APPENDIX A

16 F.4th 164

United States Court of Appeals, Fifth Circuit.

Erica TALASEK, Plaintiff—Appellant,

v.

NATIONAL OILWELL VARCO, L.P., Defendant—Appellee.

No. 21-20069

FILED October 19, 2021

Appeal from the United States District Court for the Southern District of Texas, USDC No. 4:18-CV-3306, Sim T. Lake, III, U.S. District Judge

Nitin Sud, Sud Law, P.C., Bellaire, TX, for Plaintiff—Appellant.

Wesley E. Stockard, Littler Mendelson, P.C., Atlanta, GA, Elizabeth L. Bolt, Littler Mendelson, P.C., Houston, TX, for Defendant—Appellee.

Before Owen, Chief Judge, and Clement and Duncan, Circuit Judges.

Edith Brown Clement, Circuit Judge:

This appeal arises from a dispute over life insurance benefits. Erica Talasek brought this lawsuit, stemming from a group policy sponsored by her late husband's employer. Talasek claimed benefits in the amount of $300,000 following her husband's death. The insurance company and district court denied her relief. We agree and affirm.

I.

In 2013, Ben Talasek, Erica Talasek's husband, attempted to enroll in a supplemental life insurance

plan through his employer, National Oilwell Varco, L.P. ("NOV"). Unum Life Insurance Company of America provided coverage to NOV's employees, vis à vis NOV, through issuance of a "Summary of Benefits."

On November 17, 2013, Ben Talasek received a "Benefits Confirmation Statement" from Unum, reflecting his new elections, which were to begin in 2014. The November 2013 statement noted that "[a]ny coverage listed as suspended requires approval," and it indicated that several of his elections were "suspended." The statement included these notations because Unum required its enrollees to complete an "Evidence of Insurability" form before coverage could begin. Accordingly, Ben Talasek submitted the form on January 2, 2014.

Later that month, Ben Talasek was diagnosed with pancreatic cancer. About this time, he and Unum began corresponding more frequently about his benefits. On January 18, 2014, Unum sent Ben Talasek a letter, informing him that it had identified an error in his application, specifically, with respect to his Evidence of Insurability form, and that more information was needed.[1] Accordingly, he corrected the error and re-submitted his Evidence of Insurability form.

On February 12, 2014, Ben Talasek contacted Unum again to discuss the status of his benefits and was told that the review process would take four to six weeks. Part of the review process required him to

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[1] Before receiving the letter, Ben Talasek—and an NOV representative—also called Unum to follow up on the status of his coverage.

provide blood and urine samples, which he did on March 3, 2014. Because of the subsequent "abnormal" lab results, Unum sent Ben Talasek a letter—dated March 6, 2014—explaining that it was "not able to approve the insurance coverage listed."

Ben Talasek died on December 24, 2017. Throughout this entire period, however, the Talaseks received statements from the NOV Benefits Service Center, reflecting the same elections he made in 2013 and showing that NOV was deducting funds from Ben Talasek's paycheck for the coverage. Absent from these statements were the "suspended" notations included in the November 2013 statement.

Following Ben Talasek's passing, Talasek submitted a claim under the group life insurance policy, which Unum both approved and denied. In denying Talasek's claim for $300,000 of benefits, Unum indicated that it had rejected Ben Talasek's application for supplemental life insurance by letter dated March 6, 2014. Talasek unsuccessfully appealed this decision.

As a result, Talasek brought suit against Unum and NOV in federal court in September 2018, alleging estoppel, negligence, and violations of the Employment Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*[2] Unum and NOV

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[2] Talasek's original complaint alleged only claims for ERISA denial of benefits and estoppel. She subsequently twice amended her complaint to include claims for ERISA breach of fiduciary duty and negligence and to name NOV as a defendant. Talasek named both NOV and Unum as defendants in her claims for estoppel and negligence. She named Unum as the sole defendant in her ERISA denial of benefits claim and NOV as the sole defendant in her negligence claim.

jointly moved to dismiss Talasek's claims for ERISA breach of fiduciary duty and negligence,[3] and the magistrate judge recommended that the district court grant the motion, which it did. The parties then proceeded through discovery on Talasek's estoppel and ERISA denial of benefits claims. Unum and NOV ultimately moved for summary judgment on both claims.

The magistrate judge issued a report and recommendation, recommending that the district court grant the motions for summary judgment. The district court adopted the recommendation of the magistrate judge.[4] Talasek timely appealed.

II.

"Standard summary judgment rules control in ERISA cases." *Ramirez v. United of Omaha Life Ins. Co.*, 872 F.3d 721, 725 (5th Cir. 2017) (quoting *Cooper v. Hewlett-Packard Co.*, 592 F.3d 645, 651 (5th Cir. 2009)). Thus, "[w]e review the grant of summary judgment *de novo*, applying the same standard as the district court," and take all inferences in the light most favorable to Talasek. *Bryan*

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[3] At this point, the district court referred the matter to Magistrate Judge Nancy K. Johnson. It was later referred to Magistrate Judge Christina A. Bryan.

[4] In doing so, the district court ordered Talasek to file a motion for judgment. Talasek's summary judgment briefing included a request, in the alternative, for the return of the premiums she had paid, in the event the court denied her claims. Thus, in order to fully resolve the claims at bar, the district court ordered this issue be considered. The magistrate judge issued a second report and recommendation, recommending that the district court grant Talasek's motion for judgment. The district court adopted the recommendation and then entered judgment.

v. McKinsey & Co., Inc., 375 F.3d 358, 360 (5th Cir. 2004) (citation omitted).[5]

Summary judgment is appropriate "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." *Celotex Corp. v. Catrett,* 477 U.S. 317, 322, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986) (citation omitted); *see* FED. R. CIV. P. 56.

III.

On appeal, Talasek challenges only the district court's grant of summary judgment in favor of NOV on her estoppel claim. Therefore, our review of the decision below is so confined. We conclude that she cannot meet the second element of her claim and hold that her claim must fail as a matter of law.

To survive summary judgment on her estoppel claim, Talasek needed to create a genuine dispute of material fact as to whether NOV made a material misrepresentation, on which she reasonably and detrimentally relied, under extraordinary circumstances. *Mello v. Sara Lee Corp.*, 431 F.3d 440, 444–45 (5th Cir. 2005) (Clement, J.). Caselaw regarding ERISA estoppel claims is sparse in the Fifth Circuit. Accordingly, we have often looked to our sister cir-

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[5] The parties have not contended—below or on appeal—that an abuse of discretion standard applies to Talasek's estoppel claim. "Because [Talasek's] estoppel claim is not a review of a decision of the [Unum claims administrator]," we review the decision of the district court *de novo*. *Mello v. Sara Lee Corp.*, 431 F.3d 440, 444 (5th Cir. 2005).

cuits for help in resolving these claims. *See, e.g.*, *High v. E-Systems Inc.*, 459 F.3d 573, 579–81 (5th Cir. 2006); *Mello*, 431 F.3d at 444–48.

Talasek contends that NOV misrepresented the status of her husband's life insurance coverage by continuing to deduct premiums from Ben Talasek's paycheck and by confirming these deductions in the annual benefits statements. Material misrepresentations need not stem directly from the insurance plan itself but rather "can be made in informal documents," such as NOV's Benefit Confirmation Statements. *Mello*, 431 F.3d at 445. And, where "there is a substantial likelihood that [a misrepresentation] would mislead a reasonable employee in making an adequately informed decision," a misrepresentation is material. *Curcio v. John Hancock Mut. Life Ins. Co.*, 33 F.3d 226, 237 (3d Cir. 1994) (quoting *Fischer v. Philadelphia Elec. Co.*, 994 F.2d 130, 135 (3d Cir. 1993)).

It is difficult to imagine a misrepresentation more likely to mislead a recipient. Every year for four years, Talasek and her husband received statements from NOV, purporting to identify the benefits elected and indicating the amount of the deduction for each element of coverage. *Cf. id.* ("Here[, the decedent's employer] was actually representing that the plan was offering a new benefit; thus, we find that the representations [the employer] made were 'material misrepresentations.'"). The district court acknowledged NOV's erroneous actions but failed to find that Talasek satisfied the first element of her claim. That omission was error. However, the error was harmless, as Talasek cannot create a genuine dispute of material fact with respect to the remaining elements

of estoppel.

Talasek must also have relied—(1) reasonably and (2) to her detriment—on NOV's material misrepresentation. *Mello*, 431 F.3d at 444–45. The district court found that Talasek "presented a genuine issue of material fact regarding detrimental reliance[.]" We agree. Thus, the crux of the second element is whether that reliance was reasonable.

Our precedent clearly indicates that an employee cannot reasonably rely on informal documents in the face of unambiguous terms in insurance plans. *See Nichols v. Alcatel USA, Inc.*, 532 F.3d 364, 375 (5th Cir. 2008); *High*, 459 F.3d at 580 ("[A] 'party's reliance can seldom, if ever, be reasonable or justifiable if it is inconsistent with the clear and unambiguous terms of plan documents available to or furnished to the party.'" (quoting *Sprague v. Gen. Motors Corp.*, 133 F.3d 388, 404 (6th Cir. 1998) (en banc))); *Mello*, 431 F.3d at 447; *see also Marks v. Newcourt Credit Grp., Inc.*, 342 F.3d 444, 456 (6th Cir. 2003) ("A party cannot seek to estop the application of an unambiguous written provision in an ERISA plan .... When a party seeks to estop the application of an unambiguous plan provision, he by necessity argues that he reasonably and justifiably relied on a representation that was inconsistent with the clear terms of the plan." (internal citations omitted)), *superseded on other grounds by regulation*, 29 C.F.R. § 2560.503-1(l) (2003), *as recognized in Wallace v. Oakwood Healthcare, Inc.*, 954 F.3d 879, 889 (6th Cir. 2020).

