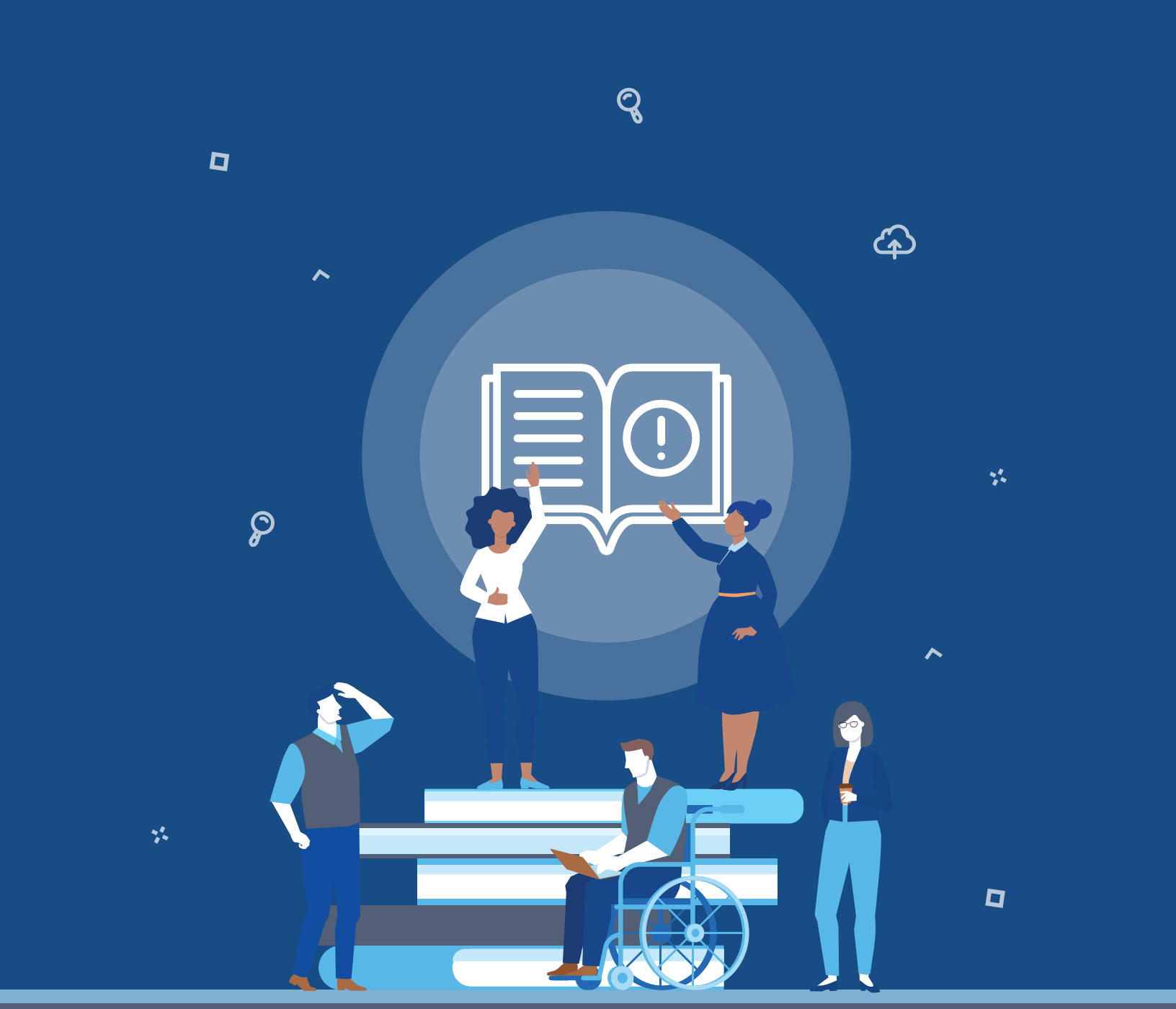


A COMPLETE GUIDE TO

# LONG-TERM DISABILITY

Many of us start out as young adults believing that we are invincible. Over time, we begin to realize just how wrong we were. If we are lucky, we maintain our health until old age — but many Americans are not so fortunate.

