APPENDIX

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

NOT FOR PUBLICATION

SOOHYUN CHO,

Plaintiff-Appellee,

v.

FIRST RELIANCE STANDARD LIFE INSURANCE COMPANY,

Defendant-Appellant.

v.

GIORGIO ARMANI CORPORATION,

Third-party-defendant-Appellee.

Nos. 20-55314, 20-55581
D.C. No. 2:18-cv-04132-MWF-SK

MEMORANDUM[*]

Appeal from the United States District Court
for the Central District of California
Michael W. Fitzgerald, District Judge, Presiding

Argued and Submitted: June 11, 2021
Pasadena, California

Filed: July 9, 2021

Before: CALLAHAN and FORREST, Circuit Judges, and SEEBORG[**], Chief District Judge.

First Reliance Standard Life Insurance Company ("First Reliance") appeals from the district court's order awarding Soohyun Cho the full amount of her dependent spouse's life insurance policy. First Reliance also appeals from the district court's dismissal of its third-party complaint against Giorgio Armani Corporation ("Armani"). We have jurisdiction pursuant to 28 U.S.C. § 1291, review findings of fact for clear error and legal findings de novo, *Pannebecker v. Liberty Life. Assurance Co. of Boston*, 542 F.3d 1213, 1217 (9th Cir. 2008), and affirm.

First Reliance contends no benefits are due under the terms of the plan and, furthermore, that the

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[*] This disposition is not appropriate for publication and is not precedent except as provided by Ninth Circuit Rule 36-3.

[**] The Honorable Richard Seeborg, Chief United States District Judge for the Northern District of California, sitting by designation.

inclusion of the non-waiver clause makes *Salyers v. Metropolitan Life Insurance Company* inapposite. 871 F.3d 934 (9th Cir. 2017). On the first point, First Reliance is correct. Though the policy was somewhat sloppily drafted, the "Effective Date of Dependent Insurance" clause emphasizes the evidence of insurability requirement so clearly that no reasonable person would doubt proof of good health was a necessary condition to coverage. Thus, no benefits are due under the terms of the plan.

Nonetheless, Cho is entitled to the benefits for which she paid. Because the plan was self-administered and Armani handled "nearly all the administrative responsibilities," its "direct interaction with plan participants" would have suggested it was acting with "apparent authority on the collection of evidence of insurability." *See Salyers*, 871 F.3d at 940–41 (citation and internal quotation marks omitted). For over a year Armani accepted Cho's premiums without any submission of evidence of insurability though it "knew or should have known" the terms of the plan required such evidence. *See id.* at 941. Armani's actions were "so inconsistent with an intent to enforce" the requirement that it was reasonable for Cho to believe she was not required to submit such evidence. *See id.* (citation and internal quotation marks omitted).

The insertion of a non-waiver clause in the operative policy does not displace this conclusion. The *Salyers* court emphasized that the incorporation of agency principles into the federal common law governing employee benefit plans "creates incentives for diligent oversight and prevents an insurer from relying 'on a compartmentalized system to escape responsibility.'" *Id.* at 940 (citation omitted). Allowing insurers like

First Reliance essentially to vitiate *Salyers* and the good behaviors it seeks to promote by including one sentence in their plans would be unfair and unjust. In this case, therefore, Armani is deemed to have waived on First Reliance's behalf the evidence of insurability requirement.

Separately, First Reliance cannot maintain a claim for contribution or indemnification against Armani. In *Kim v. Fujikawa*, the court concluded that 29 U.S.C. § 1109, as referenced in 29 U.S.C. § 1132(a)(2), "cannot be read as providing for an equitable remedy of contribution in favor of a breaching fiduciary." 871 F.2d 1427, 1432 (9th Cir. 1989) (emphasis omitted); *see also Call v. Sumitomo Bank of Cal.*, 881 F.2d 626, 631 (9th Cir. 1989) (rejecting arguments that ERISA authorizes contribution among co-fiduciaries and noting "[t]he *Kim* opinion is unambiguous and undistinguishable"). Furthermore, there is no indication that Congress, in the course of enacting a comprehensive scheme for the protection of ERISA plans and beneficiaries, intended to "soften[] the blow on joint wrongdoers." *Kim*, 871 F.2d at 1433. First Reliance makes no persuasive argument to avoid application of this settled rule to 29 U.S.C. § 1132(a)(3).

Lastly, the district court's award of attorney's fees to Cho is affirmed. In the absence of opposition from First Reliance, her additional request that the action be remanded for consideration of fees incurred since the last award is granted.

AFFIRMED.

APPENDIX B

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CIVIL MINUTES—GENERAL

Case No. CV 18-4132-MWF (SKx)

Date: April 8, 2019

SOOHYUN CHO

v.

FIRST RELIANCE STANDARD LIFE INSURANCE COMPANY

Present: The Honorable MICHAEL W. FITZGERALD, U.S. District Judge

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Deputy Clerk:	Court Reporter:
Rita Sanchez	Not Reported
Attorneys Present for Plaintiff:	Attorneys Present for Defendant:
None Present	None Present

Proceedings (In Chambers):	ORDER RE: THIRD-PARTY DEFENDANT GIORGIO ARMANI CORPORATION'S MOTION TO DISMISS THIRD-PARTY COMPLAINT PURSUANT TO FED. R. CIV. PRO. § 12(b)(6) [37]

Before the Court is the Motion to Dismiss Third-Party Complaint Pursuant to Fed. R. Civ. Pro. § 12(b)(6) (the "Motion"), filed by Third-Party Defendant Giorgio Armani Corporation ("Armani"). (Docket No. 37). Third-Party Plaintiff First Reliance Standard Life Insurance Company ("First Reliance") filed an Opposition on March 4, 2019. (Docket No. 41). Armani filed its Reply on March 11, 2019. (Docket No. 42). The Court has read and considered the papers filed in connection with the Motion, and held a hearing on March 25, 2019.

For the reasons discussed below, the Motion is **GRANTED *without leave to amend***. A claim for contribution or equitable indemnification under ERISA by one co-fiduciary (*i.e.*, First Reliance) against another co-fiduciary (*i.e.*, Armani) is not cognizable. This Motion presents the rare situation where no leave to amend should be granted. As both parties appear to have recognized, Plaintiffs' allegations are not ambiguous. Nor are the parties disputing the underlying facts of the case. Thus, there is no amount of tinkering with the Third-Party Complaint that would change the Court's conclusions of law.

I. BACKGROUND

On May 17, 2018, Plaintiff Soohyun Cho commenced this action against First Reliance. (Complaint (Docket No. 1)). Plaintiff then filed her operative First Amended Complaint ("FAC") on July 17, 2018. (FAC (Docket No. 8)). On September 18, 2018, First Reliance filed a Third-Party Complaint ("TPC") against Armani. (TPC (Docket No. 19)).

First Reliance's TPC contains the following allegations:

At some point prior to January 1, 2013, Armani established and sponsored an employee welfare benefit plan pursuant to the Employment Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, for the benefit of its employees and their dependents (the "Plan"). (*Id.* ¶ 9). Under the terms of the Plan, Armani's employees could enroll themselves and their eligible dependents for life insurance coverage. (*Id.*). At all relevant times, Armani was a fiduciary and administrator of the Plan. (*Id.* ¶ 10).

