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**UNITED STATES DISTRICT COURT**

**NORTHERN DISTRICT OF CALIFORNIA**

**SAN FRANCISCO DIVISION**

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| CARI-ANNE PITMAN RODRIGUEZ, Administratrix of the ESTATE OF DANA F. PITMAN,<br>Plaintiff,<br><br>v.<br><br>ATG, INC., a Corporation, RELIANCE STANDARD LIFE INSURANCE COMPANY, a Corporation, and DOES 1 through 25,<br><br>Defendants. | Case No. C 03-04189 CRB<br><br>PLAINTIFF'S MEMORANDUM OF POINTS AND AUTHORITIES IN OPPOSITION TO DEFENDANT RELIANCE'S MOTION FOR SUMMARY JUDGMENT OR, ALTERNATIVELY, FOR JUDGMENT ON THE RECORD<br><br>DATE: April 2, 2004<br>TIME: 10:00 A.M.<br>ROOM: 8 |

## I. INTRODUCTION

At the Case Management Conference on January 16, 2004, the Court requested defendant Reliance Standard Life Insurance Company ("Reliance") to bring a motion for partial summary judgment on a single, narrow, issue: whether Reliance properly denied life insurance benefits to plaintiff based on the terms of its group life insurance policy with ATG, Inc. ("ATG"), assuming that the decedent, Dana F. Pitman, who was employed by ATG, had been promised coverage. The Court precluded the parties from taking discovery until it ruled on the motion, but requested Reliance to produce documents relevant to the motion to plaintiff. Reliance ignored the Court's direction. Reliance filed what it describes as a motion for summary judgment and an alternative motion for "judgment on the record under Rule 52," on all causes of action in the Complaint. Reliance produced only some of the documents that plaintiff requested in order to respond to the motion, and did so over one week after it filed its motions and just nine days before plaintiff's response was due. Reliance's motions are not supported by any admissible evidence, but merely by an incompetent declaration, and are not supported by the law.

Defendant is not entitled to judgment on plaintiff's claim for benefits because (1) defendant has failed to present any admissible evidence of the policy term upon which it relies; (2) as a matter of law, defendant cannot deny coverage on alleged policy requirement respecting eligibility for benefits that it never disclosed to Mr. Pitman; (3) as a matter of law, defendant is bound by a plan administrator/employer's representations regarding coverage; (4) the policy term upon which defendant relies is ambiguous and should be construed in plaintiff's favor; and (5) there is, at minimum, a genuine issue of fact as to whether Mr. Pitman had an objectively reasonable expectation that his life insurance coverage would be effective immediately upon completion of his first ninety days of employment that would, as a matter of law, entitle his beneficiaries to benefits. Defendant is not entitled to judgment on plaintiff's other claims because its motions do not even address the allegations of the First and Second causes of action.

## II. COUNTERSTATEMENT OF FACTS

On May 17, 2000, ATG gave a written offer of employment to Dana F. Pitman. In that offer, ATG promised Mr. Pitman that, in accordance with ATG's policy, upon completion of a 90 day probation period he would be eligible for the benefits provided by ATG to its employees, including a life insurance policy. Pl.Ex.1.[1] In connection with the offer of employment, ATG gave Mr. Pitman a copy of a Benefit Summary describing the promised life insurance benefit and a copy of ATG's Employment Policy. The Benefit Summary states that the life insurance benefit would be a minimum of $50,000. The Employment Policy states that after completion of the 90 day trial period eligible employees will receive the benefits described. Pl. Exs. 2 and 3.

In reliance upon these representations and promises, Mr. Pitman accepted ATG's offer of employment, and signed a copy of the written offer of employment acknowledging receipt and acceptance of the offer. Pl.Ex.1. The Benefit Summary that was provided to him stated that "Complete coverage information will be distributed in the form of booklets by Reliance Standard Life." In fact, Reliance never distributed such a booklet to him, and later denied that there were any such booklets. Rodriguez Decl. ¶ 6; Chilvers Decl.¶ 7. Mr. Pitman commenced his employment with ATG on June 1, 2000, and successfully completed the 90 day probation period on August 29, 2000. He worked at ATG on August 30, 2000. On August 31, 2000, the ninety-second day of his employment, he died. Rodriguez Decl. ¶ 8.

Between the time of his employment and the time of his death, neither Reliance nor ATG provided Mr. Pitman with any additional documents or information relating to the eligibility for the life insurance he had been promised. He was given no information that contradicted the statements in his written offer of employment, the Benefit Summary and the Employment Policy

[1] Plaintiff will refer herein to her exhibits as "Pl. Ex." and to defendant's exhibits as "Def. Ex."

that he would received a life insurance policy in a minimum amount of $50,000 when he completed his ninetieth day of employment. Rodriguez Decl. ¶ 6.

