

Insurance Litigation Reporter
November 1, 2004

Feature Article

DISABILITY INSURANCE: AN ELEMENTARY AND "PURISTICAL" INTRODUCTION TO COVERAGE ISSUES

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Disability insurance is designed to provide money to those who have sustained serious enough injury that they cannot work in certain ways. [FN1][FN1] Usually, the policy proceeds are paid on a periodic basis indefinitely. Sometimes they are paid in a lump sum. More often, benefits are paid for a set period of time, or until the insured reaches retirement age. When the interval during which an insurer must make payments is a long one, the insurance is appropriately enough-called long-term disability insurance, or LTD, for short. Disability insurance has been around for a long time-indeed, most of the Twentieth Century and, in some cases, before. Some disability policies are sold to individuals; some are parts of other insurance contracts, such as life or accident insurance policies; sometimes they are purchased by or sold through employers; sometimes they are sold through other agencies, such as labor unions, fraternal lodges, and so forth. [FN2][FN2] (Of course, some types of insurance which are not generally thought of as disability insurance have disability components. Worker's compensation insurance is like this.)

The goal of this paper is to provide a unified introductory discussion of the nature, diversity, and legal problems involved in disability insurance. To that end, the paper begins with discussing background risks and economic problems. Afterward, it discusses various types of insuring agreements, various types of policies, various types of cancellation provisions, various restrictions on rate increases, some of the conditions which are to be found in disability policies, and problems surrounding incontestability clauses. Thereafter, the paper will examine some of the standard exclusions frequently found in such policies (such as they are), as well as some of the modifications upon coverage which can be made by way of endorsements. Later sections of the paper, which will be published in the next issue of *Insurance Litigation Reporter*, will discuss various kinds of adjustment practices and problems involved in suits for bad faith.

Our discussion of typical policy provisions is somewhat general. Disability insurance is a type of health insurance. Health insurance policies are far more diverse than are liability of many types of property policies. Consistent themes are to be found in health policies in general, and liability policies in particular. Nevertheless, the details of policy language and policy provisions are often quite substantial. Obviously, since disability insurance is a type of health insurance, if someone sustains a disability for some reason other than health failure of some sort-usually one specified in the policies to some degree-there is no coverage. Thus, a lawyer who is not working because he was kicked out of the bar, as opposed to the fact that he has been ill or has been injured, is not entitled to disability coverage. [FN3][FN3]

Here and there in the paper we will discuss some recent cases. For those who are mostly interested in learning about reviewing general principles, these discussions can be skipped. We have tried to create a pattern of discussion where prose about specific cases can be recognized immediately and skipped. There are a few cases, here and there, involving conflicts between disability insurers and brokers. We leave them to one side, for now. [FN4][FN4]

Many disability policies are today controlled by the Employee Retirement Income Security Act of 1974 ("ERISA"). [FN5][FN5] First, ERISA preemption is a matter of substantial importance when talking about bad faith actions in the area of disability insurance. The relationship between ERISA preemption and state law bad faith common law and statutes is experiencing some tension and uncertainty. Second, the extent to which federal courts will scrutinize coverage decisions made by ERISA-controlled entities is also a matter of some importance with substantive insurance law. Under most circumstances, the decisions of plan administrators controlled by ERISA are not subject to de novo review, and the decisions of the plan administrator will survive judicial scrutiny unless he has abused his discretionary authority to determine eligibility for benefits or to construe the terms of the plan. [FN6][FN6] Significantly, a plan administrator controlled by ERISA "may abuse its discretion when it construes provisions of the plan in a way that conflicts with the plain language of the plan or relies on clearly erroneous findings of fact in making a benefit determination." [FN7][FN7] Thus, the proper construction of a disability policy may be supported by ERISA. At the same time, ERISA preemption has some implications for how disability policies are interpreted. The language and structure of ERISA-controlled policies themselves are frequently not substantively different from disability policies which have been marketed for years. [FN8][FN8] Because this essay is "puristical" we will pay no attention to technical issues of ERISA procedure or ERISA preemption. We will discuss, to some degree, the construction of insurance policies, and their new relatives, by courts controlled by ERISA, at least to the extent they rely upon "real" insurance law. (Of course, ERISA is important law. No essay can be about everything, however. In addition, the whistle law may be changing.)

There are disability-like insurance policies which function somewhat differently from routine disability policies. They are all predicated upon someone sustaining a disability, however. One such different policy, the business overhead expense policy, requires that the policyholder sustain a disability. When the policy is triggered, it will pay for continuing overhead expenses of the policyholder's business, during at least part of the period of disability. This policy is designed for the owners of small businesses. The policy is particularly marketed to physicians, lawyers, and other service providers. [FN9][FN9]

Another such policy is predicated upon the disability of a key person in an organization. The disability policy provides money to the organization to make up for the loss of a key person. A variation on this kind of policy arises when an organization buys a disability policy to reimburse it for salary continuation benefits. [FN10][FN10] Yet another, somewhat similar policy, provides money to an organization to buy out the interest of a disabled co-principal.

RISKS

According to widely available material, the risk of disability is substantially greater than the risk of death, at least for many people. The evolution of attending to disabilities has played an important role in fairly recent politics. [FN11][FN11] This tendency is continuing, and attention to disabilities is becoming a more important part of social morality and various kinds of commitment. [FN12][FN12] The marketing literature provided by LTD carriers and their brokers is sobering. We make no representation that this data is correct. Here is some of

it, however:

- The chance of becoming disabled for 90-days or longer, at least once before age 65 is approximately 1 in 3. [FN13][FN13]
 - A 30-year old man has a 20% chance of suffering a long-term disability before retirement. Twenty percent is one chance in five.
 - A 30-year old woman has a 33% chance of suffering long-term disability before retirement. That's one in three.
 - About half of the people who suffer disabilities lasting longer than six months are still disabled after 5 years.
 - In the United States, the National Safety Council reports that a disabling injury occurs every 1.5 seconds. [FN14][FN14]
 - One out of seven employed people will be disabled for 5 years or more before age 65. [FN15][FN15]
 - Heart disease and back problems are the two most common causes of long-term disabilities.
 - More people lose their houses through disability than through either fire or death. (Fire strikes only 1 out of every 88 houses.)
 - Disability claims resulting from mental disorders are on the rise.
 - Almost two-thirds of all disabilities resulting from work are severe. [FN16][FN16]
 - According to the U.S. Housing and Home Finance Agency, 48% of all foreclosures are due to a disability. [FN17][FN17]
- Again, we do not vouch for these numbers, but one sees them repeated over and over again.

INSURING AGREEMENT

Disability policies insure against the policyholder's inability to work. Disability insurance is not designed to indemnify a person against a loss of income per se. If income is involved in describing the coverage at all, the insurance is for the loss of income resulting from a specific event, namely, the loss of the capacity to work at some sort of occupation. [FN18][FN18] Besides, disability policies are mostly "semi-valued" policies. They require the periodic payment of predetermined liquidated sums.

Disabilities, of course, fall into one of four categories, familiar from worker's compensation law: total and permanent, total and temporary, partial and permanent, partial and temporary. [FN19][FN19] Most litigation arises over total and permanent disabilities. Whether an insured has been disabled in an insured way is a jury issue, since it is an issue of fact.

Our discussion of insuring agreements in disability policies will focus on six (6) concepts. These are the concept of total disability, the concept of different occupations, the concept of schedules contained in and governing disability policies, the idea of causation of disability in disability policies, the idea of policy periods and, the concept of waiting periods.

Total Disability"

The ideas of having a *total disability*, *totalness* in a disability, *totality* when it comes to disability, or simply the idea of what it is to be a *total disability* will be discussed here in two ways. The first discussion will concern

general principles. The second topic will concern some recent cases. In the context of private insurance the concept of *total disability* is not limited to total health destruction, e.g., complete, quadra-paralysis; nor does it imply disability starting with childhood. Some thoughtful lawyers have reflected upon the central concepts in the disability insurance well, but the focus is not widespread. [FN20][FN20]

General Principles

The meaning of the word *total* is an issue for the court. This legal rule is a necessary consequence of a more general legal rule that the meaning of all language in insurance policies, under most circumstances, is a legal matter for the court alone and not for the jury. This rule of insurance policy construction, in turn, is a consequence of the even more general rule of contract construction, in accordance with which the meaning of contract terms is to be determined by judges, not juries.

Courts hold that total disability does not require quadriplegia or its equivalent. Thus, a person is totally disabled with respect to an occupation, when he cannot perform the functions of that job. He may still be able to drive a car, shop, mow a lawn for short intervals of time, and so forth, but yet fit within the category *totally disabled*. [FN21][FN21] Neither Texas courts nor courts around the country are literalistic when it comes to interpreting total disability. [FN22][FN22]

In any case, the concept of *total disability* is sometimes further subdivided. At one point, policies in Texas distinguished between total disabilities which confine a person to his house and total disabilities which do not. [FN23][FN23] Benefits for these two types of disabilities differed. The idea of a *confining* total disability is not need to be taken strictly and literally, said the court. Such an idea did not mean that a disabled person could never leave his house for any reason. [FN24][FN24]

The definition of *total disability* in many disability policies contains an additional extraneous-looking proviso. Frequently, disability policies say that a policyholder is totally disabled only if he is somehow under the care of the defined type of caregiver. Sometimes, the policy goes further and says that the policyholder must accept appropriate medical treatment during the period of time the disability is alleged. Thus, if a policyholder seeking coverage fails to see a physician, fails to see some other kind of care giver acceptable to the language of the policy, [FN25][FN25] or fails to accept appropriate medical treatment, the policyholder does not meet the definition of *totally disabled*, and is therefore not within the insuring agreement.

Here is an example of such policy language:

Total Disability or totally disabled means that due to Injuries or Sickness:

- (1) You were not able to perform the substantial and material duties of your occupation; and
- (2) You are receiving care by a Physician wh[o] is appropriate for the condition causing the disability.

[FN26][FN26]

Obviously, if a policyholder is not seeing a physician at all he will not meet the definition of being totally disabled. [FN27][FN27] If the policyholder is seeing some sort of healer, and that healer does not meet the definition of "physician" included in the contract, the policyholder will not meet the definition of total disability. Occasionally, a disability carrier suggests that if a treating physician prescribes the wrong treatment, the policyholder-patient is not receiving "appropriate" treatment, and is therefore outside the definition of total disability. [FN28][FN28] This position-which should be called the "Defense of Churls"-raises all sorts of interesting questions. Perhaps the insurer is attempting to suggest that the policyholder's inability to work is a result of physician

malpractice, not original disability. If this reasoning were sound, probably the insurer would have to demonstrate that the insured's inability to work was the result of the physician's error. This gambit would require proof of causation. No doubt the burden would be on the carrier.

The requirement that someone receive regular treatment by a physician in order to be disabled (or that the disabled policyholder receive appropriate treatment in order to receive payments from the insurer) is not always enforced by courts. [FN29][FN29] It is often enforced, however, and Texas courts have enforced this provision as a condition precedent. [FN30][FN30] The requirement serves two separate functions. The first function is to make sure that there is evidence of the underlying disability. [FN31][FN31] The other function is to combat the moral hazard of malingering. The idea is that medical treatment may well help the policyholder improve. Some courts, routinely enforce provisions in disability policies requiring insureds to be under the care of a licensed physician during the period of disability in order to receive benefits, upon the grounds that the contract language is clear and hence that the courts are obligated to enforce it. [FN32][FN32]

Some Interesting New Cases

The topic of what constitutes a *total disability* has concerned a number of cases in recent years. We will discuss several of them here. One of the most important is a case decided this year in the Texas Supreme Court. Other cases have been decided in other jurisdictions. The Texas case will be treated first, then some of the other cases will be discussed in chronological order.

Knott's Case: *Total Means All.*

In *Provident Life & Accident Insurance Company v. Knott*, [FN33][FN33] the issue was what constituted total disability for a physician who began practicing obstetrics and gynecology in 1968, who had purchased disability insurance in the early 1970s—one in 1970 and a second in 1974—and who sustained a serious injury in an airplane crash and underwent surgery—both in 1985. The issue in the case, as already stated, pertains to whether Dr. Knott had a total disability when he was not “unable to perform all of the important and usual duties of his occupation[,]” and he was “able to perform some of the important and usual duties of his occupation as a physician[.]”

The insured and the insurer had a lengthy history involving insurance, demands for coverage, payment of premiums, payments by the insurer, demands for premium refunds, and so forth. The litigation itself had a lengthy history period, involving both coverage issues and issues of bad faith. The trial court resolved the case against Knott on summary judgment; the court of appeals reversed the trial court on issues of coverage, but not those of bad faith type actions. [FN34][FN34] The issues then reached the Texas Supreme Court.

The principal issue before the supreme court was the meaning of the definition of *total disability*. The definition of that phrase was quite brief: “Total Disability means that due to Injuries or Sickness, you are unable to perform the duties of your occupation.” [FN35][FN35]

Knott was able to work part-time seeing gynecological patients. He conducted pelvic exams; he provided consulting services to other physicians; and he performed administrative duties. At the same time, Knott “claimed that he was unable to perform operative obstetrics, prolonged gynecological procedures, endoscopic procedures, and vaginal procedures because the bending and stress of these procedures aggravated his back in-

jury." [FN36][FN36] Thus, Knott did some things that were part of his occupation and not others. Thus, he was able to perform some of the duties of his occupation, but not others. At least so he said. These alleged facts were apparently undisputed.

Justice Dale Wainwright, a relatively new member of the Texas Supreme Court wrote for a unanimous court and held that Provident "met its summary judgment burden to establish that Knott was not totally disabled under the policies' language."

One of the principal arguments of the court depends upon the contrast between the definitions of *partial disability*, to be found in the two disability policies and the single definition of *total liability* to be found in the same policies. It is the short definition already quoted. The second of Knott's two policies, issued in 1974, defined *partial disability* as follows:

(a) Your inability to perform one or more of your important daily business duties, or

(b) your inability to perform your usual daily business activities for at least one-half of the time usually required for the performance of such duties.

The definition in the earlier disability policy, issued in 1970, was similar, though longer:

If injuries shall either prevent the Insured from performing one or more, but not all, important daily business duties, or shall prevent the insured from performing his usual daily business duties for at least one-half, but not all, of the time usually required for the performance of such duties, the Company [i.e., Provident] will pay periodically during the continuance of such partial disability, indemnity at the rate of the Monthly Benefit for Partial Disability beginning

Thus, given the contrasting definitions of *total liability* and *partial disability* the supreme court concluded that "under the Provident policies, the insured is totally disabled when he is unable to perform all of the important duties of his occupation." [FN37][FN37]

The principal jurisprudential reason for the court's view was reliance upon some fundamentals of contract law. Here is the main argument:

When terms are defined in insurance policy, [like any other contract] those definitions control the interpretation of the policy. Reliance on defined terms in insurance policies to construe those contracts is necessary to determine the intent of the parties and integral to the application of basic principles of contract interpretation to insurance policies. We follow long-standing principles of contract interpretation and apply the definitions contained in the parties' agreement, construing them to give meaning to all the terms of the policy and adhere to the written expression of the parties' intent. [FN38][FN38]

As a result of this view, the court rejected what may have been something of a tradition in parts of Texas insurance law. Several courts, starting years ago, have indicated that "an insured is totally disabled whenever he is unable to perform *any substantial portion* of the work connected with his occupation." [FN39][FN39] The court disapproved the language of cases Knott relied upon "to the extent that the language suggest that it is proper to disregard defined terms in a policy in favor of definitions not expressed in the parties' written agreements." [FN40][FN40]

The *Knott* decision is an extremely important one in the law of disability insurance. It requires that legal argument pay close attention to explicit definitions in the policy. The phrase *total disability* is always defined explicitly in disability policies. Lawyers must attend to those definitions, and contrast them with definitions of *partial disability*. Those buying disability insurance should also be very careful about the definitions. There are

a number of different ones, and this fact needs to be attended to.

