MARC WHITEHEAD & ASSOCIATES
ATTORNEYS AT LAW, LLP

DISABILITY DENIED BY THE HARTFORD?

Your Battle Plan for Winning Disability Insurance Benefits

Marc Whitehead, Esq.

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INTRODUCTION

No one expects to be disabled – to be robbed by circumstance of the ability to enjoy the simple pleasures of life and to do productive work. Whether you developed a painful neurologic condition, like fibromyalgia, or suffered a serious lower back injury in a car accident, you are in pain and overwhelmed.

When we are hurt and financially challenged, we need support. Hopefully, you have friends and family to help you manage the issues created by the disability and enough money to meet your basic needs. However, not everyone is that lucky. To make matters worse, The Hartford, your long term disability insurance carrier, likely has not made it easy for you to collect fair benefits.

Whether the company rejected your claim or you've been confused by the amount of paperwork and the deadlines imposed by the process, you want help. You deserve clear answers.

This ebook, while not a substitute for a consultation with a qualified disability denial attorney, provides an overview of how to respond strategically to a claim denial, prove your claim, and get the benefits you deserve from The Hartford .

CASE STUDY #1: Hess v. The Hartford Life & Accident Ins. Company, United States District Court for the Eastern District of Illinois, Danville/Urbana Division, Decided March 22, 2000

The court awarded the plaintiff, Susan Hess, $50,927.10, including benefits for March 2000, in response to a complaint she filed against The Hartford for violating ERISA. She also alleged that her employer "breached its fiduciary duty to plaintiffs under 29 U.S.C.S. 1109(a) and violated 29 U.S.C.S. 1132(a)(1)(A),(c)(1)."

Hess had been paid on commission – her only source of pay from her employer, Fleet Financial Group, Inc. But this monthly earning rate had been excluded in defiance of the intent that she should have been covered. Per the Case Summary, "despite defendant employer's assertion that it lacked bad faith in failing to respond to plaintiff's request for plan documents, it offered no justification for its failure to comply with ERISA's clear mandate to honor the request. Accordingly, a penalty was warranted for defendant employer's unjustified failure to respond to plaintiff's legitimate request for plan information."

The bottom line: Hess succeeded in obtaining back benefits as well as "augmented" benefits in the future, and Fleet had to pay a penalty for every day she had to wait for a copy of the ERISA plan beyond a 30-day deadline.

1. UNDERSTANDING THE DISABILITY INSURANCE INDUSTRY

Did you know?

Under ERISA law, you can't introduce any new evidence into the record if you lose the administrative appeal and decide to take your insurer to court.

Many people who assumed their injuries or illnesses would be covered by their disability insurance have found themselves fighting to get policy benefits.

Insurance companies first introduced disability insurance about 30 years ago. They marketed it to businesses and to individuals as a way of providing a source of income to workers who became ill or suffered an injury and couldn't do their regular jobs.

It wasn't long before insurers ran into problems because their policyholders were getting older and making more claims. That meant insurers weren't collecting enough in premiums to cover the benefits they were paying out. Investment returns from a booming stock market helped insurers make up the difference for a time, but when those returns decreased in the 1990s, the insurers hit upon another way to make the business profitable: denying or reducing disability claims. They began combing through each claim, finding ways to avoid, cut off or limit payments.

It's a practice that continues today.

If you have a disability claim denied, you need an attorney who understands the system and handles these cases every day.

The insurance companies have armies of lawyers who know how to take advantage of the ins and outs of the administrative appeal process. To give yourself a fighting chance of winning your claim, you need an attorney who understands ERISA (the Employment Retirement Income Security Act), someone who can guide you through all the steps you must take and the deadlines you must meet.

You get only one chance to present your case.