According to the Centers for Disease Control and Prevention (CDC), 26% — or 1 in 4 — Americans have some type of disability. Having a disability can affect all areas of your life, from where you live to your access to healthcare. It can also have a serious impact on your financial stability, particularly if you are unable to work due to a medical or mental health condition.

For individuals who cannot work because of a disability, there are some options. Long-term disability insurance provides monthly payments for a set period of time; these benefits are based on a portion of your salary. Not all Americans have this type of insurance, however, as it is typically offered through an employer or purchased individually.

The federal government also provides benefits to Americans with disabilities through the Social Security Administration. Both Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) offer monthly payments to people who cannot work due to medical or mental health impairment. The main difference between the two programs is that SSI is needs-based, while you must earn a certain number of credits by working and paying taxes to be eligible for SSDI.

Understanding the options available to you as a person with a disability is critical as you work to find your new normal. Whether you are interested in filing for one or all three types of benefits, a skilled disability benefits attorney can help you put together a strong application, supported by evidence, to increase your chances of approval.  This guide will focus on navigating the application process, and some of the pitfalls of applying for long term disability insurance.

# Table of Contents


# CHAPTER 1

# What Is Long-Term Disability Insurance?

Long-term disability (LTD) insurance is a type of insurance that is designed to replace a portion of your income if you cannot work for an extended period of time because of an illness or injury. It is typically offered through group insurance plans, but can also be purchased individually.

This type of disability insurance can be crucial in protecting your financial stability in the event that you experience medical hardship. According to the Social Security Administration (SSA), more than one in four 20-year-olds will experience a disability for 90 days or more before they reach the age of 67. LTD insurance can provide payments to cover a period of time that you are not able to work due to a disability.

There are two primary types of disability insurance: short-term and long-term. As the name suggests, short-term policies are intended to replace income for individuals who are unable to work for a shorter period of time, typically for one to six months (depending on the policy). There is often a waiting period, such as two weeks, before you can access short-term disability benefits.

In contrast, long-term disability benefits are meant to cover illnesses or injuries that last an extended period of time. This type of policy will provide a monthly payment of between 50 to 60% of an individual's monthly salary, for a set period of time. Depending on the policy, benefits will be paid for up to 24 months, 5 years, 10 years, or even until retirement.

There is a significantly longer waiting period for LTD insurance. Generally, you must wait between 3 and 6 months before you can apply for LTD benefits. The clock starts to run from the date that you become disabled under the terms of the policy.

# CHAPTER 2

# How Disability Is Defined

LTD policies have different definitions of "disability." While there will be variations in the specific wording, there are two primary ways that these policies define disability: (1) whether you are able to perform your "own occupation" or (2) whether you are able to perform "any occupation." The distinction between these two definitions is important and may determine whether you are entitled to benefits. Some policies will include an additional prong to this definition: whether or not you are able to earn some percentage of your pre-disability earnings (often consistent with the benefit amount).

An "own occupation" policy defines disabled as it relates to your ability to perform the duties of your regular position. In other words, if you cannot engage in the custom work of your regular position, then you will be considered totally disabled. Even if you can perform another job, you will receive benefits.

"Own occupation" policies usually refer to the specific work that you were doing at the time that you became disabled. However, the definition in each policy may be different. The exact wording of your policy will determine coverage.

This type of policy is common for many individuals performing highly compensated, highly skilled work, such as lawyers and doctors. For example, a hand surgeon may have an "own occupation" LTD policy that provides benefits in the event that they cannot perform their specific occupation (hand surgery).

LTD policies that define disability based on "own occupation" often limit benefits to a set period of time, typically the first 24 months after becoming disabled. After that time, coverage will likely change to an "any occupation" definition of disability. In this situation, benefits will likely be terminated for many policyholders.