The *Carson* Case: Ambiguity Rules and Idiotic Blundering

In *Carson v. Canada Life Assurance Company*, [FN41][FN41] the issue concerned alleged total disability resulting from fibromyalgia, which is a “complex, chronic condition that causes widespread pain and profound fatigue, as well as a variety of other symptoms, including sleep disturbances, stiffness, headaches, cognitive disorders, and depression.” [FN42][FN42] No cure is available, but the symptoms can often be mitigated by narcotic medications.” [FN43][FN43]

At the point Carson became ill, she was a senior accounting technician in California. She moved to Maryland to live with relatives, after she could no longer work. She tried to work part-time but could not do so.

Canada Life refused coverage for a variety of reasons. At one point, it conceded that the diagnosis was correct—indeed “clear”—but it held that the diagnosis does not prove a disability. Consequently, it stated that Carson should undergo a “functional capacity evaluation.” That evaluation demonstrated that Carson could not go back to the kind of job that she had; it demonstrated that she needed frequent breaks; it did not evaluate her mental capacities; it did not evaluate her ability to concentrate. In fact, both of these states of affairs had been “adversely affected by her fibromyalgia.” [FN44][FN44] Although the physician at Canada Life agreed with the diagnosis of fibromyalgia, “he denied the claim for benefits because, as he concluded, Carson could return to work at ‘light duty.’”

The definition of the phrase “totally disabled” was a lengthy and complex one:

“Totally disabled” means that the person is unable to work and fulfills either of the two conditions below:

Condition 1 [C-#1]-During the elimination period and for the next 24 months after the elimination period in a continuous period of disability, the person is unable to perform with reasonable continuity the substantial and material duties of his own occupation in the usual or customary way, or

Condition 2 [C-#2]-After the elimination period plus the next 24 months in a continuous period of disability, the person is unable to perform with reasonable continuity the substantial and material duties of any occupation for which he [or in this case she] is qualified in view of his [or in this case her] age, education, training, experience, station in life, and physical and mental capacity.

Under C-#1 a person is totally disabled if that person cannot perform the “substantial and material duties of what he usually does, i.e., his own type of job, in established and accepted ways. C-#2, if met, entails that a person is totally disabled if that person is unable to perform fundamentals of any occupation for which that person is qualified at the time of the disability application. Notice that C-#1 and C-#2 are connected by the word “or.” Thus, a person is totally disabled if either C-#1 or C-#2 is true.

Curiously, Canada Life took the position that someone was totally disabled only if C-#1 and C-#2 were satisfied over time. First one (i.e., C-#1) needed to be satisfied and then the other (i.e., C-#2) needed to be satisfied. In contrast, Carson took the view that “person is totally disabled” under this definition if either C-#1 or C-#2 is satisfied.

The Fourth Circuit court found that these definitions of “totally disabled” were genuinely ambiguous, so that the district court correctly submitted the principle issue in the case to a jury. The finding of the district court that

the definition was ambiguous is somewhat curious. This is what it said:

While Carson's interpretation persuasively fits the plain language of the contractual definition, it does render Condition 2 superfluous, because Condition 1 would always be satisfied more easily. [FN45][FN45]

Given the testimony the jury received, which will be discussed later, the jury found that Carson was indeed totally disabled within the meaning of the policy. The jury came to other negative conclusions about the way in which Canada Life had managed the claim, it shall be discussed later.

It is difficult for us to see why the Fourth Circuit, or the district court accepted the view of Canada Life at all. It is true that C-#2 would always be superfluous, if the view of the insurer was rejected. So what! The policy is not in the slightest ambiguous. The meaning of the word "or" is perfectly clear. It looks like Canada Life made a stupid blunder in drafting its policy. If it wanted both C-#1 and C-#2 to be satisfied over time, they should have made the point clear. It is not a difficult point to make clear. As far as we know, it is no part of the principles of contract interpretation to save sophisticated drafters who have thought about meaning at some length from idiotic blunders.

The Yaghoubian Case: A Knott-Like Dispute

In *Yaghoubian v. Northerwestern Mutual Life Insurance Company*, [FN46][FN46] the insured was an engineer. Under the policy, he would be totally disabled if and only if he was "(1) 'unable to perform the principal duties of his occupation' and (2) not 'gainfully employed in any occupation.'" (Italics added.) In order to be eligible for lifetime benefits under the disability policy, Yaghoubian had to have been totally disabled within the definition on the policy anniversary closest to his 60th birthday and his total disability had to continue until the first policy anniversary after his 65th birthday (a policy anniversary is the same day as the formation of the policy in later years).

Yaghoubian tried two arguments. First, he argued that he could not perform principal duties if there was one principal duty he could not perform. In the alternative, he argued that he could not perform any of the principal duties of his engineering occupation, since there was only one principal duty, and he could not perform it.

The one principal duty he could not perform was *marketing*. Because he could not market for his company, he claimed that he was totally disabled.

The Ninth Circuit panel rejected this view, just as the district court had. The first argument failed, because the inability to perform one principal duty did not meet Clause (1) of the conjunctive definition of total disability. This is certainly true if the occupation involves more than one principal duty. The courts rejected the second argument because it was perfectly clear that the policyholders occupation (i.e., job) involved more than one principal duty. In fact, for some 14 years, right up to the approximate time of his 65th birthday, Yaghoubian had functioned as an engineering consultant for various distinguished art museums in the Los Angeles, California area. His activities included discussing projects with museum officials, conducting site visits, performing field work, devising conservation methods, engaging in engineering analyses, drafting proposals, and so forth.

The circuit panel found in its memorandum opinion that neither of these argumentative routes could succeed. Hence, "[a]s a matter of law, Yaghoubian was not totally disabled because he could perform *some* of his principal duties." [FN47][FN47] It is interesting to note the similarity between the 2002 case and the 2004 *Knott* case

already discussed. Unlike Justice Wainwright's vision of the history of Texas law, whereby the *Knott* case is changing Texas law, the Ninth Circuit panel sees itself as following well-established California law. [FN48][FN48] The partially dissenting judge disagrees with this conclusion to some extent. He points out that most of what Yaghoubian did for his company was exactly what he described. "The record contains evidence that when Yaghoubian purchased a lifetime disability endorsement from Northwestern, he considered the marketing and client development aspects of his position to be the 'principal' duties he performed as the proprietor of [his company]. There also exists evidence demonstrating that before becoming disabled, Yaghoubian spent the bulk of his time engaged in marketing and business development." [FN49][FN49] Upon this basis, the partially dissenting judge, believed that the *Erreca* case tends to support Yaghoubian's position and not that of the insurer. Moreover, the dissenting judge believes that Yaghoubian was not "gainfully" employed, and that is what is required by the policy to defeat coverage, since the company that employed him didn't make any money. [FN50][FN50] The dissenting judge would have sent the case back to the district court for trial on the issue of coverage.

The *Guistra* Case: The Importance of the Important

In *Guistra v. Unum Life Insurance Company of America*, [FN51][FN51] a total disability case came to the Supreme Judicial Court of Maine. The lawsuit involved several disability policies. Two of them were controlled by ERISA, and those two policies were not an issue before the supreme court. The only policy before the appellate court was a business overhead disability policy.

Guistra was an orthopedic surgeon. He suffered from depression. As a result of his problem, he stopped handling emergency room duties and then commenced psychiatric treatment. Guistra's psychiatrist determined that he could do patient exams and minor surgery in his office, but could not perform major surgery. "Guistra acknowledged that evaluating patients in the office and performing minor surgeries were important duties in his orthopedic practice, but they were not duties that financially sustained his practice." [FN52][FN52]

The Paul Revere policy defined the phrase "total disability" as follows:

"Total Disability" means that because of Injury or Sickness:

- a. You are under the direct and personal care of a Physician; and
- b. You are completely unable to perform the important duties of Your Regular occupation.

"Partial Disability" means that because of Injury or Sickness:

- a. You are under the regular and personal care of a physician; and
- b. You are either:
 - (1) Unable to perform the regular daily duties of Your occupation at least one-half of the time usually required; or
 - (2) Unable to perform one or more important regular duties of Your occupation.

So far as *total disability* is concerned, the only real issue is the first § b. "The only dispute is whether his inability to perform major surgery renders him totally disabled under the policy definition even though he can perform

minor surgery and patient evaluations.” [FN53][FN53]

The supreme court agreed with the district court and the insurer in a hugely significant way:

The policy definition of “total disability” which refers to “the” important duties of Guistra's occupation, must be read in the context of the entire policy. Because the policy also provides for lesser benefits for partial disability, which is defined as being unable to do “one or more” of the important regular duties of his occupation, total disability refers to something more debilitating. “The important duties” of an orthopedic surgeon must, therefore, be interpreted as meaning “*all* of the important duties.” If the phrase “the important duties” was construed to mean “one of the important duties” it would mean the same as “partial disability,” and such interpretation would be unreasonable. [FN54][FN54] [Italics added.]

Upon this ground, the court concluded that so long as Guistra could perform at least one of what should be counted as an orthopedic surgeons important duties, he would not be totally disabled under the policy.

It looks like the insurer took the view that an insured could only be partially disabled if he was first totally disabled. No language provided in the opinion supports that view, but-perhaps-there is something in the policy which does support it. It's hard to see why that would make real sense, except to cut off certain kinds of fraud cases. In any case, the court was certainly right to compare and contrast the definitions of *total disability* and *partial disability*. This is certainly a valid form of reasoning.

It is not clear that the court got this completely right, however. It seems to us that the term “important” is a highly ambiguous term. An activity could be important for several different reasons and not important for the others. Thus, for example, continuing education might be an important activity of orthopedic surgeons because it helps with memory, educational improvement, and insight. The performance of new types of surgery-even if they are relatively minor-might be important because of the evolution of human illnesses. The performance of major surgeries might be important, because they generate the most income. This would even be true for major surgeries that are no longer interesting from an artistic, technical, or scientific point of view. It might even be true that some of these surgeries are not particularly usual but have to be performed every once in a while, and because younger surgeons don't know how to perform them, they are extremely important for those who know how to do them and important to the patients who need them.

The supreme court observes that Guistra did not argue that any of the terms in the definition were ambiguous. [FN55][FN55] It is clear to us that in order to do justice, an argument must be presented to a court, and the prose of the court hints that it realizes that there may be some ambiguity issues. It seems to us, quite obvious, given what was said by Guistra, that his inability to perform major surgery was enormously important in an economic sense. Given that ambiguity, the courts reasoning is-in effect-that in order to be totally disabled, an insured must be unable to perform any type of important activity whatsoever, no matter how many types of importance there are. It seems to us that if § b. in the definition of *total disability* is recognized as containing a significantly ambiguous term, i.e., the word “important,” then it might very well be true that the insured met the definition and was completely unable to perform the really important duties of his regular occupation, i.e., those money generating duties which make the occupation possible.

The Peterson Case: A Very Different Definition.

As we have already seen, the definition of the phrase *total disability* varies from policy to policy. Often, they don't vary much. Sometimes they do.

Consider *Peterson v. Pennsylvania Life Insurance Company*. [FN56][FN56] Peterson was a roofer and constructor of wooden building frames (mostly for houses), i.e., a "rough" contractor. In 1996, Peterson fell from a frame. He smashed up, or at least broke, his right heel. Working on the serious injury "required a bone graft from his hip and a metal joint[.]" [FN57][FN57] Peterson's orthopedic surgeon indicated that Peterson had been subjected to a permanent partial disability—a phrase which may remind one of worker's compensation terminology—of approximately 8%. The physician said that Peterson would probably achieve a healing plateau in about 9 months. The same physician concluded that "Peterson could no longer work as a roofer or rough contractor and restricted him from all climbing, working on inclined surfaces, walking on rough or uneven terrain and lifting more than 40 pounds." [FN58][FN58]

Pennsylvania Life paid the claim for about two years. Thereafter, it discontinued payment, because it concluded that Peterson was not, as defined by the policy, *totally disabled*.

In the trial of the case, Peterson testified he had not worked since the accident. He had tried to take a course in mathematics, but walking from the parking lot to the classroom was too painful. "In terms of everyday activity, Peterson lives by himself, drives a vehicle, does his own shopping and laundry, visits with friends and neighbors and spends time with his daughter." [FN59][FN59] The testimony of his physician involved the assertion that "Peterson could not realistically return to work as a rough carpenter." At the same time, the physician "opined that Peterson was not 100% disabled[,] although he had limitations, he would be able to do sedentary work with standing limited to approximately 30 minutes per hour." [FN60][FN60] The doctor had not prescribed pain medicine for Peterson for several years before the trial.

The physician presented by the insurer at the trial had performed an IME on Peterson. His findings substantially corroborated those of Peterson's physician. He also stated that Peterson could be some sort of carpenter at a ground level.

The insurer also presented a vocational evaluator, and she executed a vocational rehabilitation review. She testified that "Peterson possessed numerous skills learned from his work as a carpenter that, despite his injury, would qualify him for immediate employment." [FN61][FN61] Among those skills were various forms of measurement, skills associated with carpentry, the ability to understand and follow basic blueprints, extensive familiarity with the building trade, and job bidding. She concluded, "based on her survey of the ... job market [of the local county], with Peterson's physical restrictions in mind, there existed jobs available for which Peterson could reasonably apply." [FN62][FN62]

The local vocational specialists at the mental health center of the local county had come to the same conclusion. The vocational specialist had concluded, 15 months after Peterson's accident, that the following jobs were possible for him: "electronic worker, engraver, industrial order clerk and sales representative in a lumberyard." [FN63][FN63]

The phrase "totally disabled" is defined as follows:

total disability: totally disabled means that you ... are unable to engage in any employment or occupation for which you ... are or become qualified by reason of education, training or experience.

The court observed that the definition does not require that the insured be able to perform a job after her accident that he was able to perform before his accident. A court interpreted the definition this way:

the policy definition unambiguously provides that an insured is totally disabled if: (1) he cannot en-

gage in any employment or occupation with normal on-the-job training and with his current education, training and experience or (2) he cannot engage in any employment or occupation with education, training or experience which he can reasonably be expected to obtain. [FN64][FN64]

The court noted that it expressed no opinion as to whether an insured, under this policy had "any obligation to complete additional education or training so he may become employable in areas of employment for which he is not now qualified." [FN65][FN65]

The court was convinced by testimony of the vocational specialists. To a considerable extent, Peterson's argument rested on the idea that, under Wisconsin law, he would never have to undertake a job for which he had no previous experience. He relied on *Harker v. Paul Revere Life Insurance Company*, [FN66][FN66] for this view. The court of appeals indicated that the *Harker* case was unhelpful for several reasons. First, the policyholder in that case had repeatedly tried to find work, and he repeatedly failed to be able to perform the jobs. Second, the definition of the concept of *total disability* was quite different in the *Harker* case than it was in the *Peterson* case. Third, at least Harker attempted to find a job. Peterson never did.

It seems to us that the language of the definition of *total disability* in the Pennsylvania Life policy is being misinterpreted by the court. The court holds that the phrase "or become qualified [for] by reason of" X, Y, or Z, implies that a policyholder must be willing to try to become qualified to do something else, at least if the insured is "reasonably capable of acquiring the education, training or experience to be employable." [FN67][FN67]

The definition simply does not mean this. What it means is that if the policyholder becomes qualified to do something, then he is no longer totally disabled. One can understand why disability insurers and public policy would favor encouraging injured people-disabled people-to obtain skills and find jobs. Society is probably better off that way, and probably the people are better off that way, as well. That is not an issue. The only issue is what does the language mean. If we are right, the decision in the *Peterson* case was wrong, even if just from the supportive view of social policy, as opposed to a written contract.

The London Case: Saga Continues

In *London v. Berkshire Life Insurance Company*, [FN68][FN68] the issue was whether an injured doctor was totally disabled. London was a cardiologist. He claimed to be totally disabled. Berkshire denied his claim. London filed an action in New York state court, and the insurer removed it to federal court. The district court granted Berkshire's summary judgment, and the insured appealed.