In connection with investigating Mr. Pitman's life insurance benefit, plaintiff Cari-Anne Pitman Rodriguez, the administratrix of Mr. Pitman's estate, by her counsel, asked ATG and Reliance to send her any materials given to Mr. Pitman describing the eligibility requirements for the life insurance, or describing when the life insurance would be effective. Chilvers Decl. ¶¶ 2, 3 and 4, and Exs. 5, 6 and 7. The only materials sent in response to that request were the written offer of employment and a copy of the Employment Policy. Chilvers Decl. ¶¶ 5 and 6, and Ex.8. Shortly after Mr. Pitman's death, plaintiff made a claim for the life insurance benefit. Rodriguez Decl. ¶ 8 and Ex.4. On November 17, 2000, Reliance denied the claim. Deft. Ex.B. Reliance stated that the claim was denied because, notwithstanding the fact that Mr. Pitman was a "member of the Eligible Class," he was not a member of the Eligible Class for "this insurance," and stated that, under the Group Life Insurance Policy issued by Reliance, Mr. Pitman's life insurance was not scheduled to become effective until the day after he died, which would have been the ninety-third day of his employment.

Neither Reliance nor ATG ever informed Mr. Pitman that, although he would be eligible for all other benefits when he completed his ninetieth day of his employment, he would not be eligible for the life insurance benefit until the ninety-third day of his employment. Neither Reliance nor ATG ever provided a copy of the insurance policy to Pitman. Rodriguez Decl. ¶ 6; Chilvers Decl. ¶ 7.

On January 19, 2001, Plaintiff sent Reliance a written request for a review of the denial of the claim. Chilvers Decl.¶ 8 and Ex.9. On March 30, 2001, Reliance affirmed its denial, even though it acknowledged that it had no reason to believe that Pitman did not satisfy the 90 day waiting period. Def. Ex. C.

## III. ARGUMENT

### A. STANDARD OF REVIEW

#### 1. Standard Of Review Of ERISA Claims

The court reviews "de novo an ERISA plan administrator's decision to deny benefits 'unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.'" Tremain v. Bell Industries, Inc., 196 F.3d 970, 976 (9th Cir. 1999), citing, Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115, 109 S. Ct. 948 (1989). Reliance's denial of benefits is subject to *de novo* review because (1) Reliance has failed to submit admissible evidence to show that the plan gave it discretionary authority (See Section B, infra); and (2) as a matter of undisputed fact, Reliance failed to provide Mr. Pitman with a summary description or the policy containing the discretionary language as required by 29 U.S.C. §§ 1022, 1024. See Bartlett v. Martin Marietta Operations Support, 38 F.3d 514 (10th Cir. 1994) (*de novo* review applies where the fiduciary did not produce the summary description or policy containing the discretionary language until after the employee's death – an employee, through his beneficiary, cannot be bound to terms of policy of which he had no notice).

Additionally, the court should subject Reliance's decision to *de novo* review because the evidence shows that Reliance's self-interest caused a breach of its fiduciary obligations. Tremain, at 976-977. Among other things, Reliance undertook to conceal, and utterly disregarded, ATG's representations regarding the plan terms by denying plaintiff benefits and stating in the benefit denial, and to this Court, that plaintiff failed to present any proof of those representations. Def. Ex. C; [2] Def. Br., p.10; 29 U.S.C. § 1105(a)(1) (fiduciary that knowingly

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2 Reliance's claim that plaintiff has not identified the "exact nature" of ATG's representation and that it is "defendant's understanding that plaintiff is relying on an oral statement" is disingenuous, to say the least. See Complaint, ¶¶ 8, 9; Pl. Ex. 5 (Letter to Reliance referencing ATG's representation in its written offer of employment that "you will be eligible for our standard package of benefits including . . .. Life

undertakes to conceal the acts or omissions of another fiduciary that constitute a breach, is liable for the other fiduciary's breach); Tremain, at 977 (administrator's disregard of evidence that contradicted its conclusions supported *de novo* review). Whether Reliance's self-interest caused a breach of its fiduciary duty is "a threshold issue which must be decided before a court can determine what standard of review to apply to a plan administrator's benefits decision." Tremain, at 977. At minimum, it would be unfair to grant judgment to Reliance on the basis of a deferential standard of review before plaintiff has even had the opportunity to conduct discovery to establish that Reliance's self-interest caused a breach of its fiduciary duty. See e.g. Tremain, at 976 (evidence extrinsic to the record is admissible to show actual conflict). .

Nevertheless, even if the court reviewed Reliance's determination under the abuse of discretion or the "less deferential" abuse of discretion standard urged by Reliance, a "decision which validates a misleading course of action must be considered inherently arbitrary and capricious." Edwards v. State Farm Mut. Auto Ins., 851 F.2d 134 (6th Cir. 1988), citing, Rhoton v. Central States Southeast and Southwest Pension Fund, 717 F.2d 988 (6th Cir. 1983) (administrators of pension plan acted arbitrarily and capriciously in denying benefits where summary description and letter from fund misled employee). Further, an error of law is necessarily an abuse of discretion. Bergt v. The Retirement Plan for Pilots Employed by Mark Air, Inc., 293 F.3d 1139, 1145-1146 (9th Cir. 2002) (failure to provide benefits on the basis of the most favorable document where the summary and the plan conflicted was an error of law that was an abuse of discretion, and summary judgment in claimant's favor was warranted), citing, Koon v. United States, 518 U.S. 81, 100, 135 L. Ed. 2d 392, 116 S. Ct. 2035 (1996) Lancaster v. United States Shoe Corp., 934 F.Supp. 1137 (N.D.Cal. 1996) (failure to apply law that summary

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Insurance . . . upon completion of your 90-day probationary period per ATG's policy."), and attachment (Pl. Ex. 1); Pl. Ex. 7 (Letter from ATG admitting that "[t]he offer letter states that employees are eligible for all benefits upon completion of their 90-day probation period.")

of policy controls entitlement to benefits even where it conflicts with the policy terms, was legally impermissible and justified summary judgment in plaintiff's favor.) See also, Tremain at 976.

