LONG COVID DISABILITY HANDBOOK

Everything You Need To Know About
Your Long COVID Disability Insurance Claim
From the Experts

DABDOUB LAW FIRM

Disability Insurance & ERISA Attorneys

I. About the Author

"When you spend every day of your legal career committed to one area of the law, you become really good at it. And when you become very good at what you do, you do it with great success."
— Edward Dabdoub

Edward first represented a man suffering from chronic pain while in law school whose disability benefits were wrongly terminated. Edward won back his disability benefits. With that experience, he saw firsthand how his work positively impacted someone's life. From that day, he decided to dedicate his legal career to helping people who were too sick or injured to work and to hold insurance companies accountable to the promise to pay disability benefits if the insured became disabled.

Dabdoub Law Firm was built for the sole purpose of helping people get their disability benefits from insurance companies. The firm never represents insurance companies.

Led by nationally recognized attorney, Edward Dabdoub, the attorneys and staff at Dabdoub Law Firm spend every day fighting for their clients' disability insurance benefits.

The firm handles disability insurance claims at any stage, including:

- Filing an initial claim for short-term and/or long-term benefits
- Preparing and submitting an appeal to the insurance company
- Litigating cases in federal court
- Managing a claim with the insurance company

Our attorneys have successfully handled some of the most unique and complex disability insurance cases, including Long COVID. We have developed a winning strategy for these cases using various objective tests, medical records, doctor support, and Long COVID expert opinions.

II. Introduction

Facing a disability insurance claim is difficult. You are already dealing with a life-altering medical condition, unable to continue working, and facing financial hardship. Now you must deal with an insurance company asking lots of questions and requesting you fill out multiple forms—or worse, denying your claim.

The reality is disability insurance is a complex area of the law. Dealing with an insurance company in a disability claim can be frustrating and confusing. The fight to get your disability benefits is not a fair fight. Insurance companies have endless resources. Knowing what to do to protect your right to disability benefits will be crucial when facing an insurance company.

The goal of this handbook is to take the mystery out of filing, and handling, a disability insurance claim for Long COVID. We want to help you understand what the law is and what to expect during the claim process, what to do if you are approved, or what your options are if you are denied.

You are probably asking yourself:

- *Where do I start?*
- *What forms must I complete?*
- *How do I talk to my doctor about my disability claim?*
- *What else do I need to do?*

This handbook will guide you through these questions and help you navigate the murky waters of ERISA disability insurance claims due to Long COVID.

III. What is ERISA?

Mentioning the acronym ERISA to just about anyone will likely bring about a confused stare, followed by the question: "what is that?". Yet, whether you are in a blue-collar job or white-collar service work, ERISA governs the majority of claims for benefits made under an insurance policy provided through work. This includes claims for disability insurance, life insurance, and health insurance.

The truth is most people—even attorneys—do not fully appreciate the broad scope and applicability of ERISA to the large majority of working Americans.

ERISA applies to benefit plans (and insurance policies) offered by private employers. This act was passed in 1974 with the intent of protecting plan participants and beneficiaries of employee benefit plans. But not all insurance claims from an employee-sponsored disability plan or insurance policy are governed by ERISA. There are exceptions.

I) Exceptions to ERISA governance

- Church
- Government

If your employer falls under one of these two categories, then most likely your claim is governed by state law as opposed to the ERISA federal law.

II) Non-ERISA Claims:

Individual insurance purchased by you and not provided by your employer is not governed by ERISA. It is governed by the law of the state listed in the insurance policy or the state where the policy was issued.

III) How do you know if ERISA applies to your case?

ERISA applies in most (not all) situations where a private employer offers benefits to its employees. If you are dealing with a group benefit(s) offered to an employee through their employment, then your claim more likely than not falls within ERISA.

To help you decide if your claim is governed by ERISA, ask yourself:

a) Is my disability insurance coverage through my job?
b) Is my employer a private company—not government or church affiliated?

