

NO. 02-0485

IN THE SUPREME COURT OF TEXAS

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY,

Petitioner

VS.

JAMES KNOTT, M.D.,

Respondent

*On Petition for Review of the March 21, 2002 Opinion and Judgment
of the Court of Appeals for the Eleventh District of Texas,
No. 11-00-00243-CV*

**BRIEF OF PETITIONER PROVIDENT LIFE
AND ACCIDENT INSURANCE COMPANY**

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IDENTITIES OF PARTIES AND COUNSEL

1. The Petitioner is Provident Life and Accident Insurance Company ("Provident"), Appellee and Defendant below. Lead counsel for Provident, and its trial and appellate counsel below, is Andrew C. Whitaker, State Bar No. 21273600, Figari Davenport & Graves, L.L.P., 3400 Bank of America Plaza, 901 Main Street, LB 125, Dallas, Texas 75202-3796, (214) 939-2000 (office), (214) 939-2090 (telecopy).

2. The Respondent is James Knott, M.D. ("Knott"), Appellant and Plaintiff below. Upon information and belief, lead counsel for Knott will be, and his trial and appellate counsel below was, Ben C. Martin, State Bar No. 13052400, Law Offices of Ben C. Martin, 2100 McKinney Avenue, Suite 1975, Dallas, Texas 75201, (214) 761-6614 (office), (214) 744-7590 (telecopy).

3. Although not a party to this appeal, Debra Lucille Townley ("Townley"), as Independent Executor of the Estate of Ellis Garland Gatlin ("Gatlin"), deceased, was an Appellee and Defendant below. Upon information and belief, lead counsel for Townley will be, and her appellate counsel below was, Patrick Frank, State Bar No. 07363700, Fiedler, Akin, Frank & Carlton, P.C., North Central Plaza Three, 12801 N. Central Expressway, Suite 450, Dallas, Texas 75243, (972) 490-7300 (office), (972) 490-7696 (telecopy). Townley's trial counsel below was Mark Alexander, who was formerly affiliated with Mr. Frank's firm.

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STATEMENT OF THE CASE

This is a suit for benefits under two disability insurance policies (the "Policies") issued by Provident and insuring Knott. On May 19, 2000, the 44th Judicial District Court of Dallas County, Texas, the Honorable Margaret Keliher presiding, entered summary judgment in favor of Provident and Townley on all of Knott's claims. Knott appealed this ruling to the Court of Appeals for the Fifth District of Texas; however, this Court transferred the appeal to the Court of Appeals for the Eleventh District of Texas (the "Court of Appeals") for the purpose of equalizing the dockets. On March 21, 2002, the Court of Appeals entered the Opinion and the Judgment, which reversed the trial court's summary judgment in favor of Provident on Knott's breach of contract claim, remanded such claim for trial, and otherwise affirmed the trial court's summary judgment in Defendants' favor. The panel participating in the Opinion and the Judgment was comprised of Chief Justice Arnot, Justice Wright, and Justice McCall. Chief Justice Arnot authored the Opinion, which has been published at 70 S.W.3d 924 (Tex. App.--Eastland 2002, pet. filed). Neither Justice Wright nor Justice McCall filed a separate opinion. Both Knott and Provident filed motions for rehearing, which the Court of Appeals overruled on April 18, 2002.

STATEMENT OF JURISDICTION

This Court has jurisdiction under article V, § 3 of the Texas Constitution, § 22.001 of the Texas Government Code, and Rule 55.1 of the Texas Rules of Appellate Procedure.

ISSUES PRESENTED

A. Whether a court can rewrite a disability insurance policy's unambiguous definition of "total disability" and ignore its definitions of "partial disability" and "residual disability" in favor of a common-law definition of "total disability" that was adopted in readily distinguishable cases decided over 40 years ago.

B. Whether an insured's alleged total disability commenced after his 65th birthday when he was working on a full-time basis in his pre-disability occupation for several years before and at least three months after turning 65.

C. Whether ERISA governs disability insurance policies covering the shareholders in a professional association where, at the time that some of the policies were issued, one of the shareholders was an employee without any ownership interest.

D. Whether disability insurance policies that are issued to a shareholder in a professional association can be part of the same ERISA plan that provides various types of insurance coverage to the association's shareholders and employees.

TO THE HONORABLE SUPREME COURT OF TEXAS:

Provident files this brief to reverse the Court of Appeals' ruling on Knott's breach of contract claim, in which such court erroneously inserted a common-law definition of "total disability" into all of the disability insurance policies in effect in this State and, in so doing, improperly reversed the trial court's summary judgment in favor of Provident on such claim.

In support of this request, Provident states:

STATEMENT OF FACTS¹

Provident believes that the Opinion issued by the Court of Appeals, except as set forth below, correctly states the nature of the case. Provident has, however, included additional matters below that it believes are relevant to this brief:

A. The Professional Association's Formation and Ownership.

Knott was born on August 20, 1930. (CR 37.) Knott obtained his B.S. from The University of Texas in 1955 and, after a year as a practicing pharmacist, entered Southwestern Medical School. (CR 38-39.) Following his graduation from medical school in 1960, Knott completed a mixed internship² and a residency in obstetrics and gynecology at The University of Kansas. (CR 39-40.) Knott practiced obstetrics and gynecology in Corpus Christi from 1964 until 1968, when he moved to Dallas and began practicing with Robert M. Kuhne, M.D. ("Kuhne"). (CR 42.) After practicing as partners for some time,

¹Unless otherwise indicated, all emphases are supplied by counsel.

²Knott conceded that the statement in the resume that he submitted to Provident in January 1996 that his internship was in obstetrics and gynecology was in error. (CR 41, 191.)

