Conformity Clauses, Choice of Law Provisions, and ERISA Preemption

“Insurance contracts often include so-called ‘conformity clauses’ which ‘provide[] that clauses which are in conflict with [statutorily mandated coverage] are declared and understood to be amended to conform to such statutes.” Kentucky League of Cities, Inc. v. General Reinsurance Corp., 174 F. Supp. 2d 532, 540 (W.D. Ky. 2001).

This is not really a “choice of law” provision, but a provision that is used so that insurers can issue policies in multiple states without running afoul of any particular state’s minimum statutory requirements. But see Kubes v. American Med. Sec., Inc., 895 F. Supp. 212 (S.D. Ill. 1995) (treating conformity clause as a choice of law provision). Even if a policy does not contain the conformity provision, it will be treated as if it contains the mandatory provision(s). Kentucky League, 174 F. Supp. 2d at 540-41; see also Hughes v. State Farm Mut. Auto. Ins. Co., 236 N.W.2d 870, 885 (N.D. 1975).

Of course, these provisions only come into play if there is a direct or express conflict between a statutory provision and the policy at issue. Kentucky League, 174 F. Supp. 2d at 540 (citing cases).

CONTINUED ON PAGE 2>>
When a plan is governed by ERISA, the preemption provisions of that law are intended to provide uniformity by preempting state laws that relate to the plan, thereby preventing inconsistent treatment of plans in multiple states. DaimlerChrysler Corp. v. Durden, 448 F.3d 918, 928 (6th Cir. 2006) (“Numerous issues which would otherwise be decided by state law are preempted by ERISA for the specific purpose of providing uniformity.”).

Are Conflicting State Laws Saved from Preemption?

The question then becomes whether the particular law that conflicts with the plan is saved from preemption because it regulates insurance under the test set forth in Kentucky Association of Health Plans, Inc. v. Miller, 538 U.S. 329 (2003) (i.e., it is directed “specifically toward entities engaged in insurance” and it “substantially affect[s] the risk pooling arrangement between the insurer and the insured”). Id. at 341.

Some cases have concluded that this kind of “conform to” provision is immaterial if the laws of the state are preempted. For example, in Light v. Blue Cross & Blue Shield of Alabama, 790 F.2d 1247 (5th Cir. 1986), plaintiffs argued that ERISA did not preempt their claims against a self-funded plan, because the plan contained a provision stating: “The contracts [between the employer and the plan administrator] necessarily will conform to applicable state laws.” The Fifth Circuit found that “[t]his argument lacks substance,” reasoning that “[i]f ERISA preempts state law, there is no applicable state law with which the administrator must conform.” Id. at 1248.

Similarly, in Louisiana Health Service and Indemnity Company v. Rapides Healthcare System, 461 F.3d 529 (5th Cir. 2006), the court considered two provisions in a group policy that funded an ERISA plan, one of which stated that assignments would not be honored “except as required by law.” Because Louisiana had an “assignment statute,” the issue was whether that statute was preempted.

The court disagreed with the district court’s holding that the policy’s provisions were “automatically amended to conform to the requirements of the assignment statute.” Id. at 533 (citations and punctuation omitted). Rather, “ERISA plans must always conform to state law, but only state law that is valid and not preempted by ERISA.” Id.

Thus, “[t]he presence of the phrase ‘except as preempted by law’ serves no additional purpose, as all state laws are potentially subject to ERISA’s preemptive force.” Id. The court went on to determine that the assignment statute was not preempted because it did not have an impermissible connection with the plan, but acknowledged that the Eighth and Tenth Circuits have held that ERISA preempts similar statutes.

Self-Funded Plans

The Sixth Circuit followed Light with respect to a self-funded plan in Kentucky Association of Health Plans, Inc. v. Nichols, 227 F.3d 352 (6th Cir. 2000). The fact that the plan was self-funded was critical, because the “any willing provider” statute at issue would have been saved from preemption but for application of ERISA’s deemer clause, which provides that self-funded plans will not be deemed insurance companies for the purpose of state laws directed at regulating insurance. 29 U.S.C. § 1144(b)(2)(B).

The effect of a true choice of law provision in an ERISA plan document – e.g., “This policy is issued in North Carolina and shall be governed by its laws” – essentially depends on the choice of venue for the litigation in which the provision becomes an issue. Currently, there is a split in authority with regard to whether a choice of law provision can be enforced when the document containing the provision is part of an employee welfare benefit plan governed by ERISA.