**2. Standard on Motion for Summary Judgment**

The party moving for summary judgment must persuade the court through "pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, . . . that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law. . . ." Canada v. Blains Helicopters, Inc., 831 F.2d 920, 922-923 (9th Cir. 1987); Fed. R. Civ. P. 56(c). ). The Ninth Circuit "has consistently held that documents which have not had a proper foundation laid to authenticate them cannot support a motion for summary judgment." Id., at 925; Orr v. Bank of America, NT & SA, 285 F.3d 764, 773(9th Cir. 2002). Only after a motion for summary judgment is made and supported as provided for in Rule 56(c), does the burden shift to the opposing party to show that a genuine issue of material fact remains. Canada, at 922-923; Fed. R. Civ. P. 56(e). In ruling on the motion, the Court must view the evidence in the light most favorable to plaintiff and draw all justifiable inferences in her favor. Orr, at 772.

**B. DEFENDANT FAILED TO MEET ITS INITIAL BURDEN**

The court should deny defendant's motion because it failed to present any admissible evidence to justify judgment in its favor. "A trial court can only consider admissible evidence in ruling on a motion for summary judgment." Orr, at 773, citing, Fed. R. Civ. P. 56(e). The only evidence presented by Reliance in support of this motion is the incompetent declaration of Kevin P. McNamara. Mr. McNamara is not a person "through whom the exhibits could be admitted into evidence," as is required by Rule 56(e). Orr at 773-774. The Court is respectfully referred to Plaintiff's Objection to Declaration of Kevin P. McNamara in Support of Defendant Reliance's

Motion for Summary Judgment or, Alternatively, for Judgment on the Record, filed concurrently with this brief.

Defendant's entire argument is based on the alleged terms of the insurance policy. However, defendant has failed to provide the court with admissible evidence of those terms. In fact, the policy submitted by defendant as an attachment to the McNamara Declaration is not the one that was in force at the time in question. That policy is dated August 1, 1999 and is for a one-year term. Def. Ex. A. There is no evidence that it is the policy that was in force on August 31, 2000, when Mr. Pitman died, or on November 17, 2000 when the plaintiff's claim for benefits was denied.

### C. DEFENDANT IS NOT ENTITLED TO JUDGMENT EVEN IF THE POLICY SUBMITTED BY DEFENDANT WERE ADMISSIBLE

#### 1. Reliance Cannot Enforce A Policy Provision That Was Never Disclosed To Mr. Pitman

The policy states that it shall be governed by California law. Def. Ex. A, p.1. California law is clear and unambiguous – group benefit insurers cannot deny coverage on the basis of limitations on eligibility or benefits that were not disclosed to the employee. Bass v. John Hancock Mutual Life Ins. Co., 10 Cal.3d 792, 797-798 & fn.3 (1974); Bareno v. Employers Life Ins. Co., 7 Cal.3d 875 (1972); Shepard v. Calfarm Life Ins. Co., Inc., 5 Cal.App.4th 1067, 1072, fn.1, 1077-1078 (1992). Where the documents provided to the employee indicate broader coverage than that provided by the master policy, the insurer is bound by the documents provided. Bareno, at 881-882; Shepard, at 1077-1078.

Under federal law, as well, an ERISA plan may not enforce a qualification on eligibility or benefits that was never disclosed to the employee. Lancaster, supra, 934 F.Supp. 1137; Bartlett, supra, 38 F.3d 514; Feifer v. Prudential Ins. Co. of America, 306 F.3d 1202 (2nd Cir. 2002). One of the primary purposes of ERISA is to "requir[e] disclosure and reporting to

participants and beneficiaries" of essential information concerning the benefits to which they are entitled. 29 U.S.C. § 1001(a), (b). Toward that end, ERISA requires that plan participants be provided with an accurate, comprehensive, easy to understand summary of the plan.

> A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries .... The summary plan description shall ... be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.

29 U.S.C. § 1022(a)(1); Hansen v. Continental Ins. Co., 940 F.2d 971 (5th Cir. 1991). ERISA specifically requires written disclosure of "the plan's requirements respecting eligibility for participation and benefits" and "circumstances which may result in disqualification, ineligibility, or denial or loss of benefits." 29 U.S.C. § 1022(b).

Because employees are entitled to rely on the summary to provide full and accurate information, a plan fiduciary may not enforce a qualification on eligibility for benefits that the summary of the plan failed to disclose. Bartlett, supra; Feifer, supra; Lancaster, supra. This is because "[i]t is grossly unfair to hold an employee accountable for acts which disqualify him from benefits, if he had no knowledge of these acts, or if these conditions were stated in a misleading or incomprehensible manner in the plan booklets." Edwards, at 136, quoting, H.R. Rep. No. 93-533, 93rd Cong., 2d Sess., reprinted in 1974 U.S. Code Cong. & Admin. News 4639, 4646.