Knott and Kuhne formed Kuhne & Knott Gynecological Associates (the "Professional Association"), a professional association through which they practiced and of which they each owned 50%. (CR 43-46, 307-10.) In 1973, Max McGinnis, M.D. ("McGinnis") became affiliated with the Professional Association, first as an employee with no ownership interest and later as an equal shareholder. (CR 309, 312-14, 356-58.) Kuhne testified:

Q. Okay. You do recall that [McGinnis] was hired on a salary basis as a doctor employee at that point, correct?

A. Correct.

Q. All right. And [McGinnis] was not at the outset a shareholder of Kuhne and Knott Gynecological Associates?

A. That's correct.

Q. How long did he remain in that status before he became a shareholder?

A. I don't remember. I think one year.

(CR 313.) Similarly, reports in Provident's underwriting files reveal that, when they applied for coverage in 1974, Knott and Kuhne were shareholders, whereas McGinnis was an employee. Compare CR 337, 339, 342, 349-50 (characterizing Knott and Kuhne as partners and/or self-employed) with CR 356, 358 (identifying McGinnis's employer as the Professional Association and stating that he was employed as a physician by and affiliated with the Professional Association).

B. The Professional Association's Role in Providing Disability Coverage.

In 1970, Provident issued disability income policies insuring Knott and Kuhne, and in 1974, Provident issued additional policies insuring Knott and Kuhne as well as the first

policy insuring McGinnis. In connection with the issuance of the 1974 coverage, the Professional Association executed a Salary Allotment Agreement providing that the Professional Association would be responsible for remitting the premiums for all five of these policies to Provident in a timely fashion. (CR 70, 246, 319-20, 328, 334.) Provident added Salary Allotment Riders to these policies confirming the Professional Association's involvement, and these policies became part of Risk Group No. 0320. (CR 336, 345-46, 354-55, 360.) By virtue of the Professional Association's involvement, Provident provided a 10% discount on the premiums for these policies. (CR 246, 334, 344, 347-48, 357.) In the ensuing years, the Professional Association occasionally paid the premiums for these policies from its checking account.³ (CR 66-69, 243-45.) Knott relied on the employees of the Professional Association to ensure that the Policies remained in force and received assistance from at least one of its employees during the claim process with Provident. (CR 66-67, 84-85.)

C. The Professional Association's Role in Providing Other Types of Insurance Coverage.

Over time, the Professional Association employed, in addition to its shareholders,⁴ other doctors (including McGinnis) on three occasions and several additional employees. (CR 46, 49-50, 318.) The Professional Association provided health insurance to its

³Although Knott asserted that he reimbursed the Professional Association for the payments that it made on his behalf, he told Provident on his initial statements of claim in both 1985 and 1996 that his employer paid 100% of the premiums for his coverage. (CR 65-66, 90, 150-51, 254, 295.)

⁴After the formation of the Professional Association, Knott received a W-2 rather than a K-1 at year-end (CR 46), confirming his status as an employee. Similarly, Kuhne conceded that he and Knott were employees of the Professional Association. (CR 311, 314-15.)

employees (including its shareholder-employees such as Knott) as an employee benefit at no cost to them and deducted its payments as an expense on its tax return. (CR 56-58, 186-87.) The Professional Association also paid 100% of the premiums for Knott's overhead expense coverage through The Equitable Life Assurance Society ("Equitable"). (CR 82-83, 250.)

D. The Policies.

Among its terms, the first policy that Provident issued to Knott (the "First Policy") provided a \$1,500 monthly benefit for total disability, lifetime benefits for an accident resulting in total disability commencing before his 65th birthday, a maximum benefit period of 24 months for a period of disability commencing after his 65th birthday, a 90-day elimination period during which benefits were not payable, and a \$750 monthly benefit for partial disability. (CR 194.) Following applicable updates, the First Policy further provided:

Indemnity will not be paid for disability during any period of time that the Insured is not under the care and attendance of a legally qualified physician other than himself.

PART 1. DEFINITION OF TOTAL DISABILITY: Total Disability means that due to Injuries or Sickness, you are unable to perform the duties of your occupation.

* * *

PART 4. PARTIAL DISABILITY - ACCIDENT: If injuries shall either prevent the Insured from performing one or more, but not all, important daily business duties, or shall prevent the Insured from performing his usual daily business duties for at least one-half, but not all, of the time usually required for the performance of such duties, the Company will pay periodically during the continuance of such partial disability, indemnity at the rate of the Monthly Benefit for Partial Disability....

(CR 194, 219.)

Among its terms, the second policy that Provident issued to Knott (the "Second Policy") provided a \$1,000 monthly benefit for total disability, lifetime benefits for an accident resulting in total disability commencing prior to his 65th birthday, a maximum benefit period of 24 months for an accident resulting in total disability commencing on or after his 65th birthday, a 90-day elimination period during which benefits were not payable, and a \$500 monthly benefit for partial disability. (CR 223, 226.) Following applicable updates, the Second Policy further provided:

DEFINITION OF TOTAL DISABILITY: Total Disability means that due to Injuries or Sickness, you are unable to perform the duties of your occupation.

* * *

DEFINITION OF PARTIAL DISABILITY: As used in this policy, the term "Partial Disability" means:

- (a) your inability to perform one or more of your important daily business duties, or
- (b) your inability to perform your usual daily business duties for at least one-half of the time usually required for the performance of such duties.

(CR 226, 241.)

Under both of the Policies, partial disability benefits were not payable for disabilities commencing after Knott's 65th birthday. (CR 194, 226.) The Policies were delivered to Knott, and he has at all times had them in his possession and been able to review them in the event that he had any questions. (CR 62.)

