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SPECIAL REPORT

WHERE DOES IT SAY I HAVE PERSONAL LIABILITY?

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THE IMPORTANCE OF FIDUCIARY LIABILITY INSURANCE
(IT'S NOT JUST ABOUT 401(K) PLANS)
2017 REPORT

WHAT IS FIDUCIARY LIABILITY INSURANCE

- Fiduciary liability insurance will defend and pay, where required, for settlement and judgments arising out of employee benefit plans that are governed by the Federal ERISA statute.

PERSONAL LIABILITY OF A FIDUCIARY

- Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary. A fiduciary may also be removed for a violation of section 1111 of this title.

WHEN IS A PERSON A FIDUCIARY

A. According to ERISA, a person is a fiduciary with respect to a plan to the extent:

(1) they exercise any discretionary authority or discretionary control respecting management of such plan or exercise any authority or control respecting management or disposition of its assets;

(2) they render investment advice for a fee or other compensation, direct or indirect, with respect to any monies or other property of such plan, or have any authority or responsibility to do so, or;

(3) they have any discretionary authority or discretionary responsibility in the administration of such plan. This includes any person designated under Section 1105(c)(1)(B) of this title.

Plan fiduciaries may include, for example, plan trustees, plan administrators, members of a plan's investment committee or a service provider.

B. The plan administrator is the person specifically designated in the plan document or, in most cases, the plan sponsor. The plan administrator oversees the operation of the plan. This should not be confused with a third-party administrator (TPA) who serves as a contract administrator.

TYPES OF FIDUCIARY LIABILITY CLAIMS

1.	Hidden Costs	9.	Denial of Life Claim
2.	Autism	10.	Failure to Inform, re: Plan Change
3.	Experimental Treatment	11.	Mishandling Plan Funds
4.	Disability Claim Denials	12.	Plan Termination
5.	Change from Defined Benefit to Defined Contribution	13.	Misappropriation of Funds
6.	Failure to Monitor Fees	14.	Class Action by Former Employees
7.	Imprudent Plan Selection	15.	ESOP Issues
8.	Who is a Fiduciary?		

- **Many business people say that they are not concerned about claims against them as the fiduciary of their 401(k) Plan because it is "self-directed."**

  – As you can see, in a random sampling of ERISA claims, only 39% of the claims actually relate to 401(k) Plans.

THE FOLLOWING SAMPLING OF BENEFIT PLANS DEMONSTRATES THAT THE MAJORITY OF ERISA CLAIMS RELATE TO OTHER EMPLOYEE BENEFITS SUCH AS GROUP HEALTH, GROUP LIFE, GROUP DISABILITY, AND ESOP CLAIMS.

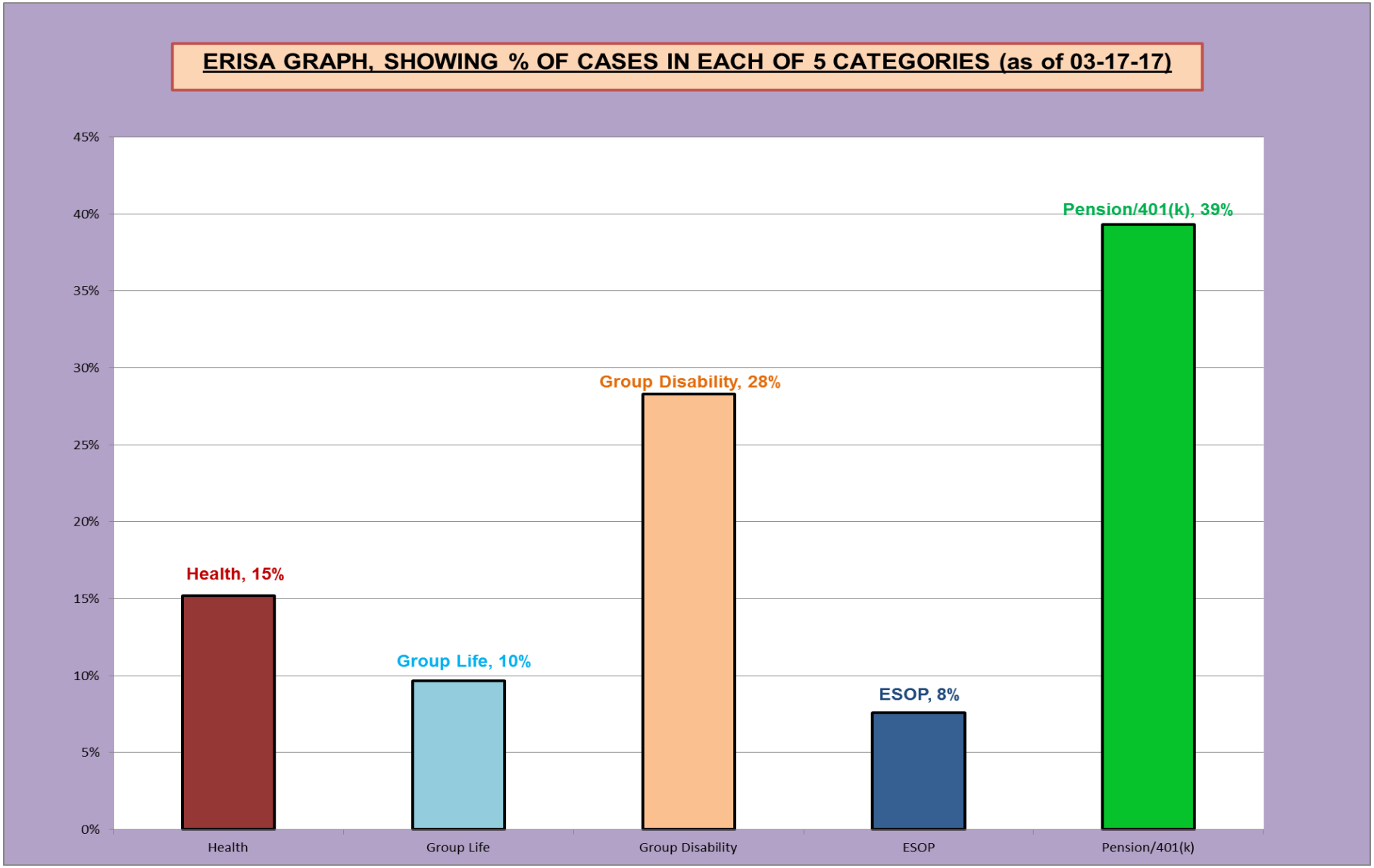
- The ERISA statute relates to all employee benefit plans, not just a pension and 401(k) plans. A sampling of 145 random ERISA claims show the breakdown by <u>type of employee benefit plan:</u>

BENEFIT PLANS	# OF CLAIMS
• Health Insurance	22
• Group Life	14
• Group Disability	41
• ESOP	11
• Pension Plans & 401(k) Plans	57
TOTAL	**145**

88 of 145 claims (or 61%) of ERISA claims are for other than 401(k) claims.

(See the following descriptions of actual ERISA / Fiduciary claims.)

NOTE: This ERISA graph represents 145 cases studied in 5 categories.



DESCRIPTIONS OF ERISA / FIDUCIARY CLAIMS

1.	**Rochow v Life Insurance Company of N.A.** *2013-Denial of Disability Benefits. $910,629 becomes $3,797,867*	**Fiduciary Duty Claim**. Employer forced plaintiff to resign in 2002 due to short term memory loss, etc. whereby he could no longer perform his duties as president. A month later he was diagnosed with HSV-Encephalitis, a rare and severely debilitating brain infection. LINA denied **long-term disability** benefits because his employment ended before his disability began. ERISA has a goal of ensuring that plan fiduciaries act solely in the interest of the participants and providing benefits, not in punishing the defendant, while also having a goal of providing inexpensive and expeditious dispute resolution. Although discovery may slow down litigation in some cases, risk of liability and extensive discovery will act as an incentive to ensure plan administrators act in the interest of the plan participants throughout the claims process. Facts showed that LINA continually ignored its own plan definitions, wrongly denying benefits for 5 years after the initial request. Plaintiff recovered an additional award for disgorgement of profits in the amount of $3.8M as damages for the breach of fiduciary duty claim in addition to denied benefits.
2.	**Kimberly A. Frazier v Life Ins. Co. of N.A.** *Long-Term Disability*	Employee working as a "mail sorter" for a publishers printing company sought to obtain **long-term disability** ("LTD") and other benefits allegedly owed her under an employer-sponsored insurance policy when, at the age of 42, she suffered pain in her back that radiated down both legs, underwent an MRI of her lumbar spine, began physical therapy and later lumbar epidural injections. Her employer's benefit plan administrator had the discretionary authority to deny the claim, which it did.
3.	**Confidential** *Autism Denied Under Group Health*	In an ERISA claim alleging that the plan administrator acted arbitrarily in denying insurance benefits, two families of children with autism brought suit against defendant national insurance company and its subsidiaries in a federal court on behalf of all other similarly-situated families who were denied coverage for applied behavior analysis therapy. The insurer had designated coverage as "experimental."
4.	**CIGNA Corp. v Amara** *Change from "Defined Benefit" to "Defined Contribution Plan"*	CIGNA changed its **pension plan** from a **"defined benefit plan"** to a "cash balance" **defined contribution** plan in 1998. To do this, they converted the previously accumulated old-plan benefits to an "opening amount" in each employee's cash balance account. The method for making and calculating this opening amount became a source of dispute. A class of about 25,000 beneficiaries sued.
5.	**Tussey v Abb** *401(k) Administrative Fees*	The district court certified the case to be a class action suit and refused to dismiss the case, also ruling that failure to disclose revenue sharing payments to plan participants is not a breach of fiduciary duty, as it is not explicitly required by ERISA or the DOL (Dept. of Labor). Following a 4-week bench trial, favor was found with the plaintiffs, awarding damages of nearly $37,000. Result: $35M verdict against **401(k) plan** fiduciaries, plus $1.7M against provider for improper use of "float" income. **Failure to monitor administrative fees, failures as to fund selection, and misuse of revenue sharing** for non-plan related purposes.
6.	**Tibble v Edison Int'l** *401(k) Imprudent Plan Selection*	Facts of the case included allegations of fiduciary breach and prohibited transactions relating to investment funds, revenue sharing and other matters. Verdict was made against **401(k) plan fiduciaries** for using **more expensive share classes**.

