

UNITED STATES DISTRICT COURT  
MIDDLE DISTRICT OF FLORIDA  
ORLANDO DIVISION

GAYLYN PHARR,

CASE NO. 6:03-CV-735-Orl-22KRS

Plaintiff,

v.

CONTINENTAL CASUALTY COMPANY,

Defendant.

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

**I. Introduction & Facts**

Gaylyn Pharr, forty-one (41) year old former Vice President/Associate Media Director of The Martin Agency, Inc., became disabled from her occupation on January 15, 1999 due to Chronic Fatigue Immune Dysfunction Syndrome (CFIDS/CFS) and fibromyalgia. As Associate Media Director and Manager of The Martin Agency's Dallas office, Ms. Pharr was in charge of the entire media planning and buying operation for a \$60 million dollar financial services account with operations and advertising needs covering 12 states.<sup>1</sup> Since the onset of her disability, Ms. Pharr has consistently experienced cognitive difficulties with respect to processing speed, memory and word search<sup>2</sup>, fatigue, pain consistent with fibromyalgia such as low back and abdominal pain, and has consistently met the Center for Disease Control's (CDC) Major Criteria as well

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<sup>1</sup> Please see a description of Ms. Pharr's occupation as told by Rebecca Fielden, Vice President/Compensation and Benefits Administrator of The Martin Agency, who also discusses that Ms. Pharr's job could not be modified by accommodations, attached as **Exhibit A**.

<sup>2</sup> See letter from Diane Baar, Senior Vice President/Media Director at The Martin Agency who explains how such symptoms affected Ms. Pharr's work capacity, attached as **Exhibit B**.

as 7 out of 8 Minor Criteria for diagnosis of CFIDS.<sup>3</sup> In addition, Ms. Pharr's lab work and other objective tests have repeatedly reflected results found typically in victims of CFIDS and fibromyalgia. Aside from general internists, Ms. Pharr has been treated by an infectious disease specialist, two CFIDS specialists, a neurologist, a gastroenterologist and a rheumatologist, all of whom support Ms. Pharr inability to work in her occupation both due to cognitive and physical impairments.

The Defendant, Continental Casualty Company ("CCC"), the insurer of Ms. Pharr's long-term disability policy by virtue of her employment with The Martin Agency, never paid Ms. Pharr any disability benefits thereby concluding that the Plaintiff was not disabled from her own occupation and its related physically and cognitively demanding duties as discussed *supra*. As a Vice President and a full-time corporate officer of the Martin Agency, Ms. Pharr enjoyed Class 1 status under The Martin Agency's Long-Term Disability Plan, the most distinct characteristic of such status being that the "Insured Employee Own Occupation Period" lasts until the end of the maximum period payable, i.e. until Ms. Pharr reaches age sixty-five (65) years of age. In other words, in order to be entitled to disability benefits, Ms. Pharr was required to be unable to perform her regular occupation for the entire life of the policy as explained in more detail in Section II *infra*.

Gaylyn first became ill in March of 1998 with an abrupt viral illness involving both an upper respiratory and a gastrointestinal focus including a three to four month period of chronic diarrhea and fever of unknown etiology. During this time, Ms. Pharr underwent five separate courses of antibiotic therapy, lasting anywhere from five to ten days. Eventually, the Plaintiff's upper tract symptoms improved but her fatigue, fever

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<sup>3</sup> For a more complete list of Ms. Pharr's symptoms, please see her Verified Answer to Defendant's Interrogatory #4 attached as **Exhibit C**.

and sore throat persisted along with unrestful sleep, fibromyalgic pain and chronic diarrhea. Due to an acceleration of abdominal pain, Gaylyn took a series of gastrointestinal diagnostic steps that all yielded essentially negative results, thereby ruling out a gastrointestinal etiology for her symptoms. She also underwent extensive blood work and a parasite screening for her unknown fevers. Gaylyn, for the most part, continued to work throughout this time period. However by summer, Gaylyn could only work from home, an accommodation that The Martin Agency could not make on a long-term basis for Gaylyn's position. The Plaintiff's infectious disease specialist entertained the idea of drug fever as well as auto-immune disease but could not make a diagnosis. Eventually, a rheumatologist, Scott Zashin, M.D., diagnosed Ms. Pharr with CFS. By late summer, Gaylyn was experiencing balance disturbances, tremors, concentration problems, and difficulties with calculation and processing speed that began to interfere with her work as was noted by the Plaintiff's co-workers<sup>4</sup>. By the end of 1998, Gaylyn's most significant symptoms were cognitive impairments, abdominal pain, low back and deep low back pain and fatigue.