E. Knott Stops Performing Obstetrics.

From 1968 to 1980, Knott spent 45% of his time on obstetrics, 45% of his time on gynecology, and 10% of his time on his administrative duties. (CR 51.) Toward the end of this period, Kuhne went on disability and left the Professional Association. (CR 51, 317.) In 1980, Knott and McGinnis quit doing obstetrics, which tended to involve more work at night and other irregular times, in favor of the more structured gynecological practice. (CR 52-53.) From 1980 until the plane crash in June 1985, Knott did not perform any obstetrics or deliver any babies. (CR 53-54.) Knott thus began spending 90% of his time on gynecology and 10% of his time on administrative duties. (CR 54.) Of his time in gynecology, 60% was seeing patients, 30% was performing surgery, and 10% was consulting with other physicians. (CR 54-55.)

F. Knott Seeks Benefits from Provident and Equitable After His Plane Crash, Even Though He Had Returned to Work in His Occupation.

On June 9, 1985, Knott was involved in a plane crash in Oklahoma, and Dr. George Wharton ("Dr. Wharton") performed a thoracolumbar fusion on Knott's back. (CR 74-76.) The operation was a success, and Knott resumed seeing patients, consulting with other physicians, and performing administrative duties less than two months after the plane crash. (CR 77.) Knott decided to seek benefits from both Provident and Equitable. (CR 78-79.) On the initial claim form he submitted in June 1985 to Equitable, Knott listed his duties as that of a "gynecologist" because he had not performed any obstetrics in over five years.⁵ (CR

⁵Although Knott advised Equitable in June 1986 that he was not actively practicing obstetrics at the time of the plane crash, he never advised Provident of this fact. (CR 104-05, 270.) In any event, Knott conceded that the reason he did not perform obstetrics after the plane crash was his decision in 1980 to stop those activities, not because of his

80-82, 249.) Although Knott asserted on his Provident claim form in December 1985 that he was totally disabled, he was at the time working on at least a part-time basis seeing patients, consulting with other physicians, and performing his administrative duties.⁶ (CR 86, 91-92, 254-55, 563.) Contrary to his efforts to minimize his work activities, contemporaneous hospital records indicated that Knott performed more surgeries in the seven months after the plane crash (65) than he had in the seven months prior to the plane crash (44):

Month	Surgeries Performed
November 1984	8
December 1984	6
January 1985	5
February 1985	3
March 1985	2
April 1985	15
May 1985	5
Total	44

Month	Surgeries Performed
July 1985	1
August 1985	3
September 1985	16

injuries. (CR 86.)

⁶Dr. Wharton's first Attending Physician's Statement indicated that Knott's total disability had ended on August 4, 1985 and that he could resume part-time work on August 5, 1985; upon realizing the import of this form, Knott obtained Dr. Wharton's signature on another statement indicating that Knott was totally disabled. (CR 87-88, 251-53, 256.)

October 1985	14
November 1985	8
December 1985	9
January 1986	14
Total	65

(CR 99-100, 266-67.)

G. Provident Denies Knott's Claim and Then Begins Paying Residual Disability Benefits to Him.

Provident initially accepted Knott's claim and began paying him total disability benefits.⁷ (CR 93.) As part of its investigation, Provident requested and received records from Dr. Wharton, and it learned of the first Attending Physician's Statement that he completed indicating that Knott's total disability had ended on August 4, 1985 (CR 94-95, 261), which was prior to the expiration of the Policies' 90-day elimination period. By letter dated February 19, 1986, Provident advised Knott that it was denying his claim and stated:

Dr. Wharton's office has forwarded [an] attending physician statement that was signed and dated by Dr. Wharton on November 20, 1985. This form indicates dates of disability from June 9 to August 4, 1985 and partial from August 5 to present.

After a careful review of this information it has been determined that the 90 day elimination period was not satisfied, and according to our records we have overpaid your claim in the amount of \$7500.00.

(CR 264.)

⁷Provident also began waiving the premiums for the Policies, and Knott did not pay a single dollar in premiums at any point in time after the plane crash. (CR 126.)

Notwithstanding his failure to satisfy the elimination period, Provident agreed to consider Knott's claim on a residual disability basis as of December 8, 1985. (CR 96-97, 265.) Provident also added to the Policies, at no cost to Knott, a residual disability rider, which provided benefits in the event that he was unable to perform "one or more of [his] important daily business duties" or "[his] usual daily business duties for as much time as is normally required to perform them," suffered a loss of monthly income of at least 20%, and was under the care and attendance of a physician.⁸ (CR 97-98, 279-80.) Knott thereafter periodically submitted the financial information necessary for Provident to determine the amount, if any, of residual disability benefits payable to him, and he understood at the time that Provident was treating his claim as one for residual disability. (CR 101-03, 166, 268.) Each time that he sought additional benefits, Knott signed an "Insured's Statement of Claim for Residual Disability Benefits" and certified that he was "residually (partially) disabled." (CR 268.)

H. Knott Continues to Work Full Time in His Occupation, and His Earnings Continue to Grow.

In December 1986, Dr. Wharton removed the Dunn device from Knott's back without any complications, and Knott did not see him again for the purpose of receiving medical

⁸In May 1985, less than one month before the plane crash, Knott received a letter from Provident suggesting that he apply for the residual disability rider. (CR 70-72, 247-48.) In this letter, one of Provident's brokerage consultants stated:

In the last 3 years, Provident has introduced Residual disability coverage. For a physician, there is a great exposure to a long-term partial disability. Our Residual rider would pay a proportionate benefit based on loss of earnings in the event that you could work part-time or part duties as the result of a disability.

(CR 248.) Knott declined to apply for such rider, which was not available at the time he applied for the Policies. (CR 73.)

treatment until November 1994. (CR 106-07, 130, 138.) Throughout 1987 and 1988, Knott worked in his pre-crash occupation, on a full-time basis, performing all of his pre-crash duties (with the possible exception of certain types of surgeries). (CR 110-11, 114-15.)