The physician-policyholder purchased a Limited Issue Executive Disability Income Policy from Berkshire in 1981. He was identified as a cardiologist in private practice and associated with a couple of hospitals. The Berkshire policy first defined the idea of *total disability* as follows: "Your inability to engage in your occupation." Several years later, the policy language defining total disability was changed as follows: "Your inability to perform the material and substantial duties of your occupation." Obviously, the new language is somewhat similar to language we have already considered. The policy also provided "residual disability benefits," as well as insurance for total disability. The concept of *residual disability benefits* was defined in the policy as

(1) Your inability to do one or more of your important daily business or professional duties; or (2) your inability to do these duties for the length of time that they usually require. [FN69][FN69]

London was diagnosed with coronary artery disease in 1997. He underwent bypass surgery. His physician advised him that he could no longer maintain his rigorous work schedule. Shortly after his surgery, London filed

for disability benefits, claiming total disability.

Berkshire required London to complete a "Description of Occupation" form. The form asked London to list his occupational duties in order of importance, along with the number of hours per week [during which] those duties were performed." [FN70][FN70] London gave a list of three such duties:

- Office duties (for 8+ weekly hours),
- Hospital duties (10+ weekly hours), and
- Night calls (21+ weekly hours).

At least partially on this information, Berkshire concluded that its policyholder was not totally disabled. He had not made any claim for benefits under the *residual benefits provision* (i.e., a partial disability) part of the policy. (Significantly, in making such claim successfully, insureds would have to demonstrate that they had suffered a 25% reduction in earnings, at least. London never submitted any earnings information to Berkshire. As a consequence, Berkshire claimed that it was unable to determine London's rights viz a viz residual benefits.)

In the context of summary judgment, Berkshire provisionally conceded that its insured could not perform "pace-maker insertions." This was a procedure that London included among his hospital duties. However, Berkshire "claimed that [London] still perform[ed] work in all three of the categories [of his list] and that he therefore 'continue[d] working as a cardiologist.'" [FN71][FN71]

According to the Second Circuit panel, which decided the case unanimously, "the definition of total disability in Berkshire's policies tracks the standard articulated by New York courts:

[A] claimant is 'totally disabled' when he or she is no longer able to perform the 'material' and 'substantial' responsibilities of his or her job.' ... Under New York law, the Court is required to [look at] the professional activities in which the insured was regularly engaged at the time of the onset of the insured's disability. If a claimant is able to perform the duties of a position of the same general character as the insured's previous job, requiring similar skills and training, and involving compatible duties, he is not totally disabled.'" [FN72][FN72]

The panel acknowledges that its decision in the *London* case was "fact-oriented." At the same time, it thought the facts were reasonably clear, even when interpreted favorably to London, as they had to be since he was the loser in the summary judgment proceeding. The panel accepted the idea that his office hours were reduced from 48 hours per week to 18 hours per week. Although he was entirely unable to conduct any hospital duties or any night visits, London was still performing some work of the "same general character" as he was prior to his disability. True enough, said the court, that London-as he himself advocates-has become nothing more than a consultant. At the same time, "it is uncontested that he continued to see and treat his own patients in his capacity as a cardiologist, using 'similar skills and training' as he used before the illness. Thus, the nature of his work was materially the same." [FN73][FN73]

The McGregor Case: Problems of a Court Reporter

In *McGregor v. Paul Revere Life Insurance Company*, [FN74][FN74] the plaintiff was a court reporter. She was entitled to benefits for a total disability, if she met the definition of the phrase. It was defined as follows: An insured is subject to "total disability" if, "because of injury or sickness," she is "(1) 'unable to perform the *important* duties of [her] regular occupation;' (2) 'not engaged in any other gainful occupation;' and (3) 'under the regular and personal care of a Physician.'" [FN75][FN75]

Under Requirement #(1) in the definition of *total disability* and California law, the policyholder who is totally disabled “must be unable to perform *all* of her *important* occupational duties in order to receive benefits.” [FN76][FN76] As in other recent California cases, the court has relied upon *Erreca v. Western States Life Ins. Co.* [FN77][FN77] The dispute in this case was whether the policyholder’s inability to “stenotype” rendered her totally disabled within the meaning of the definition.

Interestingly, § 8017 of California Business & Professional Code was important. It defines the duties of court reporters. It does so as follows: “The making by means of written symbols or abbreviations in shorthand or machine shorthand writing, of a verbatim record of any oral court proceeding ... and the accurate transcription thereof.”

McGregor presented testimony from a number of witnesses, including a judge, that she could no longer stenotype. He also presented evidence that the insurer had paid her sixteen months of benefits when she was not working, and the court found that this evidence “provide[d] additional evidence that the inability to stenotype rendered McGregor eligible for ‘total disability’ benefits. [FN78][FN78] Interestingly, the record does not establish that the policyholder saw a personal physician regularly. According to the panel, the policy does not define what it means to meet Requirement #(3). At the same time it was quite clear that she was never denied benefits as a result of not seeing a physician. One of the witnesses, who may have been somehow associated with the insurer, remarked in testifying that even if she was not seeing a physician on a quarterly basis, that fact was no big deal.

We will discuss this case further when we return to the matter of bad faith in § IX below. Significantly, the court found that the insurer had unnecessarily injured its policyholder by handling the claim unreasonably.

The Helus Case: Coverage, Facts, and Truth

In the case of *Helus v. Equitable Life Assurance Society of the United States*, [FN79][FN79] the central issue was whether the particular case of depression involved total disability. In 1990, Helus purchased a disability policy. Two years later the company he owned and ran suffered a terrible blow when a \$4.5 million project refused to pay the Helus Construction Company for its work as a general contractor. There was extensive litigation and Helus eventually went into bankruptcy. He sought disability insurance in late 1992 on the grounds of stress and depression. Equitable began paying benefits in November 1993. The benefits were \$9,100 per month.

Over the next several years, “Helus worked in several volunteer and paid positions.” [FN80][FN80] These positions included a brake construction manager, a reserve officer in a sheriff’s department, a volunteer for search and rescue missions, landscape engineering, training specialist for the sheriff’s department, volunteer with the fire department, quality control manager, safety manager, reserve officer in a police department, security guard, and body guard.

In 1999, the insurer began an investigation. It spoke to the fire department, for example. The sheriff’s department disclosed that Helus fought fires and lifted patients. He also disclosed that he got rid of Helus because he was conflict oriented and did not take orders easily. “The investigator [for the insurer] also obtained the medical record from [the fire department], in which Helus affirmed under penalty of perjury that he did not have a psychiatric disorder or any other nervous disorder, and that he was not taking any medications.” [FN81][FN81]

For obvious reasons, the insurer was troubled by its investigation and demanded two IMEs, one from the

psychologist and one from a psychiatrist. The psychologist reported to the psychiatrist, and the psychiatrist reported that Helus suffered from a major depression, and his psychiatric conditions limited his occupational functions substantially. The psychiatrist said that the symptoms involved would place Helus "at significant risk for redevelopment of a major depressive episode if he were forced to return to the work place at the current time." [FN82][FN82]

Very strangely, a medical consultant from Equitable prepared at least two versions of the report from the IME psychiatrist, and there was a third version of the report. At least one crucial sentence differed substantially.

In addition, there was a notation in a telephone log that Equitable informed Helus that the IME examiners "did not find [Helus] to be disabled-[since there was] no axis I diagnosis." Equitable wrote Helus and told him that it had two independent medical evaluations, and neither of them indicated that he was disabled. Equitable offered Helus several months of benefits. At some point, Equitable transferred the administration of Helus' claim from UnumProvident to Disability Management Services. Thereafter, Helus' benefits were again extended slightly, but Helus was again informed that the insurer lacked evidence to support any further payments of total disability benefits.

Helus sought summary judgment to the effect that Equitable had breached the contract of insurance. He contended that the facts proved, without any doubt whatever, that he was totally disabled as the result of his depression. Equitable filed an opposite motion seeking a judgment that Helus was not totally disabled on the basis of the reports it had received from the IME investigators.

The policy defined the concept of *total disability* as meaning the "policyholders inability due to Injury or Sickness to engage in the substantial and material duties of [his] regular occupation." Unlike many cases, this judge writes about the definition of *sickness*. A "'Sickness total disability' is 'disability caused or contributed to by sickness or by ... bodily or mental infirmity.'" These benefits end when the insured reaches the age of 65. The policy also has a "residual disability rider" added to it. That part of the policy provides for payments based upon differences in income when, due to injury or sickness, the insured is unable "to perform (1) one or more of the substantial and material duties of [his] occupation; or (2) the substan[t]ial and material duties of [his] occupation for as much as is usually required to perform them." [FN83][FN83]

As in virtually all contract cases, every passage of the contract must be interpreted with other passages in mind. Thus, the correct interpretation of the definition of *total disability* must keep in mind the policy's definition of *residual disability*. Since the latter definition refers to one or a small number of substantial and material duties, and the former refers to the performance of substantial and material duties, it seems natural to conclude that the definition of *total disability* means the inability to perform all of the substantial and material duties of the occupation. In other words, a policyholder is totally disabled only if he can't do anything which is part of his regular occupation, if the things he cannot do are material and substantial. If the policyholder is able to perform some of them, then he is not totally disabled. The underlying theory must be that if someone is able to perform some of the material and substantial duties of a regular occupation, then he can work and hence is not totally disabled.

There is an interesting conceptual problem here. What if a material and substantial duty was not doable by itself? What if a person who could perform a material and substantial duty could perform only that one, and no one would hire anyone who could perform only that duty? Would a person not then be totally disabled, at least as the phrase "total disability" is used in ordinary parlance? The experienced litigator is tempted by the view that

the way these policies are written is a set up for a certain kind of deposition. The lawyer for the insurer should construct a list of as many actions, activities, behaviors, and so forth as he can. He should then depose the applicant for coverage as to what he can and cannot do. Theoretically, if he can find anything that the policyholder-claimant can do, then the insurer wins. The person would virtually have to be a quadriplegic whose brains have been destroyed not to be able to do anything at all, at least if the theory that many courts are using is applied mechanically, i.e., a considerable degree of rigidity is involved in the application of the categories.

Helus was required to describe the duties of his occupation as the present owner of the construction company. He gave a variety of descriptions: supervision, no manual duties, marketing only, management, project management, bidding, and so forth. In essence, the insurance company argued that Helus could do some of these things. Helus argued that his poor performances as a hired employee in the period of time after the failure of his company proved that he couldn't do any of those things.

Several psychiatric reports differed as to Helus' mental condition. Interestingly, in their cross-motions for summary judgment, neither party "addressed which duties should be considered substantial and material" [FN84][FN84] with respect to the occupation of Helus.

Under the circumstances of this case, and on the basis of the diversity of evidence, the court found that there were disputed issues and material fact as to Helus's ability to engage in the "substantial and material duties" of his occupation, and that those differences existed when Equitable cut Helus off from any further coverage. At the same time, the court granted the insurer summary judgment on the issue of bad faith, since the insurer extended Helus's coverage a couple of times and because Helus "failed ... to put forward specific facts showing how the alleged misrepresentation[s by the insurer] impaired his contractual rights. Although the court does not exactly say so, it seems fairly obvious that the insurer was relieved of bad faith claims, at least in part, because Helus was not entirely truthful with the insurance company when discussing what he had been doing since the collapse of his construction company in 1992.

Occupation Typology

The second major issue surrounding the interpretation of the phrase *total disability* arises from the language of the policy itself. Some policies indemnify the policyholders if they are unable to engage in any occupation. Others indemnify policyholders when they are unable to engage in their own occupations. The language of policies sometimes blurs distinctions, but these two phrases-*own occupation* and *any occupation*-are the foci around which insuring agreements revolve. Sometimes courts confuse these different types of policy. [FN85][FN85] Sometimes, policies blur the two distinctions. [FN86][FN86]

Policies which are close to *own occupation* policies sometimes use other language than "own occupation." Sometimes they refer to the policyholders *usual occupation*; and sometimes they refer to the policyholder's *regular occupation*. [FN87][FN87] Sometimes *own occupation* policies talk in terms of *your occupation*. That notion is then sometimes defined as follows:

Your occupation means the occupation (or occupations, if more than one) in which you are regularly engaged at the time you become disabled. If your occupation is limited to a recognized specialty within the scope of your degree and license, we will deem your specialty to be your occupation.

Perhaps a better way to conceptualize the occupational dimension of disability policies is in terms of a spectrum rather than focal points. If so, then the spectrum would run from *own occupation* to *any occupation*, with

regular occupation somewhere in the middle. Along the spectrum there would be all sorts of variations.

Varying language in the definition of *total disability* or in the insuring agreement can have practical implications. Consider, for example, a recent case in which the claimant had two policies. One said that the phrase *total disability* meant that "due to injury or sickness' the insured is not able to perform the *substantial and material* duties of [his] occupation." The other policy stated that *total disability* means that "because of injury or sickness,' the insured is unable 'to perform the *important* duties of [his] occupation.'" [FN88][FN88] The claimant received a jury verdict in his favor with regard to the former policy but the jury resolved the latter coverage against him. [FN89][FN89]

Since the inception of disability policies there have been many controversies over what constitutes a policyholder's *own, usual, your, or regular occupation*. Still, even with the fifty states and a century of jurisprudence, there are not that many cases across the country. [FN90][FN90] The distinction between *own occupation* policies and *any occupation* policies is well-established: "Disability insurance policies generally fall into two classes: occupational insurance, which provides coverage if the insured is unable to pursue the particular occupation in which he was previously engaged; and general insurance, which provides coverage only if the insured is unable to pursue any occupation." [FN91][FN91]

In theory, occupational policies face an anomaly. If a policyholder is insured against being able to perform his regular occupation, but he can perform another one which is more lucrative, if the language of the policy is construed literally, then the carrier must pay the insured even though he is in fact working at a more lucrative occupation. [FN92][FN92] This problem does not arise very often. Nevertheless, many liability policies guard against it with express language. It is obvious why policies would do this. If a policyholder cannot perform the functions of one occupation but can perform the functions of another, in which he will make more money, there is at least a rough-and-ready inconsistency between paying the policyholder for having a disability and the Principle of Indemnity: a deeply-entrenched principle of insurance and insurance law according to which the function of insurance is to compensate for losses not to enrich. (Of course, the inconsistency is only "rough-and-ready" since the indemnity could be for something other than a loss of income. It could be for the loss of the fun and prestige one might have from engaging in one's first-chosen occupation.)

Some disability policies utilize both concepts. Some disability policies insure against both an inability to engage in one's *regular occupation* and an inability to engage in *any occupation*. Some contracts of disability insurance cover a person for a determinate period—say, 2 years—under one concept and then cover her for a later period under the other. [FN93][FN93] The first period involves the insured's *own occupation*, while the second period involves *any occupation*. [FN94][FN94] Other policies have *own occupation* coverage for physical diseases and *any occupation* coverage for mental diseases. [FN95][FN95]

There are a number of controversies about what constitutes a policyholder's being unable to perform his regular occupation. Often, these controversies hinge on policy wording. Sometimes, policies define the concept of total disability in such a way that an insured is disabled if he cannot perform *all* of the functions of his regular occupation. [FN96][FN96] A natural reading of this sort of language is that if there is a significant function which the insured cannot perform, then he is disabled. Sometimes, disability policies appear to suggest that if there is *any* component or function of the insured's regular occupation which he can perform, then he is not totally disabled. Obviously, this difference is of enormous importance. [FN97][FN97] Moreover, for obvious reasons, courts are disinclined to enforce either sort of language literally and strictly. Indeed, the law of some jurisdictions is that "total disability policies should be liberally construed[.]" [FN98][FN98] In general, courts

want to say that a person is totally disabled, even if he can perform some of his customary duties, so long as he cannot perform the really substantial duties of his regular occupation and that the duties he can perform do not constitute a substantial part of significant duties of his occupation. [FN99][FN99]

Sometimes there is a question as to what a person's occupation really is. Consider, for example, the plight of a person who has an active, physically demanding field job. Suppose in Yr-1 the person is unable to continue in that job, but his employer finds a make-shift, "virtually duty-less desk job" for the employee. It would be improper for the disability carrier to describe the latter job as the claimant's occupation.