If you answered yes to those questions, then chances are you are dealing with an ERISA claim.

IV. What Do I Need to Know About a LONG COVID Disability Claim?

Filing a disability insurance claim for Long COVID can be scary. You are dealing with a new medical condition that is not widely understood. You are suffering from symptoms that cannot necessarily be seen on an MRI or in your blood work. Your doctors may not fully understand what is going on with you and how to treat you. And then on top of all that, there are probably other medical issues that are arising secondary to Long COVID.

To begin, it is very important you regularly treat with your physicians and providers to maintain a clear record of your symptoms and conditions.

As experienced disability insurance attorneys, we have implemented a strategy for proving a disability claim caused by Long COVID and have had great success with it.

This includes compiling evidence such as:

- medical records and testing
- detailed letters and questionnaires from treating providers corroborating reported symptoms
- personal statements from you, friends and family corroborating your disability and reported symptoms
- a CPET (cardiopulmonary exercise testing) – a specialized stress test that measures the body's response to exercise, even minimal exertion. It is used in disability cases to measure post-exertional malaise.
- a neuropsychological evaluation – measures a person's cognitive functioning
- an independent medical evaluation – an in-person examination with a doctor specializing in long COVID or long COVID related illnesses
- an FCE (functional capacity evaluation) – a functional test with a physical therapist that measures at what level you are capable of working (sedentary, light, medium), if at all. Typically, these tests show the client has less than sedentary capacity and thus supporting disability.
- a peer review – a paper review of all medical record and testing

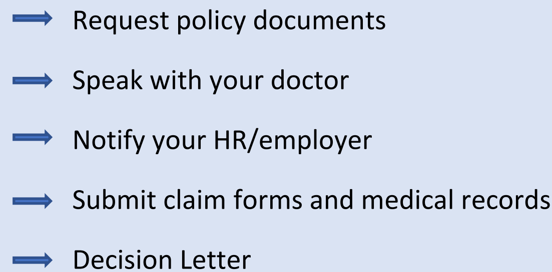
Because Long COVID is a newer condition and the symptoms can be subjective, we are seeing insurers denying these claims alleging the medical evidence does not support limitations, there is no testing confirming cognitive impairments or fatigue, and/or generally that the claimant does not meet the definition of disability.

A file with clear, supportive evidence is necessary to ensure that you:

(a) get an approval, or

(b) walk into litigation with a winning case.

V. Filing a Disability Insurance Claim due to Long COVID



If you are at the point where you and/or your doctor have decided you can no longer work, you have to prepare yourself to submit a disability insurance claim.

This is a critical part of the process because a slight mishap could be fatal to your claim. You also want to increase your chance of success from the start, as opposed to trying to fix a mistake down the road.

☑ *Send an email to HR and ask for a copy of your short-term and long-term disability insurance policies.*

Your employer is required under ERISA to keep a copy of your insurance policies and plan documents. Under ERISA, they must provide you with a copy of the requested documents within 30 days of a written request. An email is good enough.

☑ *Have a heart-to-heart conversation with your doctor(s).*

One of the most critical parts of a disability claim is doctor's support. Without it, it is difficult, if not impossible, to get an approval.

If you are suffering from Long COVID, you likely treat with various specialists for different aspects of your condition. Your doctor(s) will be asked to fill out forms and possibly respond to questions. You need to be sure you are on the same page with them, and you have their support for your disability.

☑ *Notify your HR or employer that you need to take a leave for health concerns and request forms and/or contact information for your disability insurance carrier.*

When you get the initial forms for your disability claim, read through them carefully and fill them out. You should simply answer the question that is asked and do so truthfully. Have your doctor(s) fill out the medical provider's statement (also known as an Attending Physician Statement "APS").

You should complete the forms promptly to avoid delays.

☑ *Submit claim forms, the APS, and medical records.*

The more information supporting your disability you can give up front, the quicker the process may be. The insurance company still will review your claim and determine if you qualify for benefits under the policy. If all information and records are provided upfront, the faster they can conduct a review.

