

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
MIAMI DIVISION

SHARON WOLF,

Case No. 98-6939 CIV-MIDDLEBROOKS
Magistrate Judge Brown

Plaintiff,

v.

DELTA FAMILY-CARE DISABILITY
AND SURVIVORSHIP PLAN, a foreign
corporation.

Defendant.

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

I. Introduction

This case ensued to reinstate disability benefits to the Plaintiff that were wrongfully terminated by the Defendant under a group benefit plan governed by the Employee Retirement Income Security Act, 29 U.S.C. § 1001, et seq. (ERISA). In 1994, the Plaintiff was permanently injured in an automobile accident that left her unable to work. As a result of her inability to work, the Plaintiff applied for disability benefits under the group plan. The Defendant determined that the Plaintiff was eligible under the terms of the plan and paid her benefits for more than a year.

The Defendant terminated Plaintiff's benefits when it received information it erroneously interpreted as determining that Plaintiff was no longer disabled. The Defendant received additional information proving that Plaintiff continued to be totally disabled and entitled to benefits. Ignoring its ERISA imposed duties to the Plaintiff, the Defendant did not obtain all the medical records it knew to exist and refused to consider

any information which showed that Plaintiff was disabled. In addition, the Defendant improperly asserted that additional requirements, that were not in the plan, needed to be complied with before it could determine that Plaintiff was eligible for benefits.

The Defendant's actions were contrary to the applicable provisions of ERISA and its termination of Plaintiff's benefits was not only wrong, but unreasonable. The Plaintiff is entitled to all benefits from the date they were terminated to the present as well as a decree ordering the Defendant to continue paying her benefits until she reaches sixty-five years of age.

II. Facts

The Plaintiff, Sharon Wolf, began working for Delta Airlines, Inc. as a reservations agent in 1972. Delta Airlines, Inc. offers a group benefit plan¹ to all of its employees which includes a disability plan. The plan is administered by the Defendant, Delta Family-Care Disability and Survivorship Plan (hereinafter "Delta"). The purpose of the disability plan is to provide a monthly benefit check to an employee in the event that she becomes disabled and unable to work in any occupation².

On June 18, 1993, Ms. Wolf was involved in an automobile accident. Ms. Wolf sustained injuries to her spine which were degenerative in nature and caused her continuous pain³. Ms. Wolf managed to work through the pain for awhile, but her condition deteriorated to the point that she has been unable to work since March 7, 1994. Since she could no longer earn a living, Ms. Wolf applied for short-term disability

¹ The Delta Family-Care Disability and Survivorship Plan (hereinafter "Plan") is attached as **Exhibit A**.

² "The Employee shall be eligible for Long Term Disability provided he is disabled at that time as a result of demonstrable injury or disease (including mental or nervous disorders) which will continuously and totally prevent him from engaging in any occupation whatsoever for compensation or profit, including part-time work." Plan § 4.03.

³ Ms. Wolf eventually required and underwent back surgery.

benefits under the terms of the Plan. Delta approved her claim for short-term disability benefits⁴ and paid her for the entire 26 week period which expired on September 5, 1994. While she was still receiving short-term disability benefits, Ms. Wolf applied for long-term disability benefits in accordance with the terms of the Plan. In a letter dated September 1, 1994, Delta determined that Ms. Wolf was disabled and entitled to benefits.

During the period it was paying benefits to Ms. Wolf, Delta sent a letter dated March 3, 1995 to her treating physician, Andrew C. Maser, D.O. The letter asked Dr. Maser several questions regarding Ms. Wolf's ability to work. However, Delta did not explain any of the terms in the letter or ask for specific physical limitations⁵. Dr. Maser indicated on the form that Ms. Wolf could perform light duty, sedentary or semi-sedentary work⁶, though he did not explain what this meant. Delta never followed up on this information to ask him what duties or work she was capable of performing, instead taking this information at face value and assuming it meant that Ms. Wolf was no longer disabled under the terms of the Plan⁷.

