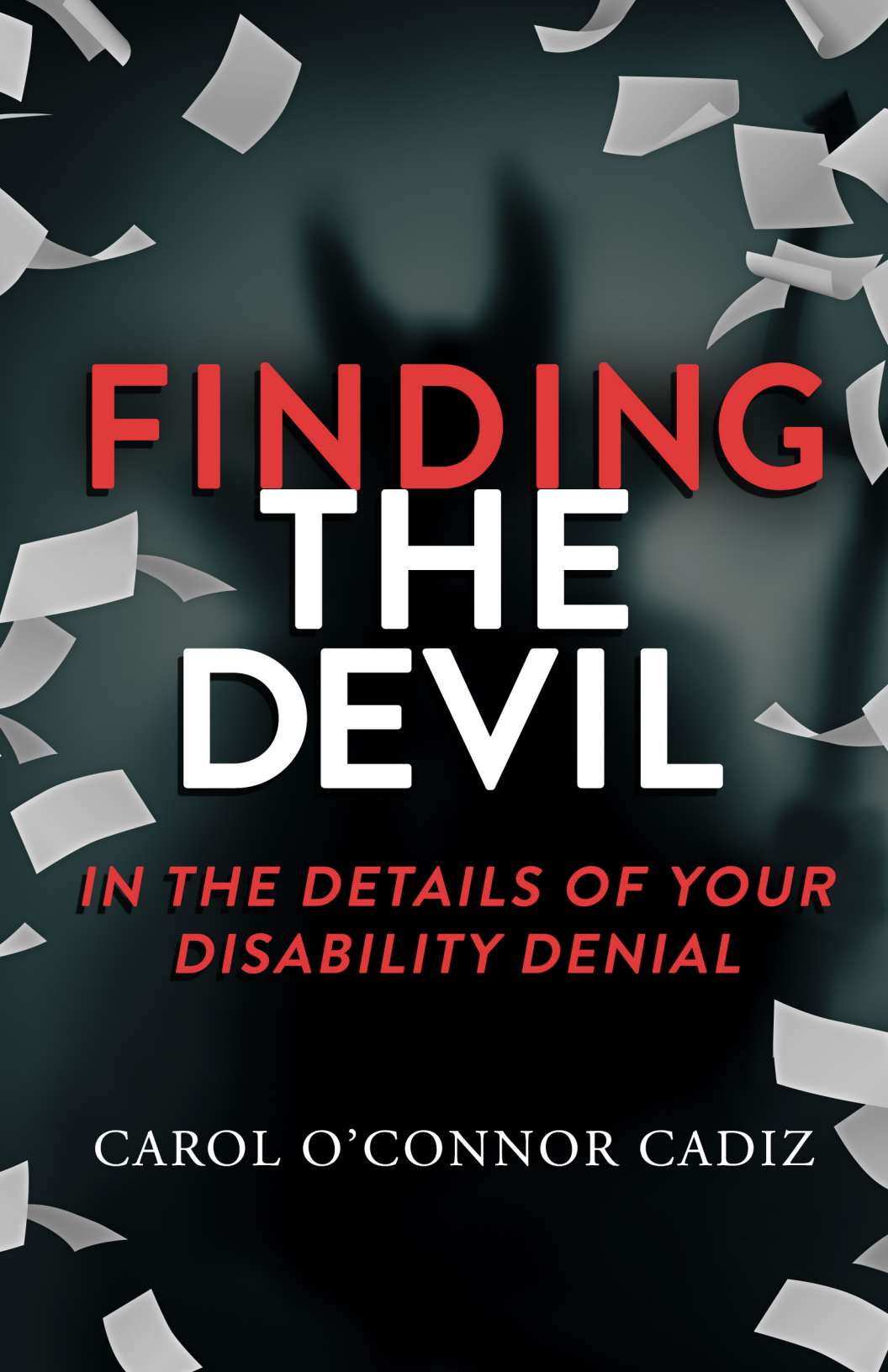
FINDING
THE
DEVIL
IN THE DETAILS OF YOUR
DISABILITY DENIAL
CAROL O'CONNOR CADIZ

FINDING THE DEVIL

In the Details of Your Disability Denial

Even Federal Judges Say You Should Get a Lawyer to Do Your Appeal for Long Term Disability Cases

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CHAPTER ONE

ARE YOU LOOKING AT YOUR DENIAL LETTER, WONDERING, "WHAT NOW?"