The provision of the group life insurance policy that required Ben Talasek to complete an Evidence of Insurability form before coverage could begin was unambiguous. The Summary of Benefits, provided by

Unum, is the governing document. It states, in no uncertain terms, that "[e]vidence of insurability is required for any amount of life insurance." Ben Talasek was on notice that "[c]overage applied for during an annual enrollment period" began at midnight following the later of two conditions: (1) the first day of the next plan year; and (2) "the date Unum approve[d his] evidence of insurability form for life insurance." The Summary of Benefits made clear that this was also the case for changes in coverage.

Furthermore, the Summary of Benefits also made clear that NOV's representations were not Unum's. And, perhaps most significant, it delineated when and by whom changes could be made to the terms—restricting those instances to narrow circumstances. Talasek does not argue that she and her husband relied on NOV's "representations to help [them] interpret an ambiguous or unclear term in the [Summary of Benefits]. Rather, [she] contends that [it] was reasonable to rely on [NOV's representations] *rather than* the unambiguous" group policy language. *Mello*, 431 F.3d at 445–46; *see id.* at 447 (analyzing and citing favorably *In re Unisys Corp. Retiree Med. Benefit "ERISA" Litigs.*, 58 F.3d 896, 907–08 (3d Cir. 1995)).[6] Against this backdrop, we cannot say that Talasek's reliance on NOV's statements and deductions was reasonable—no matter how frustrat-

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[6] In *Unisys Corp.*, a "company engaged in a 'systematic campaign of confusion[,]' which led employees to believe that their [retirement medical] benefits were to continue for life." 58 F.3d at 907 n.20. Nevertheless, the Third Circuit affirmed the district court's finding that the retirees' estoppel claim failed as a matter of law because the "finding that the [terms of the plan were] unambiguous undercut[ ] the reasonableness of any detrimental reliance by the retirees." *Id.* at 908.

ing those misrepresentations were in reality. Thus, Talasek cannot establish the second element of her claim.

Because Talasek cannot create a genuine dispute of material fact over the reasonable reliance aspect of the second element, we need not consider whether extraordinary circumstances existed. *See Mello*, 431 F.3d at 448. The district court did not err in granting summary judgment to NOV on Talasek's estoppel claim.

AFFIRMED.

APPENDIX B

2020 WL 7773899

United States District Court,
S.D. Texas, Houston Division.

Erica TALASEK, Plaintiff,

v.

UNUM LIFE INSURANCE COMPANY OF AMERICA, et al., Defendants.

Civil Action No. 4:18-cv-3306

Signed 12/30/2020

Nitin Sud, Sud Law P.C., Bellaire, TX, for Plaintiff.

Bill E. Davidoff, Figari & Davenport LLP, Dallas, TX, Wesley Earl Stockard, Littler Mendelson, P.C.., Atlanta, GA, Elizabeth L. Bolt, Littler Mendelson PC, Houston, TX, for Defendants.

ORDER ADOPTING MAGISTRATE JUDGE'S MEMORANDUM AND RECOMMENDATION

SIM LAKE, SENIOR UNITED STATES DISTRICT JUDGE

Having reviewed the Magistrate Judge's Memorandum and Recommendation dated December 15, 2020 (ECF 100) and the objections thereto (ECF 101), the court is of the opinion that said Memorandum and Recommendation should be adopted by this court.

It is therefore **ORDERED** that the Magistrate Judge's Memorandum and Recommendation is hereby **ADOPTED** by this court. It is further **ORDERED** that Plaintiff shall file a motion for judg-

ment awarding a return of premiums on or before January 25, 2021.

APPENDIX C

2020 WL 7775450

United States District Court,
S.D. Texas, Houston Division.

Erica TALASEK, Plaintiff,
v.
UNUM LIFE INSURANCE COMPANY OF AMERICA, et al., Defendants.

Civil Action No. 4:18-cv-3306

Signed 12/15/2020

Nitin Sud, Sud Law P.C., Bellaire, TX, for Plaintiff.

Bill E. Davidoff, Figari & Davenport LLP, Dallas, TX, Wesley Earl Stockard, Littler Mendelson, P.C., Atlanta, GA, Elizabeth L. Bolt, Littler Mendelson PC, Houston, TX, for Defendants.

MEMORANDUM AND RECOMMENDATION

Christina A. Bryan, United States Magistrate Judge

This case is governed by the Employment Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et seq*. (ERISA). The parties dispute whether Plaintiff Erika Talasek is entitled to supplemental life insurance benefits of $300,000 under a group policy sponsored by her deceased husband's employer National Oilwell Varco LP (NOV) and issued by Defendant Unum Life Insurance Company of America (Unum). Both Unum and NOV have moved for summary judgment. ECF 83, 85. Having considered the parties' written submissions, the administrative

record, and the law, the Court RECOMMENDS that Unum's and NOV's motions be GRANTED.

I. Factual and Procedural Background

The facts in this section are undisputed and supported by the Administrative Record.[1] Plaintiff's husband, Ben Talasek, began working for NOV in 2001. NOV offered its employees basic and supplemental life insurance as part of an ERISA Plan. Unum issued the basic and supplemental life insurance group policies offered by the Plan. NOV was the Plan sponsor and administrator and delegated authority and discretion to Unum to handle all claims and make benefits decisions.

Beginning in 2008, Ben Talasek was covered by the basic life insurance group policy which offered a benefit in the amount of two times his annual earnings. During the November 2013 open enrollment period, Ben elected for the first time the supplemental, also called voluntary, life insurance coverage. Unlike the basic life insurance, which did not require medical underwriting, the supplemental life insurance required an employee to submit evidence of insurability and obtain approval for coverage by Unum. On January 2, 2014, Ben submitted an "Evidence of Insurability Form." On January 18, 2014, Unum sent Ben a letter informing him of an error in his application and the need for additional information. Around this time, Ben was diagnosed with pancreatic cancer. Ben called Unum on January 21, 2014 to check on the status of his application and

[1] The Administrative Record is filed as Exhibit B to the Affidavit of Denise Legendre in the Appendix to Unum's Motion for Summary Judgment. ECF 84.

was told about the January 18 letter. Ben corrected the error on the Evidence of Insurability Form and supplied additional information. Ben called Unum again on February 12, 2014 to check on the status of the application and was told that the standard turnaround time for a coverage decision was 4-6 weeks. On March 3, 2014, several weeks after receiving his cancer diagnosis, Ben provided blood and urine samples and basic health history as part of Unum's requirement that he prove insurability prior to approval of coverage. He did not mention the cancer diagnosis.

The Administrative Record includes a March 6, 2014 letter addressed to Ben (at the same address as the January 18, 2014 letter Ben received) stating that Unum could not approve Ben's application due to abnormal blood test results. The Administrative Record does not contain any letter approving Ben's application for supplemental life insurance benefits. NOV received notice that Unum did not approve Ben's application for supplemental benefits. Despite the notice and the statements in the Plan that supplemental life insurance coverage is contingent on approval by Unum, NOV began deducting the increased premiums for supplemental coverage from Ben's paycheck in April 2014 and continued to do so through 2017. NOV also sent annual benefit confirmation statements to Ben for the years 2014 through 2017 which identified supplemental life insurance coverage as part of his benefits. Ben passed away from pancreatic cancer on December 24, 2017.

In January 2018, Plaintiff submitted a claim for both basic and supplemental life insurance benefits under the Plan's group life insurance policy. Unum

approved her claim for basic life insurance benefits in the amount of $135,000 but denied the $300,000 claim for supplemental life insurance benefits. Unum advised Plaintiff it was denying the claim because it had rejected Ben's application for supplemental life insurance on March 6, 2014 due to the abnormal test results from his required insurability medical examination. Plaintiff appealed Unum's unfavorable decision on grounds that NOV deducted premiums for supplemental life insurance and sent Ben confirmation statements reflecting the supplemental life insurance coverage was part of his benefits and that Ben never received notice that his application for supplemental coverage was rejected. Unum did not change its original claim decision.

Plaintiff filed this suit in September 2018 and on April 10, 2019 filed a Second Amended Complaint asserting claims for (1) benefits under ERISA § 502(a)(1)(B); (2) ERISA estoppel; (3) breach of fiduciary duty under ERISA § 502(a)(3)(B); and (4) negligence against NOV. ECF 16. The Court previously dismissed Plaintiff's breach of fiduciary duty and negligence claims. ECF 69, 73. Unum and NOV now move for summary judgment on Plaintiff's ERISA estoppel and § 502(a)(1)(B) claims for benefits.

II. Procedure for deciding ERISA Claims

The Fifth Circuit recently acknowledged "there is an open question whether it is appropriate to resolve ERISA claims subject to de novo review on summary judgment, or whether the district court should conduct a bench trial." *Katherine P. v. Humana Health Plan, Inc.*, 959 F.3d 206, 208 (5th Cir. 2020) (citing *Koch v. Metro. Life Ins. Co.*, 425 F. Supp. 3d 741,

746-47 (N.D. Tex. 2019) (surveying authorities). The Fifth Circuit declined to answer the question because the parties had not raised it but reversed the summary judgment in favor of the defendant and remanded the case for further proceedings due to a genuine issue of material fact precluding summary judgment. Some Courts have concluded the appropriate procedure for resolving this type of ERISA dispute is to make findings of fact and conclusions of law, consistent with Rule 52, based on the administrative record and the parties' briefing. *See Ingerson v. Principal Life Ins. Co.*, Civil Action No. 2:18-cv-227-Z-BR, 2020 WL 3163074, *1 n.3 (N.D. Tex. May 13, 2020) (making recommended findings of fact and conclusions of law pursuant to Rule 52 where parties requested trial on the administrative record and briefing); *O'Hara v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, 642 F.3d 110, 116 (2d Cir. 2011) (noting a trial on the papers followed by express findings of fact and conclusions of law under Rule 52 is appropriate where it is clear that the parties consent to a bench trial on the parties' submissions); *Hill v. Hartford Life & Accident Ins. Co.*, 1:08-CV-0754-CC, 2009 WL 10664970, at *1 (N.D. Ga. Sept. 16, 2009) (treating plaintiff's summary judgment motion on his ERISA claims as trial on the papers pursuant to Rule 52).

