RECORD NO. 11-20184

In The
United States Court of Appeals
For The Fifth Circuit

ERIN C. SANBORN-ALDER, Individually and as Independent Executrix of the Estate of Clifford Alder,

Plaintiff – Appellant,

v.

LIFE INSURANCE COMPANY OF NORTH AMERICA; CBCA ADMINISTRATORS, INC.; NATIONAL EMPLOYMENT BENEFIT COMPANIES, INC.; A. C. STRIP, AS RECEIVER FOR CBCA ADMINISTRATORS, INC.; CBCA INSURANCE SERVICES, INC.; CBCA INSURANCE SERVICES, INC., SAN JACINTO AGENCY, INC. AND THE LOGE GROUP,

Defendants – Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF TEXAS AT HOUSTON

BRIEF OF APPELLANT

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IN THE
UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

ERIN SANBORN-ALDER,
INDIVIDUALLY AND AS INDEPENDENT
EXECUTRIX OF THE ESTATE OF CLIFFORD ALDER

PETITIONER

v.

CIGNA GROUP INSURANCE, LIFE INSURANCE
COMPANY OF NORTH AMERICA, CBCA ADMINISTRATORS
INC., AND NATIONAL EMPLOYMENT BENEFIT COMPANIES, INC.

RESPONDENT

CERTIFICATE OF INTERESTED PERSONS
REQUIRED BY 5TH CIRC. R. 28.2.1

The undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this court may evaluate possible disqualification or recusal.

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Life Insurance Company of North America, Respondent
CBCA Administrators Inc., Respondent
National Employment Benefit Companies, Inc., Respondent

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STATEMENT REGARDING ORAL ARGUMENT

Because of the complexity of the legal issues raised by this appeal, oral argument is requested.

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STATEMENT OF JURISDICTION

This appeal involves two legal claims arising under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et. seq.* The plaintiff, Erin Sanborn-Alder ("Mrs. Alder") filed this action in the United States District Court for the Southern District of Texas. The federal courts have jurisdiction pursuant to 29 U.S.C. § 1132(e) and 42 U.S.C. § 1291. This appeal is taken from a final order, dated February 15, 2011. A timely Notice of Appeal was filed on March 15, 2011.

STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

This appeal presents the following issues for review:

(1) Did the district court err in dismissing, for failure to state a claim, plaintiff's cause of action for "equitable relief" under section 502(a)(3) of ERISA?

(2) Did the district court err in granting summary judgment thereby dismissing plaintiff's claim for life insurance benefits under section 502(a)(1)(B) of ERISA?

STATEMENT OF THE CASE

I. Factual Overview

Clifford Alder ("Mr. Alder") was a pilot for Continental Airlines ("Continental"). USCA5 654, 1407. Pursuant to a Continental employee benefit plan, he possessed two life insurance policies. USCA5 650-51, 654-55, 1407. First, he had

"Basic Life Insurance," which paid benefits of $180,000 in the case of death, for any reason. USCA5 654-55, 1009 (the "$180,000 Life Insurance Policy"). Second, he had a "Personal Accident Plan," which paid $400,000 in the case of accidental death. USCA5 654-55, 1021 ("The personal accident plan pays benefits if you die . . . as the result of a covered accident.").

In 2005, he sought to broaden his coverage. USCA5 305-06 (Complaint ¶¶11-15). As Mrs. Alder explained in her complaint: Mr. Alder wanted to obtain $400,000 in life insurance that covered death for any reason, not just via accident. USCA5 305 (Complaint ¶11) (Mr. Alder "determined that his Personal Accident Policy was unnecessary. He decided to convert his Accident Policy to a Voluntary Life Insurance.").

On June 20, 2005, Mr. Alder submitted an application that he was provided. USCA5 49 (application for insurance). On June 27, 2005, that application was approved *and Mr. Alder* was *issued a $400,000 life insurance policy that covered death by sickness*. USCA5 56-58 (documents sent to Mr. Alder regarding his new policy, #FLM-51224). This newly issued policy is hereinafter referred to as the "$400,000 Life Insurance Policy."

As would be expected given the broader coverage, Mr. Alder's premiums rose substantially: from approximately $20.00 per month to approximately $800.00 per quarter. USCA5 1408.

Relying on defendants' assurances regarding the $400,000 Life Insurance Policy, Mr. Alder chose to let lapse the $180,000 Life Insurance Policy. USCA5 306 (Complaint ¶14). Both of these policies were insured (and, thus, payable) by defendant Life Insurance Company of North America ("LINA").

Sadly, Mr. Alder died of cancer on September 28, 2007. USCA5 1415. A few months later, Mrs. Alder submitted a claim for the proceeds of the $400,000 Life Insurance Policy – a policy under which the Alders had been paying the heightened premiums for two and half years. USCA5 276 (Complaint ¶¶15, 16).

