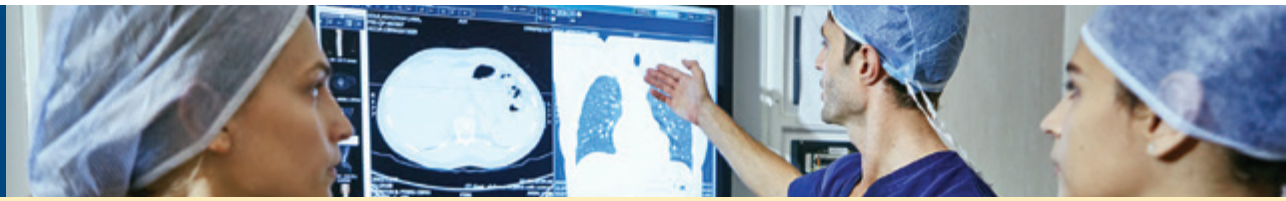
dri™ The Voice of the Defense Bar



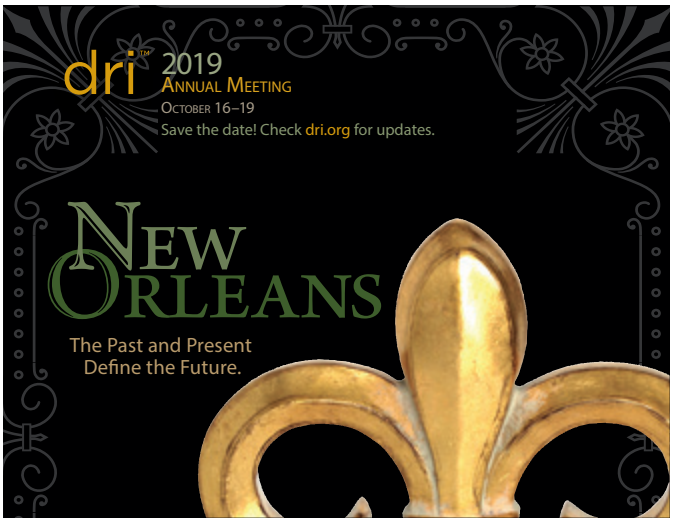
Life, Health and Disability News

The newsletter of the
Life, Health and Disability Commitee

6/3/2019

Volume 30, Issue 2

Committee Leadership



In This Issue

In This Issue

Leadership Notes

Message from the Chair

By Byrne J. Decker

Greetings fellow LHD Committee members!

As a busy winter turns to a busy spring, Committee Vice Chair Scott Trager and I have finally had the opportunity to reflect on yet another successful DRI Life, Health, Disability, and ERISA Seminar in Chicago last month. From our perspective, the seminar was a rousing success. We were particularly pleased with how some of the new offerings were received such as the new breakout sessions for young LHD lawyers. The more advanced programs were top-notch and, as always, everyone seemed to find plenty of time enjoying the various networking events, despite the hectic schedule.

Although the success of the Seminar depends on the efforts of countless, hard-working volunteers, Program Chair Pat Begos, and Vice Chairs Sarah Delaney and Jamie Moore, certainly deserve an extra shout-out. It is difficult to convey how impressive it was to watch their tireless efforts and steadfast leadership culminate in a fantastic Conference from start to finish.

Of course, there is no rest for the weary, as planning has already begun for our 2020 Seminar, which will take place April 29–May 1, 2020, in a brand new and exciting location for our Committee—the Sheraton New Orleans Hotel. Although it will be very difficult to top 2019, our 2020 Program Chair, Sarah Delaney, and Vice-Chairs, Jamie Moore and Elizabeth Doolin, are already hard at work on the planning.

Speaking of planning, we're also starting to get very excited for our annual Committee Fly-In meeting. Our meeting will take place on Friday, July 12, 2019, at the Chicago office of Hinshaw & Culbertson LLP. As in past years, many of us plan to arrive on Thursday, which will feature the always popular Women's Spa Day and Committee dinner. For those who plan to stay over Friday night, we will have another dinner before heading over to Second City to take in some stand-up comedy. Our Fly-In chair, Josh Lerner, is in the process of pinning down all the details, which will be posted on the Committee's Online Community page shortly.

All Committee members are welcome to attend and participate in the Fly-In. It is really a wonderful way to meet other Committee members in a less formal setting. It's also a wonderful way to participate and have your voice heard and get more involved in our wonderful Committee. Our Committee exists to serve the interests of its members. We want, and need, the help of as many of you as possible to fulfill our mission. As the saying goes, many hands make light work.

It's your Committee—get involved! You'll be glad you did! I look forward to seeing you in July!

Byrne J. Decker is the managing shareholder in the Portland, Maine office of Ogletree, Deakins, Nash, Smoak & Stewart, P.C. Mr. Decker has a nationwide practice that specializes in the defense of employee benefits/ERISA litigation. He has defended benefits cases in federal courts in every federal judicial circuit. Mr. Decker is the chair of DRI's Life, Health and Disability Committee.

Message from the Editor

By Moheeb H. Murray

I'm excited as I step into my role as editor of the *Life, Health, and Disability News* along with my vice editor, Stephen Roach. The first thing we'd like to do is thank Eileen Buholtz for her excellent work as the immediate past editor of this newsletter and for her valuable guidance in transitioning the editorial duties to me and Stephen. We plan to continue in Eileen's footsteps to provide you with an informative newsletter that will be a trusted resource for learning about developments in the LHD insurance world.

This issue focuses on disability insurance. We hope you'll enjoy this issue's articles covering topics of rescission of a disability policy after two years, the importance of using unequivocal denial letters, and total versus residual liability. We thank the authors for their contributions.

The next issue of *Life, Health, and Disability News* is due out in August will focus on topics relating to keyman (keyperson) insurance policies. If you have an idea for an article on that or another LHD insurance topic, please let me or Stephen know, and we'll be happy to help you get your article published.

Moheeb H. Murray leads the insurance coverage practice team at BSP Law in Troy, Michigan. He represents leading national insurers in life, disability, ERISA, and other insurance-coverage matters at all stages of litigation. He also focuses his practice on complex-commercial and construction litigation.

Featured Articles

Residual vs. Total Disability: An Old Issue Revisited

By J. Christopher Collins and Joseph M. Hamilton

Total vs. Residual Disability claims are nothing new to the disability industry. However, these types of claims continue to present legal challenges. A review of recently reported decisions demonstrate a variety of issues to address and strategies to implement to successfully handle claims that require both Total and Residual disability analysis. Properly managing these claims involves input from the many disciplines (financial, legal, medical and vocational) found in the modern-day claim department. The reported cases show that clear communication, close attention to policy language and timely decision making are critical to an insurer's success or failure in managing these complex claims. As always, ERISA played a starring role in the outcome of some of these disability cases.