In August 2013, First Reliance issued Voluntary Group Term Life Policy number VG 183839 (the "Policy") to Armani in order to provide life insurance benefits to Armani's eligible employees and dependents. (*Id.* ¶ 11). The Policy was part of the Plan and was amended on January 1, 2016, to broaden the scope of eligible employees. (*Id.* ¶¶ 9–18).

In January or February of 2016, Plaintiff, an Armani employee, participated in an open enrollment for the Policy and elected life insurance coverage for her husband in the amount of $500,000.00. (*Id.* ¶¶ 20, 23). At the time of enrollment, Plaintiff's husband had been diagnosed with pancreatic cancer. (*Id.* ¶ 19). At

no time, however, did Armani request or collect from Plaintiff an Evidence of Insurability or Proof of Good Health form that her husband was in good health. (*Id.* ¶¶ 20–21).

On June 28, 2017, Plaintiff's husband died. (*Id.* ¶ 22). On October 24, 2017, Plaintiff submitted a claim to recover life insurance benefits under the Policy, asserting that she is entitled to $500,000.00. (*Id.* ¶ 23). First Reliance began processing the claim and requested from Armani copies of Plaintiff's enrollment form for her husband. (*Id.* ¶ 24). Armani allegedly did not provide First Reliance with the information it requested and, on November 22, 2017, Plaintiff instead provided to First Reliance a copy of the claim form that Armani had provided to her. (*Id.* ¶ 25). Notably, that claim form indicated that the amount of life insurance benefit to which Plaintiff was entitled was $50,000.00 because Armani did not have evidence of insurability on file. (*Id.*).

On December 21, 2017, First Reliance against requested the enrollment forms from Armani. (*Id.* ¶ 26). On January 25, 2018, Armani responded that it does not have those forms because the enrollment was done electronically. (*Id.*). As a result, on January 31, 2018, First Reliance paid Plaintiff a life insurance benefit of $50,000.00. (*Id.* ¶ 27).

Plaintiff then commenced this action against First Reliance, asserting a single claim for breach of the Plan and seeking the payment of life insurance benefits for in the amount of $500,000.00. (FAC ¶¶ 10–31). In response, First Reliance filed the TPC against Armani, asserting two claims for relief under ERISA: (1) equitable indemnity and (2) contribution. (TPC ¶¶ 29–47).

II. DISCUSSION

Here, it does not appear that the parties dispute the underlying facts of the case. (*See* Mot. at 2–4; Opp. at 4–8). Rather, Armani argues that the law is settled that a claim for contribution or equitable indemnity by one co-fiduciary (*i.e.*, First Reliance) against another co-fiduciary (*i.e.*, Armani) is not cognizable. (Mot. at 5–8). Armani points to two Ninth Circuit cases for support, both of which the Court views as instructive:

Armani first relies upon *Kim v. Fujikawa*, 871 F.2d 1427 (9th Cir. 1989), for the proposition that a right of action under ERISA for contribution or indemnification is not cognizable between co-fiduciaries. In that case, the Ninth Circuit explicitly stated as follows:

> [T]he Supreme Court has noted that, in light of "ERISA's interlocking, interrelated, and interdependent remedial scheme, which is in turn part of a 'comprehensive and reticulated statute,'" it seems clear that "Congress did not intend to authorize other remedies [under ERISA] that it simply forgot to incorporate expressly." Given this observation, we cannot agree . . . ***that Congress implicitly intended to allow a cause of action for contribution under ERISA***.

Id. at 1432–33 (citing *Mass. Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1984) (internal quotations omitted)) (emphasis added).

The Court in *Kim* specifically rejected the attempt of one breaching fiduciary to seek contribution from other allegedly breaching fiduciaries, and noted that

implying a right of contribution is particularly inappropriate where, as here, "the party seeking contribution is a member of the class [*e.g.*, fiduciaries] whose activities Congress intended to regulate for the protection and benefit of an entirely distinct class [*e.g.*, ERISA plans]," and where there is "no indication in the legislative history that Congress was concerned with softening the blow on joint wrongdoers." *Id.* at 1433 (citations and internal quotation marks omitted).

Armani also relies upon *Call v. Sumitomo Bank of California*, where the Ninth circuit again rejected a claim for contribution under ERISA brought by a co-fiduciary—who had settled breach of fiduciary claims with the Department of Labor ("DOL") and restored money to the plan—against co-fiduciaries who had not participated in the DOL settlement. 881 F.2d 626, 630–31 (9th Cir. 1989) (concluding that appellants and the DOL as amicus curiae "offer several persuasive arguments in support of their position that ERISA may be interpreted to authorize a contribution cause of action among co-fiduciaries . . . [but that the court is] foreclosed from considering these arguments because they were rejected in [a] recent decision in *Kim*").

In response, First Reliance argues that *Kim* and *Call* are inapplicable for following reasons, all of which the Court finds unavailing:

First, First Reliance argues that "both of these cases stand for the simple proposition that claims brought under ERISA section 502(a)(2), 29 U.S.C. § 1132(a)(2), must be brought on behalf of the plan," but First Reliance is asserting its claims under ERISA section

502(a)(3). (Opp. at 11–13). At the hearing, First Reliance reiterated this distinction.

The Court is not persuaded because, as pointed out by Armani, the distinction between section 502(a)(2) and section 502(a)(3) "appears to be a distinction without a difference." (Reply at 2). First Reliance has not provided any authority explaining why this distinction matters or, perhaps more precisely, why *Kim* and *Call* are inapplicable with respect to a claim for equitable contribution and indemnity between alleged breaching co-fiduciaries under section 502(a)(3). So "[w]hether relief is claimed under subsection (a)(2) or (a)(3), neither provides a remedy for injuries to a fiduciary . . . because [they] allow relief only for the plan and its beneficiaries." *See Brown v. Cal. Law Enf't Ass'n, Long-Term Disability Plan*, 81 F. Supp. 3d 930, 936 (N.D. Cal. 2015) (dismissing third-party complaint without leave to amend because "this case demonstrates why, in every case other than *Youngberg*, courts have declined to allow breaching fiduciaries to seek relief by complaining against other fiduciaries").

First Reliance does, however, point to a case for the proposition that "[t]he right of a non-breaching fiduciary to assert claims against a breaching fiduciary under ERISA section 502(a)(3)" has been firmly established. (Opp. at 13 (citing *Youngberg v. Bekins Co.*, 930 F. Supp. 1396 (E.D. Cal. 1996)). In *Youngberg*, a plan beneficiary sued for wrongful denial of benefits due to miscalculations. *See* 930 F. Supp. at 1403. One fiduciary cross-claimed against its co-fiduciary, arguing that the entire burden should be shifted to the co-fiduciary where the co-fiduciary alone was responsible for calculating benefits and the

fiduciary had no control over the calculation of benefits. *See id.*

But *Youngberg* is factually distinguishable because, there, the plan administrator and employer was seeking equitable indemnity from the insurer who issued a disability insurance contract and was responsible for the calculation and determination of benefits under the plan. Here, it is the insurer (*i.e.*, First Reliance) who is seeking indemnity from the plan administrator and employer (*i.e.*, Armani). Moreover, unlike in *Youngberg*, the allegation here is that "First Reliance breached its duty to properly administer the plan both by failing to pay benefits allegedly owed and in rejecting [Plaintiff's] appeal." (*See* Reply at 4). Most meaningfully, the district court in *Youngberg* actually dismissed the third-party defendant's claims for equitable contribution and held that *Kim* and *Call* provided controlling authority for contribution actions. *See Youngberg*, 930 F. Supp. at 1400.