We've all heard the saying "The Devil is in the details" and that is exactly what your insurance company wants for you to believe when they deny your long term disability claim. They want you to believe that there is some detail written into your group disability policy which allows the insurance company to worm its way out of paying you what you're entitled to under the insurance policy. While it is true that there are tricky little quirks written into your policy *and* embodied in the denial letter- PAY ATTENTION because if this is

not addressed, your entire Long Term Disability Claim can completely blow up, without repair. This book will explain why, and what you can do about it.

If you are holding a denial of benefits letter from your employer-offered disability insurance plan, you are probably surprised and scared. No one files a disability benefits claim expecting to be denied.

The insurance company has just said that you and your doctors are wrong (or lying). You don't have an injury or sickness "bad enough" to prevent you from working. They are saying that the life you are leading now is a LIE.

This happens a lot. Insurance companies will tell you that they approve the vast majority of all claims. What they fail to tell you is that these claims are the easy ones: people who get in bad car accidents or have Stage 4 cancer.

But that's probably not you. If you are like most claimants, you may have:

1. An illness that was so hard to diagnose that you may have seen many different doctors before finding the answer.

2. An illness that some doctors don't even think exists (e.g,. fibromyalgia, chronic fatigue syndrome, Lyme disease) or should never be disabling (chronic back pain, sciatica, migraine headaches).

3. A long-standing condition that you have fought hard to "work through," often working longer than your doctors thought prudent, either because (a) you needed to keep your family financially safe

or (b) you really, really liked what you did for a living.

4. A cognitive impairment that is difficult to see from the "outside."

And you thought you were covered by a disability insurance policy. You didn't ask for this to happen to you. If given the choice, you would take your pre-disability life back in a heartbeat. You sent in your medical information from your doctor(s) who says you cannot work. Why does the insurance company seem to be focused on denying your claim rather than fulfilling your policy? Can they really DO that? It just keeps getting worse. Your heart begins to race every time you go to the mailbox and see an envelope with THAT return address on it. Always asking for more information. Always seeming to doubt your story.

You have a good, well-respected doctor. Why won't they accept your doctor's evidence? Why are they so aggressive in seeking to deny your claim? You have heard the stories of their tactics, including surveillance, and when you go out, you wonder if that strange car on the block is THEM recording you. You get super-careful on social media because you know THEY are watching you.

You wonder if you can ever just live your life without worrying that they will use your activities against you.

And then, your worst fears come true – you get a denial letter in the mail.

This book will help you wrap your arms around this world you have been thrust into. While we strongly believe

that you should hire an ERISA long-term disability attorney to handle your appeal, this book can help guide you if you insist on doing it yourself. Be aware though: these appeals are a LOT of work if you do them correctly, and because of the way the law is written, you normally only get ONE shot at getting your disability benefits back. Make it a good one!

The most important thing you need to know is that if your appeal is denied and you are forced into litigation, it will be too late to get an attorney who can add or change the evidence and arguments that can affect the outcome of your claim. Because there are no trials in these cases, the attorney you hire for litigation will be stuck with the medical and legal arguments you made during your appeal. They will be stuck with the evidence you submitted during your appeal. The insurance company will have packed that file in their favor.

Appeals are a LOT of work...because of the way the law is written, you normally only get **ONE** shot at getting your disability benefits back.

CHAPTER TWO

WHAT IS THIS ERISA THING I KEEP HEARING ABOUT?