Sometimes, an occupation has several components. Thus, there are podiatrists who are also actively involved in the management of clinics, and there are dentists who are only marginally involved in management. The occupations in these two cases are quite different, and courts might well resolve issues of disability quite differently. [FN100][FN100]

In general, in an *any occupation* policy, if an insured can perform some work but cannot make a living at it, the insured is entitled to indemnity. [FN101][FN101] Furthermore, in an *any occupation* policy, the policyholder is not required to spend his own resources to get training to engage in a new occupation. [FN102][FN102] Sometimes the idea of *any occupation* is modified. Under one policy, an insured is totally disabled if and only if the claimant is "unable to perform the material duties of any and every gainful occupation or employment for which the person is or becomes reasonably fitted by education, training or experience." [FN103][FN103] Obviously, not just *any* occupation will do. It's got to be an occupation for which the claimant is reasonably fitted. This is broader than the claimant's *regular* occupation-or her *own* occupation. It is narrower, however, than *any* occupation at all. It is also important to note that the claimant must be unable to perform an occupation for which the claimant *can become* reasonably fitted by training. This opens the door to mandatory vocational rehab. Such a requirement may or may not be a good thing, depending on the circumstances.

The wording of Texas policies has, at some times, been extremely interesting. Remember, there are two ideas interacting. One idea pertains to whether the policy is an *own occupation* or a *usual occupation* policy. The other idea pertains to just how much of an occupation one must not be able to perform in order to be disabled. Here is an *own occupation* wording. The policyholder shall suffer from a total disability resulting from an accident when "the insured is wholly and continuously disabling prevented from performing each and every duty pertaining to his occupation[.]" [FN104][FN104] Here is the wording of an *any occupation* policy. The insuring agreement stated that there is coverage for a disability which resulted from an injury which shall "independently of all other causes totally and continuously disable and prevent the insured from performing each and every duty pertaining to any occupation, and shall require the personal care and regular attendance of a legally qualified physician or surgeon." [FN105][FN105] The key here is the words "each and every." Both of these insuring agreements (or precisely-the definitions applicable to the insuring agreements) state or imply that an insured is entitled to disability coverage if and only if the insured is prevented from performing each and every duty of some occupation. It follows that if there is at least one duty of a relevant occupation the insured is not prevented from performing, then he is not disabled. A strict and lateral reading of these contracts would make no sense at all. However, from the point of view of insurance companies, this kind of wording sets up linguistic and logical traps and makes it more likely that the disability insurer will get to a jury and not be poured out on summary judgment. The use of these words makes it perfectly obvious how claimants will be disposed when the time comes.

A Case Illustration

The case of *McPhee v. Paul Revere Life Insurance Company* [FN106][FN106] is a perfect illustration of the battle over the meaning of words in a policy that can occasionally arise. The relevant facts are as follows: In April 1993, McPhee became the chief executive officer of a hurricane shutter manufacturer, under a contract that guaranteed his continued employment until 1999. McPhee's employer purchased a own occupation disability policy for McPhee on October 15, 1993; an additional policy increasing his monthly benefits was purchased in 1994. McPhee acted as CEO for several years despite neck and shoulder injuries from a prior automobile accident which occurred in 1993.

In 1996, McPhee's surgeon "expressed the view that [McPhee] could no longer perform gainful employment due to the aforementioned injuries." McPhee underwent surgery and returned to his job three months later, only to be fired by his employer after ten days. Interestingly enough, McPhee succeeded in winning a suit for wrongful termination on the basis that he was not physically disabled at the time of his firing. For two years, McPhee "stubbornly" continued to seek employment despite the opinion of his psychiatrist "that he could not [work]." After a failed surgery in July 1998, McPhee "accepted the fact that he could not work[,] and subsequently filed a disability claim "listing July 14, 1998 ... as the date his disability began." In the underlying trial, the primary issue addressed was whether McPhee was totally disabled under the terms of his policy. The insurer argued "that because McPhee had not worked for twenty months before making his claim, there was a jury question as to what was his occupation." Moreover, the insurer "suggested that since McPhee was not employed at the time his alleged disability began, McPhee had no determinable occupation for purposes of the disability policies and, therefore, could not prove entitlement to benefits under the policies." The policy contained the following language:

"*Your Occupation*" means the occupation or occupations in which You are regularly engaged at the time Disability begins.

"Total Disability" means that because of Injury or Sickness:

- a. You are unable to perform the important duties of your occupation; and
- b. You are receiving Physician's care.

The jury determined that, under the terms of his policies, McPhee was not totally disabled. The court of appeals reversed, holding that the policy language at issue was ambiguous because there was no express language in the policy defining "regularly engaged" to mean that the insured had to be actively employed. In the court's view, "such an interpretation [requiring active employment as a condition of coverage] would effectively eliminate any coverage and is clearly contrary to any reasonable construction of this disability insurance contract." The trial court's failure to instruct the jury on this point was, according to the court of appeals, misleading and inappropriate.

Schedules

Sometimes, disability policies will specify that some physical injury either conclusively or presumptively constitutes a total and permanent disability. Sometimes, there is a schedule of injuries which conclusively or presumptively constitute such disabilities. Since these schedules are written in usable English, there will be disputes about whether an injury or disability is on the schedule. Schedules are worded so that contrasting categories are black and white. The courts generally refuse to think in binary-"on-off switch" ways- when it comes to

disability schedules. Thus, when loss of sight is scheduled as "entire and irrevocable loss of sight," most courts will not require absolute, complete, or total blindness. The overwhelming majority of courts have held that "a 'loss of sight' insurance provision does not require [literally] total blindness, but rather that the sight remaining be of no practical use; generally, recovery has been permitted if the plaintiff could not distinguish or recognize objects, even if he or she could perceive light and darkness." [FN107][FN107]

When an injury is not on the list, whether it constitutes a total and permanent disability is a question of fact. Reasoning by analogy—a favorite form of legal reasoning—is not a valid form of inference when dealing with scheduled and nonscheduled injuries. Thus, a lawyer may not argue in an appellate court that the policy stipulates that the loss of both legs automatically constitutes a total and permanent disability, such-and-such an injury is just as bad as the loss of both legs; therefore, the actual injury is—as a matter of law, a total and permanent disability. Of course, this form of argumentation is permitted in closing argument.

Sometimes, a "policy schedule" will pertain to how long total disability payments last under a policy at or after a certain age. Thus, the disability policies in the *Knott* case, already discussed, provided that if an insured became totally disabled before the age of sixty-five, the insured would receive disability payments for the length of his life, but if his disability accrued after the age of sixty-five, then he would be entitled to 24 months of payments, at the most. Knott had applied for and received some disability payments during the late 1980s and early 1990s. Insurer refused to pay Knott after 1991. Knott performed some work as a physician from two months after his airplane accident through 1995. In 1995 he turned sixty-five. Several months after his birthday, Knott submitted a claim for total disability. "No new event or accident precipitated the claim." [FN108][FN108] After the 90-day waiting-or, elimination-period was over, the insurer paid Knott benefits under the policy and did so for two years. See § II.F. below. At that point, the insurer took the position that Knott was entitled to no more payments, since his total disability commenced after his 65th birthday. Knott, of course, took the view that his disability commenced before his 65th birthday, and so he was entitled to lifetime benefits. Knott's view was based on the fact that his injury resulted from an airplane accident in 1985. The insurer's position was based on the fact that the series of payments at issue began after the insured's 65th birthday and were hence controlled by the schedule in the policy. He classified the payments it made in the late 80s and early 90s as a mistake and argued its obligation should not be controlled by those payments, especially since they were cut off for some years.

Cause of Disability

Causation is often an issue in some forms of disability policies. In one case an insured argued for coverage on the grounds that he had lost his license as an accountant and could no longer function as such. He alleged that he had lost his license as the result of an illness which had led him into criminal conduct which had resulted in a conviction and the consequent loss of his license. The court held that loss of the policyholder's license was a legal disability and not a factual one. On this ground pertaining to causation, the court denied coverage. [FN109][FN109]

Issues of causation are particularly prominent when a disabling injury must be caused by an accident. This often happens when disability insurance is built into accident policies. [FN110][FN110] Here is an example of such wording:

The loss must result directly and independently of all other causes from accidental bodily injury which occurs while this policy is in force as to the insured[.] [FN111][FN111]

Problems of causation come up in two ways. First, it is sometimes unclear whether there has been an accident. Second, it is unclear whether the accident has caused the disability. These problems will be discussed in order.

What constitutes an accident is a topic which is discussed in all sorts of insurance policies. For example, the concept of *an accident* is crucial to standard general liability policies. There are an enormous number of cases on what constitutes an accident. Many arise under liability policies, but many have arisen under disability policies as well. The two types of cases tend to cite one another.

The question about whether there has been an accident comes up in two ways. One is factual: the issue is whether such-and-such an event actually occurred. The other way is linguistic: the issue is whether-given that an event has occurred-it should be described as an accident. These questions came up in an unusual way recently. A woman who held a disability policy through her employer elected to receive breast augmentation surgery. Some ten years after the surgery, the implants were removed, since it was determined that they had ruptured. The plaintiff alleged that she suffered a disability resulting from the rupture, but she failed to prove a qualifying accident. [FN112][FN112]

Another issue related to causation pertains to whether a disability must be *solely* caused by the qualifying accident or whether the accident must be *a* cause of the disability. [FN113][FN113] Often, such policies say-or nearly say- that the accident must be *the* cause of *the* disability. Insurers interpret the phrase "*the cause*" to mean the *sole* cause. The game then is to try and find some cause other than the accident which contributes in anyway to the disability. Sometimes, insurers argue that the aging process itself becomes- over time-one of the causes of the disability period if that happens this way. The policyholder sustains an injury in Yr-1. He receives disability payments for a decade or so, submits to a medical examination, and the insurance company cuts him off. The insurance company's explanation is that his disability is no longer caused by the original accident but is now caused both by the accident and by his getting old. The courts are not particularly sympathetic to this argument.

Issues of causation are also important when a disability policy has one set of benefits available for one cause and one set of benefits available for another. In those kinds of policies, it is crucial to determine what was the cause of the disability. In one very interesting case, a physician had disability coverage which had a much longer benefit period for disabilities caused by accidents than for disabilities caused by sicknesses. There was no question that the doctor suffered from a sickness. After quite a lengthy interval, the doctor tried to obtain coverage on the grounds that his disability was caused by an accident. He was unsuccessful for reasons to be discussed later. [FN114][FN114]

The point here, however, is that causation is an issue whenever there are two different sets of benefits. Thus, if a disability policy provides one set of benefits for disabilities caused by maladies with objective symptoms and another set of benefits formalities caused by maladies with only subjective-or self-reported symptoms, a determination of causation may be extremely important. [FN115][FN115]

When one reads a spread of disability insurance cases, one has the feeling that insurance companies get tired of paying long-term disability payments after a decade or two and begin to look for ways to get people off their payment roll- we have even heard some adjusters "slip" and say *off the dole*. Sometimes one has the feelings that insurance company officials are trying to guard their treasure against a hoard of greedy mongerers. Perhaps this could be called the "Guardian Mentality." [FN116][FN116] One also has the feeling that judges have also formed this impression and tend to go out of their way to protect insureds from the temptations to which insurers

are subject. After all, insurers are financial institutions. (This is an impression only. We have not seen statistics probative of this matter. On the other hand, in a recent case, evidence was produced that when one disability insured utilized another to administer a certain range of claims and that the two insureds had entered into some sort of an incentive agreement, pursuant to which an insurer would receive bonuses to the extent of terminated claims. [FN117][FN117])

The interaction of *causation* arguments and insurer temptations is especially important that it might be helpful to take a look at a case. This is excellent ground for the creation of bad faith problems. Consider, for example, the following problem. Suppose a person has a disability policy which restricts to accidents, and he has a permanent vegetative state following problematic heart surgery. Is this the result of accident or disease? [FN118][FN118] Something close to this issue has come up recently, so we discuss the issue in the bad faith section below, § IX.B.2. We will also discuss issues of causation in the Exclusion section, § VI.

Policy Period

In the context of disability insurance, the phrase "policy period" has two meanings. The first meaning is that period of time during which the policyholder has insurance coverage, i.e., that time interval during which an insurer will become obligated to initiate disability payments, if the insured becomes disabled. Often the purchase of disability insurance requires a medical examination. Thus, often, insurers are not able to deny coverage on the basis of pre-existing conditions. The courts reason that if the insurer had wanted to exclude some pre-existing condition, since it had a medical examination, it should have done so explicitly. [FN119][FN119] Of course, this is not always true. Moreover, some disability policies—particularly disability policies which restrict coverage to disabilities caused by accidents—require that not only the disability arise during the policy period but that it result from an accident which also occurs in the policy period.

The second meaning of the phrase "policy period" is that interval during which the insurance carrier which is obligated to make disability payments must actually make them. This interval is often called the benefit period. Of course, this second meaning of "policy period" does not apply to disability policies which obligate the insurer to make a lump sum payment. It does, however, apply to disability insurers which are obligated to make periodic payments. That interval is usually specified in one of three ways. First, it may be "for life." If the payment interval is for life, often, the disability carrier is obligated to make some sort of lump sum payment if the policyholder dies young. This is not always true, however. Second, the interval is often fixed at retirement age. Sometimes that is sixty; sometimes it is sixty-five; sometimes it is seventy; and occasionally it's some other age. Third, the interval during which the disability carrier must make payments may, sometimes, be a shorter interval fixed at a number of years or a number of months.

Sometimes, the different intervals are mixed. Thus, it is currently fashionable to have a toretirement-age interval for physical disabilities, and much shorter intervals for disabilities caused by mental disorders, alcoholism, or drug addiction. Those shorter intervals can be even as short as one-year.

Waiting Period/Elimination Period

Generally speaking, the period of time during which the disability carrier must make payments does not begin immediately upon a disabling injury. Often, the insured must wait a period of time before receiving any payments. In the jargon of the trade, this interval is called the *elimination period*. (The elimination period is also

sometimes, less misleadingly, called the *waiting period*.) Theoretically, this interval could be as short or as long as the parties negotiate. However, there are standard intervals. They are not usually shorter than thirty days, and they are not longer than a year, although we have seen one interval of 720 days. Six months is not unusual.

The elimination period functions like a deductible. It is designed to reduce the moral hazard and to reduce the probability of adverse selection. [FN120][FN120] The idea is that malingerers and cheats seldom have six months worth of assets they are willing to deplete sitting in the bank waiting for this kind of gamble. The words in the phrase *elimination period* suggest the insurance purposes to be served by this interval. At the same time, it seems to me that the phrase *elimination period* is unfortunate for insurers from a rhetorical standpoint. Moreover, the phrase *waiting period* is actually more perspicuous.

One interesting feature of elimination periods is that disability policies, quite frequently, refund premiums paid to cover elimination periods. Thus, although the insurance company does not begin the payment of benefits until the end of an elimination period, it might not charge for the insurance during the elimination period, and if it has collected premiums for that interval already, it may refund them. Of course, disability insurance contracts routinely waive the payment of premiums during the benefit period. [FN121][FN121]

Disability policies frequently provide that elimination periods are waived for recurrent disabilities. The policies vary on the period of time within which the disability must recur before the elimination period is waived. Six months is not unusual.

CANCELLATION, PUBLIC POLICY AND SIGNIFICANT CHANGES

In this section, we discuss the cancellation of disability policies, public policy regarding the avoidance of disability insurance, rate increases over time, and changes in disability insurance over time. It should be kept in mind that disability policies frequently last a long time, both before a disability comes, if one does, and thereafter, as well.

Cancellation

Obviously, disability insurance policies are not subject to cancellation during the interval during which a disability insurer is obligated to make payments. During the "policy period"-the interval during which the disability carrier may become liable for disabilities-sometimes policies are cancelable; sometimes they are not. [FN122][FN122] Better policies are not subject to cancellation. In general, group policies are not subject to cancellation for individuals.