By contrast, “any occupation” provisions in an LTD policy define disability based on whether the policyholder can work in any job, whether or not it is their current profession. With an “any occupation” policy, if you can perform in any occupation as defined by the policy, then you will not be considered totally disabled.

Importantly, the policy will define what constitutes “any occupation.” It will generally be limited to employment in a position that you are reasonably suited for, based on your education, skills, employment history, and other individual factors. The insurance policy may also define “any occupation” as a job in which you can earn a specific percentage of your pre-disability earnings (typically 60 to 80%).

The way that “any occupation” is defined is important, because it may significantly limit what other jobs you may have to consider before being considered totally disabled. As always, the specific policy terms will determine whether you are totally disabled and entitled to benefits.


# CHAPTER 3

# What Laws Govern Long-Term Disability Claims?

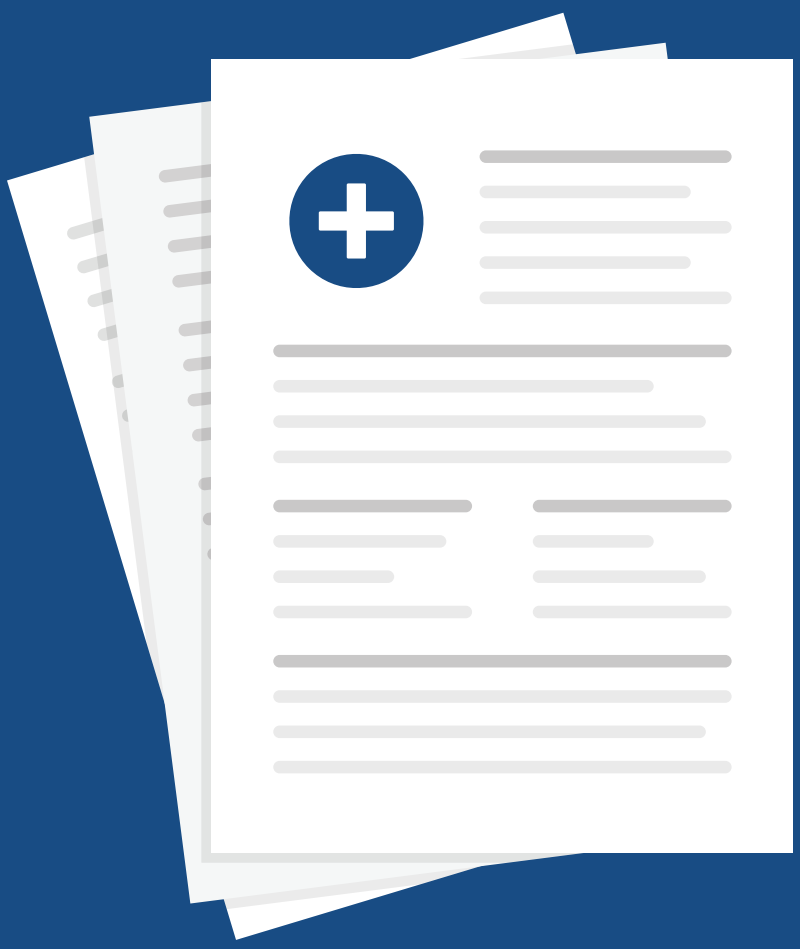
LTD policies are either regulated by federal or state law. Most group disability plans provided by an employer are subject to the Employee Retirement Income Security Act of 1974 (ERISA). Private policies that are purchased individually are not governed by ERISA.

It can make a significant difference if your policy is covered by ERISA, as this law provides legal protections to employees. ERISA sets minimum standards for employee group benefits. and ensures that employers are acting in the best interests of employees. This law regulates how disability plans are managed by the employer, such as the processing of claims, claim deadlines, and appeal rights.