As soon as you started researching disability appeals, you came across the term "ERISA.", which is actually the name of a law. Except for a minority of cases, if you are claiming benefits under a group policy issued by your employer, the claim is governed by the Employee Retirement Income Security Act (ERISA). This law was passed in 1974 to protect the cash in employees' pension funds. Just before the law was passed, however, it was changed to deal with ALL employee benefits. The problem was, little thought was put into how the changes,

while beneficial to protecting your pension fund, would affect your long-term disability claim. As a result, the courts were tasked with the duty to figure out how claims would be handled. Since there were so few good claimants' lawyers involved in the early years, the law of disability claims was largely formed by the lawyers representing the insurance companies. This, of course, resulted in a law that largely favored- you guessed it, the insurance companies.

Today, ERISA means:

1. If the insurance company denies your claim, that decision is given the benefit of the doubt in court. You must prove that the decision was not just wrong, but unreasonable.[1]

2. You get no trial and there are no witnesses to be called to a hearing. Everything the judge does is based on the papers submitted, which is one of the reasons it is crucial that the appeal is done correctly.

3. You get no discovery. Discovery is the process used in all other lawsuits of taking depositions and getting the other side to answer questions under oath. Discovery often reveals smoking guns.

4. You don't get to find the financial incentives that the so-called independent doctors get when they

1 In most other cases in the law, you have to prove, by at least 51-49% that you are right. In ERISA, the bar is much higher. You really have to show that no reasonable person would accept what the insurance company has done.

agree with insurance company denials. Many of these "doctors" have not seen a patient in years. Some sit at their kitchen tables and make over $100,000 a year denying the claims of people that they have never even met, let alone examined.

5. There is absolultely no downside for an insurance company to deny your claim. The state insurance commissioner doesn't care (because it's ERISA, not state law that is affected). If they lose, all the insurance company has to do is pay you what it owed you in the first place.

You may be asking why Congress does not fix ERISA, or even scrap it and begin again so that it protects employees instead of insurance companies. Well, Congressional disability plans—and pensions and everything else ERISA covers—are not governed by ERISA. No Congress member is ever subjected to the injustices of ERISA. Congress simply doesn't care.

Under ERISA **everything** the judge does is based on the papers submitted, which is one of the reasons it is crucial that the appeal is done correctly.

CHAPTER THREE

JUDGES SAY THIS DEAL SCREWS CLAIMANTS

United States Supreme Court Justice Ruth Bader Ginsburg said that she joined "the rising judicial chorus urging Congress and the Supreme Court to revisit what is an unjust and increasingly tangled ERISA regime." The problem, she says, is that through its decisions, the Court has made it so that virtually all state law remedies which would provide just relief are preempted, but very few federal substitutes are provided. She pointed out that a "series of the Court's decisions has yielded a host of situations in which persons adversely affected by

ERISA-proscribed wrongdoing cannot gain relief," and that the current situation needs to be remedied "quickly" because it is "untenable."

Another well-respected federal judge, William Acker, has not shied away from calling ERISA out as a twisted, legislative monster. He has conclude that ERISA is "beyond redemption."

> "Occasionally, a statute comes along that is so poorly contemplated by the draftspersons that it cannot be saved by judicial interpretation, innovation, or manipulation. It becomes a litigant's plaything and a judge's nightmare. ERISA falls into this category. […] ERISA is beyond redemption. No matter how hard the courts have tried, and they have not tried hard enough, they have not been able to elucidate ERISA in ways that will accomplish the purposes Congress claimed to have in mind."

A North Carolina federal judge said:

> For **ERISA** claimants not able or aware enough to hire legal counsel before the administrative process is complete, they likely enter into judicial review facing a **loaded deck**—a deck loaded with the expert opinions of those hired by the plan administrator and, with the possible exception of a treating physician or two, lacking the opinions of vocational or medical experts hired by the claimant.

Judge Richard D. Cudahy said:

> Sometimes it feels as if the only thing that purchasing insurance actually ensures is that one will have an unpleasant dispute with the insurer over payment of a claim.