Based solely on Dr. Maser's reply, Delta terminated Ms. Wolf's benefits⁸. In this letter, Delta stated:

“In order to perfect your claim, you must establish by **objective evidence** that on 04/01/95 you are continuously and totally disabled from engaging in any occupation or work for compensation or profit. **This information is necessary in order to show that you are disabled under the definition of the Plan.**” (emphasis added).

⁴ The May 18, 1994 letter approving benefits is attached as **Exhibit B**.

⁵ The March 3, 1995 letter is attached as **Exhibit C**.

⁶ This could mean that she was only able to cook for herself and, in general, take care of basic daily needs. It does not necessarily mean that she was able to perform any work for remuneration which is a requirement of the cases interpreting ERISA plans. E.g., Helms v. Monsanto Co., Inc., 728 F.2d 1416 (11th Cir. 1984).

⁷ This fact is significant because whenever Delta received information stating that Ms. Wolf was incapable of work, Delta immediately followed up. This is discussed further, *infra*.

⁸ The March 31, 1995 denial letter is attached as **Exhibit D**.

Nowhere in the Plan does it require, mention or refer to objective evidence as being necessary to establish entitlement to disability benefits.

Ms. Wolf, through her attorney, appealed the decision denying benefits and submitted an additional report from Dr. Maser which clarified his previous statements to Delta⁹ regarding Ms. Wolf's ability to work. The letter stated, in part:

“At this particular time she will remain on temporary total disability. I am going to see her for reevaluation in July 1995. Until that time, I've recommended she do very minimal activities other than those she can do around the house.”

Delta did not immediately reinstate Ms. Wolf's benefits in contrast to its actions to terminate benefits when it received adverse information regarding total disability. Instead, Delta scheduled Ms. Wolf's claim for “review¹⁰.” In support of her appeal, Ms. Wolf, through her attorney, submitted an additional report¹¹ from Alphonso Petti, M.D. in which he opined:

“Status post spinal surgery instrumentation and bone grafting for which she has a 15% impairment of the body and degenerative disc disease of the cervical spine.”

Dr. Maser examined Ms. Wolf and authored a report dated July 6, 1995¹². This report consisted of several opinions and conclusions regarding Ms. Wolf's disability status¹³.

“She presented today and in actuality is worse off now than she has been in the past . . . I don't think that we're going to note any more improvement . . . As a result of this I think she has reached maximum medical improvement . . . [M]y personal feeling at this time is that she will

⁹ The May 10, 1995 appeal with the April 28, 1995 attachment from Dr. Maser is attached as composite **Exhibit E**.

¹⁰ The June 1, 1995 letter is attached as **Exhibit F**.

¹¹ The July 6, 1995 letter with attachment from Dr. Petti is attached as composite **Exhibit F**.

¹² Dr. Maser's July 6, 1995 letter and report is attached as **Exhibit G**.

¹³ Dr. Maser also stated that he intended to have a functional capacity evaluation performed on Ms. Wolf as well as a *psychological evaluation with Dr. Frank*.

not be able to return to work and we will more than likely have to place her on permanent disability.”

Delta followed up with Dr. Petti and sent him the same type of questionnaire previously sent to Dr. Maser that had caused the initial confusion regarding Ms. Wolf’s disability status. Dr. Petti wrote “yes” next to a question asking if Ms. Wolf could perform some type of work¹⁴. Delta never followed up on this information to ask him what duties or work she was capable of performing, instead taking this information at face value and assuming it meant that Ms. Wolf was no longer disabled under the terms of the Plan.

Based solely on this one word response and not taking into consideration, or even acknowledging Dr. Maser’s report, Delta upheld the denial of benefits to Ms. Wolf¹⁵. Ms. Wolf, through her attorney, asked for a review of this appeal¹⁶. In response, Delta refused to reverse its previous decision because Dr. Maser had stated that Ms. Wolf was disabled from her own occupation only¹⁷. Delta also noted that Dr. Maser had not submitted any objective evidence of disability. Dr. Maser never addressed whether she was disabled from any occupation, but did specifically state that she was only capable of ½ hour of keyboard work before she would experience pain. Delta interpreted this to mean that Ms. Wolf was not disabled under the terms of the Plan. Ms. Wolf’s attorney asked that Delta reconsider its decision¹⁸.

