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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF ILLINOIS
ROCK ISLAND DIVISION

SCOTT JEFFREY DEVOOGHT,

Plaintiff,

v.

METROPOLITAN LIFE INSURANCE COMPANY,

Defendant.

No. 4:15-cv-04108-SLD-JEH

ORDER

Before the Court are Plaintiff Scott Jeffrey DeVooght's Motion for Summary Judgment, ECF No. 32, Defendant Metropolitan Life Insurance Company's ("MetLife") Cross Motion for Summary Judgment Under Fed. R. Civ. P. 56(c) or, Alternatively, for Judgment Under Fed. R. Civ. P. 52(a), ECF No. 35, and Plaintiff's Motion to Add Social Security Judge's Finding of Facts and Conclusions of Law, ECF No. 40. For the reasons that follow, Plaintiff's motion for summary judgment is DENIED, MetLife's motion for summary judgment is GRANTED, and Plaintiff's motion to add the social security judge's findings is DENIED.

BACKGROUND[1]

Plaintiff worked for L.B. Benefits, Inc., an insurance company, from 1998 until he resigned on May 19, 2011. As part of his employment benefits, he had insurance coverage through a MetLife-issued group insurance policy. The insurance policy includes long-term disability coverage, under which MetLife pays out 66 and 2/3 percent of the first $7,499 of a disabled participant's predisability earnings monthly. Disability insurance coverage under the plan, however, ends on the last date of the participant's employment.

A person is disabled under the plan if, "due to Sickness . . . [he is] receiving Appropriate Care and Treatment and complying with the requirements of such treatment; and [he is] unable to earn" more than 80 percent of his "Predisability Earnings" at his "Own Occupation" for any employer in the geographic area in which he resides during the "Elimination Period" and for the next 36 months. Admin. R. Part VII, at MET01116–17, ECF No. 37-7. After those 36 months, he must be unable to earn more than 80 percent of his "Predisability Earnings" at any occupation for which he is reasonably qualified. *Id.* "Sickness" means an illness or disease. "Appropriate Care and Treatment" means treatment that is "given by a Physician whose medical training and clinical specialty are appropriate" for the relevant disability, "consistent in type, frequency and duration" with established guidelines, consistent with the diagnosis, and "intended to maximize

[1] At summary judgment, a court "construe[es] the record in the light most favorable to the nonmovant and avoid[s] the temptation to decide which party's version of the facts is more likely true." *Payne v. Pauley*, 337 F.3d 767, 770 (7th Cir. 2003). In his motion for summary judgment, Plaintiff fails to cite to documentary evidence to support his statement of undisputed facts in violation of Local Rule 7.1(D)(1)(b). Pl.'s Mot. Summ. J. Br. 1–2, ECF No. 33. And in his response to the cross motion for summary judgment, he does not include a section responding to MetLife's statement of undisputed facts. *See* Pl.'s Resp. Def.'s Mot. Summ. J., ECF Nos. 42–42-3. Additionally, his response, which is about 70 pages long, violates the page limitations set forth in Local Rule 7.1(D)(5). Given his pro se status, the Court will not strike his filings, but as "[a] failure to respond to any numbered fact will be deemed an admission of the fact," the Court will consider all of MetLife's facts admitted. Local Rule 7.1(D)(2)(b)(6). Plaintiff again does not cite to any documentary evidence or include a statement of additional material facts in his response, but does at various points refer to the administrative record of MetLife's consideration of his claim, which was attached to MetLife's motion, and the medical records contained within that record. *See, e.g.*, Pl.'s Resp. Def.'s Mot. Summ. J. 25. Thus, the facts related here are from MetLife's statement of undisputed facts, Def.'s Mot. Summ. J. Br. 4–36, ECF No. 36, and the administrative record, App. Def.'s Mot. Summ. J., ECF Nos. 37–37-7.

[] medical and functional improvement." *Id.* at MET01116. "Physicians" is defined to include persons whose services are treated as physician's services, so long as they are licensed, certified, or registered as required in the relevant jurisdiction. "Predisability Earnings" is the gross salary or wages earned on the last day of full time work, and does not include awards and bonuses. "Own occupation" is defined as "the essential functions" regularly performed at the participant's primary job. *Id.* at MET01117. The "Elimination Period"—which is the time in which MetLife does not pay out benefits—starts on the date the disability begins and lasts for 90 days.

Under the policy, an individual is required to submit proof of his disability before he can be approved for benefits. Proof is defined as "[w]ritten evidence satisfactory to [MetLife] that a person has satisfied the conditions and requirements for any benefit described" in the policy. *Id.* at MET01118. The written evidence must establish "the nature and extent of the loss or condition." *Id.* Documentation of the following is required for an initial claim for disability benefits: date the disability began, its cause, its prognosis, and its continuity. A claimant is generally required to provide notice and proof of a claim to MetLife within 90 days of a loss. But if not provided within 90 days, "the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible." *Id.* at MET01140.