Dr. Paul Cheney, a nationally known CFIDS specialist, in December of 1998 reported that Ms. Pharr experienced cognitive impairments, pain consistent with fibromyalgia, abdominal pain and fatigue, and that she met the CDC definition for CFIDS including the Major Criteria and 7 out of 8 Minor Symptom Criteria. Dr. Cheney additionally reported that the SF-36 short form<sup>5</sup> showed a RCS score of 12, a significant level of physical impairment, but a normal emotional score of 42. Defendant's Administrative Claim File, CNA0082-85.

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<sup>4</sup> See footnote 2.

<sup>5</sup> SF-36 is multidimensional profile measure of health status.

CCC's initial denial letter of June 1999<sup>6</sup> recited the medical documentation reviewed and concluded that Ms. Pharr's ailments were not supported by objective medical evidence, a requirement that is absent from the plan documents and thus not a proper basis to deny her claim.

Notwithstanding, during the appeals process and right before Defendant's final determination of its denial of Ms. Pharr's benefits, CCC received a Bicycle Ergometry with Gas Analysis Test, the results of which reported,

Many values fall well outside of predicted ranges, including an abnormal post-exercise drop in serum cortisol. . . A failure of the primary stress response hormone to rise sufficiently after a significant stressor (maximum exercise) is not only consistent with reports of defect in the central (CNS) control of the stress response axis but adds a further dimension to the patient's inability to function, namely a post-stress exacerbation of fatigue and other symptoms in the days and weeks after a significant stressor. The characteristic clinical relapse following even mild effort may be one of the most disabling aspects of CFS and is consistent with the dynamic response defect in the hypothalamic-pituitary-adrenal axis is observed. **Taken together these abnormalities suggest a significant impairment of work capacity which cannot be explained merely on the basis of deconditioning.** Also, the defects seen in her neuroendocrine responses point to significant functional problems originating within the central nervous system. **These findings are comparable with the observations of other investigators and are likely to cause severe functional capacity difficulties for Ms. Pharr.**

Defendant's Administrative Claim File, CNA0471-72 (emphasis supplied).<sup>7</sup>

Yet, the Defendant stated in its final denial letter issued on January 31, 2000<sup>8</sup> that the Plaintiff's documentation included "no findings of severe anatomical, physiological, or psychological abnormalities as a result of her Fibromyalgia which would reasonably be considered continuously disabling . . ." as confirmed by its physician reviewer.

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<sup>6</sup> Defendant's Administrative Claim File, CNA0059.

<sup>7</sup> Attached as **Exhibit D**.

<sup>8</sup> Attached as **Exhibit E**.

Ms. Pharr was subsequently determined to be disabled from any occupation by the Social Security Administration (SSA) due to CFIDS and fibromyalgia.<sup>9</sup>

The Defendant performed no investigation of its own to determine whether Ms. Pharr was disabled under the definition of the plan. The Defendant failed to physically examine the Plaintiff or conduct any personal evaluation of Ms. Pharr and instead relied on its own interpretation of the medical information submitted.

## **II. The Policy**

For Class 1 employees, the policy provides:

“Total Disability” means that, during the Elimination Period and the Insured Employee Occupation Period shown in Statement 4 of the Application [24 months], the Insured Employee because of Injury or Sickness, is:

- (1) continuously unable to perform the substantial and material duties of his regular occupation;
- (2) under the regular care of a licensed physician other than himself; and
- (3) not gainfully employed in any occupation for which he is or becomes qualified by education, training or experience.”

The policy does not contain any limitations in duration of benefits for illnesses based on self-reported symptoms. Neither does the policy have a requirement to submit objective medical evidence to support a claim of disability. The policy does not contain any language that has ever been deemed by any federal circuit to trigger a grant of discretion to the plan administrator and relatedly an arbitrary and capricious standard of review.

## **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

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<sup>9</sup> Such SSA determination is attached as Exhibit A to Plaintiff’s Statement of Undisputed Facts in Support of Plaintiff’s Motion for Summary Judgment.

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 (11<sup>th</sup> 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.

