IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

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DONALD R. JOHANSEN,

Plaintiff,

v.

CONTINENTAL CASUALTY COMPANY,

Defendant.

OPINION AND ORDER

99-C-0252-C

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This is a civil action for monetary and injunctive relief brought pursuant to 29 U.S.C. § 1132 (the Employee Retirement Income Security Act or ERISA). Subject matter jurisdiction is present. See 28 U.S.C. § 1331. Plaintiff Donald R. Johansen contends that defendant Continental Casualty Company denied him long-term disability benefits in violation of the act. Presently before the court is defendant's motion for summary judgment. The case turns on two questions: whether plaintiff provided adequate evidence of his disability to defendant and how much discretion defendant had to deny plaintiff benefits on the basis of that evidence. I find that although plaintiff was required to present objective medical evidence of his disability, a jury could reasonably conclude that defendant abused its discretion in denying benefits to plaintiff on the basis of the evidence plaintiff provided. Because genuinely disputed issues of

material fact preclude a grant of summary judgment, defendant's motion will be denied.

Before setting out the undisputed facts for purposes of deciding defendant's motion for summary judgment, it is useful to discuss their source. When defendant first moved for summary judgment, it did not submit a body of proposed facts as required by this court's Procedure to be Followed on Motions for Summary Judgment, a copy of which was provided to the parties with the magistrate judge's preliminary pretrial conference order dated June 22, 1999. Therefore, I extended the schedule for briefing the motion to allow defendant to serve and file proposed findings of fact. I also ordered that "All submissions must conform to this court's Procedure to be Followed on Motions for Summary Judgment." Defendant then served and filed a body of proposed facts. However, many of the facts defendant proposed were supported by citations to evidence that had not been placed in the record. As the Procedure states, such proposed facts will be ignored ("Only depositions, answers to interrogatories, admissions on file . . . and affidavits may be cited in support of proposed facts."). Moreover, although plaintiff responded to defendant's proposed findings of fact, defendant did not respond to plaintiff's proposed facts. As the Procedure states at III.B., "The court will conclude that there is no genuine dispute as to any finding of fact initially proposed in a response, unless the movant's rebuttal properly puts the factual proposition into dispute." Therefore, plaintiff's proposed findings of fact are deemed undisputed for purposes of deciding this motion.

From the facts proposed by the parties, I find the following to be undisputed.

UNDISPUTED FACTS

1. Disability plan

Plaintiff is a former employee of Webcrafters, Inc., where he operated a forklift. According to an "Employer's Job Activities Statement" prepared by Webcrafters, plaintiff's job duties were: "operate forklift and general warehouse activities. Load/unload trucks with forklift." The job activities statement notes that plaintiff's job required twisting of his body while driving the forklift in reverse.

Plaintiff was an eligible participant in the employee welfare benefit plan offered by Webcrafters. Through the plan, employees were eligible to receive long-term disability benefits under policy no. SR-198346, purchased from and administered by defendant. In relevant part, the policy provides total disability benefits in the event that the participant is continuously unable to perform the substantial and material duties of his regular occupation because of sickness or injury. For filing a claim, the plan provides the following instructions:

> **NOTICE OF CLAIM.** Written notice of claim must be given to Us within 30 days after the loss begins or as soon as reasonably possible.
>
> **CLAIM FORMS.** After We receive the written notice of claim, We will furnish claim forms within 15 days. If we do not, the claimant will be considered to have met the requirements for written proof of loss if We receive written proof which describes the

occurrence, extent and nature of the loss.

> **WRITTEN PROOF OF LOSS.** Written proof of loss must be furnished to Us within 90 days after the end of a period for which We are liable. . . .
>
> **TIME OF PAYMENT OF CLAIM.** Benefits will be paid monthly immediately after We receive due written proof of loss.

The plan does not include the term "objective medical findings" or explain what evidence would constitute such findings.

2. Plaintiff's injury

On August 13, 1993, plaintiff was involved in a motor vehicle accident in which he injured his back, neck and shoulder. Plaintiff saw Dr. Florell for treatment of his injuries. Plaintiff had an MRI of his back that showed disc bulging at C4-5 and a left sided disc herniation at C5-6. An EMG was performed that was normal. The plan paid plaintiff long-term disability benefits from November 14, 1993 until June 19, 1994, but terminated the benefits when plaintiff returned to work in June 1994.