I. Plaintiff's Claim for Benefits

On April 30, 2013, Plaintiff reached out to L.B. Benefits and requested that it fill out the employer section of a disability claim form. Because coverage ended on the last day of Plaintiff's employment, Brett Lohman, his old supervisor, told him that "[t]urning in a claim would be a waste of time." Admin. R. Part VI, at MET01083, ECF No. 37-6. But on May 6, 2013, Plaintiff submitted a claim to MetLife; he filled out employee section and left the employer section blank. He listed May 2011 as the date his disability began and described his

disabling condition as "severe, debilitating headaches, insomnia & pain, exhaustion." Admin. R. Part V, at MET00821, ECF No. 37-5. His primary care provider, Sommer Livengood, who is an advanced nurse practitioner, filled out part of the form as well. She listed his diagnoses as chronic pain, cervical stenosis, migraine headaches, and depression. She wrote that his disability began prior to her initial evaluation and treatment of Plaintiff on October 15, 2012. When asked if Plaintiff could work with job modifications or restrictions, she wrote that "depending [on] job requirements absences for 'flare ups' would occur." *Id.*

MetLife contacted L.B. Benefits and talked to Vice President Scott Lohman. Lohman informed MetLife that Plaintiff quit his job by leaving at lunch on May 19, 2011, and not returning.[2] MetLife then denied Plaintiff's claim in a letter dated May 10, 2013. It explained that because his coverage ended on May 19, 2011 and the first date of treatment listed on his claim form was October 15, 2012, Plaintiff was not eligible for benefits. The letter also stated that if he intended to appeal, he needed to explain why he did not comply with the 90-day notice requirement.

On May 21, 2013, Plaintiff wrote MetLife a letter explaining that he "first became ill" and visited a doctor, Todd Wenck, in 2005. Admin. Rec. Part VI, at MET01079. He stated that he was seeing another doctor for chronic back pain as well, and that his symptoms worsened over the following six years. He said that because it was becoming more difficult to do his job, he was missing work often, to the point that he resigned on May 19, 2011. He said he contacted L.B. Benefits in June 2011, but someone named Karri Poole told him he could not turn in a claim. He said that after he was hospitalized the following summer, he contacted L.B. Benefits again. The same woman advised him again that he could not turn in a claim. After he was

[2] Plaintiff asserts, without documentation, that Scott Lohman did not oversee his employment and was not aware that he had emailed his direct supervisor, Brett Lohman, a resignation letter, which explained that he was resigning due to his failing health. Pl.'s Resp. Def.'s Mot. Summ. J. 12–13.

diagnosed with more illnesses, and "[u]pon hearing that [he] may not get better, [he] decided to file a long term disability claim." *Id.* at MET01080. He explained that he "did not pursue a claim persistently because [he] hoped to get better." *Id.*

Plaintiff submitted a new claim form on June 17, 2013. He filled out the section to be completed by his attending physician, listing May 19, 2011 as the date his disability began and June 23, 2005 as his initial date of treatment. He listed headaches and depression as the primary and secondary diagnoses and "insomnia, fatigue, exhaustion" as objective findings. *Id.* at MET01077. Dr. Wenck signed the form. Plaintiff also submitted medical records dating back to 2005. On June 27, 2013, Ms. Livengood filled out another attending physician statement. She wrote that Plaintiff had headaches most days and pain daily from cervical stenosis. She indicated that he was unable to engage in stressful situations or interpersonal relationships. She did not indicate any other functional limitations, even though there were spots to indicate if there were limits on his ability to sit, stand, walk, and lift. She did not answer the question of whether he was totally disabled. Dr. Andrew Stevenson, an ear, nose, and throat specialist, filled out an attending physician statement on June 28. Plaintiff's initial date of treatment with Dr. Stevenson was listed as August 14, 2012. Dr. Stevenson noted that he had not advised Plaintiff to cease working in his occupation and left blank the questions about psychological and physical limitations and whether Plaintiff was disabled.

On August 19, 2013, after a review of the newly submitted medical records, MetLife again denied Plaintiff's claim. It explained that he did not meet the plan's definition of disability. Through an attorney, Plaintiff appealed this decision on February 25, 2014. MetLife consulted two doctors to review Plaintiff's medical records. On May 13, 2014, it upheld its

denial of benefits. It again stated that Plaintiff did not satisfy the definition of disability as of May 19, 2011 through the 90-day elimination period and beyond.

II. Documentation in MetLife's Record

a. Pre-May 19, 2011 Medical Evidence

On June 23, 2005, Plaintiff saw Dr. Todd Wenck for the first time. He complained of depression and Dr. Wenck prescribed him fluoxetine, an antidepressant. Dr. Wenck also ordered a sleep study to rule out other causes of his symptoms. At a follow up appointment on July 10, Plaintiff explained that his symptoms had not improved and that he was easily tired, so Dr. Wenck prescribed Paxil, to replace the fluoxetine.

On August 3, Plaintiff did a sleep study at the Mississippi River Valley Sleep Disorder Clinic. Notes from the study indicate that he presented "with complaints of fatigue, daytime sleepiness, restless sleep and muscle tension." Admin. R. Part II, at MET00300, ECF No. 37-2. Dr. Ashkay Mahadevia, who oversaw the study, concluded that Plaintiff exhibited a "mild degree of snoring" and had "mild to moderate obstructive sleep apnea." *Id.* at MET00301. He recommended that Plaintiff use nasal continuous positive airway pressure ("CPAP") therapy.

On August 23, Plaintiff followed up with Dr. Wenck. He told Dr. Wenck that many nights he woke up frequently. Dr. Wenck noted that Plaintiff was "still able to do his job," but that the sleep problem was starting to affect it. *Id.* at MET00389. Plaintiff also told Dr. Wenck that he was having headaches, which Dr. Wenck thought could be related to either the depression or the sleep apnea. On September 6, Plaintiff went back to the sleep clinic and Dr. Mahadevia found that he would benefit from using CPAP therapy at home.

