INTERPRETATION AND APPLICATION OF DISABILITY DEFINITIONS IN FUND RULES.

Making sense of terms such as "trustees' opinion/own/similar/reasonable other/any/occupation/totally/permanently".

1. What is the purpose of a disability benefit? To pay a sum of money (in the form of a lump sum or a monthly benefit) to compensate a fund member who has been struck by illness or injury to the extent that she is unable to work.

2. Retirement fund rules often contain provision for a disability benefit, which as we know can only be for permanent disability – the Income Tax Act definition of a pension, provident or retirement annuity fund does not allow for temporary benefits to be paid. A lump sum could be paid as the total cash benefit from a provident fund, or a one third cash commutation of a pension benefit from a pension fund. A monthly income benefit effectively means that the member becomes a pensioner even though normal retirement age has not yet been reached, and income is provided until death.

3. When a member applies to a fund for a disability benefit, someone has to decide whether the member qualifies for the benefit – a legal decision quite distinct from the medical decision as to whether the person is functionally impaired. Who has the decision-making power depends on the rules of the fund. If the rules say disability must be present “in the opinion of the board”, or must be “proved to the satisfaction of the board” of the fund, that is the trustees, the trustees must obviously exercise the discretion. If the disability benefit has been insured by the fund, as is often the case, and the rules state that the insurer must be satisfied as to the disability, and that no benefit is payable if the insurer repudiates a claim, then the full discretion clearly lies with the insurer. Sometimes however, the fund rules provide that the trustees must still exercise a discretion even if the insurer has repudiated a claim, and the trustees must then independently

investigate the merits and apply their minds. They may come to a different conclusion, and would then pay the benefit from the fund.

4. So the first step is to identify who makes the decision. I'm going to assume for today's purposes that it is the trustees of the fund. But what I'm going to say about interpreting and applying disability definitions applies equally to insurance companies - there is clearly a large area of common ground in the way funds and insurers will approach disability benefit claims.

5. The fact is that our courts have produced very little relevant law on disability benefits, and accordingly both funds and insurers have to look firstly to our courts, but then also beyond our courts to international jurisdictions for guidance. English, American, Canadian, Australian and New Zealand authorities would be treated by our courts as persuasive. Decisions of the Pension Funds Adjudicator and the body of cases we have developed at the office of the Ombudsman for Long-term Insurance, while not binding precedent, can also be useful to trustees looking for cases in point when faced with a set of facts, and difficulty in applying the definition at hand to these facts.

6. Trustees have to weigh up the medical evidence, the personal circumstances of the claimant, and the job description, and decide whether a claimant meets the requirements set out in the particular definition in the fund rules to be considered disabled. Definitions vary; some make it harder for a member to qualify, often for good reason, such as that the funding of the benefit is such that only extreme cases can be catered for, or a perception that it may well be in the interests of the member's mental and physical health if he or she can keep up some form of work rather than too easily qualifying for permanent disability status. In any event, trustees are stuck with the definition in the rules, and that is where they must start.

7. Here's a typical definition:

The member

"will be regarded as totally and permanently disabled if **in the opinion of the trustees** after consulting the fund's medical advisers, he has been so disabled by injury or disease as to be totally and permanently incapable of engaging

(a) in his own occupation, or

(b) in any other occupation for which he is or could reasonably be expected to become qualified by his knowledge, training, education, ability and experience".

8. The phrase "in the opinion of the trustees", or "to the satisfaction of the trustees" (cf in the insurance context, "in the opinion of the insurer") gives the trustees the discretion to make the decision. Guided by the principles of administrative law on the exercise of a discretion, we can posit that the trustees must exercise the discretion properly: they must take into account all relevant considerations, discard irrelevant considerations, and not fetter their discretion. Ultimately the concept of reasonableness must be imported: courts around the world have held that it is an implied term that the trustees are required to exercise the judgment of a reasonable person. So we can simply interpret the wording in red to mean "in the *reasonable* opinion of the trustees".

9. This explains why and how a court, or the Adjudicator's office (or in the insurance context, the Ombudsman's office) can review a decision which the rules provide lies "in the opinion of the trustees". If a member complains about such a decision, the reviewing body can examine whether the decision was taken properly and, "if it was both honestly held and one which a reasonable person could arrive at on the evidence" (as held in the 2005 SCA case of *Southern Life Association v Miller*), then the decision must stand. If the reviewing body concludes that the insurer/fund was not reasonable in coming to

the conclusion it did, it may in certain circumstances, substitute its decision, or refer the decision back to the fund with instructions.

10. Let's move on to the other parts of the definition. I would just like to say at this juncture that I am indebted to Professor Richard Christie, QC and author of the definitive work *The Law of Contract*, for several opinions he has provided to the office of the Long-term Insurance Ombudsman over the years on occupational disability clauses, from which the distillation of some of the principles that follow are drawn.

