UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
MIAMI DIVISION

LINA TURNES-LOPEZ,

Plaintiff,

v. CASE NO.: 06-22479-CIV-KING

METROPOLITAN LIFE INSURANCE COMPANY,

Defendant.
_____________________________________/

PLAINTIFF'S MEMORANDUM OF LAW IN SUPPORT OF HER MOTION FOR SUMMARY JUDGMENT

I. Introduction

It is uncontested that Ms. Turnes-Lopez suffers from fibromayalgia, chronic fatigue syndrome ("CFS") and chronic pain. While diagnosed with fibromayalgia in February of 2002, the Plaintiff continued to work in her job as a Project Manager at VISA while experiencing intense pain and chronic fatigue. By October of 2002, Ms. Turnes-Lopez's medical condition deteriorated to the point where she was no longer able to work due to the severity of her symptoms. MetLife recognized Ms. Turnes-Lopez's disability from her own occupation and approved her short-term claim and then her long-term disability benefits under the Plan. She was receiving these benefits for two years when MetLife capriciously terminated Ms. Turnes-Lopez's benefits based on the Defendant's blatantly biased and unreasonably cursory Functional Capacity Evaluation ("FCE"), despite the submission of voluminous medical records establishing her inability to perform any type of gainful employment.

II. **Facts**

Please refer to *Plaintiff's Statement of Undisputed Material Facts In Support of Her Motion for Summary Judgment* being filed contemporaneously with this Memorandum.

III. **Summary Judgment Standard and Argument**

A moving party is entitled to summary judgment if the pleadings, affidavits and other supporting papers show there is no genuine issue of material fact and the movant is entitled to judgment as a matter of law. Fed. R.Civ.P., 56(c); Celotex Corp. v. Catrett, 477 U.S. 317, 322, 91 L.Ed. 2d 265, 106 S.Ct. 2548 (1986). "The burden of establishing the absence of a genuine issue of material fact is on the party seeking summary judgment." United of Omaha Life Ins. Co. v. Sun Life Ins. Co. of America, 894 F.2d 1555, 1557 (11th Cir. 1990)(citations omitted). Once this burden has been met, the adverse party must show there remains a genuine issue for trial. Fed.R.Civ.P., 56(e). "The court must view all evidence in the light most favorable to the non-movant and must resolve all reasonable doubts about the facts in favor of the non-movant." United of Omaha Life Ins. Co., 894 F.2d at 1558.

The Defendant's termination of Lina Turnes-Lopez' claim was wrong as a matter of law where it terminated the Plaintiff's benefits despite the fact that there was no change in her medical condition. MetLife evaluated Ms. Turnes-Lopez's own occupation as Project Manger at VISA as being sedentary in nature.[1] She was paid long-term disability benefits based on the Defendant's conclusion that she could not work in a sedentary job. There was no change in her medical records that would indicate any

[1] Claim File at MET0029, MET0041, MET0058.

improvement in her medical conditions that would enable her to all of a sudden, after two years of being on claim, work in a sedentary job as repeatedly concluded by the Defendant in support of its termination. Thus, even looking at the evidence, namely its FCE and its paper medical reviews in which it so heavily couches its termination, in the light most favorable to the Defendant, it is undisputed that the Plaintiff's condition did not improve. Since the Defendant has already accepted liability for the own occupation portion Ms. Turnes-Lopez' claim that entitled her to benefits if she was unable to perform her own sedentary occupation, MetLife is now legally barred from asserting that Ms. Turnes-Lopez - who's health has certainly not improved - can perform sedentary work.

IV. Applicable ERISA Standard of Review: Heightened Arbitrary and Capricious

In light of the inherent conflict in Defendant's role as decision-maker and payer of claims, the modified abuse of discretion standard of review is applicable in evaluating Defendant's termination of Ms. Turnes-Lopez's long-term disability benefits under the group plan.