When looking at the facts in the light most favorable to the Defendant, Ms. Pharr is entitled to judgment in her favor as a matter of law. Even if the applicable standard of review is arbitrary and capricious<sup>10</sup>, the Defendant lacked any rational basis to deny Plaintiff’s claim. Not one of the Plaintiff’s doctors opined she could work, and the Defendant failed to employ a doctor to conduct its own physical exam or functional capacity evaluation of Ms. Pharr. Defendant based its denial on the paper summation of its medical reviewer, Dr. Eugene Truchelut, who discounts *all* Gaylyn’s documented symptoms and treating physicians’ conclusions.

Even if Dr. Truchelut’s opinion was accurate and credible – which it is not -- and even if all Gaylyn’s treating physicians were wrong about her work capacity – which they are not -- Dr. Truchelut’s assessment does not equate to a finding that Gaylyn Pharr can work in her occupation as Vice President/Associate Media Director. First, in his principal medical review on May 13, 1999, discussed in detail *infra*, he based his

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<sup>10</sup> There is a clear lack of a grant of discretion to trigger such standard of review in the governing plan documents as discussed *infra*.

conclusion concerning Ms. Pharr's ability to work on the Plaintiff's alleged failure to submit "objective evidence." In remaining loyal to the summary judgment standard, even if it was true that no such evidence was submitted<sup>11</sup>, the Courts have held as discussed *infra* specifically with regard to fibromyalgia, an absence of "objective medical evidence" is not a proper basis to deny a claim when there is no such requirement in the policy. However, even if such were a valid reason to deny a disability claim, Dr. Truchelut concludes specifically that the claimant did not submit objective medical evidence to support *a severely restricted functional status* such that Gaylyn *could not perform sedentary or light work*. Again upholding the summary judgment standard, even if such contention were true, Ms. Pharr would not be precluded from receiving benefits under the policy that requires her only to be unable to perform her regular occupation, as she undisputedly did not work in a sedentary or light occupation but one where she spent 30% of her time traveling and the remainder giving presentations/seminars and otherwise working with last minute immediate deadlines, as documented *supra*. Thus, whether Gaylyn could perform a sedentary occupation is of no consequence to this case.

When viewing the facts at record in the light most favorable to the Defendant, that is, when looking at Defendant's sole basis for its benefit denial, Dr. Truchelut's opinion, as completely valid and correct, such basis did not allow Continental Casualty Company to deny Gaylyn's claim. Defendant's benefit decision was wrong as a matter of law.

**IV. ERISA Standard of Review: Due to the Lack of Discretionary Authority Language, the Proper Standard of Review is *De Novo*.**

The basis of Ms. Pharr's claim is a wrongful denial of disability benefits

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<sup>11</sup> It is plainly apparent from the summary of evidence discussed herein that objective tests were submitted to substantiate the Plaintiff's impairments.

pursuant to a group long-term disability insurance plan, governed by 29 U.S.C. § 1001, et seq. (ERISA). The decision to deny benefits under an ERISA plan is evaluated under varying standards of review, depending on the express terms of the plan and factual circumstances of the case. The “default” standard is “*de novo*.”

“Consistent with established principles of trust law, we hold that a denial of benefits challenged under §1132 (a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.”

Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115, 109 S.Ct. 948, 103 L.Ed. 2d 80 (1989); accord, Brown v. Blue Cross & Blue Shield, 898 F.2d 1556, 1559 (11<sup>th</sup> Cir. 1990).

The "burden of proving" that the plan contains the requisite discretionary authority is on the plan administrator and any "ambiguity in the wording of the policy should be resolved against [the insurer]". Kinstler v. First Reliance Standard Life Ins. Co., 181 F.3d 243, 252 (2<sup>nd</sup> Cir. 1999); accord, Kearney v. Standard Ins. Co., 175 F.3d 1084 (9<sup>th</sup> Cir. 1999). The terms of a plan that are required to provide discretionary authority to a plan administrator must be stated in "**express language**" that "is **unambiguous in its design** to grant discretion regarding entitlements to the fiduciary or administrator." Kirwan v. Marriott Corp., 10 F.3d 784, 789 (11<sup>th</sup> Cir. 1994)(emphasis added)(holding that the language: "the trustees have the final authority to determine all matters of eligibility for the payment of claims," is insufficient to grant discretionary authority to the administrator).