As in *Katherine P.*, the parties here do not object to having this case decided on motions for summary judgment, and no party has suggested that Rule 52 is the appropriate procedural mechanism for deciding this case. The parties have submitted this matter to the Court on motions for summary judgment, so the Court has considered the motions under the

summary judgment standards of Rule 56. *See Woods v. Riverbend County Club Inc.*, 320 F. Supp. 3d 901, 909-10 (S.D. Tex. 2019) (granting defendant's motion for summary judgment after de novo review of the administrative record because the fact issues raised by plaintiff were not dispositive); *see also Bunner*, 2020 WL 3493760, at *12-13 (denying summary judgment due to fact issues on Plaintiff's estoppel claim).

Summary judgment is appropriate when the "movant shows that there is no genuine issue as to any material fact and the movant is entitled to judgment as a matter of law." FED. R. CIV. PRO. 56. In ruling on a motion for summary judgment, the Court construes the evidence in the light most favorable to the nonmoving party and must draw all reasonable inferences in that party's favor. *R.L. Inv. Prop., LLC v. Hamm*, 715 F.3d 145, 149 (5th Cir. 2013).

III. Motions to Strike Evidence

Next, the Court addresses the parties' Motions to Strike in light of two principles specific to ERISA benefit claims. First, with only narrow exceptions, the evidence a court may review to decide an ERISA benefits claim is limited to the Administrative Record. *Estate of Bratton v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, 215 F.3d 516, 521 (5th Cir. 2000) ("The plan administrator has the obligation to identify the evidence in the administrative record and the claimant must be afforded a reasonable opportunity to contest whether that record is complete. Once the administrative record has been determined, the district court may not stray from it but for certain limited exceptions"); *see also Soileau & Assocs., LLC v.*

Louisiana Health Serv. & Indem. Co., No. CV 18-710-WBV-JCW, 2020 WL 1969984, at *4 (E.D. La. Apr. 23, 2020) (identifying 5 types of evidence outside the Administrative Record the Fifth Circuit has recognized as exceptions: "(1) evidence related to how an administrator has interpreted terms of the plan in the past; (2) evidence, including expert opinion, that assists the district court in understanding the medical terminology or practice related to a benefits claim; (3) evidence regarding the completeness of the administrative record; (4) evidence regarding whether the plan administrator complied with ERISA's procedural regulations; and (5) evidence regarding the existence and extent of a conflict of interest created by a plan administrator's dual role in making benefits determinations and funding the plan."). None of the recognized exceptions apply here. Second, the Federal Rules of Evidence, including the hearsay rule, do not govern the admissibility of, or preclude the court's consideration of, evidence in the Administrative Record. *Harmon v. Bayer Bus.*, No. CV H-14-1732, 2016 WL 397684, at *10 (S.D. Tex. Jan. 29, 2016) ("[H]earsay objections to documents in an Administrative Record are not valid because a court's review of the administrator's decision is based on the entire Administrative Record.").

Based on the above principals, for purposes of Plaintiff's § 502(a)(1)(B) claim against Unum and NOV all motions to strike (ECF 87, 88, 93, 98) should be granted to the extent they seek to strike evidence *outside* the Administrative Record filed at ECF 84. Conversely, all the motions to strike should be denied to the extent they seek to strike evidence contained *within* the Administrative Record, wheth-

er for purposes of Plaintiff's § 502(a)(1)(B) claim or the ERISA estoppel claims against Unum and NOV.

The remaining issue with respect to the motions to strike is whether the Court should strike evidence *outside* the Administrative Record for purposes of Plaintiff's ERISA estoppel claim against Unum or NOV. Unum moves to strike the following evidence that falls into this category: the Declaration of Garret Jackson (ECF 89-8); internal NOV correspondence and correspondence between Plaintiff and NOV related to premium payments (ECF 89-15, 16, 17); the deposition transcripts of NOV employees Mary Birk Jones and Tonya Kelley (ECF 89-19, 20, 21); and Erika Talasek's August 26, 2020 Declaration attaching tax and student loan information (ECF 89-23-27, 29). NOV moves to strike the Declaration of Garret Jackson (ECF 89-8). The evidence in this category that Plaintiff moves to strike is paragraph 7 of the Mary Birk Jones Declaration (ECF 85-3) and paragraph 4 of the Tonya Kelley Declaration (ECF 85-8).

The Fifth Circuit has not addressed whether or under what circumstances evidence outside the administrative record may be considered in the context of an ERISA estoppel claim. The parties have not cited any Fifth Circuit authority recognizing an ERISA estoppel claim as an exception to the general rule that limits a district court's review of ERISA benefit claims to the administrative record. Unum argues the Court may review only the Administrative Record when deciding Plaintiff's equitable estoppel claims, citing *Mullica v. Minnesota Life Ins. Co.*, CIV. A. 11-4034, 2013 WL 5429295, at *3 (E.D. Pa. Sept. 27, 2013) and *Bratton v. Schlumberger*

Tech. Corp. Pension Plan, No. 06-1747, 2007 WL 3010353, at *406 (W.D. La. Oct. 12, 2007). ECF 93 at 2, n.1. The decisions in *Mullica* and *Bratton* are based on the rationale that discovery should not be permitted on an ERISA estoppel claim where the plaintiff had an opportunity to establish the record in support of the claim during the administrative process.[2] Plaintiff has cited no contrary authority. *See* ECF 99. In this case, Plaintiff clearly had the opportunity to establish the record on her ERISA estoppel theory during the claims process and appeal. *See* ECF 84-3 at 141-175 (Plaintiff Affidavit with attached evidence). The estoppel claim was also addressed on appeal, at least as it pertains to Unum. *See Id.* at 193-200 (decision on appeal). Thus, Unum's motion to strike evidence outside the Administrative Record should be granted for purposes of Plaintiff's ERISA estoppel claim.[3]

But, with respect to the estoppel claim against NOV, Plaintiff and NOV conducted discovery by agreement and neither objects to the Court's consideration of material outside the administrative record for purposes of deciding Plaintiff's ERISA estoppel

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[2] *Mullica* does not expressly explain this rationale, but relies on *Cramer v. Appalachian Regional Healthcaare, Inc.*, Civil Action No. 5:11-49-KKC, 2012 WL 996583, at * 4 (E.D. Kty 20012), which does.

[3] As noted above, this ruling applies to the Declaration of Garret Jackson (ECF 89-8); internal NOV correspondence and correspondence between Plaintiff and NOV related to premium payments (ECF 89-15, 16, 17); the entire transcripts of depositions of NOV employees Mary Birk Jones and Tonya Kelley (ECF 89-19, 20, 21); and Erika Talasek's August 26, 2020 Declaration attaching tax and student loan information (ECF 89-23-27, 29). However, none of this evidence is dispositive, or even particularly relevant, to Plaintiff's claims against Unum.

claim against NOV. *See* ECF 88, 98. NOV objects to paragraph 6 of the Declaration of Garret Jackson, which is outside the Administrative Record, only because it is hearsay for which there is no exception, it lacks foundation, and it is speculative.[4] Paragraph 6 of Jackson's Declaration reads:

> Over the next few years, throughout 2014-2017, I had several conversations with Ben at work where he did reference the fact that he had supplemental life insurance through his employment with NOV. During these conversations, he essentially indicated that he was glad that he had obtained that insurance policy because it would help take care of his family after he was gone.

ECF 89-8. Although hearsay objections are not valid with respect to evidence in the administrative record, they do apply to evidence that is *outside* the administrative record. *See Harmon*, 2016 WL 397684, at *10 ("In an ERISA case, however, hearsay objections to documents *in an Administrative Record* are not valid because a court's review of the administrator's decision is based on the entire Administrative Record." (emphasis added)). The Court finds, only for purposes of this Memorandum and Recommendation, that the statements in Paragraph 6 are hearsay and recommends granting NOV's motion to strike Paragraph 6. However, as explained below, even if the Court denied the Motion to Strike and considered Paragraph 6 as evidence of Ben Talasek's

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[4] Plaintiff did not respond to NOV's Motion to Strike and under Local Rules 7.3 and 7.4 the Court may deem it unopposed. Nonetheless, the lack of response is not the basis for the Court decision to strike the Jackson Declaration.

reliance on representations by NOV, Plaintiff still cannot demonstrate all the necessary elements of an ERISA estoppel claim.

Plaintiff, in turn, objects to portions of Mary Birk Jones's Declaration (ECF 85-3) which state NOV "mistakenly released the 'suspended' status hold" for Ben Talasek and that this "mistake" led to an error in premium deductions and to the removal of the "suspended" notation on benefits statements. Plaintiff also objects to portions of the Declaration of Tonya Kelley (85-8) which state the NOV benefits center "mistakenly released the 'suspended' status hold on the Voluntary Employee Life Insurance coverage for Mr. Talasek without marking the coverage as denied." However, Plaintiff fails to provide a legal basis for striking these statements in Jones's and Kelley's Declarations. She contends the statements are contrary to their deposition testimony, but as explained by NOV in response to the motion to strike, the statements are in fact consistent with prior testimony. The statements reflect the personal knowledge of the affiants obtained from their involvement with the claim and review of NOV business records. Plaintiff's motion to strike portions of the Jones and Kelley Declarations (ECF 88) should be denied.

In summary, Plaintiff's Motions to Strike (ECF 87, 88) should be denied; Unum's Motion to Strike (ECF 93) should be granted; and NOV's Motion to Strike (ECF 98) should be granted in part and denied in part. Again, the Court notes the stricken evidence is not dispositive of any issue before the Court and the recommended rulings on the motions to strike do not impact the Court's recommendations on the motions for summary judgment.