On May 12, 2008, defendant LINA informed Mrs. Alder that the benefits were not payable because, according to their post-death investigation, Mr. Alder was not eligible for the $400,000 Life Insurance Policy that *they had issued him*. USCA5 782-85 (denial letter from LINA). Indeed, LINA hopes to come a *double winner*. Under its theory of the case, not only is the $400,000 Life Policy worthless, but the fact that defendants misled the Alders into dropping the $180,000 Life Insurance Policy is without any legal consequence. Put simply, LINA asks this court for permission to mislead a beneficiary with one hand and pocket the difference with the other. As the United States Supreme Court recently made clear in *CIGNA Corp. v. Amara*, 131 S. Ct. 1866 (2011) ("*Amara*"), ERISA does not tolerate such inequity.

II. Procedural History

On February 9, 2009, Mrs. Alder sued Cigna Group Insurance ("CIGNA"),[1] the Life Insurance Company of North America ("LINA"),[2] CBCA Administrators, Inc. ("CBCA"),[3] and National Employment Benefit Companies, Inc. ("NEBCO")[4] alleging various state law claims regarding the life insurance policies of her deceased husband. USCA5 1419.

On March 18, 2009, defendants removed the case to the United States District Court for the Southern District of Texas. USCA5 16-21 (notice of removal). After defendants answered and filed various motions, Mrs. Alder filed an amended complaint seeking, *inter alia*, relief under section 502 of ERISA, 29 U.S.C. § 1132. USCA5 279-81. In her amended complaint, Mrs. Alder pled two alternative grounds for relief that are at issue in this appeal. She sought relief under section 502(a)(1)(B) of ERISA (the "502(a)(1)(B) claim").[5] In the alternative, she

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[1] CIGNA is a registered service mark of CIGNA Corporation and has been dismissed as a party defendant. USCA5 668, 681.

[2] LINA was the insurance company that insured both the $400,000 Life Insurance Policy and the $180,000 Life Insurance Policy. USCA5 274 (Complaint ¶¶5, 8), 1407.

[3] CBCA was the claim administrator. USCA5 304 (Complaint ¶¶7, 8).

[4] NEBCO acquired the policy administration division of CBCA in June 2006 and thereby became the new claims administrator. USCA5 304 (Complaint ¶¶6, 8).

[5] According to the operative complaint filed by Mrs. Alder:

> Plaintiff seeks relief under 29 U.S.C. § 1132(a)(1)(B), as beneficiary under the plan for benefits due under the provisions of the plan. Pursuant to 29 U.S.C. § 1132(a)(1)(B), a "participant or beneficiary". . . may bring a civil action, in

sought relief under section 502(a)(3) of ERISA (the "502(a)(3) claim")[6].

Defendants moved to dismiss pursuant to Fed.R.Civ.P. 12(b)(6). USCA5 363-72 (LINA's motion); USCA5 388-403 (CBCA's motion); USCA5 438-449 (NEBCO's motion). On January 26, 2010, the District Court dismissed, *inter alia*, the 502(a)(3) claim. USCA5 690-91. The District Court premised this dismissal on the erroneous assumption that a plaintiff may not *plead* both 502(a)(1)(B) and 502(a)(3) claims in the same case. USCA5 691.[7]

Thereafter, defendants moved for summary judgment. USCA5 809-32 (LINA's motion); USCA5 748-58 (CBCA's motion); USCA5

> pertinent part, "to recover benefits due to him under the terms of his plan" or "to enforce his rights under the terms of the plan." ERISA defines a "beneficiary" as "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." Id. § 1002(8). Defendants have wrongfully denied Plaintiff's benefits under the plan, even though Plaintiff has demonstrated her entitlement to benefits under the plan.

USCA5 309 (Complaint ¶24).

[6] According to the operative complaint filed by Mrs. Alder:

> In the alternative, Plaintiff seeks relief under 29 U.S.C. § 1132 (a)(3) . . .[namely] appropriate equitable relief to redress such violations or to enforce the provisions of ERISA or the terms of the plan. 29 U.S.C. § 1132(a)(3). The Supreme Court has defined "appropriate equitable relief" as to include restitution to restore losses or place the parties in the position they would have been had there been no breaches of fiduciary duty.

USCA5 311 (Complaint ¶29).

[7] In the words of the District Court,

> Nor can an ERISA plaintiff sue for equitable relief under § 1132(a)(3) when there is another adequate remedy available, e.g., the plaintiff can make a claim for failure to pay benefits under § 1132(a)(1)(B).

USCA5 667 (citations omitted). This holding misunderstands the rules of pleading as well as the difference between the 502(a)(1)(B) and 502(a)(3) claims pled in this case. See pages 9 - 20, *infra*.

