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HOW TO FILE A DISABILITY CLAIM

(For Benefits Provided Pursuant to an Employer Provided Benefit Plan)

If you have Short Term Disability and/or Long Term Disability coverage by virtue of your employment, or if you have purchased an individual policy, the following is intended to help you pursue a claim with your claim administrator should you become disabled.

THE LAW WHICH APPLIES TO YOUR CLAIM

The Employee Retirement Income Security Act of 1974 (ERISA) protects the interests of participants and their beneficiaries who depend on benefits from private employee benefit plans. Millions of workers in this country are participants and beneficiaries under employer benefit plans that fall under the protection of ERISA. Typically, however, church or government plans are not covered by the act.

SHORT TERM VERSUS LONG TERM DISABILITY

A Short Term Disability (STD) plan is designed to provide income replacement benefits after you have missed work, usually seven, ten or thirty days, depending upon how your employer has designed your plan. STD benefits are payable for either three or six months. The plan is designed to provide benefits in the event of a minor or serious accident or illness. Most STD plans pay benefits on a weekly basis.

The Long Term Disability (LTD) plan is designed to provide income replacement benefits typically after six months, again depending upon the plan. Most employers who have established LTD plans also provide STD benefits, but not always. The "Elimination Period" in an LTD plan is that time-frame from your last day of work until you may first receive LTD benefits, and is typically the length of the available STD payments. Benefits under LTD plans are typically payable to age 65. The LTD plan is designed to provide benefits in the event of a serious disabling condition due to an accident or sickness that lasts longer than six months. Benefits for long term disability are typically paid monthly.

The above description for STD and LTD plans is general only. You must consult your employer's plan, summary plan description, or the policy of insurance which has been purchased by your employer. Many employer provided STD plans are self-insured, meaning that your employer pays the benefit, but the employer may have retained a third party administrator (often times an insurance company) to handle the claims processing. Most employers offer LTD benefits through insured plans, meaning that the employer has purchased a group disability insurance policy on behalf of its employees. Your claim will be processed by the insurer of those benefits.

READ AND UNDERSTAND YOUR PLAN

You must read and your STD and LTD benefit plans (or policies) and ensure you understand the type of benefit to which you are applying. Most plans provide that you have to be an "active employee" of the company meaning that you are working an established number of hours per week, usually a minimum of 30. If you are recently enrolled in the plan, perhaps as a new employee, a "pre-existing clause" may apply. If you were sick or treating for a condition which eventually became disabling, and you are filing your claim within the first twelve months of enrollment in the plan, your claim may be barred.

The most important aspect of your claim is understanding and ensuring that you will meet the definition of disability. You will need to find this definition in your plan or policy. It will ultimately be your responsibility to demonstrate (prove) that your sickness or illness renders you disabled according to this plan language. The opinions of your treating physicians will be very important in this regard. You may want to speak with your physician about the filing of a disability before you do so. (See discussions below) Perhaps your physician is the one who recommended that you seek disability and cease working.

Under most STD and LTD policies (at least for the first two years) you need to prove that you are unable to perform the material and substantial duties of your "own" or "regular" occupation. Under an LTD plan, the definition will likely change after a certain period of time (usually two years) and become more difficult to prove in that you will need to show an inability to perform "any occupation." All disability policies are slightly different. Thus, the importance of understanding your plan.

WHEN SHOULD I REPORT A DISABILITY CLAIM?

You should report a claim as soon as you believe you will be absent from work for any extended period of time. You need to consult your summary plan description or insurance policy to determine any deadlines which might apply. The general rule of thumb should be to report a claim to your employer as soon as it becomes obvious you will be missing a week or more of work.

DO I NEED TO INVOLVE MY PHYSICIAN?

Your claim will not likely be successful unless your physician believes you are disabled. However, just because you have one or more physicians who are willing to complete the necessary forms, and say that you are unable to work, does not mean that the plan or insurer will agree that you meet the definition of disability under your policy. It is important to speak with your doctor about these issues and understand your physician's willingness to cooperate and be an advocate for your claim. Some physicians simply do not want to get involved or will say that they do not do "disability determinations." It is important to understand, and perhaps speak with your physician who makes such a statement, and explain that you are not seeking a disability determination under workers' compensation or the Social Security system, where specialized training to perform such determinations is typically required. (Please keep in mind however that you may also be pursuing a work comp and/or social security disability claim as well, but that should not dissuade your physician from advocating on your STD or LTD claim). You should

also ensure that you are treating with a specialist for the medical condition which renders you disabled. That way, you may end up with the support of one or two specialists and your primary care physician. The more physician support you have, the more likely your claim will be approved.

HOW DO I COMMENCE A CLAIM?