ERISA also mandates that employees have access to information about their benefit plans. Employees who are covered by their company's LTD policy must receive a written summary of the plan that explains key features, including how the disability plan works, what benefits are offered, and any out-of-pocket costs that the employee may incur for coverage.

Coverage under ERISA is critical as this law provides a number of protections that may help an employee obtain disability benefits. For example, if a claim for benefits is denied, then the beneficiary must receive copies of any documents, records or information relevant to their claim upon request. In addition, claimants must be allowed to appeal denials.

On the other hand, as lawsuits over disability benefits have gone to court, ERISA has been interpreted in ways that benefit insurance companies. In particular, if a claim denial is upheld, a policyholder cannot add new evidence to prove their disability. It may also be difficult to have the insurance company's decision overturned by a court.



# CHAPTER 4

# Obtaining Long-Term Disability Insurance

There are several ways that you can sign up for LTD insurance. The best option will depend on your financial situation, including whether you are currently employed. Your choices include:

1. Signing up for employer-sponsored coverage at work. *Some states, including New York, New Jersey, California, Hawaii, and Rhode Island, require employers to provide disability benefits for their employees.
2. Purchasing disability insurance through your employer at a group rate.
3. Buy disability insurance through a professional association.
4. Purchase an individual disability insurance plan.

LTD policies are relatively inexpensive. There are a number of factors that can impact the cost of a policy, including your age and health, your gender, whether you smoke, your occupation, how disability is defined, your income, the length of the waiting period, the length of benefits, and any extra features.

# CHAPTER 5

# Filing for Long-Term Disability Benefits

If you are unable to work due to a disability, applying for LTD benefits is an important step in ensuring that you are financially secure during a difficult time. This is a separate process from applying for short-term disability benefits. If you have applied for and received short-term benefits and are unable to work when those benefits expire, you will need to apply for LTD benefits.

The first step that you should take is to examine your insurance policy. Did you purchase it privately, or obtain it through your employer?  If you bought it on your own, the policy documents (or the insurance company's website) will explain the application process. Otherwise, you should ask your employer for an application; ERISA will govern the claims procedure.

As you read the policy, pay attention to how "disability" is defined, as well as any limitations or exclusions for particular disabilities (such as substance abuse). Check to see if benefits are limited for mental health conditions or other medical issues. At this point, you may want to ask a disability benefits attorney to review the policy with you to help you understand all of the terms.

# Filing the Application

Once you are ready, start working on the application itself. It will typically include a place for you to submit an "employee statement." This will require you to provide information such as your address and phone number, employer name, occupation, birth date, Social Security number, work history, educational background, the date that you were injured or that your illness started, the last day that you worked, a description of your disability, any medications that you take, the names and contact information for your treating medical professionals, and any other income sources that you may be eligible for, such as Social Security benefits. Be sure to answer every question completely, and use additional pages if necessary.

As part of your application, you will need to provide objective evidence of your condition, such as medical records or test records. You may also submit documentation about your inability to work due to your disability.

Your employer will also be required to submit information if you have coverage through a group plan. Otherwise, you will need to collect medical records and a statement from your doctor. This statement will give your doctor's opinion of your condition; because it is an important part of your claim, you should meet with your doctor to discuss it before starting your application.

While your claim is pending, you should continue to receive treatment. Many policies list failure to continue treatment as grounds to terminate benefits.

# Handling Requests for Information

The insurance company will typically ask for access to all of your medical records. While the insurance company has a right to review records related to your claim, they do not have a right to access records that are unrelated to your claim. For example, if you are requesting benefits for emphysema, then records related to a gynecological condition are not likely relevant.

Information from your medical records may then be used as a basis to deny your LTD benefits. For this reason, carefully read anything that you are asked to sign, such as an authorization to release your medical records. A disability benefits attorney can review this type of document before you sign it.

You may also be asked to submit to an "independent medical examination" or IME by a doctor of their choice. Your insurance policy may require you to attend this exam in order to receive benefits.

