UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
ORLANDO DIVISION

GEORGE B. SHAW,

Plaintiff,

-vs- **Case No. 6:08-cv-1491-Orl-22GJK**

SUN LIFE ASSURANCE COMPANY OF CANADA,

Defendant.

ORDER

I. INTRODUCTION

This cause comes before the Court for consideration of Plaintiff George B. Shaw's ("Shaw") Motion for Summary Judgment (Doc. No. 21), filed on July 14, 2009. Defendant Sun Life Assurance Company of Canada ("Sun Life") filed a memorandum in opposition (Doc. No. 23) on August 13, 2009. The Court will also consider Sun Life's Dispositive Motion for Final Summary Judgment (Doc. No. 20), filed on July 13, 2009. Shaw filed a response in opposition (Doc. No. 22) on August 12, 2009. After carefully considering the parties' submissions, the Court decides that Shaw is entitled to summary judgment.

II. BACKGROUND

Shaw is the son of Thelma Thomas-Watson ("Thomas-Watson") and claims certain benefits as her designated beneficiary under the terms of a life insurance policy sponsored by her employer, Waterman Communities ("Waterman"). (Doc. No. 17 pp. 2-3.) Shaw's claim

against Sun Life is brought under section 1132(a)(1)(B) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*

Thomas-Watson was hired by Waterman on November 5, 2001. (Doc. No. 20-4 p. 68.) On February 13, 2007, Thomas-Watson took a leave of absence from work.[1] (*See id.* at 42.) It is undisputed that at that time Thomas-Watson was insured under her employer-provided life insurance policy, funded by Shenandoah Life Insurance Company ("Shenandoah"). (*See* Doc. No. 20-2 p. 1.) She did not return to work before her death on August 23, 2007. (*See id.*) During her leave of absence, Waterman replaced the Shenandoah life insurance policy with a policy issued by Sun Life, effective June 1, 2007.[2] (*See id.*)

After Thomas-Watson's death, Shaw filed a claim as the beneficiary under the Sun Life policy, which was stamped as received by Sun Life Financial on November 12, 2007. (*See* Doc. No. 20-4 p. 72.) On November 13, 2007, Sun Life sent Shaw a letter denying his claim for benefits on the grounds that Thomas-Watson was not "actively at work" on the effective date of the Group Policy and the coverage never became effective because she never returned to work after June 1, 2007. (*See id.* at 67.) In its denial letter, Sun Life stated that "Ms. Thomas-Watson was not included on the GLITS [Group Life and Transition Statement] form submitted to Sun Life on April 5, 2007." (*Id.* at 66.) According to Sun Life, the purpose of the GLITS

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[1] Shaw contends Thomas-Watson left work as a result of a sickness or injury. (Doc. No. 21 p. 1.)

[2] If Thomas-Watson is covered under the Sun Life policy, she is entitled to $99,000 in basic life insurance coverage. (*See* Doc. No. 20-4 p. 68.)

form was to notify Sun Life of any Waterman employees not actively at work on the effective date of the Group policy.[3] (*See* Doc. No. 23 p. 3.)

Shaw filed an administrative appeal of this determination by a letter dated March 27, 2008, contending that because Thomas-Watson was on a medical leave of absence, she was insured by Sun Life at the time the carriers changed. (*See* Doc. No. 20-4 p. 61.) On June 3, 2008, Shaw's counsel filed a supplemental appeal letter on his behalf. (*See id.* at 29.) The following documents were attached to the supplemental appeal letter: a copy of the "Continuity of Coverage" provision in the Sun Life policy, copies of e-mails showing that Thomas-Watson had been making contributions to her life insurance policy since 2005, and a copy of an Employer Statement demonstrating that Waterman paid Sun Life premiums for Thomas-Watson until August 31, 2007. (*See id.*) Shaw asserted that Sun Life's denial based on Thomas-Watson not being actively at work was incorrect because the "Continuity of Coverage" provision afforded coverage. (*Id.*) That provision states:

> **Continuity of Coverage**
> In order to prevent loss of coverage for an Employee when this Policy replaces a group Life policy the Employer had in force with another insurer immediately prior to June 1, 2007, Sun Life will provide the following coverage.
>
> **Employees not Actively at Work on June 1, 2007**
> An Employee may become insured under this Policy on June 1, 2007, subject to all of the following conditions:
>
> 1. he was insured under the prior insurer's group Life policy immediately prior to June 1, 2007; and
> 2. he is not Actively at Work on June 1, 2007; and

[3] Sun Life alleges if Thomas-Watson had been listed on the GLITS form, Sun Life would have advised her to seek waiver of premium benefits from Shenandoah. (Doc. No. 20 pp. 3-4.)

