

demonstrate an absence of evidence to support the nonmoving party's case. *Celotex Corp. v. Catrett*, 477 U.S. 317, 325 (1986). In determining whether this burden is met, the court must view the record in the light most favorable to the nonmoving party and give that party the benefit of all reasonable inferences in its favor. *Cadle Co. v. Hayes*, 116 F.3d 957, 959 (1st Cir. 1997). Once the moving party has made a preliminary showing that no genuine issue of material fact exists, "the nonmovant must contradict the showing by pointing to specific facts demonstrating that there is, indeed, a trialworthy issue." *National Amusements, Inc. v. Town of Dedham*, 43 F.3d 731, 735 (1st Cir. 1995) (citing *Celotex*, 477 U.S. at 324); Fed. R. Civ. P. 56(e). "This is especially true in respect to claims or issues on which the nonmovant bears the burden of proof." *International Ass'n of Machinists & Aerospace Workers v. Winship Green Nursing Ctr.*, 103 F.3d 196, 200 (1st Cir. 1996) (citations omitted).

The mere fact that both parties seek summary judgment does not render summary judgment inappropriate. 10A C. Wright, A. Miller & M. Kane, *Federal Practice and Procedure* ("Wright, Miller & Kane") § 2720 at 327-28 (3d ed. 1998). For those issues subject to cross-motions for summary judgment, the court must draw all reasonable inferences against granting summary judgment to determine whether there are genuine issues of material fact to be tried. *Continental Grain Co. v. Puerto Rico Maritime Shipping Auth.*, 972 F.2d 426, 429 (1st Cir. 1992). If there are any genuine issues of material fact, both motions must be denied as to the affected issue or issues of law; if not, one party is entitled to judgment as a matter of law. 10A Wright, Miller & Kane § 2720.

II. Factual Background

The following undisputed material facts are appropriately supported in the parties' statements of material facts submitted pursuant to this court's Local Rule 56. The plaintiff was employed by Pratt & Whitney Aircraft Manufacturing and Commercial Engine ("Pratt & Whitney") as a salaried employee

and as such was covered by group long term disability insurance, Policy Number 0597374 (“the Plan”), issued on January 1, 1996 by the defendant. Defendant’s Local Rule 56(b) Statement of Undisputed Material Facts, etc. (“Defendant’s SMF”) (Docket No. 11) ¶¶ 1,6; Plaintiff’s Statement of Material Facts in Dispute in Response to Defendant’s Statement of Undisputed Material Facts (“Plaintiff’s Responsive SMF”) (Docket No. 15) ¶¶ 1, 6. The plaintiff’s last day of work at Pratt & Whitney, where his position was that of production foreman/cell leader/offshift administrator, was March 31, 1998. *Id.* ¶ 5; Plaintiff’s Statement of Material Facts Filed in Support of His Motion for Summary Judgment (“Plaintiff’s SMF”) (Docket No. 9) ¶ 10; Defendant’s Local Rule 56(c) Opposition to Plaintiff’s Statement of Material Facts (“Defendant’s Responsive SMF”) (Docket No. 13) ¶ 10. The plaintiff attempted to work without success on April 17, 1998 but was hospitalized on that date. Plaintiff’s SMF ¶ 6; Defendant’s Responsive SMF ¶ 6.

On August 31, 1998 the plaintiff applied for disability income benefits under his employer’s short-term disability plan due to “severe chronic obstructive pulmonary disease” (“COPD”). Defendant’s SMF ¶ 7; Plaintiff’s Responsive SMF ¶ 7. The defendant administers the short-term disability plan for which the employer is self-insured. *Id.* ¶ 8. “Disability” for purposes of the short-term disability plan is defined as an “inability to perform the essential duties of your regular job because of illness, injury or pregnancy.” *Id.* ¶ 9. In order to evaluate the plaintiff’s short-term disability claim, a physician employed by the defendant called the plaintiff’s treating physician, Dr. Paul M. Laprise. *Id.* ¶ 10. That physician’s notes of the October 6, 1998 conversation include the following statement: “Dr. Laprise feels [the plaintiff] would not be able to climb 2 flights of stairs but he may be able to walk 2 blocks slowly. He feels [the plaintiff] cannot do his current (medium/heavy) job but can do a sedentary job.” *Id.* Dr. Laprise completed a “residual functional questionnaire,” dated October 13, 1998, in which he stated that, in an eight hour work day, the plaintiff could at “full

capacity” sit continuously for eight hours, stand for six hours (three continuously), and walk for two hours (one continuously). *Id.* ¶ 11. On October 13, 1998 a registered nurse employed by the defendant who was assembling and reviewing medical information concerning the plaintiff wrote: “Based on the medical information and the job requirements, the L/R’s as indicated by the AP are supported.” Plaintiff’s SMF ¶ 25; Defendant’s Responsive SMF ¶ 25. The defendant approved the plaintiff’s claim for short-term disability benefits. Defendant’s SMF ¶ 12; Plaintiff’s Responsive SMF ¶ 12.

The plaintiff filed a claim for long-term disability benefits under the Plan on October 26, 1998.

Record at 0464. The Plan provides, in relevant part:

If an Employee, while insured, becomes Totally Disabled because of an accidental injury, an illness or a pregnancy, and the Employee is no longer eligible for salary payments under the Employer’s salary continuance plan, . . . [CIGNA] Dr. Will pay the Employee Monthly Benefit Payments. . . .

An Employee Dr. Will be considered Totally Disabled if the Employee is totally and continuously disabled so that the Employee is completely prevented from engaging in any gainful occupation or employment for which the Employee is, or becomes, reasonably qualified by training, education, or experience.

Defendant’s SMF ¶¶ 2-3; Plaintiff’s Responsive SMF ¶¶ 2-3. On the application, the plaintiff was asked to “describe in your own words what is wrong with you.” Record at 0503. In response, the plaintiff wrote:

severe C.O.P.D., short of breath, wheezy, tire easy [sic], usually have a dry cough, very susceptible to colds, flues [sic] and viruses, run out of breath when speaking, chest feels like a heavy weight on it.

*Id.*¹ On October 28, 1998 a case manager employed by the defendant filed a “current case plan” in which she stated, *inter alia*, “Based on the claimant’s age, the nature of his job and his Dx and L/R,

¹ The plaintiff states that paragraph 13 of the defendant’s SMF “is disputed,” Plaintiff’s Responsive SMF ¶ 13, but the information set forth in that paragraph by the plaintiff does not address the defendant’s correct report of the contents of the application form.

believe the claimant meets the definition of total disability and LTD should be approved with medical f/u in three months.” Plaintiff’s SMF ¶ 27; Defendant’s Responsive SMF ¶ 27. The plaintiff also completed a “disability questionnaire,” which was received by the defendant on November 24, 1998, in which the plaintiff describes the “cause of his disability” as “severe C.O.P.D.” Defendant’s SMF ¶ 14; Plaintiff’s Responsive SMF ¶ 14. A document in the defendant’s file concerning the plaintiff, immediately following a “current case plan” on which the last date is December 11, 1998, has an entry under the heading “Medical Information” on a line identified as ICD-9/DSM IV reading “496.” Record at 0412-13. At the defendant’s request, Dr. Laprise completed a “physical ability assessment,” dated December 16, 1998, in which he stated that, in an eight hour work day, the plaintiff could sit for eight hours, stand for one hour and walk for one hour. Defendant’s SMF ¶¶ 15-16; Plaintiff’s Responsive SMF ¶¶ 15-16. Dr. Laprise also addressed other functional physical limitations on this form. *Id.* ¶ 16.

On December 22, 1998 the defendant referred the plaintiff’s file to Regain Disability Services, a company hired by the defendant to analyze the plaintiff’s vocational potential considering functional abilities and limitations, education, training and experience. *Id.* ¶ 17. Regain identified four jobs that the plaintiff could perform within his skills, education, physical capacities and wage requirements, as well as three jobs that were not within his wage requirement. *Id.* ¶ 18. On January 12, 1999 Dr. Laprise sent the defendant an “attending physician’s statement of disability” stating that there was “no change since December 1998” in the plaintiff’s physical limitations. *Id.* ¶ 20. On January 15, 1999 the defendant informed the plaintiff that his claim for long-term disability benefits was denied, based on its conclusion that he had the capacity to perform sedentary work. *Id.* ¶ 22.

On February 17, 1999 the plaintiff appealed the defendant’s denial. *Id.* ¶ 23. In support of his appeal the plaintiff submitted documents from Dr. Laprise including a cover letter dated February 8,

1999, a disability questionnaire dated February 5, 1999 and a disability claim form dated January 12, 1999. *Id.* The cover letter stated, in pertinent part:

Mr. Tinkham returned to see me recently having some very real concerns about some of the information that I gave you on his previous residual functional questionnaire. What he did was bring up, appropriately, the fact that he has had significant lumbar disk [sic] disease in the past and is status post surgery at L4. Because of that problem, I have made some changes in his residual functional capacity questionnaire which I believe you should take into account in an effort to be entirely fair to this patient.

Id. ¶ 25. The accompanying questionnaire stated that the plaintiff could sit continuously for one to two hours due to lumbar disc disease and COPD. *Id.* ¶ 26. The defendant also reviewed medical records regarding an MRI of the plaintiff's lumbar spine that was performed on April 20, 1998. *Id.* ¶ 29. After review, the defendant reaffirmed its denial of the plaintiff's claim by a letter dated February 25, 1999. *Id.* ¶ 27.

On February 27, 1999 the plaintiff sent the defendant information from Jerrie A. Will, Ph.D., a psychologist. *Id.* ¶ 37. In a letter dated February 1999 Dr. Will stated that the plaintiff "experiences significant depression and anxiety which are reactive to his physical problems and to the recent loss of his job . . . exacerbated by the stress he has experienced in trying to obtain disability benefits and related financial concerns." *Id.* ¶ 39. Dr. Will began regular psychotherapy treatment with the plaintiff in October 1998. *Id.* ¶ 38. The defendant informed the plaintiff on March 4, 1999 that Dr. Will's information would not support a reversal of its previous decision to deny benefits, because Dr. Will did not begin treating the plaintiff "for his current depression/anxiety" until October; since the plaintiff's last day of work was March 31, Dr. Will's records did not support a finding that he was continuously totally disabled from his last day of work. *Id.* ¶ 41.

In April 1999 the plaintiff attempted to return to work. Plaintiff's SMF ¶ 50; Defendant's Responsive SMF ¶ 50. After a week, Dr. Laprise noted that the plaintiff was suffering from an

exacerbation of his COPD and noted that “[t]he patient agrees. . . that this time we should take him out of work permanently.” *Id.* On April 28, 1999 the plaintiff’s employer sent the defendant a note from Dr. Laprise dated April 21, 1999 and a copy of a decision awarding social security benefits to the plaintiff. Defendant’s SMF ¶ 42; Plaintiff’s Responsive SMF ¶ 42. By letter dated May 20, 1999 the defendant informed the plaintiff that this information did not support a finding of continuous total disability from the last day of work. *Id.* ¶ 44. On June 9, 1999 the plaintiff’s attorney sent the defendant additional copies of these two documents. *Id.* ¶ 45. By letter dated June 21, 1999 the defendant informed the plaintiff’s attorney that it had already reviewed this material and stated that its decision to deny benefits was not influenced by the decision of the Social Security Administration. *Id.*

On September 23, 1999 the plaintiff’s attorney sent additional medical information concerning the plaintiff’s COPD, back condition, and depression and anxiety to the defendant; specifically, this information included a letter from Dr. Laprise dated August 31, 1999, a letter from Dr. Jeffrey M. Fecko dated August 12, 1999 and records from Dr. Will. *Id.* ¶¶ 29, 46. Dr. Laprise’s letter stated, in pertinent part:

Mr. Tinkham is under my care for moderately severe COPD and DJD specifically do [sic] his lumbrosacral spine and cervical spine. He has been having increased problems with this recently and has been refer [sic] to see [sic] and evaluated by physical therapy.

Id. ¶ 47. Dr. Fecko’s letter addressed the plaintiff’s “current” neck and back care and stated that a “home cervical traction unit is medically necessary to help the patient manage his pain at home once discharged from physical therapy.” *Id.* ¶ 49. Dr. Will’s records showed that she treated the plaintiff three times from May 9, 1997 through May 26, 1997 for “issues re: job, and difficulties re: 3rd shift.” *Id.* ¶ 51. Treatment ceased due to the plaintiff’s “marked improvement.” *Id.* Dr. Will’s records stated that the plaintiff was “first seen” on October 1, 1998. *Id.* On that date she diagnosed adjustment disorder with mixed anxiety and depressed mood and recommended individual

psychotherapy once or twice per week as need for depression. Plaintiff's SMF ¶ 20; Defendant's Responsive SMF ¶ 20. By letter dated October 4, 1999 to the plaintiff's attorney, the defendant reported its conclusion that this evidence did not establish the existence of total disability as of the date last worked. Defendant's SMF ¶ 52; Plaintiff's Responsive SMF ¶ 52.

On October 5, 1999 the plaintiff's attorney sent the defendant a report from Frank Luongo, Ph.D. dated October 1, 1999 and requested that the defendant reconsider its position based on this report. *Id.* ¶ 53. Dr. Luongo evaluated the plaintiff on October 1, 1999; his report stated "At this time, he is incapable of engaging in sustained gainful activity." *Id.* ¶ 54. The defendant reaffirmed its previous decision on the plaintiff's application. *Id.*

At some time that cannot be determined from the summary judgment record, the defendant had in its possession a copy of a letter addressed "To Whom It May Concern" dated August 14, 1998 from Dr. Laprise in which he stated that the plaintiff's "underlying lung disease is severe enough that he has been unable to work over the last several months and I doubt very much that he will be able to ever return to a significant full time job." Plaintiff's SMF ¶ 13; Defendant's Responsive SMF ¶ 13; Record at 0511. The defendant also had records of the plaintiff's hospitalizations for severe COPD in October 1984, February 1988, July 1996, April 1997 and April 1998. *Id.* ¶ 14. On September 25, 1998 Dr. Laprise wrote a disability note for the plaintiff that stated "Disability 3/31/98 to forever." *Id.* ¶ 16. Dr. Laprise prescribed anti-depressants for the plaintiff beginning in June 1998. *Id.* ¶ 19.

The plaintiff filed this action on November 24, 1999. Docket.

III. Discussion

The plaintiff's claim is covered by ERISA. In this circuit, when the administrator or fiduciary of an ERISA benefits plan had discretion under the plan in determining whether to award benefits, "[n]ormally . . . its decision must be upheld unless arbitrary, capricious, or an abuse of discretion."

Doyle v. Paul Revere Life Ins. Co., 144 F.3d 181, 183 (1st Cir. 1998) (internal quotation marks and citations omitted). This deferential standard of review means that the court does not have plenary authority to decide any genuinely disputable factual issue concerning the merits of the claim. *Recupero v. New England Tel. & Tel. Co.*, 118 F.3d 820, 829 (1st Cir. 1997). I have already concluded that the deferential standard of review is appropriate in this case, Memorandum Decision on Discovery Dispute (Docket No. 7) at 3, and nothing in the summary judgment record suggests any reason to alter this conclusion.² The plaintiff does argue that the standard should be applied with “more bite” because the defendant is an insurer paying benefits out of its own assets, creating a conflict of interest. Plaintiff Lawrence Tinkham’s Motion for Summary Judgment, etc. (“Plaintiff’s Memorandum”) (Docket No. 8) at 4. The plaintiff relies on *Doe v.*

² The arbitrary and capricious standard “means that [the administrator’s] decision Dr. Will be upheld if it was within [the administrator’s] authority, reasoned, and supported by substantial evidence in the record.” *Doyle*, 144 F.3d at 184 (internal quotation marks and citation omitted). Substantial evidence is “evidence reasonably sufficient to support a conclusion.” *Id.*

Travelers Ins. Co., 167 F.3d 53 (1st Cir. 1999), to support this argument.

However, application of the “more bite” standard, which the First Circuit describes as “adhering to the arbitrary and capricious principle, with special emphasis on reasonableness,” is appropriate only if the claimant shows that the decision was improperly motivated. *Doyle*, 144 F.3d at 184. The fact that a defendant decides which claims it Dr. Will pay out of its own pocket is not enough to invoke the special emphasis on reasonableness. *Id.* The plaintiff argues that the defendant’s denial of his claim and the manner in which that denial was accomplished demonstrate improper motive, specifically that the defendant was “bent on claim denial rather than relying on competent medical and vocational evidence.” Plaintiff Lawrence Tinkham’s Opposition Memorandum to Defendant’s Motion for Summary Judgment (“Plaintiff’s Opposition”) (Docket No. 14) at 8. Assuming *arguendo* that the same evidence offered by a claimant to show that a plan administrator’s decision was arbitrary and capricious may also be used to establish improper motive, the plaintiff has not carried his burden in this case. Any disappointed benefits claimant could argue that an administrator preferred denial of his claim to paying out benefits; something more must be shown to establish improper motive. In any event, because I conclude, as set forth below, that the defendant’s decision to deny benefits was not arbitrary and capricious, the plaintiff’s argument for a more rigorous standard of review falls of its own weight.

The plaintiff agrees that his last date of work for purposes of this claim was March 31, 1998. Defendant’s SMF ¶ 5; Plaintiff’s Responsive SMF ¶ 5. Yet he ignores, both in the memorandum of law submitted in support of his motion for summary judgment and in his memorandum of law submitted in opposition to the defendant’s motion for summary judgment, the requirement of the plan that he be totally disabled as of that date. Record at 0008 (active service defined), 0014 (insurance on an

employee cancelled “on the day the Employee’s Active Service terminates”), 0016 (benefits payable “[i]f an Employee, while insured, becomes Totally Disabled”). Much of the evidence upon which the plaintiff relies does not specify that the observed medical or psychiatric condition was affecting him on March 31, 1998, and, with only one exception, none of it presents the conclusion of a medical professional that the condition at issue was totally disabling as of that date. Accordingly, the defendant’s conclusion that this evidence did not establish total disability as of March 31, 1998 and continuing thereafter cannot be deemed to have been arbitrary and capricious.

The evidence at issue includes the letters and notes of Dr. Will and the report of Dr. Luongo, which the plaintiff apparently claims establish total disability due to mental illness. Plaintiff’s Memorandum at 7-8, 9. Dr. Luongo saw the plaintiff for the first and only time on October 1, 1999, Record at 0055, some seventeen months after the plaintiff’s last day at work. Dr. Luongo’s report states that the plaintiff’s “depression has been variable from mild to severe over the past two years,” *id.* at 0059, but reaches a conclusion that the diagnosed adjustment disorder renders him “incapable of engaging in sustained gainful activity” only “[a]t this time,” *id.* at 0060. The defendant’s conclusion that this report did not support a finding of total disability due to any psychiatric diagnosis as of March 31, 1998, *id.* at 0052, is neither arbitrary nor capricious. Dr. Will’s notes and letters suffer from a similar deficiency. While the plaintiff contends that he “had been treating for depression since 1997” with Dr. Will, Plaintiff’s Memorandum at 7, Dr. Will’s records make clear that he saw her three times in May and June 1997, ending with a report of “marked improvement,” Record at [0076], and that she considered him to have “recovered” at that time, *id.* at [0070]. Dr. Will next saw the plaintiff on October 1, 1998, *id.* at [0076], seven months after his last day of work, and the plaintiff does not point to any entry in her records reflecting a conclusion that the condition for which she then began to treat him had existed on March 31, 1998. The defendant’s conclusion that these records did not establish

total disability as of March 31, 1998, *id.* at 0132, is neither arbitrary nor capricious. Finally, the fact that Dr. Laprise had prescribed antidepressant medication for the plaintiff beginning in July 1998, *id.* at [0076], also fails to show total disability due to mental illness as of March 31, 1998.³

The plaintiff relies heavily on the reports of his primary treating physician, Dr. Laprise. When the plaintiff submitted his application for long-term benefits, the defendant already had Dr. Laprise's residual functional questionnaire in which he stated that the plaintiff could sit continuously for eight hours, stand for three hours and walk for one hour. Record at 0152. The defendant also had the record of its physician employee's telephone conversation with Dr. Laprise on October 6, 1998 during which Dr. Laprise stated that the plaintiff "can do a sedentary job." *Id.* at 0706. After the defendant denied the claim on January 15, 1999 the plaintiff submitted a letter and revised forms from Dr. Laprise, in which the physician indicated for the first time that the plaintiff had "significant" lumbar disc disease, *id.* at 0147, and in a residual functional questionnaire stated that the plaintiff could sit continuously for one to two hours due to lumbar disc disease and COPD, *id.* at 0148. Dr. Laprise does not state in any of the documents submitted at this time that the changed limitations were applicable as of March 31, 1998. Indeed, he notes on the residual functional capacity questionnaire that "p[atien]t has not had acute back pain recently." *Id.* at 0150. Dr. Laprise's office notes do not mention any complaints of back pain by the plaintiff after October 18, 1996. Defendant's SMF ¶ 35; Plaintiff's Responsive SMF ¶ 35. The plaintiff apparently also submitted medical records relating to an MRI of his lumbar spine that was performed on April 20,

³ Significantly, in a report dated January 12, 1999 Dr. Laprise stated under the heading "Mental Impairment" "not applicable [at] this time." Record at 0146.

1998, *id.* ¶ 29, but he fails to explain how the results of this examination demonstrate disability. The defendant's evaluation of this evidence, Record at 0137-38, is neither arbitrary nor capricious.

Even if Dr. Laprise's revisions could fairly be said to relate back to March 31, 1998, his evaluations of the plaintiff's medical condition in terms of disability at the relevant time are contradictory. *Compare, e.g., id.* at 0146, 0511 *with id.* at 0152, 0706. This court may not substitute its judgment for that of the defendant. *Terry v. Bayer Corp.*, 145 F.3d 28, 40 (1st Cir. 1998). The defendant could reject Dr. Laprise's revised evaluation, provided there is substantial evidence in the record to support that conclusion. Here, such evidence was provided by Dr. Laprise himself. Even in his revisions, Dr. Laprise stated that the plaintiff's back pain was not acute, and he had recently informed the defendant that mental impairment was not at issue. The defendant's conclusion that these revisions did not establish total impairment as of March 31, 1998, Record at 0136-39, is supported by substantial evidence. *See also Doyle*, 144 F.3d at 186 (commenting on contradictions in treating physician's reports).

The plaintiff argues heatedly that the defendant failed to provide Regain with all of the medical evidence in its possession when referring the plaintiff's case for vocational analysis and that this failure is evidence of abuse of discretion and capriciousness. Plaintiff's Memorandum at 10; Plaintiff's Opposition at 2. The referral to Regain was made on December 22, 1998 and Regain's report is dated December 30, 1998. Record at 0192. It simply was not possible for the defendant to include in the December 1998 referral materials first provided to it by the defendant after its January 15, 1999 denial of the claim. To the extent that the plaintiff means to argue that the defendant was required to pass these additional materials along to Regain and ask for a second evaluation, my conclusion that none of these materials required the defendant to find the plaintiff totally disabled as

of the relevant date means that the failure to do so could not be deemed arbitrary or capricious.⁴

The plaintiff also finds evidence of abuse of discretion, Plaintiff's Memorandum at 8-9; Plaintiff's Opposition at 8, in the notes of the registered nurse employed by the defendant, made three days before the plaintiff filed his application for long-term disability benefits, Record at 0464, to the effect that "[b]ased on the medical information and the job requirements the L[imitations and]/R[estriction]s as indicated by the A[ttending] P[hysician] are supported," *id.* at 0527, and a note made by a case manager on October 28, 1998, two days after the plaintiff notified the defendant that he sought long-term disability benefits and five days before the defendant received the plaintiff's application form, *id.* at 0503, that "[b]ased on the [claimant's] age, the nature of his job and his D[iagnosis] and L[imitations and]/R[estriction]s, believe the [claimant] meets the definition of total disability and LTD should be approved with medical f/u in three months," *id.* at 0519. The nurse's note could only refer to the plaintiff's application for short-term benefits, the only claim pending at the time. It provides no evidence of abuse of discretion. Even assuming that the defendant could and would decide a claim for long-term disability benefits two days after first being notified of the claim and before any of the written materials it requested from the claimant in connection with the claim, *id.* at 0464, had been received, the plaintiff has offered no evidence that the claims manager who authored the note was authorized to decide whether to award long-term disability benefits, a necessary element of his contention that the defendant abused its discretion. In the absence of such a showing, it is reasonable to conclude that the defendant's claim review process allowed for the

⁴ The plaintiff also spends considerable time and effort arguing that the defendant's response to a claim he filed against it with the state Bureau of Insurance is evidence of abuse of discretion. Plaintiff's Memorandum at 12-13; Plaintiff's Opposition at 9. Events that may have occurred in connection with that post-decision complaint are irrelevant to this court's consideration of the defendant's denial of the plaintiff's application for benefits, which is the only matter before the court.

expression of varying viewpoints about claims before the final decision on each was made. To hold as a matter of law that a single recorded opinion by an employee of an ERISA plan administrator that an applicant is entitled to the benefits he seeks binds that administrator to award benefits would unnecessarily stifle the careful and thorough review of such claims, without any concomitant public benefit.

The plaintiff also contends that the fact that the Social Security Administration awarded him disability benefits requires a finding that the defendant's denial was arbitrary and capricious. Plaintiff's Memorandum at 13-14. The First Circuit rejected this argument in *Doyle*. 144 F.3d at 186 n.4. Finally, the plaintiff argues without citation to authority that the defendant abused its discretion because it did not arrange for the materials submitted by the plaintiff in connection with his application for long-term disability benefits to be reviewed by a medical professional or arrange for an independent medical evaluation of the plaintiff. Plaintiff's Memorandum at 15; Plaintiff's Opposition at 2-3, 6-7, 9. My own research has located no reported case in which a court has imposed such a requirement on an ERISA plan administrator as a legal requirement in order to avoid a finding of arbitrary and capricious denial of a claim for benefits. The plaintiff suggests that, because such efforts were undertaken by the plan administrator in *Doyle*, anything short of that would constitute less than substantial evidence. Plaintiff's Opposition at 6. To the contrary, the First Circuit in *Doyle* made no suggestion at all about the nature of the review that might be required of plan administrators in all cases, but rather limited its discussion to a review of the events in the case before it. In any event, the plaintiff here fails to identify any aspect of his claim that could only have been adequately evaluated by a medical professional. This failure alone makes it impossible to find that the defendant's denial was arbitrary or capricious on this basis. In addition, as previously indicated, the facts that much of the material the plaintiff submitted did not establish total disability as of March 31, 1998 and that none

of the physicians and psychologists other than Dr. Laprise opined as to total disability as of that date are readily apparent upon objective, nonmedical review.

Finally, the plaintiff argues that “redactions” on a CIGNA form entitled “5th Day Phone Call,” Record at 0522-23, are evidence of improper motive. Plaintiff’s Memorandum at 9. In his statement of material facts, the plaintiff contends that these “redactions” “compel[] explanation by CIGNA” and speculates that the “redacted” lines “are intended to inform successful LTD applicants of the steps that will ensue following their approval.” Plaintiff’s SMF ¶ 26. In fact, the document itself belies the plaintiff’s interpretation. The first entry on the form instructs the employee to explain that the LTD disability claim investigation is “now . . . beginning.” Record at 0522. Three entries on the form have been covered with heavy black lines, and the defendant has explained that this was done because the questions listed in those entries, having to do with application for social security benefits, were not asked in this case. Defendant’s Objection at 3. This document provides no support for the plaintiff’s argument.

This analysis has focused on the plaintiff’s arguments rather than those of the defendant, which has also moved for summary judgment. The burden of proof is on the plaintiff, and his failure to submit evidence from which a reasonable factfinder could determine that the defendant’s denial of his claim for long-term disability benefits was arbitrary, capricious, or an abuse of discretion means that the defendant is entitled to summary judgment.

IV. Conclusion

For the foregoing reasons, I recommend that the defendant’s motion for summary judgment be **GRANTED** and that the plaintiff’s motion for summary judgment be **DENIED**.

NOTICE

A party may file objections to those specified portions of a magistrate judge's report or proposed findings or recommended decisions entered pursuant to 28 U.S.C. § 636(b)(1)(B) for which de novo review by the district court is sought, together with a supporting memorandum, within ten (10) days after being served with a copy thereof. A responsive memorandum shall be filed within ten (10) days after the filing of the objection.

Failure to file a timely objection shall constitute a waiver of the right to de novo review by the district court and to appeal the district court's order.

Date this 12th day of July, 2000.

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David M. Cohen
United States Magistrate Judge

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