Communication and the Statute of Limitations

Policies that include both Total and Residual Disability clauses require that insurers make a clear, accurate and timely decision on how the claim will be characterized. This is important because benefit periods can be impacted by whether a claim is a Total or Residual Disability. For example, a Total Disability may be payable for the claimant's lifetime, but a Residual Disability may end on the claimant's 65th birthday.

That was the scenario in *Finklestein v. AXA Equitable*, 325 F.Supp.3d 1061 (N.D. Cal. 2018). Finklestein was an OB/GYN who purchased four different disability polices between 1982 and 1989. The policies had language that provided benefit periods to age 65 for Residual Disability and lifetime benefit periods for Total Disability, if so classified before Finklestein reached the age of 50. In 1998, when Finklestein was 47 years old, he filed a claim for right wrist pain. Because Finklestein continued to work, Equitable characterized the claim as a Residual Disability. The claim continued to progress and in 2004, when Finklestein reached age 54, the claim was reclassified as a Total Disability claim. In 2009, Finklestein asked if the company would reclassify his claim to Total Disability dating back to 1998. A letter from the company dated December 15, 2009 clearly refused the reclassification. The claim continued

and in 2017, after Finklestein turned age 65, the company refused to pay further benefits. Finklestein filed suit.

Equitable moved to dismiss the claim based on the statute of limitations, which the company argued began to accrue after the 2009 letter denying reclassification. Finklestein argued the statute should not begin to run until after his benefits were terminated in 2016. The court agreed with Equitable and dismissed the litigation stating, "Here the court finds that the statute of limitations began to accrue when Equitable denied Plaintiff's request for reclassification and not when the insurance company ceased making payments to Plaintiff." *Id*. at 1067. The 2009 letter clearly stating the Residual Disability classification going back to 1998 would not be changed was the strong evidence relied on by the court.

The court in *Hong v. AXA Equitable*, 2018 WL 6331012 (N.D. Cal. 2018) addressed a very similar issue. In *Hong*, the policies only provided for Total Disability benefits. Further, the policy language provided that if a claim was classified as a Total Disability before age 60 the claimant would be entitled to lifetime benefits. Otherwise, benefits ended when the claimant reached age 65. In 2011, when Hong was 57 years old, she began to experience disabling symptoms that caused her to reduce the number of patients she treated. However, Hong continued to work and was earning income making her ineligible for Total Disability benefits. Nevertheless, Hong inquired about filing a claim in September 2011. Equitable explained in letters dated in November 2012 and January 2013 that no benefits were payable because the policy only provided for Total Disability benefits and there was no Residual Disability rider.

Hong's symptoms worsened over time and in 2015, at the age of 61, she stopped seeing patients and renewed her claim with Equitable. Equitable approved the claim. Hong then requested that Equitable revisit the decision to deny coverage on the 2011 claim. Equitable denied the request and refused to pay any benefits prior to 2015. Hong filed suit in July 2018.

Equitable moved to dismiss the claim on statute of limitations grounds. Hong argued the 2015 claim started a new limitations period for the earlier claim. The court rejected that argument and held, "... Hong's later request for a disability determination covering that entire period was one for reconsideration, which does not start a new limitation period" *Id*. at *4. Hong then argued that the 2013 denial did not cover the claim for lifetime benefits. The court rejected that argument too, reasoning, "If Equitable had found Hong totally disabled in January 2013, Hong would have received lifetime disability benefits. . . . By the same token, Equitable's January, 2013 determination that Hong was not totally disabled denied Hong those lifetime benefits." *Id*. The suit was dismissed.

The Seventh Circuit Tempers the Holding in *McFarland v. General American*

What happens when a claimant cannot perform his occupation in exactly the same way he did before the disability arose? Is the claim properly characterized as one for Total or Residual Disability?

In *McFarland v. General American*, 149 F.3d 583 (7th Cir. 2016) the panel deciding the case used a baseball shortstop analogy to interpret a Residual Disability clause. They posited that a shortstop who could no longer throw would be unable to do his job even if he could still run, hit and catch[1]. Since that decision, the analogy has often been used to persuade insurers to pay Total Disability benefits to a claimant who is still working at least part-time in their occupation.

However, the court was far more circumspect in its holding in *Fiorentini v. Paul Revere Life Ins. Co.*, 893 F.3d 476 (7th Cir. 2018). Fiorentini was the Owner/President of a small technology company. Cancer treatment resulted in the amputation of Fiorentini's right ear. The original claim, beginning in 2008, was for Total Disability benefits. However, five years after the claim began, Fiorentini returned to work and reported being cancer free since 2009. Paul Revere denied further benefits because Fiorentini was working full time. However, Fiorentini argued that his hearing problems made it impossible for him to engage in sales duties for his company. He argued he should receive Total Disability benefits from his own occupation as president of the company. Paul Revere denied the claim and then won summary judgment in the district court. The Seventh Circuit upheld the decision stating,

> To be sure, the record supports the inference that Fiorentini cannot discharge his duties as Panatech's president in precisely the same manner as he did before. The ongoing effects of his surgery- hearing loss, tinnitus, migraines, and difficulty localizing sound- had an adverse impact on his daily functioning. But as we have already said, a reduced capacity to perform job duties is addressed by the policy's

1 The Seventh Circuit may be unfamiliar with one Alex Rodriguez, who was once the highest paid shortstop in Major League Baseball and who continued to play MLB as a designated hitter even after injuries sidelined him from playing in the field. Perhaps it depends on how you define "occupation. "Shortstop or MLB player.

> residual disability provision. Fiorentini chose not to apply for those benefits.

Id. at 479.

The court in Fiorentini also addressed *McFarland* head on. The court distinguished *McFarland* by noting that Fiorentini functioned as Panatech's president, and that while his capacity as president had been diminished by his inability to perform one of his important duties, he was not unable to continue the occupation. The court noted that the Total Disability provision does not cover an insured who has a "diminished ability" to perform his occupation, but rather an insured who is unable to continue it.

Residual Disability Provisions in Own Occupation Policies Pose Unique Challenges

Own Occupation definitions of Total Disability in policies that also include a Residual Disability provision can frequently cause conflict between a claimant and their insurer. That was the issue central to the case of *Simmons v. Paul Revere*, 2018 WL 558960 (W.D. Wash. 2018). Simmons was a surgeon who purchased a disability policy in 1984, which included both an Own Occupation definition of Total Disability and a Residual Disability clause. Simmons was injured in an automobile accident in 2008 injuring his right shoulder. To his credit, he resumed working the day after the accident. Post-accident, he took more frequent rests and sometimes took additional appointments to complete tasks, but he worked standard hours. In December 2010, he had surgery to repair the injured shoulder and was out of work approximately one month, returning to part-time work in January 2011 and then full-time work in March 2011. His first claim with Paul Revere was not filed until May 2013, five years after the accident. Paul Revere promptly paid periods of both Total and Residual Disability in accordance with the times that Simmons was out of work completely and working part time. The claim was closed after March 2011 because Simmons was back to work full time. Simmons argued that he should continue to be considered Residually Disabled. Paul Revere disagreed and suit was filed.