Delta received a work capacities assessment summary report¹⁹ dated July 25, 1995 which stated, in part:

¹⁴ The July 20, 1995 form is attached as **Exhibit H**.

¹⁵ The August 8, 1995 denial letter is attached as **Exhibit I**.

¹⁶ The August 23, 1995 letter is attached as **Exhibit J**.

¹⁷ The September 15, 1995 letter including Dr. Maser’s report is attached as composite **Exhibit K**.

¹⁸ The October 16, 1995 letter is attached as **Exhibit L**.

¹⁹ The report is attached as **Exhibit M**.

“The results of this evaluation indicate that Ms. Wolf is currently inadequate to return to work as described by both the client and the Dictionary of Occupation Titles. **The major limitation to the client’s returning to her previous job activities is her poor sit tolerance (sustained for 24 minutes maximum) and poor typing tolerances (sustained for 2.4 minutes).** (emphasis added).

Delta sent another questionnaire to Dr. Maser which instructed him to rely only on objective findings²⁰. Dr. Maser apparently interpreted one section²¹ of the work capacities assessment summary report as stating that Ms. Wolf could perform sedentary work. Delta never followed up on this information to ask him what duties or work she was capable of performing, instead taking this information at face value and assuming it meant that Ms. Wolf was no longer disabled under the terms of the Plan.

Ms. Wolf’s attorney sent Delta additional information²² on April 15, 1996 consisting of an evaluation by Stephen S. Wender, M.D. which stated, in part:

“At this time I believe that this patient is as well as she will be. I believe she has been left with in addition to her spinal surgery that of an essentially chronic pain syndrome involving the cervical and dorsolumbar spine. I believe that this taken to account with her surgery leaves her to have approximately a 20% total body impairment. Furthermore, at this time I think that she is completely disabled from working.”

On May 23, 1996, Delta sent Ms. Wolf the final denial of her benefits²³. The letter discounted any information supporting a claim for disability and highlighted selected portions of certain reports that gave even the slightest indication that Ms. Wolf could return to some form of work. However, the letter is particularly void in describing any possible occupation Ms. Wolf was capable of performing. Delta did acknowledge Dr. Wender’s report, but did not consider it in making its determination.

²⁰ The February 12, 1996 letter and attachment is attached as composite **Exhibit N**.

²¹ He noted this section with an asterisk.

²² The April 15, 1996 letter with Dr. Wender’s report is attached as **Exhibit O**.

²³ The May 23, 1996 letter (incorrectly dated as May 23, 1995 on the first page) is attached as **Exhibit P**.

“With regard to Dr. Wender’s report, the Committee concluded that this report was received a significant amount of time after the denial in this case occurred, and the Committee felt that Dr. Maser who had been treating Ms. Wolf throughout the entire disability period was in a better position to provide an opinion on her condition around the time of the original denial of benefits.”

Dr. Wender’s report specifically stated that Ms. Wolf was unable to work in any capacity at the time of his examination. This necessarily implies that Ms. Wolf was disabled at the time of the decision. This fact did not matter to Delta.

Ms. Wolf filed suit against Delta for the wrongful termination of her benefits. When Delta discovered that Ms. Wolf had been determined as being totally and permanently disabled by the Social Security Administration and was receiving benefits, Delta sued for the overpayment of benefits due to the Social Security offset provision in the Plan²⁴.

III. Summary Judgment Standard

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).

²⁴ Delta was specifically asked whether it was aware that Ms. Wolf was receiving Social Security benefits. This question was denied. Request for Admissions (attached as **Exhibit Q**), number 31. Plaintiff admits that she is receiving total disability benefits from the Social Security Administration, but if Delta’s response to Request number 31 is accurate, then it had no good faith belief of the veracity of its allegations when it filed suit.

