FAQ

This FAQ is general information, not legal advice. Every policy is different, and the rules can vary by state and by court.

Getting started

Is my long-term disability claim covered by ERISA?

If your insurance came through a private employer's group plan, it probably is. ERISA covers most private-sector, employer-sponsored disability plans. It usually doesn't apply to plans from government employers, church plans, or policies you bought on your own outside of work. Those are usually governed by state insurance law, which often gives you more rights. If you're not sure what kind of plan you have, check your plan documents or ask HR. The type of plan affects how your claim and appeal will work.

Why do people say ERISA claims are "different"?

Because the process isn't like a typical insurance dispute. There is no jury, and usually no live testimony. In many cases the judge looks only at the "administrative record," which is the file the insurer put together during your claim and appeal. You also usually can't sue right away; you have to go through the plan's internal appeal process first. That's why the appeal is often the most important stage of an ERISA disability claim.

I got a denial letter and it's full of technical terms. What should I do?

Take your time and focus on three things:

1. The exact reason(s) for the denial or termination.
2. The deadline to appeal. It's listed in the letter, and for ERISA disability plans it must be at least 180 days.
3. Your right to request a free copy of your claim file. ERISA requires the letter to tell you about this right. Request the file right away.

Many people here start by posting a photo of their letter. If you do, **black out your name, claim number, policy number, and any other personal information first.** The letters look similar because ERISA requires them to include certain information.

Denials and appeals

What are the most common reasons LTD claims get denied?

Common reasons include:

- The insurer decides your medical evidence doesn't support the limitations you've described.
- An insurer-hired doctor (through an exam or a file review) disagrees with your doctor.
- The policy's definition of disability changes (see "Own Occupation vs. Any Occupation" below).
- A pre-existing condition exclusion is applied.
- Surveillance or social media is used to argue you can do more than you've said.

What's the difference between a denial and a termination?

A denial means your claim was never approved. A termination means you were receiving benefits and they stopped, often after a review, a change in the policy's definition of disability, or new evidence. The appeal process and deadlines are usually the same.

What should I include in an ERISA appeal?

Because a court will usually look only at what's in your file, the appeal is often your last chance to add evidence. Consider including:

- A detailed letter responding to each reason for the denial.
- Updated medical records.
- A statement from your doctor responding to the insurer's objections.
- In some cases, a functional capacity evaluation or a vocational assessment.

If the insurer gets new evidence or a new rationale during your appeal (for example, a new medical review), ERISA's disability claim rules require it to give you a copy and a chance to respond before it decides. Take advantage of that. Since you may not get another chance to add to your file, many people hire an attorney at this stage even if they didn't have one before.

Do I need a lawyer to appeal?

Not always. Many people handle their own appeals, especially when the denial is simple and the medical evidence is strong. But because the appeal usually finalizes the record for any future lawsuit, it's a good idea to get legal advice before you submit anything. That's especially true if your case is complicated, the denial relies on an exam or file review you disagree with, or you were paid benefits for a long time before they were stopped. Many disability attorneys work on contingency, and in ERISA cases a court may order the insurer to pay attorney's fees.

What happens if my appeal is denied?

You've usually exhausted your administrative remedies and can file a lawsuit. A few plans require a second level of appeal first, so check your letter. Most ERISA disability cases end up in federal court. How much new evidence you can add, and how closely the court reviews the insurer's decision, depend mostly on your plan's language, state law, and the court you're in. That's why it's important to talk to an attorney at this stage, not later.

Is there a deadline to file a lawsuit?

Yes, and it's easy to miss. Many plans set their own deadline for suing, sometimes measured from when you first had to submit proof of your claim rather than from the final appeal denial. Courts generally enforce these deadlines. Check your policy or plan document for a "legal actions" or "limitations" section as soon as your appeal is denied.

What if the insurer doesn't decide my appeal in time?

ERISA sets deadlines for insurers to decide claims and appeals (for a disability appeal, generally 45 days, with one 45-day extension if the insurer gives notice). If the insurer doesn't follow the claim rules, you may be able to go straight to court without waiting. Talk to an attorney before relying on this.

Own Occ, Any Occ, and definitions of disability

What's the difference between "own occupation" and "any occupation"?

Most policies use one definition of disability at first (usually for 24 months), then switch to a stricter one.

- **Own occupation** means you can't perform the material duties of your occupation. Many group policies define that occupation as it's normally performed in the national economy, not your specific job at your employer. So if your job was unusually demanding, the insurer may compare you to a more typical version of it.
- **Any occupation** means you can't perform any job you're reasonably suited for based on your education, training, and experience. Many policies also include an earnings test, such as a job that would pay a certain percentage of your pre-disability income.

Many claims end at the 24-month mark because the new standard is harder to meet.

Can I work while on LTD?

Sometimes. Many policies distinguish between total and partial (or "residual") disability, and many allow some work at reduced hours or reduced pay. But working while on claim is one of the most closely watched areas; insurers look for evidence that your work activity is inconsistent with your claimed limitations. If you're working, or thinking about it, understand your policy's rules first and report the work as the policy requires. Even part-time or "light" work can trigger a review.

Surveillance and social media

Do insurance companies really use surveillance?

Yes. It's a normal and legal part of how disability insurers investigate claims, especially higher-value or long-term ones. They may hire investigators to film you in public, review your public social media, and review records you authorized them to get, such as pharmacy records.

Can a photo or post really hurt my claim?

Yes, and often it's not about what you did but how it's presented. A photo of you smiling and standing at a family event for a few minutes can be used to argue you're more capable than you've said. Many people here suggest tightening your privacy settings, not accepting new friend requests while your claim is active, and being careful about what you share. Even old or unrelated posts can be taken out of context. **Don't delete existing posts once you have a claim,** though. Deleting can look like hiding evidence and can create bigger problems than the post itself.

Social Security (SSDI)

How does SSDI relate to my LTD claim?

Most LTD policies have an "offset" clause: your LTD payment is reduced by the SSDI you receive, and often by SSDI paid to your dependents and by other benefits like workers' compensation. That's why most LTD policies require you to apply for SSDI, and why some insurers hire a third-party company to help you apply. Your approval lowers what they pay.

What happens when I'm awarded SSDI back pay?

Expect your LTD insurer to claim an overpayment. Because SSDI awards are usually retroactive, the insurer will say it overpaid you for the months SSDI covers and ask you to repay that amount, often from the lump sum. Many policies let the insurer reduce or stop your LTD checks until it's repaid. Plan for this before you spend the back pay, and ask questions if the insurer's calculation doesn't look right.

Should I accept help from an SSDI company my insurer recommends?

This comes up often. It's not a scam; many of these companies do have real SSDI experience. But remember that your insurer benefits if you're approved. Understand what the company offers, who is paying it, and what you're agreeing to (including any repayment terms) before you sign. Compare it with an independent SSDI attorney or advocate.

My SSDI was approved. Does that mean my LTD claim is guaranteed?

No. They are separate systems with different rules, and Social Security's definition of disability isn't the same as your policy's. An SSDI approval can help your LTD appeal or lawsuit, but insurers can still deny or stop LTD benefits after an SSDI approval. If the insurer disagrees with Social Security's decision, ERISA's claim rules require it to explain why in its denial letter.

Specific conditions

Does LTD treat "invisible" or subjective conditions differently, like fibromyalgia, chronic fatigue, long COVID, or chronic pain?

Often, yes. Conditions without clear test results (like an X-ray or MRI finding) usually get more scrutiny. Some policies have a "self-reported symptoms" limitation that caps benefits, often at 24 months, for conditions diagnosed mainly from what you report rather than objective tests. If you have one of these conditions, keep detailed symptom logs, get consistent treatment, and pursue objective testing where possible (such as tilt-table testing, neuropsychological testing, or a functional capacity evaluation).

Are mental health claims treated differently?

Often, yes. Many LTD policies have a separate, shorter benefit limit for disabilities caused mainly by mental or nervous conditions, usually 24 months, even when other conditions would be paid until retirement age. Some policies make an exception if you're hospitalized when the limit runs out. This is a common area of dispute, so if your claim involves mental health, check your policy for a "mental/nervous limitation" clause.

ERISA vs. bad faith

What's the difference between an ERISA claim and a bad faith claim?

ERISA claims are federal and provide limited remedies: usually the benefits owed, sometimes interest, and possibly attorney's fees. There's no jury and no extra damages. A "bad faith" claim is based on state law and applies to policies ERISA doesn't cover (such as individual policies, and some government and church plans). It may allow broader damages if the insurer handled the claim unreasonably. Whether a bad faith claim is possible depends almost entirely on whether ERISA applies to your plan.

What counts as "bad faith" by an insurer?

Examples include ignoring your doctor's opinions without a good reason, relying on a reviewing doctor who always sides with the insurer, unreasonable delays, asking for the same information over and over, or stopping benefits without any real change in your condition or the evidence. Under an ERISA plan, this conduct usually isn't a separate "bad faith" claim, but it can still be strong evidence that the insurer's decision was unreasonable.

Glossary

Abuse of Discretion Standard: A deferential standard of court review (sometimes called "arbitrary and capricious") where a judge overturns the insurer's decision only if it was unreasonable. It's a much higher bar than de novo review. A court may give the insurer less deference if it both decides claims and pays them.

Administrative Record: The complete file the insurer compiled while handling your claim (application, medical records, correspondence, exam reports, etc.). In most ERISA lawsuits, it's the main or only evidence the court considers, which is why building the record during the appeal matters so much.

Adverse Benefit Determination: The formal notice denying, reducing, or terminating benefits. ERISA requires it to include specific information, including the reasons for the decision, the plan provisions relied on, what additional information you could submit, and your appeal rights.

