IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STEPHEN D. BUCK, D.D.S.,

Plaintiff,

v.

UNUM LIFE INSURANCE COMPANY OF AMERICA, et al.,

Defendants

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No. C-08-5166 MMC

ORDER GRANTING IN PART AND DENYING IN PART DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

Before the Court is defendants Unum Life Insurance Company of America and Unum Group's (collectively "Unum") "Motion for Summary Judgment or, in the Alternative, for Summary Adjudication of Claims for Relief and Prayer for Damages," filed January 20, 2010. Plaintiff Stephen D. Buck, D.D.S. ("Dr. Buck") has filed opposition, to which Unum has replied. Having read and considered the papers filed in support of and in opposition to the motion, the Court rules as follows.[1]

BACKGROUND

The following facts are undisputed.

In 1984, Unum's predecessor issued to Dr. Buck a "Disability Income Policy" (the "1984 Policy") (see Horrow Decl., filed February 5, 2010, Ex. B), and, in 1986, Unum's predecessor issued to Dr. Buck a "Disability Income Policy (the "1986 Policy") (see id. Ex.

[1]By order filed February 24, 2010, the Court took the matter under submission.

C). "The combined monthly total disability benefits under the Policies is $10,433.00." (See Berryman Decl., filed January 20, 2010, ¶ 6.)

On June 4, 2007, Dr. Buck submitted to Unum a claim for disability benefits under both the 1984 Policy and the 1986 Policy. (See id. ¶ 7.) In his claim, Dr. Buck stated he was unable to perform the duties of his profession, described therein as "clinical dentistry," because of an "accident" that occurred on July 7, 2006, which caused him to incur "bilateral post traumatic carpel tunnel syndromes." (See id. Ex. C.) By letter dated July 25, 2007, Unum advised Dr. Buck that his claim for benefits under the two policies had been approved. (See id. Ex. F.)

By letter dated January 9, 2008, Unum advised Dr. Buck of Unum's position that Dr. Buck, in order to maintain his entitlement to benefits under the two policies, was required to undergo "surgery for carpal tunnel syndrome," specifically, "carpal tunnel release" surgery, and requested Dr. Buck notify Unum as to whether he was planning to have the surgery or, if he was not, to provide his reasons for such decision. (See id. Ex. U.) In response, Dr. Buck, by letter dated February 20, 2008, advised Unum he did not intend to have the referenced surgery, and set forth his reasons for such decision, specifically, that Gary A. Belaga, M.D. ("Dr. Belaga"), Dr. Buck's treating physician, was "not able to recommend carpel tunnel syndrome for [him]." (See id. Ex. V.)

On July 31, 2008, Unum advised Dr. Buck of its determination that, based on the opinions of three physicians with whom Unum had consulted, Dr. Buck was "an excellent candidate for carpal tunnel release" and that if he "underwent carpal tunnel surgery, [his] symptoms would reasonably be expected to resolve such that it would allow [him] to return to work in [his] occupation as a dentist." (See id. Ex. FF.) Although observing that it was Dr. Buck's "choice whether or not to have the carpal tunnel release procedures," Unum stated it had interpreted the policies as requiring Dr. Buck to "undergo reasonable curative and mitigating procedures," and that, in light of Dr. Buck's statement that he did not intend to undergo carpal tunnel release, he was "not eligible" for benefits under the policies. (See id.) Consequently, Unum informed Dr. Buck, his claim was "closed." (See id.)

Thereafter, on October 15, 2008, Dr. Buck filed the instant action.

LEGAL STANDARD

Rule 56 of the Federal Rules of Civil Procedure provides that a court may grant summary judgment "if the pleadings, the discovery and disclosure materials on file, and any affidavits show that there is no genuine issue as to any material fact and that the movant is entitled to judgment as a matter of law." See Fed. R. Civ. P. 56(c).

