Be A Hero To Your Injured Client:

Help Your Injured Client Obtain All The Benefits Available

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Attorneys who handle personal injury, negligence, and similar cases know how to assist their clients obtain relief from the person causing the harm or from an insurance company. Likewise, a good workers' compensation attorney will help the client recover all the workers' compensation and medical benefits the client is entitled to from the employer and insurance company.

But, if you represent an injured person, are you helping that person get all the benefits available? Are you leaving benefits on the table that could help your client? This article will suggest a few of the other benefits your client might be entitled to through work, such as continued health insurance, continued life insurance, short-term disability benefits or long-term disability benefits.

A common misconception is that a person has to be injured on the job to get these benefits, but that is not the case. Instead, these benefits can be available for injuries, and even illnesses that happen due to almost any cause. Also, if an employee has to fight for these benefits, the law that covers that dispute usually comes from ERISA, or the Employee Retirement Income Security Act of 1974.[1]

Not only is it the right thing to do to help your clients get all the benefits they might be entitled to, but by helping your client get and keep these other types of benefits, you can help your client survive financially while you help your client recover on the main case you are helping them with.

What other benefits might an injured employee be entitled to?

a. Short-term disability and long-term disability benefits.

Many employers and unions offer short-term disability (STD) and long-term disability (LTD) benefits for employees who are hurt or sick and must stop working.[2] These benefits are often offered through insurance policies that an employee can sign up for at work, although occasionally larger companies and unions offer these benefits as self-funded benefits (i.e. benefits paid for by the employer or union). Both STD and LTD benefits are designed to replace a portion of an employee's pre-disability income; typically that is 60% of the employee's earnings, but some policies offer as little as 50% or less, and others up to 75%.

STD policies are called "short-term" disability policies because they typically offer benefits for a short period of time after a person becomes disabled, often six months, but sometimes as short as three months or as much at twelve months. The definition of "disability" under an STD plan typically requires that a person only be unable to perform his or her own occupation; thus, if a person is hurt on the job, and has a workers' compensation claim, for the time that person cannot perform his or her own occupation, the injured worker may also be eligible for STD benefits.

Beware that some STD policies exclude disabilities for work-related injuries, but many do not. Also, most STD policies offset for other benefits, including workers' compensation benefits and social security disability benefits, but sometimes the STD benefits may still be high enough that the net benefits after offset are worthwhile. If a company offers STD benefits, the injured worker should apply for those benefits if he or she cannot perform her job, and find out if the injury is covered. Additionally, if the workers' compensation claim is disputed, or for some other reason temporary workers' compensation benefits are not paid or are cut off, STD benefits can provide a valuable source of income for the injured worker while the worker is pursing the workers' compensation claim.

Similar to STD benefits, but much more valuable, long-term disability (LTD) benefits can replace a portion of a person's income if the person is disabled and unable to work. However, LTD benefits last longer. Typically, LTD benefits do not start until the person has been disabled through an elimination period that is often six months, but can be as short as three months or as long as twelve; but LTD benefits usually provide benefits up to age 65, or, in some policies, up to the "normal retirement age" under the Social Security Act (currently 67).

In order to be disabled under most LTD policies, a person must prove he or she is unable to perform his or her own occupation for the first two years of the policy, and then, to continue getting benefits, the person must prove the inability to perform any occupation. However, some policies have a shorter or longer "own occupation" period, while some really good, top-end policies pay benefits up to age 65 if the person is disabled from just his or her own occupation.

Most LTD benefits are reduced by workers' compensation benefits and social security disability benefits; however, if

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workers' compensation or social security benefits are not being paid, LTD benefits can be a valuable source of income while injured workers are pursuing those other benefits. Further, if the person's pre-disability income is high enough, the net LTD benefits can be worth a significant amount of additional income.

b. Continued health insurance.