7.	**Scarangella v Group Health** *Medical Benefits Eligibility*	In a claim for **medical benefits**, the wife of a Village Fuel employee incurred medical expenses. The carrier, GHI, determined that her husband and family **did not satisfy the eligibility requirements** and denied reimbursement.
8.	**Leimkuehler v Aul** *401(k) - Who is a Fiduciary*	AUL provided a variable annuity contract platform for plaintiff's **401(k) plan** and received revenue sharing from funds. Plaintiffs and DOL claimed functional fiduciary status for AUL. All 3 theories brought to **establish fiduciary status** for AUL were rejected; i.e., selecting available funds under FAC ≠ fiduciary status; authority over general account ≠ fiduciary authority over mutual funds/revenue sharing; non-exercise of discretion over plan investments ≠ fiduciary status.
9.	**Moon v BWX Technologies** *Denial of Life Insurance*	Plaintiff sued in the Circuit Court for payment of deceased husband's **life insurance** under the company plan when former employer denied claim based on the fact that husband was on LTD and his **termination of employment made him ineligible** for life insurance.
10.	**Porter v Lowe's** *Denial of Death Benefits*	The surviving spouse of a Lowe's employee, who participated in a **death benefits plan,** sued when his wife died in a car crash while driving to work to respond to an alarm. The plan administrator denied the death benefit claim because the plan excluded death sustained "during travel to and from work."
11.	**Graf v DaimlerChrysler** *Denial of Disability*	Plaintiff sued in state court alleging that he was discharged in violation of Sect. 510 of ERISA after seeking continued entitlement to **disability benefits** under defendant-employer's benefit plan.
12.	**Peterman v Metro Life** *Failure to Inform of Plan Change*	Plaintiff-wife asserted that defendant-ERISA plan administrator breached its fiduciary duty to her decedent husband by allegedly not informing him regarding a **change in his plan** coverage.
13.	**Hahn Acquisition Corp v Hahn et al.** *Mishandling of Plan Funds*	Plaintiff-corporation brought an ERISA action against **benefit plan** fiduciaries, claiming the fiduciaries **mishandled plan funds**.
14.	**Hamilton et al. v Carell et al.** *Who is a Fiduciary*	Plaintiff-independent **ERISA trust fund fiduciary** sued defendant-**third party administrator** regarding alleged **breaches of fiduciary duties** arising out of certain investment services defendant provided to the fund.

15.	**Briscoe et al. v Fine et al.** *Who is a Fiduciary*	Employees filed a class-action lawsuit against 5 defendant-employer's (Fine) former officers and directors and third-party administrator of its **healthcare plan,** Preferred Health Plan, alleging that plaintiffs **violated their fiduciary duties** imposed by ERISA.
16.	**Hoger v Rospatch Corp** *Who is a Plan Fiduciary*	Plaintiff sued defendant-employer for an ERISA violation. Defendant did not have ERISA liability because it was not the plan fiduciary and never knew about the ERISA violation. After a corporate reorganization, defendant terminated plaintiff CEO of one of defendant's subsidiaries. Plaintiff sued for violation of ERISA by company **failing to put stock in his 401(k) plan.**
17.	**Miller v Retirement Funding Corp** *Breach of Fiduciary Duties*	Plaintiff was trustee of a **defined benefit plan which received investment advice from defendant**. But, some of the advice was unsound and caused the plan financial losses. The plan was terminated and replaced. Plaintiff sued defendant for breach of fiduciary duties under ERISA and for state law claims.
18.	**James et al. v Pirelli Armstrong Tire Corp** *Misled Employee, re: Early Retirement Pkg*	Former employer misled plaintiff about **ERISA medical benefits** as part of an **early retirement package.** Federal district court erred by limiting relief to only those individuals who directly asked questions about the benefits and were given misleading information.
19.	**Guyan v Professional Benefits Administrators** *Fiduciary Misappropriated Plan Funds*	Four company plaintiffs (Permco, Precision Gear, Pritchard, and HAPCA) had each established an **employee benefit plan** under ERISA funded by employer contributions and covered employee payroll deductions. PBA would provide the services for the plans. PBA Federal district court ruled that defendant was a fiduciary with respect to plaintiffs' employee benefit plans and therefore could be sued for breaching its duty as an ERISA fiduciary after it **misappropriated over $1.4M in plan funds** for its own purposes while medical claims remained unpaid.
20.	**Richards v GM** *Breach of Fiduciary Duty*	Defendant-employer acting in bad faith **breached fiduciary duties owed to plaintiffs under ERISA** by firing plaintiffs and unilaterally offsetting … non-forfeitable benefits in the **stock option purchase plan**.
21.	**Griffin et al. v Flagstar Bancorp, Inc., et al.** *Class Action by Former Employees*	Class-action lawsuit was filed by 2,952 **401(k)** plan participants, all former Flagstar Bank employees, who claimed ERISA duties were breached by **continuing to offer its own stock as an investment option even though the bank was in serious financial trouble.**

22.	**Hi-Lex Controls, Inc., et al. v Blue Cross and Blue Shield of Michigan** *Hidden Surcharge and Illegal Self Dealing of Fiduciary*	Hi-Lex corporation, on behalf of itself and the Hi-Lex Health & Welfare Plan, filed suit in 2011 alleging that BCBSM **breached its fiduciary duty** under ERISA by inflating hospital claims by as much as 13% with **hidden surcharges**, keeping the markups as additional administrative compensation, then providing false reports that hid the markups.
23.	**Smith, et al. v Provident Bank, et al.** *Trustee Breached Fiduciary Duty – Conversion*	ERISA **benefit plan trustee** breached its fiduciary duty to a plan participant after being **replaced as plan trustee** because it was still a fiduciary because it controlled the plan assets. Six months after participant instructed Provident to purchase shares of Ameritrust Bank **stock,** Provident was removed as trustee for the Plans and was replaced by Society Bank. Weeks later he discovered Ameritrust shares were missing from his account. Provident had transferred the money which represented the purchase price less dividends he had received. However, the **shares had largely increased**. It was disputed as to what he should be compensated because the value of the stock continued to rise. He and the plans filed an ERISA action against Provident for its fiduciary duty as plan trustee and for damages.
24.	**Best, et al. v Cyrus** *Breach of Duty – Failure to File 5500 Forms*	In error, the federal district court ruled that defendant-ERISA **plan trustee** could not be liable for breach of his fiduciary duties when he did **not ensure that contributions and repayments** were made to the plan. Even though he was not specifically directed to act under the plan document, he still breached his fiduciary duties because a trustee has a duty to act in the interest of the plan's beneficiaries. ERISA imposes additional duties on trustees through its incorporation of the common law of trusts.
25.	**Quade v Anderson, et al.** *Plan Sued to Recover Benefits it Paid*	Even though defendants were holding funds owed to plaintiff's **welfare benefit plan**, defendants did not qualify as "fiduciaries" under ERISA. Injured in a hunting accident, defendant's medical expenses were paid by plaintiff's welfare benefit plan. According to the plan, it became subrogated to any damages he received from the tortfeasor. After hiring defendant attorney to sue and obtaining a large settlement, plaintiff wanted the entire amount. Plaintiff has moved for summary judgment. The court must **reject the view that defendants are "fiduciaries" because they had authority over the disposition of plan assets**. Plaintiff may be able to recover the funds under a federal common law breach of contract theory.
26.	**Lower, et al. v Albert, et al.** *Former Manager Sued, re: ESOP Stock Transfer*	Plaintiffs, former managers of defendant-corporation, claimed that individual defendants, directors of the corporation as well as trustees of an employee stock ownership trust, told them that company stock would be put into the **ESOT and ESOP**. Instead, available stock was sold to the individual defendants personally.
27.	**Holsey v Unum Life Ins. Co. of America, et al.** *Disability Claim Denial*	Anesthesiologist Plaintiff sued defendant-employer and insurance company claiming he was wrongfully denied **disability** payments when he became totally disabled due to blindness. He also has diabetes. When applying for disability benefits, he was told there was a **pre-existing** condition exclusion. Plaintiff argued he was misled as to his benefits.

28.	**Van Noord v Advantage Health, et al.** *Dispute was Life Benefit*	Where the amount of **life insurance benefits** defendant-employer agreed to provide plaintiff's husband was ambiguous, defendant must pay plaintiff the greater amount. Where a summary of an ERISA plan is different than the actual plan, the circuit court ruled that the summary may be relied upon by the employee. Where there is an ambiguity in benefit coverage in ERISA plans, the court must construe that **ambiguity in favor of the employee.**
29.	**Grindstaff, et al. v Green, et al.** *Claim Against Fiduciary, re: ESOP*	Plaintiff-employees and their union sued defendant-corporation and others for breach of fiduciary duty under ERISA. Plaintiffs' claims centered around an ESOP.
30.	**Olson v Chem-Trend Inc.** *Claim Against Fiduciary, re: ESOP*	During his employment, plaintiff participated in defendant's employee stock option plan (ESOP) and accumulated 744 shares of stock. After discharge, he asked for **redemption of the ESOP stock**. Defendant used a recent audit to value the stock at $126.58 per share. Eight months later, the president retired and the company was sold. The ESOP stock was sold for $270 per share. Plaintiff sued defendant with regard to the redemption of his stock, believing they assigned an unrealistically low value to his stock and withheld information about the impending sale of the company.
31.	**Wright, et al. v Heyne, et al.** *Investment Advisors Sued for Breach of Fiduciary Duties*	Plaintiff-ERISA plan trustees sued defendant-investment advisors for breaching **fiduciary duties** when making **investment decisions and charging commissions.**
32.	**Judge v Metropolitan Life Ins. Co.** *Life Insurance Policy Dispute, MetLife Denied*	Plaintiff plan participant was covered by his employer's term **life insurance** policy which provided for early payment of benefits if employee became permanently disabled, which was defined by the plan as being unable to do the employee's own job and any other job for which he was fit by education, training or experience. Plaintiff was a baggage handler and ramp agent for Delta Airlines, underwent heart surgery and applied for benefits, not being able to return to any type of work. His treating providers recommended restrictions, but he was recovering with no evidence of complications. His doctors advised against returning to work. Key Issues: Was MetLife required to 1) obtain vocational evidence, 2) send plaintiff for an IME, 3) use a doctor, rather than nurse, to review medical files? Answer to all, "No." In 2013, the court found that plaintiff was **not permanently disabled** and that MetLife had no conflict of interest that affected its denial decision.
33.	**Gardner v Heartland Industrial Partners** *Former Metaldyne Execs Sued*	During the sale of Metaldyne, an automotive supplier, the prospective buyer, Ripplewood, discovered that Metaldyne would owe plaintiffs, former executives, approximately $13M as a result of the sale, under a **change-of-control provision** in its Metaldyne's **SERP** "Supplemental Executive Retirement Plan." It threatened to back out of the deal. In response, executives persuaded Metaldyne's Board to declare the SERP invalid without notifying plaintiffs. The sale closed a month later. One executive personally collected more than $10M as a result. Plaintiffs claimed tortious interference with contractual relations. Plaintiffs were not seeking their SERP benefits;