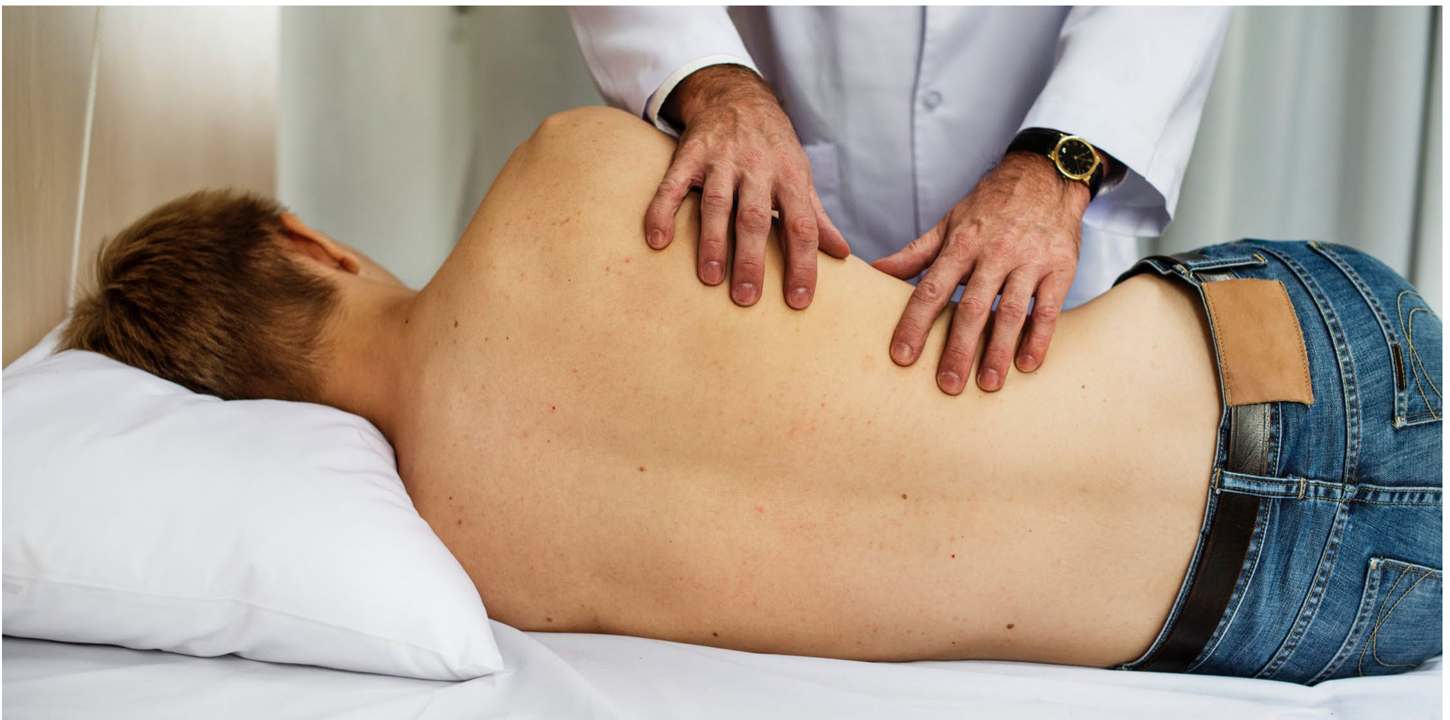
That's why you must ensure that you have all the evidence and proof of your claim filed with your administrative appeal.

When you work with an experienced ERISA attorney, you can feel confident knowing that your appeal of a denied disability claim – whether on the administrative level or in court – is as strong as you can make it. It's your best shot at obtaining the disability benefits that you deserve.

CASE STUDY #2: : Williams v. The Hartford Life & Accident Ins. Company, United States District Court for the Southern District of Ohio, Eastern Division, Decided September 25, 2009

This case concerned a plaintiff who argued that her employer's ERISA plan entitled her to long term disability benefits. Michelle Williams was a 45-year home loan consultant for Countrywide Financial Corporation who traveled frequently for work to generate sales and develop customer relationships. She often needed to go to her prospects' homes and offices to meet with them as well as to attend weekly meetings and meetings with partners.

After her injury, The Hartford Life determined that Williams wasn't eligible for benefits because she "was not disabled from 'Any Occupation' pursuant to the terms of the ERISA-qualified plan." The court denied The Hartford's Motion for Judgment on the Administrative Record and instead granted the plaintiff's Motion for Judgment on the Administrative Record.