The insurance company may also seek employment records and other evidence of your work history. You should provide this information if it is requested. In addition, a specific job description for each of your positions can help you define what exactly it is that you do in your role.

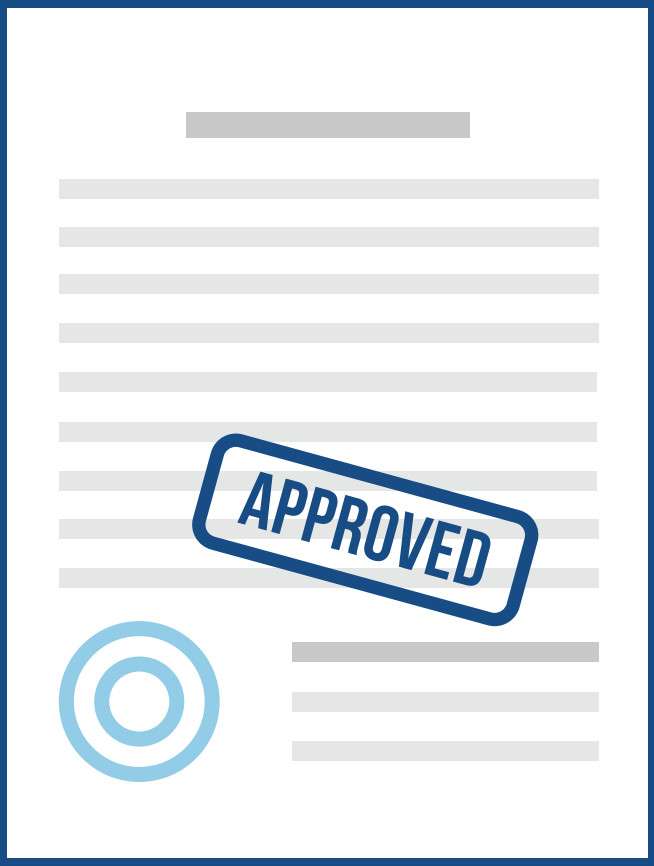
Financial and tax records may also be requested by the insurance company. These documents are used to define your occupation and ferret out fraud. While you are required to turn over your federal tax returns, you may not be required to disclose other information; a lawyer can help you determine what you must submit.

Throughout the process, the insurance company may ask for additional information. This may include requesting that your doctor complete physician statements, asking you to attend a vocational assessment or requesting updated medical records or tax information.

# Receiving a Decision

In employer-provided policies that are covered by ERISA, insurers must make a decision within 45 days of a claim being filed. However, the plan can request up to two extensions and can ask for additional information from the employee. A written decision must be made within 30 days of receiving the final information.

If your claim is granted, most policies will require you to apply for Social Security disability benefits. If you are awarded benefits, the amount that you receive will offset your LTD payments.




# CHAPTER 6

# Common Pitfalls in Long-Term Disability Cases

While long-term disability insurance can be incredibly valuable, it is often challenging to be approved for this type of benefit. Insurance companies are a for-profit business — and LTD payments are a particularly pricey type of claim to pay out to policyholders. That is why insurers often use every trick in the book to deny or delay claims, or to terminate benefits early when they can.

These tactics can make it difficult to be approved for LTD benefits. Long-term disability insurance companies may use surveillance to monitor claimants, argue that you failed to adequately describe your condition or state that your doctor has not provided sufficient support for your claim. An experienced long-term disability benefits lawyer can work with you to avoid these pitfalls -- and ensure that your application is as strong as possible.

## Denial and Termination of Long-Term Disability Benefits

Insurance companies deny and terminate LTD benefit claims for a variety of reasons. Some of the most common reasons include:

1. ***You don't meet the policy's definition of disabled.***

   As discussed above, LTD policies will either define disabled based on whether you can perform your "own occupation" or "any occupation." If you have an "own occupation" policy, your claim may be denied if the insurance company uses a generalized definition of your job that includes responsibilities that you can perform.

