CAMPBELL v. UNUM LIFE INSURANCE CO.

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ORDER & REASONS

This matter is before the Court on cross-motions for summaryjudgment, which have been the subject of extensive briefing. Themotions were heard with oral argument. Thereafter, the Courtdetermined that Policy No. 21462 (the "Policy") governed thePlaintiff's claim. After determining the applicable policy, theparties submitted post-hearing memoranda on the substantive issueof whether the Plaintiff is entitled to long-term disabilitybenefits under the Policy. The Court took the matter undersubmission. Having considered the administrative record, thememoranda filed by the parties, the applicable law, and theargument of counsel, the Court hereby GRANTS the Plaintiff'sMotion for Summary Judgment and DENIES the Defendant's Motion forSummary Judgment.

I. BACKGROUND

This is an action on a disability insurance policy provided bythe Defendant to Catlin, Inc. ("Catlin"), bearing groupidentification number 21462 (the "Policy"). The Plaintiff was afounding partner and Senior Vice President of Catlin, formerlyBCC Holdings, Inc., ("BCC") and was covered by this Policy.Catlin specializes as a contract underwriter for syndicates atLloyd's of London in writing insurance policies for entitiesengaged in the energy exploration and production business. The Defendant originally provideddisability coverage to BCC. After BCC merged with Catlin, thePolicy was continued and was endorsed by the Defendant to reflectthe change in the name of the company. The Policy remained ineffect until May 31, 2001. On June 1, 2001, a new policy wentinto effect.

After being diagnosed with congestive heart failure and dilatedcardiomyopathy, the Plaintiff terminated her employment. In Juneof 2001, the Plaintiff filed a claim for disability benefits withthe Defendant pursuant to the Policy. As explained in greaterdetail below, the Defendant denied the Plaintiff's claim. Afterappealing the denial two times, the Plaintiff filed suit againstthe Defendant in this Court on May 21, 2003.

A. Medical Condition of the Plaintiff

In December, 1999, while an in-patient at St. Luke's Hospital,Texas Heart Institute in Houston, the Plaintiff was diagnosedwith congestive heart failure and dilated cardiomyopathy. She wasreleased from St. Luke's Hospital on December 27, 1999, and wasreferred to Dr. Roland J. Bourgeois, Jr., of Metairie, Louisiana,on January 4, 2000. Dr. Bourgeois was the Plaintiff'scardiologist at all times relevant to the instant matter.

By letter dated May 7, 2001, sent to the Defendant as part ofthe Plaintiff's disability claim, Dr. Bourgeois confirmed thePlaintiff's diagnosis as congestive heart failure and severeidiopathic dilated cardiomyopathy. (UACL 00085-86).[1] Heclassified the Plaintiff's heart condition as New York HeartAssociation ("NYHA") Class II.[2] Due to her condition, Dr.Bourgeois advised the Plaintiff to avoid stress and fatigue bylimiting her activities and obtaining frequent periods of rest. He also indicated in the physicianstatement portion of the Long Term Disability Claim form sent tothe Defendant that he believed the date on which the Plaintiffwas first unable to perform all work duties was December 15,1999. (UACL 00087-88). Dr. Bourgeois treated the Plaintiff untilDecember 4, 2002. Throughout the period of time when Dr.Bourgeois was the Plaintiff's treating physician, he maintainedthat the Plaintiff was disabled from her regular occupation as aninsurance executive due to the stressful nature of the professionand the Plaintiff's inability to exert herself physically andmentally for a sustained period of time. He indicated that, dueto her condition, the Plaintiff required periods of restthroughout the day and that she should avoid stressful situationsand fatigue.

In addition to receiving treatment from Dr. Bourgeois, thePlaintiff also consulted a vocational rehabilitation expert, Mr.John M. Yent, who performed a job analysis and advised jobmodifications to address her medical condition. (UACL 00191-197).Mr. Yent concurred with Dr. Bourgeois and opined that thePlaintiff could not return to her former occupation. Mr. Yentbased his conclusion on the physical as well as the non-physicalrequirements of the Plaintiff's former position. Mr. Yentoutlined some of the non-physical requirements that he believedwere beyond the impaired capabilities of the Plaintiff asincluding: "high stress, responsible for success of `high stakes'agreements worth millions of dollars, constant rapid work pace,frequent short-turnaround deadlines, high volume of telephonecalls, and email correspondence, etc." (UACL 00191-197). As thePlaintiff required frequent periods of rest during the day, shecould not safely work in such an atmosphere. Mr. Yent and Dr.Bourgeois concluded that these non-physical elements of thePlaintiff's work were not elements that Catlin could alter toaccommodate the Plaintiff's medical condition. Rather, theseelements were simply part of the Plaintiff's daily workenvironment. Sometime in 2002, the Plaintiff moved to the State of Alabama.She began seeing Dr. Robert A. Schuster and Dr. Kevin P. Ryan asher treating physicians in Alabama. Both Drs. Schuster and Ryanconfirmed that the Plaintiff suffers from congestive heartfailure and dilated cardiomyopathy. They also independentlyconcluded that the Plaintiff should not return to her previousemployment due to her condition. (UACL 01218, 01272).

The Defendant conducted several reviews of the Plaintiff'sclaim prior to issuance of its final denial. The Plaintiff'smedical record was reviewed a total of four times by two of theDefendant's in-house cardiologists: the first and third reviewswere conducted by Dr. Tom Hashway; the second and final reviewswere conducted by Dr. George J. DiDonna. A "clinical consultant"and vocational rehabilitation consultant also reviewed thePlaintiff's records.