Simmons filed a motion for summary judgment dropping his claim for Residual Disability and focusing only on the Own Occupation definition of Total Disability. Simmons' summary-judgment argument was that he was unable to perform "the" important duties of his occupation as he had performed them before the accident. Summary judgment was denied and the court, interpreting the claim in light of both the Total and Residual Disability provisions, reasoned as follows:

> The Court further concludes that when these provisions are read together, the meaning of the word 'the' as it is used in the total disability definition becomes clear: in order to be considered totally disabled, Simmons must be unable to perform any of the important duties of his occupation; on the other hand, Simmons is residually disabled if he is not able to perform at least some of his important duties (assuming he can meet the other requirements for residual disability). *Id.* at *5.

Properly Defining the Insured's Pre-Disability Occupation Is Key to Determining Whether the Claim Should Be Handled as a Total or Residual Disability

Claimants, insurers and the courts often struggle to accurately define an insured's pre-disability occupation when making a determination on whether a claim meets the definition of Total or Residual Disability. However, that determination can be outcome determinative.

In *Nylander v. Unum*, 309 F.Supp.3d 526 (M.D. Tenn. 2018), Nylander was employed as a gynecologist and a gynecological surgeon. On April 15, 2015, she accidentally injured her right index finger during a surgical procedure. Nylander returned to work on April 24, 2015. However, in September 2015, while performing surgery she had difficulty controlling a bleed on a patient because the dexterity in her finger would not allow her to properly tie off the impacted area. She ceased doing all surgery immediately thereafter, but continued with her office gynecology practice. Nylander made a claim for Total Disability. The claim was eventually denied because Unum analyzed the claim as one for Residual Disability. Unum moved for summary judgment but the court denied the motion and held as follows, citing to 6th Circuit precedent in *Leonor v. Provident Life & Accident Company*, 790 F.3d 682 (6th Cir. 2015):

> The strongest argument the Defendants have is that 25 percent of time that Dr. Nylander spent on surgical duties does not fit 'comfortably' along the lines of 'most important duties'. . . . Overall, however, the court concludes that Dr. Nylander's circumstances still fall within the strictures of *Leonor*, which instructs the Court to strictly construe the policies in favor of the insured and identify what is 'at the core' of Dr. Nylander's occupation. . . . Accordingly, under *Leonor*, genuine issues of material fact exist as to whether lead surgical procedures were an important/material and substantial duty of Dr. Nylander's occupation and

the extent of Dr. Nylander's injury on the practice of her occupation. *Nylander*, 790 F.Supp.3d at 542–543.

Impact of ERISA on Total vs. Residual Disability Claims

The standard of review under ERISA can have an impact on the resolution of Total vs. Residual Disability claims. In *Mullaney v. Paul Revere*, 2018 WL 3328402 (W.D. Wash. 2018), the court used the de novo standard of review in analyzing whether Residual Disability benefits were payable. Mullaney was employed as a land use litigation attorney and was diagnosed as suffering from fibromyalgia. Like many fibromyalgia claims the medical conclusions were hotly contested and differed markedly between Mullaney's physicians and the physicians who reviewed the claim for Paul Revere. In the end, the court, using the de novo standard of review, concluded that Mullaney's physicians were credible and believable and therefore found that Residual Disability benefits should be paid. Query whether the outcome would have been different under the arbitrary and capricious standard of review?

In *Van Steen v. Life Insurance Company of North America*, 878 F.3d 994 (10th Cir. 2018) the court made a determination under the arbitrary and capricious standard of review whether Residual Disability benefits were payable. Van Steen was employed was a Systems Integration Business Analyst. In October 2011, he as attacked while walking his dog and suffered a mild traumatic brain injury. He was out of work until September 2012, at which time he returned to work part-time. Residual Disability benefits were paid until 2013 when the company determined Van Steen no longer suffered from any restrictions and limitations. Suit was filed and the district court ruled in favor of Van Steen. The decision was reversed on appeal to the 10th Circuit.

The court observed that the definition of Residual Disability stated that, "he or she is unable to perform each and every material duty of his or her occupation on a Full time basis." *Id.* at 997. Using this definition, the court then reasoned that if Van Steen was no longer residually disabled he would have to be able to perform each and every duty on a full-time basis. A review of the medical records were not so emphatic to support such a conclusion and therefore the insurer's decision was found to be arbitrary and capricious and Residual Disability benefits were awarded.

The Third Circuit also had an opportunity to weigh in on the Total vs. Residual Disability continuum in *McCann v. UnumProvident*, 907 F.3d 130 (3rd Cir. 2018). McCann was a radiologist, although a major dispute erupted over whether he should have been more accurately considered an interventional radiologist. Even though McCann was the owner of three individual disability policies, the court found that the policies were governed by ERISA. The claim was originally approved as a Total Disability claim based on a diagnosis of a mildly dilated aortic root aneurysm, hypertension and obesity. But, after a year of benefits were paid, a review of McCann's duties was conducted and, in particular, a review of CPT codes and billing records. All of the in-house medical reviews concluded that McCann could resume his occupation as a non-interventional radiologist. However, McCann maintained he was an interventional radiologist and his impairment prevented him from doing the physical demands of that occupation. The district court upheld the denial agreeing with UnumProvident that McCann was a non-interventional radiologist. Additionally, the court held that any claim for residual disability was untimely because it was not made before the company's final determination.

UnumProvident did not fare as well in the Third Circuit. The district court was overturned. The opinion reflects the appellate court's distaste for the over reliance on the detailed analysis that was done to better define Dr. McCann's pre-disability occupation. The court stated, "We will not define Dr. McCann's occupation and its 'substantial and material duties' solely by counting up billing units." *Id.* at 150. The Third Circuit found that McCann was an interventional radiologist, and that even if he did not meet the strictures of the Total Disability definition, the company should also consider any possible claim for Residual Disability benefits because that claim was timely. The case was remanded to the district court for further review.