11. Let's look firstly at the requirement that the member be **totally** disabled.

    The first point to take note of here is that the word totally cannot be taken literally – you do not have to be a total quadriplegic with little mental capacity, the "vegetable" of popular discourse. Again the word must receive a reasonable interpretation: the insured must in a practical sense, be unable to carry out his or her work. It is not necessary to prove that the member cannot do any part of his or her occupation.

12. The leading English case, from 1860, still generally followed in other jurisdictions, is *Hooper v Accidental Death Insurance*, about a lawyer who sprained his ankle and was confined to bed (note: permanence was not required in this case, only totality). Mr Hooper was held to be totally disabled from following his usual occupation because he was "wholly incapable of performing *a very considerable part* of his usual business", even though he could and did conduct *some* business from his bed.

13. As you can imagine, it is not possible to fix with mathematical precision the proportion of a member's occupation she must no longer be able to perform before she can be classified as totally disabled. In *Hooper* it was "a very considerable part", and other subsequent cases have used

measures such as “any substantial part”, or “what he can still do does not amount in effect to carrying on his business”.

14. In the PFA case of *Reynolds v Metal & Engineering Industries Retirement Fund* the fund repudiated a disability claim on the grounds that the complainant, a sander, could still do some of his usual tasks and was therefore not totally disabled. He had been in a motor vehicle accident and had spinal injuries which left him partly paralysed in his left leg and arm. He struggled to use the machinery, could only do the lighter work, and worked much more slowly than before, so he had to do overtime. The Adjudicator found that he was in a practical sense unable to carry out his work and met the requirement to be considered totally disabled.

15. In one of the Ombudsman cases, *CR74*, the definition required that the insured be totally disabled from performing “the material and substantial duties of his regular job”. The complainant, a waste site supervisor for a city municipality, had a stroke, but made a good recovery, although he had some right arm and leg weakness, with some mental slowing and impaired speech. At first he was not able to drive, but later he resumed driving. Occupational therapy reports, after a site visit, indicated that he was able to perform the same supervisory work he had done before, with some adaptations the employer was willing to provide. We agreed that his functional limitations did not stretch to total disability.

16. Next, the requirement of “**permanence**”. The American work Couch *Cyclopaedia of Insurance* tells us that an assured will discharge the burden of proving that his disability is permanent if he can prove that it will probably be permanent, in the sense that it will probably continue for an indefinite period of time. The member need not go so far as to prove that he has no hope of recovery.

17. Can a disabling condition be regarded as permanent if it could be removed by surgery? In the PFA case of *Hiebner v Metal and Engineering Permanent Disability Scheme* the complainant suffered from trigeminal neuralgia, a neuropathic disorder of the trigeminal nerve which causes episodes of intense pain in the eyes, lips, nose, scalp, forehead and jaw – said by Wikipedia to be among the most severe types of pain known to humanity. The medical evidence was that if the complainant had surgery he would have an 85% chance of a cure. The complainant however did not want to undergo surgery for fear of the attendant risks.

18. The Adjudicator's office obtained an opinion from Prof Christie which highlighted the leading US Court of Appeals case of *Heller v Equitable Life*. This case held that a disability insurance claim is not analogous to a delict (where there is a duty to mitigate one's damages), or a worker's compensation claim (where the statute regulates the rights and duties). In an insurance case (read also disability benefits under a pension fund) the claimant is seeking to enforce a right for which he bargained and paid (or certainly paid, in the pension fund context). It would have been open to the fund or insurer to insert a proviso in the rules (or policy) to the effect that the disability would not be permanent if it could be removed by surgery, with due allowance for risk and prognosis of success, and if it was reasonable to expect the claimant to undergo this, but *absent* such a proviso the complainant is entitled to enforce the right as it stands.

19. The surgery issue, as most people would agree, deals with a radical form of treatment, and that is why it cannot be seen as an implied term of a contract, or read into rules: it does not pass the tests of being so obvious that it goes without saying, or being necessary in a business sense to give efficacy to the contract. However it would probably be an implied term that an insured undergo reasonable treatment before it can be said that the condition she suffers from is intractable, and therefore permanent. It makes sense that one would not rush to a

conclusion that a condition, say a back problem, is permanent until treatments have been tried and failed.

20. Some insurers insist that the insured must have been optimally treated for a certain period of time. However our office has taken the view that treatment does not have to be optimal; adequate treatment is the reasonable standard. The period of time question is more tricky. In the case of serious psychiatric conditions, for example, such as major depression, comprehensive treatment including proper doses of medication and appropriate psychotherapy can take up to two years to be effective, but often it *is* effective, removing the element of permanency which might have prevailed without the treatment. In the Ombudsman's office we accept that a complainant claiming a disability benefit on grounds of a psychiatric disorder must have undergone adequate treatment for a reasonable period, say 18 months to two years, unless there are compelling medically-backed reasons as to why a condition can earlier be held to be treatment-refractory and therefore permanent. Again, it is not in the claimant's interest to be labelled permanently disabled if he or she can be successfully treated and assisted to become independent and working again.