First rate disability policies are non-cancelable. There is a very good reason why they should not be subject to cancellation. It becomes harder and harder for people to get first-class disability insurance as they get older, and that insurance becomes more and more expensive. Thus, disability insurance is similar to some life insurance in the sense that the younger you are when you get it, the cheaper it is.

Of course, if a policy is cancelable, an insurer can waive the right to cancel, and it can be estopped from asserting the right. [FN123][FN123] Whether waiver or estoppel apply as a factual matter and contract specific; waiver and estoppel do not work with respect to disability policies in the same way they work with respect to liability policies, for obvious reasons. Counsel for a policyholder-plaintiff would do well to remember that waiver and estoppel are affirmative defenses and therefore need to be pleaded. [FN124][FN124]

Sometimes, the jargon of the trade equates non-cancelability with an agreement not raise premiums. When non-cancelability is used in this sense, this sort of insurance is difficult to get.

One near-equivalent of non-cancelability is guaranteed renewability until a certain age, say, 65. While this notion is not technically identical to non-cancelability, they are frequently identical from a practical point of view. Sometimes, guaranteed renewability is equated to non-cancelability without an agreement not raise premiums.

Public Policy Voidability

Sometimes, disability insurance policies are unenforceable as a matter of law because they are so profoundly contrary to public policy. The case of *Neiman v. Provident Life & Accident Insurance Company*, [FN125][FN125] nicely illustrates this point.

Neiman had been found guilty of illegally practicing law. [FN126][FN126] Later Neiman sought disability coverage. Here is what the trial court said:

Because the Florida Supreme Court was so conclusive in its decision, this court [namely, the United States District Court for the Southern District of Florida] will not allow a jury to draw a line between where Neiman's paralegal duties ended and his illegal practice began. [¶] Allowing a jury to draw that fictional line would obfuscate the force of the Florida Supreme Court's decision. While neither the Florida Supreme Court nor the referee enjoined Neiman from engaging in paralegal tasks, neither characterized Neiman's work as that of a paralegal." [FN127][FN127]

Thereafter, he sought disability benefits to compensate him for his loss of income which derive apparently did *not* from his illegal activities. Neiman purchased disability insurance in 1989. In 2000, he submitted a claim for disability benefits spanning from 1999 through the end of 2001. He alleged that he suffered from "Bipolarity II" and that this disorder prevented him from working as a paralegal during the time he sought benefits. The disability policy listed his income in 1989 as \$130,000 and stated that his occupation was paralegal and legal investigator. The fact of the matter was that Neiman was illegally practicing law. He was prosecuted for this in the mid-1990s. One of the criminal charges against him alleged that he "committed insurance fraud regarding his collecting two months of disability income benefits from Provident. Neiman entered a plea pursuant to a bargain without actually admitting guilt. The court placed Neiman on probation and ordered him to pay restitution by mid-1996, Provident sued him to rescind the disability policy. That lawsuit was dismissed in early 1997, because "Provident did not meet the contractual provisions to rescind the policy. [¶] The policy remained in effect and on January 26, 2000, Neiman submitted a claim to Provident for the recovery of disability benefits[.]" [FN128][FN128] Neiman provided Provident with a CLAIMANT OCCUPATION DESCRIPTION. In that document he described his occupation during the preceding 10 years as a "senior paralegal."

In effect, there were two issues before the court. First, Pat Neiman lied to Provident about what his occupation was when he said he was a paralegal. The second question is, Should someone like Neiman who broke the law right and left be able to recover disability benefits under an insurance policy when he can't work because of his immoral and unlawful conduct? The district court spent most of its time focusing on the relationship between contracts and public policy. "To be void as a matter of public policy[, a] contract must have a bad tendency to contravene the accepted interests of society." [FN129][FN129] Contracts which violate public policy are not enforceable in a variety of states. In general, courts will not enforce illegal contracts, and contracts which fly in the face of established public policy are in some sense illegal. "To determine whether a contract violates public

policy courts must look to established law primarily to statutes and secondarily to decisions of the courts.” [FN130][FN130]

Unquestionably, if an assassin, a thief, or a prostitute could no longer perform because of her occupation, that person would not be entitled to disability insurance. For roughly the same reasons, a person like Neiman cannot obtain disability insurance. To enforce such a contract would “validate a condition of coverage founded in illegality. The premise for furnishing coverage-Neiman's inability to function as an unlicensed lawyer-if founded in criminal conduct is expressly prohibited by statute.” [FN131][FN131] There is a problem, in the *Neiman* case. To be sure, Neiman was convicted of a crime. If, however, he subsequently actually became a paralegal, but could no longer work as a paralegal because of his bipolar disorder, then it is difficult to see what the current violation of public policy was. If he was currently working as a legal investigator, as well as a paralegal, then it is hard to see how public policy was being violated, although-to be sure-Neiman had violated public policy in the past. Perhaps there were continuing and current violations of public policy. This is not clear from the text of the case. Suppose he was not, at the time he sought disability coverage, violating public policy, violating statutes, or doing profoundly immoral things. At that point, as a matter of public policy, it is no longer clear why he should be ineligible for coverage. Perhaps the fact that he lied to the insurer and obtained a policy of insurance he never should have obtained might be the real violation of public policy. Still, this would not be rescission for fraud, it seems to us, as opposed unenforceability for violating public policy. [FN132][FN132]

Not every application to a disability policy of a public policy, where that application is injurious to (or, at least, inconsistent with the interests of) the policyholder will be treated as a voiding of the policy. Sometimes, it is treated as an exclusion. See § VI.B. below.

Rate Increases

Sometimes, disability policies are self-regulating with respect to premium increases. Occasionally, a disability policy prohibits rate increases by its terms. In inflationary times, this is a bad idea, both from the point of view of profitability and solvency. Insureds need to be cautious about purchasing such policies, especially if the company is not a large and well-known one. On the other hand, if an insurer can raise premiums willy-nilly, that is tantamount to cancelability. Policies often self-regulate the extent to which the insurer can increase premiums. For example, increases may be tied to the rate of inflation. It may be limited by percentages per year. There are many options.

Changes in Policy Language

Occasionally, in reviewing cases, one sees that older disability policies have been changed in various ways over the years by the insurer. This happened, for example, in the *Knott* case. The most frequent place it appears to happen is in the definition of *total disability*. It is unclear to us how this is justified. We have not found a disability policy in which there is a provision explicitly authorizing the insurer to alter the policy. So! How is this done?

It looks like there are four bases for this kind of action. First, the insurer may offer the insured a change in the policy, and part of the offer may be a change in definitions. This could be an offer to increase benefits. It could be an offer to decrease premiums. It could be an offer to change claims process. And so forth.

Second, some disability policies, although noncancellable, technically last only for a year and then are renewable once a year during a given period of time—often a month. Conceivably, the company might be changing policy provisions as conditions for renewal. Probably, for a noncancellable policy, such a position is questionable, but no one appears to have ever questioned it.

Third, a company might simply make a change, except new premiums, and hope for no opposition. Of course, if the change is not something that really matters to anybody, then it is unlikely that there will be any hell raised about it, even if there is litigation.

Fourth, the company might simply make a change and ask the insured to consent to it. The insured might consent without really thinking about it. (Perhaps the insurer would say the change was automatic without some explicit indication from the insured. We have not seen policy authorization for this more). This is especially true if the change appears to be harmless.

Keep in mind that these discussions are to some degree speculative, since we have not located either contractual authorization or case authority.

CONDITIONS

The obligations of disability insurers are, like those of virtually all other insurers, subject to a series of conditions. Some of these are conditions precedent. Some prominent conditions will be discussed here, including notice, proof of loss, physician's care, independent medical examination, and cooperation.

Notice

As with most insurance, policyholders are required to give the insurer relatively prompt notice of a loss-producing event. Thus, policyholders are required to give insurers prompt notice of disabling illnesses, injuries, accidents, and the like. [FN133][FN133] An insurer can legitimately refuse to pay under a contract of disability insurance, if it receives late notice. In some jurisdictions, carriers may use the defense of late notice only if they have been prejudiced by the delay. [FN134][FN134] In still other jurisdictions they are permitted to refuse to pay in the case of any late notice. In other jurisdictions, late notice can be excused if there is a sensible reason explaining, and there was no prejudice. Not every excuse is valid of course, in one case, a radiologist suggested that she did not give prompt notice because her physician diagnosed her as having Lyme's disease rather than multiple sclerosis. The court indicated that she should have given notice on the basis of the misdiagnosis. [FN135][FN135] New York state is like that. [FN136][FN136]

Obviously, what counts as late notice in a disability situation is somewhat different than dealing with a property policy or with a liability policy, but the general theory is still the same. For example, it is quite common for policies to require that insurers see written notice of a claim X days after a covered loss begins, or as soon as reasonably possible thereafter. (Often, X equals 20. [FN137][FN137]) Obviously, if an insured doesn't know about the commencement of a covered loss, she does not have a duty to give notice until she knows about it. As a general rule, however, one knows when one has been injured or when one is ill. As a matter of law, if someone becomes disabled as the result of an accident about which he knows, a ten-year delay in reporting the claim constitutes late notice as a matter of law. [FN138][FN138] When notice is neither prompt nor late as a matter of law, both timeliness and prejudice are jury issues. [FN139][FN139]

It has long been required in liability insurance that if a carrier intends to defend its insured, but has doubts about coverage, it is obligated to obtain a non-waiver agreement or issue a reservation of rights letter. The reason for this requirement is to require that the insured knew where he stood with the insurer if the insurer was to control the insured's defense. [FN140][FN140] The issuance of reservation of rights letters is not nearly so necessary in first-party policies as it is with liability policies. In fact it is usually not necessary at all. Still, however, it is often done. Sending reservations in the wrong circumstances probably doesn't hurt anything, and it may help to keep the insured focused. As with other first-party policies, it is done with disability policies, at least some of the time. [FN141][FN141] The widespread use of unnecessary reservation of rights letters does carry one danger: sometimes, the common law converts into a legal duty what has been a custom. That would probably not be a good thing from the point of view of insurers, although it would probably be a good thing from the point of view of insureds.

Proof of Loss

In addition to whatever prompt notice the contract may require, disability insurance contracts require that the insured submit a satisfactory proof of loss. Usually, the disability contracts specify what must be in the proof of loss. Additional specifications are found in whatever response the insurer sends, or has sent, in response to the original notice. It is extremely important that the insured submit the proof of loss forms promptly. [FN142][FN142] These may include some sort of an application, a narrative of the problem, medical records, police records (if they exist), accident reports, personnel records, and so forth. More will be said of this later.

One of the reasons why it is important to comply with a proof of loss requirement at an early date is because the elimination period (a/k/a waiting period) usually runs from the date of the submission or satisfactory proof of loss, and not from the date of the injury. [FN143][FN143]

Physician's Care

As already discussed, as a general rule, in order to qualify for benefits, an insured must not only be disabled, in the common sense meaning of that term, she must be under the care of a physician, and sometimes she must accept appropriate medical treatment as it becomes available or is offered. [FN144][FN144] As indicated, this is often a part of the definition of *total disability*. This is a clever way to handle this requirement, since making it part of a definition of a term which is utilized in an insuring agreement, makes proof of medical treatment part of the insured's case and chief. However, the requirement is much more like a condition upon coverage. In all likelihood, when medical treatment requirements or disability insurance are conceived as conditions, the burden of proof would be on the insurer to show that they were not met. In the right case, counsel for a policyholder might well wish to argue this point. [FN145][FN145]

Independent Medical Examination

Often, disability policies require that insureds undergo independent medical examinations by physicians of the insurer's choosing. Sometimes IME obligations are conditions precedent upon initiating payments; sometimes they are conditions precedent upon the continuation of payments. (The latter type of condition may also be conceptualized as a condition concurrent.) Over the period of a long disability, an insurer may ask for several IMEs. IME clauses are frequently formulated in such a way that the insurer may ask for reasonable IMEs. Reas-

onableness is to be measured in terms of frequency, timing, scope, and the physicians employed. Generally speaking, the insurer's rights to require the insurer to submit to an IME is limited by the reasonableness of the request under the circumstances." [FN146][FN146] In most jurisdictions, the burden would be on the insurer to demonstrate the reasonableness of its request, and whether the requests were reasonable would be an issue for the jury. [FN147][FN147]

Cooperation

The initial adjustment of disability insurance contracts can be a onerous matter. The subsequent administration of the contracts is somewhat less so, but it too can be complicated. Moreover, all contract administration after the initial acknowledgment of coverage is subject to termination if the health and abilities of the insured improve. Virtually all insurance policies require insureds to cooperate with reasonable requests from insurers. Any other idea would be ridiculous and counterproductive. Disability insurance policies are no exception. [FN148][FN148] The cooperation clauses are usually conditions precedent or concurrent. Either way they are important. [FN149][FN149]

In some policies, a claimant is totally disabled if and only if she is unable to perform the material duties of any gainful employment for which she can become reasonably fitted by education or training. [FN150][FN150] This message opens the door to mandatory vocational rehabilitation. Obviously, the disability carrier would have to pay for this training. At the same time, the insured would have to cooperate.

INCONTESTABILITIES

The idea of *contestability* refers to what an insurer can contest. The contest may be by way of rescission or it may be by way of claim denial. Two principal forms of contest pertain to statements in the application and pre-existing conditions. The former involves rescission, policy avoidance, while the latter involves claim denial.

Contestability for False Statements

In general, insurance policies may be rescinded if the policyholder commits fraud in the application. [FN151][FN151] This is, of course, true for disability policies as well as others. Any insurance policies can be rescinded for false statements made in the application, even if they were not fraudulent. This second right-the right to rescind for false but non-fraudulent statements-is limited in life insurance and disability insurance. In both of these areas, there is an interval of time after which the insurer may not void a policy for non-fraudulent false statements in the application. That date is usually expressly specified in the contract of insurance. Before that date, the insurer may contest the validity of the policy; after that date, the policy becomes incontestable on the basis of false statements in the application which were not made with knowing intent. [FN152][FN152]

Often, contestability periods for false statements in the application are controlled by statute. Occasionally, those statutes are interpreted in ways which are very favorable to insureds. In New York, for example, there is a statutory requirement that health and disability policies contain clauses rendering a policy incontestable, except for fraud, after two years. The question is, of course, what is a contest? Significant New York authority holds that an insurer has contested a policy only if it has filed a lawsuit. Thus, the sending of a letter together with a check purporting to rescind a policy is insufficient. [FN153][FN153]

The Texas version of this rule is to be found at article 3.70-3(A)(1)(2)(a). It requires that all accident and sickness policies contain the following language:

After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant on the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such 2-year period.

Many states require this language, or something like it. Notice that if the disability begins before the close of the 2-year period, then the insurance company may have a substantial amount of time in which to rescind.

Many insurance policies require that the answers given by the insured on her application be true on a subsequent date, such as the date the policy is delivered, the date the first premium is paid, or something of the sort. Many disability policies contain provisions to this effect. Probably, incontestability clauses, and the statutes which regulate them, apply to non-revisions, or the lack of updates, just as they apply to the original answers. [FN154][FN154]

Lawyers need to keep in mind that policies are read as a whole. This means that various rights of policies will interact with each other. Thus, incontestability provision in a policy may interact with provisions pertaining to reinstatement, and both together may interact with issues of favor and estoppel. [FN155][FN155]

Contestability for Pre-Existing Conditions

Sometimes, policies authorize coverage denials on the grounds of pre-existing conditions only for a certain interval. After that, the insurer may not contest a claim on the grounds of a pre-existing condition. Extensive, standardized pre-existing condition clauses are less likely when the insurer requires a medical examination before issuing coverage.

The Texas version of this rule is to be found at article 3.70-3(A)(1)(b), and it states as follows:

No claim for loss or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from the coverage by name or specific description effective on the date of the loss had existed prior to the effective date of coverage of this policy.

Many states require this language, or something like it. Texas courts have no hesitancy whatever in applying this statute. [FN156][FN156]

In one very interesting case, the issue was how does one measure the period of contestability? A policyholder applied for supplementary disability insurance. She knew she had a serious medical problem, so she applied for supplemental benefits. She properly disclosed her prior medical history. The policy contained an exclusion for pre-existing conditions. Complications of the policyholder's maladies fell within the policies definition of preexisting condition. The policy contained an exception, however. For "total disability" which begins more than twelve months after the effective date of the policy, the pre-existing exclusion does not apply.

