CARLTON FIELDS

Circuit Courts Continue to Navigate ERISA's Murky Waters

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The Sixth Circuit Court of Appeals ruled in *Fulkerson v. Unum Life Insurance Company of America* that the beneficiary of an ERISA-covered life insurance policy was not entitled to accidental death and dismemberment (AD&D) benefits because such benefits were precluded by the crime exclusion in the policy. Daniel Tymoc had group life insurance through his employer that provided basic life insurance coverage as well as an additional AD&D benefit. The insured died in a single-car accident while speeding 20-40 miles above the posted speed limit and driving recklessly. The insurance company paid his mother, the beneficiary of the policy, basic life insurance benefits of $100,000 but denied the AD&D benefit because the insured's conduct at the time of the accident that caused his death — speeding and reckless driving — fell within the policy's crime exclusion. The district court granted the mother's motion for judgment on the pleadings and awarded her the AD&D benefits. The Sixth Circuit reversed, holding that the plain and ordinary meaning of the crime exclusion that precludes AD&D benefits for "any accidental losses caused by, contributed to by, or resulting from … an attempt to commit or commission of a crime" includes reckless driving because it is a punishable offense "in every state in the Union." The court declined to consider whether speeding would similarly trigger the crime exclusion.

In *Bunner v. Dearborn National Life Insurance Co.*, the Fifth Circuit Court of Appeals affirmed summary judgment for the insurer following the denial of long-term disability (LTD) benefits under an employer-sponsored disability plan due to a preexisting condition exclusion in the disability policy. The plaintiff had a brain tumor removed in 2015 and received postoperative radiation therapy and chemotherapy. In December 2015 and October 2016, a physician evaluated the plaintiff and noted impairments in learning and memory, and a decline in attention, working memory, and left-hand dexterity, but she "maintained adequate daily functional capacities." The week following her second (October 2016) evaluation, the plaintiff commenced work with a commercial real estate company and claimed that she was assured that her preexisting condition would not preclude coverage despite contrary language in the materials provided to her during enrollment. The plaintiff requested and was granted short-term disability benefits commencing in March 2017. Several months later, she applied for LTD benefits claiming that her disability arose from cognitive impairments rather than the treatment for her brain cancer. After de novo review of the administrative record, the court

found that the medical evaluation conducted just days before the plaintiff's start date revealed the very cognitive decline that continued its advance and further disabled her some months later. To hold otherwise, the court noted, would require a finding that "two separate events of cognitive decline occurred," which the record did not support.

The Eleventh Circuit Court of Appeals recently addressed two issues of first impression before the court. In *Gimeno v. NCHMD Inc.*, the panel considered whether ERISA Section 1132(a)(3) creates a cause of action for an ERISA beneficiary to recover monetary benefits lost due to a breach of fiduciary duty in the plan enrollment process. The court answered the question in the affirmative. Justin Polga was a medical doctor employed by NCHMD. When he was hired, NCHMD's human resources staff helped Polga complete enrollment paperwork for life insurance benefits through an ERISA plan. Polga's spouse was the primary beneficiary under the plan. Polga received $150,000 in employer-paid life insurance coverage and elected to pay for $350,000 in supplemental coverage. To receive supplemental coverage, Polga needed to complete an insurability form but the form was not provided with his enrollment paperwork, nor was he notified that the form was necessary or missing. Yet, for three years, NCHMD deducted premiums for the life insurance from Polga's paychecks and provided him with a benefits summary stating he had $500,000 in coverage. Following Polga's death, NCHMD refused to pay any supplemental benefits because it never received the insurability form. Although Section 1132(a)(3) authorizes a beneficiary of an employment benefit plan to sue for "appropriate equitable relief" for violations of ERISA or the terms of the plan, the court held that the principle of equitable surcharge, an equitable remedy between beneficiaries and fiduciaries, should be construed to allow a claim for monetary compensation resulting from a fiduciary's breach of duty. In so doing, the Eleventh Circuit now follows the Second, Fourth, Fifth, Seventh, Eighth, and Ninth Circuits in recognizing that Section 1132(a)(3) creates a cause of action for monetary relief for breach of fiduciary duty.

The Eleventh Circuit also addressed whether a district court has the discretion to consider information outside the administrative record on de novo review. In Harris v. Lincoln National Life Insurance Co., the court looked to sister circuits to determine the appropriate scope of review and joined with the Third and D.C. Circuits in holding that de novo review requires district courts to consider all relevant evidence, irrespective of whether it was presented to the plan administrator or post-dates the benefit determination. The rationale is that in conducting de novo review, the district court must put itself in the administrator's place. In contrast, when conducting a review of an ERISA benefits denial under an arbitrary and capricious standard, the Eleventh Circuit holds that the role of the district court is to determine whether there was a reasonable basis for the decision based on facts known to the administrator at the time the decision was made.

Authored By

Irma Reboso Solares

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