1188-1200 (NEBCO's motion). On February 15, 2011, the Court granted summary judgment thereby dismissing the 502(a)(1)(B) claim. USCA5 1391. The Court's opinion was premised on its erroneous conclusion that the plan's terms prohibited the issuance of the $400,000 Life Insurance Policy. USCA5 1429-30.[8] That same day, final judgment was entered. USCA5 1440. On March 15, 2011, Mrs. Alder timely filed a notice of appeal. USCA5 1441-1442.

STATEMENT OF FACTS RELEVANT TO ISSUES PRESENTED FOR REVIEW

Clifford Alder was a pilot for Continental Airlines. USCA5 1407. Continental had an ERISA plan providing employee benefits, which included life insurance. *Id.* Pursuant to this plan, Mr. Alder possessed two life insurance policies. USCA5 1407. The first was a "Basic Life Insurance" that paid benefits of $180,000 upon death for any reason. USCA5 654-55, 1009. The second was a "Personal Accident Policy" with benefits of $400,000 payable upon an accidental death. USCA5 654-55, 1021.

Mr. Alder was diagnosed with colon cancer in 2003. USCA5 1407. He got treatment but the cancer returned in 2005. *Id.* In June 2005, Mr. Alder was placed on disability and took leave. *Id.* Because he was no longer flying, he determined his accident policy was unnecessary. USCA5 305 (Complaint ¶11).

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[8] This holding, which used the incorrect standard of review, is a second instance of reversible error. See pages 20 - 21, *infra*.

On June 2, 2005, Hewitt and Associates ("Hewitt"), an employee benefits contractor of Continental, contacted Mr. Alder regarding continuation of life insurance since he would no longer be an active employee. USCA5 1413. Hewitt sent Mr. Alder an application. *Id.* Mr. Alder filled out the application and sent it to CBCA as instructed on the form. *Id.*

CBCA received Mr. Alder's application, processed it, and issued a certificate for the $400,000 Life Insurance Policy: "ported" *life insurance* (not personal accident benefits) payable by LINA. USCA5 1414. CBCA also accepted and processed Mr. Alder's premium payments, which jumped more than 1,000% from approximately $20.00 per month to approximately $800.00 per quarter. USCA5 1408.

Mr. Alder agreed and paid the increased rates for over two and a half years knowing that they would provide an increased benefit for his wife if he died. USCA5 306 (Complaint ¶14). One year into paying these increased premiums, Mr. Alder relied on the fact that the $400,000 Life Insurance Policy was effective and permitted his $180,000 Life Insurance Policy to lapse. *Id.*

Sadly, Mr. Alder died on September 28, 2007. USCA5 1415. On December 20, 2007, Mrs. Alder submitted a claim to NEBCO – who had assumed CBCA's policy administration services. USCA5 1415. On December 28, 2007, NEBCO forwarded the claim to LINA.

Id. On May 12, 2008, LINA informed Mrs. Alder that her claim for benefits had been denied, arguing that Mr. Alder had been mistakenly issued the $400,000 Life Insurance Policy. USCA5 1418. At LINA's direction, NEBCO sent Mrs. Alder a check for the premiums that Mr. Alder had paid on the $400,000 Life Insurance Policy. *Id.* According to all defendants, Mrs. Alder was (and is) entitled to nothing more.

This litigation followed.

SUMMARY OF THE ARGUMENT

The district court made two errors that require reversal. First, pursuant to Federal Rule of Civil Procedure 12(b)(6), it wrongfully dismissed Mrs. Alder's claim under section 502(a)(3) of ERISA. As explained below, plaintiffs in Mrs. Alder's circumstances may plead ERISA claims under both section 502(a)(1)(B) and section 502(a)(3) of the statute. Contrary to the district court's holding, these are different claims, and no "one or the other" pleading bar applies.

Nor is there any doubt that Mrs. Alder may seek relief beyond the return of premiums. The equitable remedies of surcharge, reformation and estoppel – all expressly held cognizable under 502(a)(3) by the United States Supreme Court in its most recent ERISA opinion – were properly pled by Mrs. Alder and should proceed to proof. Such equitable remedies, at a minimum, entitle Mrs. Alder to the $180,000 in life insurance

proceeds that LINA pocketed by misleading Mr. Alder into buying a new, allegedly worthless $400,000 policy.

Second, the district court wrongly granted summary judgment on Mrs. Alder's claim under section 502(a)(1)(B) of ERISA. The Continental ERISA plan, by its terms, does not confer interpretative discretion on defendants, and thus does not entitle their plan interpretation to judicial deference. The district court erred in engaging in deferential review when *de novo* review was appropriate.

Nor was the error harmless. No language in the Continental plan – clearly or otherwise – invalidates the $400,000 Life Insurance Policy issued to (and paid for) by Mr. Alder. The district court's grant of summary judgment should be reversed.