Language in an ERISA policy that confers discretion on the insurer to interpret entitlement to benefits dictates that courts review such interpretation for an abuse of discretion, unless a conflict of interest is present.[2]

It is quite clear from the Plan documents that Defendant MetLife underwrites VISA's long-term disability benefits. However, Defendant also makes determinations as

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[2] "A determination that the arbitrary and capricious standard applies does not end the court's inquiry with respect to the appropriate standard of review, however, because the concept of arbitrary and capricious must be 'contextually tailored.' Brown v. Blue Cross & Blue Shield, 898 F.2d 1556, 1564 (11th Cir. 1990). The Eleventh Circuit has identified a range of deference to be applied to an administrator's decision with a 'disinterested, impartial decisionmaker deserving the greatest deference' and fiduciaries with a serious conflict of interest being given slight, or even no deference, so that 'the decision, if wrong may be unreasonable.' Id."
Vann v. National Rural Electric Cooperative Assoc. Retirement and Security Program, 978 F. Supp. 1025, 1039, 1048 (M.D. Ala. 1997).

to whether claimants are disabled. The Defendant's dual role creates a clear conflict of interest in that it both determines and pays long-term disability benefits.

Fiduciary conflicts of interests are most clearly found when, as in the case before us, an insurer administers its own plan. In Brown, 898 F.2d 1556, an insurance company not only insured the plan benefits, but it also had the right to interpret the plan and make final determinations as to eligibility for benefits. The Eleventh Circuit deemed this an "inherent conflict between the roles assumed," as benefits denied to plan participants and beneficiaries would be retained by the insurer. Conversely, when the insurer determined that benefits were payable, the funds came out of the insurer's own assets. Thus, the Eleventh Circuit determined that the insurance company's "fiduciary role lies in perpetual conflict with its profit-making role as a business." Brown, 898 F.2d at 1561. The Brown court reasoned that, "when an insurance company serves as ERISA fiduciary to a plan composed solely of a policy or contract issued by that company, it is exercising discretion over a situation for which it incurs 'direct, immediate expense as a result of benefit determinations favorable to plan participants.'" Id. at 1561. More recently, the Eleventh Circuit has clarified its position, stating that an inherent or apparent conflict is presumed to be an actual conflict of interest, because "a conflicted fiduciary may favor, consciously or unconsciously, its interests over the interests of the plan beneficiaries." Adams v. Thiokol Corp., 231 F.3d 837, 842 (11th Cir. 2000).

Where a conflict of interest exists for the administrator, the arbitrary and capricious standard is still applicable, but the conflict of interest must be weighed as a "factor in determining whether there is an abuse of discretion." Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115, 109 S.Ct. 948, 103 L.Ed. 2d 80 (1989). That is, the

review in such cases is still “for an abuse of discretion, but it is less deferential.” Regula v. Delta Family-Care Disability Survivorship Plan, 266 F.3d 1130 (9th Cir. 2001)(vacated on other grounds). "[A] fiduciary operating under a conflict of interest may be entitled to review by the arbitrary and capricious standard for its discretionary decisions as provided in the ERISA plan documents, but the degree of deference actually exercised in application of the standard will be significantly diminished." Brown, 898 F.2d at 1568. *See also,* Florence Nightingale v. Blue Cross/Blue Shield of Alabama*,* 41 F.3d 1476,1481 (11th Cir. 1995) (The arbitrary and capricious deference is diminished if the claims administrator was acting under a conflict of interest); Sahlie v. Nolen*,* 984 F. Supp.1389, 1401 (M.D. Ala 1997).

The first step in reviewing the interpretations and decisions of a fiduciary with an inherent conflict of interest is for the district court to make a *de novo* review of the interpretations and decisions, in order to determine whether they were legally “correct” (*i.e.* what the court would have done) under the relevant plan provisions. Brown, 898 F.2d at 1566, n.12. If the fiduciary’s interpretations and decisions are legally correct, the district court need not consider the fiduciary’s self-interest, and the fiduciary’s interpretation or decision will be upheld. Brown, 898 F.2d at 1566, n.12. If the Plan Administrator’s interpretations or decisions were legally “wrong” (i.e. not what the court would have done), the next step would be for the district court to consider whether the interpretations or decisions were “wrong, but apparently reasonable.” *See* Brown*,* 898 F.2d at 1566-67. If the fiduciary made decisions that were "wrong" and "unreasonable" then the decisions must be reversed by the court, as being “arbitrary and capricious.”