On October 31, Plaintiff had a follow up appointment with Dr. Wenck. He stated that he was doing much better and sleeping better using the CPAP therapy. He did note that he

developed headaches in the back of his neck on an almost daily basis, but that sleep made them go away. Plaintiff was taking Ambien, but Dr. Wenck prescribed temazepam, another insomnia treatment, instead. Dr. Wenck noted that they could try a low dosage of amitriptyline if the headaches did not go away.

On March 16, 2006, Plaintiff went back to Dr. Wenck, complaining of frequent headaches, which he thought might be related to stress. He also complained of continuing problems with insomnia. But Dr. Wenck noted that he could "continue to function." *Id.* at MET00393. Amitriptyline was prescribed. On April 18, 2006, he went back to Dr. Wenck and noted that his headaches had decreased in severity. He was still having them most days, but they were "much less severe." *Id.* at MET00396. His condition seemed "to be much improved" and Plaintiff was "ecstatic about how things [were] going." *Id.* at MET00397.

Plaintiff did not see Dr. Wenck again until December 5, 2007. He was concerned about high blood pressure, but noted that he was having some problems with headaches as well. Although the headaches were daily, they were better than they had been in the past. He also noted some tingling in his left hand, but it was barely noticeable and he had no pain. He was prescribed Prinzide to treat his high blood pressure. A few months later, Plaintiff went back to Dr. Wenck to follow up on his high blood pressure, but also presented complaints of anxiety. Plaintiff had generally been feeling well, but during the week prior to the appointment had some problems with headaches. Dr. Wenck directed Plaintiff to continue on his current course of medication, including the amitriptyline.

Plaintiff saw Dr. Wenck again on September 30, 2008, for a follow up on his high blood pressure and hyperlipidemia, or elevated lipid levels in the blood. He was generally feeling well, and was taking medications for the high blood pressure. Dr. Wenck noted that "[a]s long as he

takes his bp meds he is not having problems with [headaches]." Admin. R. Part III, at MET00427, ECF No. 37-3. Plaintiff felt his headaches were "doing ok." *Id.*

In January 2009, he had another follow up appointment regarding his hyperlipidemia, high blood pressure, and headaches. He had stopped taking the amitriptyline and the headaches returned. Plaintiff believed the headaches might be related to his blood pressure, so Dr. Wenck increased the dosage of his blood pressure medication. Plaintiff was also prescribed Vicodin. In April, he saw Dr. Wenck again, complaining of testicular pain. He thought he had a disc injury because he had been having low back pain and spasms in his neck. The records of this appointment indicate that Plaintiff was once again taking the amitriptyline. In May 2009, he had a follow up appointment for his testicular pain. He noted that he stopped taking the amitriptyline and did not feel any different with respect to his headaches.

Dr. Wenck saw Plaintiff again on July 14 to follow up on the hyperlipidemia. Plaintiff noted that he continued to have periodic headaches. He was prescribed Xanax for periodic worry. In November, he was seen again regarding his high blood pressure and hyperlipidemia. At that time, he was taking Zoloft, Xanax, and blood pressure and cholesterol medications. He reported no headaches.

In February 2010, Plaintiff saw Dr. Wenck to follow up on his depression. He had been fatigued for two and a half weeks and had some headaches. This caused him to neglect house work and showering and miss two days of work. He stated that taking Xanax seemed to make his headaches go away. Dr. Wenck noted that Plaintiff's headaches seemed to be related to his anxiety and suggested considering a psychiatric evaluation if they did not improve. Plaintiff stopped taking Zoloft, and was prescribed fluoxetine and clonazepam.

On March 11, Plaintiff saw Dr. Wenck again to follow up on his high blood pressure and hyperlipidemia, but they discussed his recurring headaches as well. He was directed to continue with his medication. On March 19, Plaintiff saw Dr. Stewart Garneau, a hematologist, to discuss his anemia and elevated ferritin level. Plaintiff told Dr. Garneau that he had been having headaches for the past three years, but that they had not gotten worse. On September 9, Plaintiff saw Dr. Wenck again. He was "generally feeling well" and denied having any headaches. *Id.* at MET00465. His anxiety was being controlled by the clonazepam and fluoxetine and he felt "back to his 'old self.'" *Id.*

On May 6, 2011, he saw Dr. Wenck to discuss his hyperlipidemia and high blood pressure. Plaintiff reported that his biggest concern at that time was headaches. Over the few weeks preceding the appointment, his headaches had been bad and he noted that had to miss work. Plaintiff felt that stress and anxiety were contributing to his headaches. He also told Dr. Wenck that he was taking double his prescribed dose of clonazepam. Dr. Wenck doubled his prescription dosage, but would not go higher. Dr. Wenck also noted that he did not want to prescribe Vicodin because he was "concerned about possible overuse." *Id.* at MET00474.

Throughout this time period, Plaintiff was also taking hydrocodone and hydrocodone-acetaminophen for pain. He was seen by Dr. Kerry Panozzo every so often to monitor these prescriptions, and she noted that he was doing quite well on the hydrocodone and managing his pain. *See, e.g.*, Admin. R. Part II, at MET00325. He was seen at a pain management center on August 13, 2008 and April 14, 2011. On both of these occasions, he had lumbar epidural steroid injections, a procedure used to help reduce spine pain and inflammation.

b. Post-May 19, 2011 Medical Evidence

Plaintiff did not see Dr. Wenck again until February 2012. He went for a follow up on his high blood pressure, but his "biggest concern" was headaches. Admin. R. Part III, at MET00477. He had not been sleeping and was under a lot of stress since he quit his job. He told Dr. Wenck that he had weaned himself off of clonazepam quickly and was having withdrawal symptoms. Dr. Wenck prescribed a course of clonazepam to medically wean him off over the next six weeks. Plaintiff saw Dr. Wenck again on May 24, 2012 to follow up on his anxiety. Plaintiff was unable to wean himself off of clonazepam, and noted that if he did not use the clonazepam, he would get headaches and a loss of energy.