21. The Life Offices Association has published Guidelines for assessing specific conditions for disability, such as psychiatric conditions, and funds should certainly be aware of these guidelines, as relevant information to be taken into consideration when taking decisions on disability claims.

22. Let's move on to another part of the typical definition:

"will be regarded as totally and permanently disabled if in the opinion of the trustees after consulting the fund's medical advisers, he has been so disabled by injury or disease as to be totally and permanently **incapable of engaging**
(a) in his own occupation, or

(b) in any other occupation for which he is or could reasonably be expected to become qualified by his knowledge, training, education, ability and experience".

23. What is the meaning of the phrase "own occupation"? This doesn't usually give much difficulty in the pension fund context as it is a question of fact, of evidence, drawn from sources such as the claimant herself, employers, job descriptions, and occupational therapist reports. It should be pointed out that the meaning of the words is not limited to the specific requirements of a specific employer, but is general – so for example a head of security in a large company who had to operate from the dusty basement because that is where the security office was in that firm, and who suffers from asthma, may not be capable of continuing employment with that employer, but he is not disabled from following his occupation as a security head.

24. The second part of this type of definition throws up more problems. This deals with the notion of a "similar occupation" as it is sometimes stated or else, as in our typical definition, the concept is more frequently formulated as, "**any other occupation for which he is *or could reasonably be expected to become* qualified by his knowledge, training, education, ability and experience**". This has much the same import as "similar", although with a "similar" occupation the emphasis is shifted slightly to the content of the occupation.

25. It should be noted that the words "or could reasonably be expected to become qualified" envisage that there is an expectation that the member might have to undergo some further training, in order to *become* qualified, but her existing knowledge, training, education, ability and experience must be taken into account in determining what further training it is reasonable to expect. If these words were absent, the member must be assessed for an alternative occupation looking purely at her existing knowledge, education, etc.

26. The notion of reasonability is paramount. In the end the question must be whether it is reasonable to expect a particular member to pursue a particular occupation.

27. Our approach at the Ombudsman's office is that an insurer must specify the particular occupations which it contends the insured can follow, with the complainant being given the opportunity, if she contests this, to state why she would not be able to follow the specifically suggested occupations. The Dictionary of Occupational Titles published by the US Department of Labour is a useful resource: it lists descriptions and requirements of various occupations and then also lists occupations regarded as similar.

28. It should be pointed out that an argument that a suggested occupation is not *available* is not usually relevant – the disability cover is for disability, not unemployment. It would though be a relevant argument if the suggested occupation was no more than fanciful.

29. Most of our cases at the Ombudsman's office deal with these "own or similar/reasonable other" definitions, and the reasonability of what the insurer expects the complainant to be able to do. I'll just mention a few examples.

30. In the Ombudsman case *CR 15*, the insured was a saleslady in the fresh produce department of a supermarket. She had six hernia repair operations and could not lift packages or stand for extended periods; eventually her employer "boarded" her. She was 46, with a Std 7 education, and had never done any other work. The insurer said that although she could not fulfil her own occupation, she could work as a cashier. We found however that it was unreasonable to expect her to do this as it required more intellectual capacity than her previous occupation; she was not reasonably qualified by her education, training, or experience to do such work.

31. In *CR71* the complainant had been a lifeguard for 21 years. He had lung problems and had thoracic surgery, after which he still had intense pain and breathing difficulties which made it hard for him to swim; he also had back problems, for which a neurosurgeon had recommended that he discontinue craft rescues. The insurer repudiated his claim for a lump sum disability benefit on the basis that, while he could not do his own occupation, there was no reason why he could not do less physical work. As a senior life guard, the insurer argued, he must have had administrative responsibilities; they suggested that he could teach water safety and first aid to children or adults at a municipal swimming pool, be a public relations or administrative officer in a recreation department, do office duties answering a telephone etc, or work in a surf shop. It is apparent that the insurer tried to think of occupations that would use his knowledge, experience or training, but we took the view that these did not sufficiently take into account his education and ability (he had Std 8, had failed trade tests when he tried to qualify as an elevator mechanic and a can maker, and had no other work experience). The suggested occupations were therefore not reasonable.

