Life Insurance Law Committee

MODERN FAMILY: QDROS, DROS AND LIFE INSURANCE

By: Joan O. Vorster & Courtney Cruz

In a situation where a deceased’s widow and ex-spouse both claim entitlement to the same retirement or welfare benefits, a qualified domestic retirement order (“QDRO”) is the key to determining the rightful beneficiary. For example, Husband divorces Wife and their divorce decree states that Husband’s life insurance coverage from the group policy provided by his employer shall be maintained for “Wife.” Husband marries “Second Wife” and changes the beneficiary form to name Second Wife as the beneficiary of his life insurance. Husband dies and Wife and Second Wife both claim to be the appropriate beneficiary under the group life insurance policy. If the divorce decree is a QDRO, Wife will receive the benefit. If the divorce decree is not a QDRO, Second Wife will receive the benefit.

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1 Joan O. Vorster is a partner with Mirick O’Connell and the chair of the firm’s litigation group. Courtney Cruz is an associate with Mirick O’Connell.
Greetings from St. Louis. We are pleased to present the Summer 2012 issue of the TIPS Life Insurance Law Committee’s newsletter, which we hope you will find timely and informative.

As always, we welcome your thoughts and comments, and invite you to please consider authoring an article or case note for our next newsletter. If you would like to contribute to a future issue please do not hesitate to contact me or either of our Newsletter Editors, Eric Mathisen and Matt Creech.

In January we once again hosted the Annual Midwinter Symposium on Emerging Issues and Litigation Relating to Life, Health & Disability Insurance, Insurance Regulation and Employee Benefits. Our committee worked very hard at this meeting, presenting six of the programs. We also hosted our annual ABA business meeting. Our next business meeting is scheduled for August 3, 2012, at the ABA Annual Meeting in Chicago.

We continue to focus on developing our membership to include more plaintiff’s attorneys, in-house counsel, and younger lawyers. There is room for involvement in our committee. If you are interested in doing more, please contact me. We hope that you will attend the Annual Meeting in August, and that you will calendar now the 39th Annual Midwinter Symposium to be held under the leadership of our Chair-Elect, Robin Sanders, at the Westin Beach Resort & Spa in Fort Lauderdale, Florida, on January 17-19, 2013. Please come join us for a terrific program.

Please visit the committee website for more information: https://apps.americanbar.org/dch/committee.cfm?com=IL217000

It has been a pleasure serving as your Chair.

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We hope you find this latest issue of the Life Insurance Law Committee Newsletter to be both interesting and informative. We very much appreciate the timely articles and case notes from the contributing authors. Matt Creech and I have already started the planning of the next issue and would appreciate receiving your contributions. Also, remember to mark your calendars for the 39th Annual Midwinter Symposium to be held at the Westin Beach Resort & Spa in Fort Lauderdale, Florida, on January 17-19, 2013.

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Panel Highlights

- The Roundtable of Ex-Insurance Commissioners
- The impact of the Supreme Court’s decision upholding the Patient Protection and Affordable Care Act on the insurance industry
- Issues related to insurers’ participation in corporate internal investigations
- Issues surrounding the litigation of bad faith and misrepresentation claims
- ERISA and life insurance hot topics

Speakers

- Honorable Judge Robert N. Scola, Jr., United States District Court for the Southern District of Florida
- Steve Carlton, Vice President and General Counsel, Universal American, Lake Mary, FL
- Mike Colliflower, CLU, ChFC, FLMI, AIRC, Counsel, Aetna Senior Supplemental Insurance, Nashville, TN
- Len Guisti, Prudential Ins. Co., Newark, NJ
- William O. Williams, Deputy General Counsel, United HealthCare -Individual, Indianapolis, IN

Sponsored by the following TIPS Committees:
Life Insurance Law; Health and Disability Insurance Law; Insurance Regulation; and Employee Benefits

For more information and to register, contact Ninah Moore at 312-988-5498 or visit: www.americanbar.org/tips
In three putative class actions brought by private plaintiffs seeking to require life insurers to undertake death matches, Ohio state and federal trial courts have held that the plaintiffs lack standing to pursue such claims, with the state court also holding that the claims fail on the merits because they conflict with the policies’ plain language. These cases, Andrews v. Nationwide, Stevenson v. Western & Southern, and Range v. The Cincinnati Life Insurance Company, made up a series of putative class actions raising issues involving life insurers and the Social Security Death Master File (SSDMF) that were brought following significant regulatory activity relating to unclaimed property issues in the life insurance industry. The complaints had alleged that the defendant insurers had an affirmative duty to search the SSDMF at least annually for possible deaths of insureds under life insurance policies and to pay death benefits without requiring any further notice of death.