About half of the employees working for private businesses are covered by employer health plans.[3] Also, some union members have similar coverage through the union. Many people are familiar with COBRA[4], a law that requires many employers to allow employees to continue to be covered under their employer's health insurance plan if the employee is able to continue paying the premiums. While many are familiar with the basic rule that COBRA requires health coverage to continue for 18 months after a qualifying event, such as when a person stops working for the company, many are not familiar with rules that can allow health insurance COBRA coverage to continue longer. For example, there is a special rule that COBRA coverage can be extended up to 29 months if the person is found disabled by the Social Security Administration.[5]

In addition to continued coverage under COBRA, some employer-provided health insurance plans and union plans allow for continued coverage for employees who become disabled. Many such plans state that if a person is disabled, and entitled to benefits under the company-sponsored or union-sponsored LTD plan, then health insurance can continue as if the person were still an active employee, so long as the person remains disabled. And, if the person later is found to not be disabled, only then is that a qualifying event when insurance ends, at which time the person can then begin the 18 months of COBRA coverage (or 29 months if the person is found disabled by the Social Security Administration).

c. Life insurance.

Over half of the employees working for private business are covered by life insurance at work.[6] Many unions also offer life insurance. If a person passes away due to a work injury, or shortly thereafter, workers' compensation attorneys should remember to see if the employer or union offered life insurance, and encourage the deceased worker's family to file a claim.

Additionally, injured workers who don't pass away still may be able to keep their work-related life insurance coverage.

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Usually, the coverage for life insurance ends when a person is no longer "actively at work;" but, coverage can continue under two common policy provisions. Many life insurance policies offer a "life-waiver-of-premium" or "LWOP" provision that allows a person to keep the insurance, with premiums waived, if the person is disabled. Most of these policies require the person to apply in a limited amount of time, and then typically the person must prove he or she is "totally disabled" from any occupation as defined in the policy.

Additionally, many policies allow a person to convert the policy to one that covers the person who is no longer at work if they continue to pay the premiums. Like LWOP policy terms, conversion policy terms usually require the person to apply in a fairly short period of time after active employment ends. However, the premiums are often reasonable, and usually the person does not have to submit medical evidence or go through underwriting as if they were buying a new policy.

If a person is injured and unable to work under the definition of disability in the life insurance policy, the best tactic may be to both apply for the conversion and pay the premiums, to ensure the coverage remains in force, while simultaneously applying for a waiver of premium. For injured workers, who may have trouble obtaining other life insurance, continuing the life insurance offered through work may be their best chance to ensure they have the ability to provide for loved ones if they pass away.

How do those various benefits interplay with a personal injury recovery, workers' compensation benefits and each other?

Unfortunately, most STD and LTD policies contain integration clauses, or policy provisions that allow the STD or LTD carrier to offset the benefits due for any workers' compensation benefits received, as well as for social security disability benefits, pension benefits, or similar benefits. However, for people who had a higher pre-injury or pre-disability income, the difference in net benefits can still be a very valuable benefit.

For injured workers who are paid temporary total disability workers compensation benefits or some other temporary workers compensation benefits, then later settle for or are awarded a lump sum, the amount of the offset due to workers' compensation benefits may go down, and the LTD benefit become more valuable. Whether the LTD benefit may go up after the workers' compensation temporary checks stop can depend on the amount of the settlement, the language in the LTD policy, and the way the lump sum is structured in the settlement or award.[7]

While LTD benefits are offset by workers' compensation benefits, it is a mistake for employers and injured employees to think they should wait until the workers' compensation is settled before the employee files for LTD benefits. Many LTD plans require a claim to be filed within a short period of time, and this time can easily pass while the workers' compensation claim is pending. However, even if the LTD benefits would be greatly reduced or totally offset by the workers' compensation benefits, the person should apply for LTD benefits anyway, so that if the workers' compensation benefits are later settled, the LTD benefits can increase, and the person can potentially receive a valuable benefit.

