The 10 Most Common Legal Mistakes Professionals Make When Filing a Claim for Disability

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Most professionals know that they need to have disability insurance to replace their income if they are no longer able to practice in their profession (particularly earlier on in their careers, when they have limited liquid assets and significant debt, such as student loans, mortgages, etc.). As time goes on, and a professional's earning potential increases, his or her monthly expenses also tend to increase in kind, in anticipation of future income coming in.

When that income is suddenly lost due to a disabling condition, it can be jarring, to say the least. Losing one's professional identity is never an easy transition to make, and it becomes even more stressful if the loss of identity is compounded by a loss of income. Because of this, it is critical that professionals not only have disability insurance in place should such a contingency arise, but also understand the scope of their coverage and what the claim process entails.

Too often, we see professionals file claims blindly, without taking the time to review their policies or learn about the claims process. Then, by the time they realize that the claims process is more involved than they anticipated, it is often too late to salvage the claim.

Several years ago, in an effort to help professionals become more educated about the claims process and maximize their chances of collecting, our firm prepared an article for SEAK entitled "The 10 Biggest Legal Mistakes Physicians Make When Filing a Claim for Disability." Since that time, disability insurance companies have issued newer, more robust policies that are carefully crafted with the goal of making the policyholder's (and particularly a professional policyholder's) ability to collect benefits much more difficult. These policies are significantly longer and more detailed than policies issued in the 1980's and 1990's, and contain new provisions that circumscribe and restrict coverage in ways that can dramatically impact professionals who need to collect benefits. Key definitions—such as "total disability"—that typically only consisted of a sentence (or, at most, a few lines) in older policies can now take up a full page and usually also include several additional terms of art that are defined elsewhere in the policy.

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As a result of these dramatic changes in the industry, we have identified several additional pitfalls that most professionals are unaware of when obtaining disability insurance and/or filing a disability claim. This is not an exhaustive list of the challenges that professionals face when filing a disability claim; however, it does represent the most common mistakes we see when consulting with professionals who filed a claim under a newer (i.e. post-2000) policy and had their claim denied, terminated or downgraded from total disability benefits to partial disability benefits. We hope this information is helpful to you in better understanding the policy you have, the policies available and the claims investigation, so you are able to collect should you become disabled.

MISTAKE #1

BLINDLY RELYING ON AN INSURANCE AGENT

Many professionals who are considering purchasing a disability insurance policy rely on an agent to find the right policy for them, often providing the agent with a vague, general objective like finding the "best" policy (or the "best" policy within the professional's budget). In our experience, we've also found that it is common for professionals to go to an agent that a colleague recommended, and merely ask that agent to set them up with the "same" policy that their colleagues (e.g. the other doctors in their practice) have. Or, if the professional already has a policy, he or she may ask the agent to find them a policy that is the "same" as their existing policy.

This is problematic because, as noted above, there are no standard policies and the differences between the multiple key provisions in policies are difficult to explain—even for an agent. Therefore, asking for the "same" coverage is often a request that is impossible for the agent to achieve. Additionally, while input from an agent can be helpful, insurance companies rarely provide agents with adequate training or information about a policy beyond what is necessary to sell it. As a result, agents are often unfamiliar with many of the complex terms in a policy, and the agent may not know how certain key provisions will play out during the claims process (which is understandable, as they typically just sell the policies and do not have legal experience filing claims or litigating these matters).

By design, insurance companies have *now* explicitly placed distance between themselves and their agents, for liability purposes. Most disability policies and policy applications now contain express language stating that agents cannot alter the terms of the policy, and disclaimers stating that the insurance company cannot be held liable for representations made by an agent. In the past, an agent's representations could modify the policy under a legal principle called the "reasonable expectations doctrine," so we would advise insureds to keep notes of any conversations with their agents (as well as any marketing materials). This legal doctrine is now largely obsolete given this new policy language limiting the insurance companies' liability at the point of sale.

ACTION STEP:

If you are considering purchasing a policy, do your own research and do not rely blindly on your agent to pick your policy for you. Do not accept coverage or pay premiums for a policy until you have thoroughly reviewed the policy.

MISTAKE #2

FAILING TO CAREFULLY REVIEW POLICY APPLICATIONS

In many jurisdictions, the law allows insurance companies to void policies if the application for the policy contains a "misrepresentation." Most people believe a "misrepresentation" means something akin to fraud, but now even an honest mistake can void coverage in some instances, depending on the jurisdiction.

