

## **Disability Insurance Roulette: Can you collect on your policy?**

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You have worked as an ophthalmologist for your entire career. Your spouse and children rely on you, and you have numerous financial obligations, both at home and at the office. The stress and trauma of a disability can cause you significant problems, including the financial requirement that you contribute toward business overhead even when you are not raising revenue. To protect yourself in case of total or partial disability, you have purchased disability insurance.

Unfortunately, you suffer an injury or become so ill that you cannot continue your practice, and you then file a claim with your insurance agent. Of course, you expect it to be honored. Instead, shortly thereafter, you are contacted by an insurance adjuster, not your agent. Unlike your agent, the insurance adjuster is hostile; the questions he asks imply that you are malingering and have submitted a fraudulent claim. You try to be cooperative, providing the insurance adjuster with the additional information he requests, but again your claim is denied. Adding insult to injury, you learn from the adjuster that the insurance company has secretly videotaped your activities and, based on the tapes, believes that you are not disabled at all. Dumbfounded by the insurance company's response, you ask yourself if there is anything that you can do to make the insurance company pay the benefits it promised. The answer is yes, as I will explain in this article.

### **Policy Definitions Differ**

Typically, the type of policy that an ophthalmologist purchases is what is known as an "own occupation" policy. Such policies provide compensation following a disability that prevents the insured (the person who purchased the policy) from performing the particular duties of his or her profession. Thus, the insured may be entitled to benefits even if he or she could in fact perform work of a different nature. For example, if a surgical ophthalmologist purchases an "own occupation" policy and suffers from debilitating back pain, but could nevertheless perform the duties of a professor (or any other profession), he or she is considered disabled under an own occupation policy and entitled to benefits in addition to any other income that he or she earns outside of surgical ophthalmology.

Disability provisions vary greatly in the language used, and coverage is often circumscribed and restricted by qualifying words and phrases. Accordingly, each policy of insurance must be individually reviewed to determine whether a particular claim is covered. What may appear to be an "own occupation" policy could in fact be an "occupational policy" if "total disability" is defined to include the insured's inability to perform all duties, or every duty, pertaining to the insured's occupation. In such a case, the insured may not be entitled to benefits if he or she can perform comparable employment for which the person is suited by education, experience and physical condition.

If you purchase a "general disability" policy, as distinguished from the more limited own occupation or occupational disability policies, total disability requires that the insured be disabled not only from his or her own occupation, but also the substantial and material acts of any occupation. Despite the wording of many of these policies, courts often rule that benefits must be paid in a narrower situation, where the insured is unable to perform a comparable occupation for which he or she is suited by education, experience and physical condition. Thus, the term "total disability" is relative, depending in large measure on the character of the occupation in question, the capabilities of the insured and the circumstances of the particular case.

Total disability usually does not mean a state of absolute helplessness. Rather, it means that the insured is unable to perform the "substantial and material" acts necessary to carry out his or her profession in the customary and usual manner. That the insured performs, or is able to perform, some incidental duties connected with his or her usual employment typically does not preclude recovery of amounts due under the policy regardless of its wording.

### **Assessing Mental Disability**

A mental condition such as severe depression or generalized anxiety can also result in total or partial disability. A person may be considered mentally disabled even though he or she has moments of complete mental agility and comprehension. As might be expected, the subjective nature of the symptoms of mental conditions often result in a battle of the experts. Factors considered by courts in determining whether a mental condition constitutes a total or partial disability include: the occupation of the insured, the effect of the insured's resumption of work during or following the period of disability, the receipt and amount of other compensation or income, the wording of the particular policy and the adjudication of the insured's condition.

Disability insurance carriers often deny benefits for subjectively diagnosed conditions, which include many mental conditions, insisting that the insured's subjective symptoms do not provide objective, verifiable evidence of disability. In many cases, there is no provision or contractual requirement mandating that the insured provide objective evidence of disability. Therefore, from the insured's perspective, these insurance companies are merely trying to save money by generously interpreting policy language in favor of claim termination. In addition, these companies appear to be taking advantage of flaws in medical science, which has not yet progressed to the point of creating methodologies for objectively testing and identifying certain conditions.

