Can The Health Insurance Company Do That? How to Find Out the Rules in Your Client's Subrogation Case and Maybe Get Penalties on the Side
By Eric Buchanan and Hudson Ellis

All too often, when we win or settle a significant personal injury case, our client's health insurance company wants to be paid back for all the medical expenses that were paid. This can often be a large portion of our client's recovery. If you have not prepared your client for this, the legitimate question from the client is, "can they do that?"

If your client obtained health insurance through work or through a family member's work, the health insurance will typically fall under ERISA.[1] Unfortunately, under the ERISA statute and case law, the answer is often, "yes, the insurance company can do that," but not always.

There are several defenses that you and your client might raise to avoid having to pay back a portion of the recovery to the insurance company, but one of the most important ones is whether the ERISA health insurance plan that covers your injured client has language that allows the insurance company or plan to recover.[2]

The plan, and the language in it, is key. Under ERISA, a plan or fiduciary, like an insurance company, can only seek "to enjoin any act or practice which violates [ERISA] or the terms of the plan, or (B) to obtain other *appropriate equitable relief* (i) to redress such violations or (ii) to enforce any provisions of [ERISA] or the terms of the plan." ERISA § 502(a)(3). In an ERISA plan can only seek to recover from your client if the

[1] The Employee Retirement Income Security Act of 1974.

[2] For a more detailed discussion of the various defenses that can be raised in ERISA subrogation and reimbursement cases, and what plan language will allow a plan to recover, please visit our firms website at:http://www.buchanandisability.com/helpful-resourcesandarticles/erisa-update-subrogation-post-serboff/

plan has appropriate language allowing for reimbursement or subrogation; there is no general right of reimbursement or subrogation in ERISA.

Additionally, even if the plan has language that purports to allow the insurance company to recover, the case law requires that the language meet specific requirements in order to allow recovery. "The plan, in short, is at the center of ERISA." *US Airways, Inc. v. McCutchen*, 569 U.S. ——, ——, 133 S.Ct. 1537, 1548 (2013).

The bottom line is that we plaintiffs' attorneys must obtain the ERISA plan that applies to our client's case in order to determine whether the insurance company has a right of recovery or not, and just what that right is. If our clients might face the subrogation/reimbursement issue at some point in their injury case, I submit that the best practice is for the attorney to order a copy of the plan documents from the plan administrator very early in the injury case, find out the plan rules early, and deal with the possible subrogation/reimbursement claim early on.

Fortunately, one of the good rules under ERISA is that a plan participant or beneficiary has the right to obtain the plan documents controlling an ERISA plan, such as a health insurance plan. If a participant or beneficiary sends a written request for the plan documents to the right entity (the plan administrator) and the documents are not provided within 30 days of receipt of the written request, the plan administrator can be sued for penalties of up to $110 per day. When a plan administrator is unusually uncooperative, these plan document penalties can be substantial.

I. Administrators have an obligation to provide information, and participants and beneficiaries have a cause of action if they don't provide the information.

ERISA § 502(c), 29 U.S.C. § 1132(c) provides for penalties for an administrator's refusal to supply required information. Under that section of ERISA[3],

> (1) Any administrator .[who fails to provide certain information][4] . . (B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary . . .by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100[5] a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation.

In addition to statutory penalties for failing to provide plan documents, ERISA plan administrators, as ERISA fiduciaries, must communicate with plan participants and beneficiaries about the plans. For example, a plan administrator, as an ERISA fiduciary, "is under a duty to communicate to the beneficiary material facts affecting the interest of the beneficiary which he knows the beneficiary does not know and which the beneficiary needs to know for his protection." *Krohn v. Huron Memorial Hospital*, 173 F.3d 542,

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[3] As a matter of technical pleading, if an administrator violated ERISA § 502(c), "a civil action may be brought (1) by a participant or beneficiary (A) for relief provided for in subsection (c) of this section." In other words, an ERISA § 502(c) claim is properly pled under the cause of action granted under ERISA § 502(a)(1)(A).