Two weeks short of a year from the day she purchased the policy, the policyholder became unable to work. Nevertheless, she was kept on the payroll because she had sick leave and because a number of her co-workers donated their sick leave to her. "If her total disability is viewed as beginning when she left the payroll, [the poli-

cyholder] is entitled to receive the benefits from the policy. If her total disability is viewed as beginning on her last day able to work, she is not entitled to receive any benefits due to the pre-existing condition exclusion in her policy." [FN157][FN157] The court held that the policy was unambiguous and that the period of disability was measured from the last working day not the last day upon which she was paid. [FN158][FN158] Probably, any other result would be inconsistent with the necessity of avoiding imprudent moral hazards and unnecessary adverse selection.

Not every case has been quite so obvious or simply decided. In *Massachusetts Casualty Insurance Company v. Forman*, [FN159][FN159] the disability policy contained an incontestability clause, as they all do. One section of the uncontestability clause contained language identical to Article 3.70-3(A)(1)(b), which was required by a Florida statute. [FN160][FN160]

Some date details are important here. Forman applied for disability insurance in October 1969. He had been hospitalized in September and November of 1968. He was apparently diagnosed as having diabetes in December 1968. Forman's application for disability insurance contained "numerous and egregious false statements concerning prior illness, treatment and hospitalization, including specific denials that the applicant had ever had diabetes." [FN161][FN161] The policy was issued on November 2, 1969. On June 24, 1971, Forman filed a proof of loss for a disability based upon diabetes. He stated that it had been diagnosed a year earlier. On November 16, 1971, the insurer ceased payments. Obviously, this refusal to pay further came outside the two-year testability period.

Significantly, however, the insurance policy insured only against disabilities resulting from a "Sickness which first manifest itself during the term of this policy." [FN162][FN162] As a consequence, the court concluded that the insurer could not rescind or cancel the policy, one of the things it tried to do, but was permitted to deny coverage. To be sure, the insurer could not deny coverage because a covered illness *existed* prior to the commencement of the policy, if no claim was made for two years after the policy began. However, if the disability resulted from a sickness which *manifested* itself prior to the beginning of the policy, then it did not fall within the insuring agreement at all, since the insuring agreement worked only against disabilities caused by sicknesses which *first manifested themselves* during the terms of the policy. "[A]n incontestability clause in a disability policy does not deprive the insured from defending on the ground that the particular disability was never within the policy coverage." [FN163][FN163] This is true especially when the purpose of incontestability clauses is understood. Their purpose is to safeguard insurance from "excessive litigation many years after a policy has already been in force and assure [insureds] security in financial planning for [their] family, while providing ... insurer[s] a reasonable opportunity to investigate." [FN164][FN164] The Fifth Circuit panel cited a substantial amount of authority for its view, including both treatises and cases, and is placed itself firmly in orthodox and traditional authority. [FN165][FN165] Interestingly, this tradition of cases has had substantial impact on the relationship between disability carriers and brokers, at least in Montana. [FN166][FN166]

EXCLUSIONS

There are two types of exclusions. There are explicit ones to be found in the policy. Sometimes these are in the main body of the policy; sometimes they are in endorsements. Second, there are exclusions which are generated by public policy.

Specific Exclusions

Unlike property and liability insurance policies disability policies do not, as a matter of routine, contain long lists of exclusions. In this regard, disability policies more resemble life insurance and some health insurance contracts.

Of course, as we have already seen, some of the definitions, and the wording of some insurance agreements perform exclusionary functions. So do some of the conditions.

Still, exclusions-classically concerned-are to be found in policies, especially group policies. One policy "exclude[d] on coverage any disability 'arises out of, relates to, is caused by or results from ... emotional or psychiatric illness or disorder of any type....'" [FN167][FN167] The use of this type of exclusion was declined. Moreover, often, temporal limitations on the benefits period for some types of disability are formulated as exclusions. Thus, there is now often a 2-year maximum benefits period for disabilities caused by mental or nervous disorders. This too is less common now than formerly.

Many disability policies exclude coverage for disabilities caused by war or acts of war, whether declared or undeclared. This raises an interesting question as to the extent to which disabilities following 9/11 have met any resistance from insurers. (There do not appear to have been enormous disability claims submitted to private insurers outside workers' compensation, at least based upon news reports.) Some policies exclude disabilities resulting from the suspension, revocation, or surrender of professional licenses, where a professional license is required to practice a given occupation. Sometimes, disability resulting from normal pregnancies are excluded, although abnormalities in pregnancy, when they are classifiable as a sickness, and cause a disability, are usually covered.

Sometimes, disabilities resulting from the commission or attempts to commit a crime are expressly excluded. Often, policies exclude coverage for periods of time during a disability when the policyholder is incarcerated. Sometimes, they are not excluded, but public policy occasionally supports their refusal or coverage.

Disabilities resulting from intentionally self-inflicted injuries are often not covered as a result of express exclusion. One wonders what would happen if there was such an exclusion present, someone intended to kill themselves, but instead merely injured themselves. Many policies exclude merely attempted suicide. Lots of policies that exclude attempted suicide do so whether the policyholder is sane or insane.

Often, exclusionary sections include language that there may be other exclusions to be found in endorsements. Sometimes, exclusionary clauses eliminate benefits, at least for long intervals of time, when the disability is caused outside the United States. Some policies impose a relatively short maximum benefits-often one year-for disabilities resulting from alcohol or drug abuse.

Disability insurers can also exclude, on an individual basis, disabilities resulting from a specified group of maladies, e.g., AIDS. This is one way to handle pre-existing conditions. Of course some policies exclude some preexisting conditions in their forms. [FN168][FN168]

Pre-existing conditions present special problems. This can be observed in the *Fought v. UNUM Life Insurance Company of America*, [FN169][FN169] which concerned principally a matter of pre-existing conditions. In that case, the policy said "Your plan does not cover any disabilities caused by, contributed to by, or resulting from your pre-existing condition." The policy did not define some of the key terms in this definition, such as "caused by," "contributed to by," or "resulting from." We are always wondering how to think about the difference among these various concepts: what is the difference between X being caused by Y , and X resulting from Y ,

for example. The policy does, however, define *pre-existing condition*. It does so this way: A pre-existing condition is one for which the policyholder has "received medical treatment, consultation, care or services ... in the last 3 months just prior to [the] effective date of [the policyholder's] coverage," or where the policyholder has "had symptoms for which an ordinarily prudent person would have consulted a healthcare provider in the three months just prior to [the policyholder's] effective date of coverage," and "the disability begins in the first 12 months after [the policyholder's] effective date of coverage." Notice that pre-existing conditions are for disabilities which begin shortly after coverage and which have occurred shortly before coverage began.

In the *Fought* case, the policy began on June 1, 1998. Before she enrolled in the plan, Fought was diagnosed and treated for coronary artery disease. Fought underwent angioplasty in August of 1998. The diagnosis of coronary artery disease occurred shortly before coverage began. In March 1999, Fought elected to have coronary artery revascularization surgery. She experienced complications resulting from a severe staph infection. Consequently, she had a large number of operations for related care. UNUM denied her long-term disability benefits after she applied for them. It concluded that the staph infection was the result of the cardiac surgery. The cardiac condition, of course, was caused by, contributed to by, or resulted from a pre-existing condition as defined in the policy.

A federal magistrate granted UNUM summary judgment. The Tenth Circuit reversed upon the grounds that UNUM suffered from a conflict of interest since it both administered claims and was the payer of those claims. (UNUM had admitted this before the magistrate below, but the magistrate had denied Fought any discovery on the point.) Since it had a conflict of interest, its denial of the claim was subject to a higher standard of review than if it had no such conflict. This rule is a product of ERISA-based law.

In addition, the Tenth Circuit panel reinterpreted the pre-existing condition exclusion. According to the panel, for the exclusion to apply, the disabling condition must be attributable to the pre-existing condition both substantially and directly. If so, the pre-existing condition exclusion was not satisfied. Fought's staph infection was both separate and distinct from the pre-existing condition. It was not a manifestation of the underlying coronary disease. Most of Fought's medical conditions, said the panel, were caused by the surgery. The infection, was the debilitating condition, and it came from an unknown origin. [FN170][FN170]

Another case, *Corrington v. Equitable Life Assurance Society of the United States*, [FN171][FN171] offers a few interesting observations regarding this issue. The plaintiff was an attorney who had suffered from manic depression and bipolar disorder for some years before applying for a disability policy. Naturally, Corrington failed to disclose his condition—as well as the three hospitalizations which resulted from his illness—on his insurance application. Five years after he purchased the policy, Corrington submitted a claim for disability benefits claiming an inability to work due to his mental illness. The insurer paid benefits for six years. It subsequently denied the continuation of benefits based on a conversation with Corrington's treating physician, "and a finding that after he applied for total disability benefits he had filed fifteen lawsuits" Since the insurer had been paying benefits for six years, any claim for rescission of the policy based on grounds of fraud with regards to the false information provided on the application was not an option. Instead, the insurer argued that Corrington's claim was "barred by a term of the Policy that provides coverage only for a disability that is first diagnosed or treated while the policy is in force." Corrington countered with two arguments in support of coverage. First, he argued that the incontestability clause in the policy prevented the insurer from denying coverage. Second, he asserted a waiver argument, which for purposes of this paper we need not address.

Three policy provisions became the focal point of the court's analysis: 1. The policy's definition of

"sickness" (defined as "your sickness or disease which is first diagnosed or treated while this policy is in force."); 2. The Pre-Existing Conditions Exclusion; and 3. the Incontestability clause. Notably, the preexisting conditions exclusion reads, in part, "[t]his [exclusion] is subject to the second paragraph of Incontestability [.]". The aforementioned paragraph reads as follows:

No claim for loss incurred or disability that starts after two years from the Effective Date will be reduced or denied on the grounds that a sickness or physical condition existed prior to the Effective Date. This will not apply if such sickness or condition was excluded from coverage by name or specific description on the date of loss.

The court agrees with the insurer's argument for two reasons. First, it notes that "an incontestability clause goes only to the validity of the policy without affecting its scope, thus denying Corrington's argument-which the court characterizes as an attempt "to use the incontestability clause to expand the coverage of the policy." Second, the court distinguishes Corrington's condition, a sickness "that was *diagnosed* and *treated* prior to the issuance of the Policy[.]" and an untreated or undiagnosed preexisting condition, which would have arguably been covered. The court opines that the second paragraph of the Incontestability clause "merely emphasizes [this distinction]."

Public Policy Exclusions

Sometimes, exclusions for insurance contracts are generated by public policy. A typical example of this resemble the *Neiman* case somewhat. In *Massachusetts Mutual Life Insurance Company v. Woodall*, [FN172][FN172] the issue was whether a former lawyer qualified for disability insurance. It looks like Woodall engaged in prolonged misconduct, got himself disbarred, became extremely depressed, and then asked for disability insurance. It looks like Woodall's last sin was to charge an "obscene legal fee to an elderly gentlemen who was left to 'die comatose and in poverty,'" by his misbehaving lawyer. [FN173][FN173] Apparently, the lawyer "stipulated that he grew depressed upon being confronted with the consequences of his own grievous wrongdoing-consequences which ultimately led to his flight from Georgia and disbarment[.]" [FN174][FN174]

The court basically described the argument as Mass-Mut as asking the court "to read a public-policy exclusion into the policy 'as a matter of general insurance law and public policy.'" [FN175][FN175] The court did precisely this, even though the case was a first impression in Georgia. [FN176][FN176] Judge Edenfield describes the insured, former lawyer, as follows:

Like the defendant who kills his parents and then pleads for mercy because he's an orphan (perhaps the most fitting example of "hutzpa"), there is something inherently disturbing about a man who commits a grievous wrong, unquestionably becomes "depressed" when confronted and punished over it, and then demands that his disability insurer pay him for a disabling "depression" as documented by his own psychiatrists.... [¶] One would think that a disability policy would explicitly include a "hutzpa" exclusion of some sort. On the other hand, policy exclusion pages would be longer than policies themselves if courts required insurers to anticipate and expressly exclude every conceivable way that an insured can engage in wrongdoing and benefit from it.... [Besides it] has long been set a law, for example, that no one may benefit from his own wrongdoing.

On this basis, on the basis of discussions of cases, and on the basis of a brilliant and engaging judge-devised hypothetical, the court excused Mass-Mut from paying Woodard any further benefits. Interestingly, it did not permit the insured to recover money it had already paid and did not provide Woodard with any benefits or

premium-waiver provisions.

ENDORSEMENTS

Endorsements are additions to standard policies which somehow modify the coverage. They might expand it. They might contract it. They might redirect it. They might include exclusions. Endorsements may also change the procedures by which claims are made. The exclusion of named preexisting conditions would be done by manuscript (i.e., non-form, typed out, even handwritten, and perhaps negotiated) endorsements.

In the disability insurance industry, endorsements are frequently called *riders*. Of course, almost anything upon which parties to the insurance agree can be included as a rider. Nevertheless, there are a number of standard ones. These include cost of living adjustments, which are standardly referred to by the acronym "COLA." Another rider provides for increase in benefits as income would otherwise have increased. Such a rider might be helpful for a youngish doctor or lawyer who has just made partner, for example, and is regarded as having a brilliant future (of course, these endorsements can be troublesome. Consider, for example, a stockbroker who works on commissions.) Another related type of rider simply increases the amount of the benefits over a period of time without reference to whether the insured's income in fact would have risen or not.

One extremely interesting rider provides that an insured can receive a refund of premium if the insured goes for a certain period of time without a disability. Thus, for example, an insured might be entitled to a return of premiums for seven years, if she goes without a disability for ten years. This option, of course, is extremely expensive. Some analysts recommend against this option on the grounds that it would probably be more profitable to invest the added premium. [FN177][FN177]

Such riders are frequently subject to various conditions precedent. For example, it must be purchased before a certain date. They are also sometimes subject to different elimination periods than the underlying policy. Another significant rider guarantees that additional disability insurance can be purchased during the life of the policy, so long as the disability provisions have not already been triggered.

CONCLUSION

The goal of this paper has been to summarize the structure and evolution of disability insurance policies. It is focused on recent times, although not exclusively. It largely ignores the ups-and-downs, together with the ins-and-outs of ERISA, except to the extent that it is derivative upon common law insurance principles.

Part II of this paper will be published in the next issue of *Insurance Litigation Reporter*. Part II will to some length to describe prevailing adjustment practice in the disability insurance arena. energetic, even if there is some stumbling or blundering along.

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[FN1]. The phrase "disability insurance" is used to cover private insurance for those who cannot work but who had been able to work. It is not generally used for the social insurance of those who have had lifelong disabilities. It has nothing to do with the Americans with Disabilities Act. 42 U.S.C. §§ 12101-12213 (2000), which was originally passed in 1990 and which has been a huge source of progress and controversy ever since. See Samuel R. Bagenstos, *The Future of Disability Law*, 114 YALE L. REV.1 (2004). Professor Bagenstos argues in this essay that the improvement of life for those with permanent disabilities may be achieved by moving from an anti-discrimination approach to a social welfare approach. Obviously, that discussion has nothing to do with the proper methods for thinking about private insurance.

[FN2]. *Hassel v. Brotherhood of Locomotive Firemen and Enginemen*, 87 S.W.2d 468 (Tex. 1935).

[FN3]. *Wright v. Paul Revere Life Ins. Co.*, 291 F.Supp.2d 1104, 1114 (C.D. Cal. 2003). (The lawyer's Complaint indicated that his disability was caused by an indictment and an arrest for felony tax evasion. These events resulted in his license being suspended. This happened before his disability arose, "even though final judgment in his criminal case and his final disbarment occurred afterwards." *Id.* at 1113.

[FN4]. *Maria Deoner & Associates v. Paul Revere Life Ins. Co.*, 2004 WL 2384530 (Mont. 2004).