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2. THE DIFFERENCES IN DISABILITY: SHORT TERM, LONG TERM, CATASTROPHIC

Your employer may offer a group disability plan as part of your benefits package, or you may have purchased private disability insurance from an insurance broker. In either case, it's important that you get a copy of your policy from your employer, because the language and the provisions do vary from insurer to insurer and even from policy to policy.

There are three types of disability coverages:

Short Term Disability (STD) pays benefits if you're going to be off work for a limited period of time – usually anywhere from one week to six months. If you have a group plan, your employer often pays the premium for STD coverage. Since the policy payment period is limited, it's often easier to get benefits from an STD policy. Even if you know your illness or injury is likely to keep you out of work long term, filing for STD benefits is a first step in the process of applying for long term disability benefits.

Long Term Disability (LTD) pays benefits when an illness or injury keeps you from doing your own job from six to 24 months or longer. If you're still unable to work after two years has passed, you could receive LTD benefits up to age 65. Before you can receive benefits under an LTD policy, however, you'll have to wait up to six months and exhaust any STD benefits that you're entitled to receive.

Catastrophic benefits are reserved for those who are so severely injured or ill that they can't perform the routine tasks of daily living – feeding themselves, dressing, showering, etc. A home health nurse usually comes to the home of the disabled person to determine if he or she needs regular assistance with those activities.

How Long Can I Receive LTD Benefits?

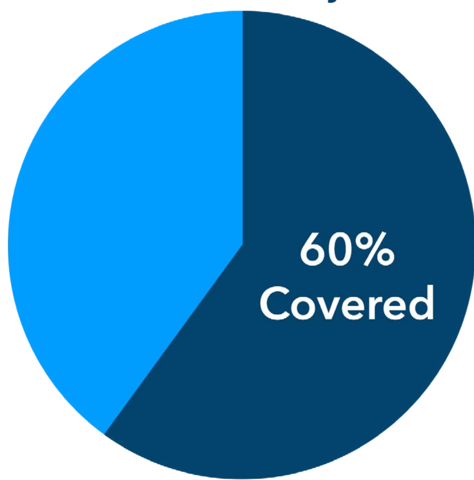
LTD benefits will cover some portion of your salary for a period of up to 24 months if you can prove that you are not capable of working at your own job. This is also known as the own occupation rule. If you can prove you are disabled past that point – and insurers scrutinize this very closely – you may qualify for LTD benefits until you reach age 65.

3. HOW MUCH WILL YOU RECEIVE IN DISABILITY BENEFITS?

The amount of money you get in each monthly check will vary, depending on:

- **Your typical paycheck. Most disability policies pay a percentage – typically 60 percent** – of an employee's usual salary. For hourly workers, or for someone paid on commission, payments depend on a calculation (found in the policy) that the insurer uses to figure the benefit due.
- **Whether you can still do some type of job.** If you can't work full time at your regular job but you can do some other type of part-time or lighter duty work, you may be eligible for a **partial or residual disability.** If the pay you're receiving from this temporary work is 20 percent or more lower than you'd get with your regular job, you might get partial disability.
- **Social Security offsets.** If you've applied for and received a Social Security Disability benefit, t**he insurer will reduce your LTD benefit by the amount of your Social Security disability check**.
- **Other offsets.** The insurance company could reduce your LTD benefit if you get workers compensation payments; disability benefits from the state; money from a lawsuit settlement; and/or retirement/retirement disability benefits. No matter what these payments total, however, the insurer usually pays at least $100 a month or 10 percent of your full benefit under your LTD plan.

Your Normal Paycheck



STD & LTD policies usually cover a little more than half of what you'd receive in your normal paycheck.

Plan an overpayment strategy. It can take some time to qualify for Social Security disability benefits, even if you apply for them at the same time that you applied for your LTD benefits. However, if your Social Security disability claim is approved, the Social Security Administration will send you payments from the time of the injury. Your LTD insurer will consider that it has overpaid you and will want the amount of the Social Security disability benefits offset repaid.

Since you are only getting 60 percent of your current paycheck with disability payments, chances are good you've already spent most of the check to keep up with your bills. But once your Social Security back pay comes through, the insurer is likely to withhold your disability check until you've repaid the total amount of the offset.