	Metaldyne's Owner and other execs re: SERP Plan	therefore they did not have a claim for benefits under ERISA. Rather, they sought damages from defendants, and not from SERP, for defendants' **tortious activity.**
34.	**US Airways v McCutchen** *Recouping of Med Costs Paid*	Injured by a third party's negligent driving in a car accident, plaintiff's employer-sponsored **health benefits plan paid his medical bills. Plaintiff retained attorneys, seeking to recover all of his accident-related damages estimated at $1,000,000.**
35.	**Bidwell/Wilson v University Medical Center/Lincoln Retirement Services Co.** *401(k) Investment Choices*	Breach of fiduciary duty under ERISA in connection with the transfer of Bidwell's and Wilson's **investments** from a stable value fund to a Qualified Default Investment Alternative was denied. Upon proper notice, participants who previously elected a specific investment could become non-electing plan participants if they **fail to respond to a specific request for an election**. The court found that the method of notice was sufficient because it was "reasonably calculated to ensure actual receipt." Participants who fail to take requested action after having been given notice should not be heard to complain of the consequences.
36.	**Seaway Food Town, Inc. v Medical Mutual of Ohio** *Did Not Act as Fiduciary*	Seaway alleged that BC/BS breached its fiduciary duties to Seaway by failing to (1) use accurate data to estimate the amount of discounts BC/BS expected to receive from **healthcare** providers, (2) disclose the true nature and extent of the **provider discounts** it actually received, and (3) pass along to Seaway the provider discounts it actually received. Seaway also alleged Ohio common law claims of breach of contract and conversion.
37.	**Libbey-Owens-Ford Co v BCBS of Ohio, et al.** *Restitution of Rebates*	Defendant, BCBS, received claims from **medical providers**, paid them, and had the authority to resolve disputes over coverage and claims. When it paid hospital claims, defendant customarily received a 3% discount or rebate, as well as other rebates when it eliminated any unnecessary charges. Defendant did not pass these rebates along to plaintiff. Plaintiff sued for an **accounting and restitution of the rebates.**
38.	**Mich. Affiliated Health Care System v CC Systems** *Who is a Plan Fiduciary*	Employee was diagnosed with breast cancer, her doctor recommended specific bone marrow transplant with high-dose chemotherapy, **coverage was denied** by defendant-plan administrator (CC Systems) because of the **experimental nature** of the treatment, and claim was referred to plaintiff-employer (Lansing General), who authorized treatment and paid for the treatment. But, when plaintiff submitted its claim to defendant-SLI, SLI denied it because treatment was experimental.
39.	**Hoeberling v Nolan** *Profit Sharing Plan - Dismissed*	Plaintiff sued in his "individual capacity" for defendant's breach of fiduciary duties in connection with the management of an ERISA **profit sharing plan's investments**.

40.	**Kuper, et al. v Iovenko, et al.** *Employee Stock Ownership Plan*	Former salaried employee-plaintiffs participated in a **Savings and Stock Ownership Plan** including both a voluntary 401(k) plan and an **ESOP** (employee stock ownership plan). Even though the stock contained in defendant-corporation's ESOP declined in value between the sale of a subsidiary and the stock's eventual transfer to the subsidiary's benefit plan, the trial court properly found that defendant's plan administrators did not violate their fiduciary duties by failing to immediately distribute the stock or diversify the stock.
41.	**Allinder v Inter-City Products Corp. (USA)** *Disability*	Defendant sprayed plaintiff's workplace with termite pesticide. Plaintiff's adverse reaction to the chemical forced her to quit work. Plaintiff filled out the claimant's section of the **long-term disability benefits** form; however, defendant refused to fill out its section because it believed she was ineligible for benefits. Bypassing defendant, plaintiff was able to receive full disability benefits from the disability insurance provider 4 years later. Despite recovery, **plaintiff sued defendant-employer under ERISA for 1) breach of its duty** to provide requested information about a disability plan and 2) damages for breach of fiduciary duties.
42.	**Sengpiel v B F Goodrich** *Transfer of Retiree's Pension and Welfare Benefits*	When B.F. Goodrich (BFG) spun off its tire division to a new company as a joint venture with Uniroyal Tire Company, it **transferred its retirees' pension and welfare benefits** obligation to the new company. Issues on appeal are: 1) Whether in effecting this transfer BFG violated its **fiduciary duties** under ERISA and 2) Whether the transferred retirees were denied benefits promised to them.
43.	**Dawson, et al. v Detroit Lumber & Building Ass'n Retirement Plan, et al.** *Termination of Employee Benefit Plan*	During the seven years or so that plan trustees decided to **terminate its employee benefit plan** and when the actual termination commenced, the Pension Benefit Guaranty Corporation objected to the termination. During those years, other employers contributing to the plan incurred **extra financial obligations**. Plaintiffs sued the plan, defendant-McLeods, and others, alleging violation of ERISA.
44.	**Consumers Energy v Smith Barney Corp. Trust v Comerica Bank** *Breach of Fiduciary Duties*	Defendant-investment firm, SBCT, was under the mistaken impression that plaintiff-plan administrator replaced defendant as an individual plan custodian, **liquidating savings and pension plan** investments. Investments were liquidated and plaintiff was sent the proceeds. Plaintiff says the liquidation was a mistake and that it was only replacing the "general custodian" with Comerica (third-party defendant) and not the individual custodians, such as defendant. Plaintiff sued for breach of fiduciary duties.
45.	**Schaefer v Multibrand** *Indemnity Agreements are Enforceable for Fiduciary Duty Breaches*	In a settled Dept. of Labor claim, plaintiff-corporate directors and trustees were claimed to have breached their fiduciary duties by purchasing company **stock at inflated prices** for employee stock ownership plans. An arbitrator concluded that an **indemnification agreement** was void, disregarding clearly established legal precedent, including that of the Sixth Circuit court, that they are enforceable. Result: Sect. 410(a) of ERISA declares that if there is any provision in an agreement that purports to relieve a fiduciary from responsibility, diminishing its statutory obligations, it shall be void as against public policy. However, Sect. 410(b) provides that **insurance may be purchased to cover a fiduciary's potential liability.**

46.	**Tassinere v American Nat'l Ins. Co.** *Director Liability – Breach of Fiduciary Duty*	Plaintiff-agents filed a suit against defendant-directors for breach of fiduciary duty. Plaintiffs appealed the dismissal and alleged that defendant failed to secure certain **pension benefits**.
47.	**Burmania v Hartford** *Denial of Long-Term Disability Benefits*	Plaintiff suffered from multiple objectively verified medical conditions, causing him pain and limiting his ability to walk, stand, squat, and bend. The issue on appeal was whether those problems prevented him from performing sedentary work or not. Plaintiff contended that the denial of his claim for long-term disability benefits was arbitrary and capricious because defendant did not have any rational basis for ignoring the opinions of his three treating physicians in favor of the flawed opinions of two non-treating physicians which defendant paid for in order to review his claim for disability benefits.
48.	**Wohlfert v Sealed Power Technologies Accidental Death & Dismemberment Plan** *When does Life Insurance Benefit Go Into Effect?*	Plaintiff's husband was enrolled in the $100,000 **life insurance coverage benefit** plan provided for employees by defendant-SPT. Only **active workers** could receive benefits. Laid off workers were eligible for the benefit if they paid the premiums themselves. When plaintiff was laid off he did not continue payment of the premium. The parties dispute whether he was given information about the payment option. Though he was scheduled to return from layoff of a specific day, the personnel office called him on that day, extending his layoff for another week. Plaintiff claims defendant told him that his benefits would go into effect during that week. Defendant denies this. **Plaintiff drowned on the morning he was to return back to work**, just hours before his shift began. Plaintiff sought insurance benefits claiming her husband had become an active worker on that day. Defendants refused to provide the insurance, arguing he had not become an active worker until he actually resumed working.
49.	**Wernimont v Unum Ins. Co.** *Long-Term Disability*	Not long after an auto accident injury, plaintiff began to report a number of neurological symptoms and his employer noticed his pace and quantity of work decreased during his contract term at Fiduciary Solutions. Six months later he was informed his contract would be terminated. Plaintiff submitted a **long-term disability** claim to the defendant who denied the benefits because plaintiff had not 1) sustained the necessary 20% loss in earnings required by the definition of disability and 2) plaintiff had not demonstrated lost income due to sickness or injury.
50.	**Gregg, et al. v Transp. Workers of America Int'l, et al.** *Breach of Fiduciary Duties*	Plaintiff-members believed defendant-union **breached its fiduciary duties** regarding **insurance premiums**. Plaintiffs participated in questions/answer sessions regarding the policy. Defendants distributed bulletins as well as question/answer sheets. Defendants' answers to questions were extraordinarily misleading or outright false. Sufficient evidence was provided that showed **incomplete and inaccurate information** was given.
51.	**Taveras v UBS AG** *401(k) Company Stock Investment*	This 2nd Circuit Court case involved two UBS **401(k) plans** that held UBS stock as an investment. The price declined over 74% from trading high. "*Moench"* presumption of prudence upheld for plan that stated that UBS stock "shall" be an investment option. No **presumption of prudence** for plan that did not require or strongly encourage company stock investments.

52.	**Harris v Amgen, Inc.** *401(k) Company Stock Investment*	A 9th Circuit Court case involved two Amgen **401(k) plans** that held company stock as an investment. There was a price decline due to publicity of drug safety concerns. There was no presumption of prudence because plans provided only that they "may" provide for a company stock fund.
53.	**Andochick v Byrd** *Retirement and Life Insurance Plan Beneficiary Payments*	ERISA preempted a state court order requiring Andochick to turn over benefits received under ERISA **retirement and life insurance** plans owned by his deceased ex-wife. ERISA obligates a plan administrator to pay plan proceeds to the named beneficiary, here Andochick. The only question before the court was whether ERISA prohibits a state court from ordering Andochick, who had previously waived his right to those benefits, to relinquish them to the administrators of his ex-wife's estate.
54.	**"In-House" Plan Litigations (3)** *401(k) Mutual Fund Choices Benefit Company*	3 Cases, re: Retirement Plan Investment. Plaintiffs **pulled fund providers under ERISA fiduciary umbrella via their own plan sponsorship**. **Conflict of interest** equaled less deferential court review of fiduciary conduct. Satisfaction of **PT exemption** unequaled prudent fiduciary conduct. 1) Bilewicz v FMR (Fidelity): The claim was that Fidelity's **officers chose high-fee Fidelity mutual fund products to benefit Fidelity**. Evidence indicated that they repeatedly added funds to the plan with little or no track record, the plan's fees were very high for a multi-billion dollar plan, and that they failed to follow **sound fiduciary practices** for multi-billion dollar plans. Plaintiffs sought to make this case a class action. 2) Knee v JP Morgan: This ERISA case concerned fairly complex retirement plan investment fund structures. Ultimately, the case was a simple scheme of **self-dealing**. Defendants abused their fiduciary responsibilities to acquire control from another company of a "stable" retirement fund by first driving it into the ground and then acquiring its asset management and participants at no cost. In a 72-page Arbitration Award against JPM and in favor of that company, American Century Corporation, the arbitrators found that JPM had committed the **wrongful conduct** alleged and awarded American Century in excess of $132M in damages. 3) Krueger v Ameriprise: Plaintiffs alleged that Ameriprise and plan fiduciaries **breached their fiduciary duty** under ERISA with respect to the Ameriprise 401(k) plan by using Ameriprise-affiliated funds in the fund menu and that these funds charged excessive fees or underperformed relevant benchmarks. Other issues involved the use by "in-house" plans of financial services companies of **"in-house" funds**. The issue regarded the application of ERISA's prudence standard to the selection and monitoring of funds in a 401(k) plan fund menu and the application of the rules laid out in that regard.
55.	**Plambeck v The Kroger Co.** *Medical Claim Denied*	Plaintiff asserted a claim for money contending a right to equitable relief to be reimbursed for a **denied medical claim** for the amount she would have been reimbursed if her medical claim had not been denied under her health insurance.
56.	**DiFelice v U.S. Airways** *401(k) Savings Plan – Stock Drop case*	Participants in US Airways' **401(k) Savings Plan** filed a case against US Airways and the plan's directed trustee, alleging a **breach of fiduciary duties** by 1) failing to provide complete and accurate information regarding investments in USAG stock, and 2) including USAG stock as an investment option in the plan in light of USAG's directors and officers liability financial condition.