In the complaints, the plaintiffs alleged that although they were alive, the “actuarial probability” of their mortality was greater than 70%. They alleged that the insurer’s duty of good faith and fair dealing required it to check the SSDMF, at least on an annual basis, to see whether any assured 70% death probability threshold have died, and to pay insurance proceeds “even in the absence of a submission of proof of death.” The plaintiffs proposed to represent a putative class of other individuals whose probability of death was greater than 70%. They sought an injunction requiring defendants to search for deaths at least annually, a declaratory judgment to the same effect and a further declaratory judgment that, as to deceased class members, defendants must “pay the proceeds of the insurance contract, without first requiring further notice of death, together with that rate of interest that the Court may determine . . . .” They also asserted a breach of the duty of good faith and fair dealing and a claim for unjust enrichment.

In three separate decisions, a state trial court and a federal district court for the Northern District of Ohio have held that plaintiffs lacked standing to bring these claims. These courts reasoned that the alleged future injury was too speculative because the plaintiffs were still living. In the Andrews decision, the state court noted that “there is nothing more certain in human life than death,” but found that it was “mere speculation” that plaintiffs’ beneficiaries would be unaware of the policies and fail to submit claims after the plaintiffs died. In Stevenson and Range (issued on the same date by the same federal district judge), the court found that the plaintiffs’ alleged injury was “highly speculative” and therefore insufficient to establish constitutional standing in federal court. Finding no standing in federal court, the district court remanded Stevenson and Range to the state court of Cuyahoga county.

The decision by the state court in Andrews also rejected the claims on the merits, holding that that
the claims were foreclosed by the express terms of the policies. This decision is the first merits ruling on these issues in private litigation. The court held that the contract placed the burden on the beneficiaries to file a claim and submit proof of death as a condition precedent to payment of death benefits. The policies at issue required the insurer to pay benefits upon receipt of “due proof of death,” a provision required by Ohio statutory law. The court held that this condition in the contract “creates a clear and unambiguous condition precedent . . . that requires . . . proof of death for their life insurance claims to be honored.” With respect to the plaintiffs’ claims that the insurer should be required to affirmatively undertake death matches, the court declined to “import additional unspoken duties and obligations onto the Defendants that will conflict with parties’ contracted terms.” For these reasons, the court granted the motion to dismiss in full. The plaintiffs have filed a notice of appeal to the Ohio Court of Appeals.

The death matching issues have primarily been the focus of state regulatory action rather than private litigation. Insurance industry practices regarding use of the SSDMF are already under scrutiny by state officials in multistate market conduct examinations and unclaimed property audits. The pace of state action continues to increase. Numerous insurance companies are subject to unclaimed property audits by multiple states, and a number of state insurance regulators are investigating insurers’ practices with respect to SSDMF searches and payment of death benefits under life insurance policies.

INSURER MAY NOT RETAIN PREMIUMS WHEN RESCINDING POLICY, EVEN IF INSURANCE WAS PROCURED BY FRAUD

By: Kenton J. Coppage

PHL Variable Life Insurance Company sued Jolly and the Faye Keith Jolly Trust for negligent misrepresentation of Jolly’s assets in the application for a $10 million life insurance policy. PHL Variable Life Ins. Co. v. Faye Keith Jolly Irrevocable Life Ins. Trust, 460 F. App’x 899 (11th Cir. 2012). The company sought to rescind the policy and to retain the premiums paid by the Trust, the policy owner. PHL also sought to recover the amount of commissions paid to the broker.

After Jolly defaulted, the district court rescinded the policy based on the default, but denied PHL’s claims for damages and retention of the premiums, which had been paid into the registry of the court. There was no evidence that the Trust, which was not in default, had participated in any misrepresentation of Jolly’s assets. The district court awarded summary judgment in favor of the Trust on the damages claims.

On appeal, PHL argued that by signing the application and representing that its contents were “full, complete and true to [my] best knowledge and belief,” the Trustee had stated falsely that it had knowledge of Jolly’s assets. According to the Eleventh Circuit’s opinion, PHL relied on Georgia cases “holding that a declaration made ‘to the best of my knowledge and belief’ in an insurance application may be false when the applicant relies on information provided by someone with no knowledge of the truth of the matter represented, such as the insurer’s agent, or when the applicant makes the declaration despite knowing that it is actually false.”

Those cases, the court held, did not apply “because PHL has submitted no evidence that [the Trustee] failed to read the application or that [the Trustee] knew that Jolly’s statements were false.”

PHL also argued that even if the Trust had made no misrepresentation, PHL nonetheless was “equitably entitled to retain the policy premiums because the default judgment against Jolly established that the insurance policy was obtained by fraud.” The Eleventh Circuit rejected this argument, noting that “Georgia law provides no support for this proposition.” Rather, “Georgia law generally requires an insurer seeking to rescind an insurance contract to return any premiums paid under the contract, even where the insured person originally obtained the policy by fraud.”

Without elaboration, the court noted that “there may be some exceptions to this general rule,” but concluded that “none apply here.”

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Johnson suffered fatal injuries while driving during the early morning hours when he lost control of his vehicle, traveled off the roadway, struck a highway sign, and overturned several times. Johnson v. American United Life Ins. Co., 2012 WL 836047 (M.D.N.C. Mar. 12, 2012). The roadway was illuminated by streetlamps and was dry under clear weather conditions. The responding officer determined that Johnson was driving too fast, estimating that he was exceeding the speed limit by 15 miles per hour. The coroner concluded that Johnson died from internal injuries resulting from the crash. As part of the investigation, it was determined that Johnson’s blood had an alcohol level of 0.289%, and that his ocular fluid had an alcohol level of 0.311%.