In June 2012, Plaintiff went to the hospital complaining of abdominal pain, nausea, and vomiting. He also reported that he had a headache that had gotten worse in the last couple weeks. He was evaluated by Dr. Bassam Assaf, who advised Plaintiff "that his headache is likely related to depression and is consistent with tension-type headache." Admin. R. Part II, at MET00347. He was diagnosed with headaches as a manifestation of his depression. Dr. Assaf ordered magnetic resonance imaging ("MRI") of Plaintiff's brain, which showed a chronic sinus infection. In August, Plaintiff had an MRI taken of his neck. It showed some desiccation, or drying, of disks and moderate disk space narrowing. Admin R. Part III, at MET00487. The interpreting radiologist concluded that he had "[m]ultilevel degenerative disk disease . . . but no focal disk herniation." *Id.*

On August 14, Plaintiff was seen by Dr. Stevenson for the first time. Dr. Stevenson ordered a computerized tomography scan, and in September, they had a follow up appointment to discuss the results. Plaintiff reported that he continued to have headaches and facial pain, "so bad sometimes that he is not able to work." Admin. R. Part II, at MET00309. While Dr.

Stevenson warned that it may not resolve his headaches, Plaintiff wanted to pursue sinus surgery. On October 15, Plaintiff saw Ms. Livengood for the first time to get clearance for the surgery. She noted that his active problems included migraine headaches and spinal stenosis. He denied having depression or anxiety. Her assessment was insomnia, chronic sinusitis, chronic pain, hypertension, and cervical spine stenosis. Plaintiff had the sinus surgery and followed up with Dr. Stevenson on November 5. He reported that he continued to have pressure and pain. At a second follow up, he reported some improvement in his symptoms.

Plaintiff saw Ms. Livengood again on November 20, 2012 complaining of back pain and body aches. She discussed the results of his August MRI with him, noting that the MRI showed "some arthritis." *Id.* at MET00258. She ordered an MRI of Plaintiff's back, which was completed on November 28. The MRI showed mild diffuse disk bulge and narrowing on a few of his vertebrae.

On March 21, 2013, Plaintiff saw Ms. Livengood again to discuss his headaches. He told her that he had had a headache every day since January 20 of that year. He was prescribed gabapentin and sumatriptan. At appointments on April 18, June 25, July 31, September 6, and October 7, Plaintiff continued to complain about headaches. At the October 7 appointment, he told Ms. Livengood that he had stopped taking one medication on his own and restarted gabapentin with an increased dosage. He also had an old prescription for trazodone, an antidepressant, that he began taking. He noted that his pain, sleeping, and headaches were better.

On October 9, 2013, Ms. Livengood filled out a Residual Functional Capacity Questionnaire for Plaintiff. She noted that he had diagnoses of cervical spinal stenosis, depression, headache, and low back pain. Given the longevity of symptoms, she assessed his prognosis as fair. She listed his symptoms as pain (in the neck and low back), headaches,

fatigue, and depression. She noted that his impairments started prior to her first evaluation of him. She indicated that he would frequently experience pain severe enough to interfere with the attention and concentration needed to complete simple work tasks. She thought he would be capable of performing a low stress job. She estimated that he could walk two or three city blocks without rest or severe pain. She estimated that he could sit for one to two hours without needing to get up and that he could stand for one hour at a time before needing to sit down or walk around. She also indicated that he could sit for about two hours total and stand or walk for less than two hours total in an eight hour workday. She noted that he could frequently lift less than ten pounds, occasionally lift ten to twenty pounds, and rarely if ever lift fifty pounds. She also noted that his impairments were likely to produce good and bad days and that he might need to be absent from work more than four days a month.

On December 17, 2013, Plaintiff was seen by a neurologist, Dr. Michael Cullen. After testing, Dr. Cullen was "unable to provide an exact explanation for [Plaintiff's] symptomatology." *Id.* at MET00234. He suggested psychological influences and recommended that Plaintiff take Mobic, an anti-inflammatory drug, in addition to the gabapentin and cyclobenzaprine he was already taking.

Plaintiff saw Ms. Livengood again on December 20, 2013. He complained of pain in the right side of his face, his neck, and his low back. He was dissatisfied with Dr. Cullen's diagnosis that his symptoms were psychological. Ms. Livengood prescribed Wellbutrin for depression. She also noted that she was suspicious, but did not confirm, that Plaintiff was suffering from trigeminal neuralgia, a condition involving the fifth cranial nerve that causes episodes of severe facial pain. According to an information sheet she provided to Plaintiff, this condition does

cause activity limits, but those suffering need to avoid "blasts of hot or cold air." *Id.* at MET00294.

c. Witness Letters

In addition to medical records, Plaintiff submitted witness letters to MetLife for consideration of his appeal. He submitted letters from his sister, mother, father, ex-wife, and former supervisor, David Ellison. All of the letters explained that over the past few years, Plaintiff's health had declined. His witnesses reported that he had complained of headaches, fatigue, and pain, and that his functioning had severely diminished.

d. **File Reviews**

In considering Plaintiff's appeal, MetLife had two doctors review his medical records: Dr. Arousiak Varpetian, who is board certified in neurology and internal medicine, and Dr. Marcus Goldman, who is board certified in psychiatry. Dr. Varpetian reviewed all of the submitted medical records and spoke with Ms. Livengood.[3] Dr. Varpetian concluded that the documentation provided did not support finding that Plaintiff had a functional limitation as of May 19, 2011. She explained that most of his examinations revealed no physical or neurological basis for his symptoms. His MRIs, though they showed mild degeneration and bulges, did not support a finding of an impairment or deficit. She also concluded that "[t]he records do not demonstrate headaches, which were so severe as to cause any impairment." Admin. R. Part I, at MET00127, ECF No. 37-1. Furthermore, she concluded that Ms. Livengood's functional capacity questionnaire recommendations were not consistent with examination results.