"Contrary to the argument of the insurance company that discretionary authority can be implied from the plan, the circuit courts which have found that particular ERISA plans granted discretion to plan administrators or fiduciaries, in cases decided after Firestone, have uniformly rested this finding upon **express language** of the ERISA plan before them. Indeed, this court has recently stated that the 'discretionary

authority' to which Firestone refers must be '**expressly give[n]**' by the plan. Guy v. Southeastern Iron Workers' Welfare Fund, 877 F.2d 37, 38-39 (11<sup>th</sup> Cir. 1989)(finding requisite grant of discretionary authority where plan stated 'full and exclusive authority to determine all questions of coverage and eligibility' as well as 'full power to construe the provisions of [the] Trust' belonged to trustees); see also, Batchelor v. Int'l Broth. Of Elec. Workers Local 861 Pension & Retirement Fund, 877 F.2d 441, 443 (5<sup>th</sup> Cir. 1989)(grant of discretion found when plan stated 'full and exclusive authority to determine all questions of coverage and eligibility . . . [and] full power to construe the provisions' of the plan belonged to trustees); Boyd v. Trustees of United Mine Workers Health & Retirement Funds, 873 F.2d 57, 59 (4<sup>th</sup> Cir. 1989)(discretion found where plan expressly gave trustees power of 'full and final determination as to all issues concerning eligibility for benefits' and 'authorized [them] to promulgate rules and regulations to implement th[e] Plan'); Lowry v. Bankers Life & Cas. Retirement Plan, 871 F.2d 522, 524 (5<sup>th</sup> Cir. 1989)(plan's language that committee had authority to 'interpret and construe' plan and 'to determine all questions of eligibility and status under the Plan' constituted grant of discretionary authority"; Bali v. Blue Cross & Blue Shield Association, 873 F.2d 1043, 1047 (7<sup>th</sup> Cir. 1989)."

Moon v. American Home Assurance Co., 888 F.2d 86, 88-89 (11<sup>th</sup> Cir. 1989)(emphasis added).

**The plan not only fails to confer discretion**, but fails even to provide that CCC will only pay benefits after it receives "due written proof of loss" or similar language. Thus Defendant's Plan documents do not contain express language, unambiguous in its design, or *any language for that matter* to give CCC discretionary authority to determine eligibility for benefits or to interpret the terms of the plan.

In conducting a *de novo* review, the district court is not limited to the information available to the plan administrator at the time of the coverage determination.

Kirwan v. Marriot Corporation, 10 F.3d 784 at 789-790 (11<sup>th</sup> Cir. 1994), Moon v.

American Home Assurance Company, 888 F.2d 86, 89 (11<sup>th</sup> Cir. 1989), Grant v.

Provident Life and Grant v. Provident Life & Accident Insurance Company, 2001 U.S.

Dist. LEXIS 21557 (S.D. Fla. June 27, 2001). Thus, Ms. Pharr's work evaluations and

testimonials to her work ethic and ability not contained in Defendant's administrative record as well as further tests conducted of her worsening condition that came about subsequent to the close of the file, as attached to Plaintiff's Statement of Undisputed Fact in Support of Plaintiff's Motion for Summary Judgment, can be examined by this Court in ruling on the parties' cross motions.

Notwithstanding, even under the most strict arbitrary and capricious standard of review, the Court will be compelled to rule in favor of the Plaintiff, as she has fulfilled all requirements, including any implied or express condition to provide objective medical evidence, to prove disability from her skilled occupation that entailed travel, spontaneous demanding deadlines as well as intense cognitively-based duties.

**V. CCC's Improper Insertion of An Additional Requirement Into the Policy With Regard to Objective Evidence and its Failure to Consider Ms. Pharr's Credibility Regarding Her Subjective Complaints**

"Because a claimant need not present clinical or diagnostic evidence to support the severity of pain, a plan administrator cannot discount self-reports of disabling pain solely because the objective medical evidence does not fully support them." Hawkins v. First Union Corp. Long-Term Disability Plan, 326 F.3d 914, 919 (7<sup>th</sup> Cir. 2003).