The Supreme Court's 1986 "trilogy" of Celotex Corp. v. Catrett, 477 U.S. 317 (1986), Anderson v. Liberty Lobby, Inc., 477 U.S. 242 (1986), and Matsushita Electric Industrial Co. v. Zenith Radio Corp., 475 U.S. 574 (1986), requires that a party seeking summary judgment show the absence of a genuine issue of material fact. Once the moving party has done so, the nonmoving party must "go beyond the pleadings and by [its] own affidavits, or by the depositions, answers to interrogatories, and admissions on file, designate specific facts showing that there is a genuine issue for trial." See Celotex, 477 U.S. at 324 (internal quotation and citation omitted). "When the moving party has carried its burden under Rule 56(c), its opponent must do more than simply show that there is some metaphysical doubt as to the material facts." Matsushita, 475 U.S. at 586. "If the [opposing party's] evidence is merely colorable, or is not significantly probative, summary judgment may be granted." Liberty Lobby, 477 U.S. at 249-50 (citations omitted). "[I]nferences to be drawn from the underlying facts," however, "must be viewed in the light most favorable to the party opposing the motion." See Matsushita, 475 U.S. at 587 (internal quotation and citation omitted).

DISCUSSION

In his complaint, Dr. Buck alleges, as the First Cause of Action, a claim for breach of the implied covenant of good faith and fair dealing, and, as the Second Cause of Action, a claim for breach of contract.

By the instant motion, Unum argues that Dr. Buck cannot establish Unum breached its contractual obligations when it terminated benefits, because, at the time of the termination, Dr. Buck had not undergone carpal tunnel release surgery, and that, under the

circumstances of this case, Dr. Buck's undergoing such surgery is a condition on his eligibility for benefits. Unum further argues that even if it is determined by the trier of fact that Unum incorrectly terminated benefits, Dr. Buck cannot establish a claim for breach of the implied covenant of good faith and fair dealing because there exists a genuine dispute as to coverage under both policies.

A. Claim for Breach of Contract

The 1984 Policy requires a claimant, in order to establish eligibility for disability benefits, to be "under the care of a physician other than [him]self." (See Horrow Decl. Ex. B at 6.) The 1986 Policy requires a claimant, in order to establish such eligibility, to be "receiving medical care from someone other than himself which is appropriate for the injury or sickness." (See id. Ex. C at 7.) The parties dispute the meaning of each "care" provision, and, specifically, whether such provisions, or either of them, condition eligibility for benefits on a claimant's submitting to particular medical care, including, in some instances, surgery.

Under California law, "interpretation of an insurance policy is a question of law." See Waller v. Truck Ins. Exch., 11 Cal. 4th 1, 18 (1995). "Words used in an insurance policy are to be interpreted according to the plain meaning which a layman would ordinarily attach to them." Reserve Ins. Co. v. Pisciotta, 30 Cal. 3d 800, 807 (1982). "Courts will not adopt a strained or absurd interpretation in order to create an ambiguity where none exists." Id. "On the other hand, any ambiguity or uncertainty in an insurance policy is to be resolved against the insurer and if semantically permissible, the contract will be given such construction as will fairly achieve its object of providing indemnity for the loss to which the insurance relates." Id. at 807-08 (internal citation, quotation, and alteration omitted); see also MacKinnon v. Truck Ins. Exch., 31 Cal. 4th 635, 655 (2003) (holding even if insurer's interpretation of ambiguous term is "considered reasonable, it would still not prevail, for in order to do so it would have to establish that its interpretation is the only reasonable one") (emphasis in original).

Because the language of the policies differs, the Court discusses each policy in turn.

1. 1984 Policy

The 1984 Policy, in relevant part, provides for a "Total Disability Benefit," as follows: "While you are totally disabled and under the care of a physician other than yourself, we will pay a monthly benefit beginning at the end of the applicable Elimination Period . . . ." (See Horrow Decl. Ex. B at 6.)[2] The parties dispute the meaning of the term "under the care of a physician." Although the term plainly requires a claimant to receive care for the disabling sickness or injury,[3] the parties dispute whether the term gives Unum the right to condition benefits on the claimant's receiving a particular type of care.

Neither party cites to any California state court decision that has interpreted disability policy language that is either identical to or similar to the policy language at issue herein. The Seventh Circuit, however, has considered language in a disability policy that is substantially similar to that at issue herein, and, further, has done so in the context of a factual scenario substantially similar to that presented herein. Specifically, in Heller v. Equitable Life Assurance Soc., 833 F.2d 1253 (7th Cir. 1987), the policy at issue therein provided: "[T]otal disability will not be considered to exist for any period during which the Insured is not under the regular care and attendance of a physician." See id. at 1255. As in the instant case, the insurer therein initially paid a claim for benefits based on disabling carpal tunnel syndrome, but later terminated benefits when the claimant declined to "undergo carpal tunnel surgery upon [the insurer's] insistence." See id. The Seventh Circuit found the term "under the regular care and attendance of a physician" to be "clear on its face to the average citizen," and that it meant that "the insured is obligated to

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[2]Under the 1984 Policy, a claimant is "totally disabled" if "as a result of sickness or injury, [the claimant] [is] unable to perform the material and substantial duties of [his] occupation." (See Horrow Decl. Ex. B at 5.) Unum has not argued that Dr. Buck is not "totally disabled" within the meaning of the 1984 Policy.

