INSIGHTS

SEPTEMBER 2007

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Consider the Impact of Employee Termination

I recently received emails from a client and broker asking that an employee be terminated from their benefits plan as soon as possible. We were able to remove the employee from the plan that day.

On the face of it this seems straight-forward. Employees are terminated from benefit plans every day. Several hours later I received another email stating "upon the advice of our lawyer, we have been advised not to terminate this employee."

This got me to thinking about the Fidler V. Sun Life Assurance Co. of Canada case. The plaintiff, Connie Fidler, was diagnosed with fibromyalgia and chronic fatigue syndrome, and in 1991, began receiving long-term disability benefits from her insurer, Sun Life Assurance Company of Canada. However, in May 1997, after conducting video surveillance of the plaintiff's activities, Sun Life asserted that she was, in fact, able to perform certain kinds of work and discontinued her benefits.

It's important for insurers and plan sponsors to address the possibility of mental distress before curtailing any type of benefits.

Connie Fidler appealed this decision over a period of two years, during which time Sun Life continued to refuse benefits. In February 1999, she sued Sun Life in the B.C. Supreme Court. Shortly before trial, in April 2002, the Company offered to reinstate her benefits from the date that they were first discontinued.

Damages for mental distress are often characterized as either unforeseeable or inapplicable to the 'commercial' nature of most contracts and have traditionally been assessed independently. The exception to this general rule had been contracts in which the central object was 'pleasure, relaxation, or peace of mind.' Where recovery was allowed, damages were usually characterized as 'aggravated damages,' an ambiguous term referring to compensation for distress and suffering, but used inconsistently by the courts.

The Fidler decision clarified the meaning of 'aggravated damages' in the context of mental distress. The Court distinguished between mental distress that flowed from 'aggravating circumstances,' and was based on a separate cause of action (such as fraud), and mental distress that arose 'out of the contractual breach itself.' The Court held that this second category, rather than being an 'exception' to the principle of reasonable expectation, should, in fact, be considered an extension of it and thus be classified as 'compensatory.' To recover under this second category, a plaintiff must demonstrate that (a) both parties might have reasonably contemplated that mental distress was a consequence that would result from a breach and (b) the degree of the distress was sufficient to warrant compensation. In applying this test to Connie Fidler's case, the Court held that mental distress was a foreseeable aspect of a breach of her long-term disability contract and ordered damages of $20,000 be paid.

The Court also addressed the issue of punitive damages, which are awarded to punish a party whose conduct has been 'malicious, oppressive and high-handed' and where an independently actionable wrong exists. In Connie Fidler's case, the Court of Appeal had found that Sun Life's investigation was, in fact, carried out in 'bad faith' due to (a) its failure to disclose the surveillance video, (b) its exaggeration of the surveillance results in an internal memorandum and (c) the absence of medical evidence to justify denying her claim. However, the Supreme Court disagreed, and agreed instead with the trial judge's assertion that Sun Life legitimately had "difficulty ... in ascertaining whether Ms. Fidler was actually disabled."

Fidler may well have consequences for the administration of long-term disability plans. Plan administrators must be sensitive to the possibility of claims for compensatory damages for mental distress. The possibility of punitive damages also exists where a plan administrator has acted in bad faith vis-a -vis the claimant.

However, the Fidler decision has made the recovery of punitive damages considerably more difficult. In its characterization of Sun Life's investigation (during which it withheld Connie Fidler's benefits for two years)

continued on reverse...

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Stay Sharp ... The Importance of Maintaining an Awareness for Unexpected Liabilities

I came across a memo I had written several years ago advising employers about certain issues that were not well known, even by benefit specialists. It deals with that topic we should all fear - the unexpected liability. Here are a few examples for you to mull over. The examples are ones that RWAM's administration team deals with every day.

Group Life & Long Term Disability Insurance - Waiver of Premium

This provision allows the Group Life Insurance to remain in force for a disabled employee, with no premium payment either by the policyholder or the insured employee. Applications should be submitted within six months from the onset of disability. Many times this provision is overlooked. This can happen if the employee is disabled as a result of an occupational disability and is collecting benefits from Workers Compensation/ WSIB or if the Long Term Disability Insurer is different from the Life Insurer.