57.	**Edgar v Avaya, Inc.** *401(k) Plan's Failure to Disclose – Stop Drop case*	3rd Court of Appeals affirmed dismissal of an ERISA stock drop case. Plaintiffs alleged that plan fiduciaries **breached their duties of prudence and disclosure** by offering Avaya common stock as an investment option in Avaya's **401(k) plans**. They alleged the price of the stock was artificially inflated by inaccurate earnings forecasts and that fiduciaries were liable for failing to disclose material adverse facts that eventually led to a 25% decline in the stock's value.
58.	**In re Schering-Plough Corp.** *ERISA Litigation re: Retirement Plan Disclosures*	This case relates to discerning when **financial representations in SEC filings** give rise to a fiduciary claim under ERISA. In general, **statements made in communications that are required only by federal securities** laws, such as SEC filings, do not constitute fiduciary communications for purposes of ERISA liability. However, when financial statements are incorporated by reference into plan documents or when plan participants are encouraged to review the company's SEC filings, those statements may be deemed to have been made in a fiduciary capacity. In this case, the SPD (Summary Plan Description) merely advised participants that they could obtain copies of prospectuses and financial reports upon request, but did not expressly incorporate the SEC filings or encourage reliance by participants. Result: The court, nevertheless, held that the SPD **impliedly incorporated the filings.** A $12.5M settlement was reached in this case, accusing the pharmaceutical giant of mishandling its **retirement plan** by **improperly steering employees into buying company stock.**
59.	**O'Neil v O'Neil** *Life Insurance Beneficiary, Not Removed*	Decedent never removed his wife as the beneficiary on his ERISA-based **life insurance policy**. Defendant-wife did not violate a separate-maintenance judgment by making a claim for the proceeds upon his death because under ERISA, the judgment was insufficient to extinguish her rights to the proceeds.
60.	**Constance O'Neil v Unum Life Ins. Co. of America** *Disability Benefits Declined*	In Plaintiff's Motion to Remand, plaintiff maintained the case was improperly removed from the Cumberland County Superior Court because her sole count alleges a **breach of contract** claim governed by state law. Defendant asserted the claim is pre-empted by ERISA. Originally hired as an associate in a law firm, plaintiff became a partner and shareholder of the firm. Years later, the law firm submitted a long-term disability claim on behalf of plaintiff, who did receive **disability benefits** for 1½ years, until defendant notified her by letter that she was no longer eligible to receive disability benefits. Plaintiff appealed; defendant denied her appeal following its review. Plaintiff initiated suit and asserted breach of contract against defendant in state court.
61.	**Krohn v Huron Memorial Hospital** *Disability Benefits & Duty to Inform*	Registered nurse-plaintiff suffered a closed-head injury in a car accident resulting in permanent disability, making her eligible for **both short- and long-term disability benefits** for a period of 23 years. Defendant's personnel assistant discussed options with plaintiff's husband and said 1) employees would normally opt for the car insurance and that they normally paid a higher rate, and 2) they couldn't collect any money from the short-term disabilities if they were collecting it from other companies.
62.	**Muhammad v Ford Motor Co.** *Benefit Plan Participant Negligence in Updating Eligibility Information*	Plaintiff-employee participant in **benefit plan** was negligent in providing **updated eligibility information** by way of documentation when asked by employer-defendant four times to do so. As there was no proof in the way of income tax returns or proof of residency of four of his dependents, defendant chose to deduct payments from the plaintiff's paycheck as reimbursement for benefit payments that were made on those dependents' behalf. Although the plaintiff provided a divorce judgment indicating that he was obligated to provide health benefits for one of his daughters until she turned 18, the tax returns he supplied did not list that daughter as a dependent. As a result, the court agreed that the defendant did not act arbitrarily or capriciously by determining the daughter was ineligible for coverage after she turned 18. The court also held that the plaintiff failed to exhaust his

		administrative remedies with respect to the three remaining audits which were never appealed internally before filing suit. It is a recent trend that with the rising cost of health insurance, more and more employers that offer some type of employee benefit plan are conducting dependent eligibility audits as a way to control costs by confirming eligibility through some form of documentation rather than simply accepting an employee's word.
63.	**Peshke v Lincoln Life & Annuity Co. of N.Y.** *Disability Claims & Exhaustion of Admin. Remedies before Appealing*	Plaintiff submitted a short-term **disability claim**, due to chronic neck/back pain, to defendant-employer listing his work restrictions for the next 2 months. Defendant approved and, subsequently, extended payments for another month and notified plaintiff if further extension was requested, he would need to provide current medical documentation including medical records and physical therapy notes. In evaluation of the April – July medical records, defendant noted "overall improvement" in plaintiff's condition, increased range of motion in all directions and decreased neck pain. So, defendant sent a letter to plaintiff that no benefits would be paid after July 28 because the medical documentation failed to support restrictions that would prevent him from working in his occupation as a VP, therefore, failing to satisfy the plan's definition of "total disability" which requires the insured not be able to perform each of the main duties of his own occupation.
64.	**Boyle v BCBS of N.C.** *Health Care Benefits Denied*	The father and legal guardian of a minor child suffering from autism (ABA) seeks to recover full **health care benefits** from defendant Continental Automotive Welfare Benefits Plan who refuses to provide or allow for coverage for a scientifically validated and beneficial treatment for **autism**, despite the State of North Carolina's finding that ABA is not an experimental treatment.
65.	**Karen McClain v Eaton Corp. Disability Plan** *Disability Benefits (ERISA)*	An assembler with Eaton Corporation suffered a back injury on the job. She had purchased the highest level of **long-term disability** insurance which was designed to replace 70% of her monthly base pay. She received disability benefits during the first 24 months under the First Tier of the Plan's coverage which defined her disability as being "totally and continuously unable to perform the essential duties of your **regular**" job. The Second Tier coverage, however, provides coverage if "you are totally and continuously unable to engage in **any** occupation . . ."
66.	**Haviland v Metropolitan Life Insurance Co.** *Retiree Life Insurance Benefits / GM Bankruptcy*	GM provided its salaried retired employees with **continuing life insurance**. As part of its re-organization, GM reduced the amount of life insurance to $10,000. The retirees sued MetLife based on letters received saying, "this life insurance remains in effect, without cost to you, for the rest of your life." 1) Because the GM plan and summary plan description both adequately reserved GM the right to amend, reduce, or end the benefit, the promissory estoppel claim was rejected because the **"reservation of rights" language** was unambiguous. The letters were merely a description of the retirees' current benefit; not a statement about future benefit. 2) The breach of fiduciary duty claim was also rejected because the information was a **truthful statement of the retirees' current benefit**. 3) The retirees' claims that MetLife had breached the GM plan's terms and claims of unjust enrichment and for equitable restitution were also rejected.
67.	**James v Liberty Life Assurance Co. of Boston** *Disability Claim*	As a passenger rear-ended by a truck, a 55-year old female buyer for DTE Energy initially sustained arm and back pain and later, mental health treatments for depression and posttraumatic stress disorder. Her claim for disability benefits was denied with defendant claiming that plaintiff failed to provide objective evidence that her condition precluded her from performing her job.

68.	**Kathy Braun v Sun Life Assurance Company of Canada and NEMACO** *Failure to Process Employee's Request for Optional Higher Life Benefit*	Nemaco employee died three years after he began paying for Optional Group Life Insurance through payroll deductions. At the time of his death he was entitled to $100,000, although he was only paid $40,000. Plaintiff's complaint is based on the ERISA and federal common law regarding **breach of the terms of an employee group benefit plan** to provide certain life insurance benefits in the amounts and at the coverage levels promised and for recovery of damages, costs, and attorney fees incurred. Plaintiff requests full benefits, disgorgement of profits or gain, reasonable attorney fees, and an order for defendants to disclose plan documents and internal documents.
69.	**Plan Participants v ABB Inc.** *Fiduciary Liability (Excessive 401(k) Plan Fees)*	In one of the first 401(k) fee cases to go to trial, ABB was ordered to pay $35,200,000 and Fidelity Investments to pay $1,700,000 in a suit over ABB's 401(k) plan. The judge said ABB and Fidelity **violated their fiduciary duty** to employees and retirees by, among other things, "selecting more expensive share classes . . . when less expensive share classes were available." Revenue-sharing payments generated by ABB's 401(k) plan subsidized other services that Fidelity provided to ABB. It was to ABB's benefit that **opaque revenue sharing** was used rather than hard dollar fees which were clearly visible to the participants.
70.	**Cultrona v Nationwide Life Ins. Co.** *Life Benefits*	Plaintiff's decedent applied for **accidental death benefits** from her insurer, Nationwide, when her intoxicated husband returned home, apparently passed out and died from positional asphyxiation and acute ethanol intoxication. The federal district court correctly ruled that an intoxication exclusion precluded plaintiff's claim for accidental death benefits. In a denial letter for plaintiff's claim, the explanation indicated "the loss is precluded from coverage by Exclusion 12" although, unfortunately, the letter cited an earlier version of Exclusion 12: "The *Covered Person* being deemed and presumed, under the law of the locale in which the Injury is sustained, to be driving or operating a motor vehicle while under the influence of alcohol or intoxicating liquors." In a letter seven days later, StarLine acknowledged the erroneous reference to an earlier version of Exclusion 12 and further explained it was amended to remove the reference to "driving or operating a motor vehicle." The court properly assessed the insurer a statutory penalty of $55 per day (total, $8,910) for its delayed response to plaintiff's written request to furnish a copy of the insurance policy.
71.	**Nilratan Javery v Lucent Technologies** *Long Term Disability Plan*	As a software engineer employee of Lucent, Plaintiff participated in its **long-term disability** plan (the administration of the Plan was delegated to a third party, CIGNA) which is offered to those who meet its defined requirements for eligibility. While plaintiff's work was fast-paced and involved supporting Lucent employees and consultants around the clock, in excess of 70-75 hours per week over 5-6 months straight, plaintiff developed back pain in 2002 and he sought treatments until his doctor advised he stop working in 2005. He then received short-term disability benefits for 26 weeks. Plaintiff's denial from the administrator to begin receiving long-term benefits in 2005 brought him to filing Chapter 13 personal bankruptcy in 2007. In 2009, plaintiff filed a complaint in the U.S. District Court regarding his denial of benefits being in violation of ERISA.