3. he is a member of an Eligible Class under this Policy; and
4. premiums for the Employee are paid up to date;
5. he is not receiving or eligible to receive benefits under the prior insurer's group Life policy

(Doc. No. 20-3 p. 93.) In a letter dated June 18, 2008, Sun Life affirmed the denial of benefits on appeal because Thomas-Watson "was not actively working at the time the Group policy became effective," and her insurance under Sun Life "never became effective" because she did not return to work after June 1, 2007. (Doc. No. 20-2 p. 1.) Sun Life also stated that "according to the prior carrier's booklet, an employee is eligible for waiver of premium if they become disabled before reaching the age of 60 while insured under their policy." (*Id.*) Shaw was not permitted to appeal what he calls this "new rational [sic] for denial." (*See* Doc. No. 21 p. 6.)

Shaw filed this present action alleging that he is entitled to the life insurance proceeds under the plan. He requests payment of those benefits, pre- and post-judgment interest, and attorney's fees and costs. The primary dispute between the parties is whether the "Continuity of Coverage" provision in the Sun Life policy entitles Thomas-Watson to coverage under the policy and Shaw to its benefits.

III. STANDARD OF REVIEW

Though this cause comes before the Court on cross motions for summary judgment, the standard of review set forth in Federal Rule of Civil Procedure 56(c) is incongruent with the ERISA standard. *See Murray v. Hartford Life & Acc. Ins. Co.*, 623 F. Supp. 2d 1341, 1349 (M.D. Fla. 2009) (explaining how the ERISA standard applies to motions for summary judgment by comparing Fed. R. Civ. P. 56(c) and *Williams v. BellSouth Telecomms., Inc.*, 373 F.3d 1132, 1138 (11th Cir. 2004)); *see also Crume v. Metro. Life Ins. Co.*, 417 F. Supp. 2d

1258, 1272-73 (M.D. Fla. 2006). Because the text of ERISA itself does not set forth a standard for district courts to apply in reviewing an administrator's denial of benefits, the district court examines the plan documents to determine the applicable standard of review. *See Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 109 (1989). The standard for reviewing a denial of benefits is whether the decision of the administrator was arbitrary and capricious. *Glazer v. Reliance Standard Life Ins. Co.*, 524 F.3d 1241, 1246 (11th Cir. 2008). "When conducting a review of an ERISA benefits denial under an arbitrary and capricious standard (sometimes used interchangeably with an abuse of discretion standard), the function of the court is to determine whether there was a reasonable basis for the decision, based upon the facts as known to the administrator at the time the decision was made." *Id.* (quoting *Jett v. Blue Cross & Blue Shield of Ala.,* 890 F.2d 1137, 1139 (11th Cir. 1989)) (internal quotation marks omitted).

Until the Supreme Court decision in *Metropolitan Life Insurance Co. v. Glenn*, --- U.S. ----, 128 S.Ct. 2343 (2008), the Eleventh Circuit standard for reviewing an administrative appeal under ERISA included six steps:

> (1) Apply the de novo standard to determine whether the claim administrator's benefits-denial decision is "wrong" (i.e., the court disagrees with the administrator's decision); if it is not, then end the inquiry and affirm the decision.
>
> (2) If the administrator's decision in fact is "de novo wrong," then determine whether he was vested with discretion in reviewing claims; if not, end judicial inquiry and reverse the decision.
>
> (3) If the administrator's decision is "de novo wrong" and he *was* vested with discretion in reviewing claims, then determine whether "reasonable" grounds supported it (hence, review his decision under the more deferential arbitrary and capricious standard).

> (4) If no reasonable grounds exist, then end the inquiry and reverse the administrator's decision; if reasonable grounds do exist, then determine if he operated under a conflict of interest.
>
> (5) If there is no conflict, then end the inquiry and affirm the decision.
>
> (6) If there is a conflict of interest, then apply heightened arbitrary and capricious review to the decision to affirm or deny it.