It becomes clear after reading the Defendant's denial letters and its administrative record documents that CCC was operating under an additional requirement not stated in the plan documents that precludes entitlement according to some requirement to submit objective medical tests. One of such many examples can be found in Defendant's January 31, 2000 final denial letter<sup>12</sup> that states in support of its denial, "It is important to know that medical evidence means medi[c]al signs and findings established by medically acceptable diagnostic techniques which show a medical impairment . . . reasonably

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<sup>12</sup> Attached as Exhibit E.

expected to produce the pain or other symptoms. . . subjective complaints or self-reported symptoms alone are not considered conclusive evidence of disability.”

**The plan administrator's decision is troubling in numerous respects. First, the plan administrator's decision relied heavily on the fact that Collins's self-reported symptoms were not supported by clinical testing. . . However, a plan administrator may not deny benefits simply because a claimant cannot provide a diagnosis that would explain her self-reported symptoms.**

Collins v. Continental Casualty Company, No. 03-1499, 2004 U.S. App. LEXIS 985 (8th Cir. Jan. 23, 2004).

Many disability policies specifically underwritten by CCC have such subjective symptom preclusions or objective evidence requirements written directly into its restrictions and limitations section. The policy at bar is not one of them. CCC’s reasoning is therefore inconsistent with the policy definitions and resulted in a “wrong” decision. *See* Mitchell v. Eastman Kodak Co., 113 F.3d 433, 422-43 (3d. Cir. 1997) (where plan administrator denied benefits because claimant could not establish etiology of chronic fatigue that disabled him, concluding plan administrator had impermissibly implied additional "clinical evidence of etiology" requirement not specified in plan). . .

Since Ms. Pharr’s several treating physicians support her inability to work, and all report similar debilitating and persistent symptoms in their documentation of the Plaintiff’s condition, the lack of objective evidence is the only reason CCC has put forth to refute her disability.<sup>13</sup> While the plaintiff strongly disputes CCC's characterization of the medical evidence, a denial cannot be based on terms that are not a part of the original contract between the parties. CCC cannot promise an insured a disability benefit that does not mention the limitation on “self-reported symptoms” or the requirement for “objective medical” evidence and then, after a claim is made, seek to add those terms. The

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<sup>13</sup> Even if the policy contained a requirement for objective medical evidence, Ms. Pharr’s litany of lab work supports deficiencies that objectively support the severity of her symptoms.

Defendant's imposition of this extra-contractual language plainly controverts the plan's language and renders CCC's entire decision-making process arbitrary and capricious. *See Barone v. UNUM*, 2002 U.S. Dist. LEXIS 2515, (E.D. Mich. 2002) (Plaintiff entitled to disability benefits despite lack of objective findings, in part because plan did not define a disability as one that must be supported with objective findings.)

More generally, it is long-standing ERISA law as interpreted by the Courts to require the plan documents to include any terms, especially with regard to eligibility and entitlement, relied upon by the administrator in determining benefits. *Bennett v. Gill & Duffus Chemicals, Inc.*, 699 F. Supp. 454, 457-58 (S.D.N.Y. 1988) (citation omitted), *Luton v. Prudential Ins. Co. of America*, 88 F.Supp. 2d 1364, 1374 (S.D. Fla. 2000).

**By requiring a claimant to submit objective medical evidence in support of his symptoms or ailments, as required in other group disability policies, CCC created an additional term that is absent from the plan documents.**

**[The Defendant] cannot exclude a claim for lack of 'objective medical evidence' unless the 'objective medical evidence' standard was made 'clear, plain and conspicuous enough [in the policy to negate layman [plaintiff's] objectively reasonable expectations of coverage.] The 'objective medical evidence' standard first appeared in correspondence between the parties and is not found in the original policy document. As such, [the Defendant] may not seek to deny [Plaintiff's claims based on standards not within the policy itself.]**

*Duncan v. Continental Casualty Co.*, No. C-96-2421 SI, 1997 U.S. Dist. LEXIS 1582 (N.D. Ca. February 10, 1997). (emphasis added).

Furthermore, it has been deemed an *abuse of discretion* to add terms to the plan or to interpret the plan in such a way that is contrary to the plain language of the plan across the Circuits.

We find that defendant's denial was arbitrary and capricious because administrators and fiduciaries are prohibited from adding a term or extra requirement into an insurance policy that is not expressly part of it.

This action alone would support a finding that a fiduciary has acted arbitrarily and capriciously.

