THE DEFENCE OF LATE SUBMISSION OF DISABILITY CLAIMS : SOME CASE STUDIES

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CASE 1

Part I

Late submission

- The complainant was covered for life and lump sum disability benefit under a group scheme of which the underwriter changed in January 2000.
- The complainant was a professor in the drama department at a university. He carried out teaching responsibilities up to December 1998. He was granted study and research leave from February 1999 to June 1999.
- He reported sick in early July 1999 and was granted sick leave from July 1999 to November 1999. He returned to work in November 1999 and participated in planning for 2000, but teaching had already stopped in October 1999 and therefore he did no further teaching that year.
- Thereafter he was on sick leave.
- A claim for disability due to depression was received by the insurer on 14 December 2001.
- When the claim was investigated by us the insurer rejected the claim on the following two grounds.
    1. The claimant was disabled prior to the commencement of risk by the insurer.
    2. The late submission of the claim by the employer.
- The claimant argued that he only became disabled in October 2001 because it was only after the fourth course of anti-depressant medication was prescribed that his medical practitioner was prepared to support a disability claim. He, therefore, argued that it was not possible to submit the claim any earlier.
- At the time of our investigation the insurer had not yet assessed the claim on its merits for validity as a disability claim.
- The relevant policy provision reads as follows :

    5. Notification of claim

    with notice to Insurer of a life Insured's death or disablement as soon as possible (but not later than 6 months in respect of a death claim and 9 months in respect

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of a disablement claim) after the date of such happening, and take all necessary steps immediately to complete, sign and deliver to Insurer –

5.1 a claim form (and/or any other form required by Insurer);

5.2 the certificate of death (if death be applicable) of the Life Insured;

5.3 proof of age if not already submitted;

5.4 such other documentary evidence, proof and/or information and details as may be required by Insurer

to enable Insurer to deal with the claim. Failure to notify Insurer of a claim within the applicable period of notification stipulated above shall invalidate the claim.

The Waiting Period is defined as:

"means a period of 6 consective months commencing on the date a Life Insured first becomes disabled and is absent from work."

- The date of disability is not a defined term in the policy. The insurer advised us that as a practice they apply the following criteria for determining the last working day/date of disablement: the day the happening or commencement of any such accident or illness occurred i.e. the date on which the claimant became disabled and the day that sick leave commenced.
- The office was of the opinion that the claimant's argument on late submission had some merit but that we should first determine or establish whether the claim could be regarded as valid in terms of the definition of the policy. We did not want to continue with the arguments regarding the validity of the submission date until we knew that the claimant was probably disabled. We, therefore, submitted the medical reports to a medical consultant on our panel of industry specialists for an opinion.
- The medical evidence, which at that stage, consisted of medical reports from the treating psychiatrist reflected that the complainant had -

AXIS I	(i)	Major Depressive Disorder, treatment resistent.
	(ii)	Alcohol Dependency in remission.
AXIS II		Passive Dependent Personality traits.
AXIS III	(i)	Previous Pancreatitis with no further symptoms.
	(ii)	Hypertension for which he was receiving treatment.

(iii) Hypercholesterolaemia.

AXIS IV Psychosocial stressors presently moderate. His stress is financial as well as the demoralisation about the inability to work.

AXIS V Level of functioning, his degree of impairment is the following.

Activities of daily living is mild impairment.

His social functioning is moderately impaired.

His concentration, persistence and pace is extremely impaired.

Adaptation is markedly impaired as is motivation. GAF score 30% (current).

- In the opinion of the medical consultant, to whom we had sent the case, the complainant had received adequate treatment. The medical consultant regarded the complainant as unable to perform his own occupation or any suited occupation.
- After receiving this opinion our office then reviewed the late submission issue and decided in favour of the complainant. In our opinion the complainant could not have been regarded as disabled prior to January 2000 (the date the insurer changed) because the permanency of his condition could not be established until after he had received adequate treatment. The claim could therefore not have been submitted to the previous insurer who underwrote the scheme.
- The earliest date that disability could be established was when the complainant's treating psychiatrist was prepared to state that he presented with treatment resistant depression.
- In terms of the policy provision the employer had 9 months after the happening of disablement (disability event) to notify the insurer of the claim. The employer had complied with this provision by submitting the claim on 14 December 2001.