Your medical records should demonstrate how Long COVID impacts your daily functioning. For example, the records and APS should reflect symptoms you experience such as fatigue, headaches, shortness of breath and cognitive dysfunction. If you have had any testing done, that should be included with your claim as well. Personal statements from you, family and friends as well as photos and videos of showing how Long COVID impacts you are also very strong pieces of evidence.

☑ *Time Frame to Approve or Deny the Claim*

Time frame for initiating a claim under ERISA:

Initiate claim → Insurer has 45 days to approve or deny

+ 30-day extension

+ 30-day extension

= 105 days total

Your insurance company must notify you of its decision to approve or deny benefits within 45-days after initiating the claim. However, under ERISA, an insurer may take up to two 30-day extensions, for a total of up to 105 days to make a decision.

Within that time frame they should send you a letter notifying you your claim has been approved or advising you it has been denied. You should also be made aware within that time frame whether additional information is needed. You want to respond to any requests for additional information promptly to avoid further delay.

If the claim is **approved**, be aware—once approved, not always approved. You will be required to show your continued disability through updated medical records, claimant forms and attending physician statements.

If the claim is **denied**, the letter must include appeal rights. Under ERISA regulations, the insurance company must explain its basis for denying your claim. It must also include language explaining your right to an appeal.

ERISA requires you **submit your appeal within 180 days** of the denial letter. If you miss this deadline, you might be barred from pursuing your claim.

VI. Preparing and Submitting an Appeal to the Insurance Company

✓ Prepare and Develop Your Claim File
- ⇨ medical records
- ⇨ support from doctors
- ⇨ personal statements

✓ Submit Appeal in Writing

✓ Respond to Medical Reviews

✓ Pay Attention to The Time Line

A pre-suit appeal to the insurance company is *required* under ERISA. You cannot initiate a lawsuit without first going through the appeal process. The appeal process is probably the most critical part of a disability insurance claim. Prepare your appeal as though you are preparing for litigation. If you do, your appeal will be very strong and likely approved. If it's denied, you made a strong case for yourself in court.

(1) Develop the claim file

Insurance companies keep claim files for each claim, which is made up of all your medical records, APSs, letters, and every other document you sent the insurance company. The claim file also includes everything the insurance company created for your claim, including its medical reviews of your disability.

As soon as you get the denial letter, get to work. Each claim is unique, thus what is needed to prepare the appeal will vary case to case.

This is not an exhaustive list, but rather a guide for the types of information you may need to gather in support of your appeal.

- Request a letter and/or questionnaire from your treating provider(s) outlining your medical condition(s), including restrictions and limitations caused by Long COVID and related conditions. Doctors do not always understand how to correctly complete their forms for a disability claim. It is important their forms are done properly.
- Request all medical records from your treating providers. Medical records should demonstrate restrictions and limitations through objective testing, physical examinations, mental status examinations, and progress notes.
- Write a personal statement explaining how Long COVID impacts your life—personally and professionally.
- Request personal statements from friends and family to corroborate your statements of disability.
- Obtain outside, independent testing: cardiopulmonary exercise test (CPET), neuropsychological evaluation, FCE or independent medical examination.
- If you regularly take medications for headaches, shortness of breath/chest pain/palpitations, muscle aches and so on, request your prescription history from your pharmacy.

(2) Submit a Written Appeal

First, your appeal letter must be in writing. You should explain your disability in the context of why you are unable to work. It should also refute the insurance company's basis for denying your benefits.

Next, submit with your appeal the medical and non-medical evidence you gathered demonstrating your disability. Once you have sent your letter and evidence, continue to send any additional records or information that is helpful to your claim.

(3) Respond to Correspondence and Medical Reviews from the Insurance Company

The insurance company is required to keep you informed and have a good faith exchange of information.