Durr v. Metropolitan Life Ins. Co., 15 F.Supp. 2d 205, 212 (citations omitted); Swaback v. American Information Technologies Corp., 103 F.3d 535, 540 (8th Cir. 1995) (When ERISA administrators *controvert the plain meaning of a plan, their actions are arbitrary and capricious.*) citing, Morgan v. Mullins, 643 F.2d 1320, 1321 (8th Cir. 1981) (Where the Trustees impose a standard not required by the pension plan itself, ... such action would result in an unwarranted and arbitrary construction of the plan) and Cousin v. New Orleans S.S.Ass'n, 16 E.B.C. 1052, 1055 (E.D. La. 1992) (The Committee abused its discretion, per se, by denying benefits based on non-existent rules.)<sup>14</sup>

The particular case law on fibromyalgia has recently spoken on its intolerance for such specific practice of requiring objective evidence where no requirement exists in the plan documents, as well as failing to conduct an “independent medical exam,” as the Defendant failed to do this case. Morgan v. UNUM Life Insurance Company of America, No. Civ. 01-1796MJDSRN, (D. Minn. Sept. 16, 2002).

Further, precedent makes clear that insurers are under a duty to consider the claimant’s credibility in assessing subjective complaints.

**Second, the plan administrator's decision does not indicate that the plan administrator assessed Collins's credibility with respect to her self-reported symptoms of chronic and disabling pain, which limited her abilities to perform the simplest of tasks. Cf. Delta Family-Care Disability & Survivorship Plan, 258 F.3d at 842-43 (plan administrator's denial of benefits was supported by, inter alia, surveillance report of claimant driving car and walking to mailbox without cane); Krizek v. Cigna Group Ins., 345 F.3d 91, 99, 101-02 (2d Cir. 2003) (court reviewing administrator's decision de novo may make credibility determinations about claimant's subjective reports of pain). **Rather, it appears the plan administrator simply refused to consider her subjective complaints as legally sufficient evidence. However, a plan administrator may not deny benefits simply because the only evidence of a disabling condition is****

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<sup>14</sup> See also, Miles v. New York State Teamsters Conference Pension and Retirement Fund, 698 F.2d 593, 599 (2d Cir.) cert. denied 464 U.S.829 (1983) (fiduciary’s denial was arbitrary and capricious because fiduciaries are prohibited from adding a term or extra requirement into an insurance policy that is not expressly part of it); Shelden v. Bar Belt Granite Employer Union Pension Fund, 25 F.3d 74 (2d Cir.1994) ([the arbitrary and capricious] standard may well be met if the trustees have, for example, impose[d] a standard not required by the plan's provisions or interpret[ed] the plan in a manner inconsistent with its plan needs.); Kekis v. Blue Cross and Blue Shield of Utica-Watertown, Inc., 815 F. Supp. 571, 579 (N.D. N.Y. 1993) ("The fiduciary's duties are dictated by the policy, such that a fiduciary who ignores the terms of the policy and inserts its own terms acts arbitrarily and capriciously.").

**subjective evidence.** See Krizek, 345 F.3d at 101-02; Connors v. Conn. Gen. Life Ins. Co., 272 F.3d 127, 136 (2d Cir. 2001) (subjective element of pain is important factor in determining disability; while court reviewing administrator's decision de novo is not required to accept such complaints as credible, court cannot dismiss complaints as legally insufficient evidence of disability).

Collins v. CCC, No. 03-1499 at \*5 -\*6.

If Gaylyn's credibility was considered, i.e. if the Defendant made any inquiries with respect to Ms. Pharr's work history, work ethic or other relevant factors such as whether Gaylyn would gain any benefit, financial or otherwise, by thwarting her promising career in its peak, CCC would have concluded that the Plaintiff's subjective complaints alone satisfied the subject definition of disability.

**VI. CCC's Reliance on its Medical Reviewer's Conclusions to Deny Ms. Pharr's Benefits Resulted in an Arbitrary and Capricious Decision**

The report of CCC's medical reviewer, Dr. Eugene Truchelut, dated May 13, 1999<sup>15</sup>, begins by erroneously stating that Gaylyn's former position as Associate Media Director "would probably fall into the sedentary and possibly light classification." Such an uneducated guess with regard to the occupational requirements of an advertising executive is the first statement in the report that evidences bias in favor of CCC.