We therefore advised the insurer to assess the claim on its merits as we had not had their response on this issue.

Part II

Assessment of the claim

The definition of disability reads as follows:

6.3 A Life Insured in Service is considered totally and permanently disabled if he:

6.3.1 is prevented by injury, surgical operation or disease from carrying out, in the case of –

6.3.1.2 any other Life Insured, his own normal occupation, or any other occupation for which he is suited or could become suited, taking into account age, education, training, knowledge, ability or experience for remuneration or profit during the Waiting Period, or

provided that the Insurer is then satisfied at the end of the Waiting period, that the disability will remain total and permanent.

- When the insurer was requested to assess the claim they called for an updated medical report from an independent psychiatrist. The new medical report was not in favour of the complainant although it was equivocal about the complainant's ability to return to work. He stated that the prognosis was not "necessarily poor". The diagnosis was:

AXIS I	Major depressive episode, in partial remission.
	Alcohol abuse, in remission.
	Phobic anxiety symptoms regarding his work situation.
AXIS II	No diagnosis.
AXIS III	Hypertension, hypercholesterolaemia.
AXIS IV	Financial difficulties, loss of vocation, unresolved insurance claim.
AXIS V	GAF = 70

It stated that further treatment options exist including switching to another anti-depressant and augmentation with mood stabiliser. It conceded that further improvement would be likely to be gradual and possibly incomplete and it made the following remark:

"Any attempt to return to his previous employment is likely to result in a relapse in his condition as long as previously stressful situations remain unresolved. His symptoms are likely to persist, as long as the perpetuating factors remained unresolved. I am not sure whether alternative employment would be available. Also, he would need to be positively motivated to have a reasonable chance of successfully returning to an alternative occupation."

- The insurer relied on this report and declined the claim. It did not mention the other reports which had been submitted by the treating psychiatrist.
- It is also appeared two psychiatrists used different criteria when scoring the GAF as these differed markedly.
- We tried to arrange a meeting between the two psychiatrists to discuss the case but the treating psychiatrist was not willing to attend such a meeting as he was of the opinion that it would serve no purpose. He suggested obtaining a further report by another psychiatrist.

- Our office advised the complainant that we could not at that stage make a decision as to disability because of the different medical reports and opinions. In particular the difference in the scores on the level of functional impairment presented a problem as we were not able to reconcile them.
- The complainant then went to another psychiatrist (well respected in the industry) for a further report.
- The third psychiatrist supported the complainant's claim for disability. The GAF score was 40 – 50. We submitted the report to the insurer.
- We now had a "2 to 1" situation. We wrote to the insurer and asked them to consider a settlement.
- The insurer offered 40% of the sum assured as a settlement. The complainant rejected the offer.
- We suggested to both parties that 60% would be a more reasonable percentage. The complainant then submitted a further report by his treating psychiatrist. The insurer accepted the 60% suggestion.
- The complainant also submitted a further medical report by a fourth psychiatrist. The GAF in this case was 55. The psychiatrist's prognosis was guarded. He found definite signs of depression.
- We confirmed our initial suggestion of 60% to the complainant and the complainant finally accepted the offer, albeit very reluctantly.

CASE 2

The policy provided:

> "N*otice must be given to Us in writing within 365 days of any occurrence which may give rise to a claim under this Policy.*
> *…*
> *All certificates, information and evidence required by Us shall be furnished in the form prescribed and without expense to Us and must be submitted to Us within 365 days following notification. After 365 days the onus shall rest with the claimant to prove that We* ***were not prejudiced in any way as a result of the late notification***".

The insured suffered a stroke on 29 July 2002. His doctor suggested that he wait "close to a year and only than (sic) it would be possible for him to say if damage is permanent or temporary". He approached his brokers during mid July 2003 but they were no longer representing the insurer.

On 15 July 2003, before the expiry of 365 days, the insured wrote directly to the insurer requesting claim forms. No response was received from the insurer and the insured approached another broker for assistance. It was only then established which brokerage was dealing with these policies. The insured obtained, completed and forwarded the claim forms to the insurer via

registered mail during August 2003. His claim was however declined due to late submission.

The office enquired from the insurer what prejudice had been suffered as a result of the late submission of the claim. It advanced that the renewal date of the scheme was on 1 April 2003 and that "*renewal terms are negotiated according to the loss ratio*".