[FN5]. 29 U.S.C. § 101ff (2004).

[FN6]. *Mason v. Equitable*, 32 Fed. Appx. 289, 202 WL 461375 (9th Cir. 2002). But see *Mason v. Equitable*, 77 F.Appx. 975, 2003 WL 22345042 (9th Cir. 2003). See then *Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1089 (9th Cir. 1999) (en banc). See also, *McDaniel v. Chevron Corp.*, 203 F.3d 1099, 1107 (9th Cir. 2000).

[FN7]. *Mason*, 32 Fed. Appx. at 291.

[FN8]. Some ERISA cases are found cited before § X. The citation to these cases is simply designed to illustrate the continuity between non-ERISA disability substantive contract provisions and those in contracts controlled by ERISA.

[FN9]. *Raifman v. Berkshire Life Ins. Co.*, 81 F. Supp.2d 412 (E.D.N.Y. 2000) and *Stanton v. Paul Revere Life Ins. Co.*, 37 F. Supp.2d 1159 (S.D. Cal. 1999).

[FN10]. *Boston Mut. Ins. Co. v. N. Y. Islanders Hockey Club*, 165 F.3d 93 (1st Cir. 1999).

[FN11]. See Sharon Barnartt and Richard Scotch, *DISABILITY PROTEST: CONTENTIOUS POLITICS 1970-1999* (2001) (mostly about the politics and social controversies surrounding permanent disability).

[FN12]. The several years of the life of Christopher Reeves illustrates this point. It is not the only illustration, of course.

[FN13]. www.disability-insurance-center.com/disability-articles-insurance.html (taken from CNN/Money article posted on site).

[FN14]. www.mutualofomaha.com/individual_products/disability_insurance.

[FN15]. www.disability-insurance-center.com/stats-of-disability.html.

[FN16]. www.efmoody.com/insurance/disabilitystatistics.html (October 27, 2004).

[FN17]. www.about-disability-insurance.com/facts.html.

[FN18]. *Jefferson Standard Life Ins. Co. v. Curfman*, 127 S.W.2d 567, 571 (Tex. App.-Dallas, 1939, error dismissed w.o.j.). The proposition that disability insurance is not income insurance is a virtual mantra of courts considering disability insurance. There is good reason to keep this proposition in mind, as we shall see. Nevertheless, disability insurance underwriting focuses on potentially loseable income, as well as classifying occupations for disability causation and on medical history. Stephen L. Crawford, *Disability Insurance Underwriting*, ABOUT DISABILITY INSURANCE, www.about-disability-insurance.com/underwriting.html (August 15, 2001). Insurers also look to where an applicant is "over insured" in the underwriting process. *Prousi v. UNUM Life Ins. Co. of Am.*, 77 F. Supp.2d 665 (E.D. Pa. 1999), *aff'd* 251 F.3d 154 (3rd Cir. 2000).

[FN19]. *Am. Cas. Co. v. Horton*, 152 S.W.2d 395 (Tex. Civ. App.-Dallas 1941, writ denied).

[FN20]. Shawn P. Nalty and Thomas K. Hockel, *Does the Disability Insurance Policy Really Mean What it Says? Understanding and Applying the Terms Total and Residual Disability*, 25.5 INS. LITIG. RPTR. 169 (2003).

[FN21]. *Conn. Gen. Ins. Co. v. Reese*, 348 S.W.2d 549 (Tex. Civ. App.-Waco 1961, writ refused n.r.e.). (In this case, the insured could do some limited work around the house and yard. He was the custodian of a church where he opened the church on Sundays and Wednesdays, turning on lights and starting up stoves. He also ran unsuccessfully for County Commissioner. At the same time, the policyholder could not hold down a job. The insurance company had suggested that the policyholder should not receive coverage, because he was "not a helpless cripple." The court responded to this callously formulated conclusion by remarking that "[i]t was not required that [the policyholder] be a helpless cripple. The definition [of total disability] in this contract is not nearly so exacting as that[.]"

[FN22]. *Gulf States Underwriters of La., Inc. v. Wilson*, 753 S.W.2d 422 (Tex. App.-Beaumont 1988, writ denied). See *Prudential Ins. Co. of Am. v. Tate*, 347 S.W.2d 556 (Tex. 1961). See *Aetna Life Ins. Co. v. Motheral*, 183 S.W.2d 677 (Tex. Civ. App.-Fort Worth, no writ). See *Doyle v. Paul Revere Life Insurance Co.*, 144 F.3d 181 (1st Cir. 1998).

[FN23]. *Am. Cas. Co. v. Horton*, 152 S.W.2d 395 (Tex. Civ. App.-Dallas 1941, writ denied).

[FN24]. Indeed, in a policy applicable in *Horton* the insured was required to go to his doctor at least once a week.

[FN25]. *United Am. Ins. Co. v. Selby*, 338 S.W.2d 160 (Tex. 1960). (If the policy requires that the insured be under the care of a licensed physician, it will not suffice that the policyholder is receiving treatments from a naturopath, whatever that is.) Is a dentist who performs oral surgery good enough? *World Ins. Co. v. Johnson*, 193 S.W.2d 275 (Tex. Civ. App.-San Antonio 1946, writ denied).

[FN26]. *Sebastian v. Provident Life and Acc. Ins. Co.*, 73 F. Supp.2d 521, 528 (D.Md. 1999).

[FN27]. *Id.* at 529.

[FN28]. *Id.* at 529-30.

[FN29]. *Stinnett v. Northwestern Mut. Life Ins. Co.*, 58 F. Supp.2d 1000, 1003 (S.D. Ind. 1999). But see *Stinnett v. Northwestern Mut. Life Ins. Co.*, 101 F. Supp.2d 720 (S.D. Ind. 2000).

[FN30]. *United Am. Ins. Co. v. Selby*, 338 S.W.2d 160, 163-64 (Tex. 1960). See *Texas Reserve Life Ins. Co. v. Lothringer*, 394 S.W.2d 660 (Tex. Civ. App.-Waco 1965, no writ).

[FN31]. *World Ins. Co. v. Johnson*, 193 S.W.2d 275 (Tex. Civ. App.-San Antonio 1946, writ denied).

[FN32]. *Stinnett* at 1005-06.

[FN33]. 128 S.W.3d 211 (Tex. 2004).

[FN34]. *Knott v. The Provident Life & Acc. Ins. Co.*, 70 S.W.3d 924 (Tex. App.-Eastland, 2002) *aff'd in part, rev'd in part, and remanded*, 128 S.W.3d 211 (2004).

[FN35]. According to Footnote 5 in the supreme court opinion, the definition of *total disability* had changed during the life of the policy in the early 1980s. Terms which are capitalized like "Injuries" or "Sickness" are usually defined terms in disability policies. Of course this is not always true.

[FN36]. *Provident Life and Acc. Ins. Co. v. Knott*, 128 S.W.3d 211, 214 (Tex. 2004).

[FN37]. *Id.* at 217. (This cite includes the present quote plus the definitions of *partial disability*.)

[FN38]. *Id.* at 219. (Citations omitted.)

[FN39]. *Id.* at 217. (Italics added.)

[FN40]. *Id.* at 219. The cases possibly rejected in a limited way are *Commonwealth Bonding & Cas. Ins. Co. v. Bryant*, 240 S.W. 893 (Tex. 1922); *Great Southern Life Ins. Co. v. Johnson*, 25 S.W.2d 1093 (Tex. Comm'n at 1930, holding approved), and *Prudential Ins. Co. v. Tate*, 347 S.W.2d 556 (Tex. 1961). In fact, these three predecessor cases are factually distinguishable from the *Knott* case. As a result, they probably still contain good law, so long as the decisions are understood as based upon explicit definitions to be found in the policy.

[FN41]. 28 Fed. Appx. 262, 2002 WL 99736 (4th Cir. 2002).

[FN42]. *Id.* at 263. ("The American College of Rheumatology specifies that fibromyalgia's diagnosis is characterized by widespread, musculoskeletal pain for longer than three months in all four quadrants of the body by an absence of other systemic disease that could be the cause of the pain, and by the presence of 11 of 18 designated 'tender points' (points of extreme tenderness) at characteristic locations in the body.... The disease can be permanent and its causes are unknown." *Id.*)

[FN43]. *Id.*

[FN44]. *Id.*

[FN45]. *Id.* at 4.

[FN46]. 44 Fed. Appx. 92, 2002 WL 1634537 (9th Cir. 2002).

[FN47]. *Id.* at 2.

[FN48]. *Erreca v. Western States Life Ins. Co.*, 121 P.2d 689, 695-96 (Cal. 1942). This case is discussed at some length in the essay by Nalty and Hockel, *supra* n. 20 at 176-78.

[FN49]. *Id.* at 2.

[FN50]. *Id.* at 3.

[FN51]. 815 A.2d 811 (Me. 2002).

[FN52]. *Id.* at 813.

[FN53]. *Id.* at 813-14.

[FN54]. *Id.* at 814.

[FN55]. 814 n.1.

[FN56]. 669 N.W.2d 151 (Wis. App. 2003, rev. denied).

[FN57]. *Id.* at 152.

[FN58]. *Id.* at 153.

[FN59]. *Id.* at 153.

[FN60]. *Id.*

[FN61]. *Id.*

[FN62]. *Id.* at 153.

[FN63]. *Id.* at 154.

[FN64]. *Id.* at 155-56.

[FN65]. *Id.* at 156 n.4.

[FN66]. 137 N.W.2d 395, 400 (Wis. 1965).

[FN67]. *Id.* at 155. See *Drexler v. All Am. Life & Cas. Co.*, 241 N.W.2d 401, 406 (Wis. 1976).

[FN68]. 71 Fed. Appx. 881, 2003 WL 21796578 (2d Cir. 2003).

[FN69]. *Id.* at 882-83.

[FN70]. *Id.* at 883.

[FN71]. *Id.* at 883.

[FN72]. *Id.* at 884. The court is utilizing language from *Klein v. National Life of Vermont*, 7 F.Supp.2d 223, 227 (E.D.N.Y. 1998). Several other cases are also involved.

[FN73]. *Id.* The district court had apparently concluded that London was working 3- 1/2 days a week. London said he was working 3 half days a week. According to the Appellate panel, this difference made no difference to the outcome of the case. London was not totally disabled.

[FN74]. 92 F. Appx. 412, 2004 WL 68692 (9th Cir. 2004).

[FN75]. *Id.* at 415.

[FN76]. *Id.*

[FN77]. 121 P.2d 689, 695-96 (Cal. 1942).

[FN78]. *Id.*

[FN79]. 309 F.Supp.2d 1170 (N.D. Cal. 2004).

[FN80]. *Id.* at 1173.

[FN81]. *Id.* at 1174.

[FN82]. *Id.*

[FN83]. *Id.* at 1177. The words contained in brackets are supplied by the court. The bracketed letter in the middle of a word is supplied by us.

[FN84]. *Id.* at 1182.

[FN85]. As the district court did in *Aetna Life Ins. Co. v. Allen*, 137 S.W.2d 78 (Tex. Civ. App.-Beaumont 1939, no writ).

[FN86]. *Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243, 252-53 (2d Cir. 1999). *McCluney v. Gen. Am. Life Ins. Co.*, 1 F. Supp.2d 1347, 1353 (N.D. Fla. 1998), *aff'd* 162 F.3d 1178 (11th Cir. 1998). This case treated the policy as an *any occupation* policy. The language of the definition of *Total Disability and Totally Disabled* was as follows: "You are unable to perform the material and substantial duties of any occupation in which you reasonably may be expected to engage because of education, training or experience, with due regard for your occupation and earnings at the start of your Disability." *Id.* at 1348.

[FN87]. *Dionida v. Reliance Std. Life Ins. Co.*, 50 F. Supp.2d 934 (N.D. Cal. 1999) (ERISA). In this case, a nurse could not perform any of the functions that nurses are suppose to be able to perform according to the "Nurse General Duty" entry in the UNITED STATES DEPT. OF LABOR'S DICTIONARY OF OCCUPATIONAL TITLES. Consequently, she was entitled to disability benefits.

[FN88]. *Hollis v. Provident Life & Acc. Ins. Co.*, 259 F.3d 410 (5th Cir. 2001) [2001 Lexis 17653]. (Italicized material and bracketed material are found in the case.)

[FN89]. ERISA issues prevented the judgment in favor of the policyholder entered upon the verdict as to the former carrier from withstanding appeal.

[FN90]. *Blasbalg v. Mass. Cas. Ins. Co.*, 962 F. Supp. 362 (E.D.N.Y. 1997). ("There is a considerable dearth of judicial authority on the meaning of the term 'regular occupation' in occupational disability policies." *Id.* at 367.)

[FN91]. *Id.* at 366. (See citing authority.)

[FN92]. *Id.* at 368.

[FN93]. *McFarland v. General Am. Life Ins. Co.*, 149 F.3d 583 (7th Cir. 1998), *remanded*, 210 F.3d 375 (7th Cir. 2000).

[FN94]. *Aetna Life Ins. Co. v. Luman*, 456 S.W.2d 484 (Tex. App.-Tyler 1970, no writ).

[FN95]. Occasionally, policyholders and others have complained that this sort of differentiation violates the Americans with Disabilities Act. Generally speaking, these cases have not gotten very far. See *Rogers v. Dept. of Health & Env'tl Control*, 174 F.3d 431 (4th Cir. 1999), *Ford v. Schering-Plough Corp.*, 145 F.3d 601 (3rd Cir. 1998), *cert. denied*, 525 U.S. 1093 (1999). See *Parker v. Metropolitan Life Ins. Co.*, 121 F.3d 1006 (6th Cir. 1997), *cert. denied*, 522 U.S. 1084 (1998), *Soshinsky v. First UNUM Life Ins. Co.*, 105 F. Supp.2d 10 (N.D.N.Y. 2000), *aff'd* 2001 U.S. App. LEXIS 2939 (2d Cir. 2001), *Boots v. Northwestern Mut. Life Ins. Co.*, 77 F. Supp.2d 211 (D.N.H. 1999), *Samson v. Citibank, F.S.B.*, 53 F. Supp.2d 13 (D.D.C. 1999), *aff'd without decision*, 221 F.3d 196 (D.C.C. 2000), *cert. denied*, 531 U.S. 970 (2000) (ERISA case), *Winslow v. IDS Life Ins. Co.*, 29 F. Supp.2d 557 (D. Minn. 1998), *Dorsk v. UNUM Life Ins. Co. of Am.*, 8 F. Supp.2d 19 (D. Me. 1998), *Lewis v. Aetna Life Ins. Co.*, 982 F. Supp. 1158 (E.D. Va. 1997), and more. The *Lewis* case has a complicated history. In the cited case, summary judgment was granted. In a subsequent decision, with the same style, a judgment was entered. 7 F. Supp.2d 743 (E.D. Va. 1998). The latter decision was vacated and remanded. *Lewis v. KMart Corp.*, 180 F.3d 166 (4th Cir. 1999), *cert. denied* 528 U.S. 11 36 (2000). See also *Tolson v. Avondale Industries, Inc.*, 141 F.3d 604 (5th Cir. 1998) (ERISA case) and *Lynd v. Reliance Standard Life Ins. Co.*, 94 F.3d 979 (5th Cir. 1996) (ERISA case citing many other cases). See Note, Jesse A Langer, *Combating Discriminatory Insurance Practices: Title III of the Americans With Disabilities Act*, 6 CONN. INS. L. J. 435 (1999-2000).

[FN96]. *Buchanan v. Reliance Std. Life Ins. Co.*, 5 F. Supp.2d 1172, 1174 (D. Kan. 1998).

[FN97]. Some problems arise in connection with *any occupation* policies. Consider for example a policy which agreed to pay benefits only if someone was wholly and continuously disabled and actually prevents it from performing "each and every duty pertaining to any business or occupation." *Connell v. Provident Life & Accident Ins. Co.*, 219 S.W.2d 835 (Tex. App.-Ft. Worth 1949) *rev'd o.g.* 224 S.W.2d 194 (Tex. 1949).