The Court also views as particularly persuasive authority *Meoli v. American Medical Services of San Diego*, 35 F. Supp. 2d 761 (S.D. Cal. 1999). In *Meoli*, the plaintiff brought a class action on behalf of participants and beneficiaries of an employee benefit plan, alleging breach of fiduciary duty. *Id.* at 762. The defendants were several individuals, business entities, and the trustees of the plan. *Id.* The trustees filed a counterclaim against the plaintiff and another plan participant, seeking a judicial declaration that the plaintiff and the other plan participant were co-fiduciaries and were required to "partially or fully indemnify the trustees." *Id.* The district court dismissed the counterclaim, concluding that ERISA

"does not accord [a co-fiduciary] the right to seek indemnity from a[nother] co-fiduciary for breach of fiduciary duty" under section 502(a)(3). *Id.*

In reaching its conclusion, the district court in *Meoli* first looked to the express language of section 502(a)(3), as follows:

> [A] civil action may 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.

Id. at 763 (citing 29 U.S.C. § 1132(a)(3)) (emphasis added).

The district court then noted that the question to be answered was "whether 'other appropriate equitable relief' includes inter-fiduciary indemnity." *Id.* The court concluded that section 502(a)(3) "cannot fairly be read to support a claim for indemnity against a co-fiduciary . . . [because section 502(a)(3)] enables a participant, beneficiary, or fiduciary to seek 'other appropriate equitable relief,' but only for a particular purpose—'to redress such violations.'" *Id.* "Such violations," in turn, refers to the antecedent statutory phrase "any act or practice which violates any provision of this subchapter or the terms of the plan." *Id.* While the court recognized the "perceived unfairness" of making one party (here, First Reliance) liable because of the negligence of another (here, Armani), equitable indemnity among co-fiduciaries simply does not redress "any act or practice which violates any provision of [ERISA]." *Id.* at 764. If the

Ninth Circuit were concerned only about the perceived unfairness, *Call* and *Kim* would have been decided differently.

Second, First Reliance also contends that *Kim* and *Call* "appear to represent a minority position amongst the Circuits." (Opp. at 12). But regardless of whether *Kim* and *Call* are in the minority across the country, in the Ninth Circuit, these opinions are binding on the Court.

Finally, First Reliance argues that the Ninth Circuit has incorporated the law of agency into the federal common law of ERISA, thereby permitting claims for contribution and indemnity against co-fiduciaries. (Opp. at 9–11). First Reliance specifically relies upon on *Salyers v. Metropolitan Life Insurance Company*, 871 F.3d 934 (9th Cir. 2017).

In *Salyers*, the plaintiff was a nurse at Providence Health and Services ("Providence") and participated in a life insurance plan offered by Providence. *Id.* at 936. The benefits were paid from a group life insurance policy issued to the plan by Metropolitan Life ("MetLife"), and under the terms of that policy, a participant was required to submit evidence of insurability if the participant wanted to elect life insurance in an amount greater than $50,000.00. *Id.* While MetLife was the insurer, the plan was administered by Providence. *Id.* The plaintiff elected a policy for $250,000.00 in life insurance for her husband, thereby triggering the requirement that she submit evidence of insurability showing that her husband was in good health. *Id.* at 937. Providence failed to collect the required health information. *Id.*

When the plaintiff's husband died, MetLife only paid the guaranteed issue amount of up to $50,000.00 because it never received evidence of insurability demonstrating that the plaintiff's husband was in good health at the time the plaintiff enrolled him in coverage. *Id.* The plaintiff pursued an action against only MetLife, and the Ninth Circuit concluded that "Providence was MetLife's agent for purposes of enforcing the evidence of insurability requirement," and by failing to do so, MetLife could be held responsible for the conduct of Providence. *Id.* at 939–41.

First Reliance is correct to the extent that the facts in *Salyers* and in this action are virtually identical. But of course, *Salyers* does not address indemnification or contribution between co-fiduciaries. To the extent First Reliance relies upon the law of agency as applicable to ERISA, it has not offered a single case supporting this theory. It is an ingenious theory, but frankly one for the Ninth Circuit to consider.

With or without leave to amend. The Court is ordinarily reluctant to grant a motion to dismiss without leave amend when pleading deficiencies have not been previously addressed and where a party has not been warned that it will not have another opportunity to amend. Here, as recognized by the parties and as noted by the Court at the hearing, the parties do not appear to dispute the underlying facts. Nor are the allegations in First Reliance's TPC ambiguous. Therefore, no amount of tinkering with the TPC could change the conclusions of law that the Court is making under Rule 12(b)(6).

III. CONCLUSION

For the reasons discussed above, the Motion is **GRANTED *without leave to amend***.

As it did at the hearing, the Court commends counsel on the brevity and clarity of their briefs and their arguments.

IT IS SO ORDERED.

APPENDIX C

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

SOOHYUN CHO,

Plaintiff,

v.

FIRST RELIANCE STANDARD LIFE INSURANCE COMPANY and Does 1-10, inclusive,

Defendant.

CASE NO. CV-18-4132-MWF (SKx)

Dated: March 5, 2020

ORDER FOLLOWING COURT TRIAL

This Employee Retirement Income Security Act of 1974 ("ERISA") dispute is over life insurance benefits for Plaintiff Soohyun Cho's spouse. Plaintiff challenges Defendant First Reliance Standard Life Insurance Company's ("First Reliance") denial of $500,000 in benefits when her spouse died. Defendant argues the denial should be upheld. Plaintiff further argues that Defendant is subject to statutory penalties for failing to provide documents within

thirty days. For the reasons discussed below, the Court rules that Defendant breached the plan in denying $500,000 in benefits to Plaintiff. Specifically, the Court concludes that Plaintiff has demonstrated that Defendant waived its right to require evidence of insurability and proof of good health. However, the Court determines that Defendant is not subject to statutory penalties because it is not a plan administrator pursuant to 29 U.S.C. § 1132(c)(1).

Plaintiff filed an Opening Trial Brief (the "Plaintiff's Motion") on December 3, 2019. (Docket No. 54). Defendant also filed its Opening Trial Brief on the same day. (Docket No. 53). Plaintiff filed an Opposition Trial Brief on December 12, 2019, and Defendant filed an Opposition Trial Brief on December 17, 2019. (Docket Nos. 57, 58). On January 7, 2020, both parties filed Reply Briefs. (Docket Nos. 59, 60).

On February 21, 2020, the Court held a hearing, which is technically named a Court trial, but was procedurally closer to the review of an administrative record or a hearing on dueling motions for summary judgment. To the extent it is thought necessary, the Court constitutes its determinations as the Court's findings of fact and conclusions of law. Fed. R. Civ. P. 52(a)(1).