ACTION STEP:

Rather than completing the policy application in your agent's office, take the application home with you so that you can carefully complete, review, and sign it on your own. Then keep a copy of your application in an organized file, so you have a record of the answers you provided.

Most policy applications contain unclear, compound questions or ask for detailed medical information that may be difficult to recall on the spot, off the top of your head. Additionally, most companies also require applicants to sign a disclaimer stating that the applicant has thoroughly reviewed the application and all statements made in the policy application are true. In some cases, an agent may complete the application for the applicant, or the applicant may provide the answers to the application questions via a phone interview, further increasing the risk that an incorrect statement, omission, or misrepresentation will be inadvertently made during the application process.

Accordingly, applicants should be very careful when completing policy applications, as an incorrect response to even a seemingly innocuous or unimportant question can be construed as a misrepresentation that could result in the limitation or loss of coverage.

MISTAKE #3

FAILING TO UNDERSTAND THE LIMITATIONS IN NEWER DISABILITY POLICIES

Professionals should carefully review their policies to make sure they understand the scope of coverage provided. An important consideration in evaluating a new policy *now* involves whether it imposes conditions on eligibility for benefits that conflict with those imposed by an existing policy. For instance, one policy may only pay total disability benefits if an insured is unable to work in his prior occupation *and* is working in another occupation (an "own-occupation" policy with a "work" provision), whereas another policy may provide benefits only if the insured is *not* working in *another* occupation (an "own-occupation" policy with a "no work" provision).

Thus, if you are not careful and intimately familiar with the terms of your existing policy or policies, you can end up purchasing a new policy (and paying years of premiums) for coverage that is essentially worthless (because it is impossible to collect benefits under both policies at the same time). Some policies even have "offset" provisions that deduct the amount of benefits you receive if you receive disability insurance benefits from other sources.

ACTION STEP:

When you receive the full policy, read it cover to cover and make sure you are aware of all its terms, conditions, and limitations.

It is also important to take note of limitations or exclusions in the policy that may limit recovery for certain conditions. Many policies contain limitations on benefits for disability caused by a mental illness or an illness with largely subjective symptoms that cannot be verified with objective testing. Other policies that provide for lifetime benefits may permit lifetime recovery for disabilities caused by "injury," but place a limitation on disabilities caused by "illness or disease."

MISTAKE #4

MISTAKENLY BELIEVING THAT THEY HAVE A TRUE "OWN OCCUPATION" POLICY

Most professionals know that they should purchase an "own occupation" policy that provides benefits if they are no longer able to practice their profession. In the past, these policies all contained virtually the same language, so it was easy for the agent to explain the coverage. What professionals don't realize is that there are *now* several iterations of "own occupation" provisions and the differences are difficult to explain. Regardless, insurers market all of these as "own occupation" policies because they know that professionals are just looking for these two magic words. Unfortunately, the new policy variations typically contain additional requirements and limitations that restrict coverage and/or make it much more difficult to collect.

A *true* "own occupation" policy pays benefits if you cannot perform *at least one* of the material and substantial duties of your occupation *and* allows you to work in another occupation (that does not have any overlapping duties with your previous occupation). Under these policies, the insured is essentially allowed to "double-dip"—collect benefits under their policy and collect earnings from another occupation. These provisions used to be commonplace in the industry, but now you will likely need to specifically ask your agent for this type of coverage, and you may need to look into policies offered by multiple insurance companies before you find a *true* own occupation provision.

Some of the more common limitations and restrictions that are included in the *new* "own occupation" policies include: (1) "no work" provisions that only allow a claimant to collect benefits if he or she is not working in any capacity; (2) "work" provisions that require a claimant to be working in a new occupation before he or she can collect benefits; (3) provisions that offset the monthly benefit based upon the amount of income a claimant earns working in a new occupation; (4) provisions that require a claimant to prove that he or she is unable to

perform *all* of the duties of his or her occupation; (5) provisions that require a claimant to prove that there are no workplace modifications that exist that would allow him or her to perform his or her prior occupation; and (6) provisions that initially provide "own occupation" coverage, but after a certain time frame (usually somewhere between 2 to 5 years) shift to an "any occupation" provision that only pays benefits if the claimant can demonstrate that he or she is unable to work at all, in any capacity, and allows the company to terminate benefits if they think the claimant could be working (even if the claimant is not actually working at the time).

ACTION STEP:

Read your policy carefully and fully understand the definition of total disability before filing a claim.