In January 1996, plaintiff fell on ice exacerbating his prior condition. Plaintiff injured his neck the same day when he caught his wife to prevent her from falling.

3. Plaintiff's medical examinations

On January 23, 1996, plaintiff sought treatment from Dr. Florell again for neck, left shoulder and arm pain. Dr. Florell's examination revealed decreased range of motion in plaintiff's neck and muscle spasms. Dr. Florell released plaintiff to return to work on February 13, 1999, but the release was retracted later because plaintiff showed inadequate improvement. Dr. Florell delayed the release until February 20, 1996. Plaintiff began receiving physical therapy on February 5, 1996. On Dr. Florell's recommendation, plaintiff saw Dr. Timmerman on February 19, 1996. Dr. Timmerman ordered plaintiff to perform only light duties until his next evaluation. On February 29, 1996, Dr. Timmerman restricted plaintiff as follows: "light duty recommended (no lifting over 20 pounds, no twisting of the neck, no repetitive left arm work, no forklift driving) until further eval. -- two more weeks." On March 11, 1996, during an office visit, Dr. Timmerman noted improvement through physical therapy for plaintiff's neck and shoulders but added that "today he is unable to walk or sit without extreme difficulty." Dr. Timmerman continued his previous restrictions "for three weeks. (No lifting, twisting, bending, or forklift driving.)" On May 6, 1996, Dr. Timmerman continued "current restrictions of no lifting over 20 pounds, no forklift driving until September 10." In September 1996, Dr. Timmerman recommended that plaintiff increase his work activity to "a limit of six hours of forklift driving per day." On October 3, 1996, Dr. Timmerman stated that the recommendation that plaintiff resume forklift driving "has in fact been reversed and [he] is

supposed to be at this time not to be doing any forklift driving." On October 22, 1996, plaintiff's progress was set back because of injuries he sustained in an automobile accident. Dr. Timmerman continued to recommend the same restrictions up to and after July 7, 1997 correspondence with defendant's consultant, Dr. Ziffer. Since January 18, 1996, plaintiff's physicians have not allowed him to return to his regular occupation as a forklift driver.

4. Communications with defendant

On or about May 6, 1996, plaintiff completed an initial claim form that included a signed statement describing the nature of his injuries. Plaintiff stated on the form that he had injured his arm, neck, and shoulder and was experiencing lower back pain. Dr. Timmerman prepared an "Attending Physician's Statement" for defendant in which he described both subjective and objective findings, including decreased range of motion and neck and back tenderness. He restricted plaintiff to light duty, including no forklift driving. On June 6, 1996, Dr. Timmerman prepared another statement in which he continued the same restrictions. On June 20, 1996, Dr. Timmerman prepared an "Attending Physician's Return to Work Recommendations Record" in which he recommended "continue current restrictions of no forklift, no twisting, no bending until July 10, 1996." On June 24, 1996, Dr. Timmerman responded to defendant, noting "no change in work status -- light duty with no forklift driving

or twisting or bending."

On August 28, 1996, defendant denied plaintiff's claim for benefits under the plan because he was not "continuously unable to perform the substantial and material duties of his regular occupation." Defendant stated that there was no objective medical evidence that plaintiff's condition had worsened since he returned to work in 1994 following his first injury in 1993. Defendant explained that the "objective medical findings" it required meant "medical signs and findings established by medically acceptable diagnostic techniques which show the existence of a medical impairment that results from an anatomical, physiological, or psychological abnormality which could reasonably be expected to produce pain or other symptoms alleged."

On October 9, 1996, plaintiff requested an appeal of the benefits denial. His claim was referred to the appeals committee. The committee reviewed records from Dr. Florell, Dr. Timmerman and physical therapy notes. By letter dated October 23, 1996, the appeals committee denied plaintiff's appeal. Defendant stated again that plaintiff had failed to provide objective medical evidence that his condition had worsened since he had returned to work in 1994. Acknowledging that Dr. Florell had written, defendant said Dr. Florell had stated that plaintiff was "unable to work due to this continuing pain problem. He writes that your restrictions are no lifting over 20 pounds and no forklift driving. He claims you are unable to

work with this restriction because your employer does not have any work for you to do."