For example, in Buce v. Allianz Life Insurance Company, 247 F.3d 1133, 1147 (11th Cir. 2001), the group policy at issue stated that “the Plan is to be interpreted in accordance with the laws of the State of Georgia.” The Eleventh Circuit determined that this provision gave “the vague terms of the policy ... cognizable doctrinal context....” Id. As a result, Georgia law was imported into the plan for the purpose of clarifying vague terms (in that case, the term “accident”), which was a different inquiry than whether the law of Georgia was preempted. ERISA still preempts Georgia law, but the court was not actually applying Georgia law, just using it for guidance to interpret the terms of the plan.

In Tyler v. AIG Life Insurance Company, 273 F. App’x 778, 785 (11th Cir. 2008), the Eleventh Circuit spoke further on the issue, holding that where the ERISA-governed policy contained a choice of law provision stating that a particular state’s law applied, the state law would be applied in situations where state law conflicted with federal common law.

Claim Decision Based on State Law

The Second Circuit also has upheld an administrator’s claim decision under an ERISA-governed policy where that decision was consistent with the law.
of the state designated in the choice of law provision. *Greenberg v. Aetna Life Ins. Co.*, 421 F. App’x 124 (2d Cir. 2011) (”[T]he policy on its face elects Pennsylvania law as controlling in its interpretation and stipulates that it is to be delivered in Pennsylvania. [Plaintiff] has not provided any evidence to the contrary. Accordingly, as permitted under Pennsylvania law, and pursuant to the policy’s terms, he is permanently excluded from eligibility.”). The court did so in the context of an arbitrary and capricious standard of review.

In contrast, the court in *Jessen v. Cigna Group Insurance*, 812 F. Supp. 2d 805, 814 (E.D. Mich. 2011), held that ”[t]he statement on the front page of the policy that the ‘policy shall be governed by the laws of the state in which it is delivered’ does not alter the default rule that in evaluating questions of policy interpretation under ERISA, federal courts must develop and apply a body of substantive federal common law.” Thus, the court applied federal common law “to give some unity to the concept of ‘accident.’” *Id.* at 814-15 (citing the Sixth Circuit’s definition of “accident” in *Kovach v. Zurich Am. Ins. Co.*, 587 F.3d 323 (6th Cir. 2009)).

The Seventh Circuit has held (albeit in dicta) that a choice of law provision does not limit interpretation of an ERISA plan to state law. See *Morton v. Smith*, 91 F.3d 867, 871 (7th Cir. 1996). At least one district court within the Seventh Circuit has interpreted its decisional law to preclude application of state law in the manner employed by the Eleventh Circuit in *Buce*. See *In Re Sears Retiree Group Life Ins. Litigation*, 90 F. Supp. 2d 940, 951 (N.D. Ill. 2000) (“Even if Sears intended to adopt Illinois law for purposes of interpreting the Plan documents, ... ERISA preemption would negate such an attempt. A choice of law provision does not operate to waive the applicability of federal law regarding interpretation of an ERISA plan.”).

As to which circuit’s federal common law decisions apply, the court in *Dabertin v. HCR Manor Care, Inc.*, 177 F. Supp. 2d 829, 839 (N.D. Ill. 2001), held that a choice of law provision designating the laws of Delaware did not subject the claims to Third Circuit decisional law. Rather, Seventh Circuit law was controlling because “[c]laims that are brought under federal law must be decided under the decisional law of the Circuit in which the claim was filed” and there was “no express choice of law provision in the Plan that selects Third Circuit decisional law.” *Id.*

Finally, with regard to “residual choice of law” provisions (i.e., provisions providing for the application of state law to the extent it is not preempted by ERISA), courts have applied two different tests. The Ninth and Eleventh Circuits have held that “[w]here a choice of law is made by an ERISA contract, it should be followed, if not unreasonable or fundamentally unfair.” *Buce*, 247 F.3d at 1149; *Wang Labs., Inc. v. Kagan*, 990 F.2d 1126, 1128-29 (9th Cir. 1993).