Doyle v. Liberty Life Assur. Co. of Boston, 542 F.3d 1352, 1356 (11th Cir. 2008) (citing *Williams*, 373 F.3d at 1138). After *Glenn*, the sixth step of the *Williams* analysis is no longer necessary; the heightened standard of review is inappropriate and district courts use a modified standard. *See Doyle*, 542 F.3d at 1357-58. The court in *Doyle* explained that "the existence of a conflict of interest should merely be a factor for the district court to take into account when determining whether an administrator's decision was arbitrary and capricious." *Id.* at 1360. The court further held that, "while the reviewing court must take into account an administrative conflict when determining whether an administrator's decision was arbitrary and capricious, the burden remains on the plaintiff to show the decision was arbitrary; it is not the defendant's burden to prove its decision was not tainted by self-interest." *Id.*

This case falls under the category of ERISA actions involving a conflict of interest because Sun Life, acting as the administrator of the plan, also acts as a fiduciary and makes discretionary decisions, all while serving as the insurance company paying the claims out of its own assets.[4] *See Glenn*, 128 S.Ct. 2343 (holding that where a plan administrator is not the employer but is itself a professional insurance company, a conflict exists). Thus, pursuant to

[4] The issue is whether the "claim administrator's" decision was arbitrary and capricious. *See Doyle*, 542 F.3d at 1356. Though Waterman apparently was the Plan Administrator, the policy provides that Waterman gave Sun Life complete discretion to administer the policy. (*See* Doc. No. 20-4 p. 20.) Thus, the Court considers Sun Life as holding the role of the administrator.

Glenn and *Doyle*, this Court should consider Sun Life's conflict when determining whether Sun Life's decision was arbitrary and capricious.

IV. Analysis

A. Shaw's Motion for Summary Judgment

Though Sun Life filed its motion for summary judgment prior to Shaw's, the Court will address Shaw's motion first for analytical reasons. Shaw's position is that the Continuity of Coverage provision entitles Thomas-Watson to benefits under the Sun Life policy. Shaw admits that Sun Life has discretion to determine eligibility under the policy but contends that Sun Life has a conflict of interest because it is both the insurer of the policy and pays claims out of its own assets. (Doc. No. 21 at 10.) Shaw argues that Sun Life has no discretion to interpret the Shenandoah policy in order to determine whether Thomas-Watson would have been covered under the Shenandoah policy. (*Id.* at 10 n.4.)

Shaw asserts that the decision to deny Thomas-Watson benefits under the Sun Life policy was wrong and arbitrary and capricious because in the first denial letter, Sun Life only considered that Thomas-Watson was not actively at work and did not mention the Continuity of Coverage provision. (*Id.* at 11.) Shaw contends that because Thomas-Watson was on medical leave, the Continuity of Coverage provisions applies. (*Id.*) According to Shaw, Sun Life's determination that Thomas-Watson was totally disabled and could have applied for waiver of premium under the Shenandoah policy is wrong.[5] (*Id.* at 13-15.) Shaw contends that

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[5] The Shenandoah policy offers waiver of premium if the following requirements are met:

> 1. the Employee becomes Totally Disabled before reaching age 60 while insured under this Policy;

"no medical evidence was obtained by Sun Life before making the decision that Thomas-Watson was entitled to a waiver of premiums." (*Id.* at 14.) As Shaw points out, Kristen Goodwin ("Goodwin"), the Sun Life Senior Claims Examiner who denied Shaw's appeal, "felt that it was 'reasonable to assume' that Ms. Thomas-Watson was disabled based on the cause of death listed on her Death Certificate (end stage renal disease)." (*Id.*) (citing Goodwin's Deposition (Doc. No. 20-1) p. 35). Shaw also points out that Goodwin testified that Shaw's "indication that his mother was on a 'medical' leave of absence was 'relevant' in determining whether she was totally disabled." (*Id.*) (citing Doc. No. 20-1 p. 35). Shaw asserts Goodwin "was obviously aware that there was an insufficient factual basis for her decision." (*Id.* at 14 n.6.) Shaw contends that it is "impossible to make a 'reasonable assumption,' much less an actual determination of disability," on the basis of the death certificate and Shaw's statement that she was on a medical leave of absence. (*Id.* at 14.) Shaw argues that Goodwin's

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2. the Employee remains Totally Disabled for at least 9 months beginning on the date the Employee becomes Totally Disabled (the **Elimination Period**);
3. satisfactory proof of continuous Total Disability is submitted to Shenandoah Life within one year of the date such Total Disability began; and
4. Premiums are paid for the Insured Employee until written notification is received from the Company that life insurance is extended. Premiums will then be waived during the continuation of the Waiver of Premium benefit. If premiums are not paid during the Elimination Periods, premiums will not be waived under this section and coverage will not be extended. If Insured dies during the Elimination Period and premiums have not been paid, no death benefit will be paid.