On January 20, 1997, defendant denied plaintiff's claim again. Defendant acknowledged receiving another letter from Dr. Florell stating that "you cannot work" but claimed that there was an absence of "objective medical evidence of any findings which would substantiate a condition of such severity that would render you unable to perform the substantial and material duties of your job."

On or about February 12, 1997, at the request of the appeals committee, plaintiff's claim was reviewed by Dr. Al Ziffer of Best Consulting, a medical consultant retained by defendant to review plaintiff's claims. On February 19, 1997, defendant denied plaintiff's claim again. Defendant stated that it was "the Committee's opinion that there are no objective changes which would prevent you from returning to your job. Your MRI is unchanged from 1993, after which, [sic] you returned to work for a year and a half. You have had no other testing recently, such as an EMG, to objectively substantiate a condition of the severity that would prevent you from returning to your job."

On March 7, 1997, defendant wrote again to plaintiff, reiterating that "objective medical evidence fails to substantiate a condition of such severity as to prevent you from engaging in the substantial and material duties of your occupation."

On April 22, 1997, Dr. Timmerman wrote to defendant that:

> Due to both objective and subjective findings, including decreased ROM of the neck and surface EMG documented upper back and neck muscle spasms, we have placed Mr. Johansen on light work duty. It is my understanding that his occupation involves driving a forklift, which would obviously exacerbate his condition and quite likely be unsafe, given the objective findings that we have documented. While it is unfortunate that his company has not been able to keep him under some employment within the light duty work restrictions, it is clear that he is not able to return to full duty at this time.

Plaintiff was evaluated by Dr. Salvi at the University Hospital Spine Clinic on May 12, 1997. Dr. Salvi confirmed Drs. Timmerman's and Florell's diagnosis that plaintiff has a component of degenerative disc disease with bulging at C4-5 and C5-6 but noted that there was no "evidence for radicular weakness or reflex deficits that would be consistent with these levels of injuries." He also diagnosed "whiplash type cervical and periscapular myofascial pains as well as a component of rotator cuff strain." Dr. Salvi noted that "the bulk of plaintiff's injuries appear consistent with soft tissue myofascial pains" and recommended "a gradual reduction in the patient's current light duty work restrictions as his symptoms improve." Dr. Salvi also stated that "in his present state, however, I feel that he would have difficulty returning to the type of job at which he was previously employed (driving a forklift)" but predicted a "significant reduction in pain symptoms over the next four to six weeks" with physical therapy and pain medication. Dr. Salvi also recommended that plaintiff return to his clinic for a follow-up evaluation in approximately six weeks.

On July 7, 1997, Dr. Timmerman wrote in response to questions from Dr. Ziffer that

he considered Dr. Salvi's prediction of a significant reduction in pain in four to six weeks "naive" in light of the failure of physical therapy to produce such results to that point. In regard to the need for objective medical findings substantiating plaintiff's complaints and the failure of a recent MRI to show significant changes from a previous MRI conducted in 1993, Dr. Timmerman wrote:

> As for objective findings, the MRI is overrated and not terribly accurate (approximately 85-90% sensitivity and specificity). Please see my clinic notes for other objective findings, such as decreased range of motion, tenderness, muscle spasm, pain on motion, impingement, weakness, etc.

On July 7, 1997, Dr. Ziffer wrote to defendant that after reviewing plaintiff's medical records and Dr. Timmerman's responses to his questions, "It is my opinion that Mr. Johansen could have returned to light duty work in early 1996 and can return to his forklifting job at this time. This opinion is substantiated by the reports of Dr. Florell and Dr. Salvi."

On July 23, 1997, defendant wrote to plaintiff denying his claim again. Defendant noted again that plaintiff had been able to return to work following his original injury, and that

> There is no evidence of worsening of your condition other than your subjective complaints of pain in your neck, shoulder and back. The medical evidence available does not substantiate your inability to perform the substantial and material duties of your occupation. Work restrictions placed upon you must be accompanied by the medical evidence supporting these restrictions.

On September 10, 1997, defendant denied plaintiff's claim yet again. Defendant stated that it had reviewed notes and records from Dr. Florell, Dr. Timmerman, Dr. Stewart and Dr.

