



Steps to
Getting

Key
Person
Claims Paid



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Key person coverage is a kind of life insurance on critical

employees where the proceeds are paid to the corporation.

Its purpose is to indemnify the employer against a potential loss of income that may result from the untimely death of a key employee. The tax-free proceeds from this type of policy (also known as corporate-owned life insurance) can be used to compensate for lost business, hire a replacement or any number of other business-related transactions. In addition, many investors will look for the added protection key person life insurance provides.

It should be noted that there are statutes and regulations, particularly in New York, that limit such insurance to people who are truly irreplaceable to a business operation (and to prevent insuring or trading on the lives of lower-level employees). Common requirements are that the key person be one of the five highest paid officers, a 5% owner or an employee who is among the highest paid 35% of all employees (see New York Insurance Department, Regulation No. 180, NYCRR 48).

Key person insurance is expected to give peace of mind to a corporation that can ill afford to

lose top executives. When such a tragedy does occur, it can often be compounded by the callous actions of insurance companies that refuse to pay claims or severely delay payment even though their policies state that the claim is supposedly "incontestable." Fortunately, courts generally understand that the burden in these situations is rightfully placed upon the insurance companies, and that policyholders should receive payment once they have met the basic requirements of the key person policy.

When it comes to terminology, key person life insurance policies contain the normal provisions found in most life policies. One of the most im-

portant provisions is the "incontestable clause." This states that an insurance company may not raise any defenses against payment—making the claim "incontestable"—if the employee's death occurs after a specified amount of time has passed since the purchase of the policy (usually two years).

If the insured employee's death occurs within the policy's contestability period, the insurance company will have access to any and all of its potential defenses against payment of the claim, which usually revolve around claims of fraud in the insurance application or failure to reveal a pre-existing medical condition that caused the death. For example, insurance companies often will try to prove that an applicant who listed himself as a nonsmoker occasionally smoked cigars or used chewing tobacco. Even this seemingly minor detail can be used by the insurance company to delay or deny payment of key person claims.

When the insured employee's death occurs after the two-year contestability period has ended, the incontestable clause is supposed to prevent such defenses. In practice, however, it may not afford corporate policyholders the level of protection that its name would seem to indicate.

The insurance company still might have several defenses available despite the presence of the incontestable clause. The main defenses that insurance companies have interposed, which they argue should be applicable even after the conclusion of the contestability period, include misrepresentation (in the application form) and failure to reveal a pre-existing condition. Because insurance companies have been able to work around the incontestable clause in their efforts to delay or deny payment, corporations with key person policies must be prepared to face a lengthy battle against their insurance companies before receiving payment on their key person claims.

The Right to Investigate vs. the Duty to Pay

The right to investigate allows the insurance company a "reasonable" amount of time to examine the cause and manner of death and to look into the insured employee's full medical history. Courts have permitted investigations that last for up to two years while insurance companies gathered information.

One problem that may arise with the insurance companies' investigation is that, under the 1996 Health Insurance Portability and Accountability Act (HIPAA), medical information on the deceased employee cannot be obtained without authorization from the next of kin or the executor of the estate. Under the HIPAA requirements, there are only two methods of obtaining medical records or information on a deceased individual. The first method

is to obtain authorization from the next of kin or executor of the estate. Absent such authorization, the only remaining method of obtaining access to medical records under HIPAA is through a judicial or administrative proceeding. Such proceedings are not guaranteed to lead to production of the requested medical information, however, and even where production of the records is court-ordered, certain medical providers may not be bound by courts that have no jurisdiction over them.

Often, the next of kin or executor has no incentive to authorize either the insurance companies or the deceased's former employer to review these records in accordance with the HIPAA require-



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ments. In this scenario, the insurance companies may attempt to use the impasse created by their inability to obtain records they claim are necessary to determine the validity of the key person claim in order to indefinitely delay determination of the claim, or even deny payment all together. Practice tip: Although the HIPAA regulations were promulgated in 2001 and are still relatively new and untested, gaining prior signed approval from the next of kin of an insured key employee (at the time the policy is purchased), which states their agreement to authorize the release of any necessary medical information, may prevent delays in getting the required medical records to the insurance companies in a timely manner.

Some courts have taken the view that a claim is not "properly investigated" until the insurance company meets its responsibility of marshal-

ing all of the medical facts, and that a proper investigation should ensue prior to reaching an ultimate determination of the claim. On the other hand, several courts have held that insurance companies must pay life insurance claims when liability becomes reasonably clear, and that it is the insurance company's burden to obtain information it feels is necessary to investigate a claim, rather than the policyholder's. [See, e.g., *Manhattan Life Ins. Co. v. Harkrider*, 396 S.W.2d 207, 215 (Tex. Civ. App. 1965).]