J. Christopher Collins is a member of Mirick O'Connell's Life, Health, Disability and ERISA Litigation Group. He focuses his practice on life and health insurance matters with a concentration on disability and life insurance and he assists the Firm in client development both locally and nationally. Chris is known for his extensive experience in litigating first party bad faith matters and insurance cases governed by ERISA. Prior to joining the Firm, Chris was Senior Vice President and General Counsel at Unum US, the largest provider of group and individual disability insurance in the U.S. and a fast growing voluntary insurance business with over $6B in annual revenue. In that role he provided counsel and managed all of the legal resources serving Unum's largest business sector. During his tenure at the company from 1984 – 2015, he helped to lead the legal department through both acquisitions and mergers and was a key par-

ticipant in working to solve significant regulatory challenges facing the company in the early 2000's.

Joseph M. Hamilton is a Partner at Mirick O'Connell and Co-Chair of the Firm's Life, Health, Disability and ERISA Litigation Group. He concentrates his practice in life, health and disability insurance defense, and ERISA. Mr. Hamilton serves as counsel for numerous life, health and disability insurers and self-insureds at all levels of the state and federal courts. Mr. Hamilton is a past Chair of the ABA's Life Insurance Law Committee; and a Vice Chair of the ABA's Health and Disability Law Committee.

Yes, You Can Rescind a Policy After Two Years—A Disability Policy: A Framework

By Michelle J. d'Arcambal and Dierdre A. Connolly


There is a significant amount of litigation regarding when and whether an insurer may rescind a life policy after the two-year contestable period has passed. The two-year contestability clause to rescind a life insurance policy is mandated by virtually every state. Some states will also allow rescission of a life policy after two years upon a showing of intentional fraud, especially with respect to the insurability requirement. Investor funded Stranger Owned Life Insurance ("STOLI") polices, which violate important public policy against wagering on the life of the insured, are also subject to rescission in some states. What is not widely litigated is the rescission of disability policies two years after issuance. Rescission of disability policies after two years is authorized both by state statutes and insurance department approved language in the policy, so long as the material misrepresentations rise to the level of fraud.[1]

In refusing to extend the two-year contestability period in a life policy to matters where there was no insurable interest, the New York Court of Appeals in *New England Mut. Life Ins. Co. v. Caruso* pointed to the language of the New York statute which permitted rescission of certain accident and disability polices after two years. *New England Mut. Life Ins. Co. v. Caruso,* 73 N.Y.2d 74, 535 N.E.2d 270, 538 N.Y.S.2d 217 (1989). The Court of Appeals held that if the legislature had intended that the incontestability clause not bar such claims with respect to life policies, "it could have stated so." The states which rescind life insurance policies after two years typically apply a heightened standard as compared to the ordinary fraud standard applied to actions to rescind disability policies after two years. *See*, *e.g., Sadel v. Berkshire*, 476 Fed. Appx. 152, 2012 WL 3644735 (3rd Cir. 2012) (rejecting plaintiff's argument that a "special higher burden" applies where rescission of a disability policy is sought after expiration of contestability clause because plaintiff only cited and relied on cases involving life policies. The Third Circuit held that with respect to disability rescission matters, the typical fraud requirements and clear-and-convincing standard of proof apply.).

Disability policies are underwritten in a manner similar to life policies. The proposed insured answers a series of questions about financial and medical history. The underwriter reviews the completed application and requests additional information if the application includes disclosures: for example, an attending physician's statement will be requested from a physician identified by the applicant. Phone interviews to the prospective insured asking the application questions again is another tool used by underwriters.

Duty to Investigate

As with life policies, the disability insurer "has an absolute right to rely on the representations in the written application as long as the application is signed by the insured and attached to the policy." *N.W. Mut. Life Ins. Co. v. Cupo*, 1995 WL 117892, *2 (S.D.N.Y. 1995).

An insurer has no duty to undertake a more extensive investigation because:

1 Typical policy language: "after two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two year periods."

> the "duty to disclose" clearly rests with the insured . . ., not the insurer. The insured is required to reveal "every fact bearing on or pertaining in any way to the insurability of [his] life, especially where specific questions are put to the applicant calling for such information. . . ." "An insured cannot remain silent while cognizant that his insurance application contains misleading or incorrect information."

Schondorf v. SMA Life Assurance, Co., 745 F.Supp. 866, 870–71 (E.D.N.Y. 1990) (emphasis supplied)(citations omitted); *see also New England Life Insurance Co. v. Taverna,* 2002 WL 718755, *7 (E.D.N.Y. 2002) (It is the insured's "'duty to disclose . . . every fact bearing on or pertaining in any way to the insurability of [his] life, especially where specific questions are put to the applicant calling for such information.'") (citations omitted).

For example, in *In Re Green,* 241 B.R. 550 (N.D. Ill., 1999), the federal district court held that the justifiable-reliance requirement imposes no duty to investigate unless the falsity of the representation is obvious upon cursory glance. Citing Restatement (second) of Torts, §541 cmt. a.

Thus, an application that does not contain questionable history (aka a "clean app") triggers no duty to investigate. "Absolutely nothing about the applications [at issue in *In Re Green*] indicates that [the insured's] representations of health were false and that he had a long and complex medical history." Id at 565. The insurer justifiably relied upon the application. *Id. See also Bhakta v. Hartford,* 673 Fed.Appx. 762, 765, 2016 WL 7448766 (9th Cir. 2016) (where the beneficiary argued that evidence in the underwriting file of depression, respiratory infection, no work history and elevated ALT & HDL levels should have caused Hartford to conduct further investigation, the court held that that evidence did not "flatly contradict the insured's answers"); *Kerrigan v. Metropolitan Life Ins. Co.*, 2013 WL 2110828, 2013 N.Y. Slip Op. 33591(U) (N.Y. Sup. Ct. 2013) *aff'd*, 117 A.D.3d 562, 986 N.Y.S.2d 99 (1st Dep't 2014)) *lv to app denied*, 24 N.Y.3d 912, (Dec. 18, 2014) (court held EKG results were not sufficient to prove actual notice of serious heart disease.).

In *Chawla v Transamerica*, 440 F.3d 639 (4th Cir. 2006), the Fourth Circuit held that "although Transamerica had knowledge of some facts, it was limited to the least significant facts the insured was obligated to disclose . . ." and

> Transamerica was not aware of the meningioma surgery, the shunt surgery, or Giesinger's three hospitalizations. Moreover, because Transamerica was unaware of these events, it did not possess the records made in connection with them, several of which suggested that Giesinger's drinking problems exceeded the consumption of a bottle of wine per day. Because Transamerica lacked awareness of material facts concealed by Giesinger's misrepresentations, it could not and did not waive the defense of misrepresentation.

Id. at 646.