Johnson was a participant in an employee welfare benefit plan as defined by ERISA, providing life and accidental death benefits funded by insurance policies issued by American United Life (“AUL”). AUL promptly paid life insurance benefits to Johnson’s wife, but denied her claim for accidental death benefits on the basis that the death was not accidental due to the intoxicants found in Johnson’s system. AUL upheld its decision on administrative appeal, and litigation ensued.

AUL was not conferred decision-making discretion under the plan, so the federal district court applied the de novo standard of review. Because the policies required their terms to conform to North Carolina law, the court applied N.C. Gen. Stat. § 58-3-30 to determine “the meaning of the term ‘accident’” in the policies. Under that statute, “‘Accident’ . . . shall be defined to imply ‘result’ language and shall not include words that establish an accidental means test.” Although the statute does not identify the “‘result’ language” to which it refers, the court noted that “under a results test, if death is the unanticipated and unexpected result of an intentional, voluntary act, then the death is an accident.”

Thus, Mrs. Johnson had the burden to “prove that the crash was ‘unanticipated and unexpected.’” Rather than affirmatively pointing to evidence in the record to support such a finding, Mrs. Johnson relied “on the alleged absence of evidence that Mr. Johnson did anticipate or expect to die or, more accurately, to crash.” Because Mrs. Johnson “failed to point to any evidence that would establish what her husband expected or anticipated when he drove a vehicle down a highway at an unlawful speed while severely intoxicated,” her motion for summary judgment was denied. Her failure to point to record evidence on a matter for which she bore the burden of proof authorized summary judgment in AUL’s favor.

“Where (as here) an individual with an intoxication level approaching four times the legal limit drives a car down a highway 30% above the speed limit,” the court said, “a crash is in no commonly understood sense an ‘unanticipated and unexpected result,’ unless some unusual circumstance (absent here) would make it so.” The court noted, however, that “[o]n another record, e.g., one involving a driver with a lower intoxication level that nevertheless exceeded the limit, a car crash might fall within the definition of ‘accident’ under § 58-3-30 ....”

The case has been appealed and is currently pending before the Fourth Circuit.

By: T. Matthew Creech

T. Matthew Creech is an associate in the Greensboro, North Carolina office of Smith Moore Leatherwood LLP.
In 2004, Speedway hired Oasis Trading Group, of which David Blihovde was a member, to provide consulting services about opportunities in the petroleum products business. *Speedway Motorsports, Inc. v. Pinnacle Bank*, 727 S.E.2d 151 (Ga. Ct. App. 2012). Beginning in 2006, Blihovde allegedly sent fraudulent invoices to Speedway and misappropriated the payments. By 2010, Blihovde allegedly had obtained more than $5 million from Speedway by fraud.

In 2007, Blihovde obtained a policy of insurance on his life. When Blihovde died in 2010, the insurer paid the death benefits to Blihovde’s designated beneficiaries, who were his former wife, Deborah, his two adult children by Deborah, and a minor child by a subsequent marriage.

In a lawsuit involving multiple claims against multiple parties, Speedway sued Deborah and the two adult children, asserting that they had been unjustly enriched by their receipt of the death benefits, and that Speedway was equitably entitled to the proceeds of the policy, at least up to the amount of premiums paid with funds that Blihovde had acquired by fraud.

The trial court dismissed the complaint, relying on O.C.G.A. § 33-25-11(a), which provides:

> Whenever any person residing in this state shall die leaving insurance on his or her life, such insurance shall inure exclusively to the benefit of the person for whose use and benefit such insurance is designated in the policy, and the proceeds thereof shall be exempt from the claims of creditors of the insured unless the insurance policy or a valid assignment thereof provides otherwise.

Speedway argued in the trial court and on appeal that it was not a “creditor,” as that term was used in the statute, because, as the unwitting victim of fraud, it never voluntarily undertook to extend credit to Blihovde.

The Georgia Court of Appeals said that the term “creditor” appears in several sections of the Georgia Code, “but it does not always have precisely the same meaning.” Its “generic meaning,” the court said, “refer[s] to any person to whom another ‘is liable and bound to pay … an amount of money.’” In its “more circumscribed and ordinary meaning,” the term “creditor” refers to “the holder of an obligation arising [by contract].”

The court reviewed previous versions of what is now § 33-25-11(a), back to the Code of 1933, all of which used the term “creditors,” and affirmed the trial court’s dismissal of Speedway’s claim. “Given this statutory history,” the court said, “and given our conclusion that the 1933 statute, to which the current statute traces its lineage, used ‘creditor’ in the ‘generic sense,’ including voluntary and involuntary creditors alike, we conclude that Speedway is a ‘creditor,’ as that term is used [in the statute].”