The insurance company is required to provide you an opportunity to review and respond to any unfavorable information created during the appeal. This is typically a medical review by the insurance company's medical reviewers, vocational reviews, surveillance and internet searches of you. You are

allowed to receive and comment on this information before it is used against you in a final denial of benefits.

Take the time to read through the reviews, go over them with your treating providers, and respond. Do not waste the opportunity to refute the insurance company's position. Provide additional information that supports your disability and rebut the insurance company's reviews. Remember, this is your last chance to get any and all information you want into the file before it closes.

(4) Keep an Eye on Timelines

ERISA Appeal Time Frame

45 days + 45-day extension* = 90 days

*Only for a "special circumstance"

Under ERISA, an insurance company has 45 days to approve or deny the appeal. The decision must be given in writing and explain the basis and rationale for the denial. ERISA allows an insurance company to take up to one 45-day extension only for a "special circumstances."

A "special circumstance" must be something out of their control that has limited or prevented them from making a decision within 45 days. For example, a medical review is routinely conducted by an insurance company during the appeal process. In fact, ERISA requires a medical review to be done. Thus, requesting an extension to conduct or complete a medical review is **not** a "special circumstance."

Word of caution—insurers like to use the special circumstance as a free pass to a take the extension. Do not sit back and allow this to happen. Do not allow them to drag out the review process. Hold them to the deadline set by law.

VII. Filing an ERISA Lawsuit for Denied Benefits

Because ERISA is a federal statute, ERISA disability insurance dispute lawsuits are filed in federal court. Your disability insurance policy will have a deadline by which you have to file the lawsuit. Pay close attention to that date. Failure to file your lawsuit timely may forever bar you from pursuing the denial further.

Standard of Review in ERISA Disability Cases

The standard of review is how the court reviews a case. In ERISA, the default standard is called *de novo*. Under *de novo*, the court reviews the case "anew." It means the judge looks at the policy requirements and evidence to determine whether you meet the definition of disability. This standard is more favorable to you.

However, most ERISA cases are reviewed under a standard called arbitrary and capricious. This means that the judge is reviewing your case to determine whether the insurance company made a reasonable decision to deny your benefits. Even if the judge believes you are disabled, you could still lose your lawsuit if the judge also believes that the insurance company's review process was reasonable.

To determine which standard will apply in your case, you must carefully read the policy. For arbitrary and capricious to apply, the insurance policy must have a provision that states the insurance company has

discretion to interpret and apply the terms of the policy. With *proper* discretionary language, an insurer is given discretion, and the court will apply the arbitrary and capricious standard.

Which standard applies in your case will make a huge difference in the outcome. Arbitrary and capricious is a higher standard and one that is difficult for a plaintiff/claimant to overcome. The majority of ERISA disability lawsuits reviewed under this standard are won by the insurance company throughout the country.

You have to prove that you are disabled as well as that the insurance company was unreasonable in its denial of benefits. It is for this reason the appeal process is so critical. Building up your claim file and making the insurance company look unreasonable through the appeal process sets up the case for a win in litigation.

VIII. Important Information to Keep in Mind

1. **Definition of Disability – Own Occupation vs Any Occupation**
2. **Limitations in Policy**
3. **Surveillance and Social Media Investigation**

Your disability insurance policy will tell you everything you need to know going into the claim process and staying in it. The definition of disability is what you need to prove to get on claim and stay on claim. *Remember—once approved, not always approved.*

Definition of Disability

The definition of disability is the first and most important definition you need to know. This is what you need to prove to be approved and to continue to receive disability benefits.

In ERISA LTD policies, typically, the definition of disability changes after a specified amount of time of paid benefits. Initially, you must prove you are disabled from your own occupation. Then, the definition changes to disability from work in any occupation. The any occupation definition is a harder one to prove and is where we most often see denials.