The Fifth and Sixth Circuits have employed the Restatement (Second) of Conflict of Laws “to decide whether to give effect to a choice of law provision in an ERISA plan.” *Jimenez v. Sun Life Assurance Co. of Canada*, 486 F. App’x 398, 407 (5th Cir. 2012); *Durden*, 448 F.3d at 922-23 (6th Cir. 2006).

**Conclusion**

Litigants in ERISA cases should be aware of whether plan documents contain conformity clauses or choice of law provisions, whether those provisions are treated similarly in the jurisdiction where the suit is pending, and how the jurisdiction applies choice of law provisions with respect to plan interpretation. In any event, the interpretation of plan terms must be consistent with the substantive provisions and the underlying objectives of ERISA. See *West v. Aetna Life Ins. Co.*, 171 F. Supp. 2d 856, 880 (N.D. Iowa 2001).
Deferential Standard Applies to Decision On First Level of Administrative Review

**Harvey v. Standard Ins. Co., 503 F. App’x 845 (11th Cir. 2013)**

Harvey sued to recover ERISA disability benefits after Standard Insurance Company affirmed its original claim denial on appeal and before it completed an additional voluntary level of review. In connection with the voluntary appeal, Harvey had submitted additional information, including an award of Social Security disability benefits.

After the district court ruled in favor of Standard, Harvey appealed and made four arguments.

First, she contended that the company’s “failure” to make a decision on the voluntary appeal constituted a “deemed denial” and entitled her to de novo review.

Second, Harvey argued that Standard unreasonably disregarded several pieces of evidence submitted during the voluntary review.

Next, Harvey argued that Standard unreasonably accepted the opinions of “biased” record reviewers over the opinion of her treating physician.

Finally, she asserted that the approval of her short term claim followed by denial of her long term claim demonstrated a conflict of interest.

Rejecting the first argument, the Eleventh Circuit concluded that “Harvey was not denied a full and fair administrative review of her claim as her LTD benefits policy only required one administrative appeal for purposes of exhaustion and the regulations governing voluntary appeals do not provide any time frame for decision-making.” That Harvey did not await the company’s decision on the voluntary level of review before filing suit did not mean that she was entitled to de novo review.

Addressing the second argument, the Eleventh Circuit determined that the district court had properly concluded “that Standard did not unreasonably disregard [the additional documents] as they were not submitted to Standard until after it had rendered a final decision on her administrative appeal . . . .” Instead, Harvey had submitted these documents as part of the voluntary review, the completion of which she chose not to await before filing suit. Only the documents before Standard at the time of the initial review and at the time of the original administrative appeal were relevant, the court held.

Next, the court rejected Harvey’s argument that because the independent reviewers had been paid by Standard, they were “necessarily biased.” The record did not support evidence of bias, the court concluded. The independent reviewers acknowledged the existence of Harvey’s lumbar disc degeneration and scoliosis but determined, along with a vocational consultant, that Harvey could perform sedentary work. Harvey’s physician, by contrast, did not address the question of Harvey’s functional impairment and ability to work.

Finally, the Eleventh Circuit rejected Harvey’s conflict of interest argument based on the approval of her short term claim. Harvey did not explain why the decisions were inconsistent, and the “two forms of benefits are covered under two different policies with two different definitions of disability,” the court reasoned. 📰
No Duty under ERISA to Disclose Nonpublic Information Affecting Plan Sponsor’s Stock

Fisch v. SunTrust Banks, Inc.,
2013 WL 791414 (11th Cir. Mar. 5, 2013)

Plaintiffs brought a putative class action, asserting that the fiduciaries of an Eligible Individual Account Plan breached a duty under ERISA by failing to disclose material, negative, nonpublic financial information about the plan sponsor, where the plan sponsor’s stock was an investment option. Plaintiffs also alleged that the fiduciaries breached a duty by continuing to invest in the sponsor's stock when it was imprudent to do so.

The district court denied the fiduciaries’ motion to dismiss the disclosure claim, concluding that plaintiffs had sufficiently alleged an obligation to disclose such information. The district court dismissed the prudence claim on the grounds that it was a “veiled diversification” claim and was barred by 29 U.S.C. § 1104(a)(2). The district court certified both issues for interlocutory appeal.