The first such review by Dr. Hashway occurred on July 27, 2001.Based merely on a review of the Plaintiff's medical records, theDefendant concluded that the medical evidence did not support

thesevere limitations placed upon the Plaintiff by her treatingphysician. (UACL 00141-144). The Defendant noted that nofunctional testing had been performed. The Defendant furtherconcluded that the Plaintiff's condition had improved, requiredonly slight restrictions, and did not preclude her fromperforming the requirements of her job. Accordingly, theDefendant denied the Plaintiff's claim for benefits by letterdated August 20, 2001. (UACL 00157-159).

Thereafter, in November 2001, the Plaintiff appealed the denialof her disability claim. (UACL 00172). On December 5, 2001, Dr.DiDonna again reviewed the Plaintiff's medical records. Similarto the first review, Dr. DiDonna found that the Plaintiff'smedical record did not support the conclusion that she was unableto perform the requirements of her employment. (UACL 00257). Dr.DiDonna also noted that he was "not aware of any evidence thatshows a direct relationship between mental stress and dilatedcardiomyopathy." (UACL 00257). He did agree that the Plaintiffshould rest during the workday, but opined that periodic restdoes not preclude working.

On December 21, 2001, the Defendant arranged for a vocationalreview and occupational analysis. (UACL 01016-1022). This reviewalso consisted of a review of medical and other records. TheVocational Rehabilitation Consultant, Kelly Marsiano, whocompleted the review, also concluded that the Plaintiff couldperform her occupation. Her conclusion was based primarily on thephysical demands of the Plaintiff's job, which were admittedlynot great. The most difficult physical requirement was the factthat the Plaintiff traveled a significant percentage of her time.Ms. Marsiano felt that traveling required light physical exertionbecause of the availability of valets and sidewalk luggagecheck-in.

Based upon these additional reviews, the Defendant denied thePlaintiff's appeal by letter dated January 25, 2002, butrequested an independent medical examination ("IME") of thePlaintiff to provide a good faith effort in the review. (UACL00352-354). The IME was conducted on July 8, 2002, by Dr. Kansal.In his report, Dr. Kansal confirmed that the Plaintiff sufferedfrom congestive heart failure and dilated cardiomyopathy. (UACL01091-1093). He noted that the Plaintiff also suffered fromdecreased mental capacity and mental quickness, which he thoughtwas due to factors other than her heart condition. He felt thatshe should undergo a psychiatric evaluation and an exercise test.Dr. Kansal did not address whether or not he felt that thePlaintiff was able to perform the requirements of her employment.

On May 28, 2002, the Plaintiff was awarded Social SecurityDisability benefits pursuant to the Notice of Decision-FullyFavorable by Judge Donald Colpitts. (UACL 01079-1081). Afterreviewing all of the medical evidence, Judge Colpitts found thatthe Plaintiff was totally disabled since May 31, 2001. Judge Colpitts based his conclusionin large part on the following findings: In November 2001, Dr. Bourgeois provided that Ms. Campbell sufferes from severe physical symptoms related to dilated cardiomyopathy. These symptoms render Ms. Campbell unable to tolerate prolonged low level activity and severely reduces her ability to tolerate mental stress. Moreover, Mr. John Yent, a vocational counselor, revealed that Ms. Campbell is unable to perform sedentary work for more than

one hour without the need to rest. Mr. Yent further indicated that Ms. Campbell is unable to tolerate even four hours of sedentary work during an eight hour day.(UACL 01079-1081). As part of his decision, Judge Colpitts alsonoted that prior to May, 2001, the Plaintiff had an excellentwork history.

On July 26, 2002, the Defendant authorized another review ofthe Plaintiff's record by Dr. Hashway, including the results ofthe IME and the award of Social Security benefits. Dr. Hashwayessentially confirmed his prior opinion and concluded that thePlaintiff was capable of performing at the "sedentary or lightactivity level." (UACL 01094-1096). No definition of the kinds ofactivities that might be appropriate at this exertion level wereprovided.

Additionally, the Defendant requested that the Plaintiffundergo an exercise stress test. The Defendant contacted thePlaintiff by letter dated July 29, 2002, to inform her that astress test had been scheduled with Dr. Kansal for August 12,2002. (UACL 01110). On the advice of her treating physician, Dr.Bourgeois, the Plaintiff refused to take the stress test. Dr.Bourgeois advised the Plaintiff and the Defendant that a stresstest, which measures physical activity over a short amount oftime, would not be helpful in an evaluation of the Plaintiff'scondition. (UACL 01128). According to Dr. Bourgeois, thePlaintiff was able to exert herself for a short amount of time,but was unable to sustain physical or mental exertion over longerperiods of time, a result of her medical condition that a stresstest would not measure. Thus, Dr. Bourgeois advised against having the Plaintiff undergo a test which would reveal nonew or useful information about her condition.