By stipulation of the parties and the approval of the Court, the Administrative Record was filed under seal. This Order, like the parties' briefs to the Court, references materials contained in the Administrative Record. *See, e.g., Foltz v. State Farm Mut. Auto. Ins. Co.*, 331 F.3d 1122, 1136 (9th Cir. 2003) (noting that "the presumption of access is not rebutted where, as

here, documents subject to a protective order are filed under seal as attachments to a dispositive motion").

I. FINDINGS OF FACT

1. The Armani Life Insurance Policy

Plaintiff is employed by Giorgio Armani Corporation ("Armani"). (*See* Administrative Record ("AR") 106-141 (Docket No. 61)) (AR documents with Bates stamp "RSLI/CHO 00001-00819" are referred to as "AR 1-819"). On August 1, 2013, Armani established an employee welfare benefit plan (the "Plan"), which included dependent spouse life insurance benefits. (*See* AR 1-33). As part of the Plan, Defendant agreed to provide a life insurance policy, policy number VG 183839 (the "Policy") to Armani. (AR 1). The Policy was amended effective January 1, 2016. (*Id.*). Under the amended terms of the Policy, eligible Armani employees could enroll themselves as well as their eligible dependents for life insurance coverage. (AR 9).

Eligible employees include "[a]ll Actively-at-Work, Full-time Employees of [Armani's] who have completed 89 days of continuous employment, except any person employed on a temporary or seasonal basis," and who are under the age of 75. (*Id.*). Maximum age for an eligible employee is 75 years old. (*Id.*). Eligible dependents include "the employee's legal spouse" who is under the age of 75. (*Id.*).

"Each eligible employee and spouse may elect an Amount of Insurance (in increments of $10,000) for which he is eligible." (*Id.*). "The minimum amount of insurance coverage which may be elected is $10,000 and the maximum is $500,000, subject to age and

evidence of insurability requirements, as applicable." (*Id.*).

The Policy provides a "guaranteed" coverage of up to $50,000 for a dependent spouse under the age of 70. (AR 10). For amounts over the "guaranteed" amount, the Policy provides the following provision:

> AMOUNTS OVER THE GUARANTEED ISSUE AMOUNT AND AMOUNTS APPLIED FOR AFTER THE INITIAL ELIGIBILITY PERIOD:
>
> An Eligible Person's Effective Date of coverage will be the date the application is signed, provided the Insurance Company agrees to insure such person and any additional premium is received.
>
> . . .
>
> Insurance applied for during a First Reliance Standard-approved annual enrollment that takes place beyond the eligible employee's initial enrollment period or beyond the employee's initial eligibility period will become effective according to the specific rules for such enrollment . . .

(AR 10-11).

The Policy also has the following effective date provision relating to Dependent Life Insurance:

> EFFECTIVE DATE OF DEPENDENT INSURANCE:
>
> An Insured may insure his Dependents by making written application, paying the applicable premium, and providing proof of good health. The Insured must have insurance

> coverage under this Policy in order for Dependents to be insured. The insurance for Dependents will take effect on the date:
>
> (1) we approve the required proof of good health; and
>
> (2) the applicable premium is paid.

(AR 28).

2. <u>Plaintiff's Enrollment of Dependent Life Insurance</u>

In early 2016, Armani held a one-time open enrollment with an effective date of March 1, 2016. (AR 89). Armani sent an email about the offer of new coverage for employees. (AR 292-93). The email included the following explanation:

> ***Additional Life Insurance with Reliance Standard:***
>
> - Full-time associates may purchase additional Life Insurance with a maximum of $500,000 for which associates will pay premiums through payroll deductions.
> - You may be required to provide evidence of insurability in order to qualify for coverage over $150,000.
> - Eligible associates may also purchase life insurance for their spouse, domestic partner and/or dependent children.
>
> . . .

(AR 292).

During open enrollment, Plaintiff purchased life insurance for her husband, Andrew Cho, who was born in 1962 and was under the age of 70. Plaintiff

elected coverage of "$500,000" for her spouse with a premium rate of $219.90 per month. (*See* AR 142). In accordance with this premium rate, $101.49 was deducted from Plaintiff's paycheck for spouse life insurance every two weeks between February 29, 2016 and June 18, 2017. (AR 106-140).

Defendant's life insurance plan was "self-administered" by Armani. (*See* AR 50, 800). Therefore, Armani was "responsible for ensuring that coverage elections (including any required proof of good health) are processed in accordance with the terms and conditions of the applicable policy and premium remittances are accurate and timely." (*Id.*). Under this option, Defendant "typically has no record of individual coverage or premium amounts until and unless proof of good health is submitted for review." (*Id.*).

Between Plaintiff's enrollment in February 2016 and June 2, 2017, neither Armani nor Defendant asked Plaintiff to submit Evidence of Insurability or Proof of Good Health. (*See* AR 95-102). Plaintiff continuously paid her premium during this time as well. (*See* AR 106-140).

3. Defendant's Review and Change of the Policies

In late April and May of 2017, Defendant began reviewing voluntary employee and spouse life insurance elections over the guaranteed issue. (AR 101-102). During this review process, Defendant realized there were multiple Armani employees who signed up for life insurance for themselves and/or their spouses over the guaranteed amount without submitting Evidence of Insurability. (AR 95-102).

On May 19, 2017, Defendant's Assistant Sales Manager Jessica O'Sullivan wrote:

> Since employees have been paying for this since their respective enrollmenst [sic] in error, if they were approved for amounts above the [Guaranteed Issue Amount], could we retro-approve back to the eff[ective] date?

(AR 96). Employees from Defendant's underwriting division approved this decision to retro-approve the policy for amounts above the Guaranteed Issue Amount so long as Defendant approved the full amount. (AR 95).

On June 2, 2017, Armani's HR Senior Manager Diane Rodriguez emailed Plaintiff with the following message:

> Dear Soohyun,
>
> As you know, you are currently enrolled in additional voluntary life insurance for your spouse in the amount of $500,000.00. Please note that the policy has a guarantee issue of $50,000 and any amount over this threshold must be accompanied by an Enrollment Application and Statement of Health for approval by Reliance. Reliance has confirmed that they do not have this application on file for your policy and have asked that you complete the attached and submit back to RELIANCE at your earliest convenience. . . .

(AR 245).

On June 4, 2017, Plaintiff responded by email:

Dear Diane,

I have had an opportunity to review your email, the Enrollment Application and Statement of Health and have some questions before filling everything out. However, first let me summarize why I opted to obtain life insurance through the company.

In December 2015, my husband was diagnosed as having pancreatic cancer. He was unable to work and was placed on disability. Because his basic living needs were exorbitant, our family decided to cash out his life insurance policy, which my two daughters and I were the beneficiary, so we could pay his monthly expenses. This decision was easier knowing Giorgio Armani's group plan offered a life insurance plan in the event of a spouse passing away. This was my safety net.

So, in early 2016, I applied for life insurance for my husband in the amount of $500,000. The monthly premium of $217 has been deducted from my paycheck since March 2016. At no time did Reliance or the HR department ask for an application. In addition, as your email confirms, I am currently enrolled in additional voluntary life insurance for my spouse in the amount of $500,000.00

My question is this — is it possible that Reliance can suddenly cancel the additional voluntary life insurance policy for my spouse?