To avoid this situation, you can either put some money aside from your disability check to cover the offset or ask the insurer to withhold the amount it estimates the offset will be.

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4. HOW PRE-EXISTING CONDITIONS AFFECT YOUR DISABILITY CLAIM

Under the terms of most disability policies, the insurer will not have to pay benefits if you get certain illnesses or suffer certain injuries less than a year after you first sign up for disability coverage. Insurance companies also may use a look-back period of three months before the policy started to determine whether there were any indications that the illness or injury existed at that time.

The insurer may define exclusions broadly. Suppose two months before you enrolled in the disability plan, your doctor prescribed a medication to help you cope with panic attacks. Then – in a completely unrelated incident – you hurt your back after the disability coverage is in place. Another doctor prescribes the same medicine to treat the muscle spasms, and the insurer argues that, since you were taking the same medicine, the back problem must have already existed. The company could cite this "evidence" to refuse to pay your disability claim.

Other ways that insurers try to reduce disability payments include:

- **Limits On Mental Health Coverage:**

  If you suffer from anxiety, depression or bipolar disorder, the insurer will usually limit your disability benefits to 24 months under the terms of your policy.

- **Classifying Your Problem As Mental Rather Than Physical**

  When you suffer from chronic pain, it's not unusual to suffer from depression as well. The insurance company may try to claim that your disability is mental rather than physical, so it can limit the benefits it pays to 24 months.

  If the narcotic drugs you're taking for pain are causing some cognitive problems, or if you're having side effects from the medication, the insurer may also claim that your problem is mental rather than physical.

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- **Demanding Physical Evidence Of Disability**

  Not all injuries or illnesses show up in diagnostic tools like x-rays and MRIs. If you're suffering from chronic fatigue syndrome, fibromyalgia or similar problems, the insurer may try to limit or deny your disability payments. They will say there's no objective evidence to support claims of these self-reported conditions.

  Insurers may also dispute the validity of other problems that you report yourself, including fatigue, intellectual and cognitive limitations, headaches, memory loss and medication side effects.

CASE STUDY #3: : McLeod v. The Hartford Life & Accident Ins. Co, United States District Court for the Eastern District of Pennsylvania, Decided September 27, 2004

Shirley McLeod had been debilitated by multiple sclerosis, which stopped her from being able to work on January 28, 2000. She got approved for short term disability coverage from February through May of 2000, around which time The Hartford announced that it would investigate whether she would be eligible for long term disability (LTD) benefits as well.

The Hartford denied the LTD benefits, arguing that her disease was a pre-existing condition. The district court originally granted the insurer summary judgment, but an appellate court reversed that decision, and then the district court denied further administrative review, saying McLeod had been eligible for LTD from May 5, 2000 through May 4, 2002.

Ultimately, the court awarded McLeod $11,291.09 in LTD benefits, and she won her ERISA claim.

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5. APPEALING YOUR DISABILITY CLAIM: ERISA FEDERAL LAW OR STATE LAW?

When an insurer denies your disability claim, your remedies differ depending on how you purchased your policy. If you bought your policy as an individual (IDI), state laws apply. If your disability is part of a group policy purchased through your employer, you will need to follow the procedures required by ERISA

State insurance laws (contract and bad faith law) govern individual insurance policies. You have procedural rights and remedies. You can request a trial by jury, and during that trial, your attorney can present evidence – including any new evidence you have gathered since you lost your appeal with the insurance company. You also have the right to cross-examine witnesses representing the insurance company.

ERISA (Employment Retirement Income Security Act of 1974) governs virtually all group disability policies. You have fewer protections under ERISA, and insurers face no real penalties for delaying or denying valid disability claims.

ERISA spells out a procedure that you must follow to appeal your denied claim. Unfortunately, you'll be making that appeal to the same insurer that turned down your claim in the first place.

Under ERISA:

- You have no right to pursue your claim in state court.
- There are no real penalties for the insurer; if you win your case, all you will be awarded are the benefits you should have received in the first place. You receive no damages because the insurer delayed or denied your claim. If you're fortunate, the judge will also order the insurer to pay your attorney's fees.
- Your own doctor's opinion can be ignored by the insurer.
- The burden of proof is on you to prove that the insurer didn't have a good reason to deny your claim. (Under state law, you only have to prove that it is likely you are disabled.)