72.	**Ruff v Ruff & Operating Engineers' Local 324 Pension Fund** *Retirement Benefits*	In December 1989, decedent while married to defendant, retired and began receiving benefits from the Pension Fund which provided for surviving spousal benefits. They divorced in 1993 and entered into a consent agreement which was incorporated into a divorce judgment. Verbage laid out the pension benefits. In 1997 the decedent married plaintiff and in 2011 he executed a beneficiary election form awarding plaintiff "any death benefits" that he was entitled to from the Pension Fund. "Surviving spouse benefits" were not referenced. The decedent passed away shortly after executing the beneficiary form, and plaintiff received certain death benefits from the Pension Fund. Plaintiff also applied for monthly surviving spouse benefits, but the Pension Fund denied her request, stating that plaintiff was not the spouse at the time of the decedent's retirement, as required by section 1.22. However, because defendant was the decedent's spouse at the time of his retirement, the Pension Fund paid defendant monthly surviving spouse benefits of $521.08. Consequently, plaintiff filed the instant action against defendant, alleging **breach of contract, promissory estoppel, and unjust enrichment, and sought declaratory relief and imposition of a constructive trust**.
73.	**Joseph Moyer v Metropolitan Life Ins. Co.** *Fiduciary; Disability Denial*	Solvay America employee, Moyer, participated in its ERISA-governed Long Term Disability Plan. He applied for **disability benefits** in 2005. MetLife initially approved the claim, but reversed its decision in 2007 after determining Moyer retained the physical capacity to perform work other than his former job. Moyer filed an administrative appeal, and MetLife affirmed the revocation of benefits. Moyer's adverse benefit determination letter included notice of the right to judicial review but failed to include notice that a **three-year contractual time limit** applied to judicial review. The Summary Plan Description failed to provide notice of either Moyer's right to judicial review or the applicable time limit for initiating judicial review. In 2012 Moyer sued MetLife, seeking recovery of unpaid plan benefits. The district court concluded that MetLife provided Moyer with constructive notice of the contractual time limit for judicial review. Moyer appealed, requesting **equitable tolling**. Being unaware of the contractual time limit, Moyer filed his complaint late. He asked the U.S. Court of Appeals to toll the filing deadline, alleging that MetLife **breached its obligations** under ERISA by failing to include in his benefit revocation letter the time limit for seeking judicial review. The court agreed that on the date his revocation letter was sent, it was required to include the time limit for judicial review. ERISA § 1133 governs adverse benefit determination letters.
74.	**Smith v Continental Casualty Co.** *ERISA, Disability*	The federal district court's upholding of an insurance company's denial of plaintiff's application for **short-term disability benefits** was vacated because the denial was arbitrary and capricious. The record shows that in denying the claim, CCC, the plan administrator, incorrectly asserted in a letter that plaintiff had returned to work when, in fact, this was not true. In addition, there were unexplained discrepancies in the number of pages of medical records sent for review and the actual number of pages reviewed. Plaintiff's treating physician was not interviewed, nor was plaintiff seen by an independent examiner. Finally, CCC never obtained plaintiff's job description.

75.	**Gaylon Hayden v. Martin Marietta Materials, Inc. Flexible Benefits Program** *ERISA Disability*	Gaylon Hayden appeals from two adverse judgments in her suit for **long-term disability benefits** under ERISA against her former employer, Martin Marietta Materials, Inc. She applied for benefits under their long-term disability plan, which was insured and administered by Liberty Life Assurance Company of Boston ("Liberty"), when she stopped working as an office manager on January 4, 2010. Her claims are related to physical- and mental-disability benefits. Any employee that desires benefits must have proof that they are disabled beyond the ability to perform their job adequately, disabled being defined under the Plan as being "unable to perform the Material and Substantial Duties of his Own Occupation" as well as "unable to perform the Material and Substantial Duties of Any Occupation." Hayden suffers from many physical ailments, which exacerbate her mental issues. Her primary physician considers her condition should be met with total permanent disability. Her file was then referred by Liberty to two other physicians for review. Both did not see any specific impairment, brushing off her mental disabilities to general fatigue and weakness. Liberty then denied Hayden's claim for benefits seven months after she left her job. Hayden then brought suit under ERISA. The district court denied her physical disability claim, but opined that Liberty's review of Hayden's mental health records was faulty. After another review by another doctor, the court affirmed Liberty's denial of benefits. Hayden's arguments assert that Liberty and the district court ignored evidence from her primary care physician, with Liberty not being seen as arbitrary or capricious in these conclusions. The remand of the court of another doctor in the review of Hayden's records was inadequate in the proper definition of mental disability as well as that Hayden's mental health issues were made with her job in mind. In the end, the district court remanded Hayden's claim of mental disability and required Liberty to award benefits consistent with the terms of the Plan.
76.	**Louis Leonor v. Provident Life and Paul Revere Life** *Disability*	A dentist suffered an injury and in March 2009 had a cervical spine surgery that prevented him from performing dental procedures. The **dentist owned 3 disability income insurance policies**. He claimed benefits for total disability and in July 2009 both Provident and Paul Revere began paying Total Disability benefits. After his injury, he was still able to manage and operate the other businesses he owned, as well as more aggressively seek out investment opportunities in terms of purchasing dental practices, successfully increasing his overall income. The insurers made payments until September 2010 when the insurers decided that Leonor was engaged in another gainful occupation, managing his business. In August 2011, the insurers stopped paying Total Disability benefits under the 2 lesser policies. Each provided "total disability benefits" if he became unable to perform "the important duties of his Occupation." The Court of Appeals ruled in favor of the insured and that the policy language did not necessarily mean "all the important duties." Reasonable interpretations of policy language and time spent performing the various portions of his job duties were considerations. A Court of Appeals opinion reversed the district court's denial of penalty interest with instructions to modify the award to include penalty interest.
77.	**Farmington Hills Employees Retire-ment Sys v Wells Fargo** *Investment Fiduciary*	Under its securities lending program, Wells Fargo Bank lent its clients' securities to third parties. In turn, the borrowers deposited cash collateral to secure the lent securities' return; Wells Fargo then invested the cash collateral and split the proceeds with the clients. The invested cash collateral suffered losses which plaintiffs claimed came despite Wells Fargo's assurance that the investments would be safe and conservative. The class action settlement will be shared by approximately 100 pension funds, corporations, insurance companies and others who participated in the **Bank's securities lending program**. Settlement amount, $62M.

78.	**Bear Stearns Cos Ins Securities** *Pension Plans*	A $294.9M settlement against Bears Stearns, former officers and directors, and former outside auditor was reached due to **misrepresentation** of its exposure to the subprime mortgage lending crisis before its collapse. Although billions of dollars in value of Bear Stearns' stock was lost during the class period of Dec. 14, 2006 to March 14, 2008, the class members supported the verdict because of the case's complexity, the amount of discovery completed, the difficulty of pinpointing damages, and the challenge of maintaining a class action for a protracted period. Defendant Deloitte & Touche, which certified Bear Stearns' 10-K and other filings, is responsible for paying $20M to settle claims it ignored red flags about Bear Stearns' alleged wrongdoing. This case reflects the influence of major institutional investors such as the Michigan public pension funds. The class was led by lead plaintiff, State of Michigan Retirement Systems, in the multidistrict litigation, which invests on behalf of Michigan public school employees, state employees, state police and state judges. The beneficiaries of the **state pension funds** total about 563,500 people and include 1 in 18 Michigan residents. The state retirement systems bought 494,600 shares of Bear Stearns common stock and sold 11,600 during the class period. It lost about $62M when the firm collapsed. The settlement is one of the **top 40 largest settlements** since the passage of the PSLRA.
79.	**American Int'l Group Inc., 2008 Securities Litigation** *Pension Plans*	A $970.5M settlement was reached for American International Group Inc. (AIG) shareholders resolving claims they were misled about its subprime mortgage exposure, leading to a liquidity crisis and $182.3B in federal bailouts. This is one of the **largest class action settlements** to come out of the 2008 financial crisis. No criminal or regulatory enforcement actions were ever pursued. The settlement amount was very substantial and shareholders would face significant risk if they continued to litigate instead of settling. The settlement covers investors who bought **AIG securities** between March 16, 2006 and Sept. 16, 2008, when the company received its first bailout. Investors led by the State of Michigan Retirement Systems, which oversees several state pension plans, accused AIG of failing to disclose the risks it took on through its portfolio of credit default swaps and a securities lending program. They said the failures led investors to buy stock and debt they otherwise would not have bought, resulting in billions of dollars in losses. A government rescue in 2008 led taxpayers to take a nearly 80% stake in the New York-based insurer.
80.	**Marie C. Kellow v Lincoln Financial Group** *Disability*	Plaintiff Kellow became disabled as a result of fibromyalgia and sued Lincoln regarding **long-term disability benefits** denial through employer, Hospice of Michigan. Lincoln had approved short-term benefits and initially approved her claim for long term; however, later notified her that her benefits were being terminated. She appealed the decision, but it was denied. During the appeal, various documents were requested from Lincoln, including the Policy and the Summary Plan Description (SPD). The SPD, however, was not furnished until 11 months after the request. Kellow claimed she was entitled to an award of statutory damages based upon Lincoln's failure to furnish the SPD. The Policy did not identify the Plan administrator or the Plan sponsor; however, the SPD did identify Hospice as both the Plan administrator and Plan sponsor, and also that Hospice is the designated agent for the service of legal process for the Plan.
81.	**General Retirement Sys of City of Detroit v Onyx Capital Advisors LLC**	Two Detroit pension funds and the Pontiac pension fund entered into a partnership with Roy Dixon to invest monies in a limited partnership. Following a period of due diligence, these funds had invested more than $23M with the Onyx Fund between 2007 and 2009. Plaintiffs argued that **pension funds were mismanaged**, with substantial portions of it converted by a number of the defendants to their own benefit through a fraudulent scheme. Defendants had directed the majority of the funds earmarked for other investments to Dixon's friend, Michael Farr, and his Second Chance Motors family of companies; also, the taking of impermissible

