FILING A CLAIM

FOR YOUR DISABILITY BENEFITS

EMPLOYEE BENEFITS SECURITY ADMINISTRATION
UNITED STATES DEPARTMENT OF LABOR

This publication has been developed by the U.S. Department of Labor, Employee Benefits Security Administration (EBSA).

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To order publications or speak with a benefits advisor, contact EBSA electronically at: **askebsa.dol.gov.**

Or call toll free: **1-866-444-3272**

This material will be made available in alternate format to persons with disabilities upon request:
Voice phone: **(202) 693-8664**
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This booklet constitutes a small entity compliance guide for purposes of the Small Business Regulatory Enforcement Fairness Act of 1996.

Introduction

If you participate in a workplace plan that provides disability benefits, this booklet describes some of your plan's obligations and briefly explains the procedures and timelines for filing a disability benefits claim.

The Employee Retirement Income Security Act of 1974 (ERISA) protects your disability benefits and sets standards for those who administer your plan. Among other things, the law and related rules include:

- Requirements for processing benefit claims,
- The timeline for a decision, and
- Your rights when a claim is denied.

The rules for disability claims discussed in this booklet generally apply to people who receive disability benefits from a private-sector employment plan. However, there are exceptions:

- If your plan benefits depend on someone other than the plan issuing a finding of disability; or
- For plans sponsored by government or most religious bodies.

For example, if, under the terms of a pension plan, the plan will pay benefits to a person whom the Social Security Administration or the employer's long-term disability plan has determined to be disabled, then the ERISA rules for pension claims would cover the claim for pension benefits, not the rules for disability claims.

If you're not sure whether ERISA applies to you, contact your plan administrator for more information.

Language Assistance

If you live in a county where 10 percent or more of the population is literate only in the same non-English language, the plan must provide oral language assistance in that language and provide written notices in that language upon request. In such counties, benefit denial notices must include a prominent statement in the relevant non-English language about the availability of language assistance.

Reviewing Information from Your Plan

When you first enroll in your employer's plan, you will receive a document called the Summary Plan Description (SPD). It provides a detailed overview of the plan: how it works, what benefits it provides, how to file a claim for benefits, and any limitations that may apply. It also describes your rights and responsibilities under ERISA and your plan. If you participate in a single-employer collectively bargained plan, your claim filing, grievance, and appeal procedures may also be affected by the collective bargaining agreement.

Before you apply for benefits, review the Summary Plan Description to make sure you meet the plan's requirements for disability and understand the claim-filing procedures. Sometimes claims procedures are contained in a separate booklet. If you do not have a copy of your plan's Summary Plan Description or claims procedures, contact your plan's administrator, who is required to provide you with a copy. Keep a photocopy or similar documentation of your request for your records.

Filing a Claim

An important first step is to check your Summary Plan Description to make sure you meet your plan's requirements to receive benefits. Also, be aware of what your plan requires to file a claim. The Summary Plan Description or claims procedure booklet must include information on where to file, what to file, and whom to contact if you have questions about your plan. If that information is not in the booklets, write your plan administrator, your employer's human resource department (or the office that normally handles claims), or your employer to notify them that you have a claim. Keep a copy of the letter for your records. You may also want to send the letter by certified mail, return receipt requested, so you will have a record that the letter was received and by whom.

If an authorized representative is filing the claim on your behalf, your plan may require you to complete a form to name the representative. The authorized representative must follow the plan's claims procedure in the Summary Plan Description.

When a claim is filed, be sure to keep a copy for your records. Note: plans generally cannot charge any money for filing claims and appeals.

Waiting For a Decision on Your Claim

ERISA sets specific time limits for plans to evaluate your claim and inform you of the decision. The time limits are counted in calendar days, so weekends and holidays are included. Plans are required to pay or provide benefits within a reasonable time after a claim is approved, though ERISA does not specify a time limit. Check your Summary Plan Description for how and when benefits are paid.

Disability claims must be decided within a reasonable period of time. Generally, if you submit a disability claim, then **the plan must make a decision within 45 days of receiving the claim**. There are some circumstances that could extend the timeline:

IF...	AND THE PLAN...	THEN THE PLAN CAN EXTEND THE DEADLINE FOR MAKING A DECISION...
The plan needs more time to review, for reasons beyond its control	• Tells you, within the initial 45-day period, that it needs more time, • Explains why, • Does not request any additional information needed, and • Tells you when it plans to make a final decision	Up to 30 days
	• Tells you, within the initial 45-day period, that it needs more time, • Explains why, • **Requests additional information** (in which case the plan must give you at least 45 days to supply the information), and • Tells you when it plans to make a final decision	Up to 30 days after receiving the information OR when the time period to provide the information ends, whichever comes first
The plan still needs more time to review after the first extension	• Notifies you before the first extension expires	Up to 30 days more
	• Notifies you before the first extension expires, and • **Requests additional information** (giving you at least 45 days to supply the information)	Up to 30 days after receiving the information OR when the time period to provide the information ends, whichever comes first

For any additional extensions, the plan needs your consent. The plan must notify you whether your claim has been denied before the end of the time allotted for the decision.

If your claim is denied, the plan administrator must send you a notice, either in writing or electronically. The notice must include:

- A detailed explanation of why your claim was denied. If applicable, the notice must explain why the plan disagreed with the views of a medical professional or vocational expert (including those who treated you and those whose advice was obtained by the plan), or a disability determination made by the Social Security Administration;
- A reference to the specific plan provisions on which the denial is based;
- A statement that you are entitled to receive copies of all documents relevant to your claim for benefits, upon request and at no cost to you;
- The plan rules, guidelines, protocols, standards, or other similar criteria relied upon in denying the claim, or a statement that such documents do not exist; and
- A description of the plan's appeal process, including the time limits involved, and a statement of your right to pursue your claim in court if your claim is denied on appeal.

Appealing a Denied Claim

Claims are denied for various reasons. Perhaps you are not eligible for benefits. Or, perhaps the plan simply needs more information about your claim. Whatever the reason, you have at least 180 days to file an appeal (check your Summary Plan Description or claims procedure to see if your plan provides a longer period).

Use the information in your claim denial notice in preparing your appeal. Be sure to include in your appeal all information related to your claim, particularly any additional information or evidence that you want the plan to consider, and get it to the person specified in the denial notice before the end of the 180-day period.

Reviewing an Appeal

On appeal, your claim must be reviewed by someone new who looks at all of the information submitted and consults with qualified medical professionals if a medical judgment is involved. This reviewer cannot be the same person who made the initial decision or that person's subordinate, and the reviewer must give no consideration to the initial decision.

Disability appeals must be reviewed within a reasonable period of time, but not later than 45 days after the plan receives your request to review a denied claim. If the plan determines special circumstances justify an extension, the plan may take up to an additional 45 days to decide the appeal. However, before taking the extension, the plan must notify you in writing during the first 45-day period explaining the special circumstances, and the date by which the plan expects to make the decision.

There are two exceptions to these time limits:

- **Single-employer collectively bargained plans** generally may use a collectively bargained grievance process for their claims appeal procedure if it has provisions on filing, determination, and review of benefit claims.
- **Multiemployer collectively bargained plans** have special timeframes to allow them to schedule reviews on appeal of disability claims for the regular quarterly board of trustee meetings.

If you are a participant in one of those plans and you have questions about your plan's procedures, you can consult your plan's Summary Plan Description and collective bargaining agreement or contact the Department of Labor's Employee Benefits Security Administration (EBSA) at **1-866-444-3272**.

Your plan cannot deny your appeal based on evidence or rationales that were not included when the benefit was first denied, unless you are given notice of the new information and a reasonable opportunity to respond before the plan's decision is due. For example, if, during consideration of your appeal, the plan causes a new medical report to be generated, the plan must provide any new or additional evidence in that report to you before the 45-day period expires and you must be given a reasonable opportunity to respond.