ARGUMENT

I. The District Court Erred in Dismissing Mrs. Alder's 502(a)(3) Claim for Failure to State a Claim.

A. An ERISA plaintiff is permitted to plead entitlement to relief under *both* 502(a)(1) and 502(a)(3).

Plaintiffs may plead alternative theories of relief. Fed. R. Civ. P. 8. In this case, Mrs. Alder pled two distinct claims under ERISA: a 502(a)(1)(B) claim and a 502(a)(3) claim.[9] The district court dismissed the 502(a)(3) claim on the theory that

[9] A section 502(a)(1)(B) claim is one seeking "benefits due . . . under the plan." 29 U.S.C. § 1132(a)(1)(B). A section 502(a)(3) claim is one seeking "appropriate equitable relief." 29 U.S.C. § 1132(a)(3).

Mrs. Alder was not permitted to plead entitlement to relief under both 502(a)(1)(B) and 502(a)(3) in the same complaint. USCA5 689-91. The district court is mistaken.

It is easy to see why: the two claims are not the same. The 502(a)(1)(B) claim is essentially a contract claim based on the language of the plan. If the plan permits the issuance of a $400,000 life insurance policy to someone in Mr. Alder's circumstances, then, *under the terms of the plan*, Mrs. Alder is entitled to the proceeds. If, however, the plan bars the issuance of such a policy, then Mrs. Alder will lose on the merits.[10]

In contrast, the 502(a)(3) claim is not based on the language of the plan *at all.* Instead, it is based on the various misrepresentations that defendants made to Mr. Alder regarding his coverage status. Were it not for those misrepresentations, Mr. Alder would not have let the $180,000 Life Insurance Policy lapse. Unsurprisingly, it is well-settled that misleading statements by fiduciaries constitute breaches of duty under ERISA and thus trigger a claim under section 502(a)(3). See *Varity Corp. v. Howe*, 516 U.S. 489, 492 (1996)

[10] In other words: the plan clearly permits *some* insurance policies to be issued to participants. USCA5 56-58. Defendants argue that the plan does not authorize Mr. Alder to have obtained Policy No. FLM-51224, i.e., the $400,000 Life Insurance Policy. USCA5 1411. Mrs. Alder argues that it does. ERISA technicalities aside, Mrs. Alder has pled a simple contract claim that turns on the meaning of the relevant plan terms. USCA5 309 (Complaint ¶24).

(a participant may sue under section 502(a)(3) of ERISA for breach of fiduciary duty to obtain "appropriate equitable relief").[11] A plan administrator who does not speak the truth has breached his fiduciary duty. *See, e.g., McCall v. Burlington Northern/Santa Fe Co.*, 237 F.3d 506, 510-11 (5th Cir. 2000) ("When an ERISA plan administrator speaks in its fiduciary capacity concerning a material aspect of the plan, it must speak truthfully.").

Here, Mrs. Alder pled numerous misrepresentations that formed the basis for her 502(a)(3) claim:

- Plan fiduciaries admittedly but "mistakenly" sent Mr. Alder a specific application through which he could obtain $400,000 in voluntary life insurance coverage from LINA; USCA5 1413;
- upon receipt of the completed application that was sent to Mr. Alder, plan fiduciaries admittedly but "mistakenly" issued him a certificate for "ported" life insurance benefits of $400,000 from LINA; USCA5 1414;
- plan fiduciaries admittedly but "mistakenly" collected premiums for over two and a half years on the $400,000 Life Insurance Policy; USCA5 306 (Complaint ¶15); and
- plan fiduciaries admittedly but "mistakenly" told Mr. Alder that the $400,000 Life Insurance Policy would stay in effect until he went back to work as long as he paid premiums. USCA5 1414-15.

The district court failed to realize that the 502(a)(1)(B) and 502(a)(3) claims are *alternative* claims, not duplicative

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[11] As fiduciary breaches are "violations of [ERISA]," the text of 502(a)(3) plainly permits plaintiffs to seek "appropriate equitable relief" for such breaches. 29 U.S.C § 1132(a)(3). The *relief* available in the cases of such breach depends on the circumstances of the case and the historical requirements of equity. *See generally Amara*, 131 S. Ct. 1866 (2011).

ones. The former depends on the language of the plan; the latter on (admitted) fiduciary misrepresentations. Nor does the latter seek to vindicate any entitlement under the plan; it only seeks to recover losses resulting from the misrepresentations.[12]

The district court's holding is apparently based on a misunderstanding of Justice Breyer's observation in *Varity Corp v. Howe*, that 29 U.S.C. § 1132(a)(3) "act[s] as a safety net, offering appropriate equitable relief for injuries caused by violations that [§ 1132] does not elsewhere adequately remedy." *Varity Corp v. Howe et al.*, 516 U.S. 489, 512 (1996).