Accordingly, in Bartlett, supra, the court refused to give effect to a qualification in a policy that would have rendered the deceased employee ineligible for life insurance benefits because the qualification was not contained in the summary information provided to the employee. In that case, the insurer provided the employees with a "workbook," that briefly summarized the various benefits, which it stated were available to all "full-time employees." The actual plan, as described in a subsequently created summary plan description, provided that

only "full-time *active* employees" were eligible for the benefits. When Mr. Bartlett died after an extended sick leave, the plan administrator denied the beneficiary's claim for benefits on the ground that Mr. Bartlett was not an "active" employee on the effective date of the policy because he was on sick leave. The appellate court upheld the district court's conclusion that "Mr. Bartlett's eligibility should be determined with reference to the language stated in the plan enrollment workbook . . . Mr. Bartlett, through his beneficiary, could not be bound to terms of the policy of which he had no notice." Id., at 517.

In Lancaster, supra, the employer's plan summary did not disclose any monetary or durational limits on extended convalescent care benefits, although the underlying policy clearly did so. The Court concluded that the Plan Administrator could not deny benefits on the ground that the employee had reached the policy limits where the summary did not disclose these limits. Id., 934 F.Supp. at 1155-1156. Similarly, in Feifer, supra, the employees were provided with a brief description of their benefits in a "Program Summary." Among other things, the Program Summary failed to disclose that the insurer was entitled to offset worker's compensation and social security payments against an employee's long-term disability benefits. The Second Circuit refused to allow the insurer to enforce this limitation on benefits because it was not contained in the program summary provided to the employee.

In this case, ATG provided Mr. Pitman with a written offer of employment which stated: "You will … be eligible for our standard package of benefits including … life insurance … upon completion of your 90-day probation period …." Pl. Ex. 1. He was also given a handbook which contained the statement: "The first 90 days of continuous employment at ATG is considered a trial period. … After completion of the trial period, eligible employees will receive the benefits described in this handbook." Pl. Ex. 2. The documents that contain these representations were produced by Reliance from its own files. Chilvers Decl. ¶ 8. Even if Reliance's position regarding the eligibility date were correct, at a minimum, Reliance had a duty

to inform Mr. Pitman that the representations that had been made to him were not accurate. Barker v. American Mobil Power Corp., 64 F.3d 1397 (9th Cir. 1995).[3] The handbook also contained the "Benefit Summary" which is attached as Exhibit 3 of the Rodriguez Declaration. The Benefit Summary identifies a life insurance policy in the amount of $50,000 issued by Reliance as one of the benefits Mr. Pitman was to receive. That Benefit Summary contains Reliance's logo and purports to summarize the Reliance life and disability benefits that would be provided to ATG employees. Nothing in the Benefit Summary disclosed that Mr. Pitman's benefits would not be effective immediately upon eligibility, but rather the month after he became eligible.[4] As in Bartlett, Lancaster, and Feifer, the court should determine Mr. Pitman's eligibility on the basis of the representations that were made to him and the information that was provided to him, and disregard any contrary language in a policy of which defendants gave Mr. Pitman no notice.

> Any burden of uncertainty created by careless or inaccurate drafting of the summary must be placed on those who do the drafting, and who are most able to bear that burden, and not on the individual employee, who is powerless to affect the drafting of the summary or the policy and ill equipped to bear the financial hardship that might result from a

[3] In Barker, the Ninth Circuit held that a fiduciary has an obligation to convey complete and accurate information material to the beneficiary's circumstance, even when a beneficiary has not specifically asked for the information and, further, that a fiduciary breaches its duty when it is on inquiry notice of conduct that would constitute a breach of responsibility of another fiduciary, and fails to make further inquiry or take action to protect participants; this is true even though the defendant fiduciary had no authority to control the other fiduciary and was not responsible for the conduct of the other fiduciary

[4] In the Benefit Summary, Reliance represented that it would provide Mr. Pitman with "complete coverage information" in the "form of booklets." Plf.Ex.3 Reliance never provided Mr. Pitman with any "booklet" or other additional coverage information. On February 6, 2001, when plaintiff's claim was being processed by Reliance, Dorothy Winston, the Reliance employee in charge of the claim, told plaintiff's counsel that no such booklet existed and that Reliance did not "use" booklets. Chilvers Decl. ¶ 7. On March 3, 2004, more than 3 years later, Reliance produced what it's counsel said is "the Certificate booklet for the policy." Plf. Ex.13. However, that booklet is dated September 9, 2002, more than two years after Mr. Pitman died. That booklet also contained the Summary Plan Description attached as Exhibit 12 to the Chilvers Declaration. Even if it is assumed that this Summary Plan Description is the same as the Summary Plan Description that should have been provided to Mr. Pitman when he was alive, it also does not contain any qualification on an employee's eligibility for benefits.

> misleading or confusing document. Accuracy is not a lot to ask. And it is especially not a lot to ask in return for the protection afforded by ERISA's preemption of state law causes of action — causes of action which threaten considerably greater liability than that allowed by ERISA.