When Misrepresentations Are Identified

Evidence of material misrepresentations on a life application is typically identified during the usual two-year contestability investigation conducted by the insurer if an insured dies within two years of issuance. Evidence of material misrepresentations on a disability policy application is often identified after a disability claim is made based on medical records that are submitted in support of the claimed disability. If a review of the medical records reveals material misrepresentations made in the application, and the claim is made within the contestability period, the insurer can rescind without a showing of fraud. If the claim is filed after the contestability period, the insurer can still rescind if it satisfies the additional burden of establishing that the misrepresentation was made fraudulently. This hurdle (absent claims of not understanding the question, waiver or duty to investigate further) may be readily met because the misrepresentation was made by the insured in writing and is signed and verified by the insured. Clear and material misrepresentations can be the basis of a successful motion for summary judgment.

The Elements That Must Be Established

A party seeking to rescind a disability insurance policy beyond the initial two-year contestability period must prove the following elements:

> (1) a material misrepresentation or omission of fact, (2) made with knowledge of its falsity, (3) with an intent to defraud, and (4) reasonable reliance on the part of the [party seeking to establish fraud], (5) that causes damage to [that party].

Ehrlich v. Berkshire Life Insurance Co., 2002 WL 368444, *8 (S.D.N.Y. Mar. 7, 2002); *see Dwyer v. First Unum Life Ins. Co.,* 41 A.D.3d 115, 837 N.Y.S.2d 635, 636 (1st Dep't 2007). (An insurer may only rescind an insurance policy that has been in effect for over two years if the insurer can "identify a material misrepresentation in the [insured's] application that was intended to defraud the insurer.") (Citing N.Y. Ins. Law §3216(d)(1)(B)(i)).

Intent to Deceive

The first question to be resolved is not whether the plaintiff understood that she should have disclosed her treatment, but whether a reasonable person would have believed that these facts were significant and should have been disclosed as a response to the questions in the application. *See Falcon Crest Diamonds, Inc. v. Dixon,* 173 Misc.2d 450, 458, 655 N.Y.S.2d 232, 237 (N.Y. Co. 1996). In determining whether or not a plaintiff has improperly failed to disclose a particular fact, the court is required to employ an objective standard, *i.e.*, whether "'a reasonable person in the insured's position would know that the particular fact is material' . . . or something which would have controlled Underwriters' decision to accept the risk." *Id.* (citation omitted). *See also Spencer v. Minnesota Life Ins. Co.*, 493 F.Supp.2d 1035, 1041 (S.D. Ohio 2007) ("Where an applicant knowingly makes a false statement on an application for insurance regarding prior medical treatment . . . the false statement is presumed to be willfully and fraudulently made, [and the claimant] has the burden of going forward with evidence tending to prove . . . that such consultation was not for or not known by the insured to be for any serious ailment or condition, or that the false answer was an honest mistake.")

A misrepresentation is thus material and intentional if a reasonably careful and intelligent person would believe that the omitted facts substantially increased the insurer's risk under the policy and might cause the insurer to reject the application. *In Re Green*, *supra*, 241 B.R. 550, 566 (N.D. Ill. 1999), citing *Methodist Medical Center of Illinois v. American Medical Sec. Inc.,* 38 F.3d at 320 (7th Cir. 1994). Where a person knowingly or recklessly makes false representations which the person knows or should know will induce another to act, the finder of fact may logically infer an intent to deceive. In *In Re Green*, *supra*, the court concluded "a reasonable person would have to believe that a long history of serious illness and serial hospitalizations substantially increased [the insurer's] risk under the disability policies." *Id.* at 567. The Court held it "had no choice but to infer that [the insured] intended to deceive" the insurer by omitting significant portions of his medical and hospitalization history to obtain the disability policies at issue. *Id.* at 565.

Furthermore, "absent direct evidence, intent 'may be proven by circumstantial evidence.'" *Ehrlich v. Berkshire Life Insurance Co.*, 2002 WL 368444, at *10, citing *Cofacredit, S.A. v. Windsor Plumbing Supply Co. Inc.*, 187 F.3d 229, 241 (2d Cir.1999). In *Ehrlich v. Berkshire Life Insurance Co.*, the plaintiff/insured was unable to recall at his deposition the source of his representations concerning his income and net worth statement. The plaintiff claimed that "the statement of his income was a good faith projection" of income for that year. In fact, the representation as to current year income was made with fewer than two weeks left in the year. Thus, the Court found it was not a "good faith projection" because he should have been able to better project the income for that year. The financial misrepresentations made by the plaintiff in *Ehrlich* allowed him to improperly obtain a policy with a higher monthly benefit than he would have received had he answered truthfully.

Case Study: *Dormer v. Northwestern*

Dormer v. Northwestern Mut. Life Ins. Co., 408 Fed. Appx. 452 (2d Cir. 2011) illustrates the various permutations of a disability rescission case from discovery of the misrepresentations, through a motion for summary judgment, trial and appeal. *Dormer* involved a doctor who made material misrepresentations and omissions concerning her medical history in the applications for two disability policies. These misrepresentations became known to Northwestern Mutual ("NWM") after she submitted a claim of disability from her medical practice, shortly after the expiration of the two year contestability period. The medical records submitted in connection with her claim of disability due to myasthenia revealed that Dormer had a significant medical history, including numerous additional conditions. Specifically, in addition to the symptoms of myasthenia (including muscle weakness, facial weakness and difficulty with eyelid elevation), she suffered from intermittent facial paralysis and Bell's Palsy; recurrent low back pain and disc herniation at the L3-L4 levels; episodes of severe fatigue including a diagnosis of chronic fatigue syndrome; asthma; neurogenic hypotension; and chronic cystitis. While, as a medical professional, Dormer should have had full knowledge and understanding of her own medical condition, none of these ailments was disclosed in the application process.

The underwriting process included a personal history interview. Also, as part of the underwriting process, NWM requested and received medical records from the doctor Dormer had identified on the application, Dr. Lipschitz. After its review of the records submitted, NWM denied Dormer's claim, rescinded the policies and returned the premiums. Dormer sued NWM and the case was removed to the Southern District of New York and assigned to Judge Rakoff. After discovery, NWM moved for summary judgment because there was no issue of material fact that Dormer had intentionally misrepresented her medical condition. In opposition, plaintiff raised an issue as to

whether a one-page handwritten report by Dr. Lipschitz (which listed certain medical conditions Dormer omitted from the application) had been received by NWM during the underwriting process. Judge Rakoff held:

> The disputed issue of whether Northwestern Mutual received the Statement before or after the issuance of the policies is crucial to resolving the defendant's allegation that Dr. Dormer intentionally and fraudulently misled the defendant in her various application for disability insurance. For this reason, the Court hereby denies Northwestern Mutual's motion for summary judgment.