IV. Analysis

A. Claim for Benefits Under § 502(a)(1)(B)

1. Standard of Review

The Court must determine the proper standard of review to be applied to Unum's denial of benefits when deciding Plaintiff's § 502(a)(1)(B) benefits claim. NOV argues that because as Plan administrator, it "delegated to Unum discretionary authority to make benefits determinations," this Court must review Unum's denial of Plaintiff's claim for benefits using an abuse of discretion standard.[5] *See* ECF 85 at 19. Plaintiff did not brief the standard of review but appears to assume the abuse of discretion standard applies. *See* ECF 89 at 8; 18 (stating "the Plan Administrator abused its discretion"). However, Unum, the party whose decision is under review, essentially conceded in its Motion for Summary Judgment that de novo review is required.[6] *See* ECF 83 at 8 (stating that the issue to be decided by the Court is whether Unum's "claim decision was correct."); *See also*, *Pike v. Hartford life and Acc. Ins. Co.*, 368 F. Supp.3d 1018, 1030 (E.D. Tex. 2019) (under a de novo standard of review, the Court's task is to determine whether the administrator made a correct decision); *Ingerson v. Principal Life Ins. Co.*, Civil Action No. 2:18-cv-227-Z-BR, 2020 WL 3163074, *8 (N.D. Tex. May 13, 2020) (same).

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[5] NOV does not cite *Ariana M. v. Humana Health Plan of Tex., Inc.*, 884 F.3d 246, 247 (5th Cir. 2018) or other current authority on this issue.

[6] Unum changed its tune in its Reply, seeking to hold Plaintiff to her concession that abuse of discretion is the proper standard. ECF 92 at 5 n.1.

Generally, if the plan at issue lawfully delegates discretionary authority to a plan administrator, the Court's review is limited to determining whether the plan administrator abused that discretion. *Bunner v. Dearborn Nat'l Life Ins. Co.*, No. CV H-18-1820, 2020 WL 3493760, at *7 (S.D. Tex. May 26, 2020), report and recommendation adopted, No. CV H-18-1820, 2020 WL 3490611 (S.D. Tex. June 26, 2020) (citing *Ariana M. v. Humana Health Plan of Tex., Inc.*, 884 F.3d 246, 247 (5th Cir. 2018). If the ERISA plan does not have a valid delegation clause, the Court's review is de novo for both legal and factual determinations. *Id.*

The Plan Summary of Benefits in this case contains a discretionary clause.[7] ECF 84-1 at 75. However, Texas law prohibits insurers from using discretionary clauses. *See Bunner*, 2020 WL 3493760, at *7 (citing TEX. INS. CODE § 1701.062(a); TEX. ADMIN. CODE § 3.1203); *Woods v. Riverbend Country Club, Inc.*, 320 F. Supp. 3d 901, 909 (S.D. Tex. 2018). The Fifth Circuit has not ruled definitively on whether ERISA pre-empts Texas's anti-delegation statute. *See Ariana M.*, 884 F.3d at 250 and n.2 (de-

[7] DISCRETIONARY ACTS

The Plan, acting through the Plan Administrator, delegates to Unum and its affiliate Unum Group discretionary authority to make benefit determinations under the Plan. Unum and Unum Group may act directly or through their employees and agents or further delegate their authority through contracts, letters or other documentation or procedures to other affiliates, persons or entities. Benefit determinations include determining eligibility for benefits and the amount of any benefits, resolving factual disputes, and interpreting and enforcing the provisions of the Plan. All benefit determinations must be reasonable and based on the terms of the Plan and the facts and circumstances of each claim.

clining to address preemption but noting that "[e]ach court to decide this issue has concluded that ERISA does not preempt state anti-delegation statutes"); *Rittinger v. Healthy All. Life Ins. Co.*, 914 F.3d 952, 955 (5th Cir. 2019) (declining to address preemption because "even though Texas Insurance Code § 1701.062 bans insurers' use of delegation clauses in Texas, Missouri law governs this case"). In the absence of clear guidance, district courts within the Fifth Circuit have differed in their approach to the pre-emption issue. *Compare Bunner*, 2020 WL 3493760, at *7 (applying de novo review in light of Texas law) *with Experience Infusion Centers, LLC v. Wilsonart, LLC*, No. 4:19-CV-868, 2020 WL 6365528, at *2 (S.D. Tex. Sept. 9, 2020) (applying abuse of discretion review where the parties did not dispute that the policy vested Plan Administrator with discretion); *see also Lebron v. Boeing Co.*, No. CV H-18-3935, 2020 WL 444428, at *2 (S.D. Tex. Jan. 13, 2020), report and recommendation adopted sub nom. *Lebron v. Boeing Co. Employee Health & Welfare Plan*, No. 4:18-CV-3935, 2020 WL 430964 (S.D. Tex. Jan. 28, 2020) (applying a de novo standard of review "because the validity or lawfulness of the delegation cannot be determined on this record, and because the courts that have considered the applicability of section 1701.062 of the Texas Insurance Code have found that it does render a delegation of discretionary authority unenforceable.).

The Court makes no finding as to whether Texas law applies in this case, but will apply the de novo standard of review to Unum's denial of benefits in this case because (i) Unum essentially conceded in its motion for summary judgment that de novo re-

view applies; (ii) no party has established that the delegation clause recited above is "valid;" and (iii) in this particular case, the Court's decision on the motions for summary judgment would be the same under either standard.

2. Unum's Benefits Decision Was Correct

Unum received Plaintiff's claim for life insurance benefits on January 22, 2018. ECF 84-2 at 2. The claim form indicated that Ben Talasek was hired by NOV on April 23, 2001, last worked on December 23, 2017, paid premiums through December 31, 2017, had an annual salary of $70,695.33, and died on December 24, 2017.[8] *Id.* at 29. Plaintiff's claim sought basic life benefits of $142,000 and supplemental, or voluntary, life benefits of $300,000. *Id.* Unum promptly confirmed receipt of the claim and asked Plaintiff to return a copy of the death certificate. *Id.* at 23. Unum also immediately notified NOV of the claim and asked for information to support the claim. *Id.* at 18. Very shortly thereafter, Unum discovered in its files an adverse decision letter dated March 6, 2014. *Id.* at 11. Unum again contacted NOV and asked for any information that showed Unum's approval of supplemental coverage. *Id.* NOV responded that its records show Ben Talasek elected $300,000 supplemental benefits as of January 1, 2014 and provided payroll information showing payroll premium deductions beginning in April 2014. *Id.*

[8] Unum later confirmed that Ben's last day of work was August 17, 2017 and he received a pay raise after that date. ECF 84-2 at 185, 188. His salary as of his last day of work was used to calculate basic life benefits and that decision is not at issue here.

at 10, 141. NOV could not provide any information showing that Unum approved coverage. *Id.* at 178. However, a screen shot from NOV's human resources program shows the status of Ben's application as "Declined" as of 03/06/2014. *Id.* at 123.

In light of Plaintiff's belief that supplemental life insurance coverage began in January 2014 despite Unum's inability to locate any evidence in its own or NOV's files showing Ben had been approved for supplemental life insurance coverage, Unum's claims handler reached out to Unum's National Client Manager for assistance. ECF 84-2 at 177. The National Client Manager confirmed that NOV received notification from Unum in March 2014 that Ben's supplemental coverage was declined. ECF 84-3 at 8. Also, an "action report" in the claims file shows that Ben's application for $300,000 in supplemental coverage was declined as of March 6, 2014. *Id.* at 22.

Plaintiff contacted Unum for a status update several times while the claim was pending and was told that the claim was still under review. *Id.* at 23, 47. On March 8, 2018, Unum informed Plaintiff that while basic benefits would be released soon, the claim for supplemental benefits was still under review because Unum's records showed that supplemental life insurance coverage was declined based on Ben's medical history. *Id.* at 78. Plaintiff expressed concern because Ben had paid premiums for the coverage and received benefit confirmation statements from NOV. *Id.* In a March 13, 2018 letter, Unum notified Plaintiff that it was unable to approve her claim for supplemental life insurance benefits because it had not approved the January 2, 2014 Evidence of Insurability form submitted by Ben

and therefore he was not covered by the supplemental life insurance policy at the time of his death. *Id.* at 97-100.

Plaintiff appealed Unum's unfavorable decision on June 19, 2018. *Id.* at 138-40. Plaintiff argued that Ben was covered for $300,000 in supplemental life insurance because: (i) premiums for the coverage were deducted from his paychecks beginning in April, 2014; (ii) benefits confirmation statements from 2013, 2014, 2015, 2016, and 2017 show he was enrolled in the voluntary employee life plan; and (iii) neither Ben nor Plaintiff received the March 6, 2014 denial letter. *Id.* Plaintiff supported the appeal with her Affidavit attaching the benefit confirmation statements, payroll records, and statements from friends saying Ben had told them how happy he was to have insurance for his family. *Id.* at 141-175. Her Affidavit confirmed that Ben was diagnosed with pancreatic cancer in January 2014. *Id.* at 141.

Records from medical underwriting regarding Ben's 2014 application for supplemental life insurance show that Ben first submitted the required Evidence of Insurability Form at 11:58 p.m. on January 2, 2014. ECF 84-2 at 132. The form incorrectly listed Ben's name where it should have listed his spouse's name. ECF 84-2 at 127. It also shows Ben answered "no" in response to whether he had received medical advice or sought treatment for cancer or gastrointestinal issues in the past 7 years. ECF 84-2 at 127-129. On January 21, 2014 Ben called Unum to check on the status of his application on and was told to correct the spousal information and resubmit the form. ECF 84-3 at 118. Ben returned a corrected form, signed by himself and Plaintiff, on January 28, 2014.

Ben again called to check the status of his application on February 13, 2014 and was told the standard turnaround time for a decision was 4-6 weeks. *Id.* at 119. On March 3, 2014 Ben gave blood and urine samples as part of the exam for evidence of insurability. *Id.* at 186. Lab results from these samples showed multiple abnormalities. *Id.* at 188-90. Notes created for appeal by medical underwriting indicate Ben's medical records show an office visit with an oncologist on January 20, 2014 and that appointments with an oncologist usually occur after a referral from another physician. *Id.* at 207. The notes confirm that Ben did not reveal his cancer diagnosis to Unum at any time during the medical underwriting process which spanned the period from January 2, 2014 through March 3, 2014. *Id.* After his March 3, 2014 exam, Ben never called Unum to check on the status of his application. The record contains no statement from Unum approving Ben's application for supplemental life insurance benefits. Unum issued a decision upholding its claim decision on July 12, 2018. *Id.* at 193-200.