Benefit Extension for Terminated Employeees

We are seeing more and more employee severance packages due to mergers, acquisitions, and earlier retirements. These may require extension of benefits after the employee has terminated their active employment. Many times the employer's perception of benefits and the former employee's perception are quite different. Plan sponsors need to know, 'Does your Master Insurance Policy permit these benefit extensions or are you granting coverage beyond what either your policy or the Employment Standards Act allows?' The liability is yours if the Insurer declines a claim because it falls outside of the contractual provisions.

To prevent any difficulties in this area, we recommend that you contact RWAM in ALL instances before you offer an extension of benefits to a terminated employee, or an employee who takes early retirement or a leave of absence. Ideally, this should be done in advance of the actual termination date so that RWAM can negotiate the appropriate approval from Co-Operators, La Capitale, ESI or Green Shield prior to the actual termination date. Please keep in mind that the insurer has the final say as to whether or not the extension of coverage is approved. This way, you will know if the insurer has agreed to the extension before you actually commit to it. We recommend that you always convey the decision in writing to the employee.

Amounts of Coverage in Excess of Non-Evidence

Your Group Life Insurance and Long Term Disability may provide a certain level of coverage which is available on a non-evidence (no questions asked) basis. Any additional amounts that the employee may be eligible for will require that health evidence information be submitted to Co-Operators, R.B.C., or La Capitale and subsequently approved by them.

RWAM has found some instances where the employer has not advised an employee that they are eligible for a level of benefit beyond the non-evidence limit or if they do advise the employee, that the employee does not respond to the request. In the event of a death or disability, it could be legally challenged that through error or neglect on the part of the employer that the employee was never given the opportunity to apply for the coverage. If this went to court, and the decision was found against the employer, the Insurer has no liability for any amount beyond the non-evidence maximum.

RWAM recommends that in all instances there be proper documentation on record. This should signify that the employee was notified of their eligibility for coverage beyond the non-evidence limit and that the employee either did or did not submit the required health evidence. Furthermore, it should show whether it was approved or declined, and that the employee was properly notified of this. If the employee elects not to apply for the coverage, ensure that they sign a statement to that effect and that you have it on file for future reference.

Coverage Based on Income Levels

Life Insurance, Accidental Death and Dismemberment, and Long Term Disability benefit amounts are customarily a function of earnings. In most instances as an employee's income level increases they become eligible for increased levels of benefit. Policy provisions usually require the Insurer to be notified of these increases within 31 days of the change in salary.

If this procedure is not followed, and an employee dies or becomes disabled, problems will ensue as the Insurer is only liable to pay benefits based on the income level submitted by the employer.

Conversion of Group Life Insurance and Group Health and Dental

Employers should advise terminated employees in writing of their right to convert their group life, health and dental benefits. The employee must do so within 31 days of their leaving their employment. The employer's correspondence should be clear on what can be converted and the time line that the employee has to complete the application process.

Transferring Group Coverage to Another Provider

Be aware that there are some pitfalls. Brokers need to be mindful that the prior carrier should be made aware of anyone who was absent from work due to illness on the date that the change in provider takes place. As a courtesy, the prior carrier should also receive written confirmation that no one was away from work on the date the change occurs. Failing to notify the prior carrier may mean that the broker and the employer are now responsible for any claims that are incurred by the absent employee. Employers need to be sure that any existing contractual commitments are fulfilled before they entertain a move. Issues like the 'Survivor Benefit' that may currently be in place for a deceased employee's family may not necessarily be grand-fathered by the new carrier, and knowing that all your waiver of premium obligations for life and disability insurance have been covered off is prudent.

Impact of Termination, continued

as one of 'good faith,' the Supreme Court held that the threshold for "malicious, oppressive and high-handed" conduct extends well beyond a mistaken assessment of a claim. The Court has therefore left considerable room for legitimate, claimant-sensitive investigations of disability claims based on mental distress.

It's important for insurers and plan sponsors to address the possibility of mental distress before curtailing any type of benefits from a plan member. It's equally important to seek legal counsel before any employee is terminated.

Until next time…

Source: Murray Gold, Koskie Minsky LLP, Benefits Canada, April 2007

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