Specifically, Knott testified:

Q. But would it be fair to say that, as of 1987, and for all of 1987 and all of 1988, basically the only thing that you had been doing prior to the plane crash that you weren't doing were certain gynecological surgeries?

A. That's fair to say that, yes.

(CR 111.) Less than a year after the accident, Knott's income had grown to the point where he was on occasion no longer suffering the monthly income loss necessary to receive residual disability benefits, and he made more money in 1987 and 1988 than he had in any year before the plane crash. (CR 107-08, 113-14.) Because of the growth in his income, there were several months in 1987 and 1988 in which Knott did not receive any residual disability benefits. (CR 111-13, 273-74.) In June 1987, Equitable closed Knott's claim due to his "demonstrated ability to perform the material and substantial duties of [his] occupation since [his] accident." (CR 108-09, 272.)

I. Provident Stops Paying Benefits to Knott.

In early 1989, because of the continued growth in his income, Knott stopped submitting the necessary forms to Provident to continue his claim, and the last check that he received for residual disability benefits was dated June 22, 1989. (CR 116-18, 275-76.) Moreover, Knott continued to perform all of the duties that he had performed prior to the plane crash with the possible exception of certain types of surgeries. (CR 119-21.) Since he was no longer entitled to benefits, Provident sent Knott a notice resuming the billing of premiums. (CR 121-22, 277.) Knott retained an attorney, and by letter dated May 20, 1991, Provident responded to the inquiries of such attorney and attached a copy of the residual disability rider under which it had been adjudicating Knott's claim. (CR 123-25, 278-80.) In this letter, Provident stated that it was putting the Policies on permanent waiver of premium by agreement, would administer any future claims in accordance with the Policies' terms, and requested that Knott promptly advise Provident of any objections to this approach. (CR 278.) The record is bereft of evidence that Knott made any sort of objection.

Provident was administratively required to complete forms to put the Policies on permanent waiver of premium and checked the box stating "Maximum Benefits have been paid but premiums should be suspended because of continuing total disability. Records should be marked permanent." (CR 583-84.) Provident's vice-president of disability claims, Lee McClurg, denied that this box was filled in because Knott in fact had a continuing total disability (CR 579); rather, this box was the only box on the form that was even remotely close to the situation at hand. If this box reflected the truth, Knott would never have been entitled to any additional benefits because "[m]aximum [b]enefits [had] been paid," and if

he were truly totally disabled at the time, he would have renewed his application for such benefits. Knott did not seek additional benefits, and Provident did not resume paying benefits to him.

J. Knott Continues to Work Full Time in His Occupation.

From 1990 to 1995, Knott made over \$200,000 per year working in his pre-crash occupation on a full-time basis performing surgeries (both in his office and at Presbyterian Hospital and Medical City), seeing patients, consulting with other physicians, and performing administrative duties. (CR 127-29, 133-34, 142-43, 281-87.) Specifically, Knott testified:

Q. You were working on a full-time basis, correct?

A. Yes, sir.

Q. You were seeing patients?

A. Yes.

Q. You were performing minor gynecological surgery, correct?

A. Right.

Q. You were consulting with physicians?

A. Right.

Q. You were performing administrative duties?

A. Right.

Q. All of which you did just prior to the plane crash, correct?

A. Yes.

(CR 129.) During this period, Knott spent 30% to 40% of his time performing surgeries, 50% to 60% of his time seeing patients and consulting with other physicians, and 10% of his time performing administrative duties. (CR 131-32.) Knott turned 65 years old on August 20, 1995 (CR 137); accordingly, any alleged total disability beginning after that date would entitle him to no more than 24 months of benefits. (CR 194, 223.)

K. Knott Submits Another Claim for Benefits.

In January 1996, Knott again sought total disability benefits from Provident. (CR 149, 295-301.) Knott sought benefits from Equitable as well, and both he and Dr. Wharton stated on multiple occasions that Knott's total disability began on December 15, 1995.⁹ (CR 147-48, 156, 288-89, 293, 295, 298.) On his claim form to Equitable, Knott asserted that "the duties of his occupation(s) in order of their importance" included "surgery" (for 10 hours per week), "patient consultation" (for 30 hours per week), and "obstetrics" (for 0 hours per week). (CR 291.) In turn, on his claim form to Provident, Knott listed the "duties of [his] occupation(s) in order of importance" as "surgical gynecology" (for 10-12 hours per week), "office gynecology" (for 37 hours per week), and "office obst[etrics]" (for 3 hours per week). (CR 297.)

Knott was unable to point to anything (such as a car wreck or fall) exacerbating his condition on December 15, 1995; rather, he purportedly became "tired of playing with pain." (CR 138-39, 157.) In fact, Knott conceded that he had worked at roughly that level of pain

⁹Knott conceded that as of December 14, 1995 (i.e., the day before the onset of his alleged total disability), he was working on a full-time basis performing all of the duties that he had performed prior to the plane crash with the exception of certain types of surgeries, was not suffering a 20% loss of income, and had not submitted a claim form to Provident in over five years. (CR 142-43.)

for four years. (CR 140-41.) Moreover, even though he advised Provident on his initial claim form that he had last worked on December 15, 1995 and had not returned to work on either a part-time or a full-time basis (CR 295), Knott continued after December 15, 1995 to work three to four hours a day, five days a week, seeing patients, performing office surgical procedures and at least one hospital surgery, consulting with other physicians, and performing his administrative duties. (CR 144-46.) In this regard, Knott testified:

Q: Isn't [it] true, Doctor, that you continued to work on a part-time basis after December 15, 1995?

A: That's true.

Q: Isn't it true that you were not totally and completely unable to work beginning on December 15, 1995?

A: That's true.

Q: In fact, isn't it also true that at no point in time after December 15, 1995, have you been totally and completely unable to work?

A: That's true.