Notwithstanding the subjective nature of a particular condition, the insured may be able to secure or reinstate disability benefits with ample documentation and medical records supporting his or her diagnosis, including sufficient evidence that the insured is unable to work due to his or her symptoms and limitations. More recently issued disability insurance policies have significant limitations relating to "subjective" or "self-reported" illnesses. For example, these policies limit the duration of payment for psychiatric or psychological disorders, cutting off benefits after 2 or 3 years. Policyholders often blindly accept their disability carrier's decision to deny or limit benefits based on such conditions without considering numerous relevant factors, including whether there are any physical aspects to the insured's mental condition, whether the mental condition has a biological cause, or whether another, covered condition, was the legal cause of the disability.

Many policies contain exclusions for certain medical conditions, including conditions which pre-date the insurance policy. These exclusions, however, often have no effect if an intervening ailment is the true cause of the disability. For example, a policy may exclude a pre-existing heart condition. The insured, after purchasing the policy, may then suffer an infection or accident that further damages the heart. In such situations, coverage may exist.

### **How to Fight a Denied Claim**

What happens if the insurance company denies your claim and, because of financial hardship, you are forced to work either in your chosen field of medicine or in another? The answer is that being forced to return to work because of the insurance company's improper handling of your claim cannot be used as a defense so as to justify the denial of benefits. In other words, the insurance company cannot force

you back to work and then use the fact that you are working to deny you disability benefits.

Under the law, an insurance company is obligated to investigate your claim reasonably and in a timely manner. Insurance companies must also give your interests and its interests equal consideration. In many instances, however, the insurance company may deny your claim out-of-hand without conducting any investigation whatsoever, hoping that you will simply drop your claim and go away. When later pressured, the insurance company may then perform a cursory investigation in order to obtain information that supports its denial. You, as the insured, may be obligated to cooperate with your insurance company and provide it with the information it requests. You may also even be asked to undergo an "independent" medical examination, which is, incidentally, an examination by a doctor chosen by the insurance company.

When making a claim for benefits under a disability policy, careful consideration should be given to the information that you provide to the insurance company, including any decision to submit to an independent medical exam. A coordinated effort should be undertaken, usually with the assistance of an attorney, in presenting your claim, providing subsequent information and, in many instances, detailing the law establishing your claim. This needs to be done in order for the insurance company to give your claim the consideration that it is due or, in some instances, to give the insurance company enough rope to hang itself. In other words, you can build your case against the insurance company by providing it with information that will prove that its denial was unreasonable, and thus a breach of the insurance agreement, and constitutes bad faith.

A wrongful denial of a claim for benefits can expose the insurance company to damages in two ways. The first is a claim for breach of contract, and the second is typically referred to as a claim for "bad faith." In order to prove breach of contract, the insured needs to establish that he or she purchased the insurance from the company, that the insured is disabled, and that the company denied the insured's claim. To prove a bad faith claim, the insured needs to prove that the insurance company committed bad faith either by failing to conduct a reasonable investigation or by unfairly denying the claim.

Damages can be recovered for the policy benefits until the disability is removed or through age 65, which is normally considered retirement age. In bad faith cases, the insurance company may be required to pay additional damages for such items as pain and suffering, and the effect the denial of benefits may have had on the insured's credit. In some cases, punitive damages may also be awarded.

### **Know Your Rights**

Anyone who purchases disability insurance may be faced with a situation where the insurance company refuses to honor its commitment. The insured can then either abandon his or her claim, even though he or she has paid premiums to the insurance company, or the insured can insist that the insurance company honor its legal obligations by filing a lawsuit seeking damages for breach of contract and bad faith. Insurance companies are vigilant in protecting their own interests, which often means not paying claims. Policyholders may often need to be even more vigilant in protecting their own interests.