Truchelut's review amounts to a recital of every single test and physical exam that Gaylyn underwent that yielded negative results. Truchelut does mention some of the Plaintiff's symptoms but completely and improperly<sup>16</sup> discounts them based on his ultimate conclusion that, "there is no objective medical evidence to support a severely restricted functional status such that she could not perform sedentary or light work activities." **The irony in invalidating a disability due to a claimant's doctors'**

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<sup>15</sup> Such medical review is attached as **Exhibit F**.

<sup>16</sup> The invalidity of discounting subjective symptoms, especially where there is no objective evidence requirement in the policy, is discussed *supra*.

**inability to define its etiology is obvious; it is the inability to define symptoms' etiology that adds to the severity, complexity and potential duration of a patient's impairments, as there is no sure way to treat the illness or predict its course or longevity.** Further bias is displayed by failing to afford any credibility to Ms. Pharr's subjective symptoms as discussed *supra*.

Truchelut conspicuously attempts to add an "insurance company spin" to every aspect of Ms. Pharr's claim. For instance, the report mentions that Dr. Cheney is in North Carolina and points out that Ms. Pharr must have traveled to see him, intimating that travel is an activity Gyalyn can handle. Dr. Cheney is a nationally renowned CFIDS specialist who has published numerous studies and is sought after by the majority of the CFIDS/fibromyalgia community. Contrary to Dr. Truchelut's interpretation, Gaylyn Pharr's illness was of such a severity that she *was willing* to travel to North Carolina, *despite the stress that such travel would impose because of her illness*, to obtain the best medical care available and the chance for improvement of her condition.

The most startling aspect of Truchelut's report is his omission of Gaylyn's cognitive deficiencies<sup>17</sup>, the most disabling facet of her illness as recorded by her co-workers who watched her decline and growing inability to perform her job due to such cognitive impairments, and his related conclusion that she could perform sedentary or light activities. The Plaintiff's physical ability, while certainly impaired, is not dispositive when evaluating Gaylyn's work capacity as her cognitive problems, as clearly

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<sup>17</sup> Save for one sentence stating, "She alleged cognitive problems at one point in the history, but there is no record of detailed neuropsych testing having been performed to evaluate this." As such test results would help with this Court's *de novo* review, please see the same eventually obtained, attached as Exhibit C to Plaintiff's Statement of Undisputed Facts in Support of Summary Judgment.

documented by her treating physicians, present the largest barrier to the ability to perform her former occupation.<sup>18</sup>

Dr. Truchelut's subsequent and final report was issued in November of 1999<sup>19</sup> wherein he states that he has not received any additional information that changed his opinion. He notes Dr. Cheney's lab findings but fails to mention that such findings are consistent with CFIDS. Interestingly, this later report omits, along with several additional medical notes, the bicycle ergometry test performed in July of 1999, discussed *supra*, that so clearly communicates Gaylyn's significant functional impairments and the objective medical basis in support thereof.

Though used by Defendant CCC on a regular basis, Dr. Truchelut and his medical conclusions have been criticized before by at least one other federal court.

Further, the opinion of Continental's medical reviewer, Dr. Truchelut--which concluded there was not "convincing evidence" that Collins could not perform her job, but which notably made no affirmative findings regarding Collins's ability to function--did not constitute substantial evidence that could discount the consistent opinions of Collins's treating physicians. Cf. Morgan v. UNUM Life Ins. Co. of Am., 346 F.3d 1173, 1178 (8th Cir. 2003) (reviewing physician's opinion was not substantial evidence where the opinion was contrary to opinions of two primary treating physicians, and record did not show reviewing physician had expertise or experience with disability at issue). . .

Collins v. CCC, No. 03-1499 at \*8-9.

Such court opinion reflects great similarity to the case at bar where Dr. Truchelut, again, failed to offer any affirmative findings regarding the Plaintiff's ability to function, and his conclusion was contrary to Ms. Pharr's treating and consulting physicians who consistently documented the severity of her symptoms.

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<sup>18</sup> See attached as **Exhibit G** the Plaintiff's performance evaluation for the period ending June 30, 1998 before her cognitive problems began that reveals the skills necessary for her job as well as those in which she excelled and that paved the way for her promotion.

<sup>19</sup> Attached as **Exhibit H**.