Hansen, at 982; Bergt, 293 F.3d at 1145-1146 (quoting, Hansen.) Whether the court applies California or federal law, defendant cannot deny plaintiff benefits on the basis of an undisclosed policy provision that purports to require Mr. Pitman to wait up to 120 days after becoming an ATG employee before his benefits would be effective. See Bartlett, supra, Lancaster, supra, Feifer, supra. Reliance, rather than Mr. Pitman's estate, should bear the burden and financial hardship that resulted from Reliance's incomplete "Benefit Summary." The Court should certainly not reward Reliance for its failure to meet its obligation to provide Mr. Pitman with accurate information regarding the eligibility requirements for his life insurance.[5]

**2. Reliance Was Bound By ATG's Representations**

Reliance attempts to avoid ATG's written representations that Mr. Pitman would receive the life insurance benefit upon completion of his 90-day trial period on the grounds that (1) ATG cannot be deemed an agent of Reliance with authority to bind Reliance; and (2) those representations constituted a "change" to the policy that Reliance did not authorize. Def. Br., pp. 7-10. The Court should reject these arguments

As a preliminary matter, plaintiff would be entitled to the life insurance benefit even if the Court disregarded ATG's representations. In the absence of ATG's representations, Mr.

[5] ERISA contemplates and authorizes the plan administrator to delegate the performance of its responsibilities to other individuals and plan fiduciaries (29 U.S.C. § 1102(a)(1), (b)(2)), who are obligated to perform their delegated responsibilities with care, skill, prudence and diligence. 29 U.S.C. §§ 1104(a)(1)(B), 1105. Even if ATG was initially obligated to provide a summary plan description, the evidence shows that ATG delegated that responsibility to Reliance. See Pl. Ex. 3 (Benefit Summary containing Reliance's logo and statement that "complete coverage information will be distributed in the form of booklets by Reliance Standard Life."); Pl. Ex. 12 (2002 Summary Plan Description prepared by Reliance purportedly "at the request of" ATG). There are, at minimum, genuine issues of fact as to Reliance's obligations, and summary judgment in favor of defendant would be inappropriate in the absence of an opportunity for plaintiff to conduct discovery on this.

Pitman would have been eligible for life insurance benefits immediately upon his acceptance of employment with ATG because the only other information provided to Mr. Pitman, the Benefit Summary, did not contain any qualification on eligibility for benefits other than employment with ATG. See Bartlett & Feifer, supra (eligibility should be determined only on the basis of the information provided to the employee.) Further, Reliance's arguments have no factual or legal merit.

**a. ATG's Representations Regarding Plan Coverage, Which Reliance Ignored, Determined Plaintiff's Entitlement to Benefits**

The policy specifically states that it is governed by California laws. McNamara Decl. Ex.A p.1. Under California law, the employer's representations regarding coverage are binding even where they conflict with the policy. Bareno, 7 Cal.3d at 881-883; Shepard, 5 Cal.App.4th at 1077-1078. Federal law also provides that statements by an employer regarding coverage are binding: statements by a Plan Administrator are binding. Bower v. Bunker Hill Co., 725 F.2d 1221, 1224-25 (9th Cir. 1984) (misleading employer representations precluded summary judgment); Gould v. GTE North, Inc., 40 F.Supp.2d 434 (W.D. Mich. 1999) (statements by Plan Administrator were binding); Lancaster, 934 F.Supp. at 1153 (benefit summary created by employer was binding on insurer, even if it conflicted with policy), citing, Atwood v. Newmont Gold Co., 45 F.3d 1317, 1321 (9th Cir. 1995); Feifer, supra (Program Summary created by employer established employee's rights under the plan.); Edwards, supra, 851 F.2d 134, citing, Rhoton, supra, 717 F.2d 988.

In this case, the statements by ATG are binding under California law because Reliance placed ATG in the position of informing employees of the terms of the policy, and are binding under federal law because Reliance has admitted that ATG was the Plan Administrator:

A. Reliance itself contends that ATG was the plan administrator and that ATG was responsible for providing Mr. Pitman with a description of the policy. Pl. Ex.11.

B. The Benefit Summary that ATG provided to Mr. Pitman appears to have been prepared by Reliance; among other things it is presented under Reliance's logo. Pl. Ex. 3. The inference to be drawn in plaintiff's favor, as is required on a motion for summary judgment, is that Reliance prepared this summary itself, and authorized, and expected, ATG to provide a summary description of the policy on Reliance's behalf.

C. Reliance represented in a 2002 Summary Plan Description that it prepared the summary "at the request of and on behalf of" ATG. Even though Reliance admits that it prepared this summary plan description (which describes Reliance's own policy), Reliance purports to disclaim all "responsibility for the accuracy or sufficiency of the information," in that summary plan description, indicating its belief that ATG is the party that is ultimately responsible for summarizing the policy terms. Pl. Ex. 12.

Defendant's reliance on UNUM Life Ins. Co. of America v. Ward, 526 U.S. 358 (1999), to avoid the binding effect of ATG's written representations, is misplaced. In UNUM, the Supreme Court held that the employer could not be deemed the agent of the insurer for the purposes of receiving a notice that should have been given to the insurance company, because the policy in that case specifically stated that the employer was not, and could not, be deemed the agent of the insurer. Id., at 377-378. The Court held that it would be improper to impose the duties of an agent on the employer when the evidence showed that the employer had not voluntarily undertaken such duties. Id. In UNUM the policy did not state that it was governed by California law, and the Court applied federal law to reach its decision. Here, however, (a) unlike the UNUM policy, the Reliance policy does not state that the employer is not the agent of the insurer, and (b) unlike the UNUM policy, the Reliance policy does specifically state that it is

governed by California law.[6] It should be noted that the Reliance policy was issued after the Court's decision in UNUM. The policy in effect when Mr. Pitman died was issued on August 1, 2000; UNUM was decided on April 20, 1999. Even the expired policy attached as Exhibit A to the McNamara Declaration was issued after UNUM, in August 1999.