However, if the decisions were "wrong, but apparently reasonable," the analysis must continue further.

Even if a court finds Defendant's denial wrong but reasonable, the burden shifts to the Defendant to prove that its interpretation of the policy and medical evidence was not tainted by self-interest, *based on a benefit conferred to the plan participants/beneficiaries as a class*. Lee v. Blue Cross/ Blue Shield of Alabama, 10 F.3d 1547 (11th Cir. 1994). Such notion could not possibly be proven by the Defendant where benefits are funded by the insurer who determines the claims as well, as it is disingenuous for the Defendant to assert that participants and beneficiaries benefit from such an arrangement. MetLife's decision was wrong and unreasonable, and clearly tainted by self-interest as discussed *infra.*

V. MetLife's Determination was Arbitrary and Capricious

To illustrate, not one of the Plaintiff's doctors opined she could work. Ms. Turnes-Lopez experiences chronic pain in her muscles and joints, severe fatigue, nonrestorative sleep, weakness, severe headaches, and has tested positive for 17 of 18 trigger points.[3] Ms. Turnes-Lopez can only sit, stand or walk for less than 1 hour and can only occasionally carry up to 5 pounds.[4] The Plaintiff must be able to lie down for substantial periods of time during the day.[5] Given the severity of her symptoms and the effect that these symptoms have on her physical abilities, Dr. Delgado communicated to MetLife that Ms. Turnes-Lopez cannot perform sedentary work.[6] The Defendant relied on similar medical records and the opinions of the Plaintiff's treating physicians *for the*

[3] Claim File at MET0179.
[4] Claim File at MET0176.
[5] Claim File at MET0177.
[6] Claim File at MET0175.

two years it paid her claim for her inability to perform her own sedentary job. Moreover, the opinions of the Plaintiff's treating physicians are unwavering in regard to her lack of improvement and her inability to work, and her medical records are consistent with regard to her reported symptoms. However, and despite the continued submission of fully favorable medical documentation, the Defendant capriciously terminated Ms. Turnes-Lopez' claim without conducting its own physical exam or having any contrary credible medical evidence in support thereof.

The Defendant did conduct an FCE at which the Plaintiff only passed 13 of the 31 tests administered. While the FCE reported that Ms. Turnes-Lopez gave sub-maximal effort in performing the exam, it is well known by the Defendant that she suffers from diseases that cause chronic pain and severe fatigue, especially when required to engage in physical or mental activities. Such allegation of sub-maximal effort is unfounded and thus clearly the result of bias. Furthermore, this testing was conducted on only one occasion for a minimal period of time and surely does not outweigh the years of observation and testing conducted by her treating physicians who have concluded that she is unable to work. The Defendant's unreasonable weight on this exam is the essence of arbitrariness.

The Defendant based its termination of benefits on the paper summation of its medical reviewers who actually corroborate the diagnoses of Ms. Turnes-Lopez's treating physicians, only to refute, without any basis, the restrictions and limitations recommended by those same doctors who have had the benefit of treating her conditions over numerous years. These medical reviews were deficient and conclusory in nature and

should be afforded very little weight, however MetLife arbitrarily viewed such paper reviews as more credible than the Plaintiff's very well known and reputable treating physicians, namely Dr. Patricia Major, renowned CFS specialist. While it may be the law that the treating physician is not "automatically" accorded special weight, it is well-established that, "Plan Administrators, of course, may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician." See Black & Decker Disability Plan v. Nord, 538 U.S. 822, 834 (2003). In denying Ms. Turnes-Lopez's claim, MetLife entirely ignored her medical documentation and the favorable opinions of her treating physicians **even though MetLife paid her benefits for over two years based on the same or similar evidence of disability from a sedentary occupation**.