Many of the professionals we consult with checked "own occupation" on their policy application but didn't bother to read their full policy when it arrived, assuming that it contained *true* own occupation language. They are then surprised to learn that, upon closer inspection, although their policy contains the phrase "own occupation," the policy that they have been paying premiums on for years does not actually provide *true* own occupation coverage.

MISTAKE #5

MISUNDERSTANDING THE NEW DEFINITIONS OF "OCCUPATION"

Disability insurance policies generally define "occupation" as the occupation the insured was performing at the time he or she became disabled. This can be problematic for insureds who have reduced their work hours (see Mistake #6, below), or for those who have decided to focus on an aspect of their work that they would not consider to be their occupation, such as managing their medical practice rather than practicing medicine. Oftentimes, professionals dealing with a disabling condition will seek out other avenues of income, prior to filing, such as selling real estate, or teaching. While seemingly innocuous, these types of decisions can dramatically impact a professional's ability to collect under his or her policy, because doing so allows the insurance company to argue that the professional has modified his or her occupation prior to filing and expanded his or her list of material job duties. For example, the

ACTION STEP:

Read your policy carefully and fully understand the definition of occupation before filing a claim. Do not make changes to your job duties prior to filing without first conferring with an experienced disability insurance attorney.

insurance companies *now* often take the position that the professional is a part-time dentist and a part-time realtor or professor. Or the company might characterize the professional's occupation as part-time, rather than full-time, or say that the professional is really a physician and a "business owner" (as opposed to a practicing medical professional).

MISTAKE #6

REDUCING WORK HOURS PRIOR TO FILING A CLAIM

Reducing work hours may seem like a logical solution for a professional experiencing a condition that is beginning to impact his or her ability to work. However, as noted above, working fewer hours per week for an extended period of time prior to filing can make it much more difficult to collect, because it opens the door for the insurance company to argue that the professional has modified his or her job duties and is no longer practicing full-time. Continuing to work post-diagnosis of a potentially disabling condition also raises malpractice concerns and cuts against the severity of the condition.

ACTION STEP:

Consult with an experienced disability insurance attorney before reducing your work hours or selling your practice, particularly if you have a progressive or degenerative condition.

Delaying filing, while reducing hours and continuing to work may also reduce the amount of lifetime benefits an insured is entitled to. Many policies that provide for lifetime benefits *now* only pay benefits if a claim is filed before a certain age or pay a lower lifetime benefit amount if a claim is not filed before a certain date. Additionally, some policies *now* require insureds to work a certain number of hours per week to maintain coverage, and if an insured's work hours per week drop below the minimum threshold, he or she may lose coverage altogether.

The decision of when to stop working and/or reduce work hours is one that is particularly difficult for professionals who suffer from slowly progressive or degenerative conditions. Many professionals also need to sell their practice as part of the work transition, and need to keep up the value in the meantime. In these situations, the timing of both the sale and your claim is critical.

MISTAKE #7

BEING CAUGHT OFF-GUARD BY THE AGGRESSIVENESS OF THE CLAIM INVESTIGATION

Many professionals do not understand what the claims process entails, and are caught off-guard by the insurance company's aggressive tactics. One of the most common and first mistakes made by professionals filing a disability claim is assuming that the claims investigation does not begin until *after* they file the initial packet of claim forms.

While insurance companies used to provide their claim forms online, most insurance companies *now* require insureds to call the company to request the initial claim forms, so that they can conduct a *recorded* impromptu interview and collect as much information from you as they can before you have a chance to see the claim forms, review your policy or talk with an attorney about the proper scope of a disability claim investigation. The interviewer may request information about your condition, exactly what you can and can't do, when you think you will be able to go back to work, the timeline of events leading up to the claim, your exact job duties, and plans for future employment. The interviewer may also ask about your daily schedule, so the company's private investigators know where to find you when they conduct surveillance, which is *now* practically an inevitability.

Although the tone of the interview may seem informal and friendly, it is important to recognize that the company's review of your claim begins from the moment of your first contact with the insurance company, and that, from that point forward, the insurance company will be searching for reasons to deny your claim.

Another common tactic that is *now* widely used by insurance companies is termed the "peer-to-peer" call. This is something that typically occurs behind the scenes, without any prior notice to the claimant, and involves the insurance company's in-house doctors contacting your treating physicians directly, in an effort to obtain statements that can be presented out of context as a basis for denying the claim.