The Eleventh Circuit noted that its decision in Lanfear v. Home Depot, Inc., 679 F.3d 1267 (11th Cir. 2012), resolved both questions. First, the court concluded in Lanfear “that ERISA does not impose a duty to provide plan participants with nonpublic information affecting the value of the company’s stock.” Second, the court in that case also concluded that a prudence claim “was not a veiled diversification claim, and thus does not fall within the § 404(a)(2) exemption.”

As a result, the Eleventh Circuit reversed the district court’s order in both respects.

Action to Recover Benefits under Individual Disability Policy Properly Removed to Federal Court under ERISA

Gowen v. Assurity Life Ins. Co.,

Gowen filed an action in state court, asserting state law claims to recover disability benefits and other damages against Assurity Life Insurance Company and Gowen’s insurance agent. Assurity removed the case to the federal district court, relying on federal question jurisdiction under ERISA. Gowen filed a motion to remand.

In opposition to the motion to remand, Assurity showed that Gowen was part owner of a family business, that Assurity issued disability policies to Gowen and to other family members, that all of the family members were employees of the business, and that the business paid the premiums for their policies.

In denying the motion to remand, the district court conducted a thorough analysis of issues respecting the removal of an action involving an ERISA plan.

First, the court discussed the general rule that for purposes of removal, a federal question must appear on the face of the well-pled complaint. The court noted, however, the “narrow exception” which allows removal even when a federal question does not appear on the face of the complaint and “where the preemptive force of a federal statute [such as ERISA] is so extraordinary that it converts an ordinary state law claim into a statutory federal claim.”

The court discussed the two types of ERISA preemption, complete and defensive. Complete preemption creates the basis for removal; defensive preemption does not.

Complete preemption derives from ERISA § 502(a), 29 U.S.C. § 1132(a), which “converts an ordinary state common law complaint into one stating a federal claim for purposes of the well-pled complaint rule.” Thus, state law claims seeking relief available under § 502(a) are recharacterized as ERISA claims. This requires the court to consider (1) whether the plaintiff could have brought his claim under § 502(a), and (2) whether no other legal duty supports the plaintiff’s claim.

On the other hand, defensive preemption arises from ERISA § 514(a), 29 U.S.C. § 1144(a), which expressly preempts

CONTINUED ON PAGE 6>
Caudell suffered from failing health and faced an impending judgment against him by First Georgia Banking Company. He executed a durable power of attorney, giving his son, Stephen Caudell, authority to act on his behalf as attorney-in-fact. Caudell asked Stephen to change the primary beneficiary of a life insurance policy issued by Transamerica Life Insurance Company from Caudell’s estate to his wife, Reba Caudell.

Stephen completed a beneficiary designation form to that effect, but failed to submit additional paperwork that Transamerica required when a beneficiary change was made by power of attorney. He also failed to designate contingent beneficiary percentages that equaled 100%.

Substantial Compliance with Life Insurer’s Requirements Sufficient to Change Beneficiary

Plaintiff, a medical doctor, alleged that she was disabled by the effects of electroconvulsive therapy (ECT) treatments she underwent to treat depression. Northwestern Mutual determined, however, that she was disabled due to depression, and that a 24-month mental illness limitation applied to her claim.

Plaintiff alleged that a report by the insurer's medical expert regarding ECT was deficient, because it indicated that the expert was unaware of key studies in the ECT field, that the expert misunderstood or was unaware of certain material facts, and that some of his other statements concerning the long-term effects of ECT were ambiguous.

Because Northwestern Mutual did not follow up on these deficiencies, for example, by instructing its medical reviewer to discuss the claim with the plaintiff herself and her medical care providers, the court denied Northwestern Mutual’s summary judgment on plaintiff’s claim for bad faith. The court also rejected a summary judgment challenge to the underlying breach of contract claim based on the statute of limitation.

Plaintiff also asserted claims for negligence, negligent misrepresentation, reformation, specific performance, promissory estoppel, equitable estoppel, and unjust enrichment, and she sought to recover future insurance benefits and punitive damages. The court granted summary judgment to Northwestern Mutual on all of those claims.

The basis for the negligence and estoppel claims was plaintiff’s allegation that an insurance agent had misrepresented, or alternatively had failed to explain, that the coverage she was purchasing had a mental disorder limitation. The court disposed of those claims, because there was no evidence that the agent made either a misrepresentation or a false promise about coverage.