32. In *CR13*, the definition included the words "own occupation, or any other *suited* occupation, for which he is or could reasonably be expected to become qualified by his knowledge, training, education, ability and experience". The complainant, a bus driver, had suffered a gunshot wound, and as a result his left leg was amputated above the knee, and he had to wear a prosthesis. An OT report indicated that he was clearly compromised by physical limitations and pain for his occupation as a bus driver, but took the view that he had the potential for retraining for semi-skilled, sedentary occupations to which he would be suited, such as a machine operator, which it seems he even had some limited experience of doing. The insurer said he could reasonably be expected to undergo a vocational rehabilitation programme, so that he could do this kind of light work. We however said that "any other *suited* occupation" must be interpreted to refer to

an occupation at the same level, not a lower level. The complainant's work history indicated that over the 22 years of his working life he had gradually bettered himself and his prospects. He started out as a handyman, later became a machine operator, then left to become a truck driver, which entailed training for a specific licence. After five years he obtained a bus driver's job, which came with improved benefits, and he gained experience and salary increases by working in this position for eight years. To expect him to work as a machine operator at this stage, or to start out in some other form of semi-skilled sedentary work, would be to expect him to work at a lower level than at the time of his disablement. It would also involve him in further training, which is envisaged by the definition – but we said that must imply that any further training would be towards the end of qualifying him for a job at the same level as his "own" occupation or at a higher level, but not a lower one.

33. The LOA published a booklet in 2003 entitled "Guidelines for the Assessment of Impairment and Disability", in which, at page 29-30, they provide a useful summary of some of the relevant factors to take into account when evaluating the reasonableness of an alternative or similar occupation:

- Age. Generally a person close to retirement age (>58 years) should not be expected to adapt to any amount of change in job requirements, unless the work is very similar to his previous one.
- Income. A general guideline should be that a fall in income of more than 25% should be regarded as unfair.
- Years in current position. The lower one's qualifications, and the longer one is in one specific occupation, the less reasonable will any alternative position become. In this regard it is recommended that it should be unfair to expect the following categories to do any alternative work, ie own/similar definitions should effectively become own occupation:

- Any manual labourer with qualifications less than Grade 12 in school, and doing manual work for > 10 years, and
- Artisans practicing their trade > 10 years

34. The own or similar type definition is the most common, but there are two other extremes found in disability definitions, though less often in the retirement fund context.

35. On the one side is the “own occupation” only definition, where a member will be considered disabled if he cannot do his own occupation. It is obviously easier to qualify with this type of definition (which is why such cover is more expensive), as the complainant does not have to show that he is also unable to do any similar occupation – as soon as he cannot do his former occupation, say underground mining, he qualifies, and the insurer cannot argue for example that he could still do strip mining.

36. On the other side is the “any other occupation” definition, where a member will be considered disabled if she cannot do her own occupation or any other occupation whatsoever. This is the cheapest form of cover, giving the least protection to a member, because it is so hard to qualify. Some of the American cases have taken a fairly lenient approach to interpreting these type of clauses, stating that a court should not interpret “any occupation” so strictly as to ignore the previous employment, training or capabilities of the insured, but it does not seem that our courts would follow this line of thinking as it would effectively equate an “any occupation whatsoever” clause with an “own or similar occupation” clause. This would not do justice to the ordinary grammatical meaning of the words, and would ignore the presumption against tautology. Nevertheless in light of the fact that case law from other jurisdictions appears to be contradictory on this point, we have taken the approach that an insurer should try to find a compromise between a very strict literal interpretation and one that applies “own or similar” reasoning.

37. For example, in *CR76* we dealt with a teacher who suffered from verified major depressive disorder and personality dysfunction. His policy would pay a disability premium waiver if he was totally and permanently "prevented from engaging in any business or occupation and from performing any work for remuneration, compensation or profit". On a medical form in answer to the question "Do you consider that the disabled is at present totally incapable of performing any occupation whatsoever?" the insurer's chief medical officer had responded "No", and in explanation indicated that the insured was capable of "creative handwork". On this basis the claim was refused. We pointed out to the insurer that if it sought to rely on an alleged ability to do creative handwork, it would have to demonstrate that creative handwork is a business, occupation or work as distinct from a part-time activity or hobby, and that the activity would generate an income enabling the insured to earn a living. The insurer then admitted the claim.

38. Finally I just want to say a quick word about the burden of proof. The standard of proof is the usual standard in civil cases: the entitlement to payment of a disability benefit must be proved on a balance of probabilities. It is clear that the onus of proving entitlement lies in the first instance on the member – "he who asserts must prove". The member must therefore bear the cost of medical reports, unless provided otherwise by the fund rules. If a member provides inadequate information it is my view that, in keeping with its duty of good faith and its duty to protect the interests of members, the trustees should invite the member to put forward additional evidence to support her claim. If the fund needs an independent medical or other opinion to assist in making a decision, for example where there is contradictory evidence before it, the cost of that should be for the fund.

Sue Myrdal
September 2008