CHAPTER FOUR

ENOUGH SAID.
BUT, YOU MIGHT STILL BE SAYING...

1. Paying a lawyer 1/3 of my benefits is just too much.

We get it – the insurance company made a mistake and you are searching for an option that lets you get back on claim quickly and with ALL your benefits restored. After all, that is the right thing here. The problem is, as we just discussed, ERISA stacks the deck hugely in the insurance company's favor. The moment you got that denial letter, you lost something, and there is no way under the law to be made fully whole. There will be no damages you can use to pay your attorney's fees. Hiring a lawyer is going to reduce your

benefit amount. How much a factor this plays into your decision depends on your evaluation of your chances of winning without a good lawyer. Right now, the insurance company has turned you down. 180 days from the date you received the denial letter, this decision will be permanent. Keep in mind that virtually no lawyer will "pick up" your case if you have done the appeal on your own. We might consider it, after we have carefully reviewed your claim file and appeal to see if there is enough there to have a decent chance at winning a lawsuit. But that review is expensive for you, and if we find there's not enough in the file already, we are all stuck – it's too late to add any evidence. Investing in an ERISA attorney to represent you can make all the difference in getting you on claim and away from "zero". And isn't 2/3 of something a lot better than 100% of nothing? And ask yourself this: When a lawyer will discount their fees, how strongly do you think they will stand up to the insurance company on your behalf?

2. I found a lawyer who will do the work for a flat fee or an hourly rate.

Some, often inexperienced lawyers, make this offer. We've heard about their appeals. We've also heard of claimants who spend thousands of dollars of money they really didn't have to spend on losing appeals. One lawyer billed nearly 40 hours for "ERISA research." And when they're done, you're done...if you lose the appeal, that's all the material you would have to take into a lawsuit.

3. My doctor will write a letter for me.

Your doctor probably already submitted records and forms and that led to a denial. Let doctors be doctors, not lawyers, and do what they are supposed to do. Doubt us? Ask them what the definition of disability is under ERISA. It matters – a lot – and most doctors will give you a definition that does not match what's in your policy.

4. Human Resources said I didn't need a lawyer.

They are right. You aren't required to get a lawyer. We call this the "well-meaning but crazy advice given by some folks in Human Resources." They don't know what is involved and at the end of the day, it is you who has to live with the result of your appeal, not the people up in HR.

5. We found a national firm that does this all over the country.

Insurance company denials are usually a numbers game: deny 10 claims, 6 people will just go away, 4 will find a lawyer, and even if all 4 get back on claim, the insurance company comes out ahead. **Beware** of lawyers who use a similar model: submit 10 appeals, don't spend too much time on any of them, and even if only a few are winning appeals, the law firm still comes out ahead. But who loses? You don't want to look in the mirror and see the answer to that question! And with a huge firm, good luck talking to the attorney who will actually be handling your case. I am committed to personally handling the cases that come into my firm for appeals and am just a phone call away. AND we

are committed to filing a lawsuit for any of our appeals that get denied – some national firms will file an appeal, and when it gets denied, say they can't help you with a lawsuit-perhaps because they are in the 'wrong' part of the country. Also, the truth is, many lawyers are actually afraid of going to Federal Court. (Yes, you read that right, lawyers who are afraid to go to court). ALWAYS ask, "what happens if my appeal gets denied?" This should not mean the end of the road for you. Your appeal is not decided by a judge but your lawsuit will be. Don't let a law firm deprive you of that final step, if that is what your case requires.