The court acknowledged Speedway’s argument that its construction of the statute might give “thieves and fraudsters an incentive to launder the proceeds of their wrongdoing through life insurance,” but concluded that this concern was outweighed by considerations of public policy.

> “There are competing policy interests that are furthered by [the statute],” the court said, “including the policy interest in providing certainty for insurers about the persons to whom proceeds of policies should be paid, as well as the policy interest in ensuring that the beneficiaries of life insurance – for some of whom the life insurance proceeds may represent the only valuable assert that the insured has left for their care – promptly receive the proceeds of the policy. It is to further these interest that the General Assembly appears to have written the current version of the statute as it did . . . .”

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4th Annual ABA TIPS School Kits for Kidz

For the fourth year in a row, TIPS is sponsoring the TIPS School Kits for Kidz program. This year we are going to once again provide students in Chicago, the home of the ABA, with desperately-needed school supplies to give them the tools necessary to achieve their goals in life.

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On January 9, 2012, the United States Court of Appeals for the Eleventh Circuit affirmed the conviction of Ismael Baca Rodriguez for conspiracy to commit mail fraud, in violation of 18 U.S.C. §§ 1341 and 1349, and mail fraud, in violation of 18 U.S.C. §§ 1341 and 1342. United States of America v. Ismael B. Rodriguez, 454 F. App’x 812 (11th Cir. 2012). The case arose from a life insurance claim that Rodriguez’s wife filed with Modern Woodmen of America. From 2002 through 2006, Rodriguez secured four life insurance policies with Modern Woodmen, the aggregate death benefit of which totaled $2,000,000.

On December 8, 2008, Rodriguez’s wife, who was the primary beneficiary of the life insurance policies, mailed to Modern Woodmen a Mexican death certificate stating that Rodriguez had died on November 10, 2008. Modern Woodmen investigated the accuracy of the Mexican death certificate, and unable to verify it, denied Rodriguez’s wife’s claim in February 2009.

Over a year later, in August 2010, Rodriguez and his wife were taken into custody on federal arrest warrants. After hearing conflicting stories of Rodriguez’s alleged kidnapping and ransom in Mexico, a jury ultimately found Rodriguez guilty of conspiracy to commit mail fraud and mail fraud, and the district court sentenced him to 60 months’ imprisonment.

On appeal, the court found that based on the inconsistencies in his kidnapping story and the evidence contradicting it, a reasonable fact finder could have disbelieved it and found that he had constructed it to cover up his involvement in the scheme. The court also found that his disappearance just before the claim was filed and reemergence just after the claim was denied, his knowledge of the life insurance policies, the financial problems the Rodriguezes were facing, and his admission that he contacted his wife to request money from the life insurance policies, were enough to infer his knowledge of, and participation in the scheme.

By: Brian T. Casey

Brian T. Casey is a partner at LOCKE LORD, LLP, (404) 870-4638, bcasey@lockelord.com.
MASSACHUSETTS COURT FINDS NEW JERSEY LAW APPLIES TO POLICY ISSUED WHEN THE INSURED WAS DOMICILED IN THAT STATE

By: Joan O. Vorster and David L. Fine

In Carrieri v. Liberty Life Insurance Company, 2011 WL 3794893 (D. Mass. Aug. 26, 2011), the District Court of Massachusetts, in connection with a motion for summary judgment, was required to determine what state law governed the competing claims to a life insurance policy.

The deceased, Joseph Tafaro, under a divorce decree entered in New Jersey, was required to maintain a life insurance policy designating an educational trust for his two children as the beneficiary. He did not do so. Several years later he began a relationship with Carrieri, who resided in Massachusetts. After borrowing money from her, he promised to obtain a life insurance policy, naming her as the beneficiary in an amount sufficient to cover the loan. The following year he obtained the policy naming Carrieri as the beneficiary. A year later he moved to Massachusetts and became engaged to Carrieri. They did not marry and he subsequently died. Both Tafaro’s children and Carrieri made claims on the policy. The insurer, Liberty, interpleaded and Carrieri filed a motion for summary judgment.

The court raised the threshold issue as to whether Massachusetts or New Jersey law applied. The court held it must follow Massachusetts choice-of-law rules that apply a functional approach influenced by the Restatement (Second) of the Conflict of Laws. The court noted the Restatement provision that holds, absent an express choice of law, a life insurance policy is governed by the law of the state where the insured was domiciled when the contract was applied for, unless another state has a more significant relationship when evaluated under the Restatement principles.

Finding the policy was applied for in New Jersey, which is where the insured was residing at the time the policy was issued, the court found the facts weighed heavily in favor of New Jersey. The court also noted that Carrieri could not claim surprise that New Jersey law would apply since she knew the insured lived in New Jersey. The court also held Massachusetts had no greater interest in the dispute than New Jersey.

With regard to the summary judgment motion, the court found issues of fact and denied it.

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In Gay v. Stonebridge Life Insurance Company, 660 F.3d 58 (1st Cir. 2011), the First Circuit Court of Appeals upheld the denial of Gay’s motion for a new trial, brought on the grounds that Stonebridge’s expert testimony exceeded the scope of the expert report.