Lastly, some, but not all STD and LTD plans offset for the recovery of personal injury benefits. In some cases, the language is clear, and this can be a significant offset. But, if the person had a high pre-disability wage or earnings, or if the personal injury recovery is small, the STD and LTD benefits may have significant value. Also, not all plans offset for a personal injury recovery, which can make the STD or LTD benefits a significant source of additional benefits.

How should the injured employee and the attorney find out about those benefits?

As mentioned in the introduction, when a union or private employer (but not a government employer or church) provides benefits like the STD, LTD, life insurance, or health insurance discussed above, the law controlling those benefits is the Employee Retirement Security Act of 1974 ("ERISA")[8]. ERISA rules require employers and unions, as plan administrators of such plans,[9] to act as fiduciaries to the covered employees, who must provide information about those benefits when asked. Further, as plan administrators, employers or unions that provide benefits also must provide copies of plan documents to an employee (usually called a plan participant under ERISA) who makes a written request for the documents, of be subject to a $110 penalty.[10]

When a worker is injured on the job and may no longer be able to work for a period of time, or may lose his or her job and benefits, the best course of action is for the attorney to simply write a letter asking the employer what other benefits the person may be entitled to on account of the disability, and what other benefits the person could apply to keep, and to ask for that information as soon as possible. This letter should be sent certified to the employer, as "plan administrator" of any employee benefits plans.

a. An employer or union has an obligation to respond to a request for information.

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i. ERISA fiduciary duties.

ERISA Plan Administrators, (such as employers and unions that provide benefits) and other ERISA fiduciaries (such as insurance companies that pay out the benefits) are under a fiduciary obligation to communicate with a plan participant, and to fully inform a plan participant of the material facts necessary to assist with a question about coverage or a claim for benefits.

While attorneys should do their best to ask questions about the specific benefits an employee might be interested in or entitled to, once the attorney informs the ERISA fiduciary of the employee's situation, the fiduciary should provide complete information, and even should provide information about other benefits that were not asked about, in order to best protect the rights of the employees.

ERISA requires that a fiduciary "discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—(A) for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries. . ." ERISA § 404(1), 29 U.S.C. § 1104. Courts have held that an ERISA fiduciary is specifically charged with the obligations of a trustee, who "is under a duty to communicate to the beneficiary material facts affecting the interest of the beneficiary which he knows the beneficiary does not know and which the beneficiary needs to know for his protection." *Krohn v. Huron Memorial Hospital,* 173 F.3d 542, 548 (6th Cir. 1999) (citing Restatement (Second) of Trusts). A fiduciary must give complete and accurate information in response to participant's questions. *Drennan v. General Motors,* 977 F.2d 246, 251 (6th Cir. 1992).

The duty to inform entails not only a negative duty not to misinform, but also an affirmative duty to inform when the ERISA fiduciary knows that silence might be harmful. *Krohn v. Huron Memorial Hospital,* 173 F.3d 542, 548 (6th Cir. 1999), *citing Bixler v. Central Pa. Teamsters Health and Welfare Fund,* 12 F.3d 1292, 1300 (3rd Cir. 1993). When an "ERISA beneficiary has requested information from an ERISA fiduciary who is aware of the beneficiary's status and situation, the fiduciary has an obligation to convey complete and accurate information material to the beneficiary's circumstance, even if that requires conveying information about which the beneficiary did not specifically inquire." *Killian v. Concert Health Plan,* 2013 U.S. App. LEXIS 22657, 34-35 (7th Cir., 2013). Even if the participant or his attorney does not ask just the right questions, "[r]egardless of the precision of his questions, once a beneficiary makes known his predicament, the fiduciary 'is under a duty to communicate ... all material facts in connection with the transaction which the trustee knows or should know.'" *Id.* at 34-35 (quoting Restatement (Second) of Trusts § 173, cmt. d (1959)) (other internal citations omitted).