Q: Isn't it also true that at all points in time after December 15, 1995, you have been able to perform at least some of the duties of your occupation?

A: That's true.

(CR 152-53.) After December 15, 1995, the only aspect of Knott's occupation that he was purportedly unable to perform was certain types of gynecological surgeries. (CR 155.)

L. Provident Pays Benefits to Knott for 24 Months and Then Closes His Claim.

By letter dated April 1, 1996, Provident advised Knott that it would pay total disability benefits to him for the period beginning after the 90-day elimination period. (CR 159, 302.) From this letter, Knott could see that Provident was considering his disability to have commenced on December 15, 1995 and applying a new elimination period, rather than continuing his earlier claim. (CR 160.) Provident continued to pay total disability benefits to Knott on a monthly basis for 24 months (CR 162-63), which was the maximum benefit period for total disability beginning after his 65th birthday. Even though he was receiving full benefits from Provident, Knott earned over \$117,000 in 1997 from his medical practice. (CR 164, 303.)

By letter dated March 11, 1998, Provident advised Knott that it was closing his claim because it had paid the maximum 24 months of benefits. (CR 165, 304.) Knott disagreed with Provident's decision because he contended that he had been totally disabled since the plane crash, notwithstanding the fact that he was performing on a full-time basis all of his pre-crash duties (with the possible exception of certain types of gynecological surgeries), made more money than he had before the crash, and did not submit any claim forms to Provident for several years. (CR 167-68.) Knott continues to this day to work three to four hours a day, five days a week, performing office surgeries, seeing patients, consulting with other physicians, and performing administrative duties. (CR 161-62, 171-72.) Knott has also recently begun performing telephone consultations for insurance companies. (CR 172-73.)

M. Knott Files This Action.

On December 30, 1998, Knott filed this action. (CR 4.) In Plaintiff's Second Amended Original Petition, Knott asserted claims against Provident for breach of contract and breach of the duty of good faith and fair dealing and against Provident and Townley for alleged violations of the DTPA and Texas Insurance Code. (CR 620-26.) On May 19, 2000, the trial court entered summary judgment in favor of Provident and Townley on all of Knott's claims. (CR 647-48.) Knott appealed this ruling, and on March 21, 2002, the Court of Appeals entered the Opinion and the Judgment, which reversed the trial court's summary judgment in favor of Provident on Knott's breach of contract claim, remanded such claim for trial, and otherwise affirmed the trial court's summary judgment in Defendants' favor.

SUMMARY OF THE ARGUMENT

The Court should reverse the Court of Appeals' ruling on Knott's breach of contract claim, as the Opinion (which was published) conflicts with numerous prior decisions of this Court on important issues of law and contains errors of law of such importance to the State's jurisprudence to require correction. In the Opinion, the Court of Appeals purportedly relied on three readily distinguishable cases from this Court,¹⁰ two of which are over 70 years old, to rewrite the Policies' unambiguous terms. Under the Court of Appeals' analysis, an insurance policy's definitions of total disability, partial disability, and residual disability are irrelevant; rather, the sole question for the trial court in such a case is whether the insured is "unable to do any substantial portion of the work connected with his occupation." (Opinion

¹⁰See Opinion at 5-6 (citing Prudential Ins. Co. of Am. v. Tate, 347 S.W.2d 556 (Tex. 1961); Great Southern Life Ins. Co. v. Johnson, 25 S.W.2d 1093 (Tex. Comm'n App. 1930, holding approved); and Commonwealth Bonding & Cas. Ins. Co. v. Bryant, 240 S.W. 893 (Tex. 1922)).

at 6.) The Court of Appeals' standard suggests that a Texas resident with disability coverage and his insurer are not bound by the definitions in the policy between them; instead, their relationship is governed (at least in part) by terms that do not appear anywhere within the four corners of their agreement. In rewriting the Policies' terms, the Court of Appeals improperly failed to follow numerous recent decisions of this Court interpreting insurance policies and other contracts as written and requiring that all provisions of a contract be given meaning. In addition, the Court of Appeals erred in failing to find that ERISA governed Knott's claims under the Policies, as one of the physicians to whom Provident issued coverage was an employee at the time of issuance, and the plain terms of ERISA require that the Policies be considered as part of the same plan that provided various types of other insurance benefits to the Professional Association's employees. Provident thus requests that the Court reverse the Court of Appeals' ruling on Knott's breach of contract claim and affirm the trial court's summary judgment in favor of Provident in all respects.

ARGUMENT

Issue One: Whether a court can rewrite a disability insurance policy's unambiguous definition of "total disability" and ignore its definitions of "partial disability" and "residual disability" in favor of a common-law definition of "total disability" that was adopted in readily distinguishable cases decided over 40 years ago.

A. The Policies' Definition of Total Disability Must Be Applied as Written.

Initially, the Court of Appeals erred in replacing the Policies' unambiguous definition of total disability with a common-law definition. After correctly acknowledging that the interpretation of an insurance contract is governed by the same rules of interpretation as other contracts (Opinion at 5), the Court of Appeals proceeded to ignore the language of the

Policies in favor of a common-law definition adopted in three cases decided long ago. In relying on these old opinions, the Court of Appeals improperly overlooked numerous subsequent decisions from this Court that require that the trial court's summary judgment be affirmed in all respects.