At least one court has ruled more favorably for the policyholder and held that once a policyholder submits a claimant's statement (or proof of loss) and a death certificate, the insurance company cannot unduly delay payment in the event that it is unable to obtain certain medical records. [*Minnesota Life Insurance Company v. Vasquez*, 2004 WL 690835 at *7 (Tex. App. Corpus Christi Apr. 1, 2004).]

In *Vasquez*, the court found that an insurance company that was investigating the cause of an individual's death had been "stymied by the hospital records department during its investigation, and it had no control over this delay." However, the court held that the hospital's unresponsiveness to the request for records for an extensive period of time did not excuse the insurance company from its responsibility to pay the claim promptly because once the proof-of-loss documents noting an accidental cause of death were received, the insurance company's liability was sufficiently clear, and it was under a duty to pay the claim.

The insurance company in *Vasquez* argued that its liability could not be sufficiently clear until it received and reviewed certain hospital records. The court held that this argument "is clearly unacceptable" because it would allow insurance companies to permanently

delay payment of valid claims as they could never be completely certain of their liability.

Numerous other jurisdictions have held likewise. See *Fortune Ins. Co. v. Pacheco*, 695 So.2d 394, 396 (Fla. Dist. Ct. App. 1997); *Van Houten v. New Jersey Manufacturers Ins. Co.*, 387 A.2d 419, 424 (N.J. Super. 1978); *Stewart v. Gulf Guaranty Life Ins. Co.*, 846 So.2d 192, 204 (Miss. 2003) (holding that claims handling was improper when the insurance company “attempted to place the burden of submitting [medical] information regarding the claim on [the policyholder]”).

Although insurance companies undoubtedly will continue to attempt to delay payment of key person life insurance claims, the growing collection of case law supports the policyholder’s right to payment once the insurance company has been provided a reasonable period to investigate (which depends upon the factual circumstances) and liability for the claim is “reasonably clear.”

One new factor arguing against insurance company delay is the existence of an organization, run by insurance companies, devoted to collecting and sharing this exact type of medical information that insurers seek in life insurance matters.

The Medical Information Bureau

The Medical Information Bureau (MIB), is a membership organization of life insurance companies that operates as an informational exchange bureau on behalf of its members. Whenever any policyholder applies for life, health or disability insurance, the insurance company makes a report to the MIB, and the policyholder is required to authorize this in order to have the insurance applica-

tion processed. If a policyholder later applies to any other member insurance company for life, health or disability insurance, or if a claim for benefits is submitted to such a company, the MIB, upon request, will supply that company with any information it may have in its file.

The MIB therefore acts as a central database of medical information shared by insurance companies. Approximately 15 million Americans and Canadians are on file in the MIB’s computers. About 600 insurance firms use the services of the MIB, primarily to obtain information about life insurance and individual health insurance policy applicants.

If a policyholder reveals medical conditions upon applying for insurance that insurance companies consider significant, the insurance company will report that information to the MIB.

The MIB provides a simple resource for insurance companies to obtain any and all medical information that a policyholder has ever disclosed when applying for insurance. As such, insurance companies should not be able to use unavailability of a policyholder’s medical records as an excuse for delaying payment of a key person insurance claim.

The Claims Process

The first step in dealing with the key person coverage claims process is the submission of the claim itself, which includes processing the reams of paperwork required by the insurance companies. It also involves obtaining certified copies of the death certificate of the principal and documents naming the executor of the estate. After submission of the claims, it is often critical to establish and maintain contact with

the insurance companies and their counsel on an almost daily basis to ensure that the claims are being handled promptly.

When complications arise, usually due to the failure to obtain full cooperation from the next of kin and, more commonly, the medical providers, there are multiple options available to avoid the extensive delay potentially presented by these hurdles.

One possibility is for a court action to be instituted allowing for the use of subpoenas to obtain records from the medical providers. If the medical providers continue to balk at handing over the records without the consent of the family, then negotiations must be conducted with the next of kin until a successful protective order can be agreed upon to safeguard the rights of all parties involved. This often can be accomplished without extensive litigation, despite the lack of cooperation from the next of kin and the medical providers.

The ideal result is for the corporation to recoup the full proceeds of its key person policies, plus interest and returned premiums, in the shortest time possible. Depending upon the language in the insurance policy, interest will be calculated either by terms set out in the policy itself or by reference to the statutory rate in the applicable jurisdiction. ■

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