. . .

(AR 246).

From March 2016 to May 2017, Plaintiff's benefits statement stated that Plaintiff was enrolled in a spouse life insurance for the benefit amount of $500,000 with a premium of $219.90. (*See* AR 142-157). However, in June 2017, Defendant reduced Plaintiff's spouse benefit amount from $500,000 to $50,000, with a premium of $21.99. (*See* AR 158-160).

4. Plaintiff's Claim and Denial of $500,000 Benefits

On June 28, 2017, Plaintiff's husband died. (AR 205). On July 25, 2017, Armani submitted a claim form to Defendant, listing the death benefit as $50,000. (AR 78). On July 31, 2017, Plaintiff wrote to Armani that the claim should be for $500,000. (AR 260). She explained that she had been paying premiums for the $500,000 benefit amount and that she had never been denied the coverage for the $500,000 benefit amount. (*Id.*). She also explained that she was not interested in having her premiums returned. (*Id.*).

On October 18, 2017, Plaintiff signed a formal claim for $500,000, which her counsel submitted to Defendant on October 20, 2017. (AR 266, 72-76).

On October 26, 2017, Defendant's Senior Life Benefit Examiner Kimberly Wilson requested Plaintiff's enrollment form from Armani's HR Supervisor Cinzia Gagliano. (AR 429-433). Instead of the enrollment form, Armani provided the claim form. (AR 430-431).

On December 21, 2017, Wilson again reached out to Armani regarding Plaintiff's enrollment forms. (AR 448). On January 25, 2018, Gagliano responded that Armani's "enrollment process is done digitally" and

that it does not have any physical forms of the enrollment to send to Defendant. (*Id.*). Gagliano also stated that the requested amount was $500,000. (*Id.*).

On January 31, 2018, Defendant sent Plaintiff a letter and enclosed a benefit check in the amount of $50,000. (AR 64). However, Defendant denied Plaintiff's claim for the remaining $450,000 in benefits. (AR 63-64). Defendant explained that Proof of Good Health must have been provided in order for any amount in excess of $50,000 to become effective, but Defendant did not have any record of receiving and approving evidence of insurability for Plaintiff's spouse. (AR 63-64). Defendant also stated that it is advising Armani to issue a refund to Plaintiff for any premium paid in excess of the premium due for $50,000. (AR 64).

On March 23, 2018, Armani refunded $3,105.56 in premiums to Plaintiff. (AR 308, 310). At the hearing, Plaintiff clarified that she had not cashed this refund.

5. Plaintiff's Appeal

On March 5, 2018, Plaintiff appealed the denial of her claim for $500,000 in benefits. (AR 103-104). Plaintiff also requested "all documents, records, and other information relevant to the claimant's claim for benefits" under 29 C.F.R. § 2560.503-1(h)(2)(iii). (AR 104).

On April 5, 2018, Defendant rejected the appeal. (AR 68-71).

On April 10, 2018, Plaintiff's counsel wrote to Defendant, stating that the requested copy of the file had not been provided. (AR 311-313). Plaintiff asserts that Defendant did not respond to the document request. Instead, Defendant only provided

the documents on May 26, 2019, after this litigation commenced.

II. CONCLUSIONS OF LAW

A. Standard of Review

1. Rule 52(a)

Federal Rule of Civil Procedure 52 provides that "[i]n an action tried on the facts without a jury . . . the court must find the facts specially and state its conclusions of law separately." Fed. R. Civ. P. 52(a)(1). "In a Rule 52 motion, as opposed to a Rule 56 motion for summary judgment, the court does not determine whether there is an issue of material fact, but actually decides whether the plaintiff is [entitled to benefits] under the policy." *Prado v. Allied Domecq Spirits and Wine Group Disability Income Policy*, 800 F. Supp. 2d 1077, 1094 (N.D. Cal. 2011) (citing *Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1095 (9th Cir. 1999)). In making that determination, the court must "evaluate the persuasiveness of conflicting testimony and decide which is more likely true" in order to make findings of fact that will be subject to review under a clearly erroneous standard if appealed. *Kearney*, 175 F.3d at 1095.

2. ERISA Standard of Review

A denial of ERISA benefits challenged under 29 U.S.C. § 1132 "is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Orzechowski v. Boeing Co. Non-Union Long-Term Disability Plan, Plan No. 625*, 856 F.3d 686, 691 (9th Cir. 2017). However, "[California Insurance Code] § 10110.6 voids any 'provision that

reserves discretionary authority to the insurer, or an agent of the insurer.'" *Orzechowski v. Boeing Co. Non-Union Long-Term Disability Plan, Plan No. 625*, 856 F.3d 686, 695 (9th Cir. 2017) (quoting Cal. Ins. Code § 10110.6(a)). "The statute, which became effective on January 1, 2012, is 'self-executing'; thus, if any discretionary provision is covered by the statute, 'the courts shall treat that provision as void and unenforceable.'" *Id.* at 692 (quoting Cal. Ins. Code § 10110.6(g)). Section 10110.6 applies to a policy that provides life insurance coverage even if the policy is part of an ERISA plan document. *Id.* at 694.

Here, it is undisputed that the Policy at issue was issued after January 1, 2012 and that it provides life insurance coverage. Therefore, the Court reviews Plaintiff's claim under a de novo standard and "evaluate[s] whether the plan administrator correctly or incorrectly denied benefits, without reference to whether the administrator operated under a conflict of interest." *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 963 (9th Cir. 2006).

B. Plaintiff's Breach of Policy Claim

Plaintiff argues that Defendant must pay the entire claim for $500,000 because (i) the Policy documents are ambiguous on what is required to obtain more than $50,000 in Dependent Life Insurance; (ii) Defendant waived its right to require evidence of insurability and proof of good health; and (iii) Defendant is estopped from contesting coverage. (Plaintiff's Motion at 13-22). Plaintiff further argues that Defendant failed to conduct a full and fair review. (*Id.* at 22-23). Because the Court concludes that waiver applies, the Court need not determine

Plaintiff's other arguments as to whether Defendant is required to pay the entire claim for $500,000.

1. Agency

As a threshold matter, the parties dispute whether Armani acted as Defendant's agent when Armani received applications for coverage and collected premiums on Defendant's behalf. To determine whether Armani acted as an agent, the Court must examine federal common law of agency. *See Salyers v. Metro. Life Ins. Co.*, 871 F.3d 934, 939 (9th Cir. 2017) (developing a federal common law of agency under similar fact patterns because ERISA statutory scheme does not address this issue). Under the federal common law, "agency [is] the fiduciary relationship that arises when one person (a 'principal') manifests assent to another person (an 'agent') that the agent shall act on the principal's behalf and subject to the principal's control, and the agent manifests assent or otherwise consents so to act." *Id.* at 939 (internal quotation marks and citation omitted). "The nature of the relationship between the employer and insurer and the nature of the interactions with the insured must be considered on a case-by-case basis." *Id.* at 941.

