02-426-CD
EUGENE SMITH -vs- CIGNA GROUP INSURANCE COMPANY

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

EUGENE SMITH,

Plaintiff,

vs.

CIGNA GROUP INSURANCE COMPANY,

Defendants.

: NO. 2002 GN
: 02-426-CD
: CIVIL ACTION - LAW
:
: Type of Filing:
: COMPLAINT FOR DENIAL OF
: INSURANCE BENEFITS
: PURSUANT TO THE
: EMPLOYMEE RETIREMENT
: INCOME SECURITY ACT,
: 29 U.S.C.A. §1001, et. seq.
:
: Filed by:
:
: Alan R. Krier, Esquire
: P.A. I.D. #06672
: Attorney for Plaintiff,
: M&T BANK
: Park View Center
: Ten Sheraton Drive
: P.O. Box 2024
: Altoona, Pennsylvania 16603
: (814) 943-1149
:
:
: Attorney for Plaintiff:
: **EUGENE SMITH**
:

FILED

MAR 21 2002
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William A. Shaw pd
Prothonotary $80.00
K. Sheriff

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

EUGENE SMITH,	:	NO. 2002 GN
	:	
Plaintiff,	:	
	:	CIVIL ACTION - LAW
vs.	:	
	:	
CIGNA GROUP INSURANCE COMPANY,	:	
	:	
Defendant.	:	

NOTICE

You have been sued in court. If you wish to defend against the claims set forth in the following pages, you must take action within twenty (20) days after this complaint and notice are served, by entering a written appearance personally or by attorney and filing in writing with the court your defenses or objections to the claims set forth against you. You are warned that if you fail to do so the case may proceed without you and a judgment may be entered against you by the court without further notice for any money claimed in the complaint or for any other claim or relief requested by the plaintiff. You may lose money or property or other rights important to you.

YOU SHOULD TAKE THIS PAPER TO YOUR LAWYER AT ONCE. IF YOU DO NOT HAVE A LAWYER OR CANNOT AFFORD ONE, GO TO OR TELEPHONE THE OFFICE SET FORTH BELOW TO FIND OUT WHERE YOU CAN GET LEGAL HELP.

SOUTHERN ALLEGHENIES LEGAL AID, INC.
1107 12th Street, Suite 508
Altoona, Pennsylvania 16601
(814) 943-8139

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

EUGENE SMITH,	:	NO. 2002 GN
	:	
Plaintiff,	:	
	:	CIVIL ACTION - LAW
vs.	:	
	:	
CIGNA GROUP INSURANCE COMPANY,	:	
	:	
Defendant.	:	

COMPLAINT FOR DENIAL OF INSURANCE BENEFITS PUSUANT TO THE EMPLOYMEE RETIREMENT INCOME SECURITY ACT, 29 U.S.C.A. §1001, et. seq.

AND NOW, comes Plaintiff, **EUGENE SMITH**, by and through his attorneys, **JUBELIRER, CAROTHERS, KRIER & HALPERN**, and files the following Complaint, and in support thereof aver as follows:

1.

Plaintiff, **EUGENE SMITH** is an individual residing at R.D. #1, Box 297, Frenchville, Clearfield County, Pennsylvania.

2.

Defendant, **CIGNA GROUP INSURANCE COMPANY (Cigna)**, is a mutual insurance company authorized to do business, and doing business in the Commonwealth of Pennsylvania and throughout the United States with a place of business as 1600 W. Carson Street, Suite 300, Pittsburgh, Pennsylvania 15219.

3.

This complaint is brought under the Employee Retirement Income Security Act of 1974 (hereinafter cited as ERISA), 29 U.S.C. §1001, et seq. Specifically, pursuant to section 1132(a)(1)(B) of ERISA, 29 U.S.C. §1132(a)(1)(B), Plaintiff has been deprived of his rights and benefits secured to the Plaintiff by Cigna under a Long-Term Disability Insurance Plan (hereinafter referred to as the

"Plan"). The Plan is maintained by Plaintiff's former employer, the Baltimore Life Insurance Company (hereinafter referred to as "Baltimore Life").

4.

This Court has jurisdiction of this action under Section 1132(e)(1) of ERISA, 29 U.S.C. §1132 (e)(1).

5.

Plaintiff's employment with Baltimore Life commenced in March of 1984. During his period of employment, Plaintiff executed an application for group disability insurance issued by Cigna for the employees of Baltimore Life.

6.

At the time Plaintiff executed the application, he was an employee of Baltimore Life as a sales agent and was eligible for the aforementioned group disability insurance policy. The Plaintiff remained an employee of Baltimore Life through October 2, 1993 when the Plaintiff became disabled.

7.

Defendant accepted Plaintiff for coverage under the group disability policy. A true and correct copy of policy issued by Defendant to Baltimore Life is attached hereto and made a part hereof, marked as "Exhibit "A". Plaintiff was and is now a participant in the Plan.

8.

The policy provides for payments of sixty percent (60%) of the employee's base salary, up to a maximum benefit of $4,000 per month, during periods of total disability.

9.

On or about October 2, 1993, Plaintiff's poor physical condition, caused by chronic fatigue syndrome, became so debilitating that he was unable to work.

10.

Plaintiff has been totally disabled from working due to chronic fatigue syndrome from the time he went off work and he continues to be totally disabled at the present time.

11.

At the time Plaintiff left the employment of Baltimore Life, he filed a disability claim with Defendant, supplying all the requested information and authorizations in accordance with the applicable policy provisions.

12.

Thereafter, Defendant notified Plaintiff that his claim had been accepted and payment would be made in accordance with the policy commencing on January 30, 1994.

13.

Thereafter, Plaintiff received payments through June 30, 2001 when payments were stopped when Defendant notified him that he no longer met the definition of disability as established in the policy.

14.

Initially, Defendant based its denial on a flawed physical capacity evaluation submitted by Defendant to Plaintiff's family physician which did not account for issues of stamina sustained effort over time and endurance which is the essence of chronic fatigue syndrome. Plaintiff's family physician issued a clarifying report to Defendant, expressing her opinion as his treating physician that Plaintiff was disabled from any gainful employment establishing a prima facie basis for continued disability payments. In addition, Defendant was aware that Plaintiff had qualified for Social Security disability on virtually the same standard as set forth in the policy.

15.

Since Defendants alleged basis for denial of benefits was clearly not viable, instead of paying the claim, Defendant sought to develop new medical evidence to support its denial and demanded that Plaintiff submit to a functional capacity evaluation.

16.

On November 7 and 8, 2001, at the request of Defendant, the Plaintiff underwent a Functional Capacity Evaluation at Nittany Valley Rehabilitation Hospital, 550 West College Avenue, Pleasant

Gap, Pennsylvania. The evaluation states that the Plaintiff's endurance/aerobic capacity was undeterminable making it impossible for the Defendant to determine from that test that Plaintiff's disability, chronic fatigue syndrome, no longer met the definition of disability as stated in the policy. In addition, Defendant produced no medical interpretation of the test.

17.

Plaintiff has received no payments from the Defendant for the period from June 30, 2001 to the present time.

18.

In accord with the procedures of the Plan, Plaintiff internally appealed the decision of the Defendants on or about July 16, 2001. The Defendants informed plaintiff that his appeal was denied on December 14, 2001. The denial exhausted Plaintiff's internal remedies.

19.

Plaintiff is entitled to certain long-term disability income insurance benefits under the policy in full force and effect and fully applicable because his condition meets the definition of a disability after monthly benefits have been payable for 24 months, as established under the policy.

20.

By virtue of the results of the evaluation conducted on November 7 and 8, 2001, the decision of the Defendants to deny payment to Plaintiff is arbitrary and capricious, a product of bad faith and not supported by substantial evidence.

WHEREFORE, Plaintiff prays that this Honorable Court:

a. Decree and declare that Plaintiff has vested contractual rights to the full extent of the long-term disability benefits provided under the Plan, and that Defendants have a binding obligation to pay to Plaintiff benefits to the full extent provided by the Plan; and that

b. Order Defendants to pay Plaintiff the unpaid contributions in the amount of $771.00 per month for the period from June 30, 2001 to the present with interest, together

with costs of this action and reasonable attorney fees, pursuant to ERISA, 29 U.S.C. §1132(g); and that

c. Provide such other relief, as the Court may deem necessary to secure Plaintiff's rights.

Respectfully submitted,

JUBELIRER, CAROTHERS, KRIER & HALPERN

BY: _____

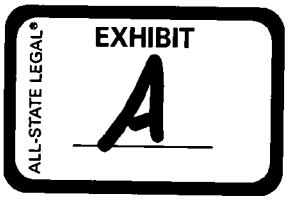
Alan R. Krier, Esquire
P.A. I.D. #06672
Park View Center
Ten Sheraton Drive
Altoona, Pennsylvania 16601
(814) 943-1149

Long-Term Disability Insurance Plan

Designed Especially

for Employees of

THE BALTIMORE LIFE INSURANCE COMPANY



FOREWORD

This brochure describes the Long-Term Disability Income Insurance available to eligible employees of The Baltimore Life Insurance Company.

The Plan helps assure a continuing income when, due to illness or injuries, an employee is no longer able to work. It covers disability sustained on or off the job and lasting longer than 120 days.

ELIGIBILITY

Class I: All active home office, field clerical and field management employees, over age 18, working a minimum of 21 hours per week are eligible.

Class II: All active commissioned employees, over age 18, regularly working a minimum of 21 hours per week are eligible upon completion of two continuous calendar years of service with the company.

THE BENEFIT

If you become disabled, this Plan will pay you an income equivalent to 60% of your base salary, subject to a maximum benefit of $4,000 per month, less any amounts for which you may also be eligible under:

a) the Canada-Quebec Pension Plans
b) any local, provincial or federal government disability or retirement plan or law
c) any state disability or retirement benefits which you receive (or are assumed to receive on your own behalf;
d) any salary or wage continuation plan of the Employer
e) the Jones Act; or any Workers' Compensation, occupational Disease or similar law, including all permanent as well as temporary disability benefits
f) any disability or old age benefits payable under the Federal Social Security Act which you receive (or are assumed to receive) on your own behalf;
g) any disability or old age benefits payable under the Federal Social Security Act which you receive (or are assumed to receive) on behalf of your dependents; or which your dependents receive on account of your receipt (or assumed receipt) of such benefits; and
h) any retirement benefits which you receive under (a) a retirement plan sponsored by the employer; (b) the Canada and Quebec Pension Plans; (c) the Railroad Retirement Act or the Railroad Unemployment Insurance Act, to the extent these benefits are funded by the Employer.

In no event will such reductions result in the benefit from this Plan being less than $50 per month.

The benefit is computed on basic earnings at commencement of disability. Overtime and bonuses are excluded.

Commission earnings will be averaged over the 60 months immediately prior to disability or over the period of such earnings if that period is less than 60 months.

BENEFIT PERIOD

A benefit period commences on the 121st consecutive day of disability and can continue, depending on your age at commencement of disability, as outlined below:

Age at Commencement of Disability	*Duration of Benefit Period*
Age 62 or under	the later of (a) the employee's 65th birthday; or (b) the date the 42nd monthly benefit is payable
63 years	the date the 36th monthly benefit is payable
64 years	the date the 30th monthly benefit is payable
65 years	the date the 24th monthly benefit is payable
66 years	the date the 21st monthly benefit is payable
67 years	the date the 18th monthly benefit is payable
68 years	the date the 15th monthly benefit is payable
Age 69 or over	the date the 12th monthly benefit is payable

DEFINITION OF DISABILITY

You will be considered disabled if, because of injury or sickness: (1) you are unable to perform all the material duties of your regular occupation; and (2) after monthly benefits have been payable for 24 months, you are unable to perform all the material duties of any occupation for which you are or may reasonably become qualified based on your education, training or experience.

RESIDUAL DISABILITY BENEFIT

Designed to provide incentive or motivation to encourage an employee's return to work from a potential long-term disability.

1) Any employee can return to part-time work during the waiting period and still collect benefits at the end of such waiting period as long as they meet the definition of disability.
2) During the first 12 months of return to work our benefit will not be reduced by return to work earnings until the sum of the monthly benefit, earnings, and "other benefits" (offsets) exceeds 100% of the indexed basic monthly earnings.

This provides a financial incentive for someone to return to work. We will also index basic earnings to continue to provide a "real" financial advantage to employees who are out on disability for twelve months or longer.

3) After 12 months the residual benefit will be equal to the monthly benefit minus 50% of the employee's monthly earnings received while residually disabled. If the sum of the employee's monthly benefit, earnings and other benefits exceeds 80% of the indexed basic monthly earnings, the benefit will be reduced by the excess.

   While the initial benefit was designed to provide financial incentive for an employee to return to work, we must realize that the desired end result is to bring the claimant back to productive, full-time employment. To do this there must be an incentive for the employee to make this move. Therefore, after the first year and beyond, we will begin to offset with 50% of earnings, and bring the cap from 100% down to 80%.

FAMILY BENEFITS

If death occurs after you have been receiving the benefit from this Plan for at least six months, your eligible survivor (*i.e.*, your spouse or children) will receive your plan benefit payment for six months following your death, but not beyond your benefit period. This benefit is not applicable if there are no eligible survivors.

SUCCESSIVE PERIODS OF DISABILITY

During the waiting period, successive periods of disability due to the same or related causes shall be considered as one period of disability if separated by less than 20 days of active, full-time employment.

If, however, after the expiration of the waiting period, you have received the benefit under this plan, return to work and subsequently become disabled from the same or related causes, no new waiting period will be applied provided a period of less than 180 days separates the two periods of disability.

LIMITATIONS

Pre-Existing Conditions

We will not pay Monthly Benefits for any period of disability which results, directly or indirectly, from an injury or sickness for which you incurred expenses, received medical treatment, took prescribed drugs or medicines or consulted a physician during the three months prior to the most recent effective date of your insurance. This limitation will not apply to a period of disability which begins more than 12 months after the most recent effective date of your insurance.

The pre-existing conditions provision is waived for commissioned employees.

Continuity of Coverage and Pre-Existing Condition Limitation

The pre-existing condition limitation will be waived if you were insured on the day before the effective date of this policy under a group long-term disability policy sponsored by your employer and replaced by this policy, provided you are actively at work on the effective date of this policy, and have fulfilled the requirements of any pre-existing condition limitation of the replaced policy.

However, if you are actively at work on the effective date of this policy and have not fulfilled the requirements of any pre-existing condition limitation of the replaced policy because the time period required before the start of total disability has not been satisfied, any portion of time which may have been satisfied under the pre-existing condition limitation of the replaced policy will be applied toward the satisfaction of the time period requirement of the pre-existing condition limitation of this policy.

If Monthly Benefits are determined to be payable, they will be paid according to the provisions of this policy.

Mental Illness, Alcoholism and Drug Abuse Limitation

The monthly benefit will be payable for disabilities resulting from these conditions for no more than 24 months during your lifetime, except while you are continuously confined for at least 14 days in a hospital licensed to provide care and treatment for your condition. Monthly income payments will be made while you are so confined. Coverage commences on the first day following the 120-day waiting period.

EXCLUSIONS

The income is not payable for disability resulting from any act or hazard of a declared or undeclared war or intentionally self-inflicted injury.

TERMINATION OF INSURANCE

You will be insured so long as the Group Plan is continued, in force, and you remain an eligible employee making the required contribution.

Should the Plan be discontinued for any reason, payments on an established claim would continue as though the Plan had remained in force.

CONVERSION PRIVILEGE

If you should leave the Company for a reason other than disability or retirement, or take an uninsured leave of absence, you have the privilege of converting your coverage to an individual LTD policy, providing you are under age 70 and have been covered by our Group LTD insurance for at least a year. The new, individual coverage will provide a specific monthly disability benefit for total disability lasting longer than 180 days. Benefit provisions, limitations and exclusions are described in the disability conversion insurance brochure and application.

To exercise your conversion privilege, simply make application and pay the first quarterly premium within 31 days of termination from the Company's Group LTD plan.

COST OF LONG-TERM DISABILITY INSURANCE FOR YOU

Schedule Amount

Non-Contributory Insurance — 60% of monthly pay subject to a maximum Schedule Amount of $750 per month.

Contributory Insurance (for covered persons whose annual pay is more than $15,000) — 60% of monthly pay subject to a maximum Schedule Amount of $3,250, provided that the combined Non-Contributory and Contributory amounts will not be greater than $4,000.

ENROLLMENT PROVISIONS

You will be insured without medical certification if you enroll within 31 days after you become eligible. Delayed enrollment requires evidence of your insurability, provided at your expense, and is subject to acceptance by the Insurance Company.

If you are absent because of accident or sickness, on the date your insurance would normally become effective, the effective date is postponed until you have returned to the full performance of your duties.

CERTIFICATE OF INSURANCE

This booklet describes the Plan in general terms and is not to be considered the Contract of Insurance.

THE BALTIMORE LIFE INSURANCE COMPANY SUPPLEMENTAL SELF-INSURED LONG-TERM DISABILITY PLAN

(provided by The Baltimore Life Insurance Company and not CIGNA Benefits)

In order to maintain an equitable 60% of annual salary for all eligible disabled employees, effective March 1, 1983, Baltimore Life will implement the following Supplemental Self-Insured Long-Term Disability Plan:

1) Under this Plan, Baltimore Life will supplement the amount of benefit you receive if the total payments from CIGNA Corporation Long-Term Disability Insurance Plan and the other sources listed in the Policy do not equal 60% of your base annual salary. Baltimore Life will supplement your benefit up to that 60% level.

2) To be eligible to receive benefits from this Supplemental Long-Term Disability Plan, all conditions and information to certify disability under the plan must be met and approved by both the long-term disability carrier and Baltimore Life's Medical Director.

3) The Supplemental Long-Term Disability Plan will remain in effect as long as the employee is receiving benefits under the Long-Term Disability Plan.

SUPPLEMENTAL INFORMATION

for

THE BALTIMORE LIFE INSURANCE COMPANY
LONG-TERM DISABILITY PLAN

required by the Employee Retirement Income Security Act of 1974

The following information together with the information contained in this booklet to which this supplement is attached constitute the Summary Plan Description required by the Employee Retirement Income Security Act of 1974.

The Plan is established and maintained by The Baltimore Life Insurance Company.

The Employer Identification Number is 52-0236900.

The Plan Number is 503.

This Plan is administered directly by the Plan Administrator with benefits provided in accordance with the provisions of the group insurance contract, LK-7860, issued by Life Insurance Company of North America, 1601 Chestnut Street, Philadelphia, PA 19192.

The Plan Administrator is The Baltimore Life Insurance Company.

All plan administration is done at 10075 Red Run Boulevard, Owings Mills, MD 21117. The Plan Administrator has authority to control and manage the operation and administration of the plan.

The agent for service of legal process is Gary C. Harriger. Service of legal process may also be made upon the Plan Administrator or any plan trustee.

This plan of benefits financed by Employer and Employee.

Date of the end of the Plan Year: 9-1.

For a description of the eligibility requirements of the plan, the amount and type of benefits available, the circumstances under which benefits under the plan are not available or may terminate, please refer to this booklet.

Plan Termination: The right is reserved in the plan for the Plan Administrator to terminate, suspend, withdraw or amend the plan in whole or in part at any time, subject to the applicable provisions of the Group Insurance Policy. Your rights upon termination or amendment of the plan are set forth in your booklet

CLAIM PROCEDURES

Filing a Claim for Benefits

When you are reasonably sure that you are eligible to receive benefits under this plan, you may request a claim form from your employer. All claims submitted to the Insurer must be on forms provided by the Insurer (unless forms are not currently available), in which case you may simply supply the appropriate party with a written statement outlining proof and extent of loss.

Complete the claim form according to directions and return the claim form to your employer.

From the date your notice of claim is returned, the insurance company has 90 days in which to review the claim to determine whether or not benefits are payable in accordance with the terms and provisions of the Group Policy. Under special circumstances the insurance company may require an extension of this 90-day period in which case you will receive written notice from the insurance company, prior to the end of the initial 90 days, informing you of the need for an extension. This extension period allows the insurance company an additional 90 days to review your claim. During this period the insurance company may require a medical examination, at its own expense, or additional information in order to make a determination on your claim. If additional information is required you will receive a request, in writing, specifying the nature of the information needed and an explanation as to why it is needed. If a medical examination is necessary you will be given the time of appointment and the doctor's name and location. It is important to keep any appointments made since rescheduling exams will delay the claim process.

If you are not notified of the claim status within 90 days and you have not been notified that the extension period has been applied, you may request a review of your claim by following the procedure outlined under ***Claim Review Procedure.***

Once your claim has been approved, you will receive the appropriate benefit from the insurance company.

What If Your Benefits Are Denied?

If your claim for benefits is denied in whole or in part, you will receive written notice of such denial within the 90-day period stated above (or 180 days if the extension period is required).

Each written notice of denial shall set forth:

1) the specific reason(s) for the denial of the claim
2) a specific reference to the provision(s) of the Group Policy upon which the denial is based; and
3) notice of your right to have the denial reviewed by the Plan Administrator.

Claim Review Procedure

If you receive a written notice of denial, you or your duly authorized representative may request a review of the claim by giving written notice to the Insurance Company. This request for a review must be made to the Plan Administrator within 60 days of the receipt of denial by the Insurance company. If such request is not made within 60 days you will be deemed to have

waived your right to a review by the Insurance Company.

Once the Insurance Company receives a request for a review, a prompt review of the claim must take place. You or your authorized representative have the right to review documents that might have a bearing on the claim including the documents which establish and control the plan, and to submit issues and comments that you feel might affect the outcome of the review.

Upon completion of a full and complete review, the Insurance Company will notify you in writing of the results, citing plan provisions that control the decision. The Insurance Company has 60 days to notify you of its decision unless special circumstances require an extension of time. If an extension is required, the Insurance Company shall notify you of the need for an extension before the end of the initial 60-day period for completing the review procedure. This means that the Insurance Company will have an additional 60 days to notify you of the decision on your denied claim.

Statement of ERISA Rights

As a participant in the plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974. All plan participants are entitled to:

a. Examine, without charge, at the Plan Administrator's office, 10075 Red Run Boulevard, Owings Mills, MD 21117, all plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor such as annual reports and plan descriptions.

b. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator who may make a reasonable charge for the copies.

c. Receive a summary of the plan's annual financial report which the law requires the Plan Administrator of certain plans to provide to each plan participant.

   (Unless there are reasons beyond the control of the Plan Administrator, materials that you request should be received within 30 days. If they are not, you may file suit in a federal court. The court may require the Plan Administrator to pay up to $100 for each day's delay until the materials are received.)

d. Receive a written explanation of the reasons why your claim for benefits has been denied in whole or part and a review and reconsideration of your claim.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. These people are called *fiduciaries,* and they must act prudently and with the sole interests of you and other participants in mind.

No one, not even your employer, may fire you or discriminate against you in order to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If you are improperly denied a welfare benefit in whole or part, or if you believe plan fiduciaries are misusing plan funds, or if you are discriminated against for asserting your rights, you may request assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees, but if you lose you may be required to pay the costs and fees; for example, if the court finds that your claim is frivolous.

If you have any questions about your plan contact your Plan Administrator. If you have any questions about this statement, or your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor–Management Services Administration, Department of Labor.

While ERISA requirements are established by federal law and regulation, The Baltimore Life Insurance Company has always attempted to provide its employees with welfare plans that meet the same high standards imposed by the law. We are pleased that the law will enable better application of these standards.

VERIFICATION

I, EUGENE SMITH, the plaintiff herein, state that the facts set forth in the foregoing COMPLAINT are true and correct to the best of my knowledge, information and belief. I understand that statements herein are made subject to the Penalties of 18 Pa.C.S.A. Section 4904, relating to unsworn falsifications to authorities.

EUGENE SMITH

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

EUGENE SMITH,

Plaintiff,

v.

CIGNA GROUP INSURANCE COMPANY,

Defendant.

CIVIL ACTION – LAW

No. 02-426-CD

TYPE OF DOCUMENT:

NOTICE OF FILING NOTICE OF REMOVAL

Filed on behalf of defendant Life Insurance Company of North America (incorrectly identified as Cigna Group Insurance Company)

Counsel of Record for This Party:

William M. Hassan, Esquire
Pa. ID No. 63436

Klett Rooney Lieber & Schorling
A Professional Corporation
One Oxford Centre, 40th Floor
Pittsburgh, PA 15219-6498
(412) 392-2000

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

EUGENE SMITH,	)	
	)	
Plaintiff,	)	Civil Action – Law
	)	
v.	)	
	)	No. 02-426-CD
CIGNA GROUP INSURANCE COMPANY,	)	
	)	
Defendant.	)	

NOTICE OF FILING NOTICE OF REMOVAL

To: Prothonotary of Clearfield County

You are hereby notified, pursuant to 28 U.S.C. §1446(d), that on April 19, 2002, defendant Life Insurance Company of North America (incorrectly identified as Cigna Group Insurance Company) filed a Notice of Removal of the above action from the Court of Common Pleas of Clearfield County, Pennsylvania to the United States District Court for the Western District of Pennsylvania. A copy of the Notice of Removal is attached hereto.

Respectfully submitted,

WM Hassan

William M. Hassan (Pa. ID No. 63436)
Klett Rooney Lieber & Schorling
A Professional Corporation
40th Floor, One Oxford Centre
Pittsburgh, PA 15219-6498
(412) 392-2000

Attorneys for defendant Life Insurance Company of North America (incorrectly identified as Cigna Group Insurance Company)

Dated: April 19, 2002

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

EUGENE SMITH,	)	
	)	
Plaintiff,	)	
	)	Case No. _____
v.	)	
	)	
CIGNA GROUP INSURANCE COMPANY,	)	
	)	
Defendant.	)	

NOTICE OF REMOVAL

Pursuant to 28 U.S.C. §1441, defendant Life Insurance Company of North America (incorrectly identified as Cigna Group Insurance Company), by its undersigned attorneys, files the following Notice of Removal of the above-captioned action from the Court of Common Pleas of Clearfield County, Pennsylvania, where it is now pending, to the United States District Court for the Western District of Pennsylvania. Removal is based on the following:

1. Plaintiff Eugene Smith commenced an action against Life Insurance Company of North America (incorrectly identified as Cigna Group Insurance Company and hereinafter referred to as "Defendant"), in the Court of Common Pleas of Clearfield County, Pennsylvania captioned "Eugene Smith v. Cigna Group Insurance Company," Civil Action No. 02-426-CD by the filing of a complaint on or about March 21, 2002.

2. Defendant's receipt of the initial pleading in this matter occurred when it was served with a copy of the complaint on March 28, 2002 by mail. A copy of all process, pleadings and orders served on Defendant is attached hereto as Exhibit A.

3. Plaintiff's complaint is premised on Defendant's withholding of long-term disability benefits allegedly due plaintiff under an employee welfare benefit plan, a cause of action under the Employee Retirement Income Security Act, 29 U.S.C. § 1001, *et seq.* ("ERISA"). Compl. at ¶ 3.

4. ERISA's exclusive application to employee benefit plans and resulting preemption of state law claims is very broad due to a congressional intent to create a federal common law, not to be supplemented or supplanted by varying state laws. *See Metropolitan Life Insurance Co. v. Taylor*, 107 S.Ct. 1542 (1987).

5. Accordingly, this action is removable pursuant to 28 U.S.C. § 1441 and 28 U.S.C. § 1331, under this Court's federal question jurisdiction.

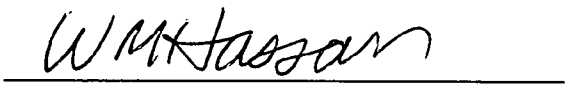
6. This Notice of Removal is being filed within thirty (30) days of the Defendant's receipt of the initial pleading by service or otherwise, and is timely filed pursuant to 28 U.S.C. § 1446.

7. Written notice of the filing of this Notice of Removal has been served on all parties.

8. A copy of this Notice of Removal has been filed with the Prothonotary of the Court of Common Pleas of Clearfield County, Pennsylvania.

WHEREFORE, Defendant Life Insurance Company of North America (incorrectly identified as Cigna Group Insurance Company) hereby removes this action to the United States District Court for the Western District of Pennsylvania.

Respectfully submitted,



William M. Hassan (Pa. ID No. 63436)
Klett Rooney Lieber & Schorling
A Professional Corporation
40th Floor, One Oxford Centre
Pittsburgh, PA 15219-6498
(412) 392-2000

Attorneys for defendant Life Insurance Company of North America (incorrectly identified as Cigna Group Insurance Company)

Dated: April 19, 2002

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

EUGENE SMITH,

Plaintiff,

vs.

CIGNA GROUP INSURANCE COMPANY,

Defendants.

: NO. 2002 GN
:
:
: CIVIL ACTION - LAW
: 02-426-CD
: Type of Filing:
: COMPLAINT FOR DENIAL OF
: INSURANCE BENEFITS
: PURSUANT TO THE
: EMPLOYMEE RETIREMENT
: INCOME SECURITY ACT,
: 29 U.S.C.A. §1001, et. seq.
:
:
: Filed by:
:
: Alan R. Krier, Esquire
: P.A. I.D. #06672
: Attorney for Plaintiff,
: M&T BANK
: Park View Center
: Ten Sheraton Drive
: P.O. Box 2024
: Altoona, Pennsylvania 16603
: (814) 943-1149
:
:
: Attorney for Plaintiff:
: EUGENE SMITH
:

209-32-1509

I hereby certify this to be a true and attested copy of the original statement filed in this case.

MAR 21 2002

Attest.

Prothonotary/
Clerk of Courts

EXHIBIT

tabbies

A

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

EUGENE SMITH,	: NO. 2002 GN
Plaintiff,	:
	: CIVIL ACTION - LAW
vs.	:
CIGNA GROUP INSURANCE COMPANY,	:
Defendant.	:

NOTICE

You have been sued in court. If you wish to defend against the claims set forth in the following pages, you must take action within twenty (20) days after this complaint and notice are served, by entering a written appearance personally or by attorney and filing in writing with the court your defenses or objections to the claims set forth against you. You are warned that if you fail to do so the case may proceed without you and a judgment may be entered against you by the court without further notice for any money claimed in the complaint or for any other claim or relief requested by the plaintiff. You may lose money or property or other rights important to you.

YOU SHOULD TAKE THIS PAPER TO YOUR LAWYER AT ONCE. IF YOU DO NOT HAVE A LAWYER OR CANNOT AFFORD ONE, GO TO OR TELEPHONE THE OFFICE SET FORTH BELOW TO FIND OUT WHERE YOU CAN GET LEGAL HELP.

SOUTHERN ALLEGHENIES LEGAL AID, INC.
1107 12th Street, Suite 508
Altoona, Pennsylvania 16601
(814) 943-8139

IN THE COURT OF COMMON PLEAS OF CLEARFIELD COUNTY, PENNSYLVANIA

EUGENE SMITH,	: NO. 2002 GN
Plaintiff,	: CIVIL ACTION - LAW
vs.	:
CIGNA GROUP INSURANCE COMPANY,	:
Defendant.	:

COMPLAINT FOR DENIAL OF INSURANCE BENEFITS PUSUANT TO THE EMPLOYMEE RETIREMENT INCOME SECURITY ACT, 29 U.S.C.A. §1001, et. seq.

AND NOW, comes Plaintiff, **EUGENE SMITH**, by and through his attorneys, **JUBELIRER, CAROTHERS, KRIER & HALPERN**, and files the following Complaint, and in support thereof aver as follows:

1.

Plaintiff, **EUGENE SMITH** is an individual residing at R.D. #1, Box 297, Frenchville, Clearfield County, Pennsylvania.

2.

Defendant, **CIGNA GROUP INSURANCE COMPANY (Cigna)**, is a mutual insurance company authorized to do business, and doing business in the Commonwealth of Pennsylvania and throughout the United States with a place of business as 1600 W. Carson Street, Suite 300, Pittsburgh, Pennsylvania 15219.

3.

This complaint is brought under the Employee Retirement Income Security Act of 1974 (hereinafter cited as ERISA), 29 U.S.C. §1001, et seq. Specifically, pursuant to section 1132(a)(1)(B) of ERISA, 29 U.S.C. §1132(a)(1)(B). Plaintiff has been deprived of his rights and benefits secured to the Plaintiff by Cigna under a Long-Term Disability Insurance Plan (hereinafter referred to as the

"Plan"). The Plan is maintained by Plaintiff's former employer, the Baltimore Life Insurance Company (hereinafter referred to as "Baltimore Life").

4.

This Court has jurisdiction of this action under Section 1132(e)(1) of ERISA, 29 U.S.C. §1132 (e)(1).

5.

Plaintiff's employment with Baltimore Life commenced in March of 1984. During his period of employment, Plaintiff executed an application for group disability insurance issued by Cigna for the employees of Baltimore Life.

6.

At the time Plaintiff executed the application, he was an employee of Baltimore Life as a sales agent and was eligible for the aforementioned group disability insurance policy. The Plaintiff remained an employee of Baltimore Life through October 2, 1993 when the Plaintiff became disabled.

7.

Defendant accepted Plaintiff for coverage under the group disability policy. A true and correct copy of policy issued by Defendant to Baltimore Life is attached hereto and made a part hereof, marked as "Exhibit "A". Plaintiff was and is now a participant in the Plan.

8.

The policy provides for payments of sixty percent (60%) of the employee's base salary, up to a maximum benefit of $4,000 per month, during periods of total disability.

9.

On or about October 2, 1993, Plaintiff's poor physical condition, caused by chronic fatigue syndrome, became so debilitating that he was unable to work.

10.

Plaintiff has been totally disabled from working due to chronic fatigue syndrome from the time he went off work and he continues to be totally disabled at the present time.

11.

At the time Plaintiff left the employment of Baltimore Life, he filed a disability claim with Defendant, supplying all the requested information and authorizations in accordance with the applicable policy provisions.

12.

Thereafter, Defendant notified Plaintiff that his claim had been accepted and payment would be made in accordance with the policy commencing on January 30, 1994.

13.

Thereafter, Plaintiff received payments through June 30, 2001 when payments were stopped when Defendant notified him that he no longer met the definition of disability as established in the policy.

14.

Initially, Defendant based its denial on a flawed physical capacity evaluation submitted by Defendant to Plaintiff's family physician which did not account for issues of stamina sustained effort over time and endurance which is the essence of chronic fatigue syndrome. Plaintiff's family physician issued a clarifying report to Defendant, expressing her opinion as his treating physician that Plaintiff was disabled from any gainful employment establishing a prima facie basis for continued disability payments. In addition, Defendant was aware that Plaintiff had qualified for Social Security disability on virtually the same standard as set forth in the policy.

15.

Since Defendants alleged basis for denial of benefits was clearly not viable, instead of paying the claim, Defendant sought to develop new medical evidence to support its denial and demanded that Plaintiff submit to a functional capacity evaluation.

16.

On November 7 and 8, 2001, at the request of Defendant, the Plaintiff underwent a Functional Capacity Evaluation at Nittany Valley Rehabilitation Hospital, 550 West College Avenue, Pleasant

Gap, Pennsylvania. The evaluation states that the Plaintiff's endurance/aerobic capacity was undeterminable making it impossible for the Defendant to determine from that test that Plaintiff's disability, chronic fatigue syndrome, no longer met the definition of disability as stated in the policy. In addition, Defendant produced no medical interpretation of the test.

17.

Plaintiff has received no payments from the Defendant for the period from June 30, 2001 to the present time.

18.

In accord with the procedures of the Plan, Plaintiff internally appealed the decision of the Defendants on or about July 16, 2001. The Defendants informed plaintiff that his appeal was denied on December 14, 2001. The denial exhausted Plaintiff's internal remedies.

19.

Plaintiff is entitled to certain long-term disability income insurance benefits under the policy in full force and effect and fully applicable because his condition meets the definition of a disability after monthly benefits have been payable for 24 months, as established under the policy.

20.

By virtue of the results of the evaluation conducted on November 7 and 8, 2001, the decision of the Defendants to deny payment to Plaintiff is arbitrary and capricious, a product of bad faith and not supported by substantial evidence.

WHEREFORE, Plaintiff prays that this Honorable Court:

a. Decree and declare that Plaintiff has vested contractual rights to the full extent of the long-term disability benefits provided under the Plan, and that Defendants have a binding obligation to pay to Plaintiff benefits to the full extent provided by the Plan; and that

b. Order Defendants to pay Plaintiff the unpaid contributions in the amount of $771.00 per month for the period from June 30, 2001 to the present with interest, together

with costs of this action and reasonable attorney fees, pursuant to ERISA, 29 U.S.C. §1132(g); and that

c. Provide such other relief, as the Court may deem necessary to secure Plaintiff's rights.

Respectfully submitted,

JUBELIRER, CAROTHERS, KRIER & HALPERN

BY: _____

Alan R. Krier, Esquire
P.A. I.D. #06672
Park View Center
Ten Sheraton Drive
Altoona, Pennsylvania 16601
(814) 943-1149

Long-Term Disability Insurance Plan

Designed Especially

for Employees of

THE BALTIMORE LIFE INSURANCE COMPANY

FOREWORD

This brochure describes the Long-Term Disability Income Insurance available to eligible employees of The Baltimore Life Insurance Company.

The Plan helps assure a continuing income when, due to illness or injuries, an employee is no longer able to work. It covers disability sustained on or off the job and lasting longer than 120 days.

ELIGIBILITY

Class I: All active home office, field clerical and field management employees, over age 18, working a minimum of 21 hours per week are eligible.

Class II: All active commissioned employees, over age 18, regularly working a minimum of 21 hours per week are eligible upon completion of two continuous calendar years of service with the company.

THE BENEFIT

If you become disabled, this Plan will pay you an income equivalent to 60% of your base salary, subject to a maximum benefit of $4,000 per month, less any amounts for which you may also be eligible under:

a) the Canada-Quebec Pension Plans
b) any local, provincial or federal government disability or retirement plan or law
c) any state disability or retirement benefits which you receive (or are assumed to receive on your own behalf;
d) any salary or wage continuation plan of the Employer
e) the Jones Act; or any Workers' Compensation, occupational Disease or similar law, including all permanent as well as temporary disability benefits -
f) any disability or old age benefits payable under the Federal Social Security Act which you receive (or are assumed to receive) on your own behalf;
g) any disability or old age benefits payable under the Federal Social Security Act which you receive (or are assumed to receive) on behalf of your dependents; or which your dependents receive on account of your receipt (or assumed receipt) of such benefits; and
h) any retirement benefits which you receive under (a) a retirement plan sponsored by the employer; (b) the Canada and Quebec Pension Plans; (c) the Railroad Retirement Act or the Railroad Unemployment Insurance Act, to the extent these benefits are funded by the Employer.

In no event will such reductions result in the benefit from this Plan being less than $50 per month.

The benefit is computed on basic earnings at commencement of disability. Overtime and bonuses are excluded.

Commission earnings will be averaged over the 60 months immediately prior to disability or over the period of such earnings if that period is less than 60 months.

BENEFIT PERIOD

A benefit period commences on the 121st consecutive day of disability and can continue, depending on your age at commencement of disability, as outlined below:

Age at Commencement of Disability	*Duration of Benefit Period*
Age 62 or under	the later of (a) the employee's 65th birthday; or (b) the date the 42nd monthly benefit is payable
63 years	the date the 36th monthly benefit is payable
64 years	the date the 30th monthly benefit is payable
65 years	the date the 24th monthly benefit is payable
66 years	the date the 21st monthly benefit is payable
67 years	the date the 18th monthly benefit is payable
68 years	the date the 15th monthly benefit is payable
Age 69 or over	the date the 12th monthly benefit is payable

DEFINITION OF DISABILITY

You will be considered disabled if, because of injury or sickness: (1) you are unable to perform all the material duties of your regular occupation; and (2) after monthly benefits have been payable for 24 months, you are unable to perform all the material duties of any occupation for which you are or may reasonably become qualified based on your education, training or experience.

RESIDUAL DISABILITY BENEFIT

Designed to provide incentive or motivation to encourage an employee's return to work from a potential long-term disability.

1) Any employee can return to part-time work during the waiting period and still collect benefits at the end of such waiting period as long as they meet the definition of disability.
2) During the first 12 months of return to work our benefit will not be reduced by return to work earnings until the sum of the monthly benefit, earnings, and "other benefits" (offsets) exceeds 100% of the indexed basic monthly earnings.

This provides a financial incentive for someone to return to work. We will also index basic earnings to continue to provide a "real" financial advantage to employees who are out on disability for twelve months or longer.

3) After 12 months the residual benefit will be equal to the monthly benefit minus 50% of the employee's monthly earnings received while residually disabled. If the sum of the employee's monthly benefit, earnings and other benefits exceeds 80% of the indexed basic monthly earnings, the benefit will be reduced by the excess.

   While the initial benefit was designed to provide financial incentive for an employee to return to work, we must realize that the desired end result is to bring the claimant back to productive, full-time employment. To do this there must be an incentive for the employee to make this move. Therefore, after the first year and beyond, we will begin to offset with 50% of earnings, and bring the cap from 100% down to 80%.

FAMILY BENEFITS

If death occurs after you have been receiving the benefit from this Plan for at least six months, your eligible survivor (*i.e.*, your spouse or children) will receive your plan benefit payment for six months following your death, but not beyond your benefit period. This benefit is not applicable if there are no eligible survivors.

SUCCESSIVE PERIODS OF DISABILITY

During the waiting period, successive periods of disability due to the same or related causes shall be considered as one period of disability if separated by less than 20 days of active, full-time employment.

If, however, after the expiration of the waiting period, you have received the benefit under this plan, return to work and subsequently become disabled from the same or related causes, no new waiting period will be applied provided a period of less than 180 days separates the two periods of disability.

LIMITATIONS

Pre-Existing Conditions

We will not pay Monthly Benefits for any period of disability which results, directly or indirectly, from an injury or sickness for which you incurred expenses, received medical treatment, took prescribed drugs or medicines or consulted a physician during the three months prior to the most recent effective date of your insurance. This limitation will not apply to a period of disability which begins more than 12 months after the most recent effective date of your insurance.

The pre-existing conditions provision is waived for commissioned employees.

Continuity of Coverage and Pre-Existing Condition Limitation

The pre-existing condition limitation will be waived if you were insured on the day before the effective date of this policy under a group long-term disability policy sponsored by your employer and replaced by this policy, provided you are actively at work on the effective date of this policy, and have fulfilled the requirements of any pre-existing condition limitation of the replaced policy.

However, if you are actively at work on the effective date of this policy and have not fulfilled the requirements of any pre-existing condition limitation of the replaced policy because the time period required before the start of total disability has not been satisfied, any portion of time which may have been satisfied under the pre-existing condition limitation of the replaced policy will be applied toward the satisfaction of the time period requirement of the pre-existing condition limitation of this policy.

If Monthly Benefits are determined to be payable, they will be paid according to the provisions of this policy.

Mental Illness, Alcoholism and Drug Abuse Limitation

The monthly benefit will be payable for disabilities resulting from these conditions for no more than 24 months during your lifetime, except while you are continuously confined for at least 14 days in a hospital licensed to provide care and treatment for your condition. Monthly income payments will be made while you are so confined. Coverage commences on the first day following the 120-day waiting period.

EXCLUSIONS

The income is not payable for disability resulting from any act or hazard of a declared or undeclared war or intentionally self-inflicted injury.

TERMINATION OF INSURANCE

You will be insured so long as the Group Plan is continued, in force, and you remain an eligible employee making the required contribution.

Should the Plan be discontinued for any reason, payments on an established claim would continue as though the Plan had remained in force.

CONVERSION PRIVILEGE

If you should leave the Company for a reason other than disability or retirement, or take an uninsured leave of absence, you have the privilege of converting your coverage to an individual LTD policy, providing you are under age 70 and have been covered by our Group LTD insurance for at least a year. The new, individual coverage will provide a specific monthly disability benefit for total disability lasting longer than 180 days. Benefit provisions, limitations and exclusions are described in the disability conversion insurance brochure and application.

To exercise your conversion privilege, simply make application and pay the first quarterly premium within 31 days of termination from the Company's Group LTD plan.

COST OF LONG-TERM DISABILITY INSURANCE FOR YOU

Schedule Amount

Non-Contributory Insurance — 60% of monthly pay subject to a maximum Schedule Amount of $750 per month.

Contributory Insurance (for covered persons whose annual pay is more than $15,000) — 60% of monthly pay subject to a maximum Schedule Amount of $3,250, provided that the combined Non-Contributory and Contributory amounts will not be greater than $4,000.

ENROLLMENT PROVISIONS

You will be insured without medical certification if you enroll within 31 days after you become eligible. Delayed enrollment requires evidence of your insurability, provided at your expense, and is subject to acceptance by the Insurance Company.

If you are absent because of accident or sickness, on the date your insurance would normally become effective, the effective date is postponed until you have returned to the full performance of your duties.

CERTIFICATE OF INSURANCE

This booklet describes the Plan in general terms and is not to be considered the Contract of Insurance.

THE BALTIMORE LIFE INSURANCE COMPANY SUPPLEMENTAL SELF-INSURED LONG-TERM DISABILITY PLAN

(provided by The Baltimore Life Insurance Company and not CIGNA Benefits)

In order to maintain an equitable 60% of annual salary for all eligible disabled employees, effective March 1, 1983, Baltimore Life will implement the following Supplemental Self-Insured Long-Term Disability Plan:

1) Under this Plan, Baltimore Life will supplement the amount of benefit you receive if the total payments from CIGNA Corporation Long-Term Disability Insurance Plan and the other sources listed in the Policy do not equal 60% of your base annual salary. Baltimore Life will supplement your benefit up to that 60% level.

2) To be eligible to receive benefits from this Supplemental Long-Term Disability Plan, all conditions and information to certify disability under the plan must be met and approved by both the long-term disability carrier and Baltimore Life's Medical Director.

3) The Supplemental Long-Term Disability Plan will remain in effect as long as the employee is receiving benefits under the Long-Term Disability Plan.

SUPPLEMENTAL INFORMATION

for

THE BALTIMORE LIFE INSURANCE COMPANY LONG-TERM DISABILITY PLAN

required by the Employee Retirement Income Security Act of 1974

The following information together with the information contained in this booklet to which this supplement is attached constitute the Summary Plan Description required by the Employee Retirement Income Security Act of 1974.

The Plan is established and maintained by The Baltimore Life Insurance Company.

The Employer Identification Number is 52-0236900.

The Plan Number is 503.

This Plan is administered directly by the Plan Administrator with benefits provided in accordance with the provisions of the group insurance contract, LK-7860, issued by Life Insurance Company of North America, 1601 Chestnut Street, Philadelphia, PA 19192.

The Plan Administrator is The Baltimore Life Insurance Company.

All plan administration is done at 10075 Red Run Boulevard, Owings Mills, MD 21117. The Plan Administrator has authority to control and manage the operation and administration of the plan.

The agent for service of legal process is Gary C. Harriger. Service of legal process may also be made upon the Plan Administrator or any plan trustee.

This plan of benefits financed by Employer and Employee.

Date of the end of the Plan Year: 9-1.

For a description of the eligibility requirements of the plan, the amount and type of benefits available, the circumstances under which benefits under the plan are not available or may terminate, please refer to this booklet.

Plan Termination: The right is reserved in the plan for the Plan Administrator to terminate, suspend, withdraw or amend the plan in whole or in part at any time, subject to the applicable provisions of the Group Insurance Policy. Your rights upon termination or amendment of the plan are set forth in your booklet

CLAIM PROCEDURES

Filing a Claim for Benefits

When you are reasonably sure that you are eligible to receive benefits under this plan, you may request a claim form from your employer. All claims submitted to the Insurer must be on forms provided by the Insurer (unless forms are not currently available), in which case you may simply supply the appropriate party with a written statement outlining proof and extent of loss.

Complete the claim form according to directions and return the claim form to your employer.

From the date your notice of claim is returned, the insurance company has 90 days in which to review the claim to determine whether or not benefits are payable in accordance with the terms and provisions of the Group Policy. Under special circumstances the insurance company may require an extension of this 90-day period in which case you will receive written notice from the insurance company, prior to the end of the initial 90 days, informing you of the need for an extension. This extension period allows the insurance company an additional 90 days to review your claim. During this period the insurance company may require a medical examination, at its own expense, or additional information in order to make a determination on your claim. If additional information is required you will receive a request, in writing, specifying the nature of the information needed and an explanation as to why it is needed. If a medical examination is necessary you will be given the time of appointment and the doctor's name and location. It is important to keep any appointments made since rescheduling exams will delay the claim process.

If you are not notified of the claim status within 90 days and you have not been notified that the extension period has been applied, you may request a review of your claim by following the procedure outlined under ***Claim Review Procedure.***

Once your claim has been approved, you will receive the appropriate benefit from the insurance company.

What If Your Benefits Are Denied?

If your claim for benefits is denied in whole or in part, you will receive written notice of such denial within the 90-day period stated above (or 180 days if the extension period is required).

Each written notice of denial shall set forth:

1) the specific reason(s) for the denial of the claim
2) a specific reference to the provision(s) of the Group Policy upon which the denial is based; and
3) notice of your right to have the denial reviewed by the Plan Administrator.

Claim Review Procedure

If you receive a written notice of denial, you or your duly authorized representative may request a review of the claim by giving written notice to the Insurance Company. This request for a review must be made to the Plan Administrator within 60 days of the receipt of denial by the Insurance company. If such request is not made within 60 days you will be deemed to have

waived your right to a review by the Insurance Company.

Once the Insurance Company receives a request for a review, a prompt review of the claim must take place. You or your authorized representative have the right to review documents that might have a bearing on the claim including the documents which establish and control the plan, and to submit issues and comments that you feel might affect the outcome of the review.

Upon completion of a full and complete review, the Insurance Company will notify you in writing of the results, citing plan provisions that control the decision. The Insurance Company has 60 days to notify you of its decision unless special circumstances require an extension of time. If an extension is required, the Insurance Company shall notify you of the need for an extension before the end of the initial 60-day period for completing the review procedure. This means that the Insurance Company will have an additional 60 days to notify you of the decision on your denied claim.

Statement of ERISA Rights

As a participant in the plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974. All plan participants are entitled to:

a. Examine, without charge, at the Plan Administrator's office, 10075 Red Run Boulevard, Owings Mills, MD 21117, all plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor such as annual reports and plan descriptions.

b. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator who may make a reasonable charge for the copies.

c. Receive a summary of the plan's annual financial report which the law requires the Plan Administrator of certain plans to provide to each plan participant.

   (Unless there are reasons beyond the control of the Plan Administrator, materials that you request should be received within 30 days. If they are not, you may file suit in a federal court. The court may require the Plan Administrator to pay up to $100 for each day's delay until the materials are received.)

d. Receive a written explanation of the reasons why your claim for benefits has been denied in whole or part and a review and reconsideration of your claim.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. These people are called *fiduciaries*, and they must act prudently and with the sole interests of you and other participants in mind.