	Pension mismanagement; Conversion	management fees and using investment funds to build a multimillion-dollar Atlanta residence for Dixon. The retirement systems were able to get preliminary injunctive relief to prevent the spoliation of evidence and gain access to Onyx's Detroit offices. Following substantial document and deposition discovery and dispositive motion practice, judgment was entered in favor of the funds and against Onyx, the Second Chance Motors entities and Farr, in the combined amount of $119,099,721, exclusive of attorney fees and taxable costs.
82.	**Raymond Shaw v AT&T Umbrella Plan No. 1** *Disability*	As a customer service representative for Michigan Bell, Shaw, 39, stopped working as a result of chronic neck pain. He was covered under the AT&T Midwest Disability Benefits Program. STD benefits were approved, but when he was informed that the STD benefits would expire, he began the process for **LTD benefits**. He did not qualify. The plaintiff sued AT&T for long-term disability (LTD) denial. The district court had granted summary judgment to the Plan and found it had properly denied benefits. However, the U.S. Court of Appeals reversed this judgment and found the Plan acted **arbitrarily and capriciously** in denying LTD benefits. Shaw demonstrated that he was denied benefits to which he clearly was entitled; therefore, the case was remanded to the district court and directed to enter an order awarding Shaw LTD benefits. The Court of Appeals had concluded that the Plan had ignored favorable evidence submitted by Shaw's treating physicians, selectively reviewed evidence that it did consider from treating physicians, failed to conduct its own physical examination, and heavily relied on non-treating physicians. The Plan had also made a factually incorrect assertion that Shaw had not submitted specific measurements of range of motion. It also ignored a doctor's residual-functional-capacity questionnaire which had been submitted as part of Shaw's appeal and concluded that Shaw could perform sedentary work. A plan cannot reject summarily the opinions of a treating physician but must, instead, give reasons for adopting an alternative opinion. The Plan also ignored favorable evidence from Shaw's treating physicians by failing to make a reasonable effort to speak with them; instead, those physicians were given only 24 hours to respond before they made their disability decisions. Finally, this selective review of the administrative record in justifying a decision to terminate coverage was arbitrary and capricious. The Plan's decision-making process was flawed.
83.	**Laura Waskiewicz v Unicare Life** *Long-Term Disability*	Plaintiff Waskiewicz worked for Ford Motor Co. as a product design engineer from 1990 until Oct. 26, 2010. She subsequently sought **long-term disability** benefits. Unicare serves as the claims processor for the Plan and did not grant the benefits because she had already been terminated by Ford when she sought those benefits. The court reversed the decision. Plaintiff suffers from Type-1 diabetes, major depression, and gender identity disorder (she was formerly known as David Waskiewicz). Absent for more than 5 consecutive workdays, plaintiff did not inform Ford within the five-day required period. Rather, her father notified Unicare of the disability claim on behalf of his daughter in December. Her parents had lost contact with her on Oct. 15, came to check on her weeks later, and found her barricaded in her home. A human resources employee indicated she sent a certified letter to her on Nov. 18, 2010 informing her that her employment with Ford had been terminated because of her failure to report to work or to provide satisfactory medical or other documentation to justify her absence. Plaintiff signed for the letter on Nov. 23, 2010. Ford averred that she was fired under the '**5-day quit rule**.' Plaintiff did not seek medical help until Nov. 24. The doctor returned a disability certificate on Dec. 13. Since plaintiff had not been treated between Oct. 24 and Nov. 24, her treatment was untimely as far as long-term benefits were concerned. The court decided that rubber-stamp decisions by plan administrators were unfair. The plaintiff was a Covered Employee at the onset of her disability, and thus entitled to benefits. Failure to comply with the notification

		deadlines was understandable since she was suffering from severe mental illness. Ford's termination and denial of disability benefits was found to be inconsistent with the spirit of employer-provided health care benefits. In fact, the Plan mentions, 'unless the Participant is Disabled on that date.' The spirit of ERISA is designed to protect employee benefits, not subject them to arbitrary termination. Unicare's denial of benefits was arbitrary and capricious. Plaintiff will be given the opportunity to show that her alleged failure to comply with requirements of the Plan were due to the very disability for which she seeks benefits.
84.	**Pfeil v State Street Bank** *ESOP imprudence*	A bank's decision to keep buying General Motors stock for plaintiff's Employee Stock Ownership program and **not divest its GM holdings** while market conditions declined was **not "actionably imprudent"** under the Employee Retirement Income Security Act. ESOPs are designed to invest primarily in qualifying employer securities rather than to diversity across securities of many companies. Plaintiffs, prior to GM's most recent financial difficulties, elected to invest in the GM **ESOP**. State Street Bank served as fiduciary of certain pension plans, including the Common Stock Plan for employees of GM. The Plan lost money in 2008, but the bank declined to stop buying GM stock until Nov. 8, 2008, and did not divest the fund of GM stock until March 31, 2009. A week later, Pfeil filed suit against State Street, claiming that its investment decisions to continue to buy and also to decline to sell GM common stock during certain dates in 2008 were actionably imprudent under ERISA. In 2010, the district court dismissed the suit on State Street's motion, applying the presumption of prudence to the behavior of ESOP fiduciaries. On Feb. 22, 2012, the 6th U.S. Circuit Court of Appeals reversed, holding that the presumption of prudence did not apply earlier than the summary-judgment stage of proceedings. On remand, the parties agreed to certify a class. The Class Period extended from July 15, 2008 to March 21, 2009. After class certification, State Street moved for summary judgment. The district court, applying the presumption of prudence at the summary-judgment stage, granted the motion. Pfeil timely appealed. In evaluating State Street's conduct at the time it occurred, the mere fact that GM's stock value decreased after certain dates did not affect their judgment. To fulfill its responsibilities, State Street discussed GM stock scores of times during the class period. State Street's managers repeatedly discussed at length whether to continue the investments in GM that are at issue in this case. State Street's Independent Fiduciary Committee held more than 40 meetings during the Class Period of less than 9 months to discuss whether or retain GM stock. At those meetings, bank employees discussed the performance of General Motors, both its stock and its business, and factors that may have affected that performance. State Street's experts opined that State Street's process for monitoring GM and other stock was prudent; and other experts – fiduciaries of other pension plans and non-pension plan investment funds – decided, like State Street, to hold GM Common Stock on each of the four 'imprudent dates' chosen by Pfeil. Pfeil failed to demonstrate a genuine issue as to whether State Street satisfied its duty of prudence. The bank's actual processes demonstrated prudence, as well as the decision of other expert professionals both to invest and not to divest on or near the dates that State Street made those decisions.
85.	**Vella v Adell Broadcasting Corp.**	Plaintiff's decedent Robert Vella worked for WADL Channel 39 as an account executive in sales. Just days following the renewal of his health insurance, he suffered a heart attack and later learned he had bladder cancer, as well. While in the hospital, WADL owner, Kevin Adell, ordered that Vella be re-categorized as an exempt independent contractor without benefits. When Vella discovered his insurance had been cancelled,

	ERISA, Disability	he made a written complaint and was terminated minutes later, which plaintiff alleged was retaliation. WADL disputed plaintiff's unemployment until the COBRA window closed. Vella was unable to afford insurance and suffered severe complications, ultimately dying mid-litigation. An expert testified that prompt treatment of the bladder cancer that killed Vella had a 90% cure rate. The case was pleaded as an ERISA and ADA discrimination and retaliation case, with pendent claims under the Persons With Disabilities Civil Rights Act and various state common law theories including fraud, silent misrepresentation and unjust enrichment. Vella's daughter was also considered as loss of consortium. *Settlement, $1.3M.*
86.	**Van Loo v Cajun Operating Co.** *Life Ins., Breach Of Fiduciary Duty*	In 2007, when Donna Van Loo began working full time at Church's Chicken, she opted for supplemental life insurance coverage that would equal two times her salary. Deductions for the premium were then taken from her paycheck. Later that year, she again submitted a change form to increase coverage to three times her salary. 3 years later, she submitted another enrollment change form to increase it to four times her annual salary. By 2013, her salary had surpassed $120,000. Church's regularly deducted premium payments from her paycheck. When she took disability leave, she paid the premiums directly and without interruption. Upon her death from cancer, the plaintiff's estate submitted a claim which was partially denied because the plaintiff's decedent had never completed the EIF form which had never been mailed to her. Instead of the full insurance benefit payout of $614,000, only $300,000 was paid to the estate. Because payments were paid and Church's accepted, and because Church's communications with plaintiff's decedent throughout her employment constituted material misrepresentations regarding her coverage and a breach of fiduciary duty, decedent was granted pre-trial motion for summary judgment, determining that Church's breached its fiduciary duty and is liable to pay $314,000.
87.	**Schilling v CMS Energy Corp.** *401(k), Breach of Fiduciary Duty; Round-Trip Trading*	In 2001-2002, thousands of employees of Consumer Energy Company, operating as CMS Energy Corp. based in Jackson, participated in one of the company's 401(k) plan options in which some of the money invested by employees was matched by the company in stock shares. Thousands of other employees participated in an employee investment plan in which a small percentage of their salary was earmarked for the matched purchase of stock options. "Round-trip trading" took place, thereby padding CMS' revenues by $4.4B. Revenues appeared larger than they actually were and stock prices began falling rapidly. Class size was estimated at 9,800 employees. *Settlement, $28M.*
88.	**Production Tool Supply v Blue Cross Blue Shield** *Breach of Fiduciary Duty*	BCBS was accused of self-dealing and breaching its fiduciary duties in violation of ERISA. It collected hidden fees by secretly marking up certain hospital claims that it passed along to the plaintiff's ERISA plan. Customer complaints were minimized because the markups would be "no longer visible to the customer." BCBSM admitted it was collecting the markups but that the reimbursement claim was time-barred. *Settlement, $2.5M.*
89.	**Johns v Blue Cross Blue Shield** *Breach of Fiduciary Duty*	In this class action lawsuit, BCBS of Michigan refused coverage for behavioral therapy for children with ASD (autism spectrum disorder). Defendant had denied coverage since the therapy was experimental. Actions were arbitrary and capricious. *Settlement: $1M* to reimburse all families who paid for behavioral therapy for their children at Beaumont's GIFT program after May 1, 2003 if they were covered under a BCBS insurance policy.