"The legal consequences of an agent's actions may be attributed to a principal when the agent has actual authority (express or implied) or apparent authority." *Id.* at 940 (citation omitted). "Express actual authority derives from an act specifically mentioned to be done in a written or oral communication." *Id.* "Implied actual authority comes from a general statement of what the agent is supposed to do; an agent is said to have the implied authority to do acts consistent with that direction." *Id.* "Apparent

authority results when the principal does something or permits the agent to do something which reasonably leads another to believe that the agent had the authority he purported to have." *Id.*

Here, it is not clear whether Plaintiff is asserting that Armani had actual or apparent authority to act as an agent. Regardless, Plaintiff argues that Armani had authority to act as an agent for Defendant because Armani was performing administrative duties on behalf of Defendant. (Plaintiff's Motion at 22). For example, Armani was responsible for enrolling customers and collecting premiums for Defendant. (*Id.*; Defendant's Motion at 17; AR 50). Accordingly, Plaintiff argues that Armani acted as an agent for Defendant.

In response, Defendant appears to argue that Armani's administrative responsibilities cannot be imputed to Defendant because Armani was solely responsible for enrollment of its employees, including obtaining the necessary evidence of insurability, recording the employee's elections of coverage, and deducting the accordingly premiums. (Defendant's Motion at 1-3). Because Armani was solely responsible for enrollment and for obtaining the evidence of insurability, Defendant argues that Armani is not an agent of Defendant.

Defendant's argument is not persuasive. In *Salyers*, the Ninth Circuit held that an employer was an agent of a life insurance company under nearly identical facts. There, the life insurance company and the employer similarly "created a system in which [the employer] was responsible for interacting with plan participants and [the life insurance company] remained largely ignorant of individual plan

participants' coverage elections." *Salyers*, 871 F.3d at 938. Specifically, "[t]he task of flagging policies for missing evidence of insurability was delegated to [the employer] and [the employer] was responsible for insuring that a statement of health or evidence of insurability accompanied Salyers' selection of coverage." *Id.* at 940. Based on these facts, the Ninth Circuit had "no trouble concluding that [the employer] had apparent authority, and perhaps even implied actual authority, to enforce the evidence of insurability requirement on [the life insurance company's] behalf." *Id.*

The same reasoning applies here. As in *Salyer*, Armani was similarly responsible for enrolling customers, including collecting the evidence of insurability requirement. Therefore, Armani had apparent authority, and possibly implied actual authority, to collect, track, and enforce the evidence of insurability requirement on Defendant's behalf. Therefore, Armani's knowledge and conduct with regard to those matters are attributed to the life insurance company. *See Salyers*, 871 F.3d at 941.

2. Waiver

The parties next dispute whether Defendant has waived its right to rely on such evidence as grounds of denial of benefits.

"A waiver occurs when a party intentionally relinquishes a right or when that party's acts are so inconsistent with an intent to enforce the right as to induce a reasonable belief that such right has been relinquished." *Salyers*, 871 F.3d at 938 (internal quotation marks and citation omitted). "Courts have applied the waiver doctrine in ERISA cases when an insurer accepted premium payments with knowledge

that the insured did not meet certain requirements of the insurance policy." *Id.*; *see also Gaines v. Sargent Fletcher, Inc. Grp. Life Ins. Plan*, 329 F. Supp. 2d 1198, 1222 (C.D. Cal. 2004) (holding that an insurer waived its right to rely on evidence of insurability requirement as grounds for denial of benefits by receiving payments without "giving any indication" that the insured had failed to submit evidence of insurability); *Pitts v. Am. Sec. Life Ins. Co.*, 931 F.2d 351, 357 (5th Cir. 1991) (finding waiver in ERISA action where insurer continued accepting payments after learning of plan participant's breach of policy requirements).

Plaintiff again argues that *Salyers* is on all fours. There, the plaintiff elected life insurance coverage for $20,000 for her spouse. *Salyers*, 871 F.3d at 936. Because evidence of insurability was not required for coverage below $50,000, the plaintiff was not asked to submit evidence of insurability. *Id.* However, the employer mistakenly entered $500,000 in its system, and deducted premiums from the plaintiff's paycheck based on $500,000 in coverage. *Id.* During the next enrollment period, the plaintiff elected $250,000 in life insurance coverage for spouse. The plan documents stated that evidence of insurability was required for elections of coverage of over $50,000 and the plan's open enrollment guide also stated that "any coverage you elect requiring a statement of health will not take effect until approved by MetLife." *Id.* at 936-37. However, neither the employer nor the life insurance company asked for a statement of health or other evidence of insurability, and the plaintiff did not submit one. *Id.* at 937. The plaintiff's premium

payments were adjusted to reflect her new election of $250,000 in coverage. *Id.*

Based on these facts, the Ninth Circuit determined that the life insurance company waived the evidence of insurability requirement, and it could not contest coverage on that basis. *Id.* at 941. The court reasoned that the employer "knew or should have known that [the plaintiff's] 2014 coverage election required evidence of insurability, because [the plaintiff's] system showed $250,000 in coverage." *Id.* "Despite having not received evidence of insurability from [the plaintiff] in 2014 or earlier, [the employer] began deducting premiums from [the plaintiff's] paycheck every two weeks between September 2013 and February 2014, in amounts corresponding to $500,000 in coverage for 2013 and $250,000 for 2014." *Id.* Moreover, "five days after [the spouse's] death, having still not received evidence of insurability, [the employer] sent a letter to [the plaintiff] confirming coverage of $250,000." *Id.* The court explained that "the deductions of premiums, [the life insurance company and the employer's] failure to ask for a statement of health over a period of months, and [the employer's] representation to [the plaintiff] that she had $250,000 in coverage were collectively so inconsistent with an intent to enforce the evidence of insurability requirement as to induce a reasonable belief that [it] ha[d] been relinquished." *Id.* (internal quotation marks and citation omitted).

Plaintiff argues that the same reasoning applies here. The Court agrees. Armani, acting as Defendant's agent, deducted the premium rate for $500,000 from Plaintiff's paycheck for over a year. Neither Defendant nor Armani asked for evidence of

insurability during that same time period. Moreover, Plaintiff's benefit statements from March 2016 to May 2017 stated that Plaintiff was enrolled in spouse life insurance for the benefit amount of $500,000. As in *Salyers*, "[t]he deductions of premiums, [the insurance company and the employer's] failure to ask for a statement of health over a period of months, and [the insurance company's] representation to [the plaintiff] that she had [$500,000] in coverage [are] collectively so inconsistent with an intent to enforce the evidence of insurability requirement as to induce a reasonable belief that [it] ha[d] been relinquished." *Salyers*, 871 F.3d at 941 (internal quotation marks and citations omitted).

Not surprisingly, Defendant attempts to distinguish *Salyers* by noting certain factual differences.

First, Defendant argues that in *Salyers*, there was no indication that the decedent was uninsurable or that the plaintiff or the employer knew he was uninsurable. (Defendant's Motion at 18). In contrast, Defendant argues that Plaintiff knew her spouse was uninsurable. (*Id.*). This argument is not persuasive.