(Doc. No. 20-4 p. 93.)

determination that Thomas-Watson was "totally disabled" as defined by the Shenandoah policy "is not 'reasonable' and in fact utterly unreasonable." (*Id.*)

Further, Shaw contends that the waiver of premium provision in the Shenandoah policy "specifically provides that death benefits will not be paid if premiums have not been paid and the participant dies during the elimination period." (*Id.* at 15.) Shaw notes that this "was the case here." (*Id.*) He also states that the administrative record contains no evidence to show that premiums were paid to Shenandoah beyond June 1, 2007; instead, the record shows that premiums were paid to Sun Life for Thomas-Watson's coverage on and after that date. (*Id.*) Shaw points out that Sun Life makes the "bizarre argument" that paying premiums to Sun Life satisfies the requirement of continued premium payments under the Shenandoah policy. (*Id.* at 16-17) (citing Doc. No. 20-1 p. 53.) Shaw argues that "Sun Life cannot accept the premiums and then ask that another insurance company be responsible for paying the claim." (*Id.* at 17.) Shaw contends that Sun Life's statement in the appeal denial letter that the prior carrier "may" be liable is insufficient to prove that Thomas-Watson was eligible to receive benefits under the prior carrier and was thus precluded from continuity of coverage under the Sun Life policy. (*Id.* at 18.)

Finally, Shaw contends that Sun Life's denial of benefits was "wrong and arbitrary and capricious because Sun Life's decision on appeal, for the first time, disputed the applicability of the continuity of coverage provision and Sun Life did not permit Plaintiff to appeal such decision." (*Id.* at 18.) Shaw argues this was "clearly in violation of the applicable ERISA regulations." (*Id.* at 12.) Shaw cites the applicable regulations as 29 C.F.R. § 2560.503-1(g)(1),

which require a plan administrator to provide, "in a manner calculated to be understood by the claimant":

> (i) The specific reason or reasons for the adverse determination;
> (ii) Reference to the specific plan provisions on which the determination is based;
> (iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
> (iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring civil action under section 502(a) of the Act following an adverse benefit determination on review.

29 C.F.R. § 2560.503-1(g)(1). Specifically, Shaw alleges that because Sun Life did not include reference to the Continuity of Coverage provision or the Shenandoah policy's waiver of premium clause in its initial denial letter, Sun Life violated 29 C.F.R. § 2560.503-1(g)(1)(ii) by not referencing "the specific plan provisions on which the determination is based." (Doc. No. 21 p. 12.) Shaw cites a Fourth Circuit case where the court reviewed "the propriety of an administrator changing the rational [sic] for its denial during the administrative appeal process." (*Id.* at 20) (citing *Gagliano v. Reliance Standard Ins. Co.*, 547 F.3d 230 (4th Cir. 2008)). The *Gagliano* court remanded the case to the administrator on the grounds that the administrator's second letter violated ERISA when it raised a new rationale for denying the appeal and failed to provide the required information. 547 F.3d at 236. Shaw argues that Sun Life has similarly violated ERISA by failing to cite "the specific plan provisions and/or identify the reasons for the Continuity of Coverage denial until the final denial letter" and by not providing Shaw with the Shenandoah policy. (Doc. 21 p. 22) (citing 29 C.F.R. § 2560.503-1(h)(2)(iii), which requires the administrator to provide the claimant with all "relevant" documents for use in the

appeal). However, Shaw distinguishes the remedy in *Gagliano* and maintains that remand is unnecessary in his case. (*Id.* at 22-23.) Shaw argues that, unlike in *Gagliano*, the "new" reason for denial articulated in Sun Life's appeal letter is not a potentially valid reason for denying benefits.[6] (*Id.* at 22) (citing 547 F.3d at 239).

In its memorandum in opposition, Sun Life argues that the Court should both grant its motion for summary judgment and deny Shaw's cross motion for summary judgment because its denial of benefits was not de novo wrong.[7] (Doc. No. 23 p. 5.) Sun Life contends that its decision was not de novo wrong because Thomas-Watson was not actively at work when the Sun Life policy became effective and the Continuity of Coverage provision did not apply to her. (*Id.* at 6.) Sun Life states that Thomas-Watson "was entitled to apply for and receive waiver of premium benefits which would have rendered her eligible for coverage under the Shenandoah Life policy thereafter." (*Id.*) Sun Life contends that Shaw's argument that the administrative record contained no detailed medical evidence proving Thomas-Watson was totally disabled when she went on leave is flawed because any inability to determine her eligibility "is strictly the fault and result of conduct of Waterman" and Thomas-Watson. (*Id.*) Sun Life adds that the record before it when it decided the claim and its administrative appeal contained documents that provided a reasonable basis on which to assume that Thomas-Watson would have been approved for a waiver of premium. (*Id.*) The basis on which Sun Life relied

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[6] Shaw contends that if the Court chooses to remand, he should be permitted to appeal the decision regarding the Continuity of Coverage provision. (Doc. No. 21 p. 23.)