“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.

A genuine issue of material fact exists when “the evidence is such that a reasonable jury could return a verdict for the nonmoving party.” Anderson v. Liberty Lobby Inc., 477 U.S. 242, 248, 91 L.Ed. 2d 202, 106 S.Ct. 2505 (1986). “The mere existence of a scintilla of evidence in support of the [nonmoving party’s] position will be insufficient; there must be evidence on which the jury could reasonably find for the [nonmoving party].” Id at 252. “ If a review of the evidence presented reveals that the non-movant has failed to produce evidence sufficient to support a jury verdict in his favor, then summary judgment should be granted.” United of Omaha Life Ins. Co., 994 F.2d at 1558.

IV. ERISA Standard of Review

The basis of Ms. Wolf’s claim is a wrongful termination of disability benefits pursuant to a group 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.

“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 (11th Cir. 1990).

The Plan at issue in this case does contain the necessary discretionary authority. Therefore, the proper standard of review would be arbitrary and capricious, unless a conflict of interest exists.

"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).

In this case, a conflict of interest exists making application of the heightened arbitrary and capricious standard applicable. The Delta Plan is a non-contributory plan²⁵ funded solely through contributions from the assets of Delta Airlines, Inc.²⁶ The amount of contributions required by Delta Airlines, Inc. varies based on an annual actuarial valuation evidencing the actuarial position and actuarial costs of the Plan²⁷. If the costs or amount of claims to the Plan increase, the actuarial valuation would necessarily require an increase in the amount of contributions from the assets of Delta Air Lines, Inc. This is exactly how an insurance company manages its reserves and investment portfolio²⁸.

²⁵ Plan § 11.01.

²⁶ Plan § 11.02.

²⁷ Id.

²⁸ Plaintiff is aware that the arbitrary and capricious standard of review has been applied to this Plan in one case. However, there has never been a judicial determination that a conflict of interest does not exist because the issue has never been raised. In Paramore v. Delta Air Lines, Inc., 129 F.3d 1446 (11th Cir. 1997), the Plaintiff stipulated that the interpretation of the plan terms was subject to an arbitrary and capricious standard of review. Id. at 1449. The issue was whether the Court should have reviewed both the interpretation of the plan terms and the factual determinations under the arbitrary and capricious standard. Id. The question of whether or not a conflict of interest was present was never raised and, thus, never addressed.

“In Brown, a panel of this court held that the heightened arbitrary and capricious standard must be used when the plan was administered by an insurance company which paid benefits out of its own assets. ‘Because an insurance company pays out to beneficiaries from its own assets rather than the assets of a trust, its fiduciary role lies in perpetual conflict with its profit-making role as a business.’”

Buckley v. Metropolitan Life, 115 F.3d 936, 939 (11th Cir. 1997).

In Buckley, the plan’s decision was reviewed under an arbitrary and capricious standard. However, there is a difference between the manner in which the plan was funded there and in the present case. In Buckley, the plan was funded by fixed, nonreversionary contributions; therefore, the employer:

“incurs no direct expense as a result of the allowance of benefits, nor does it benefit directly from the denial or discontinuation of benefits.”

Id.

Delta Airlines, Inc. does not have fixed contributions. Whether or not Delta is an insurance company in name is irrelevant. The contributions from Delta Airlines, Inc.’s assets depend on the actuarial valuation of the Plan. The actuarial valuation of the Plan depends on the amount of costs and claims paid. Delta Airlines, Inc., through Delta, incurs a direct benefit from the discontinuation of benefits; its fiduciary role lies in perpetual conflict with its profit-making role as a business. Delta is operating under a conflict of interest, therefore, the heightened arbitrary and capricious standard of review applies.