Gay brought suit as the executor of the estate of his sister who died after a fall. An autopsy revealed that the sister died as a result of a fractured skull following a stroke. The insurance policies at issue only paid a benefit in the event of an “accidental death which was a direct and independent cause of death.” In a pretrial ruling, the district court ruled that the policy language required Gay to prove that the fall, as opposed to the stroke, was the “dominant cause” of the sister’s death.

In his testimony at trial, Stonebridge’s expert stated that the skull fracture contributed to the sister’s death but it was not a major cause of death. Gay moved to strike this testimony (the motion was denied) and later moved for a new trial on the grounds that the expert’s conclusion that the skull fracture was not a major cause of death was inadmissible because it had not been adequately disclosed in the expert’s report. The district court also denied the motion for a new trial.

On appeal, the First Circuit affirmed the district court’s ruling that the expert’s testimony fell within the scope of the report. The court found that although the expert’s testimony used different words than the expert report it was a reasonable elaboration of the opinion disclosed in the report.

EXPERT’S TESTIMONY REGARDING CAUSE OF DEATH DID NOT EXCEED BOUNDS OF PRE-TRIAL DISCLOSURE

By: Joseph M. Hamilton and Courtney Cruz¹

In McCravy v. Metropolitan Life Insurance Company, 2012 WL 2589226 (4th Cir. 2012), the plaintiff, Debbie McCravy (“McCravy”), was a participant in her employer’s life insurance and accidental death and dismemberment plan (the “Plan”) that was insured and administered by Metropolitan Insurance Company (“MetLife”). The Plan offered the option to purchase coverage for “eligible dependent children.” McCravy elected coverage for her daughter and paid premiums to MetLife until her daughter was murdered in 2007 at the age of 25. McCravy, the beneficiary of the policy, made a claim for benefits. MetLife denied the claim based on its conclusion that the daughter did not qualify for coverage under the plan’s “eligible dependent children” provision based on her age (she was 25 at the time of her death). MetLife attempted to refund the premiums that it had accepted to provide coverage for the daughter.

In light of the Supreme Court’s 2011 decision in Amara, the Fourth Circuit held that remedies beyond a return of premiums, such as surcharge and equitable estoppel, were available to McCravy. To conclude otherwise “would encourage abuse by fiduciaries” who “would have every incentive to wrongfully accept premiums” and either keep the premiums if no claim ever arose or refund them if a claim was made. The Fourth Circuit rejected the argument that the portion of the decision in Amara regarding equitable remedies was “dicta” and stated that even if it was dicta, the Fourth Circuit “cannot simply override a legal pronouncement endorsed just last year by a majority of the Supreme Court.”

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FOURTH CIRCUIT ALLOWS SURCHARGE REMEDY

By: Eric P. Mathisen¹

In McCravy v. Metropolitan Life Insurance Company, 2012 WL 2589226 (4th Cir. 2012), the plaintiff, Debbie McCravy (“McCravy”), was a participant in her employer’s life insurance and accidental death and dismemberment plan (the “Plan”) that was insured and administered by Metropolitan Insurance Company (“MetLife”). The Plan offered the option to purchase coverage for “eligible dependent children.” McCravy alleged that MetLife breached its fiduciary duty by representing to her that her daughter had dependent life and accidental death and dismemberment insurance coverage under the Plan up to the time of her death and accepting premiums for this coverage. The district court decided that McCravy could recover under Section 502(a)(3), but that her recovery was limited to a refund of the premiums.

In light of the Supreme Court’s 2011 decision in Amara, the Fourth Circuit held that remedies beyond a return of premiums, such as surcharge and equitable estoppel, were available to McCravy. To conclude otherwise “would encourage abuse by fiduciaries” who “would have every incentive to wrongfully accept premiums” and either keep the premiums if no claim ever arose or refund them if a claim was made. The Fourth Circuit rejected the argument that the portion of the decision in Amara regarding equitable remedies was “dicta” and stated that even if it was dicta, the Fourth Circuit “cannot simply override a legal pronouncement endorsed just last year by a majority of the Supreme Court.”

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An insurer abuses its discretion in denying death benefits when the denial is contrary to the language of the policy and substantial evidence does not support its decision. In McClelland v. Life Insurance Co. of North America, -- F.3d --- (8th Cir. 2012), Life Insurance Company of North America (“LINA”) denied accidental death benefits to the insured’s beneficiary under an ERISA plan. On October 26, 2007, the insured had dinner with his wife and consumed a couple of mixed drinks. The next morning, the insured decided to ride his motorcycle. He visited friends and family and no one believed he was intoxicated. Later that morning, while weaving through traffic and traveling at a high rate of speed, the insured lost control of the motorcycle and died in the subsequent accident. At the time of the crash, his blood alcohol content was over .20.