Any Occupation: The stricter definition of disability, typically applying after an initial period (often 24 months). It requires that you be unable to perform any job you're reasonably suited for, not just your own.

Bad Faith: A state-law claim (not available under most ERISA plans) that an insurer unreasonably handled or denied a claim. It can allow damages beyond the benefits owed.

COBRA: A federal law that lets you temporarily keep employer health insurance after leaving a job, usually at your own cost. It applies to employers with 20 or more employees; many states have similar laws for smaller employers. It's often relevant when a disability leads to losing your job. If Social Security finds you disabled, you may qualify for extended COBRA coverage.

De Novo Review: A standard of court review where the judge decides the claim fresh, without deferring to the insurer's decision. Whether you get this more favorable standard or the tougher abuse of discretion standard usually depends on your plan's language and, for insured plans, whether your state bans discretionary clauses.

Discretionary Authority Clause: Plan language giving the insurer or administrator the power to interpret the plan and decide claims. It usually triggers the more deferential abuse of discretion standard, which is why it's so heavily litigated. Many states ban these clauses in insurance policies, but those bans generally don't apply to self-funded plans.

Elimination Period: The waiting period between when your disability begins and when LTD benefits start (commonly 90 or 180 days). It's often covered by short-term disability or sick leave.

ERISA: The Employee Retirement Income Security Act of 1974, the federal law governing most private employer-sponsored disability, retirement, and health plans.

ERISA Preemption: The rule that ERISA overrides most state laws for covered plans, including many state consumer-protection and bad faith remedies. It's a major reason ERISA claims are handled so differently from other insurance disputes. State laws regulating insurance can still apply to insured plans.

Exhaustion of Administrative Remedies: The requirement that you complete the plan's internal appeal process before you can sue.

Functional Capacity Evaluation (FCE): A structured physical or occupational therapy assessment measuring what tasks you can and can't physically do. It's often used as evidence in a claim or appeal.

Independent Medical Examination (IME): An exam by a doctor selected and paid by the insurer (not "independent" in the everyday sense) to evaluate your claimed impairment.

Limitations Period: The deadline to file a lawsuit. Many plans set their own, and it may start running before your appeal is decided. Check your plan for it.

Mental/Nervous Limitation: A common policy clause capping the benefit period (often at 24 months) for disabilities caused mainly by mental health conditions.

Offset: A reduction in your LTD benefit for other income you receive, most commonly SSDI (including dependent benefits), workers' compensation, or state disability benefits.

Overpayment: An amount the insurer says it paid you that it didn't owe, most often because of a retroactive SSDI award. Insurers usually demand repayment or reduce future benefits to recover it.

Own Occupation: The more favorable definition of disability, usually applying for an initial period. It requires only that you be unable to perform the material duties of your occupation, which many policies measure as that occupation is generally performed, not your specific job.

Peer Review: A file-only review by a doctor hired by the insurer who evaluates your records without examining you (unlike an IME, which involves an exam).

Plan Administrator: The entity named in the plan document as responsible for running the plan, usually the employer. The insurance company is often the "claims administrator" that actually decides claims.

Pre-Existing Condition Exclusion: A policy clause denying benefits for a disability caused by a condition you received treatment, consultation, care, or prescribed medication for during a look-back period before your coverage started (often 3 months). It usually applies only if the disability begins within a set period after coverage starts (often the first 12 months).

Reservation of Rights: Language an insurer uses when paying benefits (often temporarily) while preserving its right to deny or stop paying later after further review.

Right to Sue: The point at which you've finished the plan's appeal process (or the insurer failed to follow the claim rules) and can file a lawsuit.

Self-Funded vs. Fully Insured Plan: In a fully insured plan, an insurance company pays claims and bears the financial risk. In a self-funded plan, the employer pays claims directly, often hiring an insurer only to administer the process. This matters because state insurance laws, including bans on discretionary clauses, generally apply only to insured plans.

Self-Reported Symptom Limitation: A policy clause capping benefits (commonly at 24 months) for disabilities based mainly on reported symptoms rather than objective findings. It frequently affects claims involving fibromyalgia, chronic fatigue, and chronic pain.

Short-Term Disability (STD): Disability coverage for a shorter period (often a few months) before LTD begins, usually with a less strict definition of disability. Some STD programs are paid directly by the employer and aren't ERISA plans.

Social Security Disability Insurance (SSDI): The federal disability program run by the Social Security Administration. It's separate from LTD, but most LTD policies require you to apply and offset your benefits by what you receive.

Summary Plan Description (SPD): The plain-language summary of your benefits, definitions, and procedures that ERISA requires plans to provide. It's usually easier to read than the full plan, but it usually isn't the controlling document. Request the SPD, the insurance policy, and the plan document in writing from your plan administrator.

Surveillance: Observation (often video) by or for an insurer to gather evidence about your daily activities and physical abilities.

Vocational Expert: A specialist who assesses what jobs someone could do given their medical restrictions, education, and work history. Both insurers and claimants' attorneys use them, especially in "any occupation" disputes.