90.	**Perez v Bruister** *ESOP Mismanagement*	As owner of a DirecTV installation company, Bruister mismanaged an ESOP and must turn over 3 vehicles as part of a *$6.5M judgment*, as well as $3M in attorneys' fees, for causing the employee stock ownership plan to purchase his company stock at an inflated price.
91.	**EEOC v Det. Community Health** *ERISA, Disability*	Detroit Community Health Connection violated federal law by both denying a disabled medical biller a reasonable accommodation and firing her because of her disability after she had requested a 2-week leave of absence because of her rheumatoid arthritis.
92.	**U.S. v U of M** *ERISA, Disability*	The Univ. of Michigan was sued by a disabled employee that questioned the school's policy that required an employee to be the best qualified for a vacancy when seeking reassignment. The Dept. of Justice ruled this policy is a violation of the Americans with Disabilities Act which merely requires that a disabled employee be "qualified," not the "best qualified." Contrary to most employers' hiring practices, the ADA deems that a qualified disabled employee be given preference for a job opening, even if there is a better qualified applicant. *Settlement: $215K.*
93.	**U.S. Justice Dept v The Scooter Store** *Disability Ad's*	The Scooter Store's advertising enticed seniors to obtain power scooters paid for by Medicare and then sold patients more expensive scooters that they did not want or need. In 2005 the U.S. Justice Dept. sued the store. *2007 Settlement: $4M.* However, by 2011 government auditors estimated the store received $47M - $88M in improper payments for scooters. Believing this estimate was flawed, the Scooter Store offered to repay $19.5M in overpayments. The store spent near $1M lobbying Congress during 2011-2013, laid off employees, eliminated more jobs, and in 2013 announced it was shutting down following the loss of its Medicare business. In 2013, the EEOC settled Americans with Disabilities Act (ADA) claims for *$99,000* in a 5-year consent decree with Scooter Store-Levittown.
94.	**EEOC v Dillard's** *Medical Disclosure/ Terminations*	A national retail chain's longstanding national policy and practice of requiring all employees to disclose personal and confidential medical information in order to be approved for sick leave became a 2008 class action disability discrimination lawsuit, which also resolved claims that Dillard's terminated a class of employees nationwide for taking sick leave beyond the maximum amount of time allowed, in violation of the ADA. *2012 Settlement, $2M.*
95.	**EEOC v J.A. Thomas & Asso.** *Disability & Termination Discrimination*	In a settlement agreement filed with U.S. District Court for the Eastern District of Michigan, the company agreed to pay *$350K* in back pay and compensatory damages to a former employee, a bilateral amputee, who was a health information management specialist who alleged that the company did not rehire her due to her disability, after the company decided to make the position remote, violating the ADA.
96.	**EEOC v Pace Solano** *Medical Disclosure/ Terminations*	A California organization providing training and employment services for adults with developmental disabilities, agreed to pay *$130K* to a woman who was refused a job at the agency because she suffered from partial paralysis in her left hand. Due to her disclosure of the condition during her pre-employment physical, even though she successfully completed all tests and was cleared to do the job by Pace Solano's own occupational health provider, it refused to hire her as an instructor because of her paralysis.

97.	**EEOC v American Tool & Mold** *Medical Disclosure/ Terminations*	A Clearwater, Fla.-based company violated federal disability discrimination law by withdrawing a job offer as a process engineer because of the applicant's old back injury. The job offer preceded a health release. The post-offer medical exam revealed his successful back surgery 6 years prior. He could not provide a medical release indicating he had no restrictions. At this point, after ATM's medical provider learned this, it refused to perform a back screen and complete his physical exam. He was falsely regarded as disabled, the job offer was withdrawn and he was terminated after he had actually performed the job at ATM for 2 months while he attempted to obtain the requested medical release. He was in good health and had no physical limitations on his ability to perform his job. *2014 Settlement, $150K.*
98.	**EEOC v The Scooter Store** *Disability Termination*	An employee's request for a temporary leave of absence due to a knee injury was refused. He was then fired from its Farmingdale, N.Y. store, purportedly for job abandonment, although he had presented medical documentation of his psoriatic arthritis. *Settlement, $99K.*
99.	**EEOC v Womble Carlyle Sandridge & Rice** *Disability Discrimination*	Diagnosed with breast cancer in July 2008, a support services assistant received treatment for the cancer, including the removal of some lymph nodes. Her job required her to perform copying, scanning, and other duties in the law firm's copy rooms. In Nov. 2009, she developed lymphedema which is a physical impairment caused by cancer treatment where the lymphatic system is damaged and/or lymph nodes are removed. This condition limits a person's circulatory and/or immune system. By June 2010, her lymphedema was exacerbated by lifting boxes and she suffered swelling in her shoulder, neck, arm, thumb and finger. A doctor's note stated she was unable to lift over 10 lbs. Her Feb. 2011 follow-up doctor's note stated she could lift up to 20 lbs. She was informed she could not work until her doctor withdrew the lifting restriction. She was placed on disability leave in Feb. 2011 and was fired around Aug. 9.
100.	**EEOC v Journal Disposition** *Disability Discrimination*	The operator of a full-service print, manufacturing and distribution company in St. Joseph, Mich. agreed to settle a disability discrimination suit for $*55,000*. The operator terminated a long-time employee diagnosed with cancer because he exhausted his time under its short-term disability insurance policy. The employee, prior to the exhaustion of his leave, returned back to work, working part-time hours while he received chemotherapy, performing all essential functions of his job. His accommodation request to work part-time for about 5 months was acknowledged by the company, but in violation of ADA, he was terminated until he could work full time. The company should have considered his ability to perform the job, the reasonableness of his request, or if this request provided an undue hardship to the company.
101.	**Montanile v Bd. Of Trs. of Nat'l Elevator Ind. Health Benefit Plan** *Health Care Reimbursement*	In 2008, a man was injured in Florida by a drunk driver. He received a settlement from that driver, but in 2015 the U.S. Supreme Court heard oral arguments as to whether the injured man is required to **reimburse his health plan administrator** for medical expenses.

102.	**Cipriani v Liberty Life Assur. Co.** *Disability Discrimination*	In 2014, a Pennsylvania court in an ERISA disability case addressed whether the plaintiff would be allowed to take two depositions. The case arose after Liberty terminated the plaintiff's disability payments after he reached the two-year **change in definition** from "own occupation" to "any occupation." Liberty Life objected to the depositions on the grounds that the depositions related to the merits of the claim decision, which it claimed was not an appropriate subject of discovery.
103.	**Williams v Rohm & Haas Pension Plan** *Pension Plan Cost of Living*	The Plaintiff Class alleged that the Rohm and Haas **Pension Plan** violated ERISA by failing to include a **cost-of-living** adjustment in lump sum distributions from the Plan.
104.	**Call v Ameritech Mgmt. Pension Plan** *Pension Plan Calculations*	A participant in a defined-benefit **pension plan** was given a choice between taking pension benefits as an annuity or in a lump sum. The **lump sum must be so calculated** as to be the actuarial equivalent of the annuity. *(Settlement: $31M)*
105.	**Esden v Bank of Boston Retirement Plan** *Pension Benefit Reductions*	The first case to successfully challenge case balance type defined-benefit plans, this matter required the attorneys to navigate the complex parallel statutory provisions of the Internal Revenue Code, ERISA and its regulations to remedy the **improper reduction of pension benefits** by the defendant. *(Settlement: $7M)*
106.	**Berger v Xerox Retirement Income Guar. Plan** *Pension Plan*	Attorneys contested the legality of Xerox's **cash balance pension plan** on behalf of a class of its retirees and obtained a $255M judgment for the class. *(Settlement: $239M)*
107.	**Cooper v IBM Personal Pension Plan** *Pension Plan*	A class of IBM retirees challenged IBM's **pension equity plan** on the grounds that it violated ERISA's prohibition against **age discrimination.** *(Settlement: $324M)*
108.	**Malloy v Ameri-tech Pension Plan** *Pension Plan*	Attorneys challenged the mortality table used by the plan to calculate payments to those plan participants who, upon termination of employment, elected to receive their **pension** benefits in the form of a **lump sum distribution** rather than a monthly annuity benefit as violative of ERISA. *(Settlement: $185M)*
109.	**Laurenzano v Blue Cross/Blue Shield of Mass. Ret. Inc. Trust** *Pension Plan*	Under the benefit plan at issue in this class action, a participant's normal **retirement benefit** was a life annuity beginning at age 65. It increased every year to include a **cost-of-living** adjustment payment that reflected changes in the Consumer Price Index. *(Settlement: $18M)*

110.	**Clevenger v Dillards, Inc.** *Pension Plan Calculations*	The plaintiff in this case accrued substantial benefits under a benefit plan that was terminated the year her employer was sold to Dillards. She claimed the manner in which l**ump sum benefits were calculated** under the plan and its late amendments violated ERISA. *(Settlement: $35M)*
111.	**Tullock v K-Mart Employees Retirement Plan** *Pension Plan*	Participants in K-Mart's employee **retirement plan** alleged that lump sum distributions from the plan violated ERISA because they were computed using the **wrong interest rate**. *(Settlement: $1.25M)*
112.	**Asbury v May Dept. Store Co. Ret. Plan** *Pension Plan*	$600,000 was recovered in **pension** benefits for retirees whose lump sum **distributions were undervalued**.
113.	**Kohl v Asso. Of Trial Lawyers of America** *Pension Plan*	A class of retirees claimed that the value of a **cost of living** adjustment should have been included in their **lump sum distributions**. *(Settlement: $450K)* *Cost of Living*
114.	**Nichols v B.P. America Pension Plan** *Pension Benefits*	20,000 former employee's lump sum **pension** benefits were miscalculated. *(Settlement: $71M)*
115.	**Berkowitz v Nat'l Westminister Bancorp Ret. Plan** *Pension Miscalculation*	A Connecticut district Court **pension miscalculation** case resulted in a $4,000,000 to the putative class.
116.	**Pierce v Gold Kist** *Pension Miscalculations*	This is an ERISA class action concerning **miscalculated lump sum distributions.** *(Settlement: $920K)*
117.	**Richardson v Fairchild Space & Defense** *Pension Distributions*	This is an ERISA class action concerning **undervalued lump sum distributions**. *(Settlement: $740K)* distributions. *(Settlement: $740K)*
118.	**Seifert v May Dept Stores Pension Plan** *Pension Miscalc.*	Approximately $28,000,000 was recovered in **pension benefits for retirees** whose lump sum distributions were **miscalculated.**