[7] Sun Life essentially raises the same arguments in its memorandum in opposition as in its motion for summary judgment.

was that Thomas-Watson "went out on medical leave on February 13, 2007, and died within a few months of end stage renal disease." (*Id.* at 6-7.)

Further, Sun Life argues that it is not responsible for what it calls "Waterman's failure to apply for the waiver of premium benefits with Shenandoah Life . . . ." (*Id.* at 7.) Sun Life contends if Waterman had properly administered the plan, Thomas-Watson would have applied for a waiver, she would have paid premiums until a determination of that request, and her subsequent death "would have triggered the payment of benefits by Shenandoah Life." (*Id.*) Sun Life also asserts that Shaw did not provide the affidavit of David Billsborough (Doc. No. 21-1) to Sun Life during the administration of the claim, which was an "egregious" procedural flaw.[8] (*Id.*) Sun Life states that the Court cannot consider this affidavit because "district courts are confined to the evidence in the administrative record in evaluating the correctness and the reasonableness of the benefits determination." (*Id.*) (citing *Lee v. Blue Cross & Blue Shield of Ala.*, 10 F.3d 1547, 1550 (11th Cir. 1994)). Even if the affidavit was record evidence, Sun Life contends, Thomas-Watson's election to discontinue payments to Shenandoah and Waterman's decision "to not disclose her true status to Sun Life, cannot bind Sun Life." (*Id.* at 8.) Sun Life argues that Shaw offered no evidence, apart from a "single sentence in a letter from his counsel to Sun Life," that Shaw was not eligible to receive benefits from Shenandoah or that Shaw made an effort to obtain benefits from Shenandoah. (*Id.*) Sun Life asserts that Thomas-Watson would have been entitled to coverage under the Shenandoah policy if she had taken either of

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[8] David Billsborough testified in his affidavit that Waterman paid no further premiums for Thomas-Watson's coverage to Shenandoah after May 31, 2007. (*See* Doc. No. 21-1 p. 2.) He also testified that Waterman paid premiums for Thomas-Watson to Sun Life from June 1, 2007, until the date of her death. (*Id.*)

two actions: applied for waiver of premium or converted the group policy to an individual policy. (*Id.* at 9 n.3)

Sun Life contends that even if the Court finds its decision to be de novo wrong, it was not arbitrary and capricious. (*Id.* at 9.) Because Sun Life was vested with discretion to review claims, it argues that the appropriate standard for the Court to apply is the arbitrary and capricious standard. (*Id.* at 10.) Sun Life asserts that its decision "was reasonable because Sun Life's construction of the various contractual provisions at issue was reasonable." (*Id.*) According to Sun Life, its decision that Thomas-Watson was eligible to apply for waiver of premium under the Shenandoah policy was reasonable because the evidence in the administrative file showed that she "left her active employment at Waterman on a medical leave and died within a few months of end stage renal failure, without ever returning to work." (*Id.*)

Sun Life contends that the record is devoid of any evidence that Sun Life "has a financial interest in denying benefits to claimants or otherwise suffers from a conflict of interest." (*Id.* at 11.) Sun Life asserts that even if the Court assumed a conflict of interest because of Sun Life's status as an insurer underwriting the policy, Shaw "is unable to show that the decision was arbitrary and capricious." (*Id.*) Sun Life states that "at most the record reflects a difference of opinion regarding the application of the various contractual provisions and the conduct of Ms. Watson and/or her employer that incorrectly identified Ms. Watson in the census of employees actively at work and that wholly failed to identify Ms. Watson on the GLITS form as not actively at work and failed to apply for waiver of premium with Shenandoah Life." (*Id.*)

Finally, Sun Life contends that Shaw received a full and fair review in his administrative appeal because the basis for denial of benefits did not change. (*See id.* at 12-13.) Sun Life

argues that its decision as set forth in the appeal letter did not present a new reason for the denial but only "amplified" the original decision "by making clear that the continuity of coverage provision did not change the result." (*Id.* at 12.) Sun Life also argues that *Gagliano* is inapposite because the *Gagliano* court did not find the insurer's decision to be arbitrary and capricious or the "lack of a second appeal to be a basis for imposition of liability on the insurer." (*Id.*) Sun Life concludes with the assertion that Shaw himself has admitted that both of Sun Life's denial letters "are essentially based on the same grounds." (*Id.* at 13.)