Plaintiff makes three arguments in this Court for why Unum's decision is not correct. First, Plaintiff argues Unum failed to "take action" within two years of inception of coverage for alleged misrepresentations in Ben's application. Plaintiff cites the following provision of the group policy in support of this position:

> HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?
>
> Unum considers any material statements you or your Employer make in signed application

> for coverage or an evidence of insurability form a representation and not a warranty. If any of the material statements you or your Employer make or not complete and/or not true at the time they are made, we can:
>
> - reduce or deny any claim; or
>
> - cancel your coverage from the effective date.
>
> * * *
>
> Except in cases of fraud, Unum can take action only in the first 2 years coverage is in force.

ECF 84-1 at 39. This provision is inapplicable because the supplemental life insurance coverage was never in force and Unum did not deny Plaintiff's claim based on misstatements in Ben's application.

Second, Plaintiff argues that Unum's acceptance of the premiums for supplemental life insurance which were deducted from Ben's paychecks and sent to Unum by NOV creates coverage. The Fifth Circuit has rejected the argument that the payment of premiums can create coverage that otherwise does not exist. *See Amschwand v. Spherion Corp.*, 505 F.3d 342, 344 (5th Cir. 2007) (widow of employee who "timely paid the basic and supplemental life insurance premiums while on disability leave until his death" not entitled to benefits), *overruled on other grounds by Gearlds v. Entergy Services, Inc.*, 709 F.3d 448, 452 (5th Cir.2013); *Sanborn-Alder v. Cigna Grp. Ins.*, 771 F. Supp. 2d 713, 728 (S.D. Tex. 2011) ("payment of premiums [did not] create coverage under the plan where coverage did not exist under the terms of the plan or the policy"). *Khan v. Am. Int'l Grp., Inc.*, 654 F. Supp. 2d 617, 630 (S.D. Tex. 2009) ("In numerous cases, courts have upheld the denial

of benefits under a policy despite the defendants' acceptance of premiums for that policy." (citations omitted)).

Third, Plaintiff contends that she is entitled to benefits because she and Ben never received the March 6, 2014 letter. Even if Plaintiff could demonstrate she and Ben did not receive the denial letter,[9] she still would not be entitled to benefits because nothing in the record demonstrates that Unum ***approved*** Ben's Evidence of Insurability Form as required by the policy. Without such approval, the supplemental life insurance coverage for which Ben applied during open enrollment never began. The language of the policy makes clear that coverage applied for during an annual enrollment period begins on the later of the first day of the next plan year or the date Unum approves the evidence of insurability form:

> Group 1
>
> This plan provides additional benefits in addition to the basic benefit. When you first become eligible for coverage, you may apply for any number of benefit units, however, you cannot be covered for more than the maximum benefit available under the plan.
>
> * * *
>
> If you do not apply for additional benefits on or before the 31st day after your eligibility date, you can only apply at the next annual enrollment period or within 31 days of a change in

[9] Despite her whole-hearted belief that Ben would have told her about the letter, Plaintiff has no proof that Ben never received it.

> status. Evidence of insurability is required for any amount of life insurance. Evidence of insurability is not required for accidental death and dismemberment insurance.
>
> Coverage applied for during an annual enrollment period will begin at 12:01 a.m. on the later of:
>
> - the first day of the next plan year; or
>
> - the date Unum approves your evidence of insurability form for life insurance.
>
> * * *
>
> EVIDENCE OF INSURABILITY means a statement of your or your dependent's medical history which Unum will use to determine if you or your dependent is approved for coverage. Evidence of insurability will be at Unum's expense.

ECF 84-1 at 28-29, 61. In addition, other evidence in the record besides the March 6, 2014 letter demonstrates that Unum did not approve Ben's application for supplemental coverage — the denial was noted on NOV's human resources reports, and in the notes of medical underwriting. *See* ECF 84-3 at 8, 22, 207.

Based on a de novo review of the Administrative Record, the Court concludes that Unum's decision to deny Plaintiff's claims for $300,000 in supplemental life insurance benefits was correct.

B. Claim for Benefits Based on ERISA Estoppel

The Fifth Circuit first recognized ERISA estoppel as a cognizable legal theory in *Mello v. Sara Lee Corp.*, 431 F.3d 440, 444–45 (5th Cir. 2005). The el-

ements of ERISA estoppel are: (1) a material misrepresentation; (2) reasonable and detrimental reliance upon the representation; and (3) extraordinary circumstances. *Id.* The parties in this case do not address whether the administrative record should be reviewed de novo or for abuse of discretion for purposes of the ERISA estoppel claim. *Mello* supports de novo review. 431 F.3d at 444 ("Because Mello's estoppel claim is not a review of a decision of the Committee, the district court properly exercised *de novo* review."). Hence, the Court reviews the administrative record de novo when analyzing Plaintiff's ERISA estoppel claims.

1. Plaintiff cannot demonstrate a material misrepresentation by Unum.

Material misrepresentations contained in informal documents such as benefits statements can support a claim for ERISA estoppel. *Id.* at 445. "A misrepresentation is 'material' if there is a substantial likelihood that it would mislead a reasonable employee in making an adequately informed decision." *Id.* On the other hand, a failure to disclose information, particularly if not done with intent to deceive, is not a "material misrepresentation" giving rise to an ERISA estoppel claim. *Khan v. American Intern. Group, Inc.*, 654 F. Supp. 2d 617, 629 (S.D. Tex. 2009) (citing *Burstein v. Ret. Account Plan for Emps. of Allegheny Health Education and Research Found.*, 334 F.3d 365, 383 (3d Cir. 2003) for the proposition that ERISA reporting errors or disclosure violations do not support an ERISA estoppel claim).

Plaintiff cannot point to a material misrepresen-

tation made by Unum and therefore cannot demonstrate the first required element of ERISA estoppel as to Unum. Unum never misrepresented to Ben that the evidence of insurability requirement did not apply to him or that he was approved for supplemental life insurance benefits. NOV's actions, such as providing erroneous annual benefits confirmation statements and making erroneous payroll deductions for premiums, cannot be attributed to Unum because the policy expressly prevents NOV from acting as an agent for Unum. ECF 84-1 at 40. ("Under no circumstances will your Employer be deemed the agent of Unum."). Because Plaintiff cannot demonstrate a misrepresentation by Unum, summary judgment should be granted on Plaintiff's ERISA estoppel claim against Unum.

2. Plaintiff cannot demonstrate reasonable reliance.

The second element of ERISA estoppel requires reliance on a material misrepresentation that is both detrimental and reasonable. *Id.* Because an ERISA plan cannot be modified by oral or informal communications, an employee cannot *reasonably* rely on material misrepresentations contained in informal documents if the unambiguous terms of the plan or policy refute entitlement to benefits. *Id.* at 446-47; *see also High v. E-Sys. Inc.*, 459 F.3d 573, 580 (5th Cir. 2006) ("High cannot reasonably rely on the actual receipt of disability benefits when the policy itself details that such reliance is unreasonable."); *Nichols v. Alcatel USA, Inc.*, 532 F.3d 364, 375 (5th Cir. 2008) ("[T]here can be no 'reasonable reliance on informal documents in the face of unambiguous Plan

terms'").

As to NOV, Plaintiff cannot meet her burden as to the second element of an ERISA estoppel claim. Plaintiff has presented a genuine issue of material fact regarding detrimental reliance but cannot show that the reliance was reasonable.[10] Under the terms of the group supplemental life insurance policy, Ben was required to submit Evidence of Insurability in support of his application, and Unum coverage would begin only after Unum approved the Evidence of Insurability form. ECF 84-1 at 28-29, 61. In light of the policy requirements, it was not reasonable for Ben and Plaintiff to rely on NOV's conduct in deducting premiums and sending benefit confirmation statements as supplemental life insurance coverage. For example, in *Sanborn-Alder v. Cigna Grp. Ins.*, 771 F. Supp. 2d 713, 731 (S.D. Tex. 2011), Sandborn-Alder sued to recover benefits she believed she was due under her deceased husband's voluntary life insurance policy. The insurer denied her claim, stating that the certificate of insurance issued to her husband indicating $400,000 in supplemental life insurance coverage was issued in error. *Id.* at 722-23. Sandborn-Alder alleged that she and her husband relied to their detriment on the certificate of insurance when they let other insurance lapse and made premium payments for over two and a half years. *Id.* The court ruled that reliance on the certificate of insurance was not reasonable because the husband was not eligible for supplemental coverage under the terms of the plan and policy. *Id.* at 431. Likewise,

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[10] The Affidavit of Garrett Jackson, ECF 89-8, if considered as proper evidence, is evidence only of Ben's detrimental reliance; it is not evidence that Ben's reliance was reasonable.

reliance on NOV's payroll deductions and benefit statements was not reasonable in light of the requirement in the policy that Unum approve the Evidence of Insurability form before coverage would begin. In addition, the 2016 Benefits Confirmation Statement sent by NOV gave further notice to Ben and Plaintiff that regardless of the elections reflected in the statement, "Insurance company approval through the Evidence of Insurability (EOI) process must be granted for these benefits before coverage and deductions can begin." ECF 84-3 at 152.

The facts of this case make reliance on NOV's representations particularly unreasonable. Ben and Plaintiff knew he had cancer before he submitted the signed and corrected Evidence of Insurability Form on January 28, 2014 on which he failed to give honest answers about his medical history. Ben also knew his application for supplemental life insurance had to be approved by Unum because he called to inquire about the status of the approval during January and February 2014, and was told the underwriting decision usually took between four and six weeks. He also submitted to a paramedical examination and gave blood and urine samples for the Evidence of Insurability on March 3, 2014. Yet, after early March 2014 he never again inquired of Unum about the status of his application. These case-specific facts, in addition to the policy language, prevent reliance on the deduction of premiums and annual benefit statements from being reasonable.