From Provident's research, it appears that this Court has not interpreted the definition of "total disability" in an insurance policy since 1961. The Court of Appeals' analysis, however, is contrary to numerous recent decisions from this Court interpreting other types of insurance policies. Knott did not assert (and the Court of Appeals did not find) that the Policies were ambiguous; consequently, their interpretation is a question of law. See Coker v. Coker, 650 S.W.2d 391, 393 (Tex. 1983). The Court must enforce the Policies as written and cannot revise their terms under the guise of construing them. See Royal Indem. Co. v. Marshall, 388 S.W.2d 176, 181 (Tex. 1965) ("Courts cannot make new contracts between the parties, but must enforce the contracts as written."); see also General Am. Indem. Co. v. Pepper, 339 S.W.2d 660, 661 (Tex. 1960) ("A court is not at liberty to revise an agreement while professing to construe it."). Similarly, the Court cannot rewrite the Policies on public policy grounds without first addressing the respective rights of Knott and Provident under their terms. See Texas Farmers Ins. Co. v. Murphy, 996 S.W.2d 873, 878 (Tex. 1999) (noting that "a court should not decide the question of public policy without first determining the contractual rights of the parties under the policy").

These cases confirm that the trial court correctly found that Knott was not totally disabled. The Policies both provide: "Total Disability means that due to Injuries or Sickness, you are unable to perform the duties of your occupation." (CR 219, 241.) As this

definition makes clear, the Policies did not provide benefits for Knott's alleged inability to perform certain surgical procedures or "do any substantial portion of the work connected with his occupation"; instead, they covered his inability to perform the "duties of [his] occupation." Knott repeatedly testified, both during the claims process and in his deposition, that his duties were (1) performing surgeries, (2) seeing patients, (3) consulting with other physicians, and (4) performing administrative tasks. (CR 54-55, 270, 291, 297, 299.) From 1987 through at least the latter part of 1995, Knott worked on a full-time basis performing various types of surgeries and all aspects of his other duties; indeed, he performed more surgeries in the seven months after the plane crash than he had in the seven months prior to the plane crash. All told, Knott was not "unable to perform the duties of [his] occupation," and summary judgment was appropriate on his breach of contract claim.¹¹

In addition, Knott's analysis ignores the changes that apparently occurred over time in his capabilities. Benefits are payable under the Policies on a monthly basis, and it was thus incumbent upon Knott to establish, each month, that he satisfied the Policies' provisions. In his response to Provident's petition for review, Knott listed several surgical procedures that he was purportedly unable to perform after the crash. See Response to Petition for Review

¹¹Further support for this conclusion may be found in numerous federal-court decisions. See Provident Life & Acc. Ins. Co. v. Cohen, 193 F. Supp. 2d 845, 850-51 (D. Md. 2002) (noting that an insured "was not entitled to Total Disability benefits if he could perform one or more of the substantial duties of his occupation"); Yahiro v. Northwestern Mut. Life Ins. Co., 168 F. Supp. 2d 511, 518 (D. Md. 2001) (holding that an orthopedic surgeon was partially, but not totally, disabled where he could not perform surgery but could still treat patients and teach); Klein v. National Life of Vermont, 7 F. Supp. 2d 223, 231 (E.D.N.Y. 1998) (holding that a podiatrist who could still manage his clinics was not totally disabled even though he was unable to perform surgery); Kaufman v. Provident Life & Cas. Ins. Co., 828 F. Supp. 275, 286-87 (D.N.J. 1992) (finding that an optometrist who was able to manage his optical stores was not totally disabled, even though he was partially unable to treat patients), aff'd, 993 F.2d 877 (3d Cir. 1993). These cases are even more persuasive in light of the Court of Appeals' observation (Opinion at 6) that, "after the enactment of ERISA in the 1970s, the vast majority of reported cases involving disability insurance have been litigated in the federal court system."

at vi, 1-2, 6. An examination of Knott's citations, however, reveals that all of the cited excerpts address his activities within one year of the plane crash:

Record Cite	Testimony
CR 92, 474, and 563	Knott purportedly could not perform various procedures as of December 15, 1985, which was the date that he signed his initial claim [CR 92, 474, and 563 are all the <u>same</u> page of deposition testimony]
CR 271	Knott was purportedly unable to perform various procedures as of June 25, 1986, which was the date that he submitted an occupational description form to Equitable ¹²

Of course, Knott's alleged inability to perform certain types of procedures in the mid-1980s is irrelevant to the issue of whether he was totally disabled in late 1995 or thereafter. Knott does not cite this Court to any evidence that he was unable, at the time that Provident stopped paying him benefits, to perform any of his duties, which is not surprising in light of his deposition testimony that, from 1990 through late 1995, he made over \$200,000 per year and worked in his pre-crash occupation on a full-time basis performing his pre-crash duties. On this ground alone, the Court should reverse the Court of Appeals' ruling on Knott's breach of contract claim and affirm the trial court's summary judgment in favor of Provident.

¹²Indeed, Knott's extensive reliance on this form, which he neither submitted to Provident nor pointed to in his briefing before the trial court, is misplaced for several reasons. First, Knott cannot point to any evidence that these alleged limitations existed at any time after Provident stopped paying him residual disability benefits in 1989. Second, this form has no applicability whatsoever for any period after June 25, 1986 in light of (1) his deposition testimony that he worked from 1987 through late 1995 on a full-time basis in his pre-crash occupation and (2) the surgical log showing that he performed more surgeries in the seven months after his plane crash (65) than he had in the seven months before his plane crash (44). (CR 266-67.) Third, in sharp contrast to his current emphasis on "procedures," this form lists the pre-crash duties of Knott's occupation as (1) obstetrics (which he admittedly was not practicing at the time), (2) gynecology surgery, (3) out-patient consultations, and (4) administrative. (CR 270.)

B. The Court of Appeals' Analysis Improperly Rendered Meaningless the Policies' Definitions of Partial Disability and Residual Disability.