When a fiduciary fails to inform a participant of his or her rights, and later the person discovers that certain benefits may have been available, that can lead to a claim for a breach of fiduciary duty under ERISA. "Misleading communications to plan participants regarding plan administration (for example, eligibility under a plan, the extent of benefits under a plan) will support a claim for breach of fiduciary duty." *Drennan, supra,* 977 F.2d at 251, *citing Berlin v. Michigan Bell Telephone Co.,* 858 F.2d 1154, 1163 (6th Cir. 1988). A fiduciary breaches its duties by materially misleading plan participants, regardless of whether the fiduciary's statements or omissions were made negligently or intentionally. *Berlin,* 858 F.2d at 1163-64.

ii. ERISA 502(c) provides for penalties against plan administrators (typically employers and unions) for failing to provide plan documents.

In addition to general fiduciary responsibilities, ERISA allows a participant or beneficiary to sue a plan administrator for up to $110[11] per day when the plan administrator fails to provide ERISA plan documents, such as insurance policies, summary plan descriptions describing the benefits available, and other formal plan documents, within 30 days after a written request by the plan participant or beneficiary. ERISA § 502(c), 29 U.S.C. § 1132(c). In addition to penalties, participants and beneficiaries may seek attorneys' fees for the time spent litigating a claim.

In determining whether to award penalties and how much the penalties should be, most courts look at five factors: "(1) bad faith or intentional conduct of the plan administrator, (2) length of delay, (3) number of requests made, (4) documents withheld, and (5) prejudice to the participant." *See, e.g. Gorini v. AMP Inc.,* 94 Fed. Appx. 913, 919-920 (3d Cir. 2004). Some circuits, such as the Second and Third Circuit Courts of Appeal have adopted these factors and have suggested they all must be addressed. *See, also, McDonald v. Pension Plan of the Nysa-Ila Pension Trust Fund,* 320 F.3d 151, 163 (2d Cir. 2003). Other circuits use some of these factors, but don't require all of them to be met or to weigh in one party's favor. The Court of Appeals for the Eleventh Circuit, for example, has cited these five factors, but noted that they are not prerequisites for imposing civil penalties. *Curry v. Contract Fabricators Inc. Profit Sharing Plan,* 891 F.2d 842, 847 (11th Cir. 1990). While defendant plan administrators often argue that prejudice or bad faith are prerequisites before penalties are awarded, neither is a prerequisite in the statute, and many courts don't agree either is required. *See, e.g. Gillis v. Hoechst Celanese Corp.,* 4 F.3d 1137, 1148 (3d Cir.1993); *McGrath v. Lockheed Martin Corp.,* 48 Fed. Appx. 543, 557 (6th Cir. 2002); *Moothart v. Bell,* 21 F.3d 1499, 1506 (10th Cir.1994); and, *Faircloth v. Lundy Packing Co.,* 91 F.3d 648, 659 (4th Cir.1996) (noting that "prejudice to the party requesting the documents is not a prerequisite to the imposition of penalties....").

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While the ultimate penalty and attorneys fees awarded typically vary based on the facts and on application of the various factors, and is also within the district judge's discretion, the threat of such a penalty for simply failing to provide documents should be enough to get most employers and unions to provide documents promptly. If they do not, in addition to suing for the employer's breach of fiduciary duties, participants can recover fines and attorneys where appropriate.[12]

Conclusion

If you are helping a client recover after for an injury caused by someone else's negligence, or if you are helping a client recover worker's compensation benefits, don't forget to ask the employer, or the worker's union, (if the worker was a member of a union), for any benefits the person might be entitled to on account of their injury or disability, and about whether any other benefits can continue while the person is not working. Write a letter to the employer, as plan administrator (or to the union) early in the case, and find out what coverage for these other benefits might be available and what the worker must do to apply. And, be sure to ask for the plan documents covering any such benefits, so that you can verify what your client might be entitled to and what your client needs to do to keep the coverage or apply for benefits.

By helping your client obtain more than just their personal injury or workers' compensation benefits, you can be a hero to your client. You can help your client move forward with a future including all the benefits possible.