"The beneficiary need only show that the fiduciary allowed himself to be placed in a position where his personal interest might conflict with the interest of the beneficiary. It is unnecessary to show that the fiduciary

"Where . . . the claimant does not argue or is unable to show that the trustees had a significant conflict of interest, we reverse the denial of benefits only if the denial is completely unreasonable. Correspondingly, when the members of a tribunal – for example, the trustees of a pension fund – have a serious conflict of interest, the proper deference to give may be slight, even zero; the decision if wrong may be unreasonable." Brown v. Blue Cross and Blue Shield of Alabama, 898 F.2d 1556, 1564 (11th Cir. 1990)(citations omitted)(emphasis added).

succumbed to this temptation, that he acted in bad faith, that he gained an advantage, fair or unfair, that the beneficiary was harmed. Indeed, the law presumes that the fiduciary acted disloyally, and inquiry into such matters is foreclosed. The rule is not intended to compensate the beneficiary for any loss he may have sustained or to deprive the fiduciary of any unjust enrichment. Its sole purpose is prophylactic . . .

In other words, one reason for limiting the deference when the fiduciary suffers a conflict of interest is to discourage arrangements where a conflict arises."

Brown, 898 F.2d at 1565 (citations omitted).

V. Delta's Improper Plan Interpretation

Delta's conflict of interest is apparent from the manner in which it interpreted the Plan. When interpreting the terms of the Plan, Delta, as an ERISA fiduciary, is required to "discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries²⁹" with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims³⁰." To determine whether an interpretation is proper, the first step is to look at the express language contained in the plan.

"A key principle guiding our resolution of the Retirees' claim is that we must look to the plain language of the [] plan to determine whether the Trustees' interpretation of that plan is 'arbitrary and capricious.' We have consistently explained that 'trustees abuse their discretion if they . . . construe provisions of [a] plan in a way that clearly conflicts with the plain language of the plan.'"

Canseco v. Construction Laborers Pension Trust, 93 F.3d 600, 606 (9th Cir. 1996)(citations omitted).

²⁹ 29 U.S.C. § 1104 (a)(1).

³⁰ 29 U.C.C. § 1104 (a)(1)(B).

The Plan specifically sets forth the requirements Ms. Wolf needed to meet in order to receive benefits³¹. Nowhere in the Plan is there a requirement that objective medical evidence needs to be submitted before benefits can be paid. Notwithstanding this fact, Delta required the submission of objective evidence to show that Ms. Wolf was disabled under the terms of the Plan³². The insertion of an additional term shows how the conflict of interest influenced Delta's interpretation. Delta's interpretation cannot be upheld due to its conflict of interest and would be unreasonable under even the most deferential standard.

“A second interpretive principle guiding our analysis is that pension plan trustees or administrators may not construe a plan so as to impose an additional requirement for eligibility that clashes with the terms of the plan. Lower federal courts have held that where plan trustees ‘impose a standard [of eligibility for pension plan benefits] not required by the pension plan itself,’ that action ‘results in an unwarranted and arbitrary construction of the plan’.

...

Recently, in Saffle, we extended this principle to disability benefits. In Saffle, a plan administrator denied an employee long-term benefits for ‘total disability.’ The administrator concluded that the employee did not satisfy the definition of ‘total disability’ because medical reports concluded the employee could return to work if her job was modified to allow her to perform exclusively sedentary work. On appeal, we rejected the administrator’s interpretation of the disability plan in part because the administrator construed the plan to prohibit benefits if the employee was able to continue working with ‘accommodations.’ Such an interpretation, we concluded, would operate to ‘impose [] a new requirement for coverage’: it would require the claimant to show that accommodations were futile. We rejected this implied additional term, explaining that a ‘[plan] administrator lacks discretion to rewrite the plan.’”

Canseco, 93 F.3d at 608-9 (citations omitted).

In addition to inserting an addition requirement to determine eligibility, Delta interpreted the terms “disabled” and “work” unreasonably, effectively making the Plan

³¹ Plan § 4.03.