[3]There is no argument by Unum that Dr. Buck was not, at the time the claim was denied, regularly consulting with a physician with respect to his carpal tunnel syndrome. Indeed, the record supports a finding that Dr. Buck began to so consult with Dr. Belaga in October 2006, did so regularly through July 2008, when Unum terminated Dr. Buck's benefits, and continued to do so thereafter. (See, e.g., Humbert Decl., filed January 20, 2010, Ex. F at 13:17-19, 39:1-24, 43:5-21, 49:16-24, 50:15-22, 64:15-18, 79:15-80:3, 96:1-11, 97:22-25, 102:17-20, 105:18-106:16.)

periodically consult and be examined by his or her treating physician at intervals to be determined by the physician." See id. at 1257.

The Seventh Circuit rejected the insurer's proposed interpretation that the insurer could condition eligibility for benefits on the insured's subjecting himself to surgery to alleviate the disability, finding "[t]he clause, 'under the regular care and attendance of a physician,' was not intended to allow the insurer to scrutinize, determine, and direct the method of treatment the claimant receives." See id. ("We refuse to indulge in judicial activism and condition coverage under the contract on the insured's undergoing surgery, when the insurer failed to provide such a conditional clause in the policy.") Rather, Heller explained, "the purpose of the clause requiring the insured to be 'under the regular care and attendance of a physician' is to determine that the claimant is actually disabled, is not malingering, and to prevent fraudulent claims." See id. (citing Russell v. Prudential Ins. Co., 437 F.2d 602, 607 (5th Cir. 1971) (holding "the sole purpose of the provision requiring the regular care of a physician is to allow the insurer the means to assure itself of the fact that the insured is actually disabled")); see also Eichacker v. Paul Revere Life Ins. Co., 354 F.3d 1142, 1148 (9th Cir. 2004) (observing "many courts," including Heller and Russell, "have noted that the primary rationale for the physician's care requirement is to assure that the claimant is actually disabled, is not malingering, and is not making a fraudulent claim"; citing with approval New York state court decision holding "the purpose of the physician's care requirement is to guard against fraud").

The Court finds the Seventh Circuit's analysis persuasive,[4] and finds the term "under the care of a physician" does not condition eligibility for benefits on the insured's submitting to surgery to treat the disability.[5]

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[4]Although Heller was decided under Illinois law, the Court finds no material distinction exists between California and Illinois law with respect to the interpretation of insurance policies. See id. at 1256 (observing "Illinois courts apply the rule that any ambiguities in the provisions of an insurance policy will be construed against the drafter of the instrument, the insurer, and in favor of the insured").

[5]Heller did not purport to reach the question of whether less invasive forms of medical treatment could be required by an insurer, nor is that question presented herein.

The Court has considered the reasoning set forth in Provident Life and Accident Ins. Co. v. Van Gemert, 262 F. Supp. 2d 1047 (C.D. Cal. 2003), upon which Unum relies, but does not find the case persuasive to the extent it is inconsistent with Heller. In particular, for the reasons set forth in Heller and the above-cited cases consistent with the Seventh Circuit's reasoning, the Court disagrees with Van Gemert to the extent the district court interpreted the term "under the care and attendance of a physician" to include an "implied" requirement that the care be "appropriate." See id. at 1050-51.

Further, the Court is not persuaded by Van Gemert's attempt to distinguish Heller on the basis of the implied covenant of good faith and fair dealing. See id. at 1051 (finding Heller distinguishable because "California law is informed by the covenant of good faith and fair dealing, which is implied into all California contracts, including those for insurance"). Both California and Illinois recognize such implied covenant. See Prudential Ins. Co. v. McCurry, 492 N.E. 2d 1026, 1028 (Ill. App. Ct. 1986) ("It is well established in Illinois, as in the majority of American jurisdictions, that a covenant of good faith and fair dealing is implied in every contract as a matter of law, absent an express disavowal.").