As he went on to explain, however, Justice Breyer was quite clearly referring only to instances where a plaintiff "*repackage[s]* his or her 'denial of benefits' claim as a claim for 'breach of fiduciary duty.'" *Varity*, 516 U.S. at 513 (emphasis added). An example of such an impermissible "repackaging" likely would be a plaintiff who asserts a 502(a)(1)(B) claim that the terms of the plan entitle her to a certain medical procedure and who then duplicatively asserts that, by ignoring the terms of the plan which entitle her to that medical benefit, the administrator breached a fiduciary duty and is simultaneously subject to a 502(a)(3) claim. In such a case, the 502(a)(3) claim is simply a "repackaging" of

[12] Mrs. Alder's invocation of 502(a)(3) relief sought to "place the parties in the position they would have been had there been no breaches of fiduciary duty." USCA5 311 (Complaint ¶29).

the 502(a)(1)(B) claim; both depend on the terms of the plan being ignored. In that example, there is no separate predicate from which the fiduciary breach arises and the 502(a)(3) claim springs.

Here, of course, there *is* a separate predicate for the 502(a)(3) claim — a series of specific and *admitted* misrepresentations that harmed Mrs. Alder. Nothing in *Varity* stands for the proposition that a plaintiff who brings a 502(a)(1)(B) claim (based on the terms of the plan) somehow loses the right to bring a 502(a)(3) claim (for a series of misrepresentations) that also harmed her.

Moreover, as to those misrepresentations, Mrs. Alder does not seek contractual relief. Rather, she seeks to be put in the economic position that she would have maintained absent defendants' violation of ERISA. USCA5 311 (Complaint ¶29). Such relief could, for example, warrant an award of (1) the proceeds lost as a result of the misrepresentation-induced lapse of the $180,000 Life Insurance Policy and (2) the value of any other cognizable losses caused by defendants' breaches of trust (in an amount, of course, subject to proof). *See* pages 15 - 20, *infra* (discussing the equitable remedy of surcharge).

Of course, plaintiffs like Mrs. Alder are regularly permitted to plead 502(a)(1)(B) and 502(a)(3) claims. *See, e.g.*, *CIGNA Corp. v. Amara*, 131 S. Ct. 1866, 1878-79 (2011)

(discussing the availability of relief under 502(a)(3) after concluding that no relief was available under 502(a)(1)(B)); *Devlin v. Empire Blue Cross & Blue Shield*, 274 F.3d 76, 89 (2d Cir. 2001) (permitting both 502(a)(1)(B) and 502(a)(3) at the pleading stage); *DeVito v. Aetna, Inc.*, 536 F. Supp. 2d 523, 534 (D.N.J. 2008) ("claims under § 1132(a)(3) are not properly dismissed at the motion to dismiss stage merely because a plaintiff has also brought a claim under § 1132(a)(1)(B)"); *Bell v. Guardian Life Ins. Co.*, WL 4852840, 4-5 (D.N.J. 2008) ("Plaintiff should be able to assert § 502(a)(l)(B) and § 502(a)(3) claims at this stage of the litigation because parties are permitted to plead in the alternative.").

It is beyond dispute that the district court erred in dismissing the 502(a)(3) claim merely because Mrs. Alder also alleged a 502(a)(1)(B) claim.[13] Reversal is warranted.

[13] The cases relied on by the district court are inapposite. In each, the 502(a)(3) claim is simply a "repackaged" claim for benefits under section 502(a)(1)(B). Indeed, in *Tolson v. Avondale,* this Court (in the summary judgment context) expressly made this point. *Tolson v. Avondale Industries, Inc.*, 141 F.3d 604, 610 (5th Cir. 1998) (Plaintiff's "efforts to justify assertion of breach of a fiduciary duty claim against the Plans by distinguishing such a claim from his claims for coverage and benefits claims are woefully unavailing."). *Cf. Gore v. El Paso Energy Corp.,* 477 F.3d 833, 838 (6th Cir. 2007) (explaining that *Varity* stands for the proposition that one cannot plead (a)(3) claims when they are "nothing more than repackaged denial of benefits claims"). To the extent that any prior decision could potentially be read to bar Mrs. Alder's 502(a)(3) claim, it has been abrogated by the Supreme Court's recent decision in *Amara. See generally Amara*, 131 S. Ct. 1866 (2011) (explaining how 502(a)(1)(B) and 502(a)(3) claims are different).

B. <u>As recently confirmed by the Supreme Court, Mrs. Alder has asserted a paradigmatic 502(a)(3) claim.</u>

Independently from its mistaken conclusion that 502(a)(1)(B) bars pleading an alternative 502(a)(3) claim, the district court seemingly concluded that no 502(a)(3) claim was cognizable in this case because section 502(a)(3) of ERISA (as a matter of law) affords no possible relief other than the return of premiums paid on the $400,000 Life Insurance Policy. USCA5 1431. This too is error. Mrs. Alder's 502(a)(3) claim should proceed to the merits.