Dormer v. Northwestern Mut. Ins. Co., 2009 WL 2603123, *2 (S.D.N.Y. 2009) aff'd 408 Fed.Appx. 452, 2011 WL 310268 (2nd Cir. 2011).

Because the remedy of rescission is equitable, the case was tried before Judge Rakoff, and not a jury. As later noted by Judge Rakoff, Dr. Dormer convincingly affected a credible demeanor. During the course of the trial, however, plaintiff's counsel could not refute the clear misrepresentations made when compared to the medical records, or their materiality. The NWM witnesses, including employees from the document receiving department, established the materiality of the misrepresentations. The witnesses further established that the underwriter had never received the handwritten page sent by Dr. Lipschitz's office, and thus had no knowledge of the disclosures in that document.

The most stunning of Dormer's misrepresentations occurred during her redirect when she fabricated an event—a "second" personal history interview ("PHI")—in which she falsely claimed, for the first time in the litigation, to have disclosed her entire medical history to NWM during the underwriting period. Dormer had not previously mentioned a second PHI in the pleading stage, during extensive discovery, including her own deposition, during motion practice or on direct or cross examination. In the end, the undeniable documentary evidence established that plaintiff had simply made up an imaginary second PHI on the stand when she realized that she was losing.

After a five-day bench trial, Judge Rakoff concluded that:

> It's hard not to have sympathy for Dr. Dormer. It's hard also not to have admiration. She clearly is a woman not only of intelligence but of drive, who despite her physical problems, has successfully had two careers and plainly is a person of talent, of even some charisma; *but her testimony on the stand indicated to the court that she had a less than total punctiliousness about the truth*. . . .
>
> There are numerous other examples of Dr. Dormer's giving false or misleading testimony here in court, corroborative of the inference that the misstatements in her application about material matters were made with fraudulent intent: They were well spelled out in the defense summation. *So, I am forced to conclude, reluctantly,* that she with fraudulent intent sought to mislead Northwestern about highly material health problems relating to chronic fatigue, to Bell's Palsy and to the condition of the disks in her back, and that she carried that fraud into this court.

Dormer v. Northwestern Mut. Ins. Co., Case No. 08 Civ. 8725 (S.D.N.Y.) (emphasis added), Unpublished Transcript dated November 20, 2009, 9:11–18; 11:16–25, available on request. Judge Rakoff held he did not need to resolve the legal issue with respect to the handwritten note from Dr. Lipschitz. Instead, he held that while EMSI apparently did fail to get all of the records to NWM:

> the court does not reach the argument made by the defendant that the company cannot be charged with that information. I'm going to assume arguendo that the company constructively knew what was in Dr. Lipschitz's submission, or handwritten notes really, of his examination back in February. . . . And I will assume that the company constructively received that, *even though I think the law in this area might well go in the opposite direction.* . . . . So, there is more disclosure here, but even here an attempt was made, particularly with respect to Bell's Palsy and the chronic fatigue, to misrepresent the true extent of the problem.

Id., pp. 8:10 – 9:9 (emphasis added). The Second Circuit affirmed Judge Rakoff's decision, holding that:

> A reasonable factfinder could easily infer that this pattern of minimizing an adverse medical history, in connection with a disability insurance application, could not have been accidental and must have been intended to reduce the risk that the application would be denied.
>
> Moreover, Dormer's misrepresentations continued in her trial testimony. The district court noted numerous examples of "false or misleading" testimony and concluded that Dormer's answers "seemed designed . . . to place the best possible gloss on a momentary issue even if it was inconsistent with testimony she gave on some other related issue." These credibility findings by the trier of fact are entitled to deference, *Wade v. County Sheriff's Office,* 844 F.2d 951, 955 (2d Cir.1988), and in any event we see no error in them. This lack of candor supports the inference created by the factual record that Dormer acted with fraudulent intent.

2011 WL 310268, **1–2. It is notable that four years later, the New York Appellate Court conclusively held that only actual, not constructive, notice of the misrepresented response can bar rescission of the policy based on material misrepresentations. *Kerrigan v. Metropolitan Life Ins. Co.*, 2013 N.Y. Misc. LEXIS 6489 (N.Y. Sup. Ct. 2013), *supra*.

Conclusion

Rescinding a disability policy after the expiration of the contestability period is a very good option if the insurer can establish a material misrepresentation, even though the insurer must also prove intent by clear and convincing evidence. Assuming the plaintiff cannot present a winning argument that the insurer was on notice of the condition misrepresented, proving intent using the objectively reasonable person standard logically flows from the established facts.

For over 20 years, Michelle J. d'Arcambal, a partner of d'Arcambal Ousley and Cuyler Burk, has defended a wide variety of life, health, and disability product and plan litigations. She provides strategic advice aligned with the client's litigation and business goals, including resolution. As a result of her in-house litigation experience at MetLife, Ms. d'Arcambal understands the needs of her clients and focuses on achieving their objectives in the most efficient way possible. When a matter cannot be resolved by motion or mutual agreement, Ms. d'Arcambal leverages her trial and appellate experience in from of appellate judges and trial courts. Ms. d'Arcambal was previously a commercial litigation partner at Ross & Hardies, now known as McGuire Woods, LLP, and an associate at Brown & Wood, LLP, now known as Sidley Austin, LLP. She is a 1985 graduate of the University of Wisconsin Law School and graduated from Smith College in 1981.

Dierdre A. Connolly is a senior associate at d'Arcambal Ousley and Cuyler Burk and has been with the firm for eight years. She defends companies in contractual disputes, including bad faith claims, insurance fraud and rescission actions involving individual and group life, health, and disability insurance products. Ms. Connolly also has extensive experience with the United Nations and other international organizations in developing and implementing administrative and legal reform policy. She holds a J.D. degree from Fordham University School of Law, graduating in 1996, a 2008 post-graduate certificate in International Law from the University of London, an M.A. degree in Classics from Columbia University, and a B.A. from Wells College.

The Importance of Avoiding Equivocal Denials in Claims Processing

By Moheeb H. Murray and Vincent C. Sallan


When an insurer denies a claim, no matter the type of insurance at issue, the nuance of the specific language used to deny that claim can be overlooked. That nuance, however, can prove decisive if the denial results in litigation. An equivocal denial can breathe newfound life into a claim otherwise barred by contractual or statutory limitations periods. This article examines recent trial court decisions. The first is a disability-insurance case holding that a denial of was and two others in the property-insurance context—to provide practical guidance for claims handlers and their partners in ensuring that their denials withstand judicial scrutiny.