In Claridge v. Continental Casualty Company, Case No. 5:05cv153-RS, U.S. Dist. LEXIS 77382 (N.D. Fla. Oct. 24, 2006) Judge Smoak, while acknowledging the insurer's ability to give more weight to its non-treating, non-examining consultant's opinion even if contrary to the claimant's treating physician, stated that such consideration typically applies when the treating physician's opinion is less reliable than the consultant's opinion. In that case, however, the Judge called the medical consultant's opinion into question in light of the medical evidence he reviewed.

Consider the following questions asked by MetLife and the answers provided by MetLife's medical consultant who is Board Certified in Internal Medicine and Rheumatology:

> 1. MetLife's focus is on defining our claimant's level of functionality and abilities. Please define Ms. Turnes-Lopez's current level of functionality based on your review of all material provided, medical

> documentation and/or physical examination according to DOT physical demands.
>
> The objective medical record presently supports that Ms. Lopez is capable of performing her previous occupation at the present time.
>
> 2. Does the medical information support functional limitations and Ms. Turnes-Lopez's inability to function effective 05/10/05?
>
> No, the medical information does not support functional limitations effective 5/10/05…
>
> 4. If no, explain.
>
> The available medical record lacks specific objective measurements to support any degree of functional limitation.[7]

Not a single fact is used to support these conclusions. See Hawkins v. First Union Corp. Long-Term Disability Plan, 326 F.3d 914, 919 (7th Cir. 2003) (When discussing First Union's medical reviewer's opinion, the Court stated, "The record contains nothing more than scraps to offset the evidence presented by Hawkins and by Dr. Katz. The denial of the application was unreasonable.") Instead, the medical consultant notes that the "medical record lacks specific objective measurements to support any degree of functional limitation." It is well-known that no objective test exists by which you can objectively measure the limitation imposed upon a particular individual who suffers from fibromayalgia and CFS. Rather than support this opinion with facts, the medical consultant points to a lack of objective evidence which simply cannot be produced as a means to reach a conclusion favorable to MetLife.

Several courts have recognized that an insurer cannot insist on a standard of proof for proving disabling CFS that effectively eliminates the possibility of anyone with CFS actually receiving long-term disability benefits. *See* Mitchell v. Eastman Kodak Co., 113

[7] Claim File at MET0069.

F.3d 433 (3d Cir. 1997) (it was prima facie unreasonable to require claimants with CFS to submit objective evidence of their condition, given that there are no recognized objective physical tests and that the CFS diagnosis is one of exclusion.) Cook v. Liberty Life Assur. Co., 320 F.3d 11, 21-22 (1st Cir. 2003), Hawkins, 326 F.3d at 919, Friedrich v. Intel Corp., 181 F.3d 1105, 1112 (9th Cir. 1999), Burchill v. Unum Life Insur. Co. of Am., 327 F. Supp.2d 41, 51 (D. Me. 2004), Pralutsky v. Met. Life Insur. Co., 316 F. Supp.2d 840, 852-53 (D. Minn. 2004) (finding abuse of discretion when plan administrator relied on the opinion of the insurer's reviewing doctor, who required objective evidence in order to diagnose fibromyalgia or CFS), Maronde v. Sumco USA Group Long-Term Disability Plan, 322 F. Supp.2d 1132, 1139 (D. Or. 2004), Sansevera v. E.I. DuPont de Nemours & Co., 859 F. Supp. 106, 113 (S.D.N.Y. 1994). The court in Pharr v. Continental Casualty Company, 6-03-cv-735-Orl-22KRS, (M.D. Fla. May 12, 2004) (unpublished) also found it unnecessary to present objective medical evidence confirming the plaintiff's CFS diagnosis and the severity of her symptoms.[8]

Also consider the following questions asked and the answers provided by MetLife's medical consultant who is Board Certified in Neurosurgery:

> 1. MetLife's focus is on defining our claimant's level of functionality and abilities. Please define Ms. Turnes-Lopez's current level of functionality based on your review of all material provided, medical documentation and/or physical examination according to DOT physical demands.
>
> Based on the records reviewed, Ms. Turnes is capable of sedentary job requirements, which she performed for three years.
>
> 2. Does the medical information support functional limitations and Ms. Turnes-Lopez's inability to function effective 05/10/05?