6. I found a lawyer who doesn't charge an up-front fee.

We charge an up-front fee, and then credit you 100% of that fee when we win your case, because we work best with clients who are going to be invested in their cases. These cases are a lot of work, and while we do all we can to make it as easy as possible for you, there are still things you must do if we are to write a successful appeal (for example, you will need to get us medical records and test

I am committed to **personally handling** the cases that come into my firm for appeals and am just a phone call away.

results, and work with us to provide details about your disability and your job). Our up-front fee doesn't come close to covering our expenses, but it says to us that you are serious about this appeal and will cooperate to the extent you are able as we gather the evidence we need to build a strong case. The insurance company claim file and ERISA administrative documents we review will typically be somewhere between 500 and 2,000 pages. If we get your claim file and think there is no way at all that we can help you, we'll tell you AND give you your money back. This doesn't mean we are going to win all of our cases, but as long as you have doctors who support your claim, there's a good chance! What you are looking for in an attorney is thoroughness and careful attention to detail, combined with a very good understanding of the law.

7. If I have to hire a lawyer, maybe I'll get lost in the shuffle.

You might think that you'll be "just a case file." Never. We are committed to personalized service and great attention to detail. That is just how we have always operated in our 20+ years of practicing law.

Remember, the point of this entire process is to make the insurance company honor its contract. We believe, and our clients tell us, that we deliver an outstanding and exceptionally responsive client experience. We want for each client to feel like they are our only client!

8. My claim is so good that I really don't need a lawyer.

First, if that were true, you wouldn't even be reading this book, because your claim would not have been denied in the first place. Second, even good lawyers lose cases from time to time, and it's impossible to predict which appeals will be denied. It is a rare "do it yourself client" who can get the insurance company to reverse itself and, remember, if your appeal fails, you are stuck with the record and legal arguments you used in your appeal. Simply put, there is too much at stake to try this on your own.

CHAPTER FIVE

IF YOU HAVE NOT ALREADY STARTED YOUR CLAIM, DO THIS:

- **Read your entire policy**, not just the brochure. Search it for any of these "bad news" phrases in your policy and decide if any of them may affect your claim:
    - We have the "discretion to determine benefits".
    - We pay only if you cannot perform "each and every" material duty of your occupation.
    - We provide "own occupation" protection for less than two years.

- We provide income protection of less than "60 % of prior earnings".
- We will terminate benefits if you are "able to work part time" but do not.
- We set limitations on or refuse to pay for "self-reported symptoms".

- Request your **own copy of your medical records**. Read through them before sending them to the insurance company so you can catch any errors and work with your doctor to resolve anything that contradicts your disability status. NOTE: Usually an "After Visit Summary" that you can download from a doctor's website is NOT the same as a full office visit note...which is what the insurance company needs to evaluate your claim.
- Figure out your correct **"Date of Disability"** under your policy, which is usually a combination of when you became sick or injured AND **loss of earnings**. Also read the **Pre-existing Condition clause** because that can also affect the timing of when you can stop working and still be covered.
- Sit down with us for a strategy session. Your fee for this session will be fully credited toward any future fees we earn in your claim if your initial claim is denied.

CHAPTER SIX

OK, YOU'VE BEEN WARNED!

If you still want to do this on your own, here are your steps to a winning appeal.*

*"Winning" might happen at the appeal stage, or it may happen further in litigation after your appeal is denied. But your appeal is a slam dunk, you say? You might want to talk to my colleague Ben's client, who worked as a roofer and had a stroke. In the denial letter, the insurance company AGREED that his stroke left him unable to climb ladders or "work at heights," but they said that since he had a "sedentary" job, he was not disabled. The attorney wrote a careful appeal that documented how, shockingly, a roofer

actually did need to climb ladders and work at heights and did not have a sedentary job. The appeal was denied. The reason? Failure to submit new medical information. There is no such thing as a slam dunk appeal. (They did later settle this case for an amount the client was very happy with... but it dragged on a lot longer than it should have. Heck, it never should have been denied in the first place! And if he hadn't hired a lawyer for this dumb denial of a "can't lose" claim? Different ending for sure)

1. Make sure that this is actually ERISA-governed. The denial letter will usually tell you. Different rules and different timelines apply to ERISA and non-ERISA cases. Also, different rules apply to individual (non-group) policies.