Salvi; an MRI report read by Dr. Marshall Culbum; an MRI report dated November 19, 1993 by Dr. John Kozarek; an MRI report of the left knee dated January 19, 1995, by Dr. Richard Logan; an MRI report of the left knee dated February 17, 1995, by Dr. Kozarek; and notes from the Work Well Clinic evaluation of April 12, 1994. Defendant acknowledged that plaintiff and his doctors "are stating that you cannot work as a forklift driver" but concluded that "the medical documentation submitted does not support these opinions." Defendant informed plaintiff that it would "no longer reconsider any further arguments or evidence."

On April 30, 1998, Dr. Robert Olson reported that after conducting three examinations of plaintiff he had found:

> significant physical examination findings which substantiate the neck and back pain includ[ing] decreased sensation in his left 4th and 5th fingers, decreased left hand grasp, and generalized muscle weakness in the left arm. He also has significantly reduced range of motion in the neck and the back.

Defendant never had plaintiff examined independently. Dr. Ziffer never observed plaintiff personally or examined him.

OPINION

Summary judgment is appropriate if there are no disputed issues of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c); Weicherding v. Riegel, 160 F.3d 1139, 1142 (7th Cir. 1998). All evidence and inferences must be viewed

in the light most favorable to the non-moving party. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 250 (1986). However, the non-moving party must set forth specific facts sufficient to raise a genuine issue for trial. Celotex v. Catrett, 477 U.S. 317, 324 (1986).

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.

A. Standard of Review

The denial of benefits from an employee benefit plan governed by ERISA may be challenged pursuant to 29 U.S.C. § 1132(a)(1)(B). The court's standard of review of a plan administrator's or fiduciary's decision to deny benefits is controlled by Firestone Rubber v. Bruch, 489 U.S. 101, 115 (1989). In Firestone, the Supreme Court analogized ERISA's provisions to the common law of trusts and held that a 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.; see also Ramsey v. Hercules, Inc., 77 F.3d 199, 202 (7th Cir. 1996). If the plan gives the administrator or fiduciary such discretionary authority, then the court reviews denials of benefits under the

arbitrary or capricious standard. See id. Under the arbitrary or capricious standard, the administrator's decision will be upheld unless there is no rational basis for the decision in relevant facts and plan language. See Exbom v. Central States, Southeast & Southwest Areas Health and Welfare Fund, 900 F.2d 1138, 1143 (7th Cir. 1990). Although both the Supreme Court in Bruch and the Court of Appeals for the Seventh Circuit have emphasized that the *de novo* standard of review should be the rule and the abuse of discretion standard the exception, see Ramsey, 77 F.3d at 203-04, in practice the reverse is often the case. See Vander Pas v. Unum Life Ins. Co. of America, 7 F. Supp. 2d 1011, 1015-16 (E.D. Wis. 1998) ("In the Seventh Circuit, incrementally and perhaps without conscious design, we appear to have arrived at such a minimalist conception of what is necessary to confer discretion that almost no claim of benefits under an ERISA plan will be reviewed de novo by our district courts.").

Thus, the first question that must be answered is whether the plan grants defendant sufficient discretionary authority to invoke the arbitrary and capricious standard. See Donato v. Metropolitan Life Ins. Co., 19 F.3d 375, 379 (7th Cir. 1994). The plan's language need not contain an explicit grant of discretionary authority for the arbitrary and capricious standard to apply. See id. at 379; Sisters of the Third Order of St. Francis v. SwedishAmerican Group Health Ben. Trust, 901 F.2d 1369, 1371 (7th Cir. 1990) (citing Bali v. Blue Cross and Blue Shield Ass'n, 873 F.2d 1043, 1047 (7th Cir. 1989) ("magic words such as 'the committee has

discretion to' are unnecessary" to invoke arbitrary and capricious standard)).