Ms. Livengood responded to Dr. Varpetian's report, disagreeing with the conclusion that the functional capacity recommendations were not consistent with clinical findings. She pointed

[3] Although Dr. Varpetian attempted to make contact with Dr. Wenck, he declined to speak with her because he had not treated Plaintiff for a few years.

out that Plaintiff subjectively reported that pain limited his ability to function normally. Dr. Varpetian reconsidered the records after receiving Ms. Livengood's response, as well as a response from Plaintiff's attorney, but reached the same conclusion. She explained that "subjective complaints are important in determining function," but "usually subjective complaints eventually reveal a medical or neurological abnormality to explain the subjective symptoms." *Id.* at MET00095. One was never found in Plaintiff's case.

Dr. Goldman, a psychiatrist, also reviewed all of Plaintiff's medical records and spoke with Ms. Livengood. He explained that Plaintiff's "[r]eturn to work issues are in the context of subjective complaints of pain." *Id.* at MET000131. He stated that for a record so large, "documentation is sparse and poorly comprehensive from a psychiatric perspective," *id.* at MET000133, and pointed out that Plaintiff never had any psychological testing or diagnostic mental health assessments. Dr. Goldman concluded that there was no data to support an impairment of his cognitive functioning. Ms. Livengood responded only to say that Plaintiff was not seeking psychiatric healthcare because he could not afford it.

III. Work History

Scott Lohman provided MetLife with a description of Plaintiff's job at L.B. Benefits. It required five to six hours of sitting every day and one to two hours of both standing and walking. It also required occasional (one to thirty three percent of the time) lifting of up to ten pounds, frequent (thirty four to sixty six percent of the time) engagement in interpersonal interactions, and occasional stressful situations. Driving was also required.

Lohman also told MetLife that Plaintiff missed work occasionally for his daughter, but not for his own health. He stated that Plaintiff took three weeks of paid vacation and three paid sick days a year. Plaintiff, without pointing to specific pages, states that the administrative

record shows that he called in sick to work twenty six times in the year preceding his resignation. He also points out that he was hospitalized for pancreatitis, and thus missed work, from October 5 until October 12, 2010.

After he resigned from L.B. Benefits, Plaintiff briefly worked for a competing agency, Maynard Ellison Insurance. He asserts that he rarely went into the office, stayed only for a few hours when he did, and ultimately parted ways with the company without receiving any commissions. He then opened his own insurance agency, incorporating it online in November 2011. He sold a few policies to friends and families, but has not had any active business since September 2012. His tax records show that he made no income in 2012.

IV. Lawsuit

After Plaintiff's claim was denied in 2014, he sought information on the deadline for filing a lawsuit from MetLife. At first he was told there was no deadline, but he was eventually informed of a November 2014 deadline after it passed. He filed his lawsuit in this Court on August 11, 2015. Compl., ECF No. 1. He brought state law claims for unfair insurance practices and misrepresentation against MetLife and two MetLife employees. These claims were dismissed on August 15, 2016, but the Court construed his complaint to include a claim under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a)(1)(B), to recover benefits he was entitled to under the terms of his plan. Order, ECF No. 26. Plaintiff moved for summary judgment on this remaining claim on November 16, 2016. MetLife moved for summary judgment, or judgment under Rule 52(a), on February 3, 2017. Plaintiff then moved to add into the summary judgment record a page from a social security decision.

DISCUSSION

I. Motion to Add Social Security Judge's Finding of Facts and Conclusions of Law

Plaintiff filed a motion to add into evidence statements from a social security decision finding him disabled under the Social Security Act. Mot. Add, ECF No. 40. He attached only one page of the decision, however. The proposed exhibit does not contain an explanation of what evidence was considered, the reasoning for the decision, or even the judge's signature. MetLife responded opposing the exhibit's admission. Resp. Mot. Add, ECF No. 41.

At the summary judgment stage, courts can consider "any material that would be admissible or usable at trial, including properly authenticated and admissible documents or exhibits." *Smith v. City of Chicago*, 242 F.3d 737, 741 (7th Cir. 2001) (internal quotation marks omitted). A social security decision may be a public record. But for a public record to be self-authenticating, it needs to either bear a signature and seal, *see* Fed. R. Evid. 902(1), bear a signature of an officer of the entity producing the record and a certification that the signature is genuine, *see id.* at 902(2), or be a certified copy, *see id.* at 902(4). This document has neither a signature nor a seal, or even a heading that indicates it comes from the Social Security Administration ("SSA"). Additionally, the report includes out-of-court statements offered to prove the truth of what they assert, and thus is hearsay. *Id.* at 801(c). Public records are generally not excluded under the rule against hearsay, but only if the record sets out the office's activities and "the opponent does not show that the source of information or other circumstances indicate a lack of trustworthiness." *Id.* at 803(8). Here, the document is incomplete so Plaintiff cannot establish that it would meet the requirements for the public record hearsay exception. Moreover, without the rest of the decision, the relevance of a SSA judge's conclusion that

Plaintiff is disabled to this case is not evident. Because this page would be inadmissible, Plaintiff cannot rely on it at summary judgment. The motion to add it into evidence is DENIED.