Plans can require two levels of review of a denied disability claim to finish the plan's claims process. In such cases, the maximum time period for each review generally is half of the time period permitted for one review. For example, a plan with one appeal level must review a disability claim within 45 days after the plan receives your appeal. If the plan requires two appeals, both reviews must be completed within 45 days. If your appeal is still denied after the first review, the plan must allow you a reasonable period of time (but not a full 180 days) to file for the second review.

Once the plan makes a final decision on your claim, the plan must send you a written explanation of the decision. The notice must include:

- A detailed explanation of why your claim was denied. If applicable, the notice must explain why the plan disagreed with the views of a medical professional or vocational expert (including those who treated you and those whose advice was obtained by the plan), or a disability determination made by the Social Security Administration;
- A reference to the specific plan provisions on which the decision is based;
- Information on any additional voluntary levels of appeal;
- An explanation of your right to receive documents that are relevant to your benefit claim free of charge;
- The plan rules, guidelines, protocols, standards, or other similar criteria relied upon in denying the appeal, or a statement that none exist; and
- A description of your rights to seek judicial review of the plan's decision, including a description of any applicable contractual limitations period and its expiration date.

If Your Appeal Is Denied

If the plan's final decision denies your claim, you may want to seek legal advice regarding your rights to challenge the denial in court. Normally, you must complete your plan's claim process before filing an action in court to challenge the denial of a claim.

However, you can immediately pursue your claim in court if your plan failed to establish, or does not follow, the claims processing rules (unless the plan's violation is minimal). If a court rejects your request for immediate review of a denied claim, the plan must treat the claim as refiled on appeal.

If you believe your plan failed to establish or follow a claims procedure consistent with the Department's rules, you may want to seek legal advice regarding your right to ask a court to review your benefit claim without waiting for a decision from the plan. You also may want to contact the nearest EBSA office about your rights if you believe the plan failed to follow any of ERISA's requirements in handling your benefit claim.

Additional Protections

Your plan must decide both claims and appeals in an independent and impartial manner. For example, a person deciding your claim, or any medical or vocational expert involved in the decision, cannot be hired, promoted, terminated, or compensated based on the likelihood that person will support the denial of benefits.

The rights discussed in this booklet apply also to certain rescissions (retroactive cancellations or discontinuance) of disability coverage, for example due to alleged misrepresentations in your application for coverage. Rescissions for non-payment of premiums are not covered by these rules.

Filing a Claim – Summary

- Check your plan's benefits and claims procedure before filing a claim. Read your Summary Plan Description. Contact your plan administrator if you have questions.
- Once your claim is filed, the maximum allowable waiting period for a decision is 45 days. Your plan can extend certain time periods but must notify you before doing so. Usually, you will receive a decision within this timeframe.
- If your claim is denied, you must receive a written notice, including specific information about why your claim was denied and how to file an appeal.
- You have at least 180 days to request a full and fair review of your denied claim. Use your plan's appeals procedure and be aware that you may need to gather and submit new evidence or information to help the plan in reviewing the claim.
- Reviewing your appeal can take up to 45 days. The law and the Department's rules allow a disability plan additional time if the plan's administrator has notified you beforehand of the need for an extension.
- If the appeal is denied, the written notice must tell you why it was denied, describe any additional appeal levels or voluntary appeal procedures offered by the plan, and contain a statement regarding your rights to seek judicial review of the plan's decision.
- You may decide to seek legal advice if your claim's appeal is denied or if the plan failed to establish or follow reasonable claims procedures. If you believe the plan failed to follow ERISA's requirements, you can contact EBSA to discuss.

Resources

To view this and other EBSA publications, visit **dol.gov/agencies/ebsa**.

To order publications or request assistance from a benefits advisor, contact us at **askebsa.dol.gov** or call toll-free: **1-866-444-3272**.

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September 2018