3. Plaintiff cannot demonstrate extraordinary circumstances.

The third required element of ERISA estoppel,

"extraordinary circumstances," generally requires "(1) acts of bad faith; (2) attempts to actively conceal a significant change in the plan; (3) the commission of fraud; (4) circumstances where a plaintiff repeatedly and diligently inquired about benefits and was repeatedly misled; or (5) an especially vulnerable plaintiff." *Brown v. Aetna Life Ins. Co.*, 975 F. Supp. 2d 610, 625-26 (W.D. Tex. 2013). Thus, mistakes or oversights do not constitute extraordinary circumstances, but "acts of bad faith on the part of the employer, attempts to actively conceal a significant change in the plan, or the commission of fraud" can evidence extraordinary circumstances. *See Khan*, 654 F. Supp. 2d at 629 (quoting *Burstein*, 334 F.3d at 383 and citing *High*, 459 F.3d at 580 n.3); *see also Nicholas v. KBR, Inc.*, No. CV H-07-0657, 2010 WL 11531123, at *16 (S.D. Tex. Aug. 24, 2010), aff'd, 427 F. App'x 371 (5th Cir. 2011).

Although Ben's death from cancer at a young age and his family's loss of a husband, father and breadwinner are tragic, no "extraordinary circumstances" warrant an award of damages based on ERISA estoppel. *See Nicholas*, 2010 WL 11531123, at *16-17 (describing cases in which courts have declined to find extraordinary circumstances absent fraud or an intent to deceive and failing to find extraordinary circumstances where widow was denied life insurance benefits). The evidence does not support a finding that NOV intentionally collected excessive premiums from Ben Talasek or sent him inaccurate benefits statements in bad faith.[11] NOV

[11] Even ignoring the testimony of NOV representatives to which Plaintiff objected (ECF 88), and which claims "human error" or mistaken data entry, the record fails to demonstrate

remitted the premiums to Unum and did not profit from its error. The Third Circuit in *Gridley v. Cleveland Pneumatic Co.*, 924 F.2d 1310, 1319 (3d Cir. 1991) addressed a similar situation. In *Gridle*y, the plaintiff asserted an equitable estoppel claim seeking increased death benefits due under an amendment to her husband's group policy that took effect after he ceased working due to terminal cancer. *Id.* at 1311. Her claim was denied on the grounds that only employees actively working at the time of the amendment were entitled to increased benefits. *Id.* Plaintiff argued she reasonably relied on misrepresentations in a plan brochure that did not include the "actively at work" requirement, and on the fact that after she returned a card indicating she wanted the higher benefit, defendant began deducting the increased premiums associated with the higher benefit. *Id.* at 1314-15. The *Gridley* Court concluded these facts did not constitute "extraordinary circumstances" for purposes of ERISA estoppel. *Id.* at 1319. *see also Sandborn*-Alder, 771 F. Supp. 2d at 731 (widow whose husband relied on issuance of certificate of insurance and collection of premium payments by insurer could not show extraordinary circumstances because she had no evidence that insurer or employer acted in bad faith, concealed plan changes, or committed fraud).

Plaintiff also argues she is an "especially vulnerable plaintiff," comparing herself to the plaintiff in *Bunner*, 2020 WL 3493760, at *12-13. The comparison is inapt. Plaintiff Bunner, who was also the insured employee under her employer's ERISA plan, was a "single woman solely responsible for her own

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bad faith by NOV.

care and support" who "was already experiencing cognitive decline at the time of the relevant misrepresentations were made." *Id.* Plaintiff does not allege or present evidence that she or Ben were suffering from cognitive decline at the time of the alleged misrepresentations or their alleged reliance on them.

Because Plaintiff cannot create a genuine issue of material fact as to each element of an ERISA estoppel claim against Unum or NOV, the Court recommends that their motions for summary judgment on Plaintiff's ERISA estoppel claim be granted.

C. Return of Premiums

The pending motions for summary judgment do not resolve Plaintiff's claim for a refund of the premiums erroneously deducted from Ben's paychecks. Unum represents that it has instructed NOV to refund Plaintiff the premiums that were paid for the additional coverage. ECF 83 at 15 n.7. NOV represents that Unum has not returned the money NOV submitted in error, but nonetheless it offered to refund the premiums to Plaintiff if she completed and returned a W-9 tax form. Plaintiff refused to provide the requested W-9. NOV obtained a completed form W-9 from another case handled by her counsel and issued a check payable to counsel on behalf of Plaintiff. ECF 85 at 17 and n.7.

Plaintiff objects to NOV's attempts to refund the premiums on four grounds: (1) the refund should come from Unum; (2) the refund must include interest; (3) payment to counsel on behalf of Plaintiff is not equivalent to payment directly to Plaintiff; and (4) NOV assumed payment should be paid to Plaintiff instead of Ben's estate. ECF 89 at 24.

The current record is insufficient for the Court to recommend entry of judgment on the return of the premiums. If the recommendations herein are adopted by the District Court, Plaintiff must file a motion for judgment seeking an award of premiums and presenting authority for her four positions listed above. Defendants will then have an opportunity to respond before final judgment will be entered in this case.

V. Conclusion and Recommendation

For the reasons discussed above, the Court RECOMMENDS that Plaintiff's Motions to Strike (ECF 87, 88) be DENIED, Unum's Motion to Strike (ECF 93) be GRANTED, and NOV's Motion to Strike (ECF 98) be GRANTED IN PART and DENIED IN PART as specifically set forth above.

The Court further RECOMMENDS that Unum's and NOV's Motions for Summary Judgment (ECF 83, 85) be GRANTED, and that Plaintiff be ordered promptly to file a motion for judgment awarding a return of premiums paid in error.

The Clerk of the Court shall send copies of the memorandum and recommendation to the respective parties, who will then have fourteen days to file written objections, pursuant to 28 U.S.C. § 636(b)(1)(c). Failure to file written objections within the time period provided will bar an aggrieved party from attacking the factual findings and legal conclusions on appeal. *Douglass v. United Servs. Auto. Ass'n*, 79 F.3d 1415, 1428-29 (5th Cir. 1996) (en banc), superseded by statute on other grounds.

APPENDIX D

2021 WL 981292

United States District Court,
S.D. Texas, Houston Division.

Erica TALASEK, Plaintiff,
v.
UNUM LIFE INSURANCE COMPANY OF AMERICA, et al., Defendants.

Civil Action No. 4:18-cv-3306
Signed 03/16/2021

Nitin Sud, Sud Law P.C., Bellaire, TX, for Plaintiff.

Bill E. Davidoff, Figari & Davenport LLP, Dallas, TX, for Defendants.

ORDER ADOPTING MAGISTRATE JUDGE'S MEMORANDUM AND RECOMMENDATION

SIM LAKE, SENIOR UNITED STATES DISTRICT JUDGE

Having reviewed the Magistrate Judge's Memorandum and Recommendation dated February 26, 2021 (ECF 109), to which there are no objections, the court is of the opinion that said Memorandum and Recommendation should be adopted by this court.

It is therefore **ORDERED** that the Magistrate Judge's Memorandum and Recommendation is hereby **ADOPTED** by this court. The Court will issue a separate Final Judgment.

APPENDIX E

2021 WL 1009336

United States District Court, S.D. Texas, Houston Division.

Erica TALASEK, Plaintiff,
v.
UNUM LIFE INSURANCE COMPANY OF AMERICA, et al., Defendants.

CIVIL ACTION NO. 4:18-cv-3306
Signed 02/26/2021

Nitin Sud, Sud Law P.C., Bellaire, TX, for Plaintiff.

Bill E. Davidoff, Figari & Davenport LLP, Dallas, TX, for Defendant Unum Life Insurance Company of America.

Wesley Earl Stockard, Littler Mendelson, P.C., Atlanta, GA, Elizabeth L. Bolt, Littler Mendelson PC, Houston, TX, for Defendant National Oilwell Varco LP.

MEMORANDUM AND RECOMMENDATION

Christina A. Bryan, United States Magistrate Judge

On December 30, 2020, the District Court adopted this Court's December 15, 2020 Memorandum and Recommendation granting Defendants' Motions for Summary Judgment. ECF 100, 102. Based on the summary judgment briefing, the Court understood Plaintiff to be seeking a return of premiums in the event her claims for benefits were denied and ordered her to file a Motion for Judgment in order to

fully resolve all claims in this case. *See* ECF 100 at 21.

Plaintiff filed a Motion for Judgment against Defendant Unum seeking awards of $1,325.25 for premiums, pre-judgment interest of $392.52, and attorney's fees of $2,480.00. ECF 103. Unum responded that it did not object to entry of judgment refunding premiums but did object to judgment for interest and attorney's fees.[1] ECF 104 at 2. Defendant NOV filed a Notice informing the Court that while no response from it was necessary because the Motion for Judgment was directed only to Unum, it joins in Unum's reasoning. ECF 105. In her Reply, Plaintiff clarifies: "It is accurate that Talasek was not seeking the return of premiums as a form of relief in this case. Talasek filed her motion [for judgment] based on the Court's order and will be appealing the decision to grant summary judgment in favor of the defendants." ECF 106. Plaintiff filed her Notice of Appeal on January 29, 2021, indicating her position that the District Court's adoption of the Memorandum and Recommendation was a final judgment resolving all claims in this case. ECF 107.

Federal Rule of Civil Procedure 54(c) provides:

> A default judgment must not differ in kind from, or exceed in amount, what is demanded in the pleadings. Every other final judgment should grant the relief to which each party is entitled, even if the party has not demanded that relief in its pleadings.