Longstanding Supreme Court precedent holds that, for a remedy to be available under section 502(a)(3) of ERISA, that remedy must fall within "those categories of relief that . . . were typically available in equity." *Amara*, 131 S. Ct. at 1878 (quoting *Mertens v. Hewitt Associates*, 508 U.S. 248, 256 (1993) (internal quotations omitted)). While lower courts have struggled to identify whether particular remedies sought by plaintiffs were typical equitable remedies, and thus available under section 502(a)(3), the Supreme Court's recent decision in *Amara* has made the Court's task here straightforward.

Specifically, the *Amara* Court held that section 502(a)(3) claimants may pursue the traditional equitable remedies known as "surcharge," "reformation," and "estoppel." *Amara*, 131 S. Ct.

at 1879-1880. Each of those Supreme Court approved equitable remedies is available to Mrs. Alder in this case.[14]

The example of surcharge is illustrative. Surcharge is "a form of monetary 'compensation' for a loss resulting from a trustee's breach of duty." *Amara*, 131 S. Ct. at 1880 (citing Restatement (Third) of Trusts § 95, and Comment a (Tent. Draft No. 5, Mar. 2, 2009). Surcharge, in the words of Justice Breyer, is more than typically equitable; it was "*exclusively* equitable." *Id.* (emphasis added). *See also Manhattan Bank v. Walker*, 130 U.S. 267, 271 (1889) ("The suit is plainly one of equitable cognizance, the bill being filed to charge the defendant, as a trustee, for breach of trust."); *Princess Lida of Thurns & Taxis v. Thompson*, 305 U.S. 456, 458, 464 (1939) (describing authority of state court, in a "suit in equity," "to surcharge [a trustee] with losses incurred"); 4 John N. Pomeroy, A Treatise on Equity Jurisprudence § 1080, at 229 (5th ed.

[14] *Amschwand v. Spherion Corp.*, 505 F.3d 342 (5th Cir. 2007) is no bar to reversal. First, *Amschwand* is distinguishable on its facts. The representations in that case were made by the employer, not by the insurance company or third-party plan administrator. *Amschwand*, 505 F.3d. at 344-45. Here, *LINA and non-employer fiduciaries* misled Mr. Alder into abandoning his $180,000 Life Insurance Policy. Those otherwise payable proceeds, accordingly, were and now are wrongfully in LINA's possession. By contrast, in *Amschwand*, the defendant-employer (Spherion) never, in any conceivable way, possessed the proceeds sought by Mrs. Amschwand. Second, Justice Breyer made clear in *Amara* that the equitable remedies of surcharge and reformation are available to beneficiaries in Mrs. Alder's circumstances. *See* pages 15 - 20, *infra* (Section I.B). Thus, to the extent that *Amschwand* does not recognize surcharge or reformation as cognizable equitable remedies, it has been abrogated by *Amara*.

1941); John Adams, Jun., The Doctrine of Equity; Being a Commentary on the Law as Administered by the Court of Chancery 93 (1850); 2 Joseph Story, Commentaries on Equity Jurisprudence § 1266-78, at 519-34 (12th ed. 1877); 3 Austin W. Scott & William F. Fratcher, The Law of Trusts § 199.3, at 206 (4th ed. 1987).

The surcharge claim here is simple. It was a breach of duty for the defendant-fiduciaries to mislead Mr. Alder into believing that he was eligible for (and, in fact, was covered by) the $400,000 Life Insurance Policy which they now claim is void. As a result of those misrepresentations, Mr. Alder let the $180,000 Life Insurance Policy lapse. Mrs. Alder (a beneficiary) now seeks to "surcharge" the defendants (the trustees) in the amount of life insurance proceeds she lost because of the defendant-trustees' breaches of fiduciary duty, as well as other historically-cognizable losses she can prove she incurred. *See, e.g., Marriott v. Kinnersley*, 48 Eng. Rep. 187, 188 (High Ct. CR. 1830) (trustee charged with losses resulting from the failure to pay the premium on a life insurance policy); *Appeal of the Harrisburg Nat'l Bank*, 84 Pa. 380, 383 (1877) (court of equity may surcharge administrator of estate with life insurance policy proceeds that the administrator negligently lost).

Reformation is another theory that can, per *Amara*, be contested on the merits below. Equity permits courts to engage in "reformation of the terms of the plan, in order to remedy the false or misleading information" a fiduciary provides. *Amara*, 131 S. Ct. at 1879. "[I]t is well settled that equity would reform the contract, and enforce it, as reformed, if the mistake or fraud were shown." *Id.* (citing *Hearne v. Marine Ins. Co.*, 20 Wall. 488, 490, 22 L. Ed. 395 (1874)). Reformation, being equitable, unquestionably depends upon circumstance. Because her 502(a)(3) claim was dismissed under 12(b)(6), however, Mrs. Alder had no opportunity to establish her reformation claim. She would do so on remand.