[4] ERISA § 502(c)(1) also provides for similar penalties for an administrators failure to provide COBRA notices and required notices related to transfers of excess pension plan assets to a health benefits account.

[5] The ERISA statute provides for a penalty of $100 per day, but the amount was increased to $110 per day as required by the Debt Collection Improvement Act of 1996. 62 Fed. Reg. 40696.

548 (6th Cir. 1999) (citing Restatement (Second) of Trusts). Also, a fiduciary must give complete and accurate information in response to a participant's questions. *Drennan v. General Motors*, 977 F.2d 246, 251 (6th Cir. 1992).

II. What documents must be provided?

ERISA plan documents are crucial to understanding the terms of any ERISA plan, and the master plan document sets out the specific rules by which an employee or beneficiary is provided employee benefits. ERISA § 104(b)(4), 29 U.S.C. § 1024(b)(4) states, "The administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary[] plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated."

Of these documents, the primary document to ask for is the one under which the plan is established or operated, and is commonly referred to as the "master plan document." This is the document that controls the terms of the plan, and is the one that should have the language stating what authority the plan or insurance company has to recover in a subrogation claim.

Additionally, if there is a health insurance policy, that document is also a contract or instrument under which a plan is established or operated, and may also contain the relevant subrogation language. In fact, for many employers, there is only a health insurance policy, and not a master plan document.

The third document that should be requested is the summary plan description, or "SPD". This is a document that describes the terms of the ERISA plan in a way

calculated for an average employee to understand. However, unless it is specifically incorporated into the Plan, it is not officially part of the controlling plan documents. [6]

III. Who may be sued under ERISA § 502(c)?

A. In most circuits, including the Sixth, only the designated Plan Administrator, who is normally the employer or union providing benefits is liable for a penalty under ERISA § 502(c).

ERISA § 502(c)(1) provides that "any administrator" who "fails or refuses to comply with a request for any information which such administrator is required by this title to furnish to a participant or beneficiary" shall be, in the court's discretion, liable to the participant or beneficiary in the amount up to $110 a day from the date of such failure or refusal.

One common mistake plaintiff's attorneys make is that they request the plan documents from the insurance company or the collection company that is making a subrogation claim. Unfortunately, most circuits have read into ERISA an additional implied term that the language "any administrator" actually means only the "Plan Administrator." For example,

> It is well-settled in the Sixth Circuit that only plan administrators can be held liable for statutory penalties under 29 U.S.C. § 1132(c). *Caffey v. UNUM Life Ins. Co.*, 302 F.3d 576, 584 (6th Cir.1989); *Hiney Printing Co. v. Brantner*, 243 F.3d 956, 960 (6th Cir.2001); *VanderKlok v. Provident Life & Accident Ins. Co.*, 956 F.2d 610, 618 (6th Cir.1992). Furthermore, the Sixth Circuit has expressly held that "an insurance company, which is not a plan administrator cannot be held liable for statutory damages [under § 1132(c)] for failure to comply with an information request." *Caffey*, 302 F.3d at 58 (citing *VanderKlok*, 956 F.2d at 618).

[6] *See, e.g., CIGNA Corp. v. Amara*, 131 S. Ct. 1866, 1878 (2011) (the Summary Plan Description cannot be a controlling plan document and only serves as a summary of the plan terms contained in the Plan Document.)

Addison v. Hartford Life and Accident Insurance, 32 Emp. Ben. Cas. 1640, 2003 WL 23413737 (E.D.Tenn. 2003) (unpublished). *See also, Lee v. Burkhart*, 991 F.2d. 1004 (2d Cir. 1993); *Coleman v. Nationwide Life Ins. Co.*, 969 F.2d 54 (4th. Cir. 1992); *Anweiler v. American Electric Power Service Corp.*, 3 F.3d 986 (7th Cir. 1993); *Moran v. Aetna Life Insurance Co.*, 872 F.2d 296 (9th Cir. 1989), (the insurance company was not the "plan administrator" of an ERISA plan); *McKinsey v. Sentry*, 986 F2d 401, 404-05 (10th Cir 1993); *Davis v. Liberty Mutual Ins. Co.*, 871 F.2d 1134 (D.C. Cir. 1989).