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[1] The basis for Unum's objection to interest and attorney's fees is that NOV attempted to return the premiums to Plaintiff before she filed suit and she refused to accept them. ECF 10.

Despite her concession that she did not assert a claim for refund of premiums in this case, the summary judgment record established that she was entitled to a refund, and Defendants do not object to entry of judgment awarding the refund of premiums. The Court further finds that it is equitable to compensate Plaintiff for the lost use of the premium funds by awarding prejudgment interest. *Perez v. Bruister*, 823 F.3d 250, 274 (5th Cir. 2016) (prejudgment interest is available in ERISA cases not as a penalty but to compensate the plaintiff for the use of funds.).

The Court has discretion to award attorney's fees to a successful claimant in an ERISA case. 29 U.S.C. § 1132(g)(1); *North Cypress Med. Ctr. Operating Co., Ltd. v. Aetna Life Ins. Co.*, 898 F.3d 461, 485 (5th Cir. 2018). Plaintiff was not successful on her ERISA claims in this case. Moreover, counsel made a strategic decision to refuse to accept a return of premiums on behalf of Plaintiff prior to filing suit.

For the above reasons the Court **RECOMMENDS** that Plaintiff's Motion for Judgment in the amount of $1,717.77 for premiums and pre-judgment interest be **GRANTED,** the Motion for Judgment for attorney's fees be **DENIED**, and Final Judgment be entered awarding Plaintiff $1,717.77 and denying all other relief.

The Clerk of the Court shall send copies of the memorandum and recommendation to the respective parties, who will then have fourteen days to file written objections, pursuant to 28 U.S.C. § 636(b)(1)(c). Failure to file written objections within the time period provided will bar an aggrieved party from attacking the factual findings and legal conclu-

sions on appeal. *Douglass v. United Servs. Auto. Ass'n*, 79 F.3d 1415, 1428-29 (5th Cir. 1996) (en banc), superseded by statute on other grounds.

APPENDIX F

2020 WL 883476

United States District Court, S.D. Texas, Houston Division.

Erica TALASEK, Plaintiff,
v.
UNUM LIFE INSURANCE COMPANY OF AMERICA, Unum Group, and National Oilwell Varco, LP Defendants.

Civil Action No. H-18-3306
Signed 02/21/2020

Nitin Sud, Sud Law P.C., Bellaire, TX, for Plaintiff.

Bill E. Davidoff, Figari & Davenport LLP, Dallas, TX, Wesley Earl Stockard, Littler Mendelson, P.C., Atlanta, GA, Elizabeth L. Bolt, Littler Mendelson PC, Houston, TX, for Defendants.

ORDER ADOPTING MAGISTRATE JUDGE'S MEMORANDUM AND RECOMMENDATION

SIM LAKE, SENIOR JUDGE

Having reviewed *de novo* the Magistrate Judge's Memorandum and Recommendation (Docket Entry No. 69) dated January 21, 2020, and the objections thereto, the court is of the opinion that said Memorandum and Recommendation should be adopted by this court.

It is, therefore, **ORDERED** that the Memorandum and Recommendation is hereby **ADOPTED** by this court.

APPENDIX G

2020 WL 889413

United States District Court,
S.D. Texas, Houston Division.

Erica TALASEK, Plaintiff,
v.
UNUM LIFE INSURANCE COMPANY OF AMERICA, Unum Group, and National Oilwell Varco, LP Defendants.

Civil Action No. H-18-3306
Signed 01/21/2020

Nitin Sud, Sud Law P.C., Bellaire, TX, for Plaintiff.

Bill E. Davidoff, Figari & Davenport LLP, Dallas, TX, Wesley Earl Stockard, Littler Mendelson, P.C., Atlanta, GA, Elizabeth L. Bolt, Littler Mendelson PC, Houston, TX, for Defendants.

MEMORANDUM AND RECOMMENDATION

Nancy K. Johnson, United States Magistrate Judge

Pending before the court[1] is Defendant National Oilwell Varco, L.P.'s ("NOV") Motion to Dismiss (Doc. 23). The court has considered the motion, the response, the reply, all other relevant filings, and the applicable law. For the reasons set forth below, the

[1] This case was referred to the undersigned magistrate judge pursuant to 28 U.S.C. § 636(b)(1)(A) and (B), the Cost and Delay Reduction Plan under the Civil Justice Reform Act, and Federal Rule of Civil Procedure 72. See Doc. 42, Ord. Dated Oct. 9, 2019.

court **RECOMMENDS** that the motion to dismiss be **GRANTED**.

I. Case Background

Plaintiff filed this lawsuit asserting claims under the Employee Retirement Income Security Act of 1974 ("ERISA"),[2] as well as negligence and ERISA estoppel claims.

A. Factual Background

The following facts are gleaned from Plaintiff's second amended complaint.

1. The Policy

Plaintiff was married to Ben Talasek ("Ben") on March 9, 1996, and they had two children together.[3] Ben began working for NOV on April 23, 2001.[4] One of the benefits to which Ben was automatically entitled as an employee of NOV was a basic life insurance policy that paid twice his annual salary upon his death.[5] Ben also had the option to participate in a supplemental life insurance policy (the "Policy") offered by Defendants Unum Life Insurance Company of America and Unum group (collectively the "Unum Defendants").[6]

Ben requested coverage under the Policy and received a benefits confirmation statement on November 17, 2013.[7] The statement provided that Ben

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[2] 29 U.S.C. § 1001 et seq.
[3] See Doc. 16, Pl.'s 2nd Am. Compl. p. 3.
[4] See id.
[5] See id.
[6] See id.
[7] See id.

would pay a premium of $13.71 per pay period for a $300,000 life insurance benefit.[8] Plaintiff was named as the beneficiary of the Policy.[9] Defendants are the plan administrators and plan sponsors of the Policy.[10]

Ben began making the $13.71 premium payments in early 2014 until mid-February 2017 when the premium increased to $19.80.[11] Ben continued making premium payments following the increase.[12] NOV withdrew the premiums from Ben's wages and the Unum Defendants received the premiums.[13] As he was making continuous payments, Plaintiff alleges that Ben believed he was covered by the Policy, which would pay Plaintiff upon Ben's death.[14] Ben received benefits confirmation statements in November 2014, December 2015, and December 2016, that stated his coverage under the Policy would continue into the next year.[15]

Plaintiff alleges that the Unum Defendants never informed Ben or Plaintiff that Ben had not been approved for coverage under the Policy and never told NOV to stop deducting premiums from Ben's paycheck.[16]

2. Ben's Death

In 2014, Ben was diagnosed with pancreatic can-

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[8] See id.
[9] See id.
[10] See id.
[11] See id. p. 4.
[12] See id.
[13] See id.
[14] See id.
[15] See id.
[16] See id. pp. 3-4, 7.

cer.[17] Following the diagnosis, Ben had conversations with his family, including Plaintiff, about how the life insurance money could be utilized most effectively. Ben died on December 24, 2017.[18]

3. Denial of Coverage

In January 2018, Plaintiff sought to obtain the $300,000 life insurance benefit under the Policy.[19] On March 12, 2018, the Unum Defendants informed Plaintiff that Plaintiff would be paid twice Ben's salary under the basic life insurance policy, but they were continuing to evaluate coverage under the Policy.[20] On March 13, 2018, via letter, the Unum Defendants informed Plaintiff that her request for coverage under the Policy was denied.[21] In the letter, the Unum Defendants claimed that Ben had submitted an "evidence of insurability" form on January 2, 2014, but coverage under the Policy had not been approved.[22] Also in the letter, the Unum Defendants claimed that Ben had been informed of its decision to deny coverage under the Policy in a March 6, 2014 letter (the "Denial Letter").[23] A copy of the Denial Letter was not provided.[24]

4. Parties' Knowledge

Ben never received the March 6, 2014 Denial Let-

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[17] See id. p. 5.
[18] See id.
[19] See id.
[20] See id.
[21] See id.
[22] See id.
[23] See id.
[24] See id.

ter.[25] Plaintiff did not see the Denial Letter until after the Unum Defendants denied benefits under the Policy.[26] NOV received the Denial Letter in 2014, but did not inform Ben about the coverage denial and continued to deduct premiums from Ben's paycheck.[27]

5. Coverage Denial Appeal

On April 23, 2018, Plaintiff sent a letter to the Unum Defendants requesting an appeal of their decision to deny her request for benefits.[28] On April 30, 2018, the Unum Defendants gave Plaintiff until June 11, 2018 to submit an appeal.[29] The Unum Defendants later extended the deadline to June 22, 2018.[30] Plaintiff sent her appeal to the Unum Defendants on June 19, 2018.[31] The Unum Defendants denied Plaintiff's appeal on July 12, 2018.[32]

B. Procedural Background

Plaintiff filed this lawsuit on September 17, 2018.[33] On December 17, 2018, with the court's leave, Plaintiff filed her first amended complaint.[34] On April 10, 2019, with the court's leave, Plaintiff filed her second amended complaint.[35] On August 5,

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[25] See id.
[26] See id. p. 6.
[27] See id.
[28] See id.
[29] See id.
[30] See id.
[31] See id.
[32] See id.
[33] See Doc. 1, Pl.'s Orig. Compl.
[34] See Doc. 9, Pl.'s 1st Am. Compl.
[35] See Doc. 16, Pl.'s 2nd Am. Compl.

2019, NOV filed its pending motion to dismiss pursuant to Federal Rule of Civil Procedure ("Rule") 12(b)(6).[36] On August 26, 2019, Plaintiff filed her response to NOV's motion to dismiss.[37] On August 30, 2019, the court extended NOV's deadline to submit a reply to September 6, 2019.[38] On September 6, 2019, NOV filed a reply in support of its motion to dismiss.