³² See, Exhibits D, H, and N, discussed and explained *supra*..

meaningless except for extreme cases of complete mental or physical incapacity³³. As soon as Delta saw anything stating that Ms. Wolf could work, it interpreted the statement to mean that Ms. Wolf was not disabled under the terms of the Plan³⁴. This is a very narrow interpretation of the terms “work” and “disabled” and is unreasonable because the term could be interpreted more expansively; without further definition in the Plan, the terms are ambiguous.

Delta’s interpretation of the Plan is similar to the case of Helms v. Monsanto Co., Inc., 728 F.2d 1416 (11th Cir. 1984). Helms applied for disability benefits under a group plan which defined disability as being unable to engage in any occupation or employment for remuneration or profit. His benefits were denied because an independent medical examiner determined that, although he believed Helms was disabled, he could not say that anybody was disabled under the definition provided. This is exactly what has occurred in Ms. Wolf’s case. In Helms, the court overturned the decision denying benefits under an arbitrary and capricious standard.

“Common knowledge of the occupations in the lives of men and women teach us that there is scarcely any kind of disability that prevents them from following some vocation or other, except in cases of complete mental incapacity. Although the achievements of disabled persons have been remarkable, we will not adopt a strict, literal construction of such a provision which would deny benefits to the disabled if he should engage in some minimal occupation, such as selling peanuts or pencils, which would yield only a pittance. The insured is not to be deemed ‘able’ merely because it is shown that he could perform some task.

...

To bar recovery, under the provisions of the [plan], the earnings possible must approach the dignity of a livelihood. Mr. Helms is required to show physical inability to follow any occupation from which he could earn a reasonably substantial income rising to the dignity of an income or

³³ “An interpretation which gives a reasonable, lawful and effective meaning to all the terms is preferred to an interpretation which leaves a part unreasonable, unlawful, or of no effect.” Meredith v. Allsteel, Inc., 11 F.3d 1354, 1358 (7th Cir. 1993).

³⁴ See, Exhibits D and I, discussed and explained *supra*.

livelihood, even though the income is not as much as he earned before the disability."

Id at 1421-22.

Federal common law, as well as the law of all fifty states, dictates that when a term can be interpreted in two different ways, it must be construed in favor of coverage for the insured and against the drafter of the Plan. Kunin v. Benefit Trust Life Ins. Co., 910 F.2d 534, 540 (9th Cir. 1990), cert. denied, 498 U.S. 1013, 112 L.Ed. 2d 587, 111 S.Ct. 581 (1990).; also see, Lee v. Blue Cross/Blue Shield, 10 F.3d 1547 (11th Cir. 1994)(applying contra proferentem after determining correct standard of review is arbitrary and capricious). Since an ERISA fiduciary must act with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matter would use in the conduct of an enterprise of like character and with like aims, it would be unreasonable, under any standard of review, to not apply the rule of contra proferentem when interpreting a plan³⁵.

"We additionally note that in determining whether a decision has been made solely for the benefit of the participants, we may take account of the principle that in making a reasonable decision, ambiguity . . . must be construed against the drafting party, particularly when, as here, the contract is a form provided by the insurer rather than one negotiated between the parties. See Kunin v. Benefit Trust Life Ins. Co., 910 F.2d 534, 539 (9th Cir.)(using a presumption such as construction against the drafter in evaluating the reasonableness of an interpretation is not inconsistent with review for abuse of discretion), cert. denied, 498 U.S. 1013, 112 L.Ed. 2d 587, 111 S.Ct. 581 (1990)."

Doe v. Group Hospitalization & Medical Services, 3 F.3d 80, 88-89 (4th Cir. 1993).

Delta did not act solely in the interests of the plan participants and beneficiaries when it imposed an additional requirement for eligibility and narrowly interpreted the

³⁵ This is true unless a fiduciary has the unbounded discretionary authority to interpret terms differently than the dictates of every state and federal law.

Plan to allow Ms. Wolf's benefits to be terminated. These actions are violations of ERISA and *per se* arbitrary and capricious. In addition, the interpretations were unreasonable under any standard of review and especially unreasonable given Delta's conflict of interest.