Similarly, because there was no evidence that the agent failed to inform plaintiff of the mental disorder limitation, the court disposed of the negligence claim, stating that “there is a line of cases in South Carolina holding that where an insured fails to read and familiarize himself with...
Hunter, a former director of events for Hilton Hotels, sued Aetna Life Insurance Company to recover long-term disability benefits under his employer’s ERISA plan.

With diagnoses of sarcoidosis, hypertension, and pain in both knees, Hunter received benefits under the two-year “own occupation” test until Aetna received information from his treating physician that Hunter should be able to return to work. Although the physician later changed her opinion somewhat, she nevertheless agreed that Hunter...
Noel sought to purchase a $1 million life insurance policy from Banner Life Insurance Company. As part of the application, Noel completed a Temporary Insurance Application and Agreement (“TIAA”), which allowed for temporary insurance coverage pending approval of the application. The TIAA provided: “The Insurer’s liability will be limited to a return of the Amount Remitted if . . . any part of the life insurance application or this TIAA contains a misrepresentation material to the Insurer.”

During underwriting, Banner discovered that Noel had failed to provide accurate information about his medical history. Among other omissions, Noel did not disclose a history of elevated liver function tests, an abnormal abdominal liver ultrasound, and that his primary physician had referred him to a gastroenterologist. Banner’s medical director recommended postponing approval of the policy pending additional follow-up and diagnosis for the cause of the liver tests.

Noel died before Banner was able to notify him that it was postponing issuance of the policy. Banner then denied a claim for benefits under the TIAA due to the misrepresentations about Noel’s medical history and refunded Noel’s premium payment.

Banner filed a declaratory judgment action seeking to rescind the TIAA or to have the court declare that its obligations were limited to a return of the premium payment.

The court affirmed the district court’s grant of summary judgment to Banner. Citing Jefferson Standard Life Ins. Co. v. Clemmer, 79 F.2d 724, 733 (4th Cir. 1935), the court reaffirmed the principle that “[m]ateriality is assessed from the vantage point of the insurance company and the effect of a misrepresentation on the company’s ‘investigation and decision.’” The court found that Noel’s undisclosed medical history caused Banner to postpone issuing the policy. Thus, Noel’s misrepresentations were material under Virginia law. See, e.g., Parkerson v Fed. Home Life Ins. Co., 797 F. Supp. 1308, 1314-15 (E.D. Va. 1992) (postponement of issuing policy shows materiality).

The court rejected the proposition that the misrepresentation must be material to the issuance of the TIAA itself. The court found that the express language of the TIAA only required that a misrepresentation be material to Banner, and that a material misrepresentation in any part of the application would preclude recovery of the temporary insurance benefit. Finally, the court affirmed that Banner’s obligations were limited to refunding the premium remitted by Noel.

The Georgia Court of Appeals reviewed consolidated appeals by four applicants who sought Medicaid assistance in connection with their residential nursing home care. They argued that the Georgia Department of Community Health (“DCH”) had improperly imposed an asset transfer penalty prescribed by the federal Medicaid statute relating to long term care benefits. The applicants were considered “institutionalized spouses” under the relevant Medicaid statues and provisions.

AirTran sued Elem and her personal injury attorney under section 502(a)(3) of ERISA for reimbursement of more than $131,000 in self-funded health plan benefits paid by AirTran. The benefits were for medical treatment expenses due to injuries Elem sustained in a motor vehicle accident.

Elem filed a personal injury lawsuit against the responsible driver. Despite the fact that AirTran provided Elem and her attorney with notice of the plan’s subrogation and reimbursement rights, the lawsuit was settled and the settlement funds were distributed to Elem and her attorney without reimbursing the plan.

The personal injury lawsuit settled for $500,000, but the attorney told AirTran that the case had settled for only $25,000, and asked AirTran to accept $4,500 to resolve the reimbursement claim. AirTran discovered the true amount of the settlement, and invoked section 502(a)(3) to recover the full amount of benefits from the settlement funds in the possession of Elem and the attorney, along with an award of attorney’s fees and costs under section 502(g)(1) of ERISA. The court concluded that the attorney’s attempted concealment of $475,000 and his arguments purporting to “justify [this] deceit” were in “bad faith,” and that the arguments were “wholly unreasonable.” The court rejected objections to the fee request, and found that the factors of bad faith, deterrence, ability to satisfy the award, and the relative merits of the parties’ position justified an award of $145,723 in attorney’s fees and litigation expenses of $3,692.