As a preliminary matter, it is not clear whether Plaintiff's "knowledge" that her spouse is uninsurable is relevant in determining whether Defendant waived its right. "Generally, '[t]he doctrine of waiver looks to the act, or the consequences of the act, of one side only, in contrast to the doctrine of estoppel, which is applicable where the conduct of one side has induced the other to take such a position that it would be injured if the first should be permitted to repudiate its acts.'" *Salyers*, 871 F.3d at 941, n.5 (citation omitted). It is true that the Ninth Circuit has acknowledged that "in the insurance context, the distinction between

waiver and estoppel has been blurred" and that in a previous decision, it "require[d] an element of detrimental reliance or some misconduct on the part of the insurance plan before finding it has affirmatively waived a ***limitations defense***." *Id.* (citing *Gordon v. Deloitte & Touche, LLP Grp. Long Term Disability Plan*, 749 F.3d 746, 752-53 (9th Cir. 2014)) (emphasis added). However, in *Salyers*, the Ninth Circuit did not decide whether *Gordon* applied beyond the waiver of a statute of limitations defense at issue in that case, but assumed that, even if *Gordon* did apply, the record demonstrates "[the plaintiff] detrimentally relied on having [the insurance] great[er] than $30,000." *Id.* Therefore, it is unclear whether detrimental reliance is a required element in this analysis.

Regardless of whether detrimental reliance is an element of waiver, the evidence here amply demonstrates detrimental reliance. Plaintiff signed up for Defendant's life insurance in good faith based on her belief that her husband would be covered. Furthermore, Plaintiff asserted in an email to Armani's HR Manager that her family "decided to cash out his [other] life insurance policy . . . so [they] could pay his monthly expenses" and that "[t]his decision was easier knowing [Defendant's] group plan offered a life insurance plan in the event of a spouse passing away." (AR 246). Therefore, the Court determines Plaintiff detrimentally relied on having the insurance benefit of $500,000, to the extent that it is a required element here.

Second, Defendant argues that, unlike the plaintiff in *Salyers*, Plaintiff was informed that evidence of insurability was required prior to her husband's

death. (Opp. to Plaintiff's Motion at 4-5). This argument is also not persuasive. Here, Plaintiff was ***not*** informed that evidence of insurability was required for well over a year – from February 29, 2016 through June 2, 2017. It was not until June 2, 2017 – a few weeks before Plaintiff's husband's death – that Armani first sent Plaintiff a Statement of Health and requested that Plaintiff fill it out. In that same letter, Armani also confirmed that Plaintiff was currently enrolled in the insurance for coverage of $500,000 in benefits. The fact that Armani sent this request on June 2, 2017 rather than on June 28, 2017, when Plaintiff's husband passed away, does not change the fact that Armani deducted premiums corresponding to $500,000 for over a year and represented that Plaintiff had $500,000 in coverage during this entire time. Such actions are "so inconsistent with an intent to enforce the right [to enforce the evidence of insurability] as to induce a reasonable belief that such right has been relinquished." *Salyers*, 871 F.3d at 938.

At the hearing, Defendant argued that waiver should apply so long as it requested the evidence of insurability prior to the insured's death. The Court does not find this argument persuasive. As the Court noted at the hearing, Defendant's argument would result in a drastic outcome, where Defendant could avoid the application of waiver so long as it requested the evidence of insurability moments before Plaintiff's husband's death. However, Defendant did not explain why such a last-minute attempt could erase its conduct for over a year, which reasonably induced Plaintiff to believe that Defendant did not require an evidence of insurability or proof of good health.

Defendant has not cited, and the Court is not aware of, any cases that held that waiver should apply even if it would result in such a drastic outcome.

Third, Defendant argues that the facts in this action are distinguishable from Salyers because Defendant's Policy contains the following provision: "No agent or other person has the authority to change this Policy or waive any of its terms or provisions." (Defendant's Motion at 18). Therefore, Defendant argues that Armani's failure to request evidence of insurability cannot nullify this requirement. (*Id.*).

However, Defendant provides no case authority in support of its argument that a non-waiver provision cannot be waived. In fact, a number of cases have held otherwise. *See e.g., Shenzhenshi Haitiecheng Sci. & Tech. Co. v. Rearden, LLC*, No. 15-CV-00797-SC, 2015 WL 6082028, at *3 (N.D. Cal. Oct. 15, 2015) ("The presence of an antiwaiver provision, however, is not dispositive because the antiwaiver provision can itself be waived through words or conduct."); *Auntie Anne's, Inc. v. Wang*, No. CV 14-01049 MMM (Ex), 2014 WL 11728722, at *14 (C.D. Cal. July 16, 2014) ("Non-waiver clauses themselves can be waived"); *Bettelheim v. Hagstrom Food Stores, Inc.*, 113 Cal. App. 2d 873, 878, 249 P.2d 301, 305 (1952) ("Even a waiver clause may be waived by conduct."); *see also* 13 Williston on Contracts § 39:36 (4th ed.) ("The general view is that a party to a written contract can waive a provision of that contract by conduct despite the existence of a so-called antiwaiver or failure to enforce clause in the contract.") (collecting cases). Here, the evidence suggests that Armani either expressly or impliedly waived the antiwaiver provision of the policy when it accepted the premium for $500,000 and

provided in Plaintiff's benefit statement that she was indeed enrolled in a $500,000 policy for her spouse, without receiving the required evidence of insurability and proof of good health.

Fourth, Defendant argues that Plaintiff is impermissibly seeking to enlarge coverage beyond that actually provided by an employee benefit plan. (Defendant's Motion at 14). The Court disagrees. As the Ninth Circuit explained in *Salyers*, "where, as here, premium payments have been accepted despite the plan participant's alleged noncompliance with policy terms, 'giving effect to the waiver . . . does not expand the scope of the ERISA plan; rather it provides the Plaintiff with an available benefit for which [s]he paid.'" 871 F.3d at 941, n.4 (citation omitted). Because Plaintiff already had paid for a life insurance benefit of $500,000 and because a benefit of $500,000 is a plan provided by Defendant under the Policy, Plaintiff is not seeking to expand the scope of the Policy. While Defendant argues that it would not have approved Plaintiff's life insurance plan if it had received and reviewed the evidence of insurability, nothing in the Policy itself appears to state that someone with a pancreatic cancer diagnosis is ineligible. Therefore, the Court concludes that providing the Plaintiff with an available benefit for which she paid does not expand the scope of the Policy.

Fifth, Defendant points out that in *Salyers*, there were two enrollment periods at issue and that the employer and the insurer had the opportunity to correct the lack of submission of proof of good health during the second enrollment period, but failed to do so. (Defendant's Motion at 17). In contrast, Defendant argues that there was only one enrollment

period here. (*Id.*). However, this distinction is not meaningful because, of course, Defendant or its agent had the opportunity to correct the lack of submission of proof of insurability every month Plaintiff was enrolled and paid the premium for $500,000. In other words, Defendant or Armani had the chance to fix the issue any time between March 2016 and June 2017. Therefore, the fact that there was only one enrollment period at issue here does not meaningfully change the analysis.

Accordingly, Defendant has waived its right to require evidence of insurability and proof of good health and must pay Plaintiff the full $500,000 benefit for which she paid.