The Court in UNUM did not address, much less overrule, the federal authority cited above that statements by a Plan Administrator regarding coverage to an employee are binding, or the California authority that statements by an employer are binding where, as here, the insurer has placed the employer in the position of informing employees about the terms of the policy.[7] The evidence, cited above, shows that Reliance and ATG agreed and understood that ATG would provide employees with initial summaries of their benefits under the plan, which would render ATG's representations binding under California law. Def. Ex. A, p.1.

Reliance's attempt to avoid the obligations placed upon it by California law should be given short shrift by this Court. It is clearly a breach of fiduciary duty for Reliance to issue a policy stating on the very first page that it is governed by California law, and no doubt charging premiums based on the risks of issuing a policy governed by California law, and now to come to this Court and contend that the policy is not governed by California law because that law is pre-empted. Even if California law was pre-empted, it is a breach of fiduciary duty to misrepresent in the policy that it is governed by California law. The relief for such a breach of fiduciary duty should include an equitable determination that the policy will be enforced as if it were governed by California law. See e.g. Blau v. Del Monte Snacks, Inc., 748 F.2d 1398, 1353 (9th Cir. 1984)

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[6] For purposes of responding to Reliance's motion, we have assumed that the policy in force at the relevant time contained the same language as the policy attached as Exhibit A to the McNamara Declaration, even though that policy, by its terms, expired before Mr. Pitman died.

[7] The Court did not hold that "under the law of ERISA" an employer "cannot be deemed to be the agent of the insurer" under any circumstances, or that California's law of agency was "invalid," as Reliance represents. Def. Br., p.8:3-7.

(where violations of ERISA obligations are extreme, they should be deemed to affect the substantive content of the plan and create substantive rights under the plan.)

When acting as a plan fiduciary to determine Mr. Pitman's eligibility for benefits under the plan, Reliance was bound to consider the representations of ATG . Edwards, 851 F.2d at 135-136; Feifer, 306 F.3d at 1214 (the relative responsibilities of disclosure of the employer and insurer were irrelevant to determine the employee's entitlement to benefits under the plan). Instead, Reliance completely ignored the evidence of ATG's representations, stating that "you have not provided us with any proof that such promises were made." Compare Def. Ex. C, p.2 with Pl. Exs. 1, 2 and 9. This, in itself, was an abuse of discretion. Lancaster, 934 F.Supp. at 1150 (decision based on clearly erroneous findings of fact is an abuse of discretion); Id., at 1156 (failure to consider evidence in record is a clearly erroneous finding of fact.)[8]

**b. The Policy "Change" Provision Is Ineffective In The Context of Determining Mr. Pitman's Rights Under The Plan**

Reliance's final argument, that Mr. Pitman was not entitled to the benefits promised to him in Plaintiff's Exhibits 1, 2 and 3 because the undisclosed policy contained conflicting terms and precluded ATG from making any "change" to the terms of the policy, is equally without merit. First, as explained in Section B, supra, Reliance has failed to produce an authenticated copy of the relevant policy to establish either the allegedly conflicting term or the applicability of the 'no change' provision upon which it relies. Second, the policy provides that, to the extent any term conflicts with California law, it is deemed amended. Def. Ex. A, p. 3.1. A provision that representations by the employer do not bind the insurer conflicts with California law and is thus ineffective pursuant to the terms of Reliance's own policy.

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8 If Reliance disagreed with plaintiff's interpretation of ATG's written representations, it was bound to explain the basis for this disagreement, rather than to simply claim that plaintiff had failed to present any proof of her contention. Lancaster, at 1156; Tremain, at 977.

Third, the courts have uniformly held that the summary controls even where the summary conflicts with the plan, and even where the summary expressly informs the employee that the plan or policy terms supersede any conflict with the summary: "It is of no effect to publish and distribute a plan summary booklet designed to simplify and explain a voluminous and complex document and then proclaim that any inconsistencies will be governed by the plan. Unfairness will flow to the employee for reasonably relying on the summary booklet." Edwards, 851 F.2d at 136; Bergt, 293 F.3d at 1145-1146 (approving Edwards and Hansen and holding that where there is a conflict between the summary and the plan, the document most favorable to the employee controls.); Lancaster, 934 F.Supp. at 1153.[9] If the court gave effect to such disclaimers, "[t]he result would be that before a participant in the plan could make any use of the summary, she would have to compare the summary to the policy to make sure that the summary was unambiguous, accurate, and not in conflict with the policy. Of course, if a participant has to read and understand the policy in order to make use of the summary, then the summary is of no use at all." Hansen, at 981-982. In this case, defendant did not even disclose the disclaimer upon which it relies to the employees. (See Chilvers Decl. ¶ 7: Reliance does not give copies of the policy to employees without a specific written request.) Defendant's conclusion that the plan terms took precedence over the administrator-employer's allegedly conflicting summary of the plan, was an abuse of discretion. Bergt, 293 F.3d at 1145-1146; Lancaster, 934 F.Supp. 1137.

Fourth, to the extent the "change" provision has any applicability, it should be construed as part of the agency relationship between Reliance and ATG. If ATG's representations to Mr. Pitman were in excess of the authority granted to ATG by Reliance, that would be grounds for a claim by Reliance against ATG, not grounds for denying benefits to plaintiff.