[8] See the Court's Order attached as Exhibit A.

> The medical information submitted does not support Ms. Turnes' inability to function effective 5/10/05.
> ….
>
> 4. If no, explain.
>
> The physical evaluation capacity session May 2005 demonstrated the capability of Ms. Turnes to perform a sedentary position physical capacity with essentially no restrictions. There was no evaluation for psychological impairments other than her neuropsychological evaluation which was normal. The most recent PCE suggested psychosocial support in her job duties to alleviate stress as in any position at this level.

Once again, there is no factual support provided for the medical consultant's opinion. The FCE was an inappropriate test by which to gauge Ms. Turnes-Lopez's subjective pain. Small v. First Reliance Std. Life Ins. Co., 2005 U.S. Dist. LEXIS 3153, 2005 WL 486614, at *6 (E.D. Pa. Feb. 28, 2005) (finding that a FCE showing that the participant was physically capable of doing her job did not address the cognitive deficiencies caused by her CFS). Thus, reliance upon this exam offers no support whatsoever for this opinion. This medical consultant goes on to selectively highlight a neuropsychological evaluation which was normal but fails to address how this is relative to what her restrictions and limitations are. As in Claridge, the medical consultants' opinions in the case at hand should likewise be called into question where both doctors relied on the absence of objective evidence and a flawed FCE in support of their opinion that the Plaintiff can work in a sedentary job. Both of these reviews conducted by MetLife's medical consultants evidence the fact that the Defendant's decision to terminate the Plaintiff's benefits was wrong and unreasonable in light of the cursory reviews and conclusory medical opinions on which MetLife relied in dismissing her treating physicians' opinions and upholding the termination of the Plaintiff's disability benefits.

VI. MetLife Failed to Conduct a Full and Fair Review of Plaintiff's Claim

ERISA mandates that each claimant be afforded a full and fair review. The Code of Federal Regulations at 29 C.F.R. § 2560.503-1(h)(2) titled "Full and fair review" states:

> Except as provided in paragraphs (h)(3) and (h)(4) of this section, the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures …
>
> > **(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.**
> > (emphasis added)

If the fiduciary fails to adhere to its claims administration obligations under ERISA or the regulations promulgated by the CFR, a full and fair review has not been conducted.

MetLife ignored Plaintiff's corroborated complaints of pain and fatigue as well as her self-reported restrictions and limitations. Ms. Turnes-Lopez's claim file containing medical records and factual representations made to the Defendant is replete with complaints of chronic pain and fatigue as well as self-reported limitations and restrictions regarding her physical abilities. While Plaintiff obviously has an interest in this case, her factual representations to her doctors and to MetLife are corroborated by her friends, family and co-workers, many of whom have no interest in this cause of action whatsoever. Since the onset of her disability, Ms. Turnes-Lopez has complained of chronic pain, fatigue, sleep disturbances, inability to concentrate, and memory loss. She also reports that her cognitive abilities are severely limited, she cannot drive a car, she

cannot sit or stand for any extended period of time without needing rest, she cannot be on the phone for very long, and that any extended period of activity can leave her bedridden for the next few days as corroborated by MetLife's observations during its surveillance.

In Menard v. Hartford, Menard v. Hartford, Case No. 6:05-cv-1145-Orl-31DAB, 2006 U.S. Dist. LEXIS 78767 (M.D. Fla. Feb. 23, 2007), Judge Presnell discussed the importance of the Plaintiff's subjective complaints and refused to discount the same in favor of the Defendant's medical consultant's opinion without good reason: "Under such circumstances, this Court will not credit the opinions of Hartford's chosen physicians over the subjective complaints of the Plaintiff with regard to his own pain, and the assessment of his chosen Physician." Id. at 20. Ms. Turnes-Lopez's complaints are well-documented and consistent throughout the claim file. Here, it is equally important to credit the subjective complaints of the Plaintiff with regard to her own pain as well as the assessment of her treating physicians over that of medical consultants who have only conducted a paper review of the claimant.