LINA based its denial on the foreseeability of death based on the insured’s intoxicated state. The district court remanded the case to LINA to determine if the motorcycle accident was an “accident” as defined by Wickman v. Northwestern National Insurance Co. 908 F.2d 1077 (1st Cir. 1990). In Wickman, the court held that a fact finder must determine if the insured subjectively expected to suffer an “injury similar in type or kind to that suffered” and if the suppositions underlying the expectation were reasonable. Id. at 1088. To satisfy this standard, the insured’s wife introduced expert testimony and the insured’s friends’ affidavits regarding his behavior. LINA relied on expert medical testimony that a person with characteristics similar to the insured (i.e., age, gender, who drinks alcohol and drives at a high rate of speed) would expect that death was highly likely to occur. When denying benefits for a second time, LINA concluded that the doctor’s testimony satisfied the Wickman test for determining the subjective intent of the insured.

The District Court disagreed and the 8th Circuit affirmed, holding that LINA abused its discretion. The court held that Wickman requires the insurer to take into account the insured’s characteristics on the day of the accident rather than relying solely on expert opinion based on categorical conclusions. In this case, relevant factors for LINA to consider under Wickman were: the insured’s plans to do yard work after his motorcycle ride; the lack of indicator of intoxication; and his general mood and behavior. Such facts indicate that the insured did not subjectively expect to have an accident.

Separately, the court agreed with LINA and held that the time (over 500 hours) spent by the claimant’s attorneys was excessive. Accordingly, the court reduced the district court’s award of attorney fees from $134,088.50 to $85,000.

Death Of Intoxicated Motorcycle Rider Determined Compensable

By: William E. Kellner

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MODERN FAMILY… Continued from page 1

I. DRO v. QDRO

A “domestic relations order” (“DRO”) is defined as “any judgment, decree, or order (including approval of a property settlement agreement) that (1) relates to the provision of child support, alimony payments, or marital property rights to a spouse, former spouse, child, or other dependent of a participant, and (2) is made pursuant to a state domestic relations law.” 29 U.S.C. § 1056(d)(3)(B)(i)(I), (II). A state authority, generally a court, must issue a judgment, order, or decree to formally approve a property settlement agreement before it can be a domestic relations order under ERISA. A property settlement simply agreed to and signed by the parties is not a domestic relations order.

Only qualified domestic relations orders, or “QDROs,” are eligible for an exemption under ERISA’s general anti-alienation provision. Geiger v. Foley Hoag, LLP, 521 F.3d 60, 62 (1st Cir. 2008) (Benefits provided under an ERISA plan “may not be assigned or alienated” by a domestic relations order, unless that order “is determined to be a’ QDRO”) (citation and internal quotation marks omitted). A QDRO may be included as part of a divorce decree or court-approved property settlement, or issued as a separate order, without affecting its qualified status.

A DRO can be qualified only if it creates or recognizes the existence of an alternate payee’s right to receive, or assigns to an alternate payee the right to receive, all or a part of a participant’s benefits. An alternate payee cannot be anyone other than a spouse, a former spouse, child, or other dependent of a participant. In order to be deemed “qualified,” a domestic relations order must clearly specify (1) the name and the last known mailing address (if any) of the participant and the name and mailing address of each alternate payee covered by the order; (2) the amount or percentage of the participant’s benefits to be paid by the plan to each such alternate payee, or the manner in which such amount or percentage is to be determined; (3) the number of payments or period to which such order applies; and (4) each plan to which such order applies. 29 U.S.C. § 1056(d)(3)(c)(i)-(iv).

ERISA also includes three general prohibitions for a QDRO. The order may not require a plan to provide: (1) any type of benefit or option not provided under the plan, (2) increased benefits, or (3) payment of benefits to an alternate payee required to be paid to another alternate payee under a previous QDRO. 29 U.S.C. §§ 1056(d)(3)(B)(i)(II), (d)(3)(D); Carland v. Metropolitan Life Ins. Co., 935 F.2d 1114, 1119 (10th Cir. 1991).

II. DRO, QDRO, and Beneficiary Determinations

Whether a spouse has a valid QDRO will determine whether there is an exception to the anti-alienation requirements of ERISA. ERISA’s anti-alienation provision provides that “each pension plan shall provide that benefits provided under the plan may not be assigned or alienated.” 29 U.S.C. § 1056(d)(1). ERISA, however, provides an exception that the anti-alienation provision does not apply if a DRO is determined to be a QDRO. Under this limited exception, a participant’s benefits under a pension plan (or welfare benefit plan) may be assigned to an alternate payee (spouse, former spouse, child, or other dependent), pursuant to a QDRO. The QDRO exception to ERISA’s anti-alienation provision applies to both pension plans and welfare benefit plans.


