IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

PATRICK J. LAY,	:	
Plaintiff,	:	Case No. 2:08-CV-01083
vs.	:	
GROUP LONG TERM DISABILITY INSURANCE FOR EMPLOYEES OF COLUMBUS NEIGHBORHOOD	:	JUDGE FROST
	:	
HEALTH CENTER, INC., *et al.*,	:	MAGISTRATE JUDGE KEMP
Defendants.	:	

PLAINTIFF'S MOTION FOR JUDGMENT ON THE ADMINISTRATIVE RECORD

This is an ERISA benefits case. Plaintiff Patrick Lay ("Lay") moves for judgment as a matter of law pursuant to *Wilkins v. Baptist Healthcare System*, 150 F.3d 609 (6th Cir. 1998) with respect to his claim for short and long-term disability benefits. The motion is supported by the attached memorandum and the exhibits drawn from the administrative record and the pleadings.

Respectfully submitted,

/s/ Danny L. Caudill

Robert J. Beggs (0002966)
(*John.Beggs@BeggsCaudill.com*)
Danny L. Caudill (0078859)
(*Danny.Caudill@BeggsCaudill.com*)
BEGGS CAUDILL, LLC
1675 Old Henderson Road
Columbus, Ohio 43220-3644
(614) 360-2044
Fax (614) 448-4544

Trial Counsel for Plaintiff

MEMORANDUM IN SUPPORT

I. INTRODUCTION

Lay has applied for Short- and Long-Term Disability benefits ("STD" and "LTD" respectively) and Lincoln has denied his claim and subsequent appeals. There is no dispute regarding whether or not Lay is disabled under the policy. Lincoln has already acknowledged that he is:

> **"As part of our review, your client's file was referred to independent physician consultant specializing in Internal Medicine/Rheumatology. The independent physician consultant found that Mr. Lay would be Totally Disabled from performing the main duties of his occupation due to his conditions of fibromyalgia and fatigue. Therefore, we do agree that due to Mr. Lay's conditions he is unable to perform the main duties of his occupation."** (AR p. 4)

Lincoln's sole basis for denying Lay's claim is Lincoln's contention that Lay became disabled before the date Lincoln's policy took effect:

> **"In summary, information provided to our office indicates that Mr. Lay was unable to perform the main duties of his occupation prior to 12/1/2005, when his employer's STD coverage became effective with our company. Since Mr. Lay was not performing all the main duties of his occupation due to his health condition he would not be considered actively at work and would not be eligible for STD coverage on 12/1/2005."** (AR p. 5)

But the Court should overturn Lincoln's decision and award Lay benefits for the following reasons: (1) Lincoln's determination of the *specific* date Lay's chronic, gradually degenerating fibromyalgia rendered him "Totally Disabled" was arbitrary, unreasonable and unsupported by any medical evidence; (2) The evidence demonstrates that Lay was "actively at work" after the specific date Lincoln claims Lay became "Totally Disabled"; (3) Even if Lay was

never "actively at work" when the policy became effective, he is still entitled to LTD coverage under the policy's "prior insurance credit" provision; (4) At all relevant times, Lincoln accepted premium payments for Lay's benefits and represented to him that he was a covered insured.

Alternatively, and at a minimum, the Court should remand Lay's case back for further review because: (1) Lincoln never gave Lay an opportunity to rebut Lincoln's determination that he was actively at work on or after the effective date of Lincoln's policy; (2) Lincoln never attempted to determine if Lay ever returned to active work to trigger his eligibility for benefits; (3) Lincoln never attempted to determine whether Lay was eligible for LTD benefits by operation of the prior insurance credit provision.

II. FACTS

A. Medical and Work History

Lay was the founding CEO/Executive Director of Columbus Neighborhood Health Center, Inc. ("CNHC"), a non-profit community health care agency, from 1998 until his resignation in 2006. During his tenure, Lay worked under renewable one-year contracts. As a condition of his employment, Lay enrolled in and thus became an eligible participant in the disability benefits CNHC purchased for its employees. CNHC purchased its first group disability insurance from UNUM, which became effective in April 1998. CNHC maintained that insurance until it was replaced with the insurance provided by Defendant Lincoln National ("Lincoln").[1] As CEO/Executive Director, Lay prepared and signed the application for the Lincoln National policy on November 23, 2005 on CNHC's behalf. (Complaint, Ex. C)[2] The

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[1] Defendant Lincoln National was known at that time as Jefferson Pilot Financial Insurance Company.

