fax: 315.413.5401

ALBANY

8 Southwoods Boulevard / Suite 300, Albany, New York 12211-2364
Telephone: 518.463.5400 Fax: 518.463.5420

WHITE PLAINS

11 Martine Avenue / Suite 750, White Plains, New York 10606-1934
Telephone: 914.798.5400 Fax: 914.798.5401

LONG ISLAND

200 Old Country Road/Suite 210, Mineola, New York 11501-9801
Telephone: 516.281.9800 Fax: 516.281.9801

FOR EDUCATIONAL PURPOSES ONLY

© COPYRIGHT 2011 Goldberg Segalla LLP, ALL RIGHTS RESERVED