II. Motions for Summary Judgment

a. Legal Standard

Summary judgment is appropriate "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). At the summary judgment stage the court's function is not to weigh the evidence and determine the truth of the matter, but to determine whether there is a genuine issue for trial—that is, whether there is sufficient evidence favoring the non-moving party for a factfinder to return a verdict in its favor. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 249 (1986); *Patel v. Allstate Ins. Co.*, 105 F.3d 365, 370 (7th Cir. 1997). The court must view the evidence in the light most favorable to the non-moving party and draw all reasonable inferences in that party's favor. *McCann v. Iroquois Mem'l Hosp.*, 622 F.3d 745, 752 (7th Cir. 2010) (citing *Anderson*, 477 U.S. at 255). "A genuine issue for trial exists only when a reasonable [factfinder] could find for the party opposing the motion based on the record as a whole." *Pipitone v. United States*, 180 F.3d 859, 861 (7th Cir. 1999) (quoting *Roger v. Yellow Freight Sys., Inc.*, 21 F.3d 146, 149 (7th Cir. 1994)).

The movant in a summary judgment motion bears the initial burden of production; it must point the court to the materials in the record that "demonstrate the absence of a genuine issue of material fact" for trial. *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). Where the nonmovant bears the ultimate burden of persuasion on a particular issue, however, the movant can meet its initial burden by showing "that there is an absence of evidence to support the nonmoving party's case." *Modrowski v. Pigatto*, 712 F.3d 1166, 1168 (7th Cir. 2013) (internal

quotation marks omitted). Once the movant discharges its initial burden, the burden shifts to the nonmovant to "make a showing sufficient to establish the existence of an element essential to that party's case." *Celotex*, 477 U.S. at 322.

b. Standard of Review for an ERISA Claim

A plan participant can bring an action under ERISA "to recover benefits due to him under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B). A denial of benefits is "reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility or to construe the terms of the plan." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). Here, the plan requires submission of proof of a disability and defines proof as "[w]ritten evidence satisfactory to" MetLife. Admin. R. Part VII, at MET01118. As this does not clearly grant MetLife discretionary authority, the de novo standard applies. *See Patton v. MFS/Sun Life Fin. Distribs., Inc.*, 480 F.3d 478, 486 (7th Cir. 2007) ("[P]lan terms requiring only that proof 'satisfactory to us' be submitted for benefits are not sufficiently clear to limit review.").

The ultimate question for the Court is whether Plaintiff is entitled to benefits under the policy, and under the de novo standard, it "must come to an independent decision on both the legal and factual issues that form the basis of the claim." *Diaz v. Prudential Ins. Co. of Am.*, 499 F.3d 640, 643 (7th Cir. 2007). "What happened before the Plan administrator or ERISA fiduciary is irrelevant." *Id.* The Court must "interpret the terms of the policy in an ordinary and popular sense, as would a person of average intelligence and experience, and construe all plan ambiguities in favor of the insured." *Santaella v. Metro. Life Ins. Co.*, 123 F.3d 456, 461 (7th Cir. 1997) (internal quotation marks omitted).

c. Plaintiff's Motion for Summary Judgment

Plaintiff seeks summary judgment on his ERISA claim. He seems to argue that he is entitled to relief because his treating providers have consistently said that he is disabled and unable to work. Pl.'s Mot. Summ. J. Br. 3, ECF No. 33. He also argues that MetLife's reviewers provide no support for finding him ineligible because they did not examine him. *Id.* at 2. He cites to no evidence to support his argument that he is entitled to benefits under the policy. He has not met his burden of showing that there is no genuine dispute for trial. He also argues that he was sabotaged by MetLife's failure to provide him with the proper deadline for filing a lawsuit. But MetLife is not asserting that his suit is time-barred under the terms of the policy. Def.'s Mot. Summ. J. Br. 56, ECF No. 36. The issue is moot. Plaintiff has not established that he is entitled to summary judgment on any issue. His summary judgment motion is denied.

d. MetLife's Motion for Summary Judgment[4]

MetLife argues that Plaintiff has not met his burden of showing that he is entitled to benefits under the plan. It argues both that Plaintiff has failed to prove that he submitted his claim in accordance with the plan and that he has not shown that he satisfied the definition of disability under the policy. Def.'s Mot. Summ. J. Br. 44–54. Plaintiff argues, in essence, that the evidence in the administrative record does support a finding that he was disabled. He also

[4] MetLife argues that the Court could also grant judgment under Federal Rule of Civil Procedure 52(a). Rule 52(a) has been endorsed as a proper procedural mechanism for ERISA claims like Plaintiff's. *See Hess v. Hartford Life & Accident Ins. Co.*, 274 F.3d 456, 461 (7th Cir. 2001). But "[a]s a general rule, the conversion of cross-motions for summary judgment into a summary bench trial on the papers is appropriate only when the parties have so stipulated." *Gardner v. Ameritech Sickness & Accident Disability Plan*, No. 08-cv-1007, 2009 WL 3188302, at *12 (C.D. Ill. Sept. 30, 2009). Here, although there are cross motions for summary judgment and MetLife is willing to have judgment entered based on the administrative record attached to its summary judgment motion, there has been no clear stipulation by Plaintiff. *See* Pl.'s Report of Rule 26(f) Planning Meeting, ECF No. 29 (stating that Plaintiff thinks additional discovery is necessary); Pl.'s Mot. Summ. J. Br. 3 (noting that if the Court does not grant him summary judgment, "the Court should identify any Disputes of Fact and thus narrow the scope of Evidence the Court wishes to receive at Trial."). The Court will not decide this case under Rule 52(a).