Again, you will need to consult your plan documents. Generally, you will want to contact the human resources person or department at your employer and indicate your absence from work. You will likely be told that you need to submit the claim directly with a claims administrator (not the employer) or an insurance company. Your employer may give you the required application for claim submission, or the contact information to the administrator or insurance company.

You will then be provided a disability claim packet. The claim packet or application is typically made up of three forms: an Employee Statement, an Employer Statement, and an Attending Physician Statement. You will need to have your employer complete and submit the employer statement. You should have your treating physician (or multiple physicians) complete and submit the attending physician statement.

Please keep in mind it is the responsibility of the claimant (you) to prove you meet the definition of disability (either STD or LTD) and not the administrator's or insurer's duty to disprove the claim. As part of your burden of proof, you need to ensure that all the claim forms are submitted to the insurance company.

DO I NEED TO PROVIDE MY MEDICAL RECORDS?

The disability claim packet will likely also include an authorization form for you to sign which the administrator or insurer will use to collect your medical records. You should ensure the administrator has the name and address of all medical providers who have treated you for your disability and are willing to complete the necessary forms. The administrator/insurer will then attempt to collect your medical records from these providers. The best way to ensure they are received is to obtain them yourself and submit them directly to the insurer. Document all of these steps.

DO I NEED TO NOTIFY A STATE AGENCY OF MY ABSENCE?

You of course need to notify your manager or supervisor of your absence. Some states do provide short term disability benefits such as California, New York, New Jersey, Rhode Island, and Hawaii. If your absence from work is due to a work injury, you likely will have already filed a claim for workers' compensation benefits which may provide income replacement benefits (such as temporary partial disability, permanent partial disability, or permanent total disability).

WILL I RECEIVE CONFIRMATION OF MY CLAIM?

After you have initiated a claim, the administrator or insurance company will send you a letter confirming the receipt of your claim and assigning a claims representative. They will provide

you with the necessary contact information regarding your claim number and how to reach your claims representative.

SHOULD I TALK TO THE CLAIM REPRESENTATIVE?

Yes. The claim representative assigned to your claim should contact you after he or she has received the claim. You may find during the processing of your claim that these individuals are difficult to get on the phone. They are not likely to provide you with their email addresses either. We always recommend you keep a diary of all communications regarding your claim. If you discuss a matter with a claims representative and have provided important information regarding yourself or your claim, we recommend that you confirm the communication in writing. All written communication and documents generated or received by the claims representative must be maintained in their "claim file." This claim file is an extremely important document if your claim is denied, and an appeal becomes necessary, or you are required to pursue a lawsuit.

If your claim is governed by ERISA, a denial of your claim must be "appealed" with the same claim administrator or insurer. This appeal phase is by far the most important stage of the case, even more important than subsequent litigation in our opinion. If you would like to learn more about the importance of this appeal, please visit our website at www.colorado.disability-lawyer.com/html/appeals/process.com.

HOW LONG DO I WAIT FOR A CLAIM DECISION?

Your plan must tell you whether or not you will receive benefits within 90 days after you have filed a claim. If special circumstances exist, an additional 90-day time-frame may be needed but the administrator is required to tell you why additional time is needed and the date by which the plan expects to render a final decision. If your claim is denied, the plan administrator must notify you in writing and explain in detail why it was denied.

SHOULD I KEEP A CHRONOLOGY?

Absolutely, yes. You should most definitely keep a chronology, summary or diary of all actions you take regarding your claim. Keep copies of all correspondence you send and receive. The same holds true for any emails. It is important to keep an organized file of everything relating to your claim. If your claim is denied, you will want to speak with an attorney who specializes in handling these types of claims who will want to see all of the documentation you have maintained.

WHAT SHOULD I DO IF MY CLAIM IS DENIED?

First things first, do not panic. There are ways to have the administrator's decision overturned. But, most importantly, if your claim is governed by ERISA, and perhaps even if it is not, you are required to file an internal appeal of the adverse benefit determination. Do not take this appeal requirement lightly. You will likely be provided 180-days in which to submit this appeal. If you have read this far, you already know the importance of the appeal and have perhaps read more about the steps to take. One option is to contact an attorney who specializes in this area of the law to obtain advice or representation on how to proceed.

DISCLAIMER

This document has been produced by McDermott Law, LLC as a courtesy and is provided for informational purposes. It is intended to only provide guidance to those individuals not experienced with submitting a disability claim. This document contains information concerning the general approach to the filing of disability claims and does not cover all issues and circumstances that could arise. To obtain specific advise concerning your individual situation, you may need to retain an attorney specializing in disability claims to receive more pertinent advise. Importantly, this document does not create an attorney-client relationship nor should it be construed as an assurance or guarantee that if the above steps are followed that your claim will be granted by the disability insurance company or third party administrator.