Attorney’s Fees Awarded in § 502(a)(3) Action for Reimbursement of Plan Assets

AirTran Airways, Inc. v. Elem,

The court granted summary judgment to AirTran, holding that it was entitled to full reimbursement from the settlement fund under Zurich Am. Ins. Co. v. O’Hara, 604 F.3d 1232 (11th Cir. 2010). The court took note of the Supreme Court’s grant of certiorari in U.S. Airways v. McCutchen, 663 F.3d 671 (3d Cir. 2011), in which the Third Circuit disagreed with O’Hara, but elected to “proceed under existing Eleventh Circuit precedent.”

Certain Annuities Purchased by Medicaid Applicants Ruled Exempt from Federal Asset Transfer Penalty

Cook v. Bottesch,
740 S.E.2d 752 (Ga. Ct. App. 2013)
Near the time of their Medicaid applications, the spouses of three of the applicants ("the community spouses") used marital assets to purchase irrevocable, non-assignable, and actuarially sound annuities, naming themselves as the beneficiaries. The fourth applicant purchased a similar annuity, but named himself as the beneficiary.

Pursuant to § 2239 of the DCH’s Medicaid Manual, married applicants are required to name the state as the remainder beneficiary of any annuities.

While DCH ultimately approved the applications for Medicaid benefits, it withheld the nursing home benefit payments during a multi-month penalty period. The applicants claimed in part that the state Medicaid Manual violated the federal Medicaid statute, because the annuities did not fall within the definition of an “asset” for the purpose of imposing the penalty.

As the court noted, the federal Medicaid statute requires that a state plan for medical assistance must comply with federal law regarding transfers of assets, which requires state plans to impose a penalty for “disposal of assets for less than fair market value” during a certain look-back period. Under 42 U.S.C. § 1396p(c)(1)(F), the purchase of an annuity is treated as the “disposal of an asset for less than fair market value” unless the state is named as a remainder beneficiary.

The court’s ruling turned, however, on the next subsection of the statute, which provides that the term “assets” includes an annuity purchased “by or on behalf of an annuitant who has applied for medical assistance … unless … the annuity is irrevocable and nonassignable; is actuarially sound …; and provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.” 42 USC § 1396p(c)(1)(G)(ii).

The court determined that a plain reading of both subsections showed that annuities benefitting community spouses must name the state as a remainder beneficiary to avoid being treated automatically as the disposal of an asset for less than fair market value, but that annuities benefitting applicants who are institutionalized spouses, and that conform to the requirements of subsection (c)(1)(G)(ii), need not do so.

Accordingly, the court held that § 2339 of the Georgia Medicaid Manual violated the federal Medicaid statute, because it failed to exempt annuities that complied with subsection (c)(1) (G) from the requirement of naming the state as a remainder beneficiary. The court reversed the DCH’s ruling that the “institutionalized spouse” who purchased the annuity for himself was not subject to the transfer of assets penalty, and upheld the DCH’s ruling imposing a penalty on the applicants whose spouses named themselves as beneficiaries.

We enjoyed seeing many friends and colleagues from around the country who attended the Life, Health, Disability and ERISA Seminar sponsored by the Defense Research Institute in April. Nine lawyers from Smith Moore Leatherwood’s offices in Georgia, North Carolina, and South Carolina were in Boston for the seminar. Kent Coppage was the Program Chair, and Aaron Pohlmann was one of the speakers.

Contributors to this Issue

From left to right: Lisa Bondurant (Atlanta, Ga), Manning Connors (Greensboro, NC), Dorothy Cornwell (Atlanta, Ga), Nikole Crow (Atlanta, Ga), Jennifer Rathman (Atlanta, Ga), and Peter Rutledge (Greenville, SC).
Smith Moore Leatherwood LLP has earned a national reputation for excellence. The Team is comprised of attorneys who have represented ERISA entities and insurers in hundreds of cases in federal and state courts throughout the nation. In addition to claims brought under ERISA, the firm’s attorneys defend a broad variety of actions, including those brought under federal and state RICO Acts, the ADA, class actions, discriminatory underwriting claims, actions involving allegations of agent misconduct, and breach of contract claims for the recovery of life, accidental death, disability, and health insurance benefits.