6. WIN YOUR DISABILITY BENEFITS WITH A STRONG INITIAL APPLICATION

1. **Read questions carefully; answer thoughtfully.** Misleading questions can trip you up, so be consistent in your statements throughout your application. Avoid using words like "always" and "never."

2. **Meet your deadlines for initial filing and for filing appeals.**

3. **Review your policy terms.** Do you know how your benefits work together – STD and LTD? Does your policy exclude pre-existing conditions? How will offset payments like SSD or workers' comp affect your monthly disability check?

4. **Maximize your chances of winning benefits by focusing on medical conditions and functional limitations that are covered by your policy.**

5. **Be ready to apply for Social Security Disability.** Your insurer will likely require you to make an application within a year.

6. **Ask your doctor for support.** Remind your physician to meet deadlines for filing forms and returning calls from insurers. Make sure that the insurance company has the correct contact information for your doctors, so it can't claim it couldn't reach them.

7. **Check to see that your description of your job matches your employer's description.** The insurer will use that information to help determine whether or not you are able to work.

8. **Expect the insurer to check up on you.** Insurance companies are likely to send investigators or use video surveillance to make sure that you can't do more physically than you claimed. Remember, you don't have to speak to investigators if they show up unannounced; ask them to make an appointment to come back later and talk.

9. **Don't go it alone.** Get assistance from an experienced ERISA attorney. An attorney knowledgeable about ERISA processes and procedures can help you prepare a strong disability claim from the start. If the insurer denies your claim, seeking assistance from an ERISA attorney who understands the system and the law will help ensure you make the best case possible for your claim.

CASE STUDY #4: Post v. The Hartford Ins. Co, United States District Court for the Eastern District of Pennsylvania, Decided October 2, 2008

Carol Post suffered serious injuries in a car accident and later applied for long term disability benefits. After initially being granted these benefits, The Hartford terminated them after determining that she wasn't "Totally Disabled," prompting Post to bring an ERISA action. The court initially granted The Hartford's motion for summary judgment "under a moderately heightened … standard," but after the appellate court got involved and remanded the case, the court determined that The Hartford's decision to stop the LTD benefits was "arbitrary and capricious."

Furthermore, a detailed review of Post's medical records from 1997 through 2003 found that her condition hadn't changed and also that "the insurer failed to give credit to the opinions of various treating physicians and used aggressive tactics towards the employee."

The court denied The Hartford's summary judgment motion and instead entered judgment in Post's favor.

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7. PROVING YOUR DISABILITY CLAIM

You start off with the deck stacked against you when you're making a disability claim. The insurer gets to make the rules, defining and interpreting what a disability is and then deciding whether or not you receive benefits. There's a built-in conflict of financial interest, because the insurer benefits from denying benefits.

Insurers pay the medical providers who review your disability claim.

For group benefit disability claims, the Supreme Court has ruled that if the opinions of the in-house medical providers differ from your own doctor's, the insurer has to give your doctor's opinions great weight. (But that doesn't mean your doctor's findings are a determining factor.)

For claims made under an individual disability plan, the court has ruled that the insurer only has to consider your doctor's opinion as one factor in its decision on your claim.

Insurers discount Social Security's findings.

Although insurers want you to file for SSD when you've been hurt or become ill – your doing so reduces the amount of money they may have to pay out – they don't always abide by the agency's findings about your disability. They claim that's because Social Security uses slightly different rules when determining disability.

Flawed Vocational Reviews Can Reduce Your Benefits

Insurers hire vocational analysts who are supposed to determine what kind of work you can do based on the level of physical work you can tolerate – your residual functional capacity (RFC). But the job lists that these analysts develop are often unrealistic in their expectations of your ability.

Definitions for residential functional capacity

Sedentary
(office job) - sitting up to six hours a day, standing or walking up to two hours a day and occasionally lifting or carrying up to 10 pounds.

Light
- (security guard) - standing or walking up to six hours a day, frequently lifting and carrying up to 10 pounds, occasionally lifting up to 20 pounds.

Medium
lifting up to 50 pounds.

Heavy
lifting up to 100 pounds.

Very heavy
lifting more than 100 pounds.

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8. HOW INSURERS DETERMINE YOUR RFC

In deciding your level of residual functional capacity, insurers look at the maximum work that you can do in a 40-hour-a-week job on a regular basis. They will assess your mental and physical abilities to determine how well you can do the job, and they must consider:

- Your level of pain.
- Mental impairments – Do you have trouble understanding, remembering and carrying out instructions? Can you handle work pressures, and do you interact appropriately with your coworkers or supervisors?
- Your medical history and what medical professionals have found in reviewing your case.
- Observations from non-medical people, including family members and social workers.
- Your skill levels.
- How much time you would be away from your job because you needed treatments or because you were physically or mentally impaired.

Working at your own occupation

If your illness or injury keeps you out of work for more than 24 months (or the time frame defined in your policy), the rules about working change. For the initial period, you only have to be able to prove that you can't perform your own occupation. (A construction worker with a bad back, for example, won't be able to lift 100 pounds.)

After 24 months, the insurance company wants proof that you can't perform any occupation for which you qualify based on your skills, your background and your education. There is a salary percentage requirement, however, so you won't have to take a job that pays less than 80 percent of the salary you earned before you were disabled.

CASE STUDY #5: Rabuck v. The Hartford Life & Accident Ins. Co., United States District Court for the Western District of Michigan, Southern Division, Decided October 30, 2007

Rober Rabuck brought an ERISA action against The Hartford seeking to reinstate long term disability benefits for a policy that he had obtained from a previous employer.

The Hartford had paid him LTD benefits between January 2004 and May 2005, at which point it suspended benefits after determining that Rabuck had recovered enough function to work as a company president full time.

Fortunately for Rabuck, however, the court found that the record had no evidence that "supported the existence of part-time company president jobs." That finding makes some intuitive sense: how can you run a company working part time? Also, per the Case Summary, The Hartford's decision to terminate benefits "studiously avoided any reference to, or analysis of, the Social Security Administration's finding that the employee was totally disabled from performing the requirements of any occupation."

The court branded both The Hartford's decisions and its methods "arbitrary and capricious" and ordered the company to reinstate Rabuck's benefits, including past due benefits and prejudgment interest in addition.

9. INSURERS ' CLAIM-DENYING TACTICS

The Hartford Denial Tactics

Private Investigators: The Hartford may hire private investigators to videotape your activities, hoping they can catch you performing some physical activity your disability shouldn't let you do.

The Hartford Doctors & Nurses: Even if they have never seen you or treated you, The Hartford own doctors can still disagree with your doctor's diagnosis.

Insurance companies have refined the strategies they use to deny disability claims. They include:

- **Sending out records of various medical impairments to different doctors.**

  If your disability consists of several medical impairments, insurers try to separate them out so that no one doctor gets a complete picture of the full extent of your disability.

- **Using videos and private investigators**

  Insurers hope they'll catch you doing something that you claimed you cannot do, and they may hire investigators to follow you around to take videos. The insurance company may claim that "evidence" of you going to a doctor or picking up an order from a fast-food window demonstrates you're capable of more physical activity than you reported.

  Claims people often don't even bother to watch the video the investigator took, so it may be unfairly edited. If you've lost benefits because of a video, ask to see the investigator's report to determine whether it is biased or unfairly edited.

- **Assessing functional capacity improperly**

  Your insurer may require you to take a Functional Capacity Exam (FCE) to determine your residual functional capability. But the insurer's representative may not administer the FCE properly, producing unreliable and incorrect data that could be used to dismiss your claim.

- **Claiming you are malingering**

  The insurer may insist that there is nothing really wrong with you and that you're making the disability claim to avoid work while receiving financial benefits.

- **Labeling you as non-compliant**

  What if the medicine or a treatment the doctor prescribes seems to make your condition worse? If you stop taking it, the insurer will say you are non-compliant in your treatment and deny your claim. (This is when it pays to have an experienced attorney, who can argue that you only stopped being compliant because there were good reasons for you to do so.)

- **Saying your symptoms are related to job stress**

  They'll ask you about any problems that you've had with supervisors or co-workers to make the argument that your problem is not physical but mental.

10. THE ADMINISTRATIVE APPEAL PROCESS

> ! *It's essential that your administrative appeal contains all the necessary evidence to back your claim. You can't add anything to the record when you file a lawsuit.*

If The Hartford denies your disability claim, you'll receive a letter in the mail that will include:

- An explanation of why it denied the claim
- A list of the evidence it used in making its determination
- Who reviewed your claim (claims person, physician, nurse manager)
- Information about filing an appeal, including where you have to send it and the deadline for submitting it

Appeals under ERISA can take up to a year

The process moves slowly:

- **The insurer has 45 days** to make its initial decision rejecting a disability claim. Under certain circumstances, it may also get **two 30-day** extensions.
- **As claimant, you have 180 days** after the claim denial to prepare and file your administrative appeal.
- **The insurer has 45 days** to decide on your appeal; it may get one **45-day extension.**

Check your policy to see how long you have to file suit if your appeal is rejected. The contractual statute of limitations can vary from less than a year to three years.

CASE STUDY #6: Rist v. The Hartford Life & Accident Ins. Co., United States District Court for the Southern District of Ohio, Western Division, Decided April 18, 2011

Christopher Rist brought an ERISA action against The Hartford, after the insurer stopped paying his long term disability payments and waiver of premium benefits. Among other medical problems, Rist suffered abdominal pain, bowel-related complications, incontinence and other severe digestive system issues.

The Hartford did not give any "reasoned explanation" for its conclusion that Rist had somehow improved enough from a medical perspective to no longer be considered disabled.

In fact, per the Case Summary, The Hartford's conclusion stood "contrary to the clear and explicit findings of his treating doctors and the Social Security Administration." The court denied The Hartford's motion for judgment and instead granted Rist's motion for judgment on the administrative record.

11. APPEAL DENIED? STEPS FOR FILING A LAWSUIT

If you believe the insurer has unfairly denied your disability claim and appeal, you do have the right to file a lawsuit. The rules differ for group and individual disability policies.

If you're covered by a group policy and governed by ERISA law, you won't be able to seek either punitive or compensatory damages. If you win, you'll only receive the benefits you were entitled to.

- You can't file the lawsuit until you've exhausted all of your administrative appeals.
- You must meet deadlines. You won't be able to pursue your case in court if you don't meet the cut-off date for filing your administrative appeal or if you don't file your case in court before the deadlines listed in your policy (the contractual statute of limitations).
- The judge may – but isn't required to – order the insurance company to pay your attorney's fees if you win.

Under ERISA law, only a judge hears your disability denial case; you can't request a jury trial. Even if a judge rules in your favor and orders the insurer to start your monthly benefits, the insurance company could decide to cut your benefits off in the future if it believes you no longer meet the definition of disability as explained in your policy.

State law governs lawsuits when you've bought an individual disability insurance policy.

- You still have to meet all deadlines.
- You do have the right to seek punitive damages and attorney fees from the insurer.
- You can request a trial by jury.
- You may bring in new evidence, and you have the right to cross-examine the insurance company's witnesses.

CASE STUDY #7: Smith v. The Hartford Life & Accident, United States District Court for the Northern District for California, San Francisco Division, Decided January 30, 2013

Lori Smith brought an ERISA action against The Hartford to reinstate her life insurance waiver of premium benefits. During 2005-2006, she developed severe carpal tunnel syndrome as well as arthritis that ultimately led her to have hand surgery on her right hand, right thumb and left thumb.

In the wake of her surgery and physical therapy, she went back to work in the beginning of August 2007 at a position that required her to spend 80% of her work activities typing at a keyboard. The anxiety and stress of having to work while hurt caused depression, and she ultimately filed for (and received) short term disability, long term disability and a waiver of premium benefits from The Hartford.

The insurer later investigated and denied her benefits, and this decision ultimately prompted a bench trial on the record. The court considered the parties' briefs, bench trial arguments and administrative record and ruled that Smith should be entitled to benefits, saying that "The Hartford abused its discretion when it terminated Mrs. Smith's waiver of life insurance premium benefits."

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12. HOW CAN I FIND THE RIGHT DISABILITY ATTORNEY?

An experienced disability attorney is essential to the success of your case.

When you work with a well-qualified disability attorney, statistics suggest you can double your chances of being successful at winning the disability benefits you're due.

An experienced attorney:

- Understands how insurers operate and the tactics they use to deny claims.
- Can evaluate your case up front for its strengths and weaknesses.
- Knows the case law required to persuade judges that the insurer is wrong in denying your claim.
- Is in a better position to negotiate a cash settlement with your insurer to avoid the cost of litigation.

For a favorable outcome, contact an attorney experienced in disability claims before you first file your disability claim.

Ask these questions:

Are you a licensed attorney?
Don't be fooled by people who claim experience with disability claims but don't have the credentials necessary to take your case all the way to court if necessary.

What is your experience in handling disability claims?
Ask about ERISA experience if you're covered under a group plan. If your policy was purchased individually, ask how many cases he or she has tried in state courts.

What is the main focus of your practice?
An attorney who builds a practice around ERISA law is more likely to be up to date on the issues involved in disability cases.

Can you share articles that you've written about disability cases?
Attorneys with in-depth knowledge of disability law usually write about that experience in respected publications.

Check the attorney's rating from several sources:

- Reviews on sites like Yelp and Google can give you some indications of other people's experiences with the attorney. Look for a consensus; don't be sidetracked by one or two very negative (or positive) comments.
- To arrive at its rating of attorneys, Martindale.com asks lawyers using peer review surveys to evaluate other lawyers.
- Check an attorney's score on Avvo.com's website. Attorneys receive ratings on a 1-10 scale based on experience, professional conduct and industry recognition.
- Only attorneys who are highly regarded by their peers and who have outstanding professional achievements win a listing on the Super Lawyers website. You can choose to review listings by practice area.

13. SUMMARY: GETTING YOUR LTD CLAIM APPROVED BY THE HARTFORD

You don't do your best thinking when you are in pain and disabled from an accident, injury or serious illness. But that is the time you're expected to fight your way through the maze of contract language, procedures and deadlines that make up the disability claim system.

Don't go it alone – get help early in the process.

With disability claims, you only get one chance to appeal. Miss a deadline or forget to file an important piece of evidence, and you will never again get the opportunity to make your case. A lawyer experienced in ERISA law can work with you to make sure that your administrative appeal is as strong as possible with all the necessary supporting information included.

If the insurer still won't pay, an experienced ERISA attorney can file the lawsuit in court. Even better, that attorney will know how and when to approach the insurer to reach a settlement and avoid the expense of going to court.

At Marc Whitehead & Associates, Attorneys at Law, LLP, we have that experience. Call our offices today at 800-562-9830 for assistance in filing your initial disability claim, making an administrative appeal or taking your case to court.

ABOUT MARC WHITEHEAD

Marc Stanley Whitehead is the founding partner of Marc Whitehead & Associates, Attorneys at Law, LLP, which was established in 1992 in Houston, Texas.

Born in Memphis, Tennessee, Marc was raised in Normangee, Texas. He graduated in 1985 from Normangee High School as class valedictorian. Marc attended Texas A&M University where he graduated in 1989 with a Bachelor of Business Administration in Finance.

Marc attended the University of Houston Law Center and received his law degree (J.D.) in 1992, graduating in the top quarter of his class. He was admitted to the State Bar of Texas in 1992. He is also admitted to practice before all U.S. Federal District Courts in Texas, the U.S. Court of Appeals-Fifth Circuit and the U.S. Court of Appeals for Veterans Claims.

Marc's areas of practice include personal injury and wrongful death, Social Security disability, long term disability insurance denials, employee benefit denials, ERISA litigation and insurance claims and pharmaceutical and medical device litigation.

He is also a former adjunct professor of Law at the University of Houston Law Center teaching Civil Trial Advocacy. He has been an instructor for the National Institute of Trial Advocacy teaching Civil Trial Advocacy and an instructor for the National Business Institute teaching Social Security Disability Law.

Marc is double board certified in both Personal Injury Trial Law by the Texas Board of Legal Specialization and in Social Security Disability Law by the National Board of Social Security Disability Advocacy.

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