Additionally, to the extent Van Gemert holds the implied covenant of good faith and fair dealing is "reciprocal," see Van Gemert, 262 F. Supp. 2d at 1051, such holding is not inconsistent with the reasoning of Heller. See Heller, 833 F.2d at 1259-60 (acknowledging duty of good faith but finding "[t]he record clearly establishes that Dr. Heller acted in good faith"). Evidence that, for example, an insured is refusing, in bad faith, to submit to reasonable curative measures may well support a finding that the insured is in breach of the implied covenant. Here, however, as in Heller, there is no evidence to support a finding that the insured's refusal to undergo surgery was based on anything other than an honestly held belief that such surgery was not in the his best interest.[6]

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[6]The Court further notes that neither party has addressed whether imposing on an insured a duty to submit to reasonable curative and mitigating procedures can be read into the 1984 Policy anywhere other than under the "care" provision, and the Court makes no finding in that regard. Cf., e.g., Equitable Life Assur. Soc. v. Singletary, 71 F.2d 409, 409-10 (4th Cir. 1934) (holding, where policy required claimant to be "wholly and presumably permanently prevented [by injury or disease] from pursuing any and all gainful

Lastly, the California Supreme Court has expressly recognized that courts applying California law cannot "rewrite any provision of any contract, including [an insurance] policy, for any purpose." See Certain Underwriters at Lloyd's of London v. Superior Court, 24 Cal. 4th 945, 960 (2001). Nor is it difficult for an insurer seeking to require its insured to submit to surgery, when deemed "appropriate care," to include additional language in the policy. Indeed, as discussed below with respect to the 1986 Policy, Unum, when it chose to do so, did draft its policies to require that its insureds receive care that is "appropriate" for the injury or sickness, as opposed to simply requiring the insured to be "under the care" of a physician.

Accordingly, Unum has failed to show it is entitled to summary judgment on the Second Cause of Action to the extent such claim is based on the 1984 Policy.

2. 1986 Policy

The 1986 Policy, in relevant part, provides for a "Disability Benefit," as follows:

> We will pay the Monthly Benefit Amount in any month after the Insured has satisfied the Elimination Period that:
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> 1. the Insured experiences at least a 20% loss of net income in his regular occupation as a result of a present injury or sickness;
>
> 2. the injury or sickness which causes the loss of net income is the one which caused him to satisfy the Elimination Period;
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> 3. he is receiving medical care from someone other than himself which is appropriate for the injury or sickness; and
>
> 4. [other specified] benefits . . . have not been paid for the Maximum Benefit Period.

(See Horrow Decl. Ex. C at 7.)

The parties dispute the meaning of the term "receiving medical care from someone other than himself which is appropriate for the injury or sickness." Unum argues the term

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occupations," and where claimant's impairment "could be cured by an operation," claimant failed to prove impairment was "permanent when [it was] admittedly curable"); see also Sutton v. United Air Lines, Inc., 527 U.S. 471, 482-88 (1999) (holding, for purposes of Americans with Disabilities Act, "[a] person whose physical or mental impairment is corrected by medication or other measures does not have an impairment that 'substantially limits' a major life activity"). Although the holding Sutton was subsequently limited by legislation, see 42 U.S.C. § 12102(4)(E), the reasoning stated therein remains valid.

conditions eligibility for benefits on the claimant's receiving "appropriate" care for the disability, while Dr. Buck argues "appropriate" refers to the type of medical practitioner from whom the claimant must receive care, i.e., it requires a claimant to seek care from "someone" who has "appropriate" training to provide care for the disability.

Neither party cites to any California state court decision that has interpreted policy language either identical to or similar to the policy language at issue herein. District courts that have considered policy language essentially indistinguishable from that at issue herein, however, have found such provisions unambiguously condition eligibility for benefits on the claimant's receiving "appropriate care for his disabling condition." See Provident Life & Accident Ins. Co. v. Henry, 106 F. Supp. 2d 1002, 1004-05 (C.D. Cal. 2000) (applying California law; finding policy language requiring insured to "receive care by a Physician which is appropriate for the condition causing the disability" unambiguously requires claimant to receive "appropriate care"; defining "appropriate" care as "the treatment a patient would make a reasonable decision to accept after duly considering the opinions of medical professionals"); see also Mack v. Unum Life Ins. Co., 471 F. Supp. 2d 1285, 1287, 1290-91 (S.D. Fla. 2007) (interpreting policy language that insured receive "medical care from someone other than himself which is appropriate for that injury or sickness" to require insured to "seek[ ] and accept[ ] the care that is appropriate for a disabling condition as determined by a treating physician"); Reznick v. Provident Life & Accident Ins. Co., 364 F. Supp. 2d 635, 637-38 (E.D. Mich. 2005) (interpreting policy language requiring insured to be "receiving care by a Physician which is appropriate for the conditions causing the disability" as unambiguously imposing on claimant "duty to seek and accept appropriate care").