2. If you have been denied short-term disability benefits, determine if this is a payroll program or not, as this impacts who would be paying the benefits.

3. If you work for a governmental agency or school system, this is probably not an ERISA claim, so understand the special rules involved for those types of claims.

4. Calculate the due date for your appeal. This does not mean sending a letter that says, "I appeal," together with nothing else (if you do this, you will lose – nothing makes us sadder than seeing an appeal like this). Your entire appeal is due on the

due date. (If the case is not ERISA, calculate the statute of limitations for a lawsuit.)

5. Evaluate the denial letter for initial compliance with ERISA regulations and immediately bring to the attention of the insurance company and the employer any procedural deficiencies in the denial letter. If it doesn't pop out to you, keep looking – it's there!

6. Request the entire claim file from the insurance company and all ERISA-related documents from the employer.

7. Calculate the due date for the claim file and ERISA documents and follow up if they are late because your time for filing the appeal is very short.

8. Evaluate the claim file as soon as you can after it arrives. Notify the insurance company if any ERISA-mandated documents are missing.

9. Match up the language of the denial letter with the medical reports in the file. Have they told you everything? Look for "smoking gun" reports that reveal weaknesses in the insurance company's case. You must address each and every reason they give for denying your claim, no matter how dumb!

10. If there is video surveillance, make sure you get the DVD and watch it! Check the reports that reference the video to see if the doctors commenting

on it actually watched it – or if they just read a summary of it written by your claim manager.

11. Make sure the insurance company has accurately described all the material duties of your job. Let's face it, YOU know your job better than the people at the insurance company do and they often get this part wrong.

12. If the insurance company has used a vocational rehabilitation expert (sometimes you will see a "TSA" in the file, which stands for "Transferrable Skills Analysis"), make sure they have used all relevant and up-to-date vocational and medical data. Yes, they are allowed to change your occupational title, but they can't completely disregard what it is you actually do for a living.

13. Search for prior cases, depositions and reports of the insurance "experts" you find in the file. You will often find inconsistencies between what they said in other cases and what they are saying here.[2]

14. Carefully review the medical records in your file. You'd be amazed at how many times someone else's medical records end up in your file AND NO ONE NOTICES. Some denial letters quote medical records that simply do not belong to the claimant. THEY hope you never notice!

2 In one recent case, the plaintiff's attorney discovered and pointed out that the insurance company "expert" had been indicted for insurance fraud. That's an extreme example, but sometimes the insurance company "experts" have an office address that looks suspiciously like their summer home.

15. Do your research and make sure the insurance company has used an "appropriate medical expert" for your condition. If their "expert" is not appropriate, prove it.[3]

16. Get appropriate additional testing that meets the "objections" of the insurance company doctors. They usually tell you in the denial letter what they think is missing, so work with your doctor to either get those tests or have your doctor explain in writing to the insurance company why they are not indicated in your case. Think creatively about what evidence might help your case – a Functional Capacity Exam (available through many physical therapy practices)? A neuropsychological exam (helpful if you can't work because you can't think clearly)? If you were an insurance company appeals specialist, what piece(s) of evidence would be persuasive to you?

17. Do additional medical research on your condition and obtain appropriate articles from medical journals that support your claim. If your case goes to the lawsuit phase, you will probably be educating the judge about your condition – and remember, at the lawsuit phase it's too late to add anything new, so look ahead and add it now!

3 In one case, the insurance company had relied on a "physician consultant." Research led to a sworn statement he had made: "I'm not, you, know, **licensed to do medicine** or anything like that. My training in medicine is more so working in rehab. […] I'm not an MD, you know, nor do I generally comment on medical issues, you know." So, what do you think was he doing writing a paper review of the claimant with Parkinson's?!

18. Point out every time the insurance company and its "experts" have "cherry-picked" your record to emphasize details in their favor. Ask your doctors to comment on the insurance company medical reports.

