Disability Insurance: A Survivor’s Guide

This article by benefits expert Jacques Chambers, discusses disability insurance; it originally appeared in the HCV Advocate, mid-month December 2015

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In addition to Social Security Disability benefits, many people also have private disability insurance to supplement it. The vast majority of these policies are offered as part of the employee benefits package offered by employers, and are called Long Term Disability Insurance (LTD).

These policies are sold by insurance companies to employers, who proudly emphasize how their generosity helps their employees if they are ever in time of need and how they provide financial security during a disability. Most employees file that LTD booklet away (or lose it), with the assurance they have some extra financial protection from illness or accident. That comforting picture changes, however, when you actually need to file a claim and receive benefits.

The first thing to understand is that these companies are almost all large, very profitable corporations that must answer to their stockholders for their profits. The less they pay out in claims to the disabled, the higher the profits. There are some laws that attempt to provide some protection for claimants, and the benefits are paid under a legally enforceable contract. However, the companies still have an incentive to interpret the contract provisions and medical records very conservatively.

When someone files for Social Security Disability benefits, there is a 60 percent chance their initial claim will be denied, but once approved, the benefits tend to continue unless someone does substantial work when they are supposed to be disabled insurance carrier will regularly and frequently request information on your health status. Often, they will want you to complete a form every three months, and many carriers will insist that your physician complete a portion of that form each time.

The Two-Year Cliff
Although the carrier may try to terminate benefits earlier, most terminations occur once benefits have-been paid for two years. The reason for this is virtually all LTD policies change the contract definition of disability:

- During this first two years of a claim, disability is defined as, "…*the inability to perform the material and substantial duties of your* ***regular occupation***." [emphasis added];
- After two years, disability is defined as, "…*the inability to perform the material and substantial duties of* ***any occupation*** [emphasis added] *for which you are reasonably suited by education, training,or experience*."

Regardless how small the differences between the two may appear, they are important enough that insurance companies will always get new medical records, and, very frequently, terminate your benefits claiming "…*you no longer meet the [new] contract definition of disability*."

Under the new definition, all they need to do is find some kind of occupation you might be able to

perform, and your benefits stop. Examples include:

- You used to be a supervisor that required walking around a job site but had to stop because of bad knees. They say you could perform a sedentary job such as construction office manager or consultant.
- You used to be a file clerk, but due to arthritis,you have difficulty carrying files and bending and opening file drawers. They say that you could sit in a booth and be a parking attendant at a parking lot or garage.

All they have to show is that there is an occupation your current experience and physical condition shows you have the ability to do even if you have never done it before.

They do not have to find occupations that match your old salary; only the amount of benefit the LTD has been paying, rarely more than 60 percent of your old salary. They also do not have to show that there are job openings in that field in your area, only that such jobs exist. Insurance companies have Vocational or Transferable Skills Analysts on staff that do nothing but look for occupations a person on disability might be able to do.

In their letter terminating benefits, they often refer to a Dictionary of Occupational Titles. A more current and thorough listing of job titles and skills is found online as O*Net Online (www.onetonline.org) which is sponsored by the U.S. Department of Labor. This site can be very helpful should you need to appeal such a termination.In addition to having contract language that is favorable to limiting benefits, claims analysts obtain additional information in addition to the claimant's medical records they believe they need to justify terminating the benefits.

Physician Questionnaires – During the initial stages of a claim review, the treating physician is usually asked to complete a questionnaire about claimants condition. Knowing that physicians have little time or incentive to spend much time on such questionnaires, they frequently just list boxes to check rather than provide space of any lengthy comments. While these boxes are quick and convenient for the physician, they also allow the company to use the statement beside the checked box as if it is a quotation from the treating physician.

Internet Searches – Analysts search the net to see what activities the claimant may be participating in. They often are able to find substantial information on a claimant's Facebook, LinkedIn, and other social sites. They often find records of extensive travel, an active social life, and other activities and use that as evidence.

Surveillance – Although not very common due to the expense, insurance companies will occasionally hire an investigator to follow a claimant and videotape their activities. This can last over a period of two to three days. Insurance companies find this especially helpful to disprove statements by the claimant, or even the physician, on questionnaires about the claimant's limited

abilities.

“Independent” Medical Examinations – Carriers will occasionally require a claimant to undergo a physical examination by a physician of their choosing at their expense. These are normally performed by medical groups that only do such examinations. Although the groups are “independent,” their primary source of income is insurance companies. Failure to undergo such an examination can result in termination of benefits, as the contract usually requires them, if requested.

Functional Capacity Evaluations – Like physical examinations,insurance carriers can require a claimant to undergo an examination to “measure” what activities, movements, and strength the person has. Again, these are performed by organizations that contract with insurance companies who pay for their services.

How Does One Claimant Fight Against That?
Although, you, the claimant, are not as well financed or legally trained, there are several things you can do to protect your status as “disabled”:

- **Make sure your medical records are very detailed and complete**. In this age of electronic records and pressure on physicians to see more patients more quickly, you need to make sure the doctor is putting all of your issues in the record. All of your symptoms needed to be clearly described at each visit even if they haven’t changed. Make sure any events or anecdotes that illustrate your limitations are recorded. Ask your doctor to order any and all tests that can “objectively” support your restrictions and limitations.
- **Know when the insurance company is looking at your records.** Ask the doctor or the nurse to put a conspicuous notation in your file that you are to be contacted EVERY time the insurance company contacts your doctor. If your doctor isn’t already aware, make sure he/she knows not to speak about your condition to the company by phone, but to ask them to submit their questions in writing.
- **Know your rights**. If your LTD came through an employer, your plan comes under the federal Employee Retirement Income Security Act of1974 (E.R.I.S.A.). While that law is not the most consumer-friendly law, it does give you some rights if your claim is denied or terminated. For example, you have the right to a free copy of your complete claim file. Also, the law gives you 180 days to file an appeal so do not let some clerk rush you into quickly sending in a handwritten letter with a page or two of medical records.

- **Seek professional help.** Unfortunately, insurance companies pay very little attention to appeals unless they come from an attorney. Unfortunately, E.R.I.S.A. limits the fees attorneys can charge so it is not easy to find one. Most attorneys who do take these cases on a contingency basis charge not only a percentage of the initial retrospective payment but also a percentage of each future monthly disability payment. All the more reason to work with your doctors to make sure your records clearly show your restrictions and limitations.