B. Normally the Plan Administrator is the Employer or Union.

How is a plaintiff's attorney supposed to know who the "Plan Administrator" is in order to write to the correct entity to request documents? Under ERISA § 3(16), 29 U.S.C. § 1002(16) the Plan Administrator is either the person specifically designated in the plan. That is great, if you have a copy of the plan, you can look into the plan to see who is named as the Plan Administrator.

But what if you don't have the plan? Fortunately, that is also address in ERISA § 3(16), 29 U.S.C. § 1002(16), which states that if no one is named in the plan, it is the plan sponsor (the employer or union that offers the benefits). In my experience, most documents actually name the employer or union' but, if you don't have the documents and don't know for sure, that is the first place you should write to.

Also, because ERISA fiduciaries, which include insurance companies and Plan Administrators have a fiduciary duty to truthfully answer question when asked, I believe it is the best practice to ask the employer and insurance company to tell you who the actual Plan Administrator is so you know who to write the proper request to.

IV. When a Plan Administrator fails to respond, how does a court determine the appropriate penalty?

A. What to ask for

When an employer or Union fails to respond to a request for documents just one time, technically you have a claim for penalties, but that is not the best case to take to a federal court. The best case for penalties is also the most common sense approach to getting the documents.

I recommend that you write to the employer or union and address it to the attention of the "Plan Administrator of the health care plan." I suggest that the best practice is to say you are writing "on behalf of my client, Mrs. ____, who is a beneficiary or participant in the plan."

I recommend that you specifically ask for the "master plan document," any "health insurance policy" or "health benefits plan," and also ask for any "summary plan description" for the health care plan. I also recommend asking for a catchall seeking any documents that describe the health benefits for your client, and specifically any documents that describe the rights, procedures, and obligations for the health insurance company or health care plan to exercise a right of reimbursement or subrogation.

Next, I recommend explaining in some detail why you need those documents. For example, explain that your client may obtain a recovery in a tort case, and you need to know what your client's rights and obligations regarding subrogation and reimbursement are. Also, specifically point out that you would like the entire policy or plan document, and not just selected pages, so that you can verify all the plan's and your client's rights.

Also, I suggest that you provide a brief reminder that if the documents are not provided in 30 days, your client would have the right to seek penalties under ERISA § 502(c) of up to $110 per day.

Lastly, if you do not get a response, or only get a partial response, I recommend that you follow up with additional letters, setting out those specific documents you still need, asking the specific questions you have, and reminding the plan administrator about the penalties.

Each letter you send the plan administrator should be certified/registered and you should save the return receipts as proof for use in court later.

A good case for penalties is one where you do all that, and have to write three or four times, or more, in order to get the documents, or when you write that many times and never get all the documents.

When you have done all that, you will have a good record for obtaining penalties, because once you go to court it is up to the discretion of the district courts to award penalties under 29 U.S.C. § 1132(c). While some circuits have no reported cases involving § 502(c) penalties, the federal circuits which have addressed these claims use a variety of factors to decide whether to award penalties under § 502(c).