If the DRO is a QDRO, the plan administrator may distribute the assigned portion of a participant’s benefits to the alternate payee or payees named in the order in accordance with the terms of the order. In Metropolitan Life Insurance Company v. Drainville, Jr., C.A. No. 07-427ML, 2009 WL 2208111 (D.R.I. July 23, 2009), the Rhode Island District Court found that the divorce settlement agreement and decree constituted a valid QDRO and, therefore, qualified as an exemption to ERISA’s general prohibition against assignment or alienation of an employee benefit plan. In that case, Paul and Pamela Drainville divorced. Pursuant to their

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2 Only the Eighth Circuit has held that while ERISA’s anti-alienation provisions bar assignment of pension benefits, they do not similarly bar the alienation of welfare benefits. Therefore, in that jurisdiction, a domestic relations order affecting the disposition of welfare plan benefits is not dependent on the order’s status as a QDRO. Equitable Life Assurance Soc. of U.S. v. Cryskel, 66 F.3d 944 (8th Cir. 1995).
marital settlement agreement, both Paul and Pamela agreed to make their two children equal beneficiaries of their respective life insurance policies. Paul later married Laura. Paul executed a beneficiary form designating Laura as the primary beneficiary of his life insurance policy, and the two children as the alternate beneficiaries. Paul died and Laura filed a claim for the policy proceeds. MetLife filed an interpleader action.

The Court examined the factors outlined in 29 U.S.C. § 1056(d)(3)(c)(i)-(iv) and determined that the agreement met all the requirements of the statute to constitute a QDRO. The Court examined the factors outlined in 29 U.S.C. § 1056(d)(3)(c)(i)-(iv). First, the DRO included the names of the participants, but not their mailing addresses. Because the children were minors at the time of the settlement agreement, the lack of a mailing address was determined not to be fatal to the qualification of the order. Next, the order specified that the children would remain the primary beneficiaries under the life insurance policy “in equal shares.” The Court found that the provision of how the proceeds were to be divided was unambiguous and met the requirements of the statute. The agreement also referenced the couple’s two children and provided that the parties would continue to maintain the life insurance coverage as specified until the youngest child’s 22nd birthday. As such, the period to which the order applied was definite. Finally, the order clearly specified each plan to which the order applied. The agreement referred to “each party’s life insurance which is currently provided by New England Telephone Company” and specified the face amount of coverage. The proceeds of the policy were, therefore, assigned to the children as set forth in the agreement.

To the contrary, in ReliaStar Life Insurance Co. v. Keddell, et al., No. 09-C-1195, 2011 WL 111733 (E.D. Wis., Jan. 12, 2011), the District Court for the Eastern District of Wisconsin determined that the divorce agreement did not operate as a QDRO where there was no specific life insurance policy named in the agreement. Upon their divorce, Sarah and Kelly entered into a marital settlement agreement which required both parties to maintain their then existing life insurance naming their children as beneficiaries. At the time of the divorce, however, the only insurance in effect was a policy owned by Sarah that she obtained through her employer. Several months after the divorce, Kelly obtained a life insurance policy through his employer. The policy named his new wife Jan as the beneficiary, rather than his children. When Kelly died, Sarah made a claim for the proceeds from Kelly’s life insurance policy, arguing that the divorce agreement operated as a QDRO which would be exempt from ERISA’s preemptive reach. The court found that the marital settlement agreement was not a QDRO because at the time of the divorce, the only insurance in existence was the policy issued to Sarah. The divorce settlement agreement contained almost none of the requirements of a QDRO, and Jan was the proper beneficiary of Kelly’s life insurance benefits.

III. QDROs, DROs and Attorneys’ Fees

When ERISA is involved in litigation over the proper beneficiary to life insurance proceeds, an award of attorney’s fees to the prevailing party is available. 29 U.S.C. § 1132(g)(1). In Metropolitan Life Insurance Co. v. Leich-Bramman, Civil Action No. 3:09-CV-572, 2011 WL 3269684 (E.D. Virginia, July 29, 2011), the court determined that the divorce decree between the parties and incorporated property settlement agreement did not satisfy the requirements to be considered a QDRO. In Leich-Bramman, Adolph was a participant in his employer’s life insurance program, an employee welfare benefit plan. Adolph and Patricia divorced. In their property settlement agreement, Adolph agreed to make Patricia his beneficiary on all of his personal and group life insurance. Adolph remarried Lois and submitted a second beneficiary designation form, naming her and his two children as his beneficiaries. Adolph died and the full policy benefits were paid to Lois and the children. Patricia claimed she was the proper beneficiary. MetLife filed an action seeking a declaratory judgment as to the proper beneficiary. Adolph’s son, Julius, filed a motion for summary judgment, contending that MetLife properly paid the benefits to himself, his sister, and Lois.

The court applied the plan documents rule, which requires a plan administrator to act solely in accordance with the plan documents, so long as the documents are consistent with other provisions of ERISA. The court then considered whether there was an exception to the plan documents rule, stating that in effect “a QDRO is an exception to the plan documents rule, pursuant to which a plan trustee can pay directly the plan benefits described in the QDRO.” *3. The court found that the property settlement agreement did not satisfy the four factors provided in 29 U.S.C. § 1056(d)(3)(c) because it did not identify the plan to which the property settlement agreement applied and did not specify any amount to be awarded to Patricia.