In addition, in rewriting the Policies' definition of total disability, the Court of Appeals improperly rendered meaningless their definitions of partial disability and residual disability. As this Court has repeatedly recognized, courts are bound to read all parts of a contract together to ascertain the parties' agreement and to give effect to each part of the contract. Forbau v. Aetna Life Ins. Co., 876 S.W.2d 132, 133 (Tex. 1994); see also Kelley-Coppedge, Inc. v. Highlands Ins. Co., 980 S.W.2d 462, 464 (Tex. 1998); Balandran v. Safeco Ins. Co. of Am., 972 S.W.2d 738, 741 (Tex. 1998); R&P Enters. v. LaGuarta, Gavrel & Kirk, Inc., 596 S.W.2d 517, 519 (Tex. 1980). An interpretation that renders a provision meaningless is unreasonable and should be rejected. See Balandran, 972 S.W.2d at 741; Westwind Exploration, Inc. v. Homestate Savs. Ass'n, 696 S.W.2d 378, 382 (Tex. 1985); see also Trinity Universal Ins. Co. v. Cowan, 945 S.W.2d 819, 828 (Tex. 1997) (rejecting an insurer's interpretation of a given term on the ground that it would "render surplusage the intentional injury exclusion of many insurance policies"); State Farm Life Ins. Co. v. Beaston, 907 S.W.2d 430, 433 (Tex. 1995) (noting that "courts must be particularly wary of isolating from its surroundings or considering apart from other provisions a single phrase, sentence, or section of a contract").

Here, however, the Court of Appeals' rewriting of the definition of total disability rendered meaningless the Policies' definitions of partial disability and residual disability. Under the Policies, Knott was totally disabled if he was "unable to perform the duties of [his] occupation," partially disabled if he was unable to perform "one or more, but not all,

important daily business duties ... or his usual daily business duties for at least one-half, but not all, of the time usually required for the performance of such duties," and residually disabled if he suffered a 20% loss of income and was unable to perform "one or more of [his] important daily business duties or ... [his] usual daily business duties for as much time as is normally required to perform them."¹³ (CR 194, 219, 226, 241, 279.) Read together, these definitions establish that partial disability and residual disability covered those situations in which Knott was still working in his occupation but was unable to perform one or more of his duties.¹⁴ See McOsker v. Paul Revere Life Ins. Co., 279 F.3d 586, 588 (8th Cir. 2002) ("It is evident to us that a person who can perform some but not all of his important duties has a 'Residual Disability' within the meaning of the policy, and that therefore in order to be eligible for total disability payments a person would be required to show that he or she was unable to perform any of those important duties."); Cohen, 193 F. Supp. 2d at 850 (observing that "[w]hen the insurance contract is considered as a whole, it is clear that where the insured 'is unable to perform one or more but not all of the principal duties of the regular occupation,' he is not totally disabled, but residually disabled") (emphasis in original); General Am. Life

¹³Indeed, the presence of these definitions, standing alone, requires that they be applied as written. See Cowan, 945 S.W.2d at 823 (noting that "when terms are defined in an insurance policy, those definitions control"); Pepper, 339 S.W.2d at 662 (reciting the "well established" rule that "terms used in an insurance contract, like any other contract, are to be given their plain, ordinary, and generally accepted meaning unless the policy itself shows them to have been meant in a technical or different sense").

¹⁴If Knott was unable to perform one of his duties (such as consulting with other physicians, which involved roughly 10% of his time) in its entirety but able to perform the remainder of his duties, he would fit squarely within the definitions of residual disability (provided that he also suffered the requisite income loss) and partial disability but, by extension, not the definition of total disability. Under the Court of Appeals' analysis, however, Knott's inability to consult with other physicians, standing alone, would arguably render him totally disabled, notwithstanding these other definitions.

Ins. Co. v. Rausch, C.A. No. 3:96-CV-3253-L, slip op. at 9-10 (N.D. Tex. Nov. 5, 1999)¹⁵; see also Forbau, 876 S.W.2d at 134 (noting that contractual provisions "must be read together with the other sections of the contract to comprehensively address the rights and obligations of all parties to the insurance contract"). In support of this conclusion, the Rausch court observed that (1) "duties" was plural and was not qualified by a phrase such as "one or more" or "some of" and (2) the definition of partial disability covered situations in which the plaintiff could perform some (but not all) of her duties. Rausch, slip op. at 9-10. Knott's assertion that his alleged inability to perform a single type of surgical procedure, standing alone, makes him totally disabled improperly renders these other definitions meaningless. As one court recently observed in analyzing comparable definitions:

The wording of these definitions, taken together, implies that if the insured can perform some but not all of the substantial and material duties of his or her regular occupation (as is undisputed in this case), the insured could only be entitled to residual disability, not total disability. In other words, because it is undisputed that Dr. Falik is able to perform some but not all of the substantial and material duties of her regular occupation (as required to be residually disabled), she clearly is not unable to perform the substantial and material duties of her regular occupation (as required to be totally disabled). Therefore, she could only be entitled to residual disability (if she were working), and because her breach of contract claim is for total disability benefits only, Penn Mutual is entitled to judgment as a matter of law.

Falik v. Penn Mut. Life Ins. Co., 204 F. Supp. 2d 1155, 1157 (E.D. Wis. 2002) (emphasis in original). The same analysis is appropriate here.

Indeed, Dym v. Provident Life & Acc. Ins. Co., 19 F. Supp. 2d 1147 (S.D. Cal. 1998), is squarely on point. The plaintiff in Dym was a board-certified gynecologist with two

¹⁵A true and correct copy of this opinion is attached as Tab 5 to the Appendix in Support of the Petition for Review of Provident Life and Accident Insurance Company, which was filed herein on June 3, 2002.

Provident disability policies that provided coverage for both total disability and residual disability. The plaintiff suffered various injuries in an automobile accident, but he resumed performing minor surgeries on a part-time basis two months after his accident. In granting summary judgment for Provident, the district court stated:

A comparison of the two definitions suggests that the phrase "you are not able to perform the substantial and material duties of your occupation" as used in the "total disability" definition cannot reasonably be read as "you are not able to perform one or more of the substantial and material duties of your occupation," because if such a reading was intended, the language "one or more" would have been used, as it is in the "residual disability" definition.