argues that MetLife cannot rely on the timeliness of his claim submission because that was not the basis of its decision to deny his claim. Pl.'s Resp. Def.'s Mot. Summ. J. 3–6.[5]

Plaintiff bears the burden of showing his entitlement to benefits. *Cheney v. Standard Ins. Co.*, 831 F.3d 445, 451 (7th Cir. 2016). Thus, in the context of this summary judgment motion, the question is whether Plaintiff, as the non-moving party, has made "a showing sufficient to establish" his entitlement to benefits under the policy. *See Celotex*, 477 U.S. at 322.

i. Timeliness of Notice and Proof

MetLife argues that the notice and proof provisions in the policy are prerequisites to coverage, and that Plaintiff's failure to comply with them defeats his claim. Plaintiff argues that because MetLife did not rely on this in denying his claim, it is foreclosed from doing so now. Pl.'s Resp. Def.'s Mot. Summ. J. 3–6. However, the cases Plaintiff cites to were decided under an arbitrary and capricious standard, which applies if the plan gives discretionary authority to the plan administrator. *See Levinson v. Reliance Standard Life Ins. Co.*, 245 F.3d 1321, 1326 (11th Cir. 2001). Under the de novo standard that applies in this case, the Court must independently determine whether Plaintiff is entitled to benefits; MetLife's prior decisions are irrelevant.

Compliance with notice and proof provisions can be a prerequisite for coverage under an insurance policy. *See Zamecnik v. Abbco, Inc.*, 237 F. App'x 102, 104 (7th Cir. 2007). Under the policy in this case, notice and proof of a claim are supposed to be provided to MetLife within 90 days of the date of a loss. But a "delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible." Admin. R. Part VII, at MET01140. Although Plaintiff claims that his disability, and his disability benefit coverage, began on May 19, 2011, he did not file his claim until almost two years later on May 6, 2013.

[5] Plaintiff also appears to try to re-argue his unfair insurance practices and misrepresentation claims at the end of his response to MetLife's motion for summary judgment. Pl.'s Resp. Def.'s Mot. Summ. J. 3–12, ECF No. 42-3. These claims were dismissed by the Court on August 15, 2016. Order, ECF No. 26. The Court will not address them.

In *Zamecnik*, the Seventh Circuit upheld a grant of summary judgment to an insurance company on a claim similar to Plaintiff's. The plaintiff filed a claim for disability benefits sixteen months after the date he alleged his disability began, which was his last day of work. *Zamecnik*, 237 F. App'x at 103. His policy required notice within thirty days, or as soon as reasonably possible. *Id.* at 104. He admittedly never explained why he delayed filing his claim, but the court noted that it could "discern nothing that would have excused a delay of this length if Zamecnik really did become disabled before he ceased working." *Id.* at 104–05.

Here, unlike the plaintiff in *Zamecnik*, Plaintiff did explain why he delayed filing his claim. First, he asserts that in the months right after he resigned, L.B. Benefits told him that he was not able to file a claim and that it would not assist him in filing a claim. But he eventually did file a claim without L.B. Benefit's help, which he could have done at any time. Second, he asserts that he did not pursue his claim until he realized he might not get better. Essentially, his explanation seems to be that he waited until his conditions became permanent and he knew he would not recover. There is no evidence that he was physically unable to provide notice until two years after his alleged date of disability. And this medical condition was not new; he relies on medical evidence that was already in existence to try to prove that he was disabled as of May 19, 2011, so he did not need extra time to gather medical documentation. It strains the ordinary and popular meaning of "as soon as is reasonably possible," to conclude that it was not reasonably possible for Plaintiff to submit his claim for a disability that allegedly began in May 2011 until it got worse two years later. No reasonable factfinder could conclude that Plaintiff complied with the notice and proof provisions of the policy. As such, he cannot meet his burden of proving that he was entitled to coverage under the policy.

ii. Definition of Disability

MetLife also argues that even had Plaintiff provided notice and proof within the time limits prescribed by the policy, he cannot establish that there is a genuine issue that he met the policy's definition of disability as of May 19, 2011. Def.'s Mot. Summ. J. Br. 49–54. Plaintiff's coverage under the policy ended on his last day of employment, and thus he needs to show that he was disabled as of that date. To be considered disabled under the policy, an individual needs to have an illness or disease that causes him to be unable to earn more than 80 percent of his predisability earnings in the same job that he held before he was disabled. Proof needs to establish this disability as of the date of onset, throughout the 90-day elimination period, and throughout the following 36 months.[6] To meet his burden on summary judgment, Plaintiff needs to show that there is sufficient proof that he was disabled as of May 19, 2011, and throughout the 90-day elimination period.