A Finding of an Equivocal and Unequivocal Denial on Two Parts of One Plaintiff's Disability Claim

The Central District of California, *Daneman v. Guardian Life Ins. Co. of Am.*, No. 5:18-cv-01751, 2019 WL 1229770 (C.D. Cal. Mar. 11, 2019), recently examined the effects of an equivocal claim denial. There, the plaintiff Steven Daneman sued Guardian Life Insurance Company of America ("Guardian") and Berkshire Life Insurance Company of America ("Berkshire") alleging breach of contract and breach of the implied duty of good faith and fair dealing after the insurers denied his claim for residual disability benefits. *Id.* at *[1].

After some discovery, Guardian and Berkshire moved for summary judgment contesting their liability. *Id.* Guardian's principal argument was that Mr. Daneman's claim was barred under California's statute of limitations and under the limitations period contained in the policy. *Id.* at *3.3 The timeline of the various submissions, denials, and correspondences is critical to understanding the court's decision and reasoning:

- On March 21, 2013, Mr. Daneman telephonically submitted to Berkshire and Guardian a residual disability

1 This article focuses on the court's analysis of the California statute of limitations.

claim based on post-concussion syndrome dating back to approximately 2006. He eventually narrowed this date down to January 1 or 2, 2006. *Id.*

- On April 14, 2014, after an evaluation, Berkshire and Guardian sent a letter denying Mr. Daneman's claim for residual disability benefits from January 1, 2006 to January 1, 2013. Guardian denied Mr. Daneman's claim for two reasons: (1) he did not receive medical care from 2006 to 2011; and (2) his lost-income was below the policy threshold. The letter did, however, invite Mr. Daneman to submit additional information if he felt that he was entitled to benefits beginning on January 1, 2013. The letter also informed Mr. Daneman of the appeals process for the denial from 2006 to 2013.4 *Id.* at *[2].
- On July 31, 2014, Mr. Daneman submitted additional documents to support his post-2013 claim for residual disability benefits. On December 31, 2014, Guardian denied Mr. Daneman's claim for benefits from January 1, 2013 through December 31, 2014. Guardian again advised Mr. Daneman it was willing to review additional documents. *Id.*
- On June 16, 2015, Mr. Daneman submitted a letter and documentation informing Guardian that he stopped working entirely on September 30, 2014, and that he was now claiming *total* disability from that point forward. On August 31, 2015, Guardian informed Mr. Daneman he was not eligible for disability benefits from September 30, 2014 to August 31, 2015. Guardian further informed Mr. Daneman that he was not eligible for benefits from January 1, 2006 to September 30, 2014 because he had not yet provided the additional necessary supporting documents. Using identical language as previous letters, Guardian advised Mr. Daneman that it was willing to review any additional documentation. *Id.*
- Following a December 22, 2015 appeal, Guardian determined that Mr. Daneman was totally disabled beginning on September 30, 2014, and approved his claim for total disability benefits from that date forward. *Id.*
- On June 9, 2016, Mr. Daneman again submitted documentation to support his 2006 residual disability claim. On September 1, 2016, Guardian denied that claim, and again offered Mr. Daneman the chance to appeal the denial, noting that it would review any additional documentation.5 *Id.* at *3.

In its analysis, the court noted that the statute of limitations begins to run when the insurer unconditionally or unequivocally denies the insured's claim. *Id.* at *[3]. Guardian maintained Mr. Daneman's claims accrued on April 14, 2014, when Guardian issued its first denial letter. *Id.* Mr. Daneman argued that the April 14 letter did not constitute an unequivocal denial because it was based on information in Guardian's possession at that time and Guardian invited him to furnish additional information. *Id.*

The court rejected Mr. Daneman's argument. *Id.* Instead, the court held that under California law, an insurer's general statement that it is willing to reconsider its denial does not necessarily make its denial equivocal. *Id.* Ultimately, the court held that Guardian's April 14 letter where it advertised its willingness to reconsider its denial did not render the April 14 letter equivocal as to Mr. Daneman's claim for residual disability benefits from January 1, 2006 to January 1, 2013. *Id.*

But whether the April 14, 2014, letter was unequivocal as to Mr. Daneman's claim for post-January 1, 2013 benefits was a different story. In finding that the April 14 letter was not an unequivocal denial of the post-January 2013 claims for benefits, the court focused on the fact that Guardian never actually denied Mr. Daneman's post-January 2013 claims. *Id.* Rather, the court noted that for those claims, Guardian's April 14 letter instructed Mr. Daneman to submit specific documentation to support his January 1, 2013, to September 30, 2014, residual disability benefits claim against Guardian, but did not state that it was denying the claim. *Id.* at *5. The court found the first unequivocal denial of the post-January 2013 claim for benefits did not occur until December 31, 2014, which is when the post-January 2013 claim for benefits first accrued. *Id.*

Recent Analogous Approaches to Determining Equivocality of Denial Language in the Non-Disability Context

While not dealing with disability insurance, a pair of interesting cases from New Jersey have recently addressed equivocal denial issues after Tropical Storm Irene and Hurricane Sandy, providing additional useful insights for denials in disability claims. In *Snell v West Am. Ins. Co.*, No. 14-3985, 2017 WL 2225568 (D. N.J. May 22, 2017), the

2 Berkshire's position was always that the policy lapsed, and Mr. Daneman could not make a claim under the policy for that reason. Accordingly, this article focuses on Guardian's actions during the claims process.

3 Mr. Daneman did submit a letter from his psychologist supporting his alleged disability from January 1, 2006 through September 30, 2014. That letter did not alter Guardian's decision.

plaintiff sued West American Insurance Company ("West American") for breach of contract and breach of the implied covenant of good faith and fair dealing for denying his homeowner's insurance claims submitted after Tropical Storm Irene and Hurricane Sandy. *Id.* at *1. The parties did not dispute that Tropical Storm Irene did *some* damage to Mr. Snell's property; only the extent of the damage was at issue. *Id.* at *1. The timeline highlights are:

- Following Tropical Storm Irene in August 2011, plaintiff filed a claim. After an exterior-only property inspection (it was unclear why the interior could not be inspected at the time), American West sent a letter to plaintiff informing him the damage amount was below his policy deductible, and American West would not make a payment. *Id.* at *2.
- On April 10, 2012, the plaintiff asked to have the interior of his house inspected and American West then reopened his claim. On May 2, 2012, following the interior inspection, American West noted that the claimed his interior damage was not covered under the policy, and therefore denied coverage. *Id.*
- After Hurricane Sandy made landfall in October 2012, plaintiff also made a Sandy-related claim. *Id.*
- On July 13, 2013, American West reopened the plaintiff's Tropical Storm Irene claim after mediation of his Sandy claim, informing him it would consider documents from his contractor on the Irene claim, which it did in the following months. *Id.*
- On December 26, 2013, American West again denied the plaintiff's Irene claim because the damages still did not exceed his policy deductible. *Id.*
- On April 11, 2014, the plaintiff's attorney contacted American West and requested plan documents. Critically, following a few correspondence exchanges, American West's April 28, 2014 email to the attorney explained that American West could not consider anything further regarding the Irene and Sandy losses and would stand by its decision unless the plaintiff provided new information. *Id.*