VI. Delta's Failure to Investigate and Consider Available Information

Delta had an affirmative duty to ensure that it is in possession of all necessary and obtainable information before it makes a claims decision. Motor Vehicle Mfrs. Ass'n v. State Farm Mutual Auto Ins. Co., 463 U.S. 29, 43, 103 S.Ct. 2856, 77 L.Ed. 2d 443 (1983) (a decision is arbitrary and capricious if the decision-maker "entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before [it], or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise"). ERISA does not allow a fiduciary to sit back and wait for information to be submitted. At the very least, Delta must obtain all the medical records from the treating physicians. A failure to investigate is deemed arbitrary and capricious³⁶.

"Good faith requires an honest effort to ascertain the facts upon which its exercise must rest and an honest determination from such ascertained facts. . . . If [the fiduciary] knew of matters concerning which honesty would require investigation, and failed to act, or if it knew of matters which would honestly compel a given determination and it announced to the contrary, it cannot, in law be regarded as having exercised good faith, and its action would be arbitrary. Thus, an improper motive sufficient to set aside a fiduciary's decision may be inferred from the fiduciary's failure to investigate or to interpret honestly evidence that greatly preponderates in one direction."

Brown, 898 F.2d at 1566. Accord, Shannon v. Jack Eckerd Corp., 113 F.3d 208, 210 (11th Cir. 1997)("obligation to make a reasonably relevant inquiry"); Kunin v. Benefit

³⁶ Delta has admitted that it failed to obtain all the medical records. See, Request for Admissions, Exhibit Q, numbers 28, 36, 37, 38 and 39, *inter alia*. This fact alone is enough to conclude that Delta's decision was arbitrary and capricious under any standard of review.

Trust Life Ins. Co., 910 F.2d 534, 538 (9th Cir. 1990)(an inadequate investigation provides an unreasonable basis for a decision and is arbitrary and capricious; Halpin v. W.W. Grainger, Inc., 962 F.2d 685, 691 (7th Cir. 1992)(must ask for missing information).

Delta received a report from Dr. Maser dated July 6, 1995 stating that he intended on having a psychological evaluation performed on Ms. Wolf by Dr. Frank³⁷. This examination was conducted on August 17, 1995, prior to Delta's final decision to deny benefits. Delta never followed up with Dr. Maser to determine whether or not the psychological evaluation was performed. Dr. Frank's report was never considered by Delta when it made its decision. One of the tests performed on Ms. Wolf was a Human Activity Profile which determined that Ms. Wolf has an activity age of seventy plus years. Delta made its decision without having this valuable and easily obtainable information before it³⁸.

“Defendants, as Trustees of the Pension Plan, had a duty to take an initiative themselves to cause reasonably available evidence—that is, evidence substantially bearing upon the plaintiff's claim and available through reasonable efforts—to be developed and considered in the decisionmaking process. Their determination that they should proceed to deny plaintiff's application without having caused the reasonable available evidence to be gathered and placed before them for consideration was an error of law by reason of which their denial of his application was ‘erroneous on a question of law’.”

Toland v. McCarthy, 499 F.Supp. 1183, 1190 (D. Mass. 1980).

In addition, Delta did not ask for or ensure that it had all the treatment notes and medical records in its possession before it made the decision to deny benefits³⁹.

“The requirement that courts defer to the decisions of trustees cannot mean that we must affirm decisions by trustees who are so biased, obstinate, or lazy that they will not hear the claimant.”

³⁷ See, Exhibit G.

³⁸ Nor did Delta use its authority to have Ms. Wolf submit to a medical examination by a physician appointed on its behalf.

³⁹ See, footnote 36, *supra*.

Miller v. United Welfare Fund, 72 F.3d 1066, 1075 (2nd Cir. 1995).

Furthermore, Delta did not ask Dr. Petti or Dr. Maser what they meant when they said Ms. Wolf was capable of performing some type of work. This could mean that Ms. Wolf was only capable of performing tasks needed to be self-sufficient, it does not mean that she is capable of performing the duties of some occupation. It was unreasonable for Delta to assume that Ms. Wolf was not disabled and unreasonable for Delta to forgo any further inquiry. Its decision to terminate benefits cannot be upheld.