   Many insurance adjusters do not examine whether you can do your job based on the way that you actually perform the day-to-day functions. Instead, they rely on an outdated publication, the Dictionary of Occupational Titles, which has not been updated since the 1970s. By using this dictionary instead of what you actually do at work, insurance companies may find you to be capable of performing your job — even if the description doesn't match what you actually do.

### ❷ *Your claim is based on subjective symptoms.*

Many disabilities and health conditions are based on subjective criteria, such as pain or fatigue, such as fibromyalgia or chronic fatigue syndrome. That does not make them any less real; it is just a sign that our medical expertise has not evolved to a point where we can diagnose all conditions. Unfortunately, even when these types of symptoms are caused by an illness that has been objectively diagnosed, insurance companies will often deny benefits due to a lack of "objective findings" to support your disability.

### ❸ *There is insufficient evidence to document your disability.*

An LTD claim may be denied if the insurance company does not have sufficient evidence on file to document your disability. This may be due to missing records, a lack of detail in the records that were submitted, or another issue. In some cases, a claim may be denied if you do not have a documented history of being under the regular care of a physician for your condition.

### ❹ *Your insurance company's doctors disagree with your physician.*

Most insurance companies will conduct an independent investigation into your disability, using their own physicians and other medical professionals. If their doctors determine that you should be able to work after reviewing your case, then your LTD claim may be denied — even though your own treating physician has stated that you are unable to work.

### ❺ *The insurance company believes that you are not disabled due to surveillance.*

Because LTD payments are so expensive for insurance companies to pay out, many will take the extra step of conducting surveillance on claimants. This may range from checking your social media and online activity to having someone follow you and take pictures and video of your daily activities. While this is generally legal, it is still disconcerting.

If the insurance company catches you doing something that you should not be able to do (according to your application or your doctor), then your claim may be denied. In some cases, the denial may be based on something as simple as a post made on social media.

### 6 *You have an excluded or pre-existing condition.*

Some LTD policies specifically exclude certain conditions, such as substance abuse disorders and even certain conditions that are diagnosed through subjective symptoms. If you submit a claim for this type of condition, it may be denied on this basis. Alternatively, you may be subjected to a 12 month waiting period before you can apply for benefits for this condition.

An insurance company may also deny a claim because it claims that you have a pre-existing condition. For example, if you had back problems at the time that you obtained the policy and later claimed disability for back problems, the insurer may deny your claim. However, in many cases, your current disability is totally unrelated to any preexisting condition.

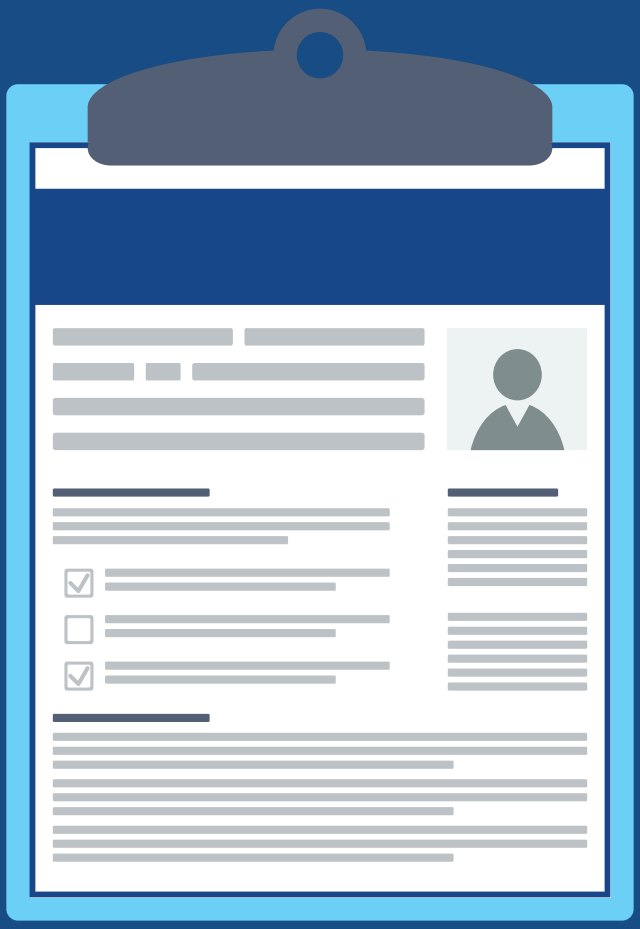
### 7 *Your insurance policy contains a limitation for certain conditions.*