The court determined that Julius, his sister, and Lois were the proper beneficiaries and that MetLife had made payment to the appropriate beneficiaries. The court then
considered whether to award attorneys’ fees to Julius as the prevailing party. The court followed the Fourth Circuit’s two-step procedure for district courts to follow when determining whether to award attorneys’ fees under ERISA. First, the party seeking attorneys’ fees must have achieved “some degree of success on the merits.” *Id.* at *865*, (quoting *Williams v. Metro. Life Ins. Co.*, 609 F.3d 622, 634–36 (4th Cir. 2010)). The court next considered five factors to decide whether a prevailing party should receive attorneys’ fees: (1) the degree of the opposing parties’ culpability or bad faith; (2) the ability of opposing parties to satisfy an award of attorneys’ fees; (3) whether an award of attorneys’ fees would deter other persons from acting under similar circumstances; (4) whether the parties requesting the attorneys’ fees sought to benefit all participants and beneficiaries of an ERISA plan or resolve a significant legal question regarding ERISA itself; and (5) the relative merits of the parties’ position. After considering each of the factors, the court concluded that Julius was entitled to attorneys’ fees and costs from MetLife, albeit in a dramatically reduced amount than he requested.

On the other hand, in *Metropolitan Life Insurance Co. v. Pettit*, 164 F.3d 857, 864 (4th Cir. 1998), the court applied the same five factor test and determined that the district court did not abuse its discretion in denying the ex-spouse’s motion for attorneys’ fees. In that case, MetLife filed an interpleader action to determine the proper disposition of insurance proceeds under ERISA. Tom and Betty divorced and had a property settlement agreement that required Tom to maintain $200,000 in insurance benefits in favor of Betty. At Tom’s death, Betty was not named as the beneficiary under any policy. Instead, his new wife Patricia was named as beneficiary. Betty submitted a claim to MetLife for the life insurance proceeds. MetLife filed an interpleader action. The district court granted Patricia’s motion for summary judgment as to her status as the proper beneficiary, but denied her request for an award of attorneys fees from MetLife. Patricia appealed and the Fourth Circuit affirmed, finding that the district court properly applied the five factors: Betty’s actions were neither frivolous nor in bad faith; the relative merits of the parties’ positions did not weigh in favor of a fee award; Betty’s claim was legitimate and it was, therefore, unnecessary to impose fees to deter others from the same conduct; and Patricia was protecting only her own interests and was not attempting to benefit others. *Id.* at 865–66. The court held that there was no abuse of discretion in the district court’s denial of attorney’s fees.

IV. Interpleader and Declaratory Judgment Actions

A. Interpleader

Generally, if a plan fiduciary treats an order as a QDRO and distributes the benefits in accordance with that order, the obligations of the plan and its fiduciaries to the affected participants and alternate payees with respect to the distribution shall be treated as discharged. However, if it is not clear that the DRO is a QDRO, the plan should consider interpleader.

Numerous courts have approved the use of interpleader in cases involving competing claims of entitlement to ERISA benefits. See, e.g., *Metro. Life Ins. Co. v. Bigelow*, 283 F.3d 436, 439-40 (2d Cir. 2002); *Aetna Life Ins. Co. v. Bayona*, 223 F.3d 1030, 1034 (9th Cir. 2000); *Metro. Life Ins. Co. v. Marsh*, 119 F.3d 415, 418 (6th Cir. 1997); see also *Fox Valley & Vicinity Constr. Workers Pension Fund v. Brown*, 879 F.2d 249, 250 (7th Cir. 1989) (approving use of statutory interpleader for such a purpose). But see *Forcier v. Metro. Life Ins. Co.*, 469 F.3d 178 (1st Cir. 2006) (expressing disapproval at the concept of an ERISA fiduciary evading its duty to make a determination before resorting to interpleader; MetLife had available to it an acceptable route, but “[f]or whatever reason, it eschewed the use of that reserved power and chose instead to burden the district court.”); see also *Metro-Life Ins. Co. v. Price*, 501 F.3d 271 (3d Cir. 2007) (endorsing a “reverse-exhaustion requirement” in at least some interpleader cases, requiring a fiduciary to first develop a record and render a final benefits decision before attempting to interplead the competing claimants).

B. Declaratory Judgment Actions

### 2012 TIPS CALENDAR

#### August 2012

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<th>Date</th>
<th>Event</th>
<th>Location</th>
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<tbody>
<tr>
<td>2-7</td>
<td>ABA Annual Meeting</td>
<td>Sheraton Chicago Hotel &amp; Towers, Chicago, IL</td>
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<tr>
<td></td>
<td>Contact: Felisha A. Stewart – 312/988-5672</td>
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</tr>
<tr>
<td></td>
<td>Speaker Contact: Donald Quarles – 312/988-5708</td>
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<td>TIPS Fall Leadership Meeting</td>
<td>La Quinta Resort and Club, La Quinta, CA</td>
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<tr>
<td>18-19</td>
<td>Aviation Litigation National Program</td>
<td>The Ritz-Carlton, Washington, DC</td>
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<td>Fidelity &amp; Surety Committee Fall Meeting</td>
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<td>Insurance Coverage Litigation Spring CLE Meeting</td>
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