19. Point out the favorable evidence the insurance company has ignored - there is usually a LOT!

20. Review the Internet, YouTube and social media for information about your disease/injury AND about the insurance company doctors. This takes some sleuthing, because you are never sure exactly what you're looking for until you find it – but this kind of "found" evidence can be very powerful.

21. Review other ERISA court cases to find cases similar to yours in order to make the best and most current arguments possible...these cases talk about how the insurance company is SUPPOSED to evaluate your claim, and you need to point out where they screwed up.

Remember, after this appeal, you will **not** be able to add any evidence to your claim before it is evaluated by a judge.

22. File a timely administrative appeal, making all legal, procedural and medical arguments that you want to make. Remember, this is your ONE SHOT– after this appeal, you will not be able to add any evidence to your claim file before it would be evaluated by a judge.

If your appeal is unsuccessful, file suit (usually in federal court) and **PREPARE FOR WAR.** Call us for a consult if needed. We might not be able to help much at that stage, but we will review your claim with you to see if you added enough evidence to potentially prevail in a lawsuit.

CHAPTER SEVEN

A SIDE NOTE ABOUT "INDEPENDENT" DOCTORS

One of our colleagues took a deposition of an insider at a "medial review company" often used by insurance companies to find doctors who will deny claims. This was a non-ERISA case. Here's what he found:

The employees who work at the front desk at the IME [independent medical examination] offices answering phones and scheduling clients each have a list taped to their desks next to the phone. These lists are taped to the desk—and not in the online scheduling system—because

what they are doing is blatantly wrong. They are "Do Not Use" lists from insurance companies who have told the IME company which doctors they do not want to see their claimants. These Do Not Use doctors, of course, are the Real Doctors who are genuinely independent, up-to-date, and unafraid to confirm a claimant's disability. The insurance companies named in this deposition included State Farm, Progressive, and Liberty Mutual.

There are also lists of preferred doctors. These doctors are referred to as "cutoff doctors," meaning, "They're the doctors that are going to give you the report that you're looking for saying the claimant can return back to work or, you know, that they're fine." The insurance companies will call and specifically ask for "a cutoff doctor."

When the IME states that the doctor has reviewed all the records, that is also a lie. The doctors rarely even glance at the records. It is the Quality Assurance employees—who are not medically trained—who summarize the records.

Usually the doctor only voice records his/her notes. The QA people then transcribe the recording. But then to quality control the exam, they double check that all the questions the insurance company asked about the client have specifically been answered. If they haven't been answered yet, **sometimes the QA employees change the report** to make sure all questions have been answered.

One insurance company can even enter the system before reports have been finalized and signed. It is unclear whether this gives them the ability to request changes to the record. But what else would you do with an ability to view IMEs before they're finalized?

CHAPTER EIGHT

WHAT TO DO NEXT

We hope this book has been helpful in setting out the main things you will need to consider before you start your appeal. This was the first step. Here's what should come next:

If you are doing "what if" research super early and have not yet made an initial application for benefits, schedule a strategy session with us. We can do this in person, or by phone. Usually this is all the help you'll ever need from us. If your claim is denied, though, we will credit your consultation fee to the appeal fee.

If your benefits have been already denied, we feel your pain. Mail or email us your denial letter for a free review

and free strategy letter. You can email your denial letter to carol@cadizlaw.com. We will tell you what we find in your denial letter and what we think you should focus on in an appeal. And we will tell you how we can help if you choose to hire us.

The worst thing someone can do when they get a disability benefits denial letter is nothing. You've already moved beyond that stage, so keep on moving in the right direction. Keep educating yourself, keep reaching out for help. Keep taking things a step at a time, making the best decision you can make – for your case, for your life – at each turn. While putting things back the way they were is sadly not an option, you do have the power to decide what comes next. We're here to help.

Mail or email us
your denial letter for a
free review and
free strategy letter.