As for equitable estoppel: the Court below made multiple mistakes. First, it wrongfully categorized and rejected the estoppel claim as an outgrowth of Mrs. Alder's 502(a)(1)(B) claim. USCA5 1428-1430. But Mrs. Alder's estoppel claim was (and is) in fact a 502(a)(3) claim. *Cf. Amara*, 131 S. Ct. at 1880 (equitable estoppel is a section 502(a)(3) remedy). Second, the district court rejected Mrs. Alder's estoppel claim on the ground that the Alders' "reliance on the Group Term Life Insurance certificate and Defendants' assurances" of coverage were "not reasonable because such 'statements' were contrary to

the terms of the plan and policy." USCA5 1430. That holding is not consistent with the precedent of this Court.[15]

In *Mello v. Sara Lee Corp.*, the pension case on which the district court relied, there was insufficient reliance on which to premise estoppel because (1) the terms of the plan at issue were unambiguously in conflict with the plaintiff's position, (2) key misrepresentations were oral, *and* (3) the documents plaintiff had relied upon contained *disclaimers*. *Mello v. Sara Lee Corp.*, 431 F.3d 440, 442, 444-448 (5th Cir. 2005). The opposite is true here: (1) the terms of the plan are ambiguous — no plan language clearly invalidates the Alders' policy, *see* pages 20 - 24 *infra* (Section II); (2) the key misrepresentations in this case were in writing — the Alders were sent the wrong form and issued actual coverage, and (3) there are no relevant disclaimers that render the Alders' reliance unreasonable.

Because there are multiple equitable theories — three of which were recently approved by the United States Supreme Court — under which plaintiff has a cognizable section 502(a)(3)

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[15] "To establish an ERISA-estoppel claim, the plaintiff must establish: (1) a material misrepresentation; (2) reasonable and detrimental reliance upon the representation; and (3) extraordinary circumstances." *Mello v. Sara Lee Corp.*, 431 F.3d 440, 444-445 (5th Cir. 2005). There is no dispute that this case involves a material misrepresentation. As explained above, the lower court was wrong to conclude that there was no reasonable reliance. And whether extraordinary circumstances were present is a matter to be resolved on remand, to the extent that Mrs. Alder relies on estoppel, rather than an alternative equitable theory.

claim, reversal and remand is warranted. Mrs. Alder's claim should proceed to proof.

II. The District Court Erred in Dismissing Mrs. Alder's 502(a)(1)(B) Claim on Summary Judgment.

In granting summary judgment and dismissing Mrs. Alder's 502(a)(1)(B) claim, the district court used an improper standard of judicial review. To be sure: in ERISA actions, the determinations of plan administrators are sometimes entitled to deference by reviewing courts. *See generally Conkright v. Frommert*, 130 S. Ct. 1640 (2010); *Metropolitan Life Insurance Co. v. Glenn*, 554 U.S. 105 (2008); *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989). But this is not one of those cases. Here, *de novo* review was required, and the trial court erred by using a deferential "abuse of discretion" standard. Accordingly, the lower court's grant of summary judgment should be reversed and the matter remanded so that the lower court may evaluate the summary judgment motion using the proper legal standard.

Benefit denials frequently involve disputes over the meaning of plan language. When a plaintiff is denied a benefit because, in the view of the plan administrator, the language of the plan does not entitle the plaintiff to the sought benefit, a reviewing court must determine whether the plan administrator's interpretation of the plan is correct. It has been settled law

for over two decades that, because ERISA was designed to protect beneficiaries, "a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard." *Firestone*, 489 U.S. at 115. Only if "the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan" is a deferential standard appropriate. *Id.* Importantly, "[d]iscretionary authority cannot be implied; an administrator has no discretion to determine eligibility or interpret the plan unless the plan language expressly confers such authority on the administrator." *Wildbur v. ARCO Chemical Co.*, 974 F.2d 631, 636 (5th Cir. 1992).