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[9] See also Hoefel v. Atlas Tack Corp., 581 F.2d 1, 3 (1st Cir. 1978) *cert. denied,* 440 U.S. 913, 99 S.Ct. 1227 (1979); Genter v. Acme Scale and Supply Co., 776 F.2d 180, 1185 (3d Cir. 1985); Gould v. GTE North, Inc., 40 F.Supp.2d 434 (W.D. Mich. 1999); Hurd v. Hutnik, 419 F.Supp. 630, 656-57 (D.N.J. 1976).

Fifth, defendant's reliance on an out of context quotation from Grosz-Salomon v. Paul Revere Life Ins. Co., 237 F.3d 1154 (9th Cir. 2001) is misplaced. In that case, the insurer attempted to enforce a statement that it had made in a summary plan description against an employer. The Court held that the integration clause in the policy, which was intended to prevent the employer from binding the insurer to promises made in extraneous documents, also prevented the insurer from binding the employer to terms in extraneous documents. Id., 237 F.3d at 1161.[10] The Court also concluded that a provision in the policy that required amendments to be signed by both the policyholder and the insurer prevented the insurer from binding the employer to an amendment contained in the Benefit Summary that the employer had not signed. Id., at 1162. The decision in that case, which involved construction of the terms of a contract between two sophisticated corporate entities, does not support disregarding the representations made to an employee in favor of undisclosed terms in an insurance policy.

Indeed, Grosz-Salomon specifically noted that, by contrast to an insurer, an employee could enforce an unauthorized and inaccurate summary plan description, "[b]ut to say that an employee may hold an employer to its own representations is a far cry from saying that an insurer may unilaterally amend a plan summary with an insured in a manner that does not comport with the underlying contract's provision for changes and then, when the insured fails to detect the change, exploit the oversight to the detriment of the insured's employees." Id., at 1162 & fn.33. To the extent the holding in Grosz-Salomon, has any application to this case whatsoever, it supports plaintiff's position. It would be equally unfair to allow a fiduciary-insurer to disregard its obligation to provide a complete and accurate summary of the relevant policy

[10] Defendant erroneously claims that this statement by the Court referred to "language similar to the language in the Reliance Standard policy which identifies the manner in which the policy can be changed." Def. Br., p.9:24-28. .

terms, claiming the employer was responsible to inform employees of the policy terms, and then avoid coverage on the basis that the employer had no authority.

Finally, even if the change provision applied, there is a genuine issue of fact as to whether Reliance waived the requirement that all changes to the policy must be signed by an executive officer and attached to the policy. The policy produced by Reliance contains a number of amendments, none of which were signed by an Executive officer. Def. Ex. A, Certificate and p.1.0.

**3. The Policy Is Ambiguous And Should Be Construed In Plaintiff's Favor**

Reliance would not be entitled to judgment even if the undisclosed policy terms were applicable. "Terms in ERISA insurance policies are to be interpreted in an ordinary and popular sense as would a [person] of average intelligence and experience. Ambiguous language is construed against the insurer and in favor of the insured." Simkins v. Nevadacare, Inc., 229 F.3d 729, 734-735 (9th 2000) (citations and quotation marks omitted.); McClure v. Life Ins. Co. of N. Am., 84 F.3d 1129, 1134 (9th Cir. 1996). The policy language at issue here could reasonably be construed to provide coverage immediately following completion of the waiting period, and is, at the least, ambiguous and should be construed against Reliance.

The policy states that the individual policy effective date will be "[t]he first of the Policy month coinciding with or next following completion of the Waiting Period." The term "Policy month" is not defined. A reasonable person could conclude that the "Policy month" begins on the effective date of an individual's policy, particularly given the fact that the term is used is in the context of defining the "individual effective date." Thus, the individual effective date would be the first day "coinciding with or next following completion of the Waiting Period." This is consistent with ATG's interpretation of the policy when it informed Mr. Pitman that ATG's

policy provided that he would be eligible for his benefits upon completion of his first 90 (90) days of employment.[11]

Even if a "Policy month" could only be interpreted as a calendar month, the policy language is susceptible of at least two interpretations. See e.g. Joyner v. Insurance, 266 S.E.2d 30 (N.C.App. 1980). In Joyner, the policy stated that coverage would be terminated on "the last day of the policy month coinciding with or next following termination of employment." By contrast to Reliance, in Joyner, the insurer argued that the terms "coinciding with or next following" must be construed to mean the month "during which" the relevant event occurred. The court held that the language was "at best, ambiguous," and "since we find the actual language in the provision at issue reasonably susceptible of several interpretations, we resolve the ambiguity in plaintiff's favor."[12] Similarly in this case, the terms "coinciding with or next following" is reasonably susceptible of several interpretations and could reasonably be interpreted to provide coverage in the month "during which" the employee completes the waiting period. This ambiguity should be resolved in plaintiff's favor.[13]

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[11] Reliance improperly asks the Court to infer that ATG understood that Mr. Pitman's insurance was not effective because ATG allegedly failed to pay a premium for his policy. Def. Br., p.3:3-10. Reliance has not provided the court with an iota of evidence to support this claim, which is irrelevant in any event. Bass, at 797 (employer's failure to pay premium is an issue between the insurer and employer that does not affect employee coverage). As in Bass, Mr. Pitman's policy would have been effective even if ATG had inadvertently failed to pay its premium. Def. Ex. A, p.3.0 (clerical error); p.6.0 Def. Ex. A, p.6.0 (allowing ATG up to 31 days after premium is due to pay), Moreover, Reliance overlooks that all inferences are to be drawn in plaintiff's favor.