CHAPTER NINE

A SIDE NOTE ABOUT THE ONE TIME YOU CAN SAFELY FILE YOUR OWN APPEAL

There is one specific instance in which it is advisable to appeal your benefits denial without an attorney. You should be able to safely appeal by yourself in this case because the error is simple to fix and **you get another shot with an attorney**.

If your denial letter says your claim was denied **solely** because the insurance company **did not receive your medical information** you should **call** the person who signed the denial letter to check two things:

First, if you send additional medical information (everything that they say they are missing), will that be considered an appeal?

If the answer is "**No,** it is NOT considered an appeal," then send your medical information right away. Hopefully this is a simple fix!

If the answer is "**Yes**, it IS considered an appeal," then you should ask: "If my claim is denied again after I send my additional medical information, **will I get another appeal?**"

If the answer is "**Yes**, you will get an additional appeal," go ahead and send your medical information, along with a letter confirming that the claim manager (name names here) told you you would get a second appeal.

If the answer is "**No**, you will NOT get an additional appeal," **call a lawyer**.

In any of these cases, make sure you document the phone call. Double check the **name** of the person you are talking with to be sure it is the same as is listed on your denial letter and write down the **date and time** and exactly what answers you are given. As I am sure you know if you have gotten this far in our book, **insurance companies do not play fair**.

Make sure you document the phone call. **Insurance companies do not play fair.**

CHAPTER TEN

ABOUT THE AUTHOR

Attorney Carol O'Connor Cadiz is a 1996 graduate of DePaul University College of Law in Chicago, having worked as a Spanish translator for attorneys while attending school. She started her legal career practicing personal injury law in the late 1990's. She is licensed in Illinois both in state court and in federal court in the Northern District of Illinois. Having worked in mid to large size law firms before forming a partnership with another local lawyer, Carol decided

that she wanted to serve clients in a more personalized way- paying particular attention to the specific needs of the individual and getting to know each and every client well. She opened her own office in the early 2000's in the Chicago loop before moving her practice out the suburbs. Formerly a Partner at A. Traub & Cadiz in Lombard, Carol Cadiz is now in solo private practice; serving Chicagoland and surrounding counties.

Carol received her bachelor's degree from the University of Illinois at Champaign- Urbana with a major in psychology. During her years as an undergraduate, she also studied at University College London (England) and at Universidad Nacional Autónoma de México (Mexico City, Mexico). She continues to attend legal seminars to keep up with the ever changing legal trends. Carol is also a respected member of a national lawyer group which meets three to four times a year in the Washington DC area to discuss how to better serve the clients of small and solo law firms.

Carol was raised bilingual, speaking both English and Spanish, offering full service in both languages. She understands not only the English and Spanish languages, but both cultures as well. She is married to a native of Chile and has two children.

She is highly rated by her clients and other members of the legal community, as can be seen on Google and on the lawyer rating site, AVVO. Ms. Cadiz is well known for being very approachable, genuine, and easy to talk to.

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If your long term disability claim is denied by your insurance company and you are claiming benefits under a group policy, that claim is governed by a 1974 law that absolutely stacks the deck against you.

We've all heard the saying "The Devil is in the details" and that is exactly what your insurance company wants for you to believe when they deny your long-term disability claim.

First the insurance company will try to convince you that there is some detail written into your group disability policy allowing them to worm their way out of paying you what you're entitled to under that very policy. While it is true that there are tricky little quirks slipped into your policy—PAY ATTENTION because if this is not addressed, your entire Long Term Disability Claim can completely blow up, without the chance of repair.

Under the Employee Retirement Income Security Act (ERISA), you must prove that your denial was not just wrong, but unreasonable. In your appeal there is no trial and there are no witnesses. Everything the judge does is based on papers submitted. You will not be given the opportunity to have the other side answer questions under oath **which may have revealed** financial incentives paid to so-called independent doctors when they agree with insurance company denials.

Why doesn't Congress fix these injustices? Because their disability plans aren't governed by ERISA. So Congress simply doesn't care.

This book explains what you can do and why you must do it immediately.

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