“Lacking necessary – and easily obtainable – information, Aetna made its decision blindfolded.

...

Had Aetna requested the needed information and offered a rational reason for its denial, it would be entitled to substantial deference. But to deny the claim without explanation and without obtaining relevant information is an abuse of discretion.”

Booton v. Lockheed Medical Benefit Plan, 110 F.3d 1461, 1463-64 (9th Cir. 1997).

Not only did Delta fail to acquire all available information, but it did not even consider all the information it did have in its possession.

“[T]he administrative Committee’s function was to evaluate the various reports in tandem and render a determination as to Paramore’s ability to engage ‘in any occupation whatsoever for compensation or profit, including part –time work’.”

Paramore, 129 F.3d at 1452.

Delta received Dr. Wender’s report which concluded that Ms. Wolf remained totally disabled. Delta did not address this opinion⁴⁰ or refute it in any way.

“There is nothing in the decision itself to indicate that the Administrative Committee in fact examined the record in its entirety. No mention is made of the supplemental medical opinions, Mr. Todorowski’s report, or the favorable decision of the Social Security Administration, finding Plaintiff completely disabled, within the meaning of the Social Security Act, as of

⁴⁰ Other than to state that it was received after the original denial in this case occurred.

June 1994. By relying only on ‘the original’ medical record and Dr. Deutsch’s report, the Administrative Committee acted arbitrarily.

By failing to address this un rebutted opinion or refute it in any way, the Administrative Committee acted unreasonably.”

Lozada v. Delta Family-Care Disability and Survivorship Plan, 1998 U.S. Dist. LEXIS 11290, *10-11 (M.D. Fla. 1998).

Delta was the defendant in Lozada. Delta did not consider all available information and examine the record in its entirety in Lozada. Its decision denying benefits was found to be arbitrary and capricious for this reason. Delta did the exact same thing in Ms. Wolf’s case. It did not address or even attempt to refute Dr. Wender’s opinion in any way; it did not examine the record in its entirety. Given Delta’s conflict of interest, its decision deserves no deference and should not be upheld. However, even under the most deferential standard of review, Delta’s decision to terminate Ms. Wolf’s benefits was arbitrary and capricious and cannot be upheld.

VII. Conclusion

Delta did anything it could to determine that Ms. Wolf was no longer disabled. It did not act solely in the interests of the plan participants and beneficiaries. Due to its inherent conflict of interest, Delta unreasonably interpreted terms of the Plan and added additional requirements for eligibility. Delta did not investigate Ms. Wolf’s claim at all resulting in an incomplete record before it. Moreover, Delta did not even consider all the information it did have in its possession and specifically ignored the conclusions of Dr. Wender. Ms. Wolf has proven that she continues to be entitled to benefits. Delta’s decision to terminate benefits was arbitrarily and capriciously made and cannot be upheld. Ms. Wolf should receive all past due benefits and Delta should be ordered to continue paying her benefits until she reaches age sixty-five.

CERTIFICATE OF SERVICE

WE HEREBY CERTIFY that a true and correct copy of the foregoing was night-box filed with an effective date of August 27, 1999 and served via U.S. mail this 30th day of August, 1999 to: Hunter R. Hughes, Esq. And J. Timothy McDonald, Esq., Rodgers & Hardin, 2700 International Tower, Peachtree Center, 229 Peachtree Street, N.E., Atlanta, Georgia 30303 and David L. Ross, Esq. And Gustavo J. Lamelas, Esq., Greenberg Traurig, P.A., 1221 Brickell Avenue, Miami, FL 33131.

THE WAGAR LAW FIRM
3250 Mary Street, Suite 207
Coconut Grove, FL 33133
Tel.: (305) 443-7772
Fax: (305) 443-1969

By: _____
KIRK W.B. WAGAR
Fla. Bar No. 994936