

PRIVATE DISABILITY INSURANCE APPEALS

The following information is about the appeals process for private disability insurance, either purchased individually through a broker or insurance company, or provided as an employee benefit. If you are appealing State Disability Insurance or Social Security benefits denials, different rules apply.

Knowing the terms of your policy, including how the plan defines “disability,” can help you understand how to qualify for benefits and help avoid getting denied benefits in the first place. Request your policy information in writing, including information about how benefits are determined and what the reporting requirements are for you to receive benefits. Request the insurance company’s approval or denial of benefits in writing as well, including the amount of benefits they will provide and any reason they are denying benefits. You should get familiar with your policy to determine exact procedures for filing a claim and appealing a denial.

The process of appealing your disability insurance claim denial will vary depending on whether you have employer-provided private disability insurance or whether you purchased the policy on your own. No matter what type of plan you have, when preparing your appeal, study the denial letter closely and note any deadlines. A missed deadline could result in losing some appeal rights.

If I am denied benefits under a private disability insurance plan *provided by an employer*, what should I do?

Employer disability insurance appeals are governed by the Employee Retirement Income Security Act, or ERISA. Under ERISA, policyholders must follow certain administrative procedures in order to keep the right to appeal or file a lawsuit in Federal court later on. ERISA requires disability insurance companies to follow certain rules as well.

When you submit your claim for benefits, the insurance company has 45 days to review your claim and send you an approval or denial. If your initial claim is denied, your insurance company must send the denial with a detailed notice of why the claim was rejected. The plan must also provide to you for free, upon request, any copies of documents, records, and expert advice that were used in making the decision. Once you understand the reason for denial, you can begin preparing helpful evidence to submit to your insurer for the appeal.

If your claim is denied, the claims reviewer must include the following in the denial letter:

- the specific reason(s) for the denial;
- reference to the specific part of the policy on which the determination is made;
- any internal rules or criteria that were relied upon in making the claims decision
- description of additional material or information, if any, is necessary to make your claim valid;
- an explanation of what steps need to be taken to have the claim denial reviewed;
- information about your right to bring a subsequent law suit under ERISA;

To tackle an ERISA claim, there are steps you are required to follow:

1. If denied, you have two choices: to either (1) accept that decision or (2) file an appeal to the insurance company if you disagree with the denial. You have 180 days to submit an appeal.
2. If you decide to appeal, the insurance company has 45 days to review your appeal -- which can be extended for up to another 30 days if they can justify the need for an extension. The person who reviews your appeal must be different from the person who reviewed your original claim and must be higher up in the company than the original person who reviewed your claim.
3. If the insurance company denies your appeal, you might need submit a second appeal to your insurance company before filing a lawsuit. If there is this second level of appeals, the insurance company has to give you a reasonable time to appeal. Check the terms of your policy to see how long that may be; it may not be another 180 days.¹
4. After you complete the final internal appeal to the insurance company, whether one or two levels as provided in the plan, then you can bring your appeal in federal court under ERISA.

What If I am denied benefits under a private disability insurance plan I purchased on my own?

If you have purchased your own disability insurance plan through a broker or insurance company, and your claim for disability benefits has been denied, pay special attention to the policy's documents. Some will allow you to appeal an initial denial, others may require additional filings before reconsidering your claims. Plans vary greatly.

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¹ <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/publications/filing-a-claim-for-your-health-or-disability-benefits>