B. Factors in Determining Awards and Amounts Awarded

The five factors most commonly used by the courts in assessing § 502(c) penalties are: "(1) bad faith or intentional conduct of the plan administrator, (2) length of delay, (3) number of requests made, (4) documents withheld, and (5) prejudice to the participant." *Gorini v. AMP Inc.*, 94 Fed. Appx. 913, 919-920 (3d Cir. 2004). The Second and Third Circuit Courts have adopted these factors, as have several district courts in the Seventh

Circuit. *See McDonald v. Pension Plan of the Nysa-Ila Pension Trust Fund*, 320 F.3d 151, 163 (2d Cir. 2003); *Jackson v. E.J. Brach Corp.*, 937 F. Supp. 735, 741 (N.D. Ill.1996); *Blazejewski v. Gibson*, 1999 U.S. Dist. LEXIS 18028 at 9-10 (N.D. Ill. 1999). Other circuits use some of these factors to varying degrees. The Eleventh Circuit, for example, has cited these five factors, but noted that they are not prerequisites for imposing civil penalties. *Curry v. Contract Fabricators Inc. Profit Sharing Plan*, 891 F.2d 842, 847 (11th Cir. 1990). In the Fourth Circuit, the Eastern District of Virginia has considered bad faith and length of delay, but awarded penalties even though neither of these factors was in the plaintiff's favor. *Freitag v. Pan Am. World Airways, Inc.*, 702 F. Supp. 128, 132 (E.D. Va., 1988).

The First, Fifth, and Sixth Circuits focus on bad faith and prejudice to the plaintiff. *Bartling v. Fruehauf Corp.*, 29 F.3d 1062, 1066-1067 (6th Cir. 1994); *Rodriguez-Abreu v. Chase Manhattan Bank, N.A.*, 986 F.2d 580, 588-89 (1st Cir. 1993); *Godwin v. Sun Life Assurance Co. of Canada*, 980 F.2d 323, 328-29 (5th Cir. 1992).

However, in these circuits, neither bad faith nor prejudice is required; they are merely considerations in determining the amount of penalties awarded. *Bartling*, 29 F.3d at 1066. In fact, the Sixth Circuit has affirmed a penalty against a plan administrator when neither prejudice nor bad faith was present. *McGrath v. Lockheed Martin Corp.*, 48 Fed. Appx. 543, 557 (6th Cir. 2002). *See also, Lampkins v. Golden*, 1996 WL 729136 at p. 3 (6th Cir. 1996) (discussing why prejudice need not be present before a court should award penalties and affirming a penalty of $75 per day for 438 days of delay, or a total penalty of $32,850.)

When arguing these cases, Plaintiff's attorneys can argue that nothing in ERISA § 502(c) requires a showing of prejudice before a court should assess a penalty under that part of the ERISA statute. The purpose of the statute is to ensure that plan Administrators expeditiously produce plan documents. Rather, courts have repeatedly held that such factors may be considered by a court, but are not dispositive, and it is in a court's discretion to award such a penalty without those factors.

However, because courts and defense counsel often focus on prejudice as the most important factor, the Plaintiff should be prepared to show prejudice. Many courts have stated that prejudice is at least an "important factor" to consider when determining the applicability of § 502(c) penalties. *See, e.g., Bartling v. Fruehauf Corp.*, 29 F.3d 1062, 1067 (6th Cir. 1994). For most courts, however, it is not determinative. Even so, some courts refuse to impose penalties or give "token" penalties in the absence of prejudice. *Patterson v. Ret. & Pension Plan for Officers & Employees of the N.Y. Dist. Council of Carpenters and Related Orgs.*, 2001 U.S. Dist. LEXIS 15949 at 22 (S.D.N.Y. 2001); *Hackett v. Xerox Corp. Long-Term Disability Income Plan*, 2001 U.S. Dist. LEXIS 21305 at 68-70 (N.D. Ill. 2001).

Fortunately, prejudice is not a particularly difficult thing to show. In addition, in the Sixth and Eleventh Circuits, the burden is on the plan administrator to prove that there is no prejudice. *Knickerbocker v. Ovako-Ajax, Inc.*, 1999 U.S. App. LEXIS 16982 at 20 (6th Cir. 1999). Often the fact that the plaintiff had to seek the advice of counsel and institute a lawsuit in order to determine his or her rights under the plan is sufficient "prejudice." Courts imposing penalties under this interpretation of "prejudice" often focus on the time and effort expended and the aggravation experienced by the plaintiff in

hiring a lawyer or bringing the suit. *Almonte v. GMC*, 1997 U.S. Dist. LEXIS 9271 at 14-16 (S.D.N.Y. 1997); *Jackson v. E.J. Brach Corp.*, 937 F. Supp. 735, 742 (N.D. Ill. 1996). Another way to look at this interpretation is that if the suit commences before the administrator has furnished the requested information, the plaintiff may have brought a suit for benefits without knowing the merits of his or her position. *Patterson*, 2001 U.S. Dist LEXIS 15949 at 22. On the other hand, the plaintiff should not argue prejudice merely as a result of hiring an attorney, since attorney's fees can be recovered under ERISA. *Geary v. Chicago Tile Inst. Welfare Trust*, 1995 U.S. Dist. LEXIS 4921 at 19 (N.D. Ill. 1995). In addition, courts have found seeking counsel and filing suit to be inadequate prejudice when the case was primarily based on other grounds such as interpretation of the plan or discrimination by the former employer. *Patterson*, 2001 U.S. Dist LEXIS 15949 at 22; *LaCoparra v. Pergament Home Ctrs., Inc.*, 982 F. Supp. 213, 230 (S.D.N.Y. 1997).

B. An example of a recent case granting substantial penalties.

Despite the statutory penalties and fiduciary duties under ERISA, some plan administrators continue to refuse to provide information to ERISA plan participants and beneficiaries. Fortunately, courts continue to recognize that plan administrators should not ignore their obligations, and are willing to assess significant penalties in the right case.

Our firm's recent case of *Harris-Frye v. United of Omaha Life Ins. Co.*, No. 1:14-CV-72, 2015 WL 5562196 (E.D. Tenn. Sept. 21, 2015) is a textbook example, where the Court assessed a $74,140 penalty on the plan administrator for repeatedly refusing to produce, or even acknowledge, the existence of controlling plan documents. In our case,

the plan administrator's refusal to cooperate led the court to assess the penalty at the full $110 per day for 674 days.

The irony of this case, like other similar cases, is that this case did not start out as a "plan document" case. Rather, our client just wanted to understand the rules, and get an answer as to why benefits were being denied. In this case, we agreed to help our client find out why her father's life insurance through his union was not in effect when he passed away, despite premiums being paid through the date of his death.

In trying to determine why life insurance benefits were denied, we wrote to the administrator on behalf of our client, as a potential ERISA beneficiary, to ask that it provide the controlling plan documents. Despite sending three letters, we were stonewalled by the plan administrator. In each of our letters we requested all the controlling plan documents, and also included language warning the plan administrator that it had a duty to provide that information and could face substantial penalties if they failed to comply. Instead, the plan administrator only provided a copy of a few pages from the Summary Plan Description (SPD), and did not provide us with the master plan document containing the official terms of the plan. Also, during that time, we were able to wrangle a copy of the insurance policy from the insurance company, who was not the plan administrator.

Even though the only document the plan administrator provided was an SPD (that stated it was not the controlling document, but only a summary, and referred to other documents as controlling,) the administrator continued to ignore our requests for all the controlling documents until we filed suit and were knee-deep into litigating the claim. Finally, at the party depositions, an employee of the plan administrator admitted a master

plan document existed and was able to provide us a copy that happened to be readily available at the administrator's office. The plan, it turned out, had essentially identical terms to those in the SPD, but we could not know that until the document was actually produced.

In federal court briefing, the administrator argued that we did not specifically ask for the plan and that, even if we did, we were not prejudiced by their not producing it because the terms in the plan were the same as the terms in the SPD. This argument got traction with the magistrate judge, who recommended a penalty of only $12,760 based solely on the 116 days the administrator had failed to provide the insurance policy, and refused to allow penalties for withholding the plan because it did not have any different terms than the SPD and the administrator used the SPD as the governing document. Fortunately, our objection to the Report and Recommendation got the judge's attention and he overruled the magistrate judge, adding an additional 558 days of penalty by holding that we were entitled to penalties for the administrator's refusal to produce the plan document.

The judge's holding has several important points. First, he held that the administrator is not excused from providing the plan where its terms are mirrored in the SPD; the plan is a controlling document and, when it is requested, the administrator must provide it. Next, the judge gave the administrator "the benefit of the doubt" about when we had first requested the plan, finding that our third request was the first totally unambiguous request for the plan and using that request as the triggering date, rather than the date we sent in the previous requests. Finally, the court found the administrator's

deliberate refusal to even reply to our second and third request justified imposing the maximum daily penalty ($110).

V. Conclusion

Often, health insurance companies have the right to be reimbursed out of the proceeds from personal injury claims, but that is not always the case, and the key to finding this out is to get a copy of the plan document. If you follow the best practices above, you should be able to quickly and easily get copies of all relevant plan documents. As a corollary benefit, in those cases where you are ignored or refused, using these best practices opens the door to recovering penalties against the plan administrator. Determining the existence of subrogation or reimbursement rights early can help you set appropriate expectations with your client, take charge of it early.

Sample Letter To the Plan Administrator and Insurance Company

Attention: Plan Administrator of the Health Care Plan

Dear Sir or Madam:

I am writing this on behalf of Brigitte Nielson. As an employee and participant in the company health care plans, she wants to make sure that we have all the documents that might apply to her rights and obligations under the company health care plan

[Depending on the situation, insert a brief explanation about what type of case our client has, and that there might be a recovery from a third party, so we need to know just what the plan says about this situation. i.e. Ms. Nielson was injured when her automobile was hit by another driver, and we believe the other driver, his insurance, or Ms. Nielson's own automobile insurance may pay or be forced to pay for Ms. Nielson's injuries and damages. We understand that some of her medical treatment for her injuries may have been paid for under the company health care plan. . In order to understand just what obligation our client has to pay out of the recovery and what the amount is that is being sought, Ms. Nielson, through us as her attorneys, is requesting that you send to us information about her health insurance coverage and this claim.]

Because we believe you are Plan Administrator of the company health care plan, we request the following information pertaining to Ms. Nielson's coverage under those plans:

1. If you are not the plan administrator of the health care plan, or this is not the correct address for the plan administrator of the health care plan, please provide us with the correct name and address of the plan administrator, and if different, the registered agent for service of process for the health care plan and plan administrator.

2. Please provide a complete copy of any plan documents related to the company health care plans, including but not limited to: any master plan document, summary plan description, policies, and any contract or administrative agreement between you and the health insurance company. We also ask for any other documents that describe the health benefits or benefits plan that covered Ms. Nielson, and specifically any documents that describe the rights, procedures, and obligations of the health insurance company or health care plan if it seeks to exercise a right of reimbursement or subrogation.

3. If you have any information about any medical bills that have already been paid that you, the plan, or any other ERISA fiduciary contend should be reimbursed if our client successfully recovers, please provide us all such information, including the amounts sought to be recovered, the actual charges that were paid, any underlying medical bills or records, and any information related to how you determined what medical expenses were related to Ms. Nielson's injuries.

We also ask that you please preserve any documents relative to Ms. Nielson's health care claims, or claims to recover from her, as well as copies of any electronic documents, E-mails or computer data, and also any audio or video recordings relative to Ms. Nielson's coverage under the company health care plan.

Under ERISA, the Plan Administrator has affirmative, legal, and fiduciary duties to provide the information requested. Pursuant to ERISA § 502(c), 29 USC §1132(c), documents required to be disclosed under Title I of ERISA must be furnished within thirty (30) days after the request or the Plan Administrator can be held personally liable for a failure or refusal to comply with this regulation with a maximum penalty of $110.00 per day.

If you would like to discuss this claim or have any questions, please do not hesitate to contact us. Thank you for all your help.

If we are writing to the insurance company in a subrogation case:

Sylvester S. Stallone has hired me to represent him regarding a claim that he must repay health benefits out of any recovery from an injury claim. In order to understand just what obligation our client has to pay out of the recovery and what the amount is that is being sought, Mr. Stallone, through his attorney, is requesting that you send to us information about his health insurance coverage and this claim. Once we receive this

information we can better address the claim that our client must repay funds out of the recovery.

We are writing to you to ask for information about the terms of the health insurance plan and for other information about the claim. We understand that you are either the insurance company or third party administrator of the Philadelphia Boxing Union Health Care Plan, and that you make claims decisions under the plan, and are the party that would seek reimbursement from our client out of any recovery for injuries for which health benefits were paid. If you are not the insurance company or third party administrator, please tell us who is, and provide us an address to contact such party. Also, if there is a different name for the health benefits plan, or the overall benefits plan for Philadelphia Boxing Union, please tell us the correct name of the plan. If you do not tell us differently, we will assume you are the insurance company or third party administrator for the Philadelphia Boxing Union Health Benefits Plan, and are the proper entity to from whom to request documents and other information about what benefits have been paid, and what recovery is sought.

Specifically, on behalf of Mr. Stallone, we request that you provide the following:

1. A complete copy of any claim file or documents showing what benefits were paid under the health benefits plan for medical treatment that you believe are related to my client's injury. This includes medical records, medical bills, payments, and any other documents that are deemed relevant to this claim or my client's medical benefits paid under 29 C.F.R. § 2560.503-1(m)(8). This also includes a copy of any master plan document, insurance policy, third party administrator agreement summary plan description or other document you contend controls the terms of any claim you might have against our client.
2. A complete list of medical bills paid, including the amount paid, the party the benefits were paid to, and the treatment paid for.
3. If any medical bills remain unpaid, state the amount not paid, the party owed the payment, and the reason the bills have not yet been paid.
4. Please provide me with the status of any claim against my client.
5. Please identify the specific plan provision you are relying on that you believe allows you to recover from my client any funds paid under the health benefit plan out of any recovery for injuries.

We are also asking the Company Health Care Plan Administrator for the following information; however, if you are the Plan Administrator, or if you have access to any of the following information, we ask you to also provide to us, on behalf of our client:

1. The Correct name and address of the Company Health Care plan administrator, and if different, the registered agent for service of process for the health care plan and plan administrator.

2. A complete copy of any plan documents related to the Company Health Care Plans, including but not limited to: any master plan document, summary plan description, policies, and any contract or administrative agreement between you and the health insurance company. We also ask for any other documents that describe the health benefits or benefits plan that covered Ms. Nielson, and specifically any documents that describe the rights, procedures, and obligations of the health insurance company or health care plan if it seeks to exercise a right of reimbursement or subrogation.

Enclosed is a release authorization signed by our client authorizing you to provide the above information as well as a release authorization signed by our client giving permission for you to send any back benefits and future benefits to my office.

Further, as an ERISA fiduciary, you have a fiduciary duty to communicate with a plan participant or beneficiary. You must provide information necessary for a plan participant or beneficiary, such as our client, to understand his or her obligations and rights under the plan, and to answer questions about the plan. An ERISA fiduciary has a duty not only to answer questions, but to inform our client about rights and obligations under the plan that our client should know, but does not know to ask.

Also, if you are also the Plan Administrator, you have an affirmative duty to provide us master plan documents, summary plan documents, insurance policies, and other documents that control the terms of the plan. If a Plan Administrator fails to provide us the documents within thirty (30) days of this request, under ERISA § 502(c), 29 USC §1132(c), the Plan Administrator can be held liable for a failure or refusal to comply with this statute and could be liable for a maximum penalty of $110.00 per day.

If you would like to discuss this claim or have any questions, please do not hesitate to contact my office.

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