Defendant's plan requires claimants to provide "written proof of loss" in order to receive benefits. Under the section entitled "time of payment of claim" the plan says that benefits will begin after defendant receives "due proof" of loss. Defendant argues that the requirement of "due" proof brings its plan within the reach of cases such as Donato, in which the Court of Appeals for the Seventh Circuit held that plan language requiring proof "satisfactory to us" conferred sufficient discretion upon plan administrators to invoke the arbitrary and capricious standard of review. See Donato, 19 F.3d at 379. Defendant argues that as used in the plan, "due" and "satisfactory" are synonymous, but its argument is unpersuasive. The word "due" does not appear in the "Written Proof of Loss" section of the plan, where one would expect to find a description of the kind and extent of the written proof claimants must submit. Rather, the term appears in the "Time of Payment of Claim" section of the plan. A reasonable interpretation of the word "due" in that section of the plan is that payments will not begin until defendant receives what is "due" from the claimant: the written proof of loss described above. Given the presumption that plans should be reviewed under the *de novo* standard, see Firestone, 489 U.S. 101, close questions such as this should be resolved in favor of the claimant. Therefore, I conclude that the word "due" in defendant's plan does not confer such discretion upon defendant that the arbitrary and standard of review applies.

However, the word "proof" may produce that result. In Patterson v. Caterpillar, Inc., 70 F.3d 503, 505 (7th Cir. 1995), the court found the arbitrary and capricious standard invoked by the provision that benefits would be payable only upon receipt of "such due proof, as shall be from time to time required, of such disability." Similarly, in Infantino v. Waste Management, Inc., 980 F. Supp. 262, 266 (N.D. Ill. 1997), the district court held that "[a]n administrator who requests 'proof' of disability must necessarily examine the evidence submitted and determine whether it suffices as proof of the alleged disability." (Citation omitted). Relying on Patterson, the court concluded that the administrator's requirement of "proof" conferred sufficient discretion on the administrator to warrant application of the arbitrary and capricious standard. See id. As in Infantino, I conclude from Patterson that defendant's plan grants defendant sufficient discretion to invoke the arbitrary and capricious standard of review of its decisions.

A decision is arbitrary and capricious only when the decision maker "has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence, or is so implausible that it could not be ascribed to a difference in view or the product of expertise." Trombetta v. Cragin Federal Bank for Savings Employee Stock Ownership Plan, 102 F.3d 1435, 1438 (7th Cir. 1996). Before concluding that a decision was arbitrary and capricious,

"a court must be very confident that the decision maker overlooked something important or seriously erred in appreciating the significance of evidence." Patterson, 70 F.3d at 505. Questions of judgment are left to the administrator of the plan. See Trombetta, 102 F.3d at 1438. With those guiding principles in mind, courts examine several factors relevant to the administrator's decision, including (1) the impartiality of the decision making body; (2) the complexity of the issues; (3) the process afforded the parties; (4) the extent to which the decision makers utilized the assistance of experts where necessary; and (5) the soundness of the fiduciary's reasoning. See Chalmers v. Quaker Oats Co., 61 F.3d 1340, 1344 (7th Cir. 1995).

B. Defendant's Decision

Defendant argues that it was justified in denying plaintiff's claim under either standard because plaintiff failed to provide objective medical evidence of a condition severe enough to prevent him from continuously performing his occupation. In contrast, plaintiff contends that it was an abuse of discretion for defendant to read a requirement of objective medical evidence into the plan and, alternatively, that he provided enough objective medical evidence to claim benefits successfully under either standard of review.

Defendant's plan contains no explicit requirement that a claimant must submit "objective medical evidence" of a disability in order to receive benefits. However, common sense

and case law from around the country support the proposition that benefits determinations should be made upon objective rather than subjective evidence if the type of disability the claimant alleges is objectively verifiable. See Johnson v. Ameritech Sickness and Accident Disability Benefit Plan, 1999 WL 199637 (N.D. Ill. 1999) (not abuse of discretion to require objective medical evidence of disability even if requirement not specified in plan); Voight v. Metropolitan Life Ins. Co., 28 F. Supp. 2d 569, 578 (N.D. Cal. 1998) (not unreasonable to require objective medical evidence even though not explicitly required in plan); Pokol v. E.I. DuPont De Nemours and Co., Inc., 963 F. Supp. 1361, 1372 (D.N.J. 1997) (requirement of objective medical evidence not arbitrary or capricious even though plan did not explicitly require it).