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[1] For a discussion explaining the basics of litigating a denied ERISA claim, please visit our website at: **https://www.buchanandisability.com/helpful-resourcesandarticles/introduction-to-erisa-welfare-benefits-claims/**

[2] According to 2009 Department of Labor (DOL) statistics 38 percent of employees of private business were covered by STD plans and 31 percent were covered by LTD plans. Sean M. Anderson ***ERISA*** *Benefits litigations: An Emperical Picture*, 28 ABA Journal Lab. & Emp. Law 1, 7 (2012), *citing* U.S. Department of Labor, National Compensation Survey. Employee Benefits in the United States, March 2009 tbls 2, 9, 16 (2009).

[3] The DOL statistics show that 52 percent of employees of private businesses are covered in an employer-sponsored health plan. Anderson, supra note 1, at 7.

[4] Consolidated Omnibus Budget Reconciliation Act of 1985. 29 U.S.C. § 1161. et. seq.

[5] 29 U.S.C. § 1162(2)(A)(i) provides for continued COBRA health insurance coverage for 18 months, but that may be extended to 29 months (for both the employee and any other qualified beneficiaries, such as a spouse or dependents) if a person is found disabled under the Social Security Act. 29 U.S.C. § 1162(2)(A)(v). However, in order to extend the coverage from 18 to 29 months, the person must 1) have been found to be disabled within the first 60 days of continuation of COBRA coverage, 2) must notify the plan administrator within 60 days of the date of determination by the Social Security Administration, and 3) must provide such notice before the end of the 18 months of continued coverage.

[6] DOL statistics show that 57 percent of employees of private businesses are covered by company-sponsored life insurance plans. Anderson, supra note 1, at 7.

[7] Many attorneys who handle workers' compensation claims are familiar with the rule that when a lump-sum settlement prorates the benefits over the lifetime of the injured worker, then the lower monthly amount is used by the Social Security Administration to reduce the offset to social security benefits due to the receipt of workers' compensation benefits. Similarly, some LTD policies allow for the offset to be reduced if the workers' compensation settlement or award spreads the lump-sum over the person lifetime, so long as the language in the workers' compensation settlement is not limited "for social security purposes only." To that point, attorneys representing injured workers should not include language prorating workers compensation benefits "for social security purposes only" as this is not a requirement of the Social Security Administration, but can be used by long-term disability insurance companies as a reason to ignore the language, see Cooper v. Life Ins. Co. of N. Am., 2011 U.S. Dist. LEXIS 21026 (E.D. Tenn. Mar. 2, 2011).

[8] For a longer paper to learn whether ERISA applies to your client's benefits, please visit our website at **https://www.buchanandisability.com/helpful-resourcesandarticles/how-to-tell-if-an-insurance-claim/**

[9] Technically, ERISA states that the plan administrator of a plan is whoever is named as the plan administrator under the terms of the plan, and if no one is named, it is deemed to be the plan sponsor (i.e., the employer or union who provided the benefits) who is the plan administrator. ERISA § 3, 29 U.S.C. § 1002. In the vast majority of cases, the employer or union is named as the plan administrator.

[10] ERISA § 502(c), 29 U.S.C. § 1132(c) provides for these penalties. Insurance companies that pay the actual benefits, and that usually make determinations about whether an employee is entitled to the benefits, etc., are also ERISA fiduciaries, and have an obligation to provide information upon request, but they are not usually plan administrators, and therefore are not subject to the $110 penalties in most circuits.

[11] As required by the Debt Collection Improvement Act of 1996, the $100 limit found in the text of the statute has been increased to $110 for violations after July 29, 1997. 62 Fed. Reg. 40696.

[12] For a full discussion of an employee's rights to obtain plan documents, and seek penalties if they are not provided, please visit our website at **https://www.buchanandisability.com/helpful-resourcesandarticles/erisa-502c-actions/**