[FN98]. *Giampa v. Trustmark Ins. Co.*, 73 F. Supp.2d 22 (D. Mass. 1999). (This case contains a helpful discussion of the phrase *regular occupation*.)

[FN99]. *Id.* at 26. (In the *Giampa* case, the court held that there was a fact question as to whether a chiropractor who had a number of clinics was totally disabled when, although he could not practice the chiropractic trade anymore, he could manage his business.)

[FN100]. *Shapiro v. Berkshire Life Ins. Co.*, 212 F.3d 121 (2d Cir. 2000).

[FN101]. See *Mowers v. Paul Revere Life Ins. Co.*, 27 F. Supp.2d 135, 141 (N.D.N.Y. 1998), *vacated & remanded*, 204 F.3d 372 (2d Cir. 2000).

[FN102]. *Jefferson Standard Life Ins. Co. v. Curfman*, 127 S.W.2d 567, 572 (Tex. Civ. App.-Dallas 1939, error dismissed).

[FN103]. *Barnable v. First Fortis Life Ins. Co.*, 44 F. Supp.2d 196, 204 (E.D.N.Y. 1999). See *Vlass v. Raytheon Employee's Disability Trust*, 96 F. Supp.2d 51 (D. Mass. 2000), *rev'd*, 244 F.3d 27 (1st Cir. 2001). (This disability insurance defined total disability as an employee who "cannot do any job for which he or she is fit by education, training or experience." *Id.* at 52.)

[FN104]. *Texas Reserve Life Ins. Co. v. Lothringer*, 394 S.W.2d 660 (Tex. Civ. App.-Waco 1965, no writ). See *Metropolitan Life Ins. Co. v. Pribble*, 82 S.W.2d 414 (Tex. Civ. App.-Fort Worth 1935).

[FN105]. *Continental Cas. Co. v. Carlisle*, 391 S.W.2d 98 (Tex. App.- Amarillo 1965, writ ref. n.r.e.). See *Grt. Am. Life Ins. Co. v. Rios*, 164 S.W.2d 521 (Tex. 1942). See also *John Hancock Mut. Life Ins. Co. v. Cooper*, 386 S.W.2d 208 (Tex. App.-Houston 1965, no writ), *Continental Cas. Co. v. Loville*, 476 S.W.2d 924 (Tex. Civ. App.-Houston 1972, no writ).

[FN106]. __ So.2d __, 2004 WL 2171006 (Fla. Dist. Ct. App. Sept. 29, 2004)

[FN107]. *Buchanan v. Reliance Std. Life Ins. Co.*, 5 F. Supp.2d 1172, 1182 n. 6 (D. Kan. 1998).

[FN108]. *Id.* at 214-15.

[FN109]. *Provident Life & Acc. Ins. Co. v. Fleischer*, 26 F. Supp.2d 1220 (C.D. Cal. 1998). (One also has the feeling that the Principle of Fortuity may have played a background role in this case.)

[FN110]. Sometimes, accident policies contain further restrictions on what constitutes as a qualifying accident. For example, some industrial policies exclude accidents happening while traveling by car. *Twombly v. AIG Life Ins. Co.*, 47 F. Supp.2d 82 (D. Me. 1999). Exclusions are coordination of-coverage decisions. The disability carrier is trying to restrict disabilities to those which arise out of accidents *at work*. Some complexities surround the *Twombly* case, although they have no affect on the point cited for here. *Twombly v. Ass'n of Farm Worker's Opportunity Programs*, 63 F. SUPP.2d 69 (D. Me. 1999), *rev'd* 212 F.3d 80 (1st Cir. 2000), *vacated and remanded* *Twombly v. AIG Life Ins. Co.*, 199 F.3d 20 (1st Cir. 1999).

[FN111]. *Pirkheim v. First UNUM Life Ins. Co.*, 50 F. Supp.2d 1018, 1021 (D. Colo. 1999), *aff'd* 229 F.3d 1008 (10th Cir. 2000) (ERISA case).

[FN112]. *Pugh v. AIG Life Ins. Co.*, 55 F. Supp.2d 366 (M.D.N.C. 1998) *aff'd*, 181 F.3d 90 (4th Cir. 1999) (ERISA case).

[FN113]. See *Continental Cas. Co. v. Loville*, 476 S.W.2d 924 (Tex. App.- Houston 1972).

[FN114]. *River v. Commercial Life Ins. Co.*, 160 F.3d 1164 (7th Cir. 1998).

[FN115]. *Russell v. UNUM Life Ins. Co. of Am.*, 40 F. Supp.2d 747 (D.S.C. 1999) (ERISA case).

[FN116]. Michael Sean Quinn, *Insurance Bad Faith and Insurance Expertise*, 22 INS. LITIG. RPTR. 80

(February 15, 2000).

[FN117]. *Norcia v. Equitable Life Assur. Soc'y of the U.S.*, 80 F. Supp.2d 1047 (D. Arizona 2000). The district judge described the conduct of the insurers as "disgraceful."

[FN118]. *Chiera v. John Hancock Mut. Life Ins. Co.*, 42 F. Supp.2d 756 (N.D. Ohio 1999), *aff'd in part and rev'd in part, remanded* 3 Fed. Appx. 384, 2001 WL 111585 (6th Cir. Feb. 2, 2001). (The actual *Chiera* case is slightly different than the hypothetical. In the actual case, the insured had a dismemberment policy period and entered a persistently vegetative state following unsuccessful surgery. The issue was whether the insured's blindness while in this state qualified his dismemberment resulting from an accident. The district court stated that it did, although the court held that the claim was precluded by late notice, a topic which will be discussed presently. The circuit court reversed without a published opinion)

[FN119]. Insurers sometimes do exactly this.

[FN120]. Courts have recognized that both of these hazards in the context of disability insurance. Sometimes they are wrapped together. "The hazards of working with computers on an intensive basis have manifested themselves in a variety of disabilities with which courts are now grappling. [These include "so-called 'repetitive stress injuries' including 'carpal tunnel' syndrome, ... de Quervain's disease, Raynaud's Syndrome, synovitis, stenosing tenosynovitis crepitans, tendinitis, tenosynovitis, and epicondylitis.]" It is no wonder that those who make their living in front of a computer screen would covet disability insurance protection. *Blasbalg v. Mass. Cas. Ins. Co.*, 962 F. Supp. 362, 369 (E.D.N.Y. 1997).

[FN121]. *Reliance Life Ins. Co. of Pittsburgh, Pa. v. Powell*, 152 S.W.2d 817 (Tex. Civ. App.-El Paso 1941, writ ref. w.o.m.). See *Sebastian v. Provident Life & Acc. Ins. Co.*, 73 F. Supp.2d 521 (D.Md. 1999).

[FN122]. Obviously, all policies are always cancelable for failure to pay premiums in an amount and on a schedule specified in the contract, subject to state law constraints. Some cancellation is discussed in the text, this sort of cancellation is not under consideration. See *Frascona v. Minn. Mut. Life Ins. Co.*, 53 F. Supp.2d 1282 (N.D. Ga. 1998). (This case holds that what, in old movies, was called madness is not an excuse for failing to pay a premium and hence does not keep coverage in place.)

[FN123]. *Arenberg v. Central United Life Ins. Co.*, 18 F. Supp.2d 1167 (D. Colo. 1998).

[FN124]. See *Burger v. Life Ins. Co. of N. Am.*, 103 F. Supp.2d 1344 (N.D. Ga. 2000). (A disability insurer had waived its right to recover overpayments but was not estopped from reducing future payments.)

[FN125]. 217 F.Supp.2d 1281 (S.D. Fla. 2002).

[FN126]. *The Florida Bar v. Neiman*, 816 So.2d 587 (Fla. 2002).

[FN127]. *Neiman v. Provident Life & Acc. Ins. Co.*, 217 F.Supp.2d 1281, 1285 (S.D. Fla. 2002).

[FN128]. *Id.* at 1284-85.

[FN129]. *Id.* at 1286.

[FN130]. *Id.*

[FN131]. *Id.* "It is well-established that 'allowing an insured to benefit from his intentionally injurious conduct is against public policy.'" *Id.* at 1287. Interestingly, the court cites a number of similar cases, some of which involve illegal lawyering.

[FN132]. This was apparently one hell of a case. At the end of the reprint of the decision of the court, there are some seven and a half double columned pages listing motions and briefs filed before the court. This is the longest we've ever seen in a district court. The continuing force of Neiman's initial lies are unclear. He said he was practicing law, apparently, -or, at least-he was practicing law no matter what he said-and perhaps he was no longer making as much money as he said he was years before. Does it follow that he should receive no disability coverage, at all, none whatever several years after he stopped breaking the law?

[FN133]. *Continental Cas. Co. v. King*, 423 S.W.2d 395 (Tex. Civ. App.- Amarillo 1969, writ ref'd n.r.e.).

[FN134]. *Dang v. Unum Life Ins. Co. of Am.*, 175 F.3d 1186 (10th Cir. 1999). See *Block v. Doubletree Hotels Corp.*, 5 F. Supp.2d 321 (E.D. Pa. 1998).

[FN135]. *Steinberg v. Paul Revere Life Ins. Co.*, 73 F. Supp.2d 358 (S.D.N.Y. 1999), *aff'd* *Steinberg v. Paul Revere Ins. Co.*, 210 F.3d 355 (2d Cir. 2000).

[FN136]. *Id.* at 361.

[FN137]. This number of days is mandated by the Texas Insurance Code, art. 3.70-3(A)(5).

[FN138]. *River v. Commercial Life Ins. Co.*, 160 F.3d 1164 (7th Cir. 1998).

[FN139]. See *Continental Cas. Co. v. King*, 423 S.W.2d 395 (Tex. Civ. App.-Amarillo 1969, writ ref'd n.r.e.).

[FN140]. Michael Sean Quinn, *Reserving Rights Rightly*, 7 COVERAGE 23 (July/August 1997)

[FN141]. *Sebastian v. Provident Life & Acc. Ins. Co.*, 73 F. Supp.2d 521 (D. Md. 1999).

[FN142]. See § IX.B.1, below.

[FN143]. *Grt. Am. Life Ins. Co. v. Rios*, 164 S.W.2d 520 (Tex. 1942). ("The period of permanent disability covered has a definite time of beginning. It is not from the time disability in fact begins, but from the time the insured furnishes the company due proof that total and permanent disability has been existent for a period of six months. It is only after expiration of that period and the furnishing of proof thereof that the liability of the company to pay the disability compensation accrues." *Id.* at 522. Quoting *Bergholm v. Peoria Life Ins. Co.*, 284 U.S. 489 (1932), the court went on to say that "the obligation of the [insurance] company does not rest upon the existence of the disability; but it is the receipt by the company of the proof of the disability which is definitely made a condition precedent to an assumption by it of payment of the premiums becoming due after the receipt of such proof." *Id.* at 523. See *Reliance Life Ins. Co. of Pgh., Pa. v. Powell*, 152 S.W.2d 817 (Tex. Civ. App.-El Paso 1941).

[FN144]. *Provident Life & Acc. Ins. Co. v. Henry*, 106 F. Supp.2d 1002 (C.D. Cal. 2000). This case stands for the proposition that unless contract makes it clear that a policyholder will have to accept surgery, "an 'appropriate care' provision requiring the insured to 'receiv[e] care by a Physician which is appropriate for the condition causing the disability,'" will not require the policyholder to undergo surgery. The court based this opin-

ion on a smattering of cases from other jurisdictions and "California's public policy recognizing a strong right to control one's own medical care."

[FN145]. *United Am. Ins. Co. v. Selby*, 338 S.W.2d 160, 163-64 (Tex. 1960).

[FN146]. *Mowers v. Paul Revere Life Ins. Co.*, 27 F. Supp.2d 135, 139-40 (N.D.N.Y. 1998), *vacated and remanded on other grounds*, 204 F.3d 372 (2d Cir. 2000). (In vacating the district court's holding, the circuit court held that the requested sums were reasonable.)

[FN147]. *Id.* at 140.

[FN148]. *Mowers v. Paul Revere Life Ins. Co.*, 204 F.3d 372 (2d Cir. 2000).

[FN149]. *Sebastian v. Provident Life and Acc. Ins. Co.*, 73 F. Supp.2d 521, 528 (D.Md. 1999) and *Arenberg v. Central United Life Ins. Co.*, 18 F. Supp.2d 1167 (D. Colo. 1998).

[FN150]. *Barnable v. First Fortis Life Ins. Co.*, 44 F. Supp.2d 196, 204 (E.D.N.Y. 1999).

[FN151]. *Boston Mut. Ins. Co. v. N. Y. Islanders Hockey Club*, 165 F.3d 93 (1st Cir. 1999) (policy indemnified business for having to pay out the salary of an injured player).

[FN152]. See *Burke v. First UNUM Life Ins. Co.*, 975 F. Supp. 310, 311 (S.D.N.Y. 1997) (containing an excellent summary discussion of the jurisprudence of incontestability clauses).

[FN153]. *Id.* at 214 n. 7 (citing *Killian v. Metropolitan Life Ins. Co.*, 166 N.E. 798 (N.Y. 1929) (Cardozo opinion)).

[FN154]. *Carden v. First UNUM Life Ins. Co.*, 46 F. Supp.2d 240 (S.D.N.Y. 1999).

[FN155]. *Raifman v. Berkshire Life Ins. Co.*, 81 F. Supp.2d 412 (E.D.N.Y. 2000).

[FN156]. *Union Bankers Ins. Co. v. Shelton*, 889 S.W.2d 278 (Tex. 1994).

[FN157]. *McGinnis v. Allianz Life Ins. Co. of N. Am.*, 77 F. Supp.2d 1297 (N.D. Ga. 1999).

[FN158]. Significantly, the district judge regarded himself as bound by a previous decision of the Georgia Supreme Court. *John Hancock Mut. Life Ins. Co. v. Frazier*, 20 S.E.2d 915 (Ga. 1942).

[FN159]. 516 F.2d 425 (5th Cir. 1975).

[FN160]. The statute had been purchased while Forman lived in New York, but both sides assumed that Florida law applied, and the court accepted this view. Many states have identical statutes regulating incontestability clauses.

[FN161]. *Id.* at 427.

[FN162]. *Id.*

[FN163]. *Id.* at 428.

[FN164]. *Id.*

[FN165]. The most significant citation is to a Cardoza opinion written when he was Chief Judge of the New York Court of Appeals, which opinion has been cited quite frequently. *Metropolitan Life Ins. Co. v. Conway*, 169 N.E. 642 (N.Y. 1930). Naturally enough, these cases have been cited following in a variety of jurisdictions. See *Doertl v. Colonial Life & Acc. Ins. Co.*, 505 F.Supp. 127 (D. 110 (Mont. 1991).

[FN166]. *Marie Deonier & Ass.'s v. Paul Revere Life Ins. Co.*, 9 P.3d 622 (Mont. 2000) (disability insurance may have to instruct brokers on the significance of Forman-type cases) and *Marie Deonier & Ass.'s v. Paul Revere Life Ins. Co.*, 2004 WL 2384530 (Mont. 2004) (insurers may be liable to such brokers for a failure to give out information about the use of a "Forum defense").

[FN167]. *Freidrich v. Intel Corp.*, 181 F.3d 1105 (9th Cir. 1999).

[FN168]. *Zavora v. Paul Revere Life Ins. Co.*, 145 F.3d 1118 (9th Cir. 1998).

[FN169]. 379 F.3d 997 (10th Cir. 2004).

[FN170]. It should be kept in mind that this is an ERISA-controlled policy. Clearly, however, the court is, at least in part, utilizing principles of insurance law. At the same time, it is using the burden of proof law derived from ERISA.

[FN171]. 265 F.Supp2d 905 (W.D. Tenn. 2003).

[FN172]. 304 F.Supp.2d 1364 (S.D. Ga. 2003).

[FN173]. *Id.* at 1367-68.

[FN174]. *Id.* at 1378.

[FN175]. *Id.* at 1374.

[FN176]. *Id.* at 1372.

[FN177]. www.inlinea.com/disopt.asp (November 1, 2004).

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