C. Statutory Penalties for Failing to Provide Documents

Under 29 U.S.C. § 1132(c)(1), a plan administrator who "fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish . . . within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper." The statutory damages have since increased from $100 a day to $110 a day. *See* 29 C.F.R. § 2575.502c-1.

As part of the administrative appeal of the denial, on March 5, 2018, Plaintiff requested "all documents, records, and other information relevant to the claimant's claim for benefits" under 29 C.F.R. § 2560.503-1(h)(2)(iii). (AR 104). Plaintiff asserts that Defendant did not provide the documents until

May 26, 2019 – after Plaintiff initiated this action. (Plaintiff's Motion at 23). Therefore, Plaintiff seeks a penalty of $110 per day from April 4, 2018 (30 days after Plaintiff requested the documents) to May 26, 2019 (the day documents were provided), for a total amount of $45,870. (*Id.*).

Defendant argues that it is not subject to statutory penalties because the penalties can only be assessed against an "administrator" as defined under ERISA. (Opp. to Plaintiff's Motion at 13). Defendant cites two cases for the proposition that only a plan administrator can be held liable for a violation of § 1132(c). *See Turnipseed v. Educ. Mgmt. LLC's Employee Disability Plan*, No. C09-03811 MHP, 2010 WL 140384, at *5 (N.D. Cal. Jan. 13, 2010); *In re WellPoint, Inc. Out-of-Network UCR Rates Litig.*, 865 F. Supp. 2d 1002, 1045–46 (C.D. Cal. 2011).

In response, Plaintiff suggests that the cases cited above are no longer the law in this circuit in light of *Cyr v. Reliance Standard Life Ins. Co.*, 642 F.3d 1202 (9th Cir. 2011). (Plaintiff's Reply at 9).

The Court agrees with Defendant, and finds the cases cited by Defendant to still be good law. In *Cyr*, the Ninth Circuit examined whether a life insurance company could be held liable under 29 U.S.C. § 1132(a)(1)(B) – a different provision of the statute not applicable here. 642 F.3d at 1205. The Ninth Circuit concluded that the insurer could be held liable even though it was not a plan or a plan administrator because "potential liability under 29 U.S.C. § 1132(a)(1)(B) is not limited to a benefits plan or the plan administrator." *Id.* at 1207. In reaching this conclusion, the court relied in part on the fact that "§ 1132(a)(1)(B) does not appear to limit which parties

may be proper defendants in that civil action" and "the Secretary of Labor [has not] promulgated a regulation setting out such limits." *Id.* at 1205.

In contrast, 42 U.S.C. § 1132(c)(1) explicitly limits liability to an "administrator." 42 U.S.C. § 1132(c)(1) ("Any administrator (A) who fails to meet the requirements . . ."). The Ninth Circuit has also confirmed that only the plan administrator can be sued for failing to provide documents under § 1132(c)(1). *See Moran v. Aetna Life Ins. Co.*, 872 F.2d 296, 299-300 (9th Cir. 1989) ("Because Aetna was not designated as plan administrator in the policy and is not the plan sponsor, it is not liable under the statute."); *Sgro v. Danone Waters of N. Am., Inc.*, 532 F.3d 940, 945 (9th Cir. 2008) ("We . . . remain bound by *Moran*"; 29 U.S.C. § 1132(c)(1) "only gives [the plaintiff] a remedy against the plan 'administrator,' and MetLife isn't the plan administrator"). *Cyr* has not overruled these cases examining § 1132(c)(1).

Moreover, since *Cyr* has been decided, other district courts in this circuit have held that liability under § 1132(c)(1) is limited to a plan administrator. *See e.g., McCollum v. Blue Shield of Cal. Life & Health Ins. Co.*, No. 12–cv–01650 PSG, 2012 WL 5389711, at *3–4 (N.D. Cal. Nov. 2, 2012) ("[T]he Ninth Circuit has instructed against a *de facto* plan administrator theory under Section 1132(c). Even where 'a third party makes the benefit determination' such that 'the administrator may not have the needed documents on hand,' the liability party remains the administrator."); *Jones v. Metro. Life Ins. Co.*, No. C08-03971-RMW, 2014 WL 4966294, at *2 (N.D. Cal. Oct. 3, 2014), *aff'd in part sub nom. Jones v. Life Ins. Co. of N. Am.*, 716 F. App'x 584 (9th Cir. 2017) ("Ninth Circuit law

precludes § 1132(c)(1) claims against third party administrators like MetLife."); *Parr v. First Reliance Standard Life Ins. Co.*, No. 15-CV-01868-HSG, 2016 WL 3439753, at *2 (N.D. Cal. June 23, 2016) ("[B]ecause Defendant was not designated as the plan administrator as defined by § 1002(16) and because Defendant is not the plan sponsor, Plaintiffs third cause of action [based on failure to turn over requested plan documents] fails as a matter of law.").

Under 29 U.S.C. § 1002(16)(A), "administrator" is defined as: "(i) the person specifically so designated by the terms of the instrument under which the plan is operated" and "(ii) if an administrator is not so designated, the plan sponsor." The "plan sponsor" is the "employer in the case of an employee benefit plan established or maintained by a single employer." 29 U.S.C. § 1002(16)(B)(i).

Here, it is undisputed that the Policy does not name an "administrator." Therefore, the employer Armani is the only party liable under 29 U.S.C. § 1132(c)(1). Accordingly, the Court concludes Defendant is not subject to statutory penalties under 29 U.S.C. § 1132(c)(1).

III. CONCLUSION

Because Defendant has waived its right to require evidence of insurability and proof of good health, the Court awards Plaintiff $500,000, less the $50,000 previously paid by Defendant, with interest. However, Defendant is not subject to statutory penalties under 29 U.S.C. § 1131(c)(1). A separate judgment shall be entered accordingly.

This Order will be temporarily filed under seal until March 20, 2020. If either party seeks to keep certain portions of this Order under seal, they shall file an Application to File Under Seal by **March 19, 2020**. If no applications are filed by then, the Order will be publicly filed on the docket.

IT IS SO ORDERED.

Dated: March 5, 2020 */s/ Michael W. Fitzgerald*
MICHAEL W. FITZGERALD
United States District Judge

APPENDIX D

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

SOOHYUN CHO,

Plaintiff-Appellee,

v.

FIRST RELIANCE STANDARD LIFE INSURANCE COMPANY,

Defendant-Appellant.

v.

GIORGIO ARMANI CORPORATION,

Third-party-defendant-Appellee.

Nos. 20-55314, 20-55581
D.C. No. 2:18-cv-04132-MWF-SK

ORDER

Filed: September 8, 2021

Before: CALLAHAN and FORREST, Circuit Judges, and SEEBORG, Chief District Judge.*

The panel has voted to deny the petition for panel rehearing. Judge Callahan votes to deny the petition for rehearing en banc and Chief Judge Seeborg so recommends. Judge Forrest votes to grant the petition for rehearing en banc. The full court has been advised of the petition for rehearing en banc and no judge has requested a vote on whether to rehear the matter en banc. Fed. R. App. P. 35. The petition for panel rehearing and the petition for rehearing en banc are denied.

* The Honorable Richard Seeborg, Chief United States District Judge for the Northern District of California, sitting by designation.