Some LTD policies contain specific limitations for mental health conditions so that benefits are only paid for 24 months. After this period, you must prove that your disability is exclusively due to physical symptoms. A skilled disability benefits attorney may be able to demonstrate that psychiatric symptoms are secondary to a physical condition to overcome this type of limitation.

### 8 *The definition of disability in your policy changes.*

If you have an "own occupation" policy, then you will be considered disabled if you cannot perform the functions of your job. However, many policies change the definition of disabled after a period of 24 months to "any occupation." This means that individuals with this type of policy may find themselves without coverage after just 2 years because the insurance company argues that they are able to work "any occupation."

The average disability lasts 31.2 months. If benefits are terminated before that time due to a change in the definition of disability, it can leave employees without coverage for 7 months or longer.



# CHAPTER 7

# Appealing a Denial or Termination of Benefits

If your application for LTD benefits has been denied or terminated, the next step will depend on whether your plan is covered by ERISA or by state law. For plans that are not governed by ERISA, policyholders should examine their policy documents — or consult with a skilled disability benefits attorney to determine the process for filing an appeal.

Otherwise, if your LTD benefits are denied or terminated, ERISA mandates that the plan administrator provide you with a written or electronic notice detailing:

- The reason for the denial
- Which specific part of the plan the denial is based on
- Notice that you are entitled to receive all documents at no cost
- Copies of the rules
- Protocols and other guidelines
- Descriptions of the appeals process and time limits

The reason for the denial is particularly important, as it can be used as the basis for a successful appeal. For example, if the insurer denied the claim due to insufficient medical documentation, then additional evidence can be submitted on appeal to support the claim.

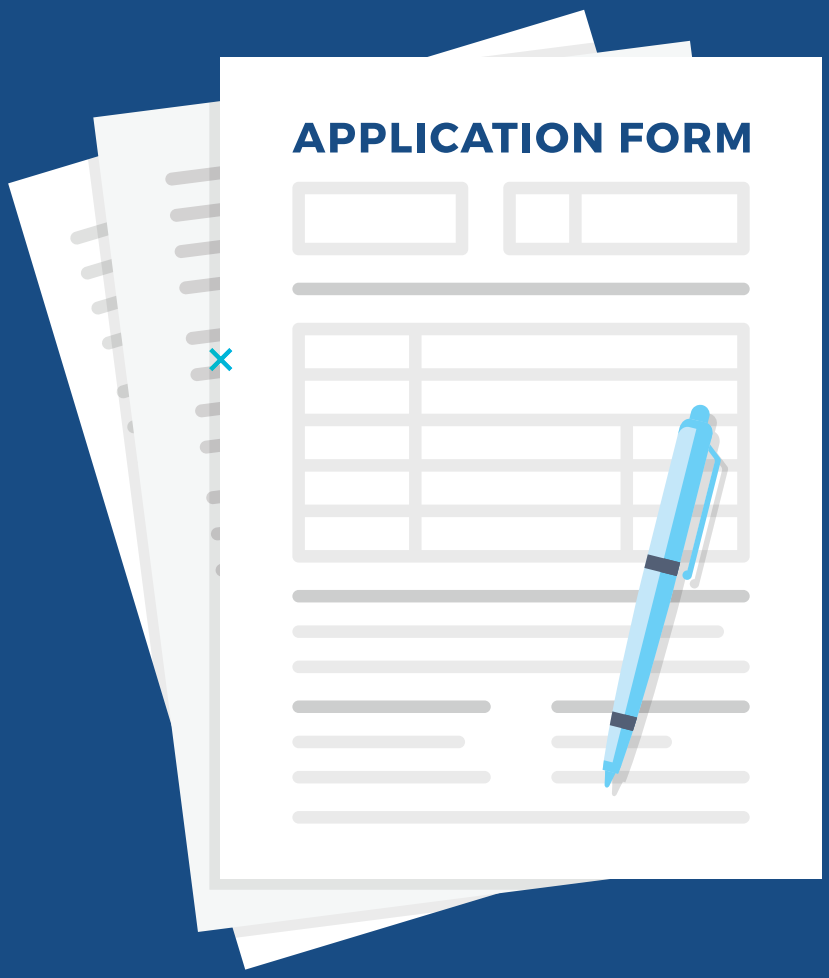
Under ERISA, employees have the right to have their appeal reviewed by someone who was not involved in the initial denial or termination of benefits. This person cannot consider the initial decision or reason for denial. The plan must allow a minimum of 180 days to file an appeal.

