

Re: RIN 1210-AB39

I am writing to comment on the Proposed Regulations issued by the Department of Labor, Employee Benefits Security Administration on November 18, 2015. As someone who has been disabled by a serious chronic illness and relies upon my employer sponsored disability plan for income, I can attest to the difficulty disabled persons go through to obtain benefits they are entitled to and how costly and unfair the process can be. I commend the Department of Labor for trying to strengthen protections for disability claimants.

Specifically, I feel that employees of disability providers should not be hired, compensated, terminated or promoted based on the likelihood of their denying disability benefits or supporting the denial of such benefits. Furthermore medical experts used by such providers should also not be hired based on their reputation for outcomes in contested cases rather than based on their expertise.

Furthermore, in the event that an application for disability benefits is denied, I feel that the notice of claim denial must include a discussion of the decision, including the basis of disagreement with a disability determination by the persons own treating doctor(s) or Social Security Administration. Specifically, the notice of claim denial must include internal rules, guidelines, protocols, standards or similar criteria of the plan that were used to deny the claim. The statement should clearly outline, and the provider should supply, any evidence that was used to deny the claim so that the disabled person can evaluate the fairness of the decision. This information should be made easily available at any point during the decision process, in a timely manner, and at no cost to the claimant so that the claimant can prepare an appropriately informed appeal using all pertinent evidence as is their right.

In the event that a LTD provider has not adhered to all rules in evaluating said claim, a claimant should be able to proceed to court without a lengthy administrative process. If such an event should occur, the court should be able to use its own judgment based on the administrative record to evaluate the claim.

A retroactive rescission (cancellation or discontinuance) of coverage should constitute a so-called adverse-benefits determination regardless of whether the beneficiary/participant is currently receiving benefits permitting the claimant to invoke the ERISA claims-procedure requirements.

I prefer my comment to remain anonymous. Thank your for your time.