Dr. Buck cites to no authority holding to the contrary. Moreover, Dr. Buck's interpretation is not reasonable as a matter of grammar. As noted, the language at issue is "receiving medical care from someone other than himself which is appropriate for the injury or sickness." (See Horrow Decl. Ex. C at 7 (emphasis added).) The word "which," as a matter of grammar, refers back to "medical care." To find otherwise would require

language that is not contained in the policy. Specifically, the policy does not state: "receiving medical care from someone other than himself who is appropriate for the injury or sickness."

Finally, Dr. Buck's reliance on the opinion of a former Unum executive who opines that "appropriate," as used the 1986 Policy, is a reference to the "medical expert" and not to the "type of treatment being rendered" (see Fuller Decl., filed February 5, 2010, ¶ 19), is unavailing, as such testimony cannot be offered to create an ambiguity. See Prudential Ins. Co. v. Superior Court, 98 Cal. App. 4th 585, 603 (2002) (holding "opinion evidence is completely inadmissible to interpret an insurance contract"; noting that because "a party's subjective intent cannot be used to create an ambiguity," it is "immaterial that the insurer's agents, employees or other representatives have misinterpreted [the policy's] meaning").[7]

Accordingly, the Court finds the term "receiving medical care from someone other than himself which is appropriate for the injury or sickness" is unambiguous, and requires the claimant to receive appropriate care for the injury or sickness upon which his claim is based.

The Court next turns to the issue of whether it is undisputed that Dr. Buck failed to receive "appropriate" care. As noted, Unum terminated Dr. Buck's benefits after concluding that carpal tunnel release surgery was the only appropriate care, which care Dr. Buck declined; Unum argues there exists no triable issue of fact as to whether such surgery is the "appropriate" care for Dr. Buck's disability. The Court disagrees. Specifically, prior to the date on which Unum terminated Dr. Buck's benefits, Dr. Belaga, Dr. Buck's treating physician, had advised Unum of his opinion that Dr. Buck "was not a suitable candidate for surgical intervention," because of "risk factors" identified by Dr.

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[7]Dr. Buck's reliance on the testimony of an attorney employed by the California Department of Insurance, given in a case filed against another insurer, likewise is unavailing. (See Horrow Decl. Ex. I at 51:24 - 52:17 (testifying she interpreted "receiving care by a physician which is appropriate for the condition causing the disability" to mean receiving care from a physician "within the license of that physician").) As discussed above, such opinion testimony is insufficient to create a triable issue of fact as to the meaning of the 1986 Policy. See Prudential, 98 Cal. App. 4th at 603.

Belaga as "hypertension," "hypercholesterolemia," and "fluctuation of blood pressure." (See Berryman Decl., filed January 20, 2010, Ex. W.) Although a trier of fact might credit the opinions of consultants who disagreed with Dr. Belaga's opinion, and upon whom Unum relied when it terminated Dr. Buck's benefits (see, e.g., id. Ex. BB, DD), credibility determinations are not appropriate at the summary judgment stage. See McGinest v. GTE Service Corp., 360 F.3d 1103, 1113 n.5 (9th Cir. 2004) (holding "it is axiomatic that disputes about material facts and credibility determinations must be resolved at trial, not on summary judgment").[8]

Accordingly, Unum has failed to show it is entitled to summary judgment on the Second Cause of Action to the extent such claim is based on the 1986 Policy.