1. Step One: Was Sun Life's Decision Wrong?

To evaluate Sun Life's application of the Continuity of Coverage provision to Shaw's claim, the Court is limited to the record that was before Sun Life when it made its decision. *See Glazer*, 524 F.3d at 1247 (citations omitted). After a de novo review of the plan documents, the Court finds that Sun Life's decision to deny benefits to Shaw as the beneficiary of Thomas-Watson's life insurance policy was wrong. The record establishes that Thomas-Watson was covered by the Sun Life policy via the policy's Continuity of Coverage provision.

Sun Life repeatedly asserts its one reason for denying Thomas-Watson coverage under the Continuity of Coverage provision. Sun Life contends that according to the terms of the Shenandoah policy, Thomas-Watson was "entitled to apply for and receive waiver of premium benefits which would have rendered her eligible for coverage under the Shenandoah Life policy thereafter." (Doc. No. 23 p. 6.) Later it declares, "Plainly under the terms of the Shenandoah Life policy if Ms. Watson had sought waiver of premium, had paid premium during the relevant timeframe and then died during the elimination period, benefits would be payable from Shenandoah Life." (*Id.* at 9.) It also asserts, "As set forth above, Ms. Watson was eligible for

benefits under the Shenandoah Life policy." (*Id.* at 10.) Sun Life never explains *why* Thomas-Watson was required to apply for waiver of premium and offers no medical evidence on which it relied to make the decision that Thomas-Watson would have been eligible for the waiver.

The Court disagrees with Sun Life's determination that Thomas-Watson was totally disabled or that this is even relevant. Goodwin states that she felt it "reasonable to assume" that Thomas-Watson was totally disabled because of her cause of death, end stage renal disease. (*See* Doc. No. 21 p. 14) (citing Doc. No. 20-1 p. 35). This is not an appropriate decision for an adjuster's unaided judgment regarding an insurance policy of another company. Even if Thomas-Watson was totally disabled, the inescapable fact is that Thomas-Watson did not apply for waiver of premium. Theoretical eligibility for waiver of premium under the prior policy does not permit Sun Life to decide the Continuity of Coverage provision does not apply. According to the provision's terms and Sun Life's concession,[9] Thomas-Watson would only be denied coverage if she was receiving or was eligible to receive benefits under the prior policy when the new policy took effect on June 1, 2007. When the Sun Life policy took effect on June 1, 2007, Thomas-Watson was not eligible to receive benefits under the Shenandoah policy, which directly conflicts with Sun Life's position that the Continuity of Coverage provision did not apply to her. The assertion that Thomas-Watson could have been eligible for coverage does not accord with the language in the Continuity of Coverage provision. Thomas-Watson was not receiving benefits under the former policy, and she was not eligible to receive benefits

[9] Goodwin conceded that Thomas-Watson satisfied the first four conditions but concluded that the Continuity of Coverage provision did not apply to Thomas-Watson because she did not satisfy its fifth condition. (*See* Doc. 20-1 p. 45.)

under the former policy. Shaw was not required to prove that Thomas-Watson would not have been eligible for waiver of premium had she applied because this has nothing to do with whether she was *actually* eligible for coverage under the Shenandoah policy when the Sun Life policy took effect on June 1, 2007.

Finally, Sun Life's accusation that Waterman improperly entered Thomas-Watson onto the "actively at work" list and neglected to identify her on the GLITS form is specious. Such an allegation does not change the fact that Thomas-Watson was covered under the Shenandoah policy only until June 1, 2007. Any claim regarding Waterman's actions is not properly raised here.

2. Step Two: Was Sun Life Vested with Discretion?

It is undisputed that the provisions in Sun Life's policy vested it with discretion. In that regard, the plan states: "The Plan Administrator has delegated to Sun Life its entire discretionary authority to make all final determinations regarding claims for benefits under the benefit plan insured by this Policy." (Doc. No. 20-4 p. 20.) Shaw concedes that the insurance policy "provides that Sun Life has discretion to determine eligibility for benefits" and to construe the terms of the policy. (Doc. No. 21 p. 10.) Thus, the Court will apply the arbitrary and capricious standard to determine whether reasonable grounds supported Sun Life's decision to deny benefits. *See Doyle*, 542 F.3d at 1356.