119.	**Graf v Automatic Data Processing** *Pension Miscalculation*	More than 5,000 former employees of ADP whose **pensions were miscalculated** shared in a settlement of $7,000,000.
120.	**MetLife v Glenn** *ERISA Claims Denials*	In 2008, the Supreme Court held that federal courts reviewing claims denials by ERISA administrators should take into account the fact that **plan administrators face a conflict of interest** because they pay claims out of their own pockets and arguably stand to profit by denying claims.
121.	**Rosamaria Powell v Aetna** *Recovery of Disability Overpayments*	In 2011, A former Ernst & Young senior manager claimed Aetna underpaid her **long-term disability** benefits because Aetna failed to factor in her state and federal tax payments when calculating the benefit amount. Having begun receiving benefits in 2009, by February 2011, Aetna reduced her monthly payments by the amount of Social Security disability benefits she started receiving. Because the SSDI benefits were retroactive to 2008, Aetna notified Powell that she had been overpaid and if it could not **recover the overpayment,** her benefits would be suspended. Powell's calculation however, was that Aetna owed her an additional $41,500. In March 2013, U.S. District Judge ruled that Aetna had not abused its discretionary authority to determine whether and to what extent employees and beneficiaries are entitled to benefits and to construe any disputed or doubtful terms of the policy.
122.	**Mildred Thomas v Aetna** *Life Insurance Requirements*	Thomas sought to recover **accidental death and personal loss benefits** under her late daughter's plan in excess of $550,000, and statutory penalties in excess of $165,000, after Aetna paid Thomas the life insurance benefit under the plan. Aetna denied Thomas' request, citing that her claim did not establish a loss that fell within the **coverage requirements** of the policy.
123.	**Jessica Tracey Thomas Scott v Aetna** *Life Insurance Death Coverage*	In 2011, a Bank of America assistant vice president **died** from an overdose of drugs, some of which had been prescribed for pain relief following jaw surgery. Aetna **disagreed that her death was an accident covered under the ADPL policy** because some of the drugs found in Scott's system exceeded levels of what had been prescribed. It was ruled that Aetna's denial of the claim was **reasonable** and plaintiff had not proffered any admissible evidence demonstrating the existence of a genuine issue of material fact. Aetna's motion to dismiss the statutory penalty claim was granted.
124.	***(unknown)*** *Disability*	A **long-term disability** case was paid in full for a total settlement of over $800,000. First, the claim was denied on initial application, but the plaintiff was able to successfully appeal this denial and produced medical and vocational evidence that convinced the insurance company to place the plaintiff back in pay status. Then, after less than two years in pay status, the carrier terminated plaintiff's benefits after surveillance was conducted and the carrier found out that the claimant had traveled out of the country.
125.	***(unknown)*** *ERISA/Disability*	A 55-year-old woman filed an application for **long-term disability** benefits. The client was presenting symptoms of severe arthritis in both knees causing her to limp significantly, along with major back problems including degenerative disc disease with disc bulges. Complicating matters was her inability to tolerate major pain medicines such as oxycodone and tramadol. The woman held a physically taxing job at a local airport where she was charged with lifting, pushing, and carrying heavy items.

126.	***(unknown)*** *Health*	In an appeal of denial of insurance coverage for psychiatric hospitalization, BCBS claimed that the hospitalization, which was for over two months, was not considered medically necessary. The entire medical records included extensive documentation that the **hospitalization was medically necessary** and convinced BCBS in this **ERISA administrative appeal** to pay the claim.
127.	***(unknown)*** *Disability Records*	The basis of an appeal of a denial of long-term **disability benefits** is profound fatigue. The carrier claimed that records did not include specific restrictions and limitations on why the client could not work nor were diagnostic tests provided. Benefits were awarded after additional medical records and reports were obtained that rebutted the denial decision. Diagnostic **test results were provided** as well as clear delineation of restrictions and limitations on activities.
128.	***(unknown)*** *Disability*	Claimant had both hips replaced and has low back pain and osteoarthritis. Plaintiff requested **long term disability and social security disability** benefits. The LTD and SSD benefits were awarded on initial application and the client remains in pay status.
129.	***(unknown)*** *Disability Termination*	In this **disability** case, the client has Multiple Sclerosis. The LTD carrier **terminated benefits** based on a single office visit not from the treating neurologist indicating that the client had an excellent exam. It required several supplemental statements from the neurologist, submission of MRI film, a vocational expert report, statements from client and spouse, and Insurance Medical Exam, and legal briefs to finally obtain **reinstatement** with payment of retroactive benefits. Plaintiff also won SSD benefits on initial application.
130.	***(unknown)*** *Disability Termination*	Plaintiff's basis of **disability** is lupus and she appealed termination from LTD benefits. Benefits were **terminated** because her treating doctor reported that her condition had stabilized and she was able to travel to visit her sick parent and move out of the country because of her husband's employment. She, however, was not well enough to resume working. Benefits were **reinstated** after supporting statements and medical records were submitted by the current treating physician out of the country as well as additional information from her prior treating physician in the U.S.
131.	***(unknown)*** *Disability Term; Application Filing*	Plaintiff's basis of **disability** is osteoarthritis of the right knee for which client underwent a total knee arthroplasty. The benefits manager at the client's company **never properly filed** the initial application with the carrier and the plaintiff was no longer eligible to apply for benefits. However, they were able to prove that the plaintiff had filed the application timely and provided sufficient evidence to have the claim awarded.
132.	***Miriam Teper v Park West Galleries, Inc.*** *Pension Plan; Wrongfully Dis-Charged; Future Benefits*	In 1976 plaintiff was hired as a part-time bookkeeper, but within two months became full time. In 1978 she was promoted to executive assistant. She then became director of marketing, auction and sales. The owner **assured** plaintiff at various times during her employment that her position was a secure one which would be available for her **lifetime** if she continued to perform well. In 1980 she qualified for participation in its defined benefit pension plan, but in 1981 she was discharged. She filed a claim in 1982 alleging that she had been **wrongfully discharged** in violation of her contract of employment. She claimed damages in the nature of past and future compensation, including future pension benefits. The principal interest in the appeal is the preemption provision of the ERISA. The court must show whether the award of **future benefits** imposes an administrative, fiscal, or legal burden upon the employee benefit plan. It must be determined whether there is language in the plan itself concerning the determination of future benefits.

133.	**Agriculture** *Breach of Fiduciary Duty*	Two employees filed a lawsuit against a seed manufacturer, alleging they had been told they were automatically enrolled in the company **401(k) plan**. The plaintiffs claimed their employer had a fiduciary duty to inform them of their non-enrollment and opportunity to enroll. The insurance company paid $80,000 in defense costs before summary judgment was granted in the insured's favor.
134.	**Telecom** *Failure to Fund Benefits*	A telecommunications firm maintained a **self-insured health plan**. When the company was forced into bankruptcy, employees sued officers and management of the company for failure to ensure that company funds would be used to pay outstanding medical benefits rather than general company obligations. Ultimately, a summary judgment in favor of the telecom firm resulted. The insurance company paid in excess of $200,000 toward defense fees.
135.	**Telecom** *Breach of Fiduciary Duty*	The Department of Labor investigated a communications company for the methodology the company used in determining the **allocation of Plan earnings** and expenses between active and non-active participant accounts. The Department of Labor initially asserted losses in the range of $317,000 to non-active participants' accounts.. The case was settled by the insurance company for $120,000.
136.	**Manufacturing** *ERISA Violation*	The Department of Labor alleged the Employee Stock Ownership Plan trustees violated ERISA by the sale of non-publicly traded stock from the **ESOP** at a price below fair market value. The insurance company spent $800,000 to resolve the matter with the Department of Labor.
137.	**Manufacturing** *Breach of Fiduciary Duty*	A Midwestern manufacturer failed to submit the requisite forms for an employee's **life insurance** policy, but continued to deduct premium from the employee's paycheck. When the employee died, the life insurer denied the claim. The employee's heirs sued the plan fiduciary and recovered $250,000 from the insurance company.
138.	**Transportation** *ERISA Violation*	A private company pension plan trustee invested plan assets in an **off-shore investment fund**. When the investment lost 60% of its value, the trustee sued, claiming the investment fund misrepresented the nature of the investment. The off-shore investment fund counter-sued, alleging the trustee violated ERISA in making the investment. The insurance company agreed to defend the counterclaim. Subsequently, the Department of Labor filed suit against the plan trustee for losses. The insurance company entered into a settlement agreement with the DoL for $50,000, the investment loss caused by the trustee's breach of fiduciary duty.
139.	**Transportation** *Failure to Pay Health Care Benefits*	The parents of a deceased child sued a trucking company and a third-party administrator for payment of **health care benefits** by a local hospital. The third-party administrator, on review of hospital charges, reduced the charges by more than $100,000. The suit alleged the failure to pay violated insured's fiduciary duty under **ERISA**. The insurance company defended the suit and the case was dismissed after incurring $30,000 in fees.
140.	**Business Services** *Benefits Communication*	Six retired employees of a nonprofit consulting firm sued the firm, alleging entitlement to early **retirement benefits.** The plaintiffs alleged they relied on oral and written representations of the plan administrator, an employee in the human resources department. The plan document was alleged to be ambiguous, preventing a successful motion for summary judgment. The insurance company provided defense to its insured and paid $150,000 in resolving the dispute.
141.	**Business Services** *Benefits Eligibility*	A group of independent contractors sued a company, asserting they were eligible to participate in the insured's sponsored employee **benefit plans**. The plaintiffs, who were accountants hired during the tax season, argued that they met the plans' eligibility requirements. The plaintiffs sought retroactive benefits, including matching contributions in the **401(k) plan** and earnings on those contributions. The court granted summary judgment to the insured; however, the insurance company paid more than $1,000,000 in legal defense fees.

142.	**Technology** *Breach of Fiduciary Duty*	A software manufacturer faced a claim for **life insurance** benefits. While the plaintiff was out of work on **long-term disability**, the insured made the decision to change life insurance carriers. During the transition, the insured neglected to identify the plaintiff as an employee. The plaintiff subsequently died, and the new life carrier denied coverage, citing a policy that only covered active employees. Since the death did not occur during the old policy period, the old carrier also denied the claim. A claim was subsequently made by the decedent's estate against the insured for the life insurance benefits. The insurance company contributed to a settlement including contributions from both the old and new carrier.
143.	**Technology** *Failure to Act in a Timely Manner*	A former employee of an internet services provider filed a suit against the company, claiming they failed to transfer his **401(k) plan** funds in a timely manner to a new plan when he resigned his employment, resulting in $25,000 in losses. The insurance company paid $15,000 to settle the claim after paying $7,500 in legal fees.
144.	**Retail** *Failure to Provide Disability Coverage*	An employee enrolled in the **long-term disability plan** filed suit against a clothing store, alleging violations of **ERISA,** the Americans with Disabilities Act, and Title VII. Specifically, the plaintiff alleged the insured had wrongfully terminated her due to disability. The insurance company afforded a defense. At trial, it was determined that the plaintiff was entitled to long-term disability benefits and that the insured had breached its duty in failing to fully consider all of the medical information. The case was appealed and was settled prior to a decision. In addition to significant defense costs of $300,000, the insurance company agreed to pay the plaintiff's attorney fees in the amount of $250,000.
145.	**Retail** *Miscalculation of Pension Benefits*	Retirees of a national retailer filed a class-action challenging the computation of **lump-sum distribution** of pension benefits. The dispute involved the pension **formula,** which contained a cost-of-living adjustment benefit. The insurance company defended and the case was ultimately settled with a recalculation of the pension formula. The insurance company agreed to pay plaintiff's attorney fees as part of the settlement and paid in excess of $200,000 to resolve the claim.