[2] *Vanderklok v. Provident Life & Accident Ins. Co.*, 956 F.2d 610, 617 (6th Cir. 1992), (holding that procedural error in the review process means Ins. Co. is not entitled to the protections of administrative review, and as such, evidence outside the administrative record can be reviewed.) In this matter, Lincoln's repeated switching of

new policy became effective on December 1, 2005. In the application, Lincoln National was informed that the new policy would replace the UNUM long-term disability policy. Importantly, the Lincoln application stated: "If replacement, prior insurance credit will be provided." And it bears repeating, it was Lay who executed the contract with Lincoln on behalf of, and in his active capacity as Executive Director of, CNHC on November 23, 2005.

Lay suffers from chronic and debilitating fibromyalgia. And Lay also suffers from a number of medical conditions including sleep apnea, spontaneous pneumothorax, gastroesophageal reflux disease, and hypertension. (AR p. 111) Additionally, Lay has undergone several procedures related to medical issues, including a uvulectomy in 1986, treatment for carpal tunnel in 1993, and a cervical spine fusion at the C5-6 level in 2001. (AR p. 111) In August 2001, Lay's former family physician, Dr. Olsen, referred Lay to Dr. Flood, who first diagnosed Lay with fibromyalgia. (AR p. 111 – 13) Dr. Flood's diagnosis was later confirmed by Dr. Elsheiki and Dr. Dadmehr, as well as Dr. Olsen. (AR p. 260) From 2001 to the present, Lay's symptoms have increased in severity.

As reported by Lay and his doctors, Lay's medical condition failed to respond significantly to treatment, despite aggressive therapy consisting of several medications. (AR p. 65) Lay's symptoms, which are consistent with fibromyalgia, include: chronic, widespread muscle and joint pain, chronic fatigue, pain flare-ups, multiple tender points, inability to sleep, stiffness, involuntary limb movement, paresthesis, headaches, gastrointestinal maladies, genitourinary problems, cognitive disorders, as well as depression and anxiety. (AR p. 64)

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rationales for denial of benefits did not give Lay an appropriate chance to appeal, or to address deficiencies in his claims, and as a result, he was denied his right to an administrative appeal under 29 USC §1133. Because of this procedural failure, this court is permitted to view materials outside the administrative record.

While Lay's condition waxes and wanes to some extent, it has consistently increased in severity from his original diagnosis in 2001 through the present. In June of 2004, Lay's symptoms were in a near constant "flared-up" state. As a result, Lay's use of sick time began to increase significantly in the final two years of his employment with CNHC. (AR p. 359)

In late 2005, as his condition continued to deteriorate, Lay notified CNHC of his intent to resign. (AR p. 86) At that time, CNHC asked Lay to stay on until a replacement CEO could be found. CNHC told Lay that other employees could assist him if the need arose. Lay agreed to stay on. In the year leading up to his last day of work, Lay began to take more and more time off due to his illness. By the time he finally resigned, effective May 31, 2006, Lay was unable to perform the essential functions of his job. Those functions were delegated to, and performed by other managers at CNHC. Specifically, Lay's fatigue and pain required him to be assisted by other members of the CNHC staff, in order to keep up with the day-to-day operation of CNHC. (AR p. 359-60) Lay's worsening condition was noted by several of his co-workers, as well as the deleterious effects it had on his performance as CEO. (AR p. 50-51, 661 – 69)

According to Lay's current family physician, Dr. Petrovich, "due to [Lay's] chronic fatigue, he would be unable to maintain any type of regular work schedule due to the need for frequent breaks to rest." (AR p. 403) Dr. Petrovich further stated, "with Patrick's numerous medical problems and constant pain and fatigue, he would be unable to perform virtually any of the jobs listed in his job description at this time." Further, Dr. Olsen indicated in his statement for Lay's disability claim that Lay would "never" be able to return to his current job. (AR p. 377)

B. Claim History

Lay applied for disability benefits in February of 2007. (AR p. 165) Although, Lay completed the application for Short-Term Disability ("STD") benefits, his claim is, and has always been, for LTD benefits as well. Per the terms of Lincoln's policy, STD benefits simply "roll" over to LTD benefits after a set period of time. (AR p. 247) STD and LTD benefits under the Lincoln policy use the exact same definitions for disability, but only differ in the length of time for which they apply. (AR p. 772 – 807 (LTD policy), AR p. 747 – 71)

It is clear Lincoln was determined to deny Lay's benefits from the start. Lincoln initially denied Lay's claim for benefits on July 19, 2007 on the basis that his insurance coverage ended with his resignation. (AR p. 121 – 23) Additionally, Lincoln stated that there was "no information to indicate that you were unable to perform each of the Main Duties of your Own Occupation for 15 consecutive days due to accidental Injury or Sickness while insured for this benefit." (AR p. 123) During the processing of Lay's initial claim, Lincoln's in-house reviewer demonstrated an early and unfounded bias against Lay's claim:

> **"I would find it odd a CEO with STD and LTD coverage would just now have thought to file?"** (R. 247)

And Lincoln issued its claim denial before it received medical information it knew was material to proving Lay's disability. On July 12, 2007, Lincoln advised Lay that he would have until July 27, 2007 to provide medical documentation from Dr. Flood before a decision would be made on his claim. Lincoln, however, issued its claim denial on July 19, 2007. Lincoln's own records show that Dr. Flood's records were faxed to Lincoln on July 27, 2007. (AR p. 575) Thus,

Lincoln prematurely denied Mr. Lay's claim before it reviewed Dr. Flood's records and before the time Lincoln promised to Lay.

In its subsequent consideration of Lay's first level appeal, Lincoln was forced to acknowledge the existence of Lay's fibromyalgia but upheld its earlier denial, this time stating:

> **"The evidence establishes that you have had similar symptoms dating back several years, and the evidence fails to document a significant change or worsening of your medical status as of May 31, 2006, that would have prevented you from continuing to work as you had prior to that date."** (AR p. 40-42).

As with Lay's initial claim, it is clear Lincoln was determined to deny his first level appeal as well. Lincoln assigned an in-house nurse reviewer, K. Denise Theisen, to review Lay's file. See Theisen's notes (AR p. 44 - 47) Nurse Theisen's notes demonstrate she gave little, if any, weight to the findings of Lay's physicians or Lay's subjective complaints of pain. Furthermore, Theisen was openly and unjustifiably critical of the treatment regimen undertaken by Lay's physicians. Theisen's review was highly suspect as pointed out by Dr. Olson:

> **"Perhaps the nurse reviewer was given an impossible task, capturing the true picture of a patient's complex course through paper notes. In my opinion, though, her report failed as a thoughtful, unbiased opinion regarding Mr. Lay's illness."** (AR p. 425 - 426)

Convinced that Lincoln was determined to deny him benefits despite the overwhelming evidence establishing his disability, Lay retained counsel to assist him with the filing of his final administrative appeal. (AR p. 37 – 38) It was then, and only then, that Lincoln had Lay's file examined by a physician reviewer. (AR p. 14 – 24) Based on this review, Lincoln finally admitted that Lay was disabled under the policy. (AR p. 1 - 5)

But because Lincoln was unhappy with this result, it sent Lay's file back to the reviewer to see if the reviewer could determine the exact date Lay became disabled. (AR p. 4 – 5)

Pointing to no supporting objective medical evidence, the examiner seized on a date Lay had indicated in his initial application for benefits and summarily determined that this was the exact date Lay's disability began. It is important to note that Lincoln didn't initially consider Lay's statements sufficient to establish *even the mere existence of his disability much less the exact date it began*, when he filed his claim for benefits and subsequent first level appeal. Conveniently, however, Lincoln now determined that Lay himself was the very best authority on exactly when his chronic, gradually degenerating condition rendered him totally disabled. And fortuitously, for Lincoln, that date was just a few months before their policy became effective.

Accordingly, Lincoln again denied Lay's claim for benefits, for the final time, on the entirely new basis that because Lay was not "actively at work" when the policy became effective, he never became eligible for benefits. (AR p. 1 – 5) Lincoln quickly concluded its final denial of benefits letter by suggesting that perhaps Lay should check with his employer to determine if he had coverage with a prior carrier and by informing him that his file would be officially closed. Lay was never given an opportunity to rebut the reviewer's determination of the date of disability nor did Lincoln ever make any attempt to determine if Lay ever became "actively at work" at any time after the effective date of the policy to trigger his eligibility for benefits. And even though Lincoln's policy contains a "prior insurance credit" provision, Lincoln never bothered to determine whether Lay was eligible for benefits by operation of that provision. Lincoln's suggestion that Lay check with his employer to determine if he had coverage with a prior carrier is troubling and aptly points out that Lincoln was much more concerned with its own interests than with Lay's. First, Lincoln should have made that determination based on the prior insurance credit provision and Lincoln's fiduciary role vis-à-vis Lay. Second, Lincoln already knew its policy was a *replacement* policy and that Lay had prior coverage.

Moreover, Lincoln's fourth and latest basis for denial is disingenuous at best. There is ample evidence in the record establishing that Lay was actively at work after the erroneous date of disability determined by Lincoln's physician reviewer. And Lincoln's position is wholly inconsistent with the fact that it was Lay himself who executed the insurance contract with Lincoln in his "active" capacity as CEO/Executive Director of CNHC after the reviewer claims Lay was totally disabled. There is no doubt that Lincoln believes the insurance contract Lay signed is binding. Furthermore, Lincoln accepted Lay as an insured and received premium payments for his coverage until his last month at work. If Lincoln's position is accepted, the practical effect is that Lincoln will have received premium payments for Lay's coverage without ever having provided him with coverage.

The evidence establishes that Lay was actively at work when the Lincoln policy took effect. Moreover, if Lay was in fact disabled prior to the Lincoln policy taking effect, then he is still entitled to benefits pursuant to the “prior insurance credit” provision of the Lincoln policy. Last, Lay is owed penalty fees from Lincoln because they failed to provide him with a copy of the LTD Summary Plan Description ("SPD") after several requests as required by ERISA.

III. STANDARD OF REVIEW

The standard of review for an ERISA benefits case in this Court is *de novo* unless the plan document governing the claim affords the fiduciaries appropriate discretion to adjudicate claims. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 (1989). If Lincoln seeks to establish deferential review, it bears the burden of establishing that it is entitled to it. *Clark v. Metropolitan Life Ins. Co.*, 19 EBC 2172, 2173 (6th Cir. 1995), citing *Brown v. Ampco-Pittsburgh Corp.*, 876 F.2d 546, 550 (6th Cir. 1990). To the extent that Lincoln asserts that the plan affords it discretion, Plaintiff will address that issue in his responsive memorandum

Even if Lincoln's actions are examined using a more deferential standard of review, such as arbitrary and capricious, however, Lincoln's decision may only be upheld "if it is the result of a deliberate, principled reasoning process and if it is supported by *substantial* evidence." *Smith v. Health Servs. of Coshocton*, 314 Fed. Appx. 848, 14 (6th Cir., 2009) (emphasis added) (internal citations omitted). In other words, an arbitrary and capricious review does not simply mean a “rubber-stamping” of Lincoln's administrative decision. Id. As demonstrated, it is abundantly clear that Lay is entitled to benefits under Lincoln's policy. It is also clear that Lincoln's decision to deny benefits was not the result of a deliberate, principled reasoning process.

Furthermore, Lincoln’s position is weakened from the outset because of its conflicted position in assessing Lay’s claim. Indeed, the Supreme Court has determined that even in cases where the “benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a ‘factor in determining whether there is an abuse of discretion.’” *Firestone Tire & Rubber Co. v. Bruch*, 109 S. Ct. 948, 956 – 67 (citing Rest. 2d. of Trusts § 187, Comment d). So, even if the Court applied an arbitrary and capricious standard in this case, Lincoln's conclusions with regard to Lay’s claim must be reviewed with an eye towards bias.

IV. DISCUSSION

A. Lincoln's determination that Lay was not "actively-at-work" at the time Lincoln's policy came into effect was arbitrary, capricious and unsupported by medical evidence.

As their fourth and final reason for denying Lay's benefits, Lincoln claimed that Lay is not covered under the policy because he was not "actively at work" at the time Lincoln's policy came into effect on December 5, 2005. Lincoln bases this on the determination of its paid physician reviewer that Lay became "unable to perform the main duties of his occupation beginning 8/22/2005." But in his report, the physician reviewer failed to point to any medical evidence establishing that August 22, 2005 was the exact date that Lay's chronic, gradually degenerating fibromyalgia rendered him "unable to perform the main duties of his occupation…." Instead, the reviewer simply and arbitrarily plucked out a date Lay had indicated in his application for benefits. First, it must be noted that Lincoln didn't initially consider Lay's own statements to be credible enough to establish even the mere existence of his disability. But when it suited Lincoln's interests, Lincoln was happy to recognize Lay as the single greatest authority on when he actually became disabled under the policy's terms. Second, Lincoln misquoted and thus misused the reviewer's findings. The reviewer actually stated that "8/22/05" was "the earliest date [Lay] was unable to perform the main duties of his occupation *full time*…." (AR p. 255) Importantly, Lay didn't have to perform the main duties of his job on a *full time* basis to be considered "actively at work" under Lincoln's STD policy. (AR p. 697) In other words, Lay could be considered "actively at work" under the STD policy definition even if he could only perform the main duties of his job on a *part time* basis. In fact, Lincoln's physician reviewer had earlier offered his opinion that Lay could perform his job on a "part-time basis."

(AR p. 22) This is in contrast to the "actively at work" definition found in Lincoln's LTD policy, which does require "full-time performance" of the main duties of Lay's job. (AR p. 775)

Lay was actively at work after August 22, 2005. This is demonstrated most compelling by the fact that it was Lay who reviewed and executed the contract with Lincoln on November 23, 2005. It is both disingenuous and inconsistent for Lincoln to rely on the binding quality of Lay's execution of the insurance contract in his active capacity as Executive Director of CNHC and then deny him coverage on the basis that he wasn't "actively at work." As the Sixth Circuit has recognized, "there is no 'logical incompatibility between working full time and being disabled from working full time.'" *Rochow v. Life Insurance Co. of North America*, 482 F. 3d 860, 865 (2007) (citing *Hawkins v. First Union Corp. Long-Term Disability Plan,* 326 F.3d 914, 918 (7th Cir. 2003)). Furthermore, Lay's sick time records support his claim that his condition periodically waxed and waned with a gradual, long-term trend toward increased severity. Not surprisingly, Lincoln never requested to see those records during its so-called review. It was Lay's counsel who obtained the records and submitted them with Lay's final administrative appeal.

B. Even if Lay was not "actively at work" on or after the effective date of the policy, he is still eligible for benefits by operation of the "prior insurance credit" provision.

In clear violation of its contractual and fiduciary duties to fairly and impartially review Lay's disability claim and to act first and foremost in his interest, Lincoln avoided reviewing Lay's claim under this very clear and obvious provision of their policy:

<u>Prior Insurance Credit Upon Transfer of Insurance Carriers</u>

To prevent loss of coverage for an Employee because of transfer of insurance carriers, the Policy will provide Prior Insurance Credit for employees insured under the prior carrier's policy on its termination date as follows.

FAILURE TO BE ACTIVELY-AT-WORK DUE TO INJURY OR SICKNESS. Subject to premium payments, the Policy will provide coverage to an Employee:

1. **who was insured by the prior carrier's policy at the time of transfer; and**
2. **who was not Actively-At-Work due to Injury or Sickness on the Policy's Effective Date.**

The coverage will be that provided by the prior carrier's policy, had it remained in force. The Company will pay:

1. **the benefit that the prior carrier would have paid; minus**
2. **any amount for which the prior carrier is liable.** (AR p. 804)

Lay did in fact have LTD coverage with CNHC's previous insurer, UNUM, a fact well known to Lincoln. (Complaint, Ex. C) And Lincoln was also aware that its own LTD policy was a replacement policy. Id. Lincoln, however, admits that it never determined whether Lay was eligible for benefits by operation of the prior insurance credit provision. See Def. Resp. to Pl. Interr. No. 2 (attached hereto as Exhibit A) This is also evidenced by the fact that Lincoln has not provided a copy of the prior policy in the administrative record.

Lincoln tries to explain away this clear breach of it duties by opining that the "only claim presented to the Plan was Plaintiff's claim for group short term disability ("STD") benefits." Def. Resp. Pl. Interr. No. 2. And Lincoln further explains that the "STD policy does not contain a [Prior Insurance Credit] provision." Again, Lincoln's position is disingenuous at best because Lay did make a claim for LTD benefits in addition to STD benefits as Lincoln is well aware. In a letter dated February 27, 2008, Lay's counsel informed Lincoln of the following:

> **"Also, your February 14, 2008 package did not contain any information related to Mr. Lay's *long-term* disability benefits. His is a continuing, long-term disability. Please forward all information related to Mr. Lay's long-term disability benefits, including a copy of the Summary Plan Description and other plan documents, as soon as possible."** (AR. 32)

In a letter dated April 11, 2008, Lay's counsel again put Lincoln on notice that Lay's claim for benefits included LTD benefits:

> **"By letter dated February 27, 2008, Mr. Lay requested, through his attorney, a copy of the Summary Plan Description and all other related plan documents for Mr. Lay's long-term disability benefits. The Plan has failed to produce the requested documents as of the date of this letter."** (AR p. 262)

Most tellingly, however, Lincoln's own internal records demonstrate that Lincoln was aware well before Lay's counsel's February 27, 2008 letter that Lay's disability was a continuing long-term disability, which would likely implicate LTD benefits. In the notes contained in Lincoln's "STD Claim Profile," Lincoln's claims handlers acknowledge that the duration of Lay's disability may require his STD benefits to "rollover" to LTD benefits:

> **"5/1/07 * * * Since it's taken him a year to file the claim, I'm sending and (sic) ISS and Voc Rehab form. 1) ISS will ask if he's worked 2) This will be needed for LTD roll) and a fraud statement."** (AR p. 247)

> **"5/1/07 * * * EE has LTD, so we will need all records in the event the claim is approvable for potential LTD roll."** (AR p. 247)

> **"5/14/07 * * * If claim goes to ltd, this will be for ltd use."**

By not examining whether Lay was entitled to benefits by operation of the prior insurance credit provision, Lincoln failed to fulfill its function as a reviewer of Lay's claim.

Lay is entitled to benefits by the clear language of the provision. The intent of the provision is unmistakable and clearly spelled out - "To prevent loss of coverage for an Employee because of a transfer of insurance carriers…." (AR p. 804) More specifically, the provision was intended to protect claimants like Lay in situations exactly like the instant case - "* * * this

Policy will provide coverage to an Employee * * * who was not Actively-At-Work due to Injury or Sickness on the Policy's Effective Date." (AR p. 804).

C. Lincoln should be equitably stopped from denying Lay's claim because Lincoln represented to Lay that he was a covered insured at all relevant times and Lincoln accepted premium payments for Lay's coverage.

The Sixth Circuit has long recognized that an equitable estoppel claim can arise under ERISA's common law. *Armistead v. Vernitron Corp.*, 944 F.2d 1287, 1298 (6th Cir. 1991). *See also Trustees of the Michigan Laborers' Health Care Fund v. Gibbons*, 209 F.3d 587 (6th Cir. 2000); *Crosby v. Rohn & Hass Co.*, 480 F.3d 423 (6th Cir. 2007). After the insurance contract was executed, Lincoln sent monthly bills to CNHC, which listed Lay as a covered insured. (Complaint, Ex. D) Lincoln had reason to expect that Lay, as Executive Director, would review those bills for accuracy and approve the subsequent premium payments because it was Lay who executed the initial contract and approved the first premium payment. Nevertheless, Lincoln continued sending Lay the bills indicating that he was covered and Lincoln continued accepting CNHC's premium payments for Lay. Lincoln never took any advance or periodic steps to determine whether Lay or any other CNHC employee was ineligible by operation of the "actively at work" provision, which it could have done with a simple questionnaire. Instead, Lincoln continued representing that Lay was at all times a covered insured and accepting premium payments for his coverage. Lincoln's failure to determine whether Lay was an eligible insured deprived him of the opportunity to make other arrangements to provide for his eventual inability to earn a livelihood. Furthermore, Lincoln compounded this failure by affirmatively representing to Lay that he was a covered insured through his inclusion in the monthly bills, which Lincoln had ample reason to believe would be reviewed by Lay. If Lincoln is permitted to

deny Lay's claim for benefits, the practical effect will be that Lincoln will have been unjustly enriched through its receipt of premiums for Lay at a time when Lincoln asserts that it had no contractual obligation to provide Lay with disability benefits.

D. The Plan is subject to ERISA penalties for its willful failure to provide Lay with copies of the LTD summary plan description after he made several requests for the documents.

Pursuant to 29 USC § 1024(b)(4), the plan administrator is required to furnish a copy of the latest policy upon the request of a party. If the administrator fails to comply, then sanctions will be applied in the amount of $100 per day from the date of "such failure or refusal." 29 U.S.C. §1132(c)(1). On February 27, 2008, counsel for Lay notified Lincoln that he was requesting copies of the summary plan description and all other information related to Lay's LTD benefits. (R. 262) Neither the Plan nor Lincoln provided this information until the administrative record was provided by Lincoln on March 2, 2009. Lay respectfully requests that the defendants be ordered to pay the appropriate penalty calculated from February 27, 2008 until March 2, 2009.

E. Lincoln's actions throughout the claims process demonstrates that Lincoln failed to act in Lay's best interests, instead acting with an inappropriate bias, which resulted in a claims decision that was unreasonable and unsupported by the evidence.

The course of action taken by Lincoln throughout the review process tells a story of a company attempting to protect its bottom line by whatever means necessary, not of an administrator fiduciary who undertook a fair and impartial review of a disability claim. Ultimately, none of Lay's potential claims against Lincoln have been fairly heard by the administrator, thus, at a minimum, all of the issues are appropriate for remand.

First, Lincoln's reason for denying benefits to Lay has changed dramatically since his initial claim. Lincoln's final rationale for denial - that Lay was totally disabled before the effective date of the policy, is fully arbitrary and capricious, and evidences ignorance with regard to Lay's condition. As has been described in the *Facts* section of this motion, Lay's condition, while severe, does tend to wax and wane at points, although the overall trend of symptoms has been towards increased severity. For years Lay's symptoms exhibited intermittent severity, and as a result, he could perform his duties most of the time, and only take time off in accord with his paid time off employment provisions. In order to suit their needs, Lincoln decided, based on an arbitrary determination, the exact date on which they alleged Lay was disabled. But much of the administrative record, which Lincoln claims to have reviewed, indicates the progressive nature of Lay's condition, which would indicate that a specific date is impossible to pin-point.

There is no doubt Lincoln failed to provide appropriate ERISA-related procedures to Lay. In order to comply with ERISA, Lincoln needed to provide Lay with a "reasonable opportunity to appeal an adverse benefit determination." 29 C.F.R. 2560.530-1(h)(1-2). Lay was not given the ability to appeal his adverse benefit decision. Although Lay's claim continued to be denied, it was denied for completely separate reasons each time. Lay did not have an opportunity to rebut Lincoln's final denial of benefits on the basis that he had been disabled all along. After Lincoln made that determination, it simply closed Lay's file and essentially told him to go away. Therefore, at a minimum, Lay is entitled to remand so that he may have an opportunity to rebut Lincoln's determination that he was not actively at work or to prove that he did return to active work status at some point before his last day at work. The aforementioned regulation also specifically says that the review afforded to a claimant is not "full and fair" if the claimant is not

provided with documents. Lay was not provided with a copy of the LTD summary documents or policy until after he filed his lawsuit.

Finally, the administrative record contains actual evidence that Lincoln was biased against Lay, and doubted his claim, from the very beginning of its review process. The very individuals who were charged with giving Lay a fair examination in order to make a reasoned benefit decision were biased against Lay's claim from the very beginning. This in and of itself is a clear violation of 29 C.F.R. 2560.503-1(h). From the outset, Lay was fighting a losing battle.

CONCLUSION

The record fully demonstrates Lay's eligibility for benefits. Moreover, because Lincoln conducted its administrative review in an arbitrary and capricious fashion, the Court should overrule the administrator's decision. In the alternative, Lincoln's failure to provide Lay with a full and fair review of this matter warrants an order of remand. Lincoln completely failed to review the possibility that Lay could be covered under the "prior insurance credit" provision. Also, Lincoln denied Lay an opportunity to present evidence rebutting Lincoln's fourth and latest reason for denial - that he was never actively at work while Lincoln's policy was in force.

Respectfully submitted,

/s/ Danny L. Caudill
Robert J. Beggs (0002966)
(*John.Beggs@BeggsCaudill.com*)
Danny L. Caudill (0078859)
(*Danny.Caudill@BeggsCaudill.com*)
BEGGS CAUDILL, LLC
1675 Old Henderson Road
Columbus, Ohio 43220-3644
(614) 360-2044
Fax (614) 448-4544

Trial Counsel for Plaintiff

CERTIFICATE OF SERVICE

I hereby certify that on this 22nd day of July 2009, I electronically filed the foregoing Motion for Judgment on the Administrative Record with the Clerk of Court using the CM/ECF system, which will serve this Motion upon counsel of record.

/s/ Danny L. Caudill
Danny L. Caudill (0078859)