No such plan language conferring interpretative discretion on any defendant is present here. The relevant language relied upon by the district court simply instructs claimants to provide "[w]ritten proof of loss, or proof by any other electronic/telephonic means authorized to the Insurance Company . . . to the Insurance Company." USCA5 1419.[16] A bare

[16] Nor does the other language relied upon by the district court evidence any discretionary grant. As the District Court noted, "[t]he policy also requires participants to submit 'due proof' to LINA to obtain waiver of premium benefits and states that participants will not be eligible for terminal illness benefits unless they have been 'determined by the Insurance Company to be Terminally Ill.'" USCA5 1419. Language regarding terminal illness benefits, however, is irrelevant to this case. Similarly, the "due proof" language refers to a different type of claim — a premium waiver benefit, not the collection of life insurance proceeds — and, in any event, does not confer discretion to interpret the meaning of the plan, as explained

requirement of proof of loss cannot possibly confer discretion on plan fiduciaries to *construe* ambiguous plan language. If that were so, every plan would be entitled to *Firestone* deference, because every insurance plan requires proof of loss.[17]

To be clear: the 502(a)(1)(B) claim in this case presents a question of plan interpretation, not proof. Here, there is no factual dispute that Mrs. Alder can "prove" as a matter of fact that she possesses a policy that entitles her to $400,000; defendants admit that the $400,00 Life Insurance Policy was issued. The 502(a)(1)(B) issue is whether there is some language in the plan that can be interpreted to render this

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herein. Simply, there is no "proof" dispute that Mrs. Alder *has* a policy entitling her to collect $400,000; the issue is whether the language of the plan somehow voids that policy.

[17] In the words of the Ninth Circuit: "No matter how you slice it, requiring a claimant to submit 'satisfactory proof' does not unambiguously confer discretion. . . . . Neither the parties nor the courts should have to divine whether discretion is conferred." *Sandy v. Reliance Standard Life Ins. Co.*, 222 F.3d 1202, 1204, 1207 (9th Cir. 2000). The Fourth Circuit has also concluded that the mere use of "satisfactory proof" language was sufficiently unclear to confer discretion. *Gallagher v. Reliance Standard Life Ins. Co.*, 305 F.3d 264, 269 (4th Cir. 2002). And the Seventh Circuit agrees: "That the plan administrator will not pay benefits until he receives satisfactory proof of entitlement likewise states the obvious, echoing standard language in insurance contracts not thought to confer any discretionary powers on the insurer." *Herzberger v. Standard Ins. Co.*, 205 F.3d 327, 332 (7th Cir. 2000) (citing 13A George J. Couch, Ronald A. Anderson & Mark S. Rhodes, Couch on Insurance § 49A:27 (2d rev. ed. 1982)). To be sure: a minority of courts have held that certain proof formulations can confer discretion; those cases, however, all involve language that is considerably more exacting than any in this case. *See, e.g.*, *Brigham v. Sun Life of Canada*, 317 F.3d 72, 81 (1st Cir. 2003) (discussing cases); *Viera ex rel. Estate of Viera v. Life Ins. Co. of North America*, 2011 WL 2279175 (3d Cir. 2011) (same).

policy *void ab initio*. And that depends entirely on plan terms and their meaning.

To wit: LINA has insisted that, *under the terms of the Continental plan*, someone like Mr. Alder cannot have rightfully obtained the $400,000 Life Insurance Policy. LINA's argument is that Mr. Alder did not have the "correct" insurance to "port" into the $400,000 policy that he was issued. USCA5 1411-12. Yet LINA never points to any specific plan language that says, in effect, that "one cannot obtain a policy like Mr. Alder's unless one previously had a particular type of policy of equivalent value to port." Either the Continental plan allows Mr. Alder to have obtained and paid for such a policy or it does not. For LINA to deny Mrs. Alder's claim, it must identify (and then interpret) language in the Continental plan that allegedly renders the $400,000 Life Insurance Policy void. It has not. If and when it does, Mrs. Alder is entitled to *de novo* review of that plan interpretation.[18]

A proof of loss requirement is not, and never has been, a *Firestone* discretionary clause. *Estate of Bratton v. National*

[18] This also explains why the district court's focus on whether LINA relied on "substantial evidence" to conclude, as a matter of fact, that Mr. Alder had nothing to port, USCA5 1420-22, begs the question. If the plan by its terms *bars* people in Mr. Alder's circumstances from obtaining the policy he was issued, Mrs. Alder concedes that she would have no 502(a)(1)(B) claim for benefits. If, however, the plan *permits* the issuance of such a policy — by "porting" or otherwise — Mrs. Alder would unquestionably prevail on her 502(a)(1)(B) claim, because such a policy was issued. Thus, there is no factual dispute that could be evaluated under a "substantial evidence" standard.

Union Fire Ins. Co. of Pittsburgh, PA, 215 F.3d 516, 522, 525 (5th Cir. 2000) (holding that an insurance policy with the language "[w]ritten proof of loss must be furnished to the Company" did "not give the administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan."). There is no proof issue here; there is only a plan interpretation question. A proof requirement does not confer discretion to interpret the plan to defendants.

CONCLUSION

For the reasons discussed above, the district court erred in dismissing Mrs. Alder's 502(a)(3) claim on the pleadings and in dismissing Mrs. Alder's 502(a)(1)(B) claim on summary judgment. Both orders should be reversed.

Respectfully submitted,

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