A decision on an appeal can be based on any information provided with the appeal, even if it was not provided with the initial application. In this way, if a policyholder's disability has gotten worse, they may be approved for benefits on appeal.

The insurance company is required to respond to an appeal within 45 days and may request an extension of up to 45 days. It cannot deny benefits for a new reason or based on a new medical report unless the policyholder is given notice and a reasonable opportunity to respond.

Some insurance companies offer a second level of appeals, known as a second or voluntary appeal. If such a process is available, the denial notice will include information about it as well as time limits for filing a voluntary appeal. Under ERISA, a policyholder must be given a reasonable amount of time to file a second appeal; the insurance company still has 45 days to respond to both levels of appeal.

Importantly, if one or both appeals are denied, a policyholder may choose to file a lawsuit against the insurance company in federal court. As a general rule, the court can only look at the evidence that was provided during the appeals process. A skilled disability benefits attorney can help to make sure that all of the necessary evidence is entered into the administrative record to increase the odds of a favorable outcome.




# CHAPTER 8

# Filing a Lawsuit

After a claim for LTD benefits has been denied and the appeals process has been exhausted, the next step is to file a lawsuit against the insurance company. For policies that are not covered by ERISA, such as policies purchased by individuals, a legal claim will be based on state law and filed in state court. Otherwise, the case will be filed in federal court.

Under ERISA, employees can file a lawsuit against an insurance company or employer for any adverse benefit determination. In addition to a wrongful denial of benefits, a federal claim can be filed for:

- Any denial of benefits
- Reduction of benefits
- Termination of benefits
- Failure to make full or partial payments
- Rescission of coverage (other than for nonpayment)
- Retroactive terminations based on claims of fraud

In addition, employees can sue their employers and insurance companies for failure to follow any ERISA rules in a non-minimal way. This can be done without finishing the appeals process. This is important, as it allows employees to file suit when employers or insurance companies are delaying a claim or otherwise violating ERISA rules — without having to wait out the administrative process.

Long-term disability insurance is an important element of any comprehensive financial plan, offering protection against the possibility of a future disability. Monthly benefits of 50 to 60% of your salary can make a substantial difference when you are unable to work. Unfortunately, even after faithfully paying premiums on your policy, an insurance company may deny your claim or terminate your benefits before you are able to return to work.

A long-term disability benefits attorney can level the playing field and increase the likelihood of a successful application. Utilizing their knowledge of the law and experience with LTD claims, a skilled lawyer can overcome the pitfalls in typical LTD benefit cases -- and help you achieve a favorable outcome.

# A COMPLETE GUIDE TO LONG-TERM DISABILITY