B. Claim for Breach of Implied Covenant of Good Faith and Fair Dealing

"The law implies in every contract, including insurance policies, a covenant of good faith and fair dealing." Wilson v. 21st Century Ins. Co., 42 Cal. 4th 713, 720 (2007). An insurer breaches the covenant "[w]hen the insurer unreasonably and in bad faith withholds payment of the claim of its insured." See id. The reasonableness of the insurer's decision "must be evaluated as of the time that [it] [was] made." See Chateau Chamberay Homeowners Ass'n v. Associated Int'l Ins. Co., 90 Cal. App. 4th 335, 347 (2001). Although the reasonableness of an insurer's denial of benefits "is ordinarily a question of fact," a court "can conclude as a matter of law that an insurer's denial of a claim is not unreasonable, as long as there existed a genuine issue as to the insurer's liability." See Amadeo v. Principal Mutual Life. Ins. Co., 290 F.3d 1152, 1161 (9th Cir. 2002) (applying California law) (internal quotations and citations omitted). The "'genuine dispute' rule"

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[8]Unum relies on deposition testimony given herein by Dr. Belaga in December 2009, at which time Dr. Belaga testified that he agreed with the opinion of a physician who consulted with Unum and who had stated the risks posed to Dr. Buck from the surgery were "minimal" (see Humbert Decl. Ex. F at 101:14 - 102:16), and that before Dr. Belaga had advised Unum in 2008 that he did not believe Dr. Buck was a suitable candidate for surgery, he had recommended to Dr. Buck, in 2007, that he undergo the surgery (see id. Ex. F. at 66:24 - 67:5). Whether such testimony is inconsistent with Dr. Belaga's opinion that Dr. Buck, in 2008, was not a suitable candidate for surgery presents an issue of credibility not properly resolved at the summary judgment stage. See McGinest, 360 F.3d at 1113 n.5.

applies to "disputes over policy interpretation" and to "factual disputes as well." See Wilson, 42 Cal. 4th at 1089.

Unum argues that there existed, at the time of the termination of benefits, a genuine dispute as to its liability under both the 1984 Policy and the 1986 Policy.

1. 1984 Policy

As discussed above, Unum's interpretation of the 1984 Policy's "care" provision is incorrect. Nonetheless, at the time of the termination of benefits, there existed no California state court decision interpreting such policy language or similar language. Although the Court, as discussed above, has not adopted in full the district court's reasoning as set forth in Van Gemert, that opinion, which applied California law and was issued several years before Unum terminated benefits in the instant case, supports the interpretation advanced by Unum at the time it terminated Dr. Buck's benefits. Further, Unum relied on the expert opinions of three different consulting physicians to support its decision that if Dr. Buck underwent carpal tunnel release surgery, his symptoms were likely to resolve such that he could return to work. (See Berryman Decl. Exs. O, T, BB, CC, DD.)

Under the circumstances, the Court finds a genuine issue existed as to Unum's liability under the 1984 Policy. See Lunsford v. American Guarantee & Liability Ins. Co., 18 F.3d 653, 656 (9th Cir. 1994) (applying California law; holding insurer entitled to summary judgment on claim for breach of implied covenant of good faith and fair dealing, where, although court subsequently found insurer had duty to defend insured, insurer had "investigated the insureds' claim and based its refusal to defend on that information and a reasonable construction of the policy"); see also Guebara v. Allstate Ins. Co., 237 F.3d 987, 995 (9th Cir. 2001) (applying California law; holding insurer entitled to summary judgment on claim for breach of implied covenant of good faith and fair dealing, where, although jury found insurer had breached terms of policy when it denied claim, insurer based denial on "independent investigation by three experts").

Accordingly, Unum is entitled to summary judgment on the First Cause of Action to the extent such claim is based on the 1984 Policy.

2. 1986 Policy

As discussed above, Unum properly interpreted the 1986 Policy's "care" provision. Further, as discussed above, Unum relied on the expert opinions of three different consulting physicians to support its decision. Under the circumstances, the Court finds a genuine issue existed as to Unum's liability under the 1986 Policy. See id.

Accordingly, Unum is entitled to summary judgment on the First Cause of Action to the extent such claim is based on the 1986 Policy.

CONCLUSION

For the reasons discussed above, Unum's motion for summary judgment is hereby GRANTED in part and DENIED in part, as follows:

1. To the extent Unum seeks summary judgment on the First Cause of Action, the motion is hereby GRANTED.

2. To the extent Unum seeks summary judgment on the Second Cause of Action, the motion is hereby DENIED.

IT IS SO ORDERED.

Dated: March 11, 2010

MAXINE M. CHESNEY
United States District Judge