Although plaintiff cites cases in which courts have held it an abuse of discretion to require objective medical evidence when the plan does not explicitly call for such evidence, in none of those cases has the court held that objective medical evidence is not required as a general rule. Instead, in each case, the court limited its holding to the particular circumstances of that case. For example, in Mitchell v. Eastman Kodak, 113 F.3d 433 (3d Cir. 1997), the Court of Appeals for the Third Circuit held that it was an abuse of discretion for the plan to deny benefits for lack of objective medical evidence when the plan did not explicitly require such evidence *and* the claimant's condition, chronic fatigue syndrome, was not objectively

verifiable:

> Although in some contexts it may not be arbitrary and capricious to require clinical evidence of the etiology of the allegedly disabling symptoms in order to verify that there is no malingering, we conclude that it was arbitrary and capricious to require such evidence in the context of this Plan and CFS.

Similarly, in Durr v. Metropolitan Life Ins. Co., 15 F. Supp. 2d 205, (D. Conn. 1998), the court found that it was arbitrary and capricious for the plan to require objective medical evidence in the form of "published studies, articles, or texts showing a connection between stress and plaintiff's condition." Id. at 212. The court noted that the claimant had already provided the plan "copies of his medical records, his medical history, and three doctors' opinions stating that he is disabled." Id. To require more objective evidence than the claimant had already provided was to read extra requirements into the plan not expressly part of it.

Assuming that plaintiff's condition is objectively verifiable at least to some extent (and plaintiff does not contend otherwise) it was reasonable for defendant to require objective medical evidence of plaintiff's disability. Much like the court in Durr, however, I find that a jury could conclude reasonably that plaintiff has met this requirement through submission of his doctors' opinions, medical records and medical history and that it was arbitrary and capricious of defendant to require more. Two factors in particular compel this conclusion. First, no doctor who examined plaintiff ever formed the opinion that he was ready to return to his occupation. Drs. Timmerman and Florell were steadfast in their opinion that plaintiff could

not operate a forklift in his condition; indeed, they noted that it would be unsafe for him to attempt to do so. Defendant makes much of the fact that Dr. Salvi predicted that with therapy plaintiff might be able to return to work in four to six weeks, but ignores Dr. Salvi's statement that "in his present state, however, I feel that he would have difficulty returning to the type of job at which he was previously employed (driving a forklift)" and his recommendation that plaintiff return to the clinic for another examination in six weeks to test his prediction -- an examination that apparently never occurred. Despite the fact that neither Dr. Timmerman, Dr. Florell nor Dr. Salvi believed plaintiff was physically capable of returning to his job, defendant's consultant Dr. Ziffer stated, without ever examining plaintiff, that "[plaintiff] can return to his forklifting job at this time. This opinion is substantiated by the reports of Dr. Florell and Dr. Salvi." Dr. Ziffer's statement is simply unsupported by the record. A jury could reasonably conclude that defendant "overlooked something important or seriously erred in appreciating the significance of evidence" in relying upon it. Patterson, 70 F.3d at 505.

Second, defendant rejected plaintiff's claim repeatedly on the ground that it was unsupported by objective medical evidence. However, in response to defendant's rejections, Dr. Timmerman wrote to defendant that "*due to both objective and subjective findings*, including decreased ROM of the neck and surface EMG documented upper back and neck muscle

spasms, we have placed Mr. Johansen on light work duty. It is my understanding that his occupation involves driving a forklift, which would obviously exacerbate his condition and quite likely be unsafe, *given the objective findings that we have documented*." When defendant rejected plaintiff's claim again, Dr. Timmerman wrote again directing defendant to "my clinic notes for other *objective findings*, such as decreased range of motion, tenderness, muscle spasm, pain on motion, impingement, weakness, etc." Under the arbitrary and capricious standard, defendant is entitled to weigh objective evidence to determine whether a claimant is entitled to benefits and make any rational decision; it is not entitled to refuse to acknowledge that a claimant has attempted to provide it with such evidence or to insist upon some other type of objective evidence without specifying what type of evidence it wants. Although a jury could reasonably conclude that defendant weighed the available objective evidence in good faith and made a rational decision, it could also conclude that it did not. That question of fact precludes summary judgment.

ORDER

IT IS ORDERED that defendant Continental Casualty Company's motion for summary judgment is DENIED.

Entered this _____ day of November, 1999.

BY THE COURT:

_____
BARBARA B. CRABB
District Judge