As just one example, the insurance company's doctor may pressure your doctor for a recovery date post-surgery, even though it may be too early to know what will happen. The company's doctor will keep pressuring until your doctor gives a generalized, estimated recovery date, which the insurance company then characterizes as a "return to work" date. If you are not back to work by then, the company will say your limitations are inconsistent with your own doctor's opinion, and use the manufactured inconsistency as a basis for terminating your claim. When you go back to your surgeon for clarification, he or she often does not want to get involved any further with your claim, so you are between the proverbial rock and a hard place.

As another example, the insurance company's doctors often purposefully mislead your doctors regarding how disability is defined under your policy. If you have a *true* "own occupation" policy, you are entitled to total disability benefits if you can no longer perform the duties of your prior occupation. However, the insurance company's doctors will ask your doctor to instead opine on broad, irrelevant questions (e.g. "Will the claimant ever be able to work again?"; "Is the claimant's ability to perform basic activities of daily living impacted by the

ACTION STEP:

Before calling your insurance company to request claim forms, consult with an experienced disability insurance attorney, review your policy carefully, and take the time to thoroughly prepare for the call.

condition?") in order to imply that you must essentially be home-bound in order to collect benefits. If you have not taken the time to explain how your policy works to your doctor (to the extent he or she is even interested), your doctor may unwittingly say something that prejudices your claim and, by the time you find out about it, it will be too late to do anything about it.

MISTAKE #8

MISUNDERSTANDING THE SCOPE OF THE INVESTIGATION

Disability insurance companies have substantially broadened the scope of claims investigations over time. While many professionals expect and anticipate that the insurance company will review their medical records and ask for reports from their treating doctors, many professionals are surprised when the insurance company also requests a long list of additional information as part of the claim investigation, including tax and financial records of personal accounts, businesses, and trusts. Whereas many older policies merely required insureds to simply submit to a physical examination while the claim was pending, *new* policies grant disability insurance companies the right to require their insureds to undergo a host of other examinations, including vocational and rehabilitation examinations, occupational analyses, and psychiatric evaluations, and threaten suspension of benefits if the insured refuses to cooperate. As you might suspect, in most cases the insurance company's evaluators are not incentivized to make fair decisions.

ACTION STEP:

Review your policy carefully and consult with an experienced disability insurance attorney prior to filing your claim, so that you know what the insurance company can and cannot do when investigating your claim.

MISTAKE #9

ALLOWING THE INSURANCE COMPANY TO DICTATE THE TERMS OF YOUR CARE

Many disability insurance policies *now* condition receipt of benefits on compliance with stringent care requirements. In contrast to older policies, which typically required an insured to obtain "regular care," many newer policies require insureds to obtain care designed to achieve "maximum medical improvement." While the older regular care requirements provided little leverage for insurance companies to require insureds to obtain specific treatments or procedures, these new requirements give them leverage to argue that an insured must undergo treatment that arguably could enable the insured to return to work.

In some cases, the insurance company may go so far as to demand surgery, leaving the insured with the choice of undergoing an operation involuntarily and bearing all of the medical and financial risks himself or herself, or potentially giving up his or her right to collect benefits.

ACTION STEP:

Contact an experienced disability insurance attorney to ensure your rights are protected if your insurer attempts to dictate the terms of your care.

MISTAKE #10

REPLACING YOUR OLD POLICY WITH A NEW ONE

Many professionals decide to replace older, smaller value policies with a new policy with a higher monthly benefit, once they reach the point that they can qualify for a higher benefit amount. While this can be more convenient (because you don't have to keep track of multiple premiums, or file with multiple companies if you end up needing to file a disability claim), generally speaking, older disability policies have more favorable policy definitions and better coverage for professionals. So, if you do have an older policy, it may be better to supplement that coverage, rather than replace it.

Another important consideration to keep in mind when assessing whether to replace existing coverage is that canceling an existing policy and choosing a new one resets pre-existing limitation periods that may have already been satisfied under the older policy. Additionally, if you purchase a new policy, you will likely have to go through the medical underwriting process again and, as a result, conditions that would have been covered under the older policy may be excluded from coverage altogether under the new policy.

ACTION STEP:

Carefully review the pros and cons of replacing an existing policy before canceling it or letting your policy lapse due to nonpayment of premiums.

The information in this article has been prepared for informational purposes only and does not constitute legal advice. Anyone reading this article should not act on any information contained therein without seeking professional counsel from an attorney.

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