II. Rule 12(b)(6) Standard

Rule 12(b)(6) allows dismissal of an action whenever the complaint, on its face, fails to state a claim upon which relief can be granted. When considering a motion to dismiss, the court may consider, in addition to the complaint itself, "any documents attached to the complaint[ ] and any documents attached to the motion to dismiss that are central to the claim and referenced by the complaint." Lone Star Fund V (U.S.), L.P. v. Barclays Bank PLC, 594 F.3d 383, 387 (5th Cir. 2010). The attached documents control in the case of a conflict between the allegations in the complaint and the contents of the documents. See United States ex rel. Riley v. St. Luke's Epis. Hosp., 355 F.3d 370, 377 (5th Cir. 2004).

The court should construe the allegations in the complaint favorably to the pleader and accept as true all well-pleaded facts. Harold H. Huggins Realty, Inc. v. FNC, Inc., 634 F.3d 787, 803 n.44 (5th Cir. 2011) (quoting True v. Robles, 571 F.3d 412, 417 (5th Cir. 2009)). A complaint need not contain "detailed factual allegations" but must include sufficient facts to indicate the plausibility of the claims asserted,

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[36] See Doc. 23, NOV's Mot. to Dismiss.
[37] See Doc. 30, Pl.'s Resp. to NOV's Mot. to Dismiss.
[38] See Doc. 32, Ord. Dated Aug. 30, 2019.

raising the "right to relief above the speculative level." Bell Atl. Corp. v. Twombly, 550 U.S. 544, 555 (2007); see also Ashcroft v. Iqbal, 556 U.S. 662, 678 (2009). Plausibility means that the factual content "allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." Iqbal, 556 U.S. 678. A plaintiff must provide "more than labels and conclusions" or "a formulaic recitation of the elements of a cause of action." Twombly, 550 U.S. at 555. In other words, the factual allegations must allow for an inference of "more than a sheer possibility that a defendant has acted unlawfully." Iqbal, 556 U.S. 678.

III. Analysis

NOV argues that Plaintiff's negligence and breach of fiduciary duty claims should be dismissed under Rule 12(b)(6) for failure to state a claim. Plaintiff argues that she has stated claims for negligence and breach of fiduciary duty.

A. Negligence

Plaintiff alleges a negligence claim against NOV, but not the Unum Defendants.[39] Plaintiff alleges that NOV was negligent when it: (1) did not inform Ben about the information obtained from the Unum Defendants; (2) continually deducted premiums from Ben's paycheck while knowing Ben had not been approved for coverage under the Policy; (3) repeatedly provided Ben with annual benefit statements that represented his coverage under the Policy was ongoing.[40]

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[39] See Doc. 16, Pl.'s 2nd Am. Compl. p. 10.
[40] See id.

If a state law, including state law causes of action, "relates to an employee benefit plan, it is preempted by ERISA." Cefalu v. B.F. Goodrich Co., 871 F.2d 1290, 1292 (5th Cir. 1989). "A law relates to an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 139 (1990) (internal quotation marks omitted) (quoting Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96–97 (1983)). "[T]he Fifth Circuit has found claims brought under state law asserting a variety of common law and statutory causes of action[, including negligence claims,] arising from the failure to pay or misrepresentations concerning benefits available under an ERISA plan to be preempted by ERISA ...." Wise v. Lucent Techs. Inc. Pension Plan, 102 F. Supp. 2d 733, 746 (S.D. Tex. 2000).

The parties agree that the policy is an employee benefits plan. Thus, it is clear that Plaintiff's negligence claim is preempted by ERISA. Plaintiff, however, argues that she must be allowed to maintain her negligence cause of action against NOV because NOV denies that it is the plan sponsor or plan administrator, potentially making ERISA inapplicable to it.[41] Even if Plaintiff's argument was legally sound, NOV admits in its reply brief that it is the plan sponsor and plan administrator of the Policy.[42]

For these reasons, Plaintiff's negligence claim should be **DISMISSED.**

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[41] See Doc. 30, Pl.'s Resp. to Def.'s Mot. to Dismiss p. 3.

[42] See Doc. 35, NOV's Reply in Support of Mot. for Summ. J. p. 2.

B. Breach of Fiduciary Duty

Section 502(a)(3) of ERISA provides a civil cause of action that can be brought "by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (I) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan." 29 U.S.C. § 1132(a)(3). Plaintiff specifically asserted a claim under Section 502(a)(3)(B) "seeking $300,000 as 'appropriate equitable relief' against Defendants."[43] Plaintiff also asserted a claim under Section 502(a)(1)(B), which provides that a civil action may be brought by a beneficiary "to recover benefits due to [her] under the terms of [her] plan, to enforce [her] rights under the terms of the plan, or to clarify [her] rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B).

"[I]f relief is available under section 502(a)(1)(B), equitable relief is not available under section 502(a)(3). Lopez v. Liberty Life Assur. Co. of Boston, CIV.A. H-13-2460, 2013 WL 5774878, at *4 (S.D. Tex. Oct. 24, 2013). "When a beneficiary wants what was supposed to have been distributed under a plan, the appropriate remedy is a claim for denial of benefits under § 502(a)(1)(B) of ERISA rather than a fiduciary duty claim brought pursuant to § 502(a)(3)." McCall v. Burlington N./Santa Fe Co., 237 F.3d 506, 512 (5th Cir. 2000) (citing Corcoran v. United HealthCare, Inc., 965 F.2d 1321, 1335 (5th Cir.1992)).

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[43] See Doc. 16, Pl.'s 2nd Am. Compl. p. 10.

Here, through her Section 502(a)(3)(B) claim, Plaintiff only seeks the $300,000 that was not paid out on the Policy.[44] Under prevailing Fifth Circuit precedent, this claim is properly brought through Section 502(a)(1)(B), and is not available to Plaintiff through Section 502(a)(3)(B). Nonetheless, in her response to NOV's motion to dismiss, Plaintiff argues that she should be allowed to bring her Section 502(a)(3)(B) claim because the court will have to order "an appropriate equitable remedy to stop Defendants from engaging in such willful blindness and exploitation of vulnerable individuals ...."[45] Plaintiff has amended her complaint twice and has not asked for anything other than "$300,000 as 'appropriate equitable relief' against Defendants" regarding her Section 502(a)(3)(B) claim.[46]

Plaintiff's Section 502(a)(3)(B) claim only seeks relief that is already available under 502(a)(1)(B). Accordingly, Plaintiff's Section 502(a)(3)(B) claim against NOV should be **DISMISSED**.

The district court may dismiss a cause of action sua sponte as long as a fair procedure is employed. Gaffney v. State Farm Fire & Cas. Co., 294 F. App'x 975, 977 (5th Cir. 2008). Fairness requires notice of the court's intention to dismiss a cause of action and an opportunity to respond. See id. Plaintiff pled her Section 502(a)(3)(B) claim against all Defendants, but only NOV has motioned for its dismissal. Accordingly, the court **RECOMMENDS** that the Section 502(a)(3)(B) claim against the Unum Defendants be **DISMISSED** sua sponte. Plaintiff will have the op-

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[44] See id.
[45] See Doc. 30, Pl.'s Resp. to NOV's Mot. to Dismiss.
[46] See Doc. 16, Pl.'s 2nd Am. Compl. p. 10.

portunity to respond to this recommendation in a timely filed objection.

C. Judicial Estoppel

Finally, Plaintiff argues that NOV should be judicially estopped from arguing that Ben was not a plan participant because in its motion to dismiss NOV stated that "no defendant has challenged the sufficiency of [Plaintiff's Section 502(a)(1)(B)] claim ...."[47]

"Judicial estoppel is ... applied in the court's discretion to prevent a party from asserting a position in a legal proceeding that is contrary to a position previously taken by [that party] in the same or some earlier legal proceeding. United States v. Farrar, 876 F.3d 702, 709 (5th Cir. 2017) (internal quotation marks omitted). The only position that was asserted by NOV was that no party has challenged Plaintiff's Section 502(a)(1)(B) claim. The court reads this to mean that NOV concedes that Plaintiff has sufficiently pled her Section 502(a)(1)(B) claim. NOV certainly did not concede liability on Plaintiff's Section 502(a)(1)(B) claim by this statement as Plaintiff argues. Accordingly, at this time, the court declines to exercise the discretion afforded it under the doctrine of judicial estoppel.

IV. Conclusion

Based on the foregoing, the court **RECOMMENDS** that NOV's motion to dismiss be **GRANTED** and that Plaintiff's Section 502(a)(3)(B) against the Unum Defendants be **DISMISSED** sua sponte. If this Memorandum and Recommendation is adopt-

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[47] See Doc. 30, Pl.'s Resp. to NOV's Mot. to Dismiss.

ed, Plaintiff's remaining claims will be her Section 502(a)(1)(B) claim and her ERISA Estoppel claim, against all Defendants.

The Clerk shall send copies of this Memorandum and Recommendation to the respective parties who have fourteen days from the receipt thereof to file written objections thereto pursuant to Federal Rule of Civil Procedure 72(b) and General Order 2002-13. Failure to file written objections within the time period mentioned shall bar an aggrieved party from attacking the factual findings and legal conclusions on appeal.

The original of any written objections shall be filed with the United States District Clerk electronically. Copies of such objections shall be mailed to opposing parties and to the chambers of the undersigned, 515 Rusk, Suite 7019, Houston, Texas 77002.

APPENDIX H

United States Court of Appeals
for the Fifth Circuit

No. 21-20069

ERICA TALASEK,

Plaintiff-Appellant,

versus

NATIONAL OILWELL VARCO, L.P.,

Defendant-Appellee.

Appeal from the United States District Court
for the Southern District of Texas
USDC No. 4:18-CV-3306

ON PETITION FOR REHEARING EN BANC

Before OWEN, *Chief Judge*, CLEMENT, and DUNCAN, *Circuit Judges.*

PER CURIAM:

Treating the petition for rehearing en banc as a petition for panel rehearing (5TH CIR. R. 35 I.O.P.), the petition for panel rehearing is DENIED. Because no member of the panel or judge in regular active service requested that the court be polled on rehearing en banc (FED. R. APP. P. 35 and 5TH CIR. R. 35), the petition for rehearing en banc is DENIED.

Filed Nov. 16, 2021