First 24 Months of LTD Payments

Own Occupation Period

- Must prove you are unable to work in your own occupation
- Typically, this is the first 24 months of paid benefits

Beyond 24 months – Maximum Benefit Period

Any Occupation Period

- After 24 months of paid benefits, there is a change in the definition of disability from own occupation to any occupation
- Must prove you are disabled from working in any occupation, as defined in your LTD policy
- Once approved, you will have to periodically continue to show you remain disabled
- Maximum benefit period is typically age 65 or your normal Social Security retirement age

Limitations in Your Policy Relevant to a Long COVID Disability Claim

The policy will also describe any limitations that may apply to your case. Limitations, as defined in the policy, are medical conditions or circumstances which limit the time you will be paid benefits.

Some common limitations include:

1. Pre-existing limitation.

If you file a claim for disability within the first year of coverage, then the insurance company will conduct a pre-existing condition review. In this situation, depending on the specific terms of the policy, the insurance company will conduct an investigation to determine whether the condition(s) for which you are claiming pre-existed in the months prior to when you became covered.

A pre-existing condition is usually a condition that existed before your coverage in the insurance policy began. You must also have been treated during what is known as the Look Back Period ("LBP") for the condition to be considered pre-existing. Most insurance policies have a LBP of 3 months before your coverage begins. For example, if you have a history of chronic back pain and were treated (i.e., took medications, saw a doctor, or had diagnostic imaging) in the 3-month window before your insurance coverage began, your medical condition is pre-existing and excluded. On the other hand, if you did not treat during the LBP, your condition is not pre-existing even though you might have had it for many years.

This is not as black and white as insurance companies like to make it. It is possible to overcome a pre-existing condition limitation depending on the circumstances, definitions in the policy and your medical history.

2. Mental health limitation.

In the case of a mental health disability, the mental health limitation typically limits disability benefits to 24 months. This means if your claim for long term disability is based on a mental health condition, you are limited to being paid benefits for 24 months. No benefits are paid beyond 24 months.

We have seen cases in which the insurance company applies the mental health limitation to claimants with Long COVID. This usually happens because of a lack of evidence supporting the physical complaints.

3. Self-reported symptom limitation.

Insurance policies usually list the conditions that fall under this limitation. If a condition is self-reported, meaning it cannot be objectively proven through medical evidence, then benefits are paid for a limited period of time—usually 24 months. Some typical self-reported conditions are fatigue or migraines.

This is particularly important for Long COVID claimants. Insurance companies will apply this limitation by claiming fatigue, pain, and headaches often associated with Long COVID are self-reported. To combat this, we use things like CPET and FCE testing to objectively demonstrate reported symptoms of post-exertional malaise.

4. Chronic fatigue conditions

Some insurance companies will limit benefits for conditions that are primarily fatigue conditions, like chronic fatigue syndrome. Because a primary symptom of Long COVID is fatigue, insurance companies may try to apply this limitation to Long COVID claims. Organizations like the CDC define Long COVID as having a wide range of symptoms involving multiple systems in the body. Thus, it is arguable that this is not simply a fatigue condition and should not fall under this limitation.

Surveillance and Social Media Investigation

Insurance companies periodically conduct internet searches and surveillance on claimants. It can happen during the initial claim, an appeal, or while being paid benefits. The insurer may order surveillance of you, conduct an internet search and/or social media search without you ever knowing. It is important to keep in mind that anything you put online for the public to see is fair game.

BE CAREFUL AND BE SMART WITH YOUR ONLINE ACTIVITY

IX. WHY DO I NEED AN ERISA DISABILITY INSURANCE ATTORNEY?

Disability insurance law is complicated, and your financial future is on the line. You need an advocate. But, just as important, you need an advocate who knows disability insurance law with experience handling LTD claims at all stages.

You don't want to be in the face of an appeal denial wishing you had done more or done things differently.

Dabdoub Law Firm is a firm built for the sole purpose of representing people in their fight for disability insurance benefits. Each attorney in the firm focuses solely on this area of the law. We have handled claims against every major insurance carrier involving a wide variety of common and unique medical conditions. We know the tactics of each insurance company and how to push back on them.

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