Ms. Turnes-Lopez's self-reported complaints are even more credible in light of the witness testimony that corroborates the Plaintiff's representations to MetLife. Her husband wrote the following in a formal statement (punishable under the penalty of perjury) submitted to the Social Security Administration:

> Lina's pain level peaks and wanes. Like with her energy level, I've noticed a correlation between her activity and stress level and the severity of pain she feels. For example, after attending the functional capacity exam that MetLife requested she undergo, she spent the next two days following in bed because she was in extreme pain and completely exhausted.
>
> …

> The Lina that I knew even 5 years ago no longer exists. She used to be extremely extroverted, now she is extremely introverted. Lina used to thrive on stress; today she becomes completely exhausted within minutes of encountering a stressful situation. She used to be able to handle complex tasks, now I have to do them. For example, she was unable to compile the documents necessary for this appeal because it involved looking for things in multiple places and putting them in a logical order. She used to be totally independent and now she is completely dependant, which is very upsetting.[9]

While the Plaintiff's husband is an interested party to this case, consider the formal statement submitted by Ms. Turnes-Lopez's former co-worker who has no interest in this matter:

> I first noticed something was wrong with Lina in 2002 because she started leaving [work] at 5:00 p.m. and missing work. This was very unusual for her. She told me that she was not feeling well, and felt extremely tired.
> …
>
> During the rest of the year, until she stopped working entirely, I would often call Lina's extension to check in on her, only to find out from others in her department that she had been unwell and had left work early or had missed work entirely.
> …
>
> During the past two years, I've seen Lina have a difficult time driving because she is unable to move her neck without pain. I've also noticed that, occasionally, Lina is unable to move her right arm.[10]

Each statement submitted to MetLife confirms that Ms. Turnes-Lopez truly struggles in her every day life with fibromayalgia and CFS and is disabled as a result of these conditions. The Plaintiff's representations and witness statements further corroborate the already well-supported medical opinions of her treating physicians. MetLife was wrong and unreasonable to completely ignore these sworn statements offered by uninterested parties – especially where they corroborate her own complaints of chronic pain and fatigue contained in her medical records.

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[9] Claim File at MET0117-MET0122.
[10] Claim File at MET0123-MET0125.

MetLife also failed to give any consideration to the plethora of evidence that established Ms. Turnes-Lopez' inability to work in a sedentary occupation. MetLife did not ignore Ms. Turnes-Lopez's medical evidence for the two years that they paid her claim, but once the FCE was conducted, MetLife soon after sought out to discount and discredit the medical opinions that it had recognized as valid and credible enough to previously support her claim for benefits. With no indication of any change in her medical condition, the Defendant chose to ignore Ms. Turnes-Lopez's treating physicians in favor of a flawed FCE and deficient paper reviews.

For example, in appeal of the Defendant's termination of her benefits, Ms. Turnes-Lopez submitted a Physical Capacities Evaluation completed by Dr. Delgado. The report from this evaluation evidenced that:

- she cannot sit, stand, or walk on a sustained basis for longer than one hour;
- she can lift 5 pounds on a sustained basis occasionally, but never any more than 5 pounds;
- she is capable of simple grasping and fine manipulation on a sustained basis, but that she cannot use her hands for repetitive pushing and pull of arm control;
- she cannot use her feet for repetitive movements as in pushing and pulling of leg controls;
- she requires complete freedom to rest frequently without restriction;
- and she must lie down for substantial periods of time during the day.[11]

Dr. Delgado's June 6, 2005 and June 8, 2005 office notes opined that Ms. Turnes-Lopez was not able to return to work.[12] The medical forms dated July 20, 2005 (discussed *infra*)

[11] Claim File at MET0098-MET0100.

evidence the severe restrictions and limitations that Ms. Turnes-Lopez's medical conditions imposed upon her. These medical records were unchanged as compared to those that previously supported the payment of her benefits. However, MetLife entirely ignored this medical evidence in deciding to uphold its termination of benefits.