In sum, applying principles of California law applicable to the interpretation of insurance contracts, the court finds no ambiguity in the definition of "total disability" and holds that Provident did not breach the insurance contract by refusing to continue to make payments to plaintiff under the "total disability" provisions of his policies, where plaintiff continues to be able to perform one of the substantial [and] material duties of his occupation.

Id. at 1150.

In the Opinion, the Court of Appeals rejected Provident's efforts to distinguish Johnson and Tate on the ground that the Policies provide for partial disability benefits "because those cases rejected express requirements that all duties be affected." (Opinion at 6-7.) Unlike the Policies, which insured against Knott's inability to perform the duties of his occupation and contained definitions of partial disability and residual disability, the policies at issue in both Johnson and Tate provided benefits for the insured's inability to engage in any occupation, did not focus in any way on the insured's duties, and did not contain

definitions of partial disability or residual disability.¹⁶ The courts in those cases were struggling with the seemingly unjust result that the plaintiff would not receive any benefits if he was capable of performing some minor aspect of some other job; here, however, it is uncontroverted that Knott was working at all relevant times in the same occupation in which he was working prior to the plane crash. Johnson and Tate are thus distinguishable and should not have been followed.

From the Opinion, it is clear that the Court of Appeals was mindful of the tension between the older decisions on which it relied and this Court's "current approach to construing insurance policies" but felt compelled to follow Johnson and Tate because such cases "have not been overruled." See Opinion at 6. As set forth above, however, those cases are distinguishable and did not require the Court of Appeals to vary the terms of unambiguous policies. Moreover, in its published opinion, the Court of Appeals has arguably rewritten all of the disability policies in force in this State by replacing some of their definitions with a common-law definition that does not appear within the four corners of such policies. To the extent that a conflict exists between these older cases and the Court's current approach to contract interpretation, the Court should overrule these older cases.

Issue Two: Whether an insured's alleged total disability commenced after his 65th birthday when he was working on a full-time basis in his pre-disability occupation for several years before and at least three months after turning 65.

A. The Court of Appeals Erred in Rewriting

¹⁶The policy in Johnson paid benefits if the insured was "permanently, continuously and wholly prevented from performing any work for compensation or profit or from following any gainful occupation." 25 S.W.2d at 1094. The policy in Tate paid benefits if the insured was "rendered wholly, continuously and permanently unable to engage in any occupation or perform any work for any kind of compensation of financial value." 347 S.W.2d at 558-59.

the Policies' Definition of Total Disability.

The Court of Appeals also erred in finding a fact issue regarding whether Knott's disability commenced after his 65th birthday. As the Court of Appeals correctly pointed out (Opinion at 1, 7), the Policies provide a maximum benefit period of 24 months for periods of disability commencing after Knott's 65th birthday, and Provident paid benefits to him for such period. In reliance on Johnson and Tate, the Court of Appeals rewrote the Policies to provide that "a period of total disability commences when the insured is unable to do any substantial portion of the work connected with his occupation" and thus found a fact issue as to whether Knott satisfied such test prior to his 65th birthday. (Id. at 7.) For the reasons set forth above, the Court of Appeals' reliance on Johnson and Tate was misplaced, and it erred in failing to enforce the Policies as written.

B. Knott Was Not Totally Disabled After His 65th Birthday.

Moreover, application of the Policies' terms confirms that Knott was not totally disabled after his 65th birthday. It is undisputed that as of December 14, 1995 (i.e., the day before the onset of his alleged total disability), Knott was working in his occupation on a full-time basis performing all of his pre-crash duties (with the possible exception of certain types of surgeries). (CR 142-43.) Knott thus was not totally disabled. In addition, Knott was not entitled to benefits for partial disability or residual disability, as such coverage ended on his 65th birthday. Moreover, both Knott and Dr. Wharton advised Provident and Equitable on multiple occasions that Knott's total disability began on December 15, 1995.

(CR 147-48, 156, 288-89, 293, 295, 298.) The trial court was thus correct in granting summary judgment in Provident's favor on Knott's breach of contract claim.

Knott's contention that he has been totally disabled at all times since the plane crash confuses the issue of "diagnosis" with that of "disability." Knott is not entitled to benefits merely because he injured his back in the crash; rather, he is entitled to benefits only if he cannot perform the duties of his occupation as a result of an injury or sickness. This is a burden that Knott failed to meet.

Similarly, Provident's entry on two forms that "premiums should be suspended because of continuing total disability" should not prevent summary judgment. Provident checked this box because some box had to be checked to put the Policies on permanent waiver of premium. (CR 579.) None of the other boxes on this form came anywhere close to Knott's situation; indeed, the box checked by Provident also states that "[m]aximum benefits have been paid."¹⁷ Moreover, in its letter to Knott's attorney putting the Policies on permanent waiver of premium by agreement, Provident stated:

I would point out, though, that it is our intention to administer any continuation of the 1985 claim in accordance with all other provisions of the [residual disability] rider as well as the existing policy. If Dr. Knott has any objections to this, I feel it's important that he point them out to us immediately.

(CR 278.) The record does not contain any objection by Knott. Neither Provident nor Knott thought that he qualified for benefits at the time, as he did not submit any claim forms or receive any benefits between June 1989 and December 1995. Simply put, Provident waived the premiums as an accommodation to Knott, not because he was totally disabled.

¹⁷Knott's reliance on these forms is sharply contrasted by his efforts to avoid the import of the statements of himself and Dr. Wharton that his total disability began on December 15, 1995.

In summary, Knott was capable, at all relevant times, of performing the "duties of [his] occupation." As such, the Court of Appeals erred in reversing the trial court's summary judgment on Knott's breach of contract claim.

Issue Three: Whether ERISA governs disability insurance policies covