IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

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TOBY D. TOFSON,

Plaintiff,

v.

METROPOLITAN LIFE INSURANCE COMPANY,

Defendant.

OPINION AND ORDER

99-C-814-C

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This is a civil action for monetary relief brought pursuant to 29 U.S.C. § 1132(a)(1)(B), the Employee Retirement Income Security Act. Plaintiff Toby D. Tofson contends that defendant Metropolitan Life Insurance Company violated ERISA when it denied his claim for long term disability benefits. Jurisdiction is present under 28 U.S.C. § 1331.

Presently before the court is defendant's motion for summary judgment. Defendant argues that its decision to deny plaintiff benefits was reasonable because plaintiff failed to meet the requirements for disability under the benefits plan. In addition, defendant asserts that plaintiff's employment had been terminated before the date his claimed disability began and therefore, he was ineligible for benefits even if he had been disabled. Because I conclude that

defendant's decision to deny plaintiff long-term disability benefits was not arbitrary and capricious, defendant's motion for summary judgment will be granted.

Before setting out the undisputed facts for the purposes of deciding defendant's motion for summary judgment, it is important to discuss their source. Instead of relying exclusively on the parties' proposed findings of fact, I have based my determination on a review of the record as a whole. I have chosen to do this for two reasons. First, a review of the parties' briefs shows that there are few facts that are disputed, genuinely or otherwise. Rather, the disputes focus on the reasonableness of defendant's interpretation of the benefits plan. Second, and more important, neither party's proposed findings of fact complied with this court's Procedures to Be Followed on Motions for Summary Judgment. Although both parties submitted documents they titled "Proposed Findings of Fact," there were few actual facts proposed by either plaintiff or defendant. Instead, conclusory statements about ultimate facts were made that provided no insight into whether any genuine disputes over material facts existed. For example, defendant's proposed finding of fact #14 states: "Plaintiff was not continuously 'Disabled' within the meaning of the Plan during the elimination period of May 14, 1998 through August 13, 1998." Similarly, plaintiff's proposed finding of fact #4 states: "Plaintiff was medically unable to perform the material duties of his job as an insurance salesman and owner/manager of an insurance agency on May 14, 1998 and throughout the 90 day elimination period as

required by the plan." These "facts" are obviously disputed; if they were not, the parties would not be here. However, neither party proposed any specific facts to support their ultimate conclusions.

Each party received a copy of Procedures to be Followed on Motions for Summary Judgment with the magistrate judge's pretrial conference order. The Procedures state explicitly that proposed findings of fact of both the movant and the non-movant shall include ALL factual propositions that are necessary for a ruling in that party's favor, including facts regarding the context of the dispute. See I.C.3; II.C.4. The purpose of proposed findings of fact is to allow the parties to identify the precise factual issues that are genuinely disputed. This purpose is thwarted when parties submit proposed findings that consist of only vague, conclusory statements, as was done in this case. Counsel for both parties are warned. If a party's proposed findings of fact fail to comply with this court's Procedures, an adverse ruling against that party is justified.

For the purpose of deciding this motion, I conclude from the record that the following material facts are undisputed.

UNDISPUTED FACTS

A. Disability Plan

Plaintiff Toby D. Tofson, a resident of Lake Delton, Wisconsin, was employed by the Tofson Insurance Agency, where he was an insurance agent. While employed at Tofson, plaintiff was insured under the Trustees of Independent Insurance Agents of Wisconsin, Group Disability Policy No. 91496-G, a qualified employee benefit plan under ERISA that was administered by defendant.

Under the plan, employees must be able to prove that they are "disabled" before they can receive long-term disability benefits. To be considered "disabled," a claimant must be able to show that he (1)"require[s] the regular care and attendance of a Doctor"; and (2) is "unable to perform each of the material duties of [his] regular job." In addition, the plan states that benefits for long-term disability do not become payable until a claimant has been disabled for the duration of the "elimination period," which is ninety days, and that "benefits will end on the date . . . employment ends." As of May 22, 1998, plaintiff was no longer employed with Tofson Insurance Agency.

The plan also states: "In carrying out their respective responsibilities under the Plan, the Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance

with the terms of the Plan."

B. Plaintiff's Claim for Long-Term Disability Benefits

1. Plaintiff's Submissions

Plaintiff filed his claim with defendant in July 1998. He claimed that he had been fully disabled as a result of neuropathy secondary to alcoholism since May 14, 1998. In early September, plaintiff submitted a report from his attending physician, Dr. Charles Miley, in which Dr. Miley stated that he had diagnosed plaintiff with polyneuropathy and encephalopathy secondary to alcoholism on August 18, 1998. In the report, Dr. Miley indicated that plaintiff experienced "moderate limitation" in regard to finger dexterity, operating heavy equipment, operating electrical equipment and concentrated visual attention. In addition, Dr. Miley indicated that plaintiff experienced "some limitation" walking or standing. Nothing was said about plaintiff's ability to drive or sit. Dr. Miley concluded that plaintiff had been "totally disabled" for his own occupation and unable to work since May 14, 1998. Dr. Miley's first consultation with plaintiff was on August 18, 1998.

Also submitted with plaintiff's statement of claim was a description of the physical requirements of plaintiff's job. The description read:

> Insurance agents generally are required to obtain and service their clients' insurance needs. This involves traveling to clients' places of business to sell

> insurance, filling out a number of insurance forms and other paperwork, entertaining clients at various locations which requires travel, and returning as often as necessary to clients' places of business to service their insurance needs. All of this requires that agents be mobile enough to travel to clients' places of business and have the manual dexterity necessary to sufficiently complete all the required paperwork.

2. Other Evidence Considered By Defendant

In addition to reviewing plaintiff's submitted materials, defendant collected plaintiff's medical records, beginning in March 1998. These records included notes made by plaintiff's attending physician, Dr. Harold Conley, regarding plaintiff's condition from May 14, 1998, to July 27, 1998. Plaintiff was hospitalized from May 14, 1998 to May 20, 1998 for "ethanol abuse." In his notes from May 14, 1998, Dr. Conley wrote that plaintiff was "quite tremorous with tremor of the hands and tongue." However, he did not make any mention of neuropathy.

On May 26, 1998, plaintiff went to Dr. Conley for a follow up consultation. Dr. Conley wrote that plaintiff had "some numbness in his feet and ankles but this seems to be progressively diminishing in area." In addition, Dr. Conley noted that plaintiff's "balance is still a little bit compromised at times." On June 1, 1998, after another visit by plaintiff, Dr. Conley wrote that plaintiff was "doing well" but that he had "a little numbness in his feet yet," that his "vibration sense is diminished in the lower extremities," and that he "does not have a lot of

weakness but he has trouble with his balance yet." He referred to plaintiff as having "peripheral neuropathy" and noted that he had put plaintiff "on a program of an exercise bike and various exercises."

On June 15, 1998, Conley noted that plaintiff thought he was "getting somewhat better." However, Conley wrote that plaintiff "still having trouble with some numbness in his feet and trouble with his balance" and that his "vibration sense is decreased in the lower extremities but he does feel vibration at the ankles, slightly more than in the arms." Finally, Dr. Conley noted that plaintiff "could not stand on one leg well at all." On June 29, 1998, Dr. Conley wrote that plaintiff had a "significant problem with discomfort in his feet as well as numbness. It is made worse by elevation, hurts to walk on it, in fact he couldn't walk nine holes to play golf . . . . Vibration sense is definitely diminished at the ankles." Additionally, Dr. Conley noted plaintiff was to call in two weeks if he had not improved so a neurology consultation could be scheduled. Three days later, plaintiff went to Dr. Conley for treatment for eye problems. Dr. Conley made no mention of plaintiff's neuropathy in his notes on this day. Finally, Dr. Conley's notes indicate that on July 27, 1998, Dr. Conley made an appointment for plaintiff to see Dr. Miley on August 18, 1998.

In a report dated September 2, 1998, Dr. Miley wrote that tests had shown "mild but definite slowing of motor nerve conduction velocities" and that plaintiff's symptoms indicated

that he had polyneuropathy. Plaintiff contacted Dr. Miley again on September 15, 1998, because he still had numbness and pain in his feet. On December 9, 1998, plaintiff returned to Dr. Miley because of foot pain. Dr. Miley wrote that plaintiff "had a terrible problem with painful neuropathy in his feet" and also that he needed treatment for his infected toe.

Plaintiff returned to the hospital on February 2, 1999 for detoxification. Dr. Conley was his attending physician. Although Dr. Conley's initial assessment was "Alcohol abuse," his final diagnosis on February 5, 1999, was both "Ethanol abuse" and "Peripheral neuropathy, feet and legs." Noting plaintiff's "very poor balance" caused in part by "significant peripheral neuropathy," Dr. Conley released plaintiff with a walker to assist in his balance and ambulatory ability. Dr. Conley noted again that plaintiff continued to be afflicted with neuropathy.

Finally, Conley saw plaintiff again on March 16, 1999. In his notes, Conley wrote that plaintiff was "still abstinent from alcohol and is feeling quite well." No mention was made of neuropathy or its symptoms.

C. Defendant's First Decision

Defendant first denied plaintiff's claim on October 2, 1998, telling plaintiff that the Trustees of Independent Insurance Agents of Wisconsin had canceled his coverage before the date plaintiff claimed his disability had begun. Later, however, when plaintiff provided

additional documentation to defendant that in fact his insurance coverage had not been canceled, defendant withdrew this initial decision.

On March 5, 1999, when defendant had still failed to issue a decision, plaintiff filed a complaint with the Wisconsin Office of the Commissioner of Insurance, complaining that defendant had failed to respond to his claim in a timely manner. On April 20, 1999, the Commissioner of Insurance wrote defendant, instructing it to promptly make a decision.

On May 10, 1999, defendant determined that plaintiff's claim would be denied. In its letter to plaintiff's lawyer, defendant concluded that plaintiff "did not meet the applicable definition of total disability at any time after August 13, 1998, the first date for which Long Term Disability benefits could have been paid under this contract." Defendant first rejected a claim based on alcoholism because there was not enough evidence that plaintiff was seeking treatment for his addiction.

Defendant also rejected a claim based on neuropathy. Although defendant admitted that plaintiff's medical records confirmed a diagnosis of mild to moderate neuropathy, it concluded that the condition was "not of such severity to preclude the performance of [plaintiff]'s regular job as a small business owner/agency manager and insurance salesman." Defendant provided the following reasons for its denial: (1) plaintiff's medical records did not indicate that he left work because of neuropathy; (2) plaintiff's neuropathy had not been

diagnosed by Dr. Miley until September 2, 1998, and that even then Dr. Miley concluded only that plaintiff had "some limitation" in his ability to walk and stand without further quantification; (3) there was no evidence of persistent complaints by plaintiff of pain or inability to walk; (4) plaintiff had required no regular physical therapy for his neuropathy; (5) plaintiff ate and slept well and there was no evidence he had been unable to sleep because of his pain; (6) Dr. Conley had recommended that plaintiff engage in aerobic activity; (7) there was no indication of decreased muscle mass, pathologic reflexes, lack of coordination, abnormal position sense or alteration of gait or station; (8) no formal evaluation of physical capacity had been conducted; (9) the duties of plaintiff's job as an insurance salesperson, as described by his employer, "fell well within [plaintiff]'s current functional capabilities;" (10) plaintiff's job could be more accurately described as "owner/manager of insurance agency," which would have included administrative tasks involving only "sedentary physical demands"; and (11) tests did not indicate that plaintiff's cognitive abilities were impaired.

Defendant also noted that Dr. Miley recommended that plaintiff achieve total abstinence in order to reduce the neuropathic discomfort. The letter stated that the record had been reviewed by both nurse coordinators and a physician consultant. The letter concluded by informing plaintiff he was entitled to a review of his claim and that he "may also submit additional medical or vocational information and any facts, data, questions, or comments you

deem appropriate for us to give your appeal proper consideration."

D. Review of Plaintiff's Claim

In response to defendant's denial, plaintiff requested that a review be performed. Plaintiff submitted additional letters from Dr. Miley and Dr. Conley supporting his claim. Dr. Miley wrote that it was his "strong medical opinion" that plaintiff "is disabled and has been disabled since May 1998." Miley continued that plaintiff "suffers from alcoholism and severe polyneuropathy," which "has left [plaintiff] unable to perform the material duties of his prior job." Miley also wrote that plaintiff had "required the regular care and attendance of a physician" and had been prescribed medication to help alleviate the pain.

In addition, Dr. Conley wrote that "plaintiff has had signs and symptoms of neuropathy in his lower extremities" and that plaintiff was "essentially disabled" from performing his duties as an insurance salesman. Conley further stated that plaintiff was "in a need for medical attention at relatively frequent intervals." He concluded by writing: "It is my opinion that [plaintiff]'s disability existed in May of 1998 and has continued to exist unabated throughout this period up until the present time."

After receiving these letters from plaintiff, defendant notified plaintiff in early September that it needed more information before it could make its decision, but promised

plaintiff a decision by November 7, 1999. Defendant then requested information from Tofson Insurance Agency, Inc. to verify plaintiff's employment. Tim Tofson, the owner of Tofson Insurance Agency, Inc., responded. Tofson stated that plaintiff had sold his interest in the company on May 22, 1998, and that his last "day of any active work" was "the day before he was admitted to the hospital in mid-May 1998." Tofson also stated that disability insurance premiums were paid on behalf of plaintiff until October 1, 1998. In response to a request for additional information, Tofson wrote defendant another letter dated October 25, 1999. In this letter, Tofson explained that before May 1998, he and plaintiff had been involved in litigation regarding "who should be running the Agency and its business direction." However, Tofson stated that even after the litigation, plaintiff remained employed at the agency until Tofson purchased his share of the business.

Defendant's records indicate that the letter from Tofson was received on November 3, 1999. In a letter dated November 2, 1999, defendant again denied plaintiff's claim. This time, defendant provided the following reasons for its decision: (1) there was no evidence that neuropathy had prevented plaintiff from working after May 14, 1998, since Dr. Miley did not diagnose plaintiff with neuropathy until August 1998 and Dr. Miley was not competent to determine plaintiff's condition three months prior; (2) hospital records from March 1998 indicated that plaintiff was no longer working with Tofson Insurance Agency at that time; (3)

Dr. Conley's notes that he made while treating plaintiff indicate that plaintiff's numbness was diminishing in June 1998, and that his circulation and balance were not problems; (4) plaintiff did not receive any treatment from Dr. Conley after July 17, 1998 and did not receive any treatment from Dr. Miley between September 2, 1998 and December 9, 1998; and (5) defendant had not received documentation from Tofson Insurance Agency documentation that plaintiff was employed there through May 14, 1998. Plaintiff did not receive the letter denying his claim a second time until he filed a request for production of documents in this lawsuit.

OPINION

The Employee Retirement Income Security Act applies to "any plan, fund or program which was heretofore and hereinafter established or maintained by an employer or employer organization or both." 29 U.S.C. § 1002(1). The parties agree that defendant's plan falls within ERISA's ambit and that ERISA governs this action.

The standard of review in this case is clear. In Firestone Rubber v. Bruch, 489 U.S. 101 (1989), the Supreme Court held that a plan administrator's denial of benefits must be reviewed *de novo* unless "the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the benefits of the plan." Id. at 115. However, if the plan gives the administrator or fiduciary such discretionary authority, the court reviews

the denial under the arbitrary and capricious standard. See id. This standard was recently clarified by the Court of Appeals for the Seventh Circuit in Herzberger v. Standard Insurance Co., 205 F.3d 327 (7th Cir. 2000). Although reluctant to announce the "magic words" that would demonstrate an administrator had discretionary authority, the court did provide the following "safe harbor" language: "Benefits under this plan will be paid only if the plan administrator decided in his discretion that the applicant is entitled to them." Id. at 331. The plan in this case states: "In carrying out their respective responsibilities under the Plan, the Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan." Although this language is not identical to Herzberger's "safe harbor" language, it states clearly and unambiguously that the plan administrator is to have discretionary authority over interpreting the plan. Accordingly, the standard of review in this case must be arbitrary and capricious.

The arbitrary and capricious standard is the least demanding form of judicial review. See Trombetta v. Cragin Federal Bank for Savings Employee Stock Ownership Plan, 102 F.3d 1435, 1438 (7th Cir. 1996). In order to prevail under this standard, it is not enough that plaintiff show that defendant's determination was incorrect. Rather he must show that the decision was "downright unreasonable." Olander v. Bucyrus-Erie Co., 187 F.3d 599, 607 (7th

Cir. 1999). In other words, “a court must be very confident that the decision maker overlooked something important or seriously erred in appreciating the significance of evidence” before concluding that a decision was arbitrary and capricious. Patterson v. Caterpillar, Inc., 70 F.3d 503, 505 (7th Cir. 1995). As long as defendant made an "informed judgment and articulate[d] an explanation for it that is satisfactory in light of the relevant facts, i.e., one that makes a 'rational connection' between the issue to be decided, the evidence in the case, the text under consideration, and the conclusion reached," the benefits decision will be upheld. Exbom v. Central States, Southeast and Southwest Areas Health and Welfare Fund, 900 F.2d 1138,1143 (7th Cir. 1990). Although the standard is very deferential, it is nonetheless a review and not a rubber stamp. See Donato v. Metropolitan Life Ins. Co., 19 F.3d 375, 380 (7th Cir. 1994).

Plaintiff argues that defendant's determination that he was not “disabled” within the meaning of the plans was arbitrary and capricious. Because plaintiff's claim indicates his disability began on May 14, 1998, the critical time period for which plaintiff must show he was disabled is May 14, 1998 to August 13, 1998. Furthermore, because plaintiff was employed at Tofson Insurance Agency until May 22, 1998 at the latest, any disabilities he incurred after this date would not be covered by the plan.

Although the parties dispute many of the reasons provided by defendant for its decision

to deny benefits, the critical preliminary question is whether defendant acted reasonably in determining that plaintiff was able to perform the material duties of his job during the elimination period. If defendant's decision on this issue was not unreasonable, plaintiff's claim that defendant acted arbitrarily and capriciously must fail. To support his claim that he was unable to perform his job's material duties, plaintiff sent defendant, along with his original claim, a report from September 2, 1998, by Dr. Miley that plaintiff had suffered from neuropathy since May 14, 1998, and that plaintiff had been "totally disabled" for his own occupation and unable to work since that time. Dr. Miley stated that plaintiff experienced "moderate limitation" in regard to finger dexterity, operating heavy equipment, operating electrical equipment and concentrated visual attention as well as "some limitation" walking or standing. In addition, after plaintiff's claim was denied once, plaintiff sent defendant letters from both Dr. Conley and Dr. Miley stating their opinion that plaintiff had been disabled since May 1998.

Although I find this to be a close case, I conclude that plaintiff has failed to show defendant's decision to deny plaintiff long-term disability benefits was "downright unreasonable." First, at the time plaintiff submitted his claim, the only medical opinion he had to support it was that of Dr. Miley. Although Dr. Miley indicated that plaintiff was unable to perform his job, he also indicated that plaintiff only experienced "some limitation" in his ability

to walk or stand and did not indicate that plaintiff was limited in driving or sitting. Furthermore, as defendant points out, Dr. Miley's conclusions are of somewhat limited value. Dr. Miley never treated plaintiff during the elimination period; plaintiff's first consultation with Dr. Miley was on August 18, 1998, five days after the elimination period ended. Therefore, Dr. Miley's determination that plaintiff could not perform the material duties of his job may indicate that plaintiff was disabled under the plan as of August 18, 1998, but it is less persuasive regarding what plaintiff's condition would have been during May or June.

More important, the notes of Dr. Conley, the only physician who treated plaintiff during the elimination period, indicate that plaintiff's impairments were mild and that plaintiff did not satisfy the requirements of being "disabled" as defined by the plan. Although Dr. Conley referred to plaintiff as having neuropathy as early as June 1, 1998, which was still more than two weeks after plaintiff claims his disability began, he did not indicate that plaintiff's condition was debilitating to the point that he would be unable to work. Rather, Dr. Conley's May 26 notes indicated only that plaintiff had "some numbness in his feet and ankles but this seems to be progressively diminishing in area" and that his "balance is still a little bit compromised at times." On June 1, 1998, Dr. Conley stated again that plaintiff "had a little numbness in his feet" and that he "does not have a lot of weakness but has trouble with his balance yet." He concluded that plaintiff was "doing well" and noted that plaintiff had been on an exercise bike

program. On June 15, 1998, Dr. Conley continued to note the numbness in plaintiff's feet and that he was having trouble standing on one of his legs. However, his notes also indicate that plaintiff believed he "was getting somewhat better."

In sum, although Dr. Conley's notes indicate some physical impairment, I cannot say it was unreasonable for defendant to conclude from these notes that plaintiff was not impaired to the point that he would be unable to travel, meet with clients and do paper work. It was not unreasonable for defendant to find Dr. Conley's notes to be the most persuasive evidence regarding plaintiff's condition during the elimination period since they were the only medical records available regarding plaintiff's condition during that time. As plaintiff's attending physician, Dr. Conley was in the best position to evaluate plaintiff's condition and to determine the degree of plaintiff's disability.

In regard to defendant's second decision to deny plaintiff's claim, plaintiff argues that the determination was arbitrary and capricious because defendant rejected the opinions of both of his doctors, who each wrote letters to defendant stating they believed that plaintiff had been disabled since May 1998. Relying on Ladd v. ITT Corp., 148 F.3d 753 (7th Cir. 1998), plaintiff argues that it is "arbitrary and even irrational" to deny a disability claim when no doctor who has examined the claimant believes he is capable of working. Although there is merit to this argument, ultimately I find that Ladd fails to help plaintiff. First, in Ladd the

court did not hold that a plan administrator's denial of benefits was arbitrary and capricious in every case in which it rejected the opinion of an examining physician. Rather, the court looked at all the circumstances, which, in addition to the conclusions of the plaintiff's examining physicians, included a previous decision of an administrative law judge of the Social Security Administration that the plaintiff was "totally disabled" and the defendant's failure to give reasons for disagreeing with the doctors' assessments. See id. at 756. It is worth noting that the court stated that it would not have found the decision to be arbitrary and capricious had the defendant given reasons for its disagreement with the examining physicians. See id. In this case, by contrast, defendant did give reasons for its disagreement with the assessment that plaintiff was disabled. In fact, defendant relied expressly on statements made by plaintiff's own attending physician to come to this conclusion, in addition to a lack of evidence that plaintiff had complained he was unable to walk or was in great pain.

In addition, the new evidence that plaintiff submitted still failed to address many of the reasons for which defendant initially denied the claim. Although both of plaintiff's doctors stated it was their belief plaintiff could not perform the material duties of his job, they did not explain *why* plaintiff could not perform his job. There is not even an indication in the letters as to what plaintiff's job duties entailed. Plaintiff also failed to explain why Dr. Conley's initial observations contradicted his later conclusion. It was not explained why there were no

persistent complaints about pain or inability to walk, why there had been no regular physical therapy, or why Dr. Conley's notes indicating plaintiff's condition was mild were not a reliable gauge of plaintiff's true ability at the time. Defendant provided these reasons to plaintiff in its initial decision to deny the claim, thereby giving notice that he needed to address them if he were to be successful in obtaining benefits. However, plaintiff never did this. In short, plaintiff failed to provide any evidence that would have indicated he was unable to perform the material duties of his job.

Finally, plaintiff argues that defendant's conclusion that he could perform the material duties of his job must be rejected because defendant re-characterized his position as requiring only sedentary activities. This was simply not the case. Although defendant appeared to believe that plaintiff's job did not require him to be as active as he claimed, defendant determined that even considering the job description presented by plaintiff, he still had not shown that he would be unable to perform his material duties.

Defendant could have made its decision *more* reasonable had it moved more swiftly and done more to verify plaintiff's claim. Defendant can be faulted for failing to do its own medical examination, but I cannot say that its failure to do so or its decision as a whole is arbitrary and capricious. The burden was on the plaintiff to show that in fact he was disabled during the elimination period. Defendant considered the evidence and provided a reasonable explanation

for denying plaintiff's claim, relying on the observations of plaintiff's own physicians to determine that he did not meet the definition of "disabled" under the plan between May 14, 1998, and August 13, 1998. Furthermore, plaintiff failed to address the reasons for which defendant initially denied plaintiff's claim, specifically why he was unable to perform the material duties of his job. Thus, regardless whether plaintiff has enough evidence to show that he met the definition at a later date, I cannot say that it was "downright unreasonable" for defendant to determine that plaintiff was not disabled during the elimination period. Olander, 187 F.3d at 1438. Moreover, I cannot say that I am "very confident that the decision maker overlooked something important or seriously erred in appreciating the significance of the evidence." Patterson, 70 F.3d at 505. Plaintiff's failure to meet this preliminary requirement is fatal to his claim.

Because I have determined that defendant's decision to deny plaintiff's claim for long-term disability benefits was reasonable on the ground that plaintiff had not shown he was unable to perform the material duties of his job, it is unnecessary to decide whether plaintiff was receiving the regular care of a physician or whether plaintiff was still eligible to receive benefits at the time he claimed he first became disabled.

ORDER

IT IS ORDERED that:

1. The motion for summary judgment of defendant Metropolitan Insurance Company is GRANTED.

2. The clerk of court is directed to enter judgment for defendant and close this case.

Entered this 20th day of September 2000.

BY THE COURT:

BARBARA B. CRABB
District Judge