In Durr v. Metropolitan Life Insurance Co., 15 F. Supp 2d 205 (Conn. 1998), the trial court examined factors that should be considered in determining the weight due to be given a physician's opinion. These factors were set forth at 20 C.F.R. § 404.1527(d)(2)-(6). They are: "(i) The frequency of the examination and the length, nature and extent of the treatment relationship; (ii) The evidence in support of opinions; (iii) The opinions' consistency with the record as a whole; (iv) Whether the opinion is from a specialist; (v) Other relevant factor." The Court further its analysis quoting Helms v. Monsanto Co., 728 F.2d 1416 (11th Cir. 1984), "Although the standards developed under the Social Security Act are not binding in ERISA cases, they are nonetheless instructive." Durr, 15 F. Supp. 2d at n2. After reviewing facts similar to those of this case, the Court in Durr held, "even if the plaintiff's treating physician's opinions are not entitled to controlling weight, we find that they are entitled to substantial weight based on the application of the above factors."

When applying the factors cited above, the opinions of Dr. Delgado and Dr. Major should be given more weight in comparison to the opinions of MetLife's paid medical consultants. An application of the facts at hand to the law clearly supports the need for greater weight to be given to Ms. Turnes-Lopez's treating physicians where, following the factors outlined above, (1) her treating physicians have consistently treated her since the onset of her disability and have had the benefit of observing her condition

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[12] Claim File at MET0353 – MET0354.

during that time, (2) they have performed a barrage of exclusionary testing and frequent tender point testing and their opinions based on this testing/observation are corroborated by her other treating physicians, (3) their opinions have not wavered and their opinions are further corroborated by MetLife's own medical consultant[13] as well as by MetLife's recognition of her disability through the payment of her claim for over two years, (4) their opinions are consistent with the initial diagnoses made by specialists, and (5) MetLife's doctors never examined the patient and their opinions lack factual support.

VII. Conclusion

In Ms. Turnes-Lopez claim, MetLife attempted to draw a distinction that does not exist – a distinction between the first 24 months of her claim and thereafter, based on a definitional change in its policy that typically renders claimants vulnerable to termination of benefits. As any profit-making business would do, MetLife directs its claims adjusters to reassess claims during this definitional change from "own occupation" to "any occupation" and terminate claims if the claimants restrictions and limitations that disabled them from their former jobs, do not necessarily disabled then from other work. Sedentary work is usually the example given for the type of work that a claimant is able to do despite his/her restrictions from his/her former job.

Here, Ms. Turnes-Lopez' former work *was sedentary*, and *her inability to do sedentary work was acknowledged by the Defendant for the first 24 months of her claim*. Thus, MetLife's systematic reassessment of claims did not apply to Ms. Turnes Lopez, but MetLife tried to make a square peg fit in a round hole anyway. In doing so, it ignored the fact that her medical condition did not improve, and that nothing changed that would now render the Plaintiff able to do sedentary work, as well as the support from her

[13] Claim File at MET0159.

reputable doctors who disagreed with their medical reviewers. All of a sudden, the surveillance that showed Ms. Turnes-Lopez did not emerge from her house for two days straight meant nothing, and an inappropriate exam that cannot possibly begin to assess pain itself or cognitive deficiencies – the FCE – was heavily used to terminate her claim.

Perhaps MetLife felt that the Plaintiff would not refute its decision, given the obstacles to litigation, or that even if she did, it could get around the lawsuit by simply relying on the FCE and their medical reviewers even if their conclusions had no factual basis. However, as courts have said in the past, the Defendant's practice is not condoned by legal precedent and certainly not by our judicial system.

Lina Turnes-Lopez respectfully asks that this Court award her past-due disability benefits, plus interest, costs, and attorney's fees, and order MetLife to reinstate her coverage so that she can receive the benefits to which she is entitled as they come due to her.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 7th day of May, 2007, I electronically filed the foregoing document with the Clerk of the Court using CM/ECF. I also certify that the foregoing document is being served this day on counsel for Defendant, Neera M. Shetty, Esq., McGuire Woods LLP, Bank of America Tower, Suite 3300, 50 North Laura Street, Jacksonville, FL 32202 via transmission of Notices of Electronic Filing generated by CM/ECF or in some other authorized manner for those counsel or parties who are not authorized to receive electronically Notices of Electronic Filing.

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