The plaintiff sued, and after some discovery, American West moved for summary judgment, arguing that the policy's two-year statute of limitations precluded the lawsuit. *Id.* at *3. The plaintiff countered that the "equitable tolling doctrine" allowed him to bring the claim more than two years after his property loss. *Id.* The court noted that under New Jersey law, contractual limitation provisions are tolled from the time the insured gives notice of the loss until the time the insurer formally denies coverage. *Id.* American West provided the court a detailed analysis of the start-and-stop nature of the Irene-related claims history used to determine that the two-year statute of limitations had expired. *Id.*

The plaintiff countered that some of American West's communications were not unequivocal denials that would have ended the policy's tolling periods. *Id.* He argued that the denials were equivocal because they did not provide the information required under New Jersey law, which includes a "full and fair statement of the reasons for its decision not to pay benefits" and a "clear statement that if the insured wishes to enforce [his/her] claim it will be necessary for [him/her] to obtain the services of an attorney and institute a court action within the appropriate time." *Id.* at *3–4.

The plaintiff also argued that he filed his complaint within the two-year policy period because "special circumstances" made American West's denials equivocal. *Id.* at 4. One case he cited was *Azze v. Hanover Ins. Co.*, 765 A.2d 1093 (App. Div. 2001) where the New Jersey Appellate Division held, *inter alia*, the tolling period for purposes of a contractual limitations period did not end when the insurance company sent a denial letter, in part because the parties were also negotiating over another claim that stemmed from the same event, thus adding confusion about which claim was denied and rendering the denial there equivocal. *Id.*

The plaintiff further argued that a November 9, 2011 letter was not an unequivocal denial under *Azze* because it only advised that American West was unable to make a payment and was silent as to other issues. *Id.* at *5. Mr. Snell also argued that the May 2, 2012 denial letter was not unequivocal because it apparently requested additional information and did not reference the policy limitations period for filing suit. *Id.*

The court rejected both of these arguments. The court held that the November 9, 2011 letter constituted an unequivocal denial because it clearly gave the reason why American West was unable to make payment (*i.e.*, the policy deductible was not met), which the court noted could constitute a sufficiently unequivocal denial. *Id.*

As to the May 2, 2012 denial, the court also found that letter was unequivocal. *Id.* The court noted that the special circumstances presented in *Azze* were not present in the plaintiff's case because his two claims stemmed from different events, one of which had not even occurred at the time of the May 2, 2012 denial letter. *Id.* The court also

noted that the May 2, 2012 letter *did not request additional information*, but simply informed the plaintiff that American West was *willing* to consider additional information which may have impacted its coverage decisions. *Id.*

For those reasons, the court found that the policy's limitation period ran for a total of two years and fourteen days, which fell just outside of the policy's two-year limitations period, and granted American West's motion for partial summary judgment. *Id.*

The other New Jersey case is *Ryan v. Liberty Mutual Fire Ins. Co.*, 234 F. Supp. 3d 612 (D. N.J. 2017). There, the plaintiffs sued Liberty Mutual for breach of contract, a bad faith denial, and a breach of New Jersey's consumer protection laws after Liberty Mutual denied their homeowner's claim following Hurricane Sandy. *Id.* at 613–15. On November 15, 2012, after two inspections, Liberty Mutual sent a letter explaining the plaintiffs' coverages and denying their claim for excluded flood damage, but approving their claims for non-flood-related damage. *Id.* The letter notified the plaintiffs that they could contact Liberty Mutual with questions or additional information which Liberty Mutual might use to reconsider its coverage decision. The letter also outlined Liberty Mutual's appeal process.

After the denial, the plaintiffs contacted a Liberty Mutual claim representative, requesting a recommendation for a contractor to perform work on their home, and thanking him in advance for revisiting their claim summary. The claim representative offered to have another adjuster go out to their home, and provided the requested recommendations. The plaintiffs never provided additional information. *Id.* at 614–15. Sometime later, the plaintiffs requested a payment letter detailing benefits paid for FEMA purposes, which Liberty Mutual provided. *Id.* at 615. The plaintiffs contacted Liberty Mutual on two other occasions advising they planned to submit additional documents in support of their claim, which they never did. *Id.*

Liberty Mutual's motion for summary judgment argued that the plaintiffs' claim was barred under the policy's one-year limitations period. *Id.* at 616. Liberty Mutual argued the statute of limitations began to run again, after being initially tolled, on December 10, 2012, when Liberty Mutual paid benefits it owed and completed the investigation. The plaintiffs argued that the December 10, 2012 letter was not an unequivocal denial sufficient to stop the tolling of the policy period. Like the plaintiff in *Snell*, the *Ryan* plaintiffs relied, in part, on the *Azze* case. *Id.* at 616–17. The court found their arguments unpersuasive. First, the court noted the December 10 letter clearly spelled out the benefits denied and approved, and that the word "denial" did not need to appear anywhere in the letter: there only must be "unequivocal denial language." *Id.* at 616–18. The court also rejected the plaintiffs' argument that existence of an internal appeals process prevented the letter from serving as an unequivocal denial, expressly noting that a body of cases held exactly the opposite. *Id* at 618. The court was also unpersuaded by the plaintiffs' argument that Liberty Mutual should have brought their attention to the limitations period in the denial letter, noting that courts had previously rejected such a requirement. *Id.*

Considerations for Best Practices

An equivocal denial letter can lead to issues in subsequent litigation over denied claims. While sending a standard or pre-filled denial letter is always tempting, claims handlers should be mindful of the specific facts, circumstances, and timelines of each claim, and strive to provide denials crafted to the relevant facts and issues of each claim. When standard or boilerplate language is utilized, claims handlers should be mindful of the distinction between simply referring the insureds to the appeals process versus requesting additional information or documentation in support of a claim. The latter can make an otherwise unequivocal denial equivocal and lead to litigation.

Moheeb H. Murray leads the insurance coverage practice team at BSP Law. He represents leading national insurers in life, disability, ERISA, and other insurance-coverage matters at all stages of litigation. He also focuses his practice on complex-commercial and construction litigation.

Vincent C. Sallan focuses his practice on commercial, employment, insurance, and product liability litigation. Vince has represented a variety of national clients and major insurance carriers in all phases of defense litigation in first and third-party auto negligence, personal injury, premises liability, and general negligence claims.