He is unable to do so. Plaintiff's clearest medical evidence showing that he had functional limitations as a result of his headaches, depression, and chronic pain comes from Ms. Livengood, who did not first see Plaintiff until October 2012. Although Plaintiff attempts to use this evidence to show that his condition was ongoing, evidence that he met the definition of disability in 2012 and 2013 or that his condition worsened in that time does not establish that he met the plan's definition of disability as of May 2011. *Cf. Ball v. Standard Ins. Co.*, No. 09 C 3668, 2012 WL 2115484, at *5 (N.D. Ill. June 7, 2012) ("Ms. Ball attempts to bolster her claim by underscoring later medical issues . . . . However, none of these issues are applicable to her instant claim for disability.").

[6] There is a second part to the definition, which requires being unable to work at any occupation after the elimination period and next 36 months. Plaintiff is unable to meet the first part of the definition, so the Court does not address the second.

From 2005 until 2011, Plaintiff saw Dr. Todd Wenck fairly regularly. He complained of headaches, but often noted that his condition had improved while taking medication. He also took various antidepressants, anti-anxiety, and pain medications over the years. But there is nothing in the medical records to indicate that Plaintiff's headaches and pain during this time were severe enough to limit his ability to work. On May 6, 2011, Plaintiff told Dr. Wenck that he had to miss work for his headaches. But this does not clearly suggest that he had a condition that fully limited his ability to work from May 19 through the next 90 days. Additionally, throughout this time, he saw Dr. Kerry Panozzo for pain relief, but she constantly noted that his pain was well-managed and that he was doing well on his medication. Only one doctor that Plaintiff saw during this time indicated that he was disabled—Dr. Wenck. But this documentation was filled out by Plaintiff and signed by Dr. Wenck. The form contained few details, and Dr. Wenck never opined on specific limitations caused by Plaintiff's conditions.

Plaintiff has also submitted no medical records that establish his condition between the day he resigned in 2011 and early 2012, when he saw Dr. Wenck again. From then on, Plaintiff's condition seemed to get worse. Ms. Livengood, Plaintiff's new primary care provider, filled out a Residual Functional Capacity Questionnaire about Plaintiff's abilities. She noted that he could only sit for a total of two hours in a work day, while the description provided by L.B. Benefits explained that he would need to sit for five or six to perform his job. She also noted that his pain could interfere with his ability to complete simple work tasks and that he could only perform a low stress job. While she noted that his impairments began prior to her first evaluation, this does not establish that the level of impairment described in her report dates back to the date that Plaintiff's coverage ended.

Plaintiff faults MetLife for relying on file reviews by physicians who never examined him. Pl.'s Resp. Def.'s Mot. Summ. J. 18. But because Plaintiff filed his claim two years after the day his disability allegedly began, a physical examination by MetLife doctors likely would not have been helpful in determining whether Plaintiff was disabled as of his alleged onset date. *Cf. Connelly v. Standard Ins. Co.*, 663 F. App'x 414, 418 (6th Cir. 2016) ("A physical exam would have been less helpful to determine whether Connelly was disabled during his coverage period, as Connelly did not file his claim until over a year after his coverage ended, and all parties agree that his condition worsened in the interim."). *See also Leger v. Tribune Co. Long Term Disability Benefit Plan*, 557 F.3d 823, 832 (7th Cir. 2009) (explaining that the Seventh Circuit has rejected the argument that opinions of doctors who only conduct medical file reviews should be considered presumptively invalid).

Both Dr. Varpetian and Dr. Goldman reviewed Plaintiff's records and determined that they did not establish that Plaintiff's symptoms caused limitations on his ability to function as of May 19, 2011. Dr. Goldman determined that the medical records did not establish that Plaintiff had a diagnosed mental health disorder; he had never had any diagnostic testing or psychiatric treatment. Ms. Livengood did not disagree, but rather contended that the failure to seek such treatment was for financial reasons. Dr. Varpetian concluded that the records did not support finding that Plaintiff was functionally limited as of May 19, 2011. She explained that while subjective complaints of pain are important in determining function, no medical or neurological abnormality was found to explain Plaintiff's symptoms.

The Seventh Circuit has cautioned against the dismissal of subjective complaints of pain in determining whether a claimant is disabled for purposes of an insurance plan. *See Diaz*, 499 F.3d at 645–46; *Hawkins v. First Union Corp. Long-Term Disability Plan*, 326 F.3d 914, 919

(7th Cir. 2003). But it has also explained that there is a distinction "between the amount of fatigue or pain an individual experiences, which . . . is entirely subjective, and how much an individual's degree of pain or fatigue limits his functional capabilities, which can be objectively measured." *Williams v. Aetna Life Ins. Co.*, 509 F.3d 317, 322 (7th Cir. 2007). While Ms. Livengood's October 2013 functional capacity recommendations were an objective measure of Plaintiff's functional limitations at that time—although the questionnaire does not explain what tests were completed or the data that backed up her recommendations—there is no evidence in the record that as of May 19, 2011, Plaintiff had similarly severe functional limitations. *See id.*

Plaintiff's coverage under the plan ended on the day he quit his job. To recover on his ERISA claim, he needed to show that he met the plan's definition of disability as of May 19, 2011 and throughout the 90-day elimination period. The medical records provided do not support a finding that his conditions caused functional limitations interfering with his ability to work before his coverage under the plan ended.

CONCLUSION

Accordingly, MetLife's summary judgment motion, ECF No. 35, is GRANTED. Plaintiff's summary judgment motion, ECF No. 32, and Motion to Add Social Security Judge's Finding of Facts and Conclusions of Law, ECF No. 40, are DENIED. The Clerk is directed to enter judgment and close the case.

Entered this 28 day of September, 2017.

s/ Sara Darrow
SARA DARROW
UNITED STATES DISTRICT JUDGE