3. Step Three: Was Sun Life's Decision Supported by Reasonable Grounds?

The Court finds that Sun Life's decision to deny benefits was not supported by reasonable grounds. The appropriate inquiry is whether there was a reasonable basis for Sun Life's decision, based upon the facts as known to the administrator at the time the decision was

made. *Murray*, 623 F. Supp. 2d at 1352 (citing *Doyle*, 542 F.3d at 1360). "As long as the decision had a reasonable basis, it 'must be upheld as not being arbitrary and capricious, even if there is evidence that would support a contrary conclusion.' " *Id.* (quoting *White v. Coca-Cola Co.*, 542 F.3d 848, 856 (11th Cir. 2008)). "If the 'evidence is close,' then the administrator did not abuse its discretion, and the requisite deference compels the affirmance of the administrator's decision." *Id.* (citing *Doyle*, 542 F.3d at 1363).

One factor the Court considers is whether Sun Life has a conflict of interest. The Court finds futile Sun Life's argument that the record "is devoid of any evidence that Sun Life has a financial interest in denying benefits to claimants or otherwise suffers from a conflict of interest." (Doc. No. 20 p. 14.) Sun Life even admits that it is the insurer underwriting the policy. (*Id.*) The policy grants Sun Life discretionary authority to determine eligibility for benefits, to determine the amount of any benefits due, and to construe the terms of the policy. (Doc. No. 20-4 p. 20.) Thus, a conflict of interest exists, and the Court considers this conflict of interest in determining whether Sun Life's decision was reasonable. *See Murray*, 623 F. Supp. 2d at 1349; *Glenn*, 128 S.Ct. at 2346. However, the Court finds nothing in the record that indicates the conflict was a "major factor" in its decision to deny benefits. *See Murray*, 623 F. Supp. 2d at 1352. Further, Shaw has not presented any evidence that demonstrates that Sun Life's decision was affected by the fact that it insured the policy.

This does not mean that the Court finds Sun Life's decision to be reasonable. On the contrary, the Court holds that Sun Life's denial of Shaw's claim was wrong and unsupported by any reasonable grounds, and therefore, arbitrary and capricious. Sun Life argues that it made a reasonable decision based on the information it had before it at the time, but the glaring

omission is that Sun Life did not even review all of the terms of its own policy. When reviewing the claim initially, Sun Life did not mention and apparently did not consider the Continuity of Coverage provision. Sun Life eventually alluded to the provision in its denial of appeal letter. Sun Life crafted its arguments in its memorandum in opposition and motion for summary judgment as if the provision stated that the employee would be covered if "he is not receiving benefits or is not possibly entitled to apply for waiver of premium that might lead to continued coverage under the prior insurer's group Life policy."[10] This is not what the provision says or implies. Thomas-Watson was covered under the policy via the Continuity of Coverage provision unless she was receiving or eligible to receive benefits under the Shenandoah policy at the time the Sun Life policy took effect. She was neither; hence, the Sun Life policy clearly provided coverage.

Sun Life based its decision that Thomas-Watson was not covered under its policy on its interpretation of a provision in the Shenandoah policy. Sun Life construed the Shenandoah policy to decide Thomas-Watson would have been "totally disabled" according to its terms and would have qualified for waiver of premium. It was totally unreasonable for Sun Life to decide that Thomas-Watson was "totally disabled," both because Sun Life had absolutely no medical records before it at the time it made the decision and because Sun Life had no discretion to decide whether Shenandoah would have considered Thomas-Watson "totally disabled" had she applied for waiver of premium under the Shenandoah policy. In order for an insured to quality

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[10] The actual language of the requirement in the Sun Life Continuity of Coverage provision states: "he *is not* receiving or eligible to receive benefits under the prior insurer's group Life policy." (Doc. No. 20-3 p. 93) (emphasis added).

for waiver of premium, the Shenandoah policy requires the insured's "total disability" to be "certified by a legally qualified Physician." (*See* Doc. No. 20-4 p. 93.) Goodwin essentially determined that a legally qualified Physician would certify Thomas-Watson as totally disabled had she applied for waiver of premium. This is far too speculative. Sun Life also does not explain how the waiver conclusively determines that she would have enjoyed continued coverage by Shenandoah. Even if she had applied for and received waiver of premium, the waiver would not have served as a guarantee that she would have been "receiving or eligible to receive benefits" under the Shenandoah policy on June 1, 2007.[11]