More importantly to this Court's review, Continental Casualty Company accepted Dr. Truchelut's opinion and utilized the same as a basis to deny Ms. Pharr's claim. At first glance, CCC's investigation should not have ended at Truchelut's reports since it completely ignores any occurrence of cognitive deficiencies. More relevant to this Motion, as discussed *supra*, even if such report was completely valid and accurate, its conclusions did not equate to a finding that Gaylyn is not disabled pursuant to the policy that only requires her to be unable to perform her occupation as a Vice President/Associate Media Director, an occupation that involves travel, putting on seminars and presentations to million dollar accounts, and fulfilling last minute immediate deadlines.

Even if CCC had complete faith in Truchelut's opinion and a total lack of faith in Dr. Cheney and Dr. Zeller, CFIDS specialists, and Dr. Zashin, rheumatologist, all of whom restricted Gaylyn from working in her occupation as she was before her illness, the Defendant should have conducted a physical exam, or more telling, a functional capacity evaluation to assess Ms. Pharr's occupational abilities due to the overwhelmingly consistent documentation of her symptomology. No such exam or evaluation was conducted. Even worse, the Defendant never once throughout its record considered Gaylyn's clearly non-sedentary occupational duties and demands or her very apparent credibility.

**Our review of the record, moreover, convinces us that the evidence overwhelmingly supported finding Collins disabled. No doctor suggested Collins was malingering or was not experiencing the degree of disability she reported, and four doctors stated she was experiencing disabling symptoms to a degree that rendered her unable to perform her job. Cf. Norris, 308 F.3d at 885 (reversing termination of benefits where there was little, if any, record evidence from which reasonable person could find claimant not disabled); Myers, 253 F.3d at 767-68 (reversing termination of benefits where plan administrator**

misread some evidence and took other evidence out of context; reasonable reading of evidence did not support conclusion that claimant could work full time in sedentary job); Lain v. UNUM Life Ins. Co. of Am., 279 F.3d 337, 347 (5th Cir. 2002) (reversing denial of benefits where record contained overwhelming amount of medical evidence supporting disability claim, and no concrete evidence supported determination that claimant was not disabled). . .

Id. at \*9-10.

## **VII. Conclusion**

Ms. Pharr's claim for wrongful benefit denial against CCC is solid with regard to the medical evidence submitted to the Defendant and now available to this Court, favorable and non-restrictive with regard to the subject policy's governing provisions, and liberal to Ms. Pharr concerning the applicable ERISA standard of review. This Court is not obligated to accord any deference to CCC and is free to consider Ms. Pharr's medical documentation, including recent exams and blood work, information about her job duties and how her performance declined, as well as the favorable determination from the SSA that Ms. Pharr cannot rejoin in the workforce in *any occupation*.

Moreover, even if this Court was compelled to accord deference to the decision of the Defendant to deny benefits, Ms. Pharr should be awarded summary judgment as a matter of law as Defendant's sole basis for its denial, its medical reviewer's opinion that Gaylyn is not prevented from performing a sedentary or light job, has no rational connection with the determination that that Plaintiff is not disabled pursuant to the subject policy that requires Gaylyn Pharr to be unable to perform her specific arduous occupation of travel, attending meetings and giving presentations, and consistently working at a high-speed pace to meet spontaneous immediate deadlines. Moreover,

Gaylyn's undisputed cognitive impairments prevent her from performing even a sedentary occupation.

Gaylyn Pharr had no reason to voluntarily leave her former quickly elevating career in which she was recognized for her ambition, work ethic, business judgment, management skills and organization. Disability at her young age, due to her clearly proven cognitive and physical impairments, from such occupation in which she was slated for further promotions and higher notoriety, is tragic indeed. Instead of recognizing such tragedy and paying Ms. Pharr her benefits that are significant in amount due to Gaylyn's previous salary, the Defendant evaded its responsibility. Gaylyn Pharr turns to this Court to right this wrong and demand that CCC be held accountable for paying her disability benefits for which premiums were paid and to which she is now and has been so clearly entitled for the last five years.

*Respectfully Submitted,*

BY: \_\_\_\_\_  
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**CERTIFICATE OF SERVICE**

WE HEREBY CERTIFY that a true and correct copy of the foregoing has been served via overnight mail this 13th day of February, 2004 to: Gregory P. McMahon, Esq., MARCUS, McMAHON & MYERS PL, The Citrus Center, 255 S. Orange Avenue, Suite 1250, Orlando, FL 32801, facsimile: (407) 447-2551.

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