The office was of view that the 365-day notification period only ended on 29 July 2003, so the renewal terms would not have been a factor as the insured could still have submitted a claim after the renewal date of 1 April 2003. It also took into consideration that the insured wrote to the insurer within 365 days even though the letter was not received.

The office made a preliminary ruling that the insurer was not prejudiced by the late submission of the claim and that the claim be considered on the merits. The claim in respect of the critical illness benefit was paid.

CASE 3

The policy provided:

> "*… all claims against the policy must be submitted within 30 days after the happening / event to the Administrators and no claim will be considered after six months; …*"

The insured submitted a disability claim as he had his bladder and prostate removed due to cancer. The claim was rejected due to late notification. He appealed the insurer's decision advancing that, due to the side effects of treatment; undergoing a major operation; fighting for his life and drastically adapting his life, he only realised in March 2003 that he could submit a claim under the policy.

The insurer responded that the insured's last day at work was 30 December 2001 and received his last salary on 31 August 2002. The claim was lodged on 24 April 2003. It advised that the policy terms and conditions stipulate that a 30-day period is allowed for notification of a claim. Thereafter 6 months is allowed for the delivery of all documentation. This clause is strictly applied and only in circumstances where it is deemed to be beyond the claimant's control will the notification period not apply. The insurer rejected the claim as the insured did not provide sufficient evidence that the circumstances were beyond his control.

The insured's brother requested that the matter be reconsidered as the insured was in and out of hospital for long periods of time and was not able to lead a "normal life" nor deal with issues of "normal life". The insured died on 2 December 2003.

The office was of view that there was little doubt that as a matter of law the insurer was entitled in terms of the policy provision to decline liability on the

basis of the late submission of the claim. However, in view of the fact that the insurer and its agent confirmed that "special circumstances" are taken into account, the submissions made by the insured and his brother were such that a case for "special circumstances" could be made on humanitarian grounds. The office enquired from the insurer whether it would be amenable to an *ex gratia* payment of half of the sum assured, which was not a substantial amount. The insurer agreed and the matter was settled.

CASE 4

The policy provided:

> "*Permanent Disability:*
> *…*
> *No claim will be payable 365 days after the happening of the event from which the permanent disablement directly resulted*"; and
>
> "*Claims*
>
> *On the happening of any event which may result in a claim under this Policy the Insured … shall at his own expense:*
>
> *(i) notify the Insurers in writing within 120 (one hundred and twenty) days of any claim for death and 365 (three hundred and sixty five) days in the case of any claim for permanent disability*".

The insured injured his knee while on duty in 1993. He continued working until 2002 when his knee started giving him problems again. He had a total right knee replacement. Due to this he could not perform his duties as a yard foreman in the shunting yards and did not return to work after the operation. A disability claim was submitted in July 2003. The insurer contended that the claim should have been submitted in 1994 as the policy provisions state that "*no claim will be payable 365 days after the happening of the event from which the permanent disablement directly resulted*". The claim was rejected.

The insured stated that he was not disabled in 1993 when the injury occurred, as he was able to perform his normal duties from 1993 until 2002.

The office is of the view that the phraseology of the provision dealing with claims "o*n the happening of any event which may result in a claim under this Policy*" lends itself to the interpretation that the injury in question must be such that a reasonable person would appreciate that it "*may result in a claim under this Policy*". The claim in question was that he is "*permanently and totally disabled*" from pursuing his occupation. That meant that the claim only had to be submitted when the manifestation of the injury was such that it could reasonably have led to a claim for permanent and total disability under the policy.

The knee operation, which eventually gave rise to the disability claim, only took place on 18 June 2002. It is arguable that the insured should at that time

reasonably have appreciated the necessity for submitting a claim. The actual claim was only submitted in July 2003, which was marginally outside the 365 days referred to in the provision. The insured advised that the reason for the delay was that his employer informed him that his boarding must first be approved before it would consider signing any claim forms. The employer completed and signed the forms in late July 2003. The fault of the late submission was therefore not primarily that of the insured.

The office is of the view that the circumstances of this case are such that it would be inequitable to refuse the claim in its entirety. We have suggested to the insurer that it makes an offer of payment on an *ex gratia* full and final settlement basis, should it be of the view that the insured is indeed disabled in terms of the contract.

The matter is still pending.