No one, not even your employer, may fire you or discriminate against you in order to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If you are improperly denied a welfare benefit in whole or part, or if you believe plan fiduciaries are misusing plan funds, or if you are discriminated against for asserting your rights, you may request assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees, but if you lose you may be required to pay the costs and fees; for example, if the court finds that your claim is frivolous.

If you have any questions about your plan contact your Plan Administrator. If you have any questions about this statement, or your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

While ERISA requirements are established by federal law and regulation, The Baltimore Life Insurance Company has always attempted to provide its employees with welfare plans that meet the same high standards imposed by the law. We are pleased that the law will enable better application of these standards.

VERIFICATION

I, EUGENE SMITH, the plaintiff herein, state that the facts set forth in the foregoing COMPLAINT are true and correct to the best of my knowledge, information and belief. I understand that statements herein are made subject to the Penalties of 18 Pa.C.S.A. Section 4904, relating to unsworn falsifications to authorities.

EUGENE SMITH

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing Notice of Removal was served upon the following by first class mail, postage prepaid, this 19th day of April 2002 addressed as follows:

Alan R. Krier, Esq.
Jubelirer, Carothers, Krier & Halpern
Park View Center
Ten Sheraton Drive
Altoona, PA 16601

William M. Hassan

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing Notice of Filing of Notice of Removal was served upon the following by first class mail, postage prepaid, this 19th day of April 2002 addressed as follows:

Alan R. Krier, Esq.
Jubelirer, Carothers, Krier & Halpern
Park View Center
Ten Sheraton Drive
Altoona, PA 16601

William M. Hassan

In The Court of Common Pleas of Clearfield County, Pennsylvania

Sheriff Docket # 12272

SMITH, EUGENE

02-426-CD

VS.

CIGNA GROUP INSURANCE COMPANY

COMPLAINT FOR DENIAL OF INSURANCE BENEFITS

SHERIFF RETURNS

NOW MARCH 22, 2002, PETER DEFAZIO, SHERIFF OF ALLEGHENY COUNTY WAS DEPUTIZED BY CHESTER A. HAWKINS, SHERIFF OF CLEARFIELD COUNTY TO SERVE THE WITHINCOMPLAINT FOR DENIAL OF INSURANCE BENEFITS ON CIGNA GROUP INSURANCE COMPANY, DEFENDANT.

NOW MARCH 28, 2002 SERVED THE WITHIN COMPLAINT FOR DENIAL OF INSURANCE BENEFITS ON CIGNA GROUP INSURANCE COMPANY, DEFENDANT BY DEPUTIZING THE SHERIFF OF ALLEGHENY COUNTY. THE RETURN OF SHERIFF DEFAZIO IS HERETO ATTACHED AND MADE A PART OF THIS RETURN STATING THAT HE SERVED MEGHAN ORR, AGENT FOR DEFT.

Return Costs

Cost	Description
27.91	SHFF. HAWKINS PAID BY: ATTY.
28.00	SHFF. DEFAZIO PAID BY: ATTY.
3.00	NOTARY PAID BY: ATTY.
10.00	SURCHARGE PAID BY: ATTY.

68.91

FILED

MAY 02 2002

01/4:00

William A. Shaw

Prothonotary

Sworn to Before Me This

2nd Day Of May 2002

William A. Shaw

WILLIAM A. SHAW
Prothonotary
My Commission Expires
1st Monday in Jan. 2006
Clearfield Co., Clearfield, PA

So Answers,

Chester A. Hawkins by Marilyn Hamm

Chester A. Hawkins
Sheriff

MEGHAN ORR

12272

25129

PETER R. DEFAZIO
Sheriff

ALLEGHENY COUNTY SHERIFF'S DEPARTMENT

436 GRANT STREET
PITTSBURGH, PA 15219-2496
PHONE (412) 350-4700

DENNIS SKOSNIK
Chief Deputy

PLAINTIFF EUGENE SMITH

VS.

DEFT. CIGNA GROUP INSURANCE COMPANY

ADD. DEFT. 1600 W. Carson St., Suite 300

ADD. DEFT. Pittsburgh, Pa. 15219

GARNISHEE

ADDRESS 19TH WARD

MUNICIPALITY or CITY WARD

DATE: 3/22/02 19

ATTY'S Phone 943-1149

CASE# 02-426-CD

EXPIRES 4/20/02

- ☐ SUMMONS/PRAECIPE
- ☐ SEIZURE OR POSSESSION
- XX NOTICE AND COMPLAINT
- ☐ REVIVAL of SCI FA
- ☐ INTERROGATORIES
- ☐ EXECUTION - LEVY OR GARNISHEE
- ☐ OTHER

ATTY. ALAN R. KRIER

ADDRESS Park View Center, Ten Sherton Drive
PO Box 2024
Altoona, Pa. 16603

INDICATE TYPE OF SERVICE: ☐ PERSONAL ☐ PERSON IN CHARGE ☒ DEPUTIZE ☐ CERT. MAIL ☐ POSTED ☐ OTHER ☐ LEVY ☐ SEIZED & STORE

Now. March 22, 2002 ~~19xx~~ I, SHERIFF OF ~~ALLEGHENY~~ Clearfield COUNTY, PA do hereby deputize the Sheriff of ALLEGHENY County to execute this Writ and make return thereof according to law

NOTE: ONLY APPLICABLE ON WRIT OF EXECUTION: N.B. WAIVER OF WATCHMAN - Any deputy sheriff levying upon or attaching any property under within writ may leave same without a watchman, in custody of whomever is found in possession, after notifying person or attachment without liability on the part of such deputy herein for any loss, destruction or removal of any property before sheriff's sale thereof.

Seize, levy, advertise and sell all the personal property of the defendant on the premises located at:

MAKE	MODEL	MOTOR NUMBER	SERIAL NUMBER	LICENSE NUMBER

SHERIFF'S OFFICE USE ONLY

I hereby CERTIFY AND RETURN that on the 28 day of MARCH, 19 2002 at 1235 o'clock A.M./P.M. Address Above/Address Below. County of Allegheny, Pennsylvania

I have served in the manner described below:

- ☐ Defendant(s) personally served.
- ☐ Adult family member with whom said Defendant(s) reside(s). Name & Relationship
- ☐ Adult in charge of Defendant's residence who refused to give name or relationship.
- ☐ Manager/Clerk of place of lodging in which Defendant(s) reside(s).
- X Agent or person in charge of Defendant(s) office or usual place of business. MEGHAN ORR
- ☐ Other
- ☐ Property Posted

Defendant not found because: ☐ Moved ☐ Unknown ☐ No Answer ☐ Vacant ☐ Other

☐ Certified Mail ☐ Receipt ☐ Envelope Returned ☐ Neither receipt or envelope returned: writ expired

☐ Regular Mail Why

You are hereby notified that on , 19 , levy was made in the case of

Possession/Sale has been set for , 19 at o'clock.

YOU MUST CALL DEPUTY ON THE MORNING OF SALE/POSSESSION BETWEEN 8:30 - 9:30 A.M.

ATTEMPTS / / / / / /

APR 0 8 2002

Sheila R. O'Brien

PETER R. DEFAZIO, Sheriff

By J Caye
Deputy

Additional Costs Due $, This is placed on writ when returned to Prothonotary. Please check before satisfying case.

District 11

NOTARIAL SEAL
Sheila R. O'Brien, Notary Public
City of Pittsburgh, County of Allegheny
My Commission Expires June 19, 2004

White Copy - Sheriff Yellow - Sheriff Pink Copy - Attorney