By letter dated October 29, 2002, the Defendant notified thePlaintiff that the decision to deny benefits would be upheld.(UACL 390-393). On October 30, 2002, the Plaintiff requestedanother review of her claims. (UACL 513-317). On December 17,2002, the Defendant arranged for Dr. DiDonna to perform anotherreview of the Plaintiff's case. Dr. DiDonna's opinion regardingthe Plaintiff's ability to perform the requirements of heremployment were substantially the same as his first opinion.(UACL 1208-1204). That is, based on his review of the Plaintiff'sentire record, including medical literature submitted by thePlaintiff, he felt that the Plaintiff's medical record did notsupport the restrictions and limitations advised by thePlaintiff's treating physicians. Thus, the Defendant upheld itsoriginal decision to deny the Plaintiff's claim, but informed thePlaintiff that it would consider additional information submittedno later than February 10, 2003. (UACL 01212-1216).

On February 7, 2003, the Plaintiff submitted additionalinformation for the Defendant to review, consisting of medicalrecords and reports. On February 25, 2003, Dr. DiDonna reviewedthe additional information and re-stated his prior opinionregarding the Plaintiff's ability to perform the duties of herposition. (UACL 1285-1287). Finally, on March 10, 2003, theDefendant informed the Plaintiff that its denial of her claim wasfinal. (UACL 1320-1321).

B. Occupational Disability of the Plaintiff

As part of the Plaintiff's claim, Catlin reported to theDefendant that, due to her medical condition,

the Plaintiff wasunable to perform the material duties of her position. Bycorrespondence addressed to the Defendant, Catlin indicated thatthe Plaintiff occupied a central management role. (UACL 01007-1008). Her duties included insuranceunderwriting; supervision of policy reporting, policy issuanceand account management; client development and sales; andtraining and supervision of other personnel. Furthermore, Catlinindicated that the Plaintiff was required to work three (3) daysper week every other week in its Houston, Texas office. She wasalso required to travel to London, England at least once peryear.

In the period following the onset of her medical condition, thePlaintiff wanted to continue to work for Catlin. Catlin indicatedthat it accommodated the Plaintiff's medical condition on atemporary basis out of respect for her as a founding partner ofthe firm and in the hopes that she would recover and be able toreturn to full work duties. Thus, Catlin allowed her to decreaseher work hours and eliminate certain elements of her work. Forexample, the Plaintiff discontinued all travel and outside callsupon clients for sales and account development. The Plaintiffworked sporadically, sometimes only two or three times a week forno more than three or four hours a day. During this period, fromJanuary 2000 to May 31, 2001, other Catlin staff members assumedthe duties that the Plaintiff was unable to complete. Catlinconsidered these accommodations temporary and continued to paythe Plaintiff her full salary in the hopes that she would recoverher health and be able to return to full-time employment. Catlinindicated that these accommodations could not have been madepermanently due to the nature of the industry and the particularduties required by the Plaintiff's job. Finally, on May 31, 2001,Catlin terminated the Plaintiff, only after determining that shewould not be able to work at her previous level of productivityfor the foreseeable future. During the pendency of thePlaintiff's claim, Catlin has maintained that the Plaintiff iscompletely disabled with regard to her regular occupation due toher medical condition. C. Unum Policy 21462

On December 10, 2003, this Court determined that Unum Policy21462 applied to the Plaintiff's claim for disability benefits.(UACL 00396-415). The relevant definition of "disability"provided in the Policy is as follows: "Disability" and "Disabled" mean that because of injury or sickness: 1. you cannot perform each of the material duties of your regular occupation; and 2. after benefits have been paid for 24 months, you cannot perform each of the material duties of any gainful occupation for which you are reasonably fitted by training, education or experience; or 3. you, while unable to perform all of the material duties of your regular occupation or another occupation on a part-time or full-time basis; and a. Performing at least one of the material duties of your regular occupation or another occupation on a part-time or full-time basis; and b. Currently earning at least 20% less per month than your indexed pre-disability earnings due to that same injury or sickness.(UACL 00414). The Policy further provides for a ninety (90)-dayelimination period. The elimination period is a period of"consecutive days of disability for which no benefit is payable,"and begins to run on the first day of disability. (UACL 00409).Moreover, the Policy outlines several scenarios under whichcoverage would terminate, including: . . . 6. the date your employment terminates. Cessation of active employment will be deemed termination of employment, except; a. if you are disabled your insurance will be continued during: i. the elimination period; and ii. while benefits are being paid.(UACL 00400).

Under the policy,

"Active employment" means you must be working: 1. for your employer on a full-time basis and paid regular earnings . . .; 2. at least [thirty (30) hours per week]; and either 3. at your employer's usual place of business; or 4. at a location to which your employer's business requires you to travel.(UACL 00410). Finally, pursuant to the Policy, benefits arecalculated according to the following formula: 1. 60% (benefit percentage) of basic monthly earnings not to exceed the maximum monthly benefit, less other income benefits. . . . 2. The maximum monthly benefit is $6000. 3. The minimum monthly benefit is the greater of: a. $100.00; or b. 10% of the monthly benefit before deductions for other income benefits.(UACL 00415).

The parties do not dispute that the Policy neither grants norreserves unto the Defendant the discretionary authority todetermine eligibility for benefits or to construe the terms ofthe plan. (UACL 00396-415).

II. CONTENTIONS OF THE PARTIES

The Plaintiff submits that she became "disabled" as defined bythe Policy as of December 15, 1999 and continued to be disabledthrough the date of her separation of employment, May 31, 2001.The Plaintiff contends that the administrative record clearlydemonstrates that her medical condition precludes her ability toperform each of the material duties of her occupation and that,regardless of the standard employed by the Court, the Defendantwas not justified in denying her claim. The Plaintiff's centralargument is that the administrative record contains no concreteevidence that after the onset of congestive heart failure anddilated cardiomyopathy, she was capable of performing thematerial and substantial duties of her regular occupation as aninsurance executive.

While the Plaintiff's treating physicians noted that herability to tolerate physical activity was reduced, moreimportantly, the Plaintiff's treating physicians all agreed thatthe Plaintiff should avoid stress and fatigue associated withnon-physical activity. Admittedly, the Plaintiff's job was notphysically demanding in the sense that she was not required toperform demanding physical labor. She worked primarily at a desk. However, thePlaintiff's occupational analysis revealed that her position wasdemanding in the sense that it was very stressful, required theability to concentrate and focus over long periods of time, andmeet sensitive deadlines: all factors that led to the mentalstress and fatigue the Plaintiff claims exacerbated her symptomsand necessitated her separation from employment. As such, thePlaintiff asks the Court to award past benefits as well as futurebenefits and attorney's fees.

For its part, the Defendant maintains that its decision to denydisability benefits is supported by the administrative record.Primarily, the Defendant submits that its determinations wererationally based on the evidence submitted by the Plaintiff andthe opinions issued by its physicians. Specifically, theDefendant has consistently asserted that the Plaintiff is capableof performing a light capacity

occupation. Based on itsoccupational analysis, the Defendant concluded that thePlaintiff's position fits into the category of light capacity orfunctional occupation. The Defendant based its conclusionsprimarily on the opinions of its two in-house physicians andoccupational analysis.

Further, even if the Court finds that the Plaintiff meets thedefinition of "disabled" provided in the Policy, the Defendantargues that the Plaintiff is nonetheless ineligible because shewas not actively employed as required when she filed her claimfor benefits. Lastly, should the Court determine that thePlaintiff is entitled to benefits, the Defendant claims that thePlaintiff is not entitled to an award of future benefits.

III. LEGAL STANDARD

A. Motion for Summary Judgment

Summary judgment will be granted only if the pleadings,depositions, answers to interrogatories, and admissions, together with affidavits showthat there is no genuine issue as to any material fact and thatthe movant is entitled to a judgment as a matter of law.Fed.R.Civ.P. 56. If the party moving for summary judgment demonstratesthe absence of a genuine issue of material fact "the nonmovantmust go beyond the pleadings and designate specific facts showingthat there is a genuine issue for trial." Willis v. RocheBiomedical Laboratories, Inc., 61 F.3d 313, 315 (5th Cir. 1995)."[A] dispute about a material fact is genuine if the evidence issuch that a reasonable jury could return a verdict for thenonmoving party." Id. To oppose a motion for summary judgment,the non-movant cannot rest on mere allegations or denials butmust set forth specific facts showing that there is a genuineissue of material fact. See Celotex Corp. v. Catrett,477 U.S. 317, 321-22 (1986).

The burden of demonstrating the existence of a genuine issue isnot met by "metaphysical doubt" or "unsubstantiated assertions."Little v. Liquid Air Corp., 37 F.3d 1069, 1075 (5th Cir.1994) (quoting Matsushita Elec. Indus. Co. v. Zenith Radio,475 U.S. 574, 586 (1986)). The Court must "resolve factualcontroversies in favor of the nonmoving party, but only whenthere is an actual controversy, that is, when both parties havesubmitted evidence of contrary facts." Id. The Court does not,"in the absence of proof, assume that the nonmoving party couldor would prove the necessary facts." Id. If the record taken asa whole could not lead a rational trier of fact to find for thenonmoving party, no genuine issue exists for trial. SeeMatsushita, 475 U.S. at 588. Finally, "the mere existence ofsome factual dispute will not defeat a motion for summaryjudgment; Rule 56 requires that the fact dispute be genuine andmaterial." Willis, 61 F.3d at 315. If the evidence leads toonly one reasonable conclusion, summary judgment is proper. SeeAnderson v. Liberty Lobby, Inc., 477 U.S. 242, 250 (1986). B. Plan Administrator's Denial of Benefits

A district court considering a denial of benefits under anERISA plan is limited, with few exceptions,[3] to theevidence contained in the administrative record. Estate ofBratton v. Nat'l Union Fire Ins. Co. of Pittsburg, PA, et al.,215 F.3d 516, 521 (5th Cir. 2000). "If an administrator hasmade a decision

denying benefits when the record does not supportsuch a denial, the court may, upon finding an abuse of discretionon the administrator's part, award the amount due on the claimand the attorney's fees." Id. The Plaintiff argues that anaward of attorney's fees is appropriate in the instant matter.

The United States Supreme Court has determined that a challengeto a denial of benefits by an administrator pursuant to an ERISAgoverned plan is to be reviewed by the district court under a denovo standard unless the benefit plan gives the administratordiscretionary authority to construe the terms of the plan.Firestone Tire and Rubber Co. et al. v. Bruch, et al.,489 U.S. 101, 115 (1989). The parties do not dispute that the language inthe Policy at issue does not grant such authority to theDefendant. Accordingly, the Court shall apply the de novostandard.

However, it is well settled in the Fifth Circuit that thefactual determinations made by the Defendant during the course ofthe Plaintiff's benefit proceeding are reviewed for an abuse ofdiscretion. Bratton, 215 F.3d at 522. A determination that aperson is disabled is a factual determination. See Sweatman v.Commercial Ins. Co., 39 F.3d 594, 598 (5th Cir. 1994). Underthe abuse of discretion standard, the Court must determine if theplan administrator acted arbitrarily or capriciously. Sweatman, 39 F.3d at 601. Adecision is arbitrary when made "`without a rational connectionbetween the known facts and the decision or between the foundfacts and the evidence.'" Lain v. Unum Life Ins. Co. of Am.,279 F.3d 337, 342 (5th Cir. 2002) (quoting Bellaire Gen.Hosp. v. Blue Cross Blue Shield of Mich., 97 F.3d 822, 828(5th Cir. 1996)). An administrator's denial of benefits mustbe "based on evidence, even if disputable, that clearly supportsthe basis for its denial." Vega v. Nat'l Life Ins. Servs. Inc.,188 F.3d 287, 299 (5th Cir. 1992).

Under Vega, the Court applies a "sliding scale" to the abuseof discretion standard when the administrator has acted under aconflict of interest. Id. at 297. The existence of a conflictis a factor to be considered in determining whether theadministrator abused its discretion in denying a claim. Id."The greater the evidence of a conflict on the part of theadministrator, the less deferential our abuse of discretionstandard will be." Id. In a situation where a conflict exists,the reviewing court is "less likely to make forgiving inferenceswhen confronted with a record that arguably does not support theadministrator's decision." Id. at 298. In the case at bar, theDefendant has an inherent conflict of interest because it is theinsurer and has acted as the plan administrator and the claimsadministrator, determining eligibility for benefits and denyingclaims made under the Policy. See House v. Am. United Life Ins.Co., 2002 WL 31729483, *5 (E.D. La., Dec. 3, 2002); Lain, 279F.3d at 343. This will be a factor in the Court's review of thedecision.

IV. DISCUSSION

A. Disability

In assessing whether to grant or deny benefits, anadministrator must make two determinations. Lain, 279 F.3d at 343 (citing Schadler v.Anthem Life Ins. Co., 147 F.3d 388, 394 (5th Cir. 1998)).First,

the administrator must determine the facts underlying theclaim. Id. After resolving the facts, the administrator mustthen determine whether the facts establish a valid claim underthe terms of the relevant policy. Id. The Defendant arguesthat, based on the facts established by the record, the Plaintiffis not disabled as defined under the Policy. The Defendant basisits argument on its conclusion that the Plaintiff could perform asedentary to light occupation, which included her regularoccupation as a vice president of an insurance company.

The relevant provision of the Policy provides: "Disability" and "Disabled" mean that because of injury or sickness: 1. you cannot perform each of the material duties of your regular occupation . . .(UACL 00414). The Defendant based its denial of the Plaintiff'sclaim on its conclusion that the Plaintiff could, in fact,perform each of the material duties of her regular occupation.According to the Defendant, the record does not support therestrictions placed on the Plaintiff by three independenttreating physicians. Thus, the Defendant contends that itsdecision to deny the Plaintiff's claim was proper.

The Fifth Circuit applies a two-prong test when reviewing anadministrator's denial of benefits. First, the district courtmust determine the "legally correct interpretation of thepolicy." Lain, 279 F.3d at 344 (citing Tolson V. AvondaleIndus., Inc., 141 F.3d 604, 608 (5th Cir. 1998)). Second, ifthe court finds that the administrator failed to apply thelegally correct interpretation of the policy, then the court mustdetermine whether the administrator's denial was an abuse ofdiscretion. Id. 1. The Legally Correct Interpretation

In ascertaining the legally correct interpretation of thePolicy at issue, the Court must consider the following: (1)whether a uniform construction of the policy has been given bythe administrator; (2) whether the interpretation is fair andreasonable; and (3) whether unanticipated costs will result froma different interpretation of the policy. Gosselink v. AT&T,Inc., 272 F.3d 722, 726 (5th Cir. 2001) (citing Wildbur v.ARCO Chem. Co., 974 F.2d 631, 637-38 (5th Cir. 1992)).

In the case at bar, there has been no allegation regardingwhether the Defendant gave the Policy a uniform interpretation.As to the third question above, the only potential unanticipatedcost resulting from a different interpretation than theDefendant's would be that the Defendant has to pay benefits tothe Plaintiff and possibly other employees similarly situated.The central issue in this case is whether the Defendant'sinterpretation of the policy is fair and reasonable.

The Defendant consistently denied the Plaintiff's claim basedon its conclusion that the medical documentation did not supportthe restrictions and limitations placed on the Plaintiff by hertreating physician concerning her employment. The Defendant'sconclusion hinged in large part on its determination of theduties of the Plaintiff's "regular occupation." The evidenceindicates that the Plaintiff's treating physician and theDefendant defined the duties of the Plaintiff's occupationdifferently.

The Plaintiff defined her occupation based on her jobdescription and the duties that she performed prior to the onsetof her disability. These duties involved mostly non-physical, buthighly stressful activities. The Plaintiff was a successfulinsurance executive with many responsibilities, includingbrokering million dollar deals in a fast-paced, highlycompetitive setting. Such work required mental acuity, concentration, focus,and the ability to perform many tasks simultaneously. Asindicated above, Catlin eliminated many of the stressful aspectsof the Plaintiff's position temporarily, which essentiallystripped the Plaintiff's position of its central functions. Theaccommodations were burdensome on the company and the otheremployees and were never intended to be permanent.

Despite the fact that Catlin and the Plaintiff repeatedlyindicated that the modifications were made as a temporarymeasure, the Defendant defined the Plaintiff's occupation basedon the modifications and accommodations provided by Catlin. ThePolicy did not define the term "regular occupation." In the FifthCircuit, it is well-settled that, in construing the language ofan ERISA plan, federal law must follow the doctrine of contraproferentem, which directs that when plan terms are ambiguous,courts construe them strictly in favor of the insured. House,2002 WL 31729483, *6. "Where the term `regular occupation' is notdefined in the Plan, a fiduciary must adopt an appropriatedescription of the claimant's occupation." Id. (citingKinstler v. First Reliance Standard Life Ins. Co.,181 F.3d 242, 252 (2nd Cir. 1999). Although the Defendant received adescription of the Plaintiff's regular occupation and a letterfrom Catlin indicating that the modifications it made weretemporary, the Defendant declined to adopt an objectivelyreasonable job description based upon the facts. Furthermore, theDefendant failed to evaluate the Plaintiff's medical conditionagainst the rigors of the material duties of her regularoccupation. Rather, the Defendant denied the Plaintiff's claimbased on its conclusion that she was capable of performing alight exertional level occupation, as evidenced by the duties shewas able to perform for Catlin after her illness.

Today's rapid paced business environment does not foster thekind of loyalty between employees and employers that used to exist. In this case, Catlinvalued the Plaintiff and was willing to undergo a significantamount of inconvenience in the hopes that the Plaintiff wouldfully recover and be able to resume her full work duties. Priorto the onset of her illness, the Plaintiff was an executive, afounding member of the company, and an excellent worker. When itbecame clear that the Plaintiff would not recover, Catlin wasforced to terminate the Plaintiff because Catlin could notcontinue to accommodate the Plaintiff's condition on a permanentor indefinite basis.

Under these circumstances, the Defendant's use of the modifiedduties in its determination of the Plaintiff's ability to performthe material duties of her "regular occupation" is contrary tothe plain language of the policy. A fair and reasonableinterpretation of the Plaintiffs "regular occupation" wouldinclude those duties required and performed by the Plaintiffprior to the onset of her disability and prior to themodifications and accommodations made by Catlin. Accordingly, theCourt finds that the Defendant incorrectly interpreted the termsof the Policy by defining the Plaintiff's "regular occupation"based on the temporary modifications and accommodations providedby Catlin.

2. Abuse of Discretion

The Court now turns to whether the Defendant's interpretationof the Policy, while legally incorrect, constitutes an abuse ofdiscretion. A legally incorrect interpretation of a policy doesnot in itself demonstrate an abuse of discretion. Lain, 279F.3d at 346. The Fifth Circuit considers the following fourfactors to determine whether there has been an abuse ofdiscretion: (1) the plan's internal consistency under theadministrator's interpretation; (2) any relevant regulations; (3)the factual background underlying the decision; and (4) anyindication of lack of good faith. Wildbur v. ARCO Chem. Co., 974 F.2d 631, 638(5th Cir. 1992).

The first and second factors are not at issue in this case.Regarding the third factor, "[t]o find an absence of abuse ofdiscretion, [this] court must scour the record and pleadings forany legal basis upon which the administrator could have based[its] interpretation." Lain, 279 F.3d at 346 (citing Kennedyv. Electricians Pension Plan, 954 F.2d 1116, 1124 (5th Cir.1992).

Throughout the claim process, the Defendant consistentlymaintained that the medical information provided by the Plaintiffdid not support any restrictions or limitations from her regularoccupation. The Defendant did not dispute that the Plaintiffsuffered from congestive heart failure and idiopathic dilatedcardiomyopathy nor that her condition could be classified as NYHAClass II. However, the Defendant found that the medicalinformation indicated that the Plaintiff's condition wasimproving and that the Plaintiff's functional capacity was suchthat she could perform the duties of her occupation as modifiedby her employer. In making this determination, the Defendantrelied in large part on the following conclusions of itsvocational rehabilitation consultant:

While it appears as though the insured's occupation in the national economy is in the sedentary exertional level, as performed for her employer it would be considered light due to her report of travelling [sic]. Per the referral and the original employer's statement, the insured was relieved of the duties that exacerbated her condition such as business travel, stressful assignments, and her hours were reduced. While the on site job analysis performed by John Yent on 10/15/01 indicated that the insured's job as performed for the employer was in the medium exertional level, this was apparently taking into consideration the weight of the luggage and business materials she traveled with. Traveling is considered to fall in the light exertional level given the walking and carrying of most individuals. With the availability of valets, sidewalk luggage check-in stations and motorized carriers inside airports, it is unusual for an individual to be required to carry their own belongings, other than a purse or briefcase, which would fall under the light exertional level. Therefore, per Dr. Hashaway's review and the on site job analysis description of tasks other than travel, it appears as though the insured is not precluded from her own occupation as it was modified by her employer or as it is described in the national economy. (UACL 01018). Dr. DiDonna, the Defendant's main reviewingphysician, concluded that the Plaintiff's condition limited herability to perform some physical activity, but opined thatpatients who are in Class II:

can perform to completion any activity requiring less than 5 metabolic equivalents such as sexual intercourse without stopping, gardening, raking, reading, roller skating, dancing the Foxtrot, and walking at 4 miles per on level ground. However, they cannot perform to completion activities requiring greater than 7 metabolic equivalents. Some of these activities would include carrying objects of 80 lbs., doing outdoor work such as shoveling snow or spading, doing recreational activities such as skiing, basketball, handball, jogging, or walking 5 miles per hour.(UACL 01214). Neither the vocational rehabilitation consultantnor Dr. DiDonna ever examined the Plaintiff in person. They basedtheir conclusions merely on a review of the Plaintiff's medicalrecord and a generic definition of the types of physicalactivities that one classified as NYHA Class II can perform.Importantly, the Defendant seemingly ignored the non-physicalaspects of the Plaintiff's position.