Sun Life's argument is not only based on conjecture; it does not comport with common sense. Thomas-Watson went on leave because she was sick. She and her employer continued paying premiums for her life insurance coverage – first to Shenandoah until June 1, 2007, and then to Sun Life from June 1, 2007, through August 31, 2007. (*See id.* at 31.) During her leave of absence, Thomas-Watson certainly expected that she was covered under the applicable policy through her employer.[12] She was not required to apply for a premium waiver or conversion. Unfortunately, she was unable to return to work because of her death on August 23, 2007. Sun Life's argument implies that she had no coverage under the Sun Life policy though Thomas-Watson and Waterman continued to pay premiums to Sun Life. Sun Life

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[11] A waiver of premium is simply a benefit for the insured when a disability results in reduced income. Certain conditions must be met by the employee for life insurance coverage to continue under the waiver. (*See* Doc. No. 20-4 p. 93.) Sun Life would have to engage in more speculation to determine Thomas-Watson would have met these conditions.

[12] If Thomas-Watson had died before the Sun Life policy came into effect on June 1, 2007, she would have been covered under the Shenandoah policy whether or not she had applied for a waiver of premium.

willingly accepted the premiums but now asserts that it provided no coverage and attempts to point the finger at Thomas-Watson's employer, stating: "The employer cannot create coverage where none exists by making omissions or misrepresentations in these documents." (Doc. No. 23 p. 2 n.2.)

Following *Glenn* and *Doyle*, the Court concludes that Sun Life's decision was both de novo wrong and unsupported by any reasonable grounds.[13] Considering the record before Sun Life when reviewing Shaw's claim, nothing supports a reasonable ground for Sun Life's denial of benefits. Therefore, the decision was arbitrary and capricious. Accordingly, the Court will grant Shaw's motion for summary judgment.

B. Sun Life's Motion for Summary Judgment

Based on the foregoing analysis, Sun Life's motion for summary judgment will be denied.

VI. CONCLUSION

Based on the foregoing, it is ORDERED as follows:

1. Plaintiff George B. Shaw's Motion for Summary Judgment (Doc No. 21), filed on July 14, 2009, is GRANTED. Defendant Sun Life Assurance Company of Canada is liable to Plaintiff George B. Shaw for death benefits totaling $99,000.00 under the terms of the Sun Life Policy, Number 22890.

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[13] Shaw also makes the argument that Sun Life's denial was wrong and arbitrary and capricious based on its neglect to disclose all applicable documentation and reasoning to Shaw in violation of 29 C.F.R. § 2560.503-1(g). (Doc. No. 21 p. 19.) It is unnecessary for the Court to address this argument having decided that Sun Life's denial of benefits was arbitrary and capricious.

2. Defendant Sun Life Assurance Company of Canada's Motion for Summary Judgment (Doc. No. 20), filed July 13, 2009, is DENIED.

3. This case is REFERRED to Magistrate Judge Gregory J. Kelly for a determination of the attorneys' fees and pre- and post-judgment interest to which Plaintiff George B. Shaw is entitled from Defendant Sun Life Assurance Company of Canada. Plaintiff George B. Shaw shall file and serve a properly-supported fee application on or before **Tuesday, November 10, 2009**. Defendant Sun Life Assurance Company of Canada shall file and serve its response to the fee application on or before **Wednesday, November 25, 2009**.

4. Following the determination regarding fees, the Court will direct the Clerk to enter a final judgment.

5. The trial of this case, previously set for December 1, 2009, is CANCELLED.

DONE and **ORDERED** in Chambers, in Orlando, Florida, on October 25, 2009.

Copies furnished to:

Counsel of Record

ANNE C. CONWAY
United States District Judge

Jean Jones

From: cmecf_flmd_notification@flmd.uscourts.gov

Sent: Monday, October 26, 2009 4:22 PM

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Middle District of Florida

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Case Name: Shaw v. Sun Life Assurance Company of Canada
Case Number: 6:08-cv-1491
Filer:
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Docket Text:
ORDER Denying [20] Defendant Sun Life Assurance Company of Canadas Motion for Summary Judgment; Granting [21] Plaintiff George B. Shaws Motion for Summary Judgment. This case is REFERRED to Magistrate Judge Gregory J. Kelly for a determinationof the attorneys fees and pre- and post-judgment interest. Plaintiff George B. Shawshall file and serve a properly-supported fee application on or before Tuesday, November 10,2009. Defendant Sun Life Assurance Company of Canada shall file and serve its response to the fee application on or before Wednesday, November 25, 2009. The trial of this case, previously set for December 1, 2009, is CANCELLED. Signed by Chief Judge Anne C. Conway on 10/26/2009. (CH)

6:08-cv-1491 Notice has been electronically mailed to:

Marie Tomassi mtomassi@trenam.com, mwallace@trenam.com

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