[12] Joyner also supports plaintiff's position that the term "Policy month" is ambiguous. In Joyner, the insurer defined the term "Policy month" in a manner that was consistent with a calendar month. The insurer's decision to define the term at all further supports that the meaning of this term is not self-evident.

[13] It is noteworthy that Reliance issued the group policy to ATG on August 19, 1999, but made the effective date August 1, 1999 (*i.e.*, the first of the month "coinciding with" issuance of the policy) rather than September 1, 1999 (*i.e.*, the first of the month "following" the issuance of the policy.)

**4. Mr. Pitman Had A Reasonable Expectation of Coverage**

Plaintiff was also entitled to benefits on the basis of Mr. Pitman's reasonable expectation that his coverage would be effective immediately upon completion of his first 90 days of employment. "In general, courts will protect the reasonable expectations of applicants, insureds, and intended beneficiaries regarding the coverage afforded by insurance carriers even though a careful examination of the policy provisions indicates that such expectations are contrary to the expressed intention of the insurer." Saltarelli v. Bob Baker Group Medical Trust, 35 F.3d 382, 386 (9th Cir. 1994), quoting, Robert E. Keeton & Alan I. Widiss, Insurance Law: A Guide to Fundamental Principles, Legal Doctrines, and Commercial Practices § 6.3 (West 1988)).. In Saltarelli, the Ninth Circuit explicitly adopted "the doctrine of reasonable expectations as a principle of the uniform federal common law informing interpretation of ERISA-governed insurance contracts." Lancaster, at 1157, quoting, Saltarelli, at 387. The reasonable expectations doctrine requires an ERISA benefits plan to be interpreted in accordance with the "objectively reasonable expectations of coverage" of the insured. Lancaster, at 1154, citing, Saltarelli, at 386-387. This doctrine applies where the summary description of the plan does not disclose the terms on which the insurer basis its denial of benefits in an unambiguous or sufficiently conspicuous manner. Id.

In this case, the restriction on eligibility upon which defendant relied to deny coverage was not contained in the Benefit Summary at all. Pl. Exs. 1-3; Lancaster, at 1160 (reasonable expectations are determined by the information disclosed in the summary, rather than the plan.) The question to be answered is: "If asked about the scenario at issue, would a reasonable insured, after examining the [summary plan description], have an objectively based reasonable expectation of coverage?" Lancaster, at 1162. After examining the materials provided to Mr. Pitman, a reasonable insured would indeed have an objectively based reasonable expectation that

he would be covered by ATG's group life insurance policy if he died on his 90-second day of employment. See Rodriguez Decl. ¶ 7

> The document containing the contract's terms is an offer that is accepted by the employee's commencing or continuing to work for the offeror. If the employee does not like the terms, he or she can decline and seek better terms elsewhere. But this choice is one that an employee, once disabled, cannot make. Nor does a disabled employee generally enjoy the retiree's advantage of being able to select, or at least predict, his or her date of separation from the company, and plan accordingly.

Feifer, at 1212. In this case, Mr. Pitman accepted the offer of employment on the terms proposed, and, once deceased, obviously could not make the choice to seek better terms elsewhere. The court should enforce the policy based on Mr. Pitman's objectively reasonable expectations of the benefits that were offered when he accepted his employment with ATG.

### D. DEFENDANT IS NOT ENTITLED TO "JUDGMENT ON THE RECORD"

Reliance's alternative motion for "judgment on the record pursuant to Rule 52" at this stage of the litigation is unsupported by any authority. Rule 52 addresses the court's obligation to make findings of fact and conclusions of law following a bench trial. It does not authorize the court to enter judgment in the absence of a trial, much less before discovery has even commenced. Defendant's reliance on Kearny v. Standard Insurance Co., 175 F.3d 1084 (9th Cir. 1999), is misplaced. In that case, the Ninth Circuit specifically held that, where there were issues of fact that precluded summary judgment, and that those "genuine issues of fact must be resolved by trial" in "open court." Id., at 1093. The Court then explained that, at the trial, it would be proper for the court to consider evidence outside the administrative record under the circumstances identified in Mongeluzo v. Baxter, 46 F.3d 938 (9th Cir. 1995). In Mongeluzo, the Ninth Circuit held that "where the original hearing was conducted under a misconception of

the law . . . it is necessary for the case to be reevaluated in light of the proper legal definition" and for the district court to admit evidence outside the administrative record. Id., at 944.

As in Kearny, and Mongeluzo, there are, at minimum, genuine issues of fact that preclude judgment. Additionally, as in those cases, the administrative appeal was conducted under a misconception that the representations made to Mr. Pitman were irrelevant, and that the terms of the undisclosed policy superceded the allegedly conflicting representations made to Mr. Pitman. Accordingly, it is proper for the Court to consider matters outside the administrative record to determine plaintiff's entitlement to benefits.

## IV. CONCLUSION

For the foregoing reasons, plaintiff respectfully requests that the Court deny Reliance's motion.

Dated: March 12, 2004

CHILVERS & TAYLOR PC

By: */s/ Robert M. Chilvers*
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