Admittedly, the Plaintiff's occupation was not physicallydemanding. According to Dr. Bourgeois, the Plaintiff's treatingphysician, the Plaintiff could and should engage in moderateexercise. However, Dr. Bourgeois repeatedly advised that shemodify her lifestyle to reduce stressful and tiring situations.Indeed, the Plaintiff's main complaints were lack of an abilityto sustain mental concentration and fatigue when attempting to doso.

Even if the Plaintiff could perform the sedentary, but highlystressful, aspects of her position, she could not physicallytolerate the amount of travel her position required. The Court isnot persuaded by the conclusions drawn by the Defendant'svocational rehabilitation consultant regarding travel. In today'sworld, air travel is both physically and mentally demanding. Onedoes not know what one will confront upon arrival at an airport.Thus, travelers must arrive early and often stand in long linesawaiting security screenings. With increased security concerns,travelers are routinely required to remove their shoes, belts,and jewelry, and to consent to a search of their bags. Uponarrival at the departing gate, one might discover that one'sflight has been cancelled or delayed. Once aboard the plane,travelers often sit in cramped and uncomfortable seats forvarious lengths of time. All of these experiences are stressful,physically tiring, and mentally draining for even a healthytraveler, much less one with a heart condition such as thePlaintiff.

A fair reading of the Policy supports the view that in order tobe considered disabled, the Plaintiff must be unable to performthe material duties of her regular occupation due to injury orsickness. Plaintiff's medical conditions and disability aresufficiently evidenced in the record. The Defendant based itsdenial on a incorrect definition of the Plaintiff's occupationand a myopic view of the demands of that position. The evidencebefore the Court indicates that the Plaintiff does qualify asdisabled under the Policy. It was unreasonable for the Defendantto focus on the purely physical aspects of the modified positionin making its determination. Accordingly, the Court finds thatthe Defendant abused its discretion in denying the Plaintiff'sclaim.

B. Active Employment

The Defendant contends that if the Plaintiff qualifies asdisabled under the Policy, she is nonetheless ineligible toreceive benefits because she was not "actively employed" asrequired when she filed her claim. Under the terms of the Policy,an employee must be in "active employment" to be enrolled in theplan. That is, an employee is not eligible to participate in theplan and be eligible for benefits under the Policy unless theemployee meets the requirements of active employment. In order to be in active employment, anemployee must work on a full-time basis, a minimum of thirtyhours per week. (UACL 651). The Policy also provides thatinsurance coverage terminates upon cessation of activeemployment. That is, one is no longer enrolled or eligible toparticipate in the plan if one changes to a part-time position orceases employment altogether.

The Defendant interprets this provision of the Policy torequire a claimant to be working thirty (30) hours per week atthe employer's usual place of business at the time a claim ismade. Thus, according to the Defendant, the Plaintiff is notentitled to benefits because at the time she made her claim shewas working sporadically and sometimes from home. That is to say,she was working under the temporary modifications Catlin allowed.

In support of its interpretation, the Defendant cites the Courtto two cases: Self v. Life Assurance Company of Carolina,227 S.E.2d 636 (N.C. Ct. App. 1976); Carazo v. Jefferson Pilot LifeInsurance Company, 764 F. Supp. 4 (D. Puerto Rico 1991). TheCourt finds the facts of these two cases distinguishable from thecase at bar.

Carazo involved death benefits on a life insurance policy.The plaintiff was ill and in the hospital when a new policy riderwent into effect which would have provided greater benefits thanthe prior terms of the policy. The plaintiff died shortly afterthe rider went into effect and never returned to employment. Thecourt found that the plaintiff's beneficiaries were not entitledto the benefits provided under the rider because the plaintiffhad not been in active employment when the rider went intoeffect. Carazo dealt with an amendment to a policy that went intoeffect eleven days before the plaintiff died. There was noquestion in that case that the plaintiff was covered under thepolicy, just that the rider did not become effective as to him.The Court is not confronted with an amended policy in this case.

In Self, the plaintiff brought an action to recover medicaland disability benefits under a group insurance policy issued tohis employer. The policy at issue required employees to beemployed on a full-time basis in order to be enrolled in theplan. In April 1974, the plaintiff changed his employment statusto semi-retired. As such, his salary and work hours wereofficially reduced on a permanent basis. Thereafter, he becameill and applied for benefits under the policy. The court foundthat the plaintiff was not entitled to benefits because hisenrollment in the plan ceased when his employment status changed.The court held, ". . . that a person, such as the plaintiff inthis case, who is scheduled to work only two days a week whenother employees work six, and who actually works even less thanthis limited schedule, cannot reasonably be considered as being `employed on a full-time basis'." Self, 227 S.E.2d at 639.Thus, the court based its holding on the fact that the plaintiffhad changed

permanently his position from that of a full-timeemployee to a part-time employee, one "scheduled to work only twodays a week."

In contrast, the Plaintiff in the instant matter never changedher employment status. Had her sickness been temporary, it isreasonable to conclude that the Plaintiff would have taken offsome time to recover, or worked for a period of time under somemodified program, and then returned to work full time. Under theDefendant's interpretation of the Policy, an employee who tooksick time, or vacation time, would fall in and out of coverage asthat employee fell in and out of "active employment." That is, anemployee would only be covered for those weeks that the employeeliterally worked at least thirty (30) hours at the employer'sregular place of business. Such an interpretation strains logic.People get sick and take vacations and do not cease to be enrolled in their insurance plans. Once an employeebecomes eligible for enrollment in a group insurance plan such asthe Policy in this case, coverage is continuous until thatemployee's status changes. Under the Defendant's interpretation,an employer could prevent an employee from making a claim bysimply prohibiting the employee from working thirty (30) hoursper week regardless of the status of the employee or thetemporary nature of allowing an employee to work reduced hours.The Court is not persuaded by the Defendant's interpretation.

The Court finds that the "active employment" provision in thePolicy is ambiguous as a matter of law. Applying the doctrine ofcontra proferentem, the Court construes the ambiguous term infavor of the insured. See House, 2002 WL 31729483, *6. TheCourt concludes that the "active employment" provision in thePolicy defines the beginning and ending points of an otherwisecontinuous period of coverage. An employee does not fall out of"active employment" when that employee's position is temporarilymodified due to illness, vacation, or other reasons, unless theemployee's status changes. Such was not the case here and, anyother conclusion would lead to absurd consequences.

V. BENEFITS

The Court finds, therefore, that the Plaintiff has beendisabled as defined by the Policy since the date of herseparation from employment, May 31, 2001. Therefore, it followsthat the ninety (90)-day elimination period commenced to run fromthat date. Thus, the Plaintiff is entitled to benefits beginningAugust 30, 2001.

The Policy defines disability in two stages: (1) the firsttwenty-four months of disability; and (2) the period after thefirst twenty-four months until the employee obtains the age ofsixty-five years provided the employee continues to meet thedefinition of disability throughout that time (UACL 00414). The Plaintiff asks the Court to award bothstages of benefits and find that the Plaintiff is currentlydisabled, as of the date of this Court's judgment. The Courtdeclines to award benefits beyond the initial twenty-four (24)month period. The Plaintiff will have to pursue benefits underthis second stage in a separate proceeding. Accordingly, theCourt finds that the Plaintiff is entitled to benefits for thetwenty-four (24) month period beginning August 30, 2001 andending August 30, 2003.

VI. ATTORNEY'S FEES

The Fifth Circuit has held that a district court may awardattorneys' fees upon finding an abuse of discretion of the partof an administrator in denying benefits. Vega, 188 F.3d at 302.In determining whether to award attorneys' fees, a district courtshould consider the following factors: (1) the degree of theopposing party's fault or bad faith; (2) the ability of theopposing party to satisfy an award of attorneys' fees; (3)whether an award of attorneys' fees would deter other personsacting under similar circumstances; (4) whether the partyrequesting the fees sought to benefit all participants andbeneficiaries of an ERISA plan or to resolve a significant legalquestion regarding ERISA itself; and (5) the relative merits ofthe respective parties' positions. Lain, 279 F.3d at 437-48(citing Iron Workers Local No. 272 v. Bowen, 624 F.2d 1255,1266 (5th Cir. 1980).

In this case, the Court had found that the Defendant abused itsdiscretion in denying benefits under the Policy. The Court findsthe denial particularly abusive in this case because it involvedan employee who was making her best effort to continue to workdespite serious medical conditions and an employer who caredenough about its employee to allow her some reasonable recoverytime before terminating her. The Court will not punish thislaudable behavior by adopting the Defendant's flawed interpretation of thePolicy. Under the circumstances of this case, the Court finds anaward of attorneys' fees appropriate. The Court will hold aseparate hearing at a future date to determine the appropriateamount of fees to award.

VII. CONCLUSION

In summary, the Court finds that the Plaintiff became disabledas of May 31, 2001. The Court further finds that the ninety(90)-day elimination period commenced to run on that date. Thus,the Plaintiff is entitled to receive benefits from the Defendantfor twenty-four (24) months as provided under the Policybeginning on August 30, 2001. The benefits owed are $6000 permonth less any Social Security benefits received by the Plaintiffduring this twenty-four (24) month period.

Accordingly and for the foregoing reasons, the Defendant'sMotion for Summary Judgment should be and hereby is DENIED, andthe Plaintiff's Motion for Summary Judgment is GRANTED.

1. All citations shall be to the administrative recordattached as an exhibit at record document number 7.

2. The New York Heart Association classification system isused to classify cardiovascular disease. (UACL 00454).

3. For example, the district court may consider other evidencerelated to how an administrator has interpreted terms of the planin other instances and evidence, including expert opinion, thatassists the court in understanding the medical terminology orpractice related to a claim. Estate of Bratton v. Nat'l UnionFire Ins. Co. of Pittsburg, PA, et al., 215 F.3d 516, 521(5th Cir. 2000) (citing Vega v. Nat'l Life Ins. Services,188 F.3d 287, 299 (5th Cir. 1999)).