QUESTIONS AND ANSWERS ON DISABILITY ISSUES

The law of disability is much more complex than it seems. You may wonder what could be so complicated, when the insurance you purchased was offered to assist you when you become disabled. Understand that the companies offering you the disability coverage did so for financial reasons. They were, in essence, making a bet that you would NOT become disabled. To 'insure' that bet, you paid a premium for the privilege of being able to collect disability benefits if become disabled from working either at your occupation or at any occupation, depending on the language in your policy.

Years after selling these policies, the companies, by and large, realized just how expensive this line of business had become. Now more than ever, they have restructured their businesses to manage this risk more conservatively.

The disability insurance industry has become very sophisticated in their **investigative** techniques. Before they part with benefit monies, they do quite a bit of "homework", to find out more about you and your claim. Are they entitled to delve into all of the areas they seek information on? How will the insurance company's contacting your co employees affect your ability to return to employment, assuming you are physically able to do so in the future?

These and other questions often arise when someone files a claim for disability benefits.

Other considerations:

What is the definition of disability in my policy and what does it really mean to me?

The definition of disability varies from policy to policy. Courts across the nation have evaluated policy language and sometimes find the insurer's limiting interpretations improper. For example, does the "any occupation" clause really mean that if an insured can do **ANY** job, he is not disabled? The answer to that question is "no". Many courts have found that the insurer must consider whether the alternative job they suggest you are able to perform would pay enough wages to qualify as "gainful" and whether the job is on par with your training, education and experience.

What are the time limits for making a claim for benefits, or filing litigation if my claim is denied or benefits terminated?

Most policies that I have seen require you to file for benefits within 30 days of learning that you are disabled. This time period can often be extended although limits apply. If you decide to file a claim in Court, check your policy carefully because a three year limitation often applies, and some policies have expressed shorter time limitations. You must seek legal counsel right away if you think that time is running out on your right to file litigation. Most group plans under **ERISA** have deadlines for submitting an appeal of the administrator's decision. The denial/termination letter should include the details and time limitations.

What is the waiting period for disability benefits to begin?

This is often referred to as the elimination period, and is set forth in the policy. Usually, it is 30-120 days.

What offset provisions do I have to worry about, and do I have to agree to pay the insurer/administrator the money I may eventually recover from another source, such as social security?

Most group policies include an offset provision, which will directly reduce the amount of money the insurer/administrator has to pay you. You may be required to apply for certain benefits, such as Social Security, and the benefits you receive would offset how much you continue to receive from the administrator of the Plan. Check your policy carefully regarding permissible offsets.

What about the newer limitations placed on the amount of time that *I* can collect benefits due to certain medical problems?

The article attached to this month's newsletter explains what has happened to the 24 month mental nervous limit and the widespread practice of companies lumping many non-psychiatric disabilities under that umbrella in order to limit their exposure.

It becomes more important than ever to have an advocate for your case early on in your claim for the following reasons:

1. The initial claim form can often be misleading and doesn't provide enough space for answers to important questions. Partial answers may adversely effect your ability to collect benefits.

2. You are often asked to sign an extensive authorization permitting the company to delve into your personal private financial and medical background, including bank information, social security information, etc.

3. Your treating doctor should be counseled on how to effectively interact with the insurer/administrator, whose claims representatives are trained in techniques to collect information in such a way as to undermine your claim.

4. You should be aware of what the investigative process entails, what you must divulge and what you should not give the insurer/administrator access to.

5. You should be advised as to the insurer/administrator right to speak with your neighbors, employees, employers, etc. and what they are entitled to find out.

6. You should be advised about the surveillance certain to occur at some time during the claim period.

7. There are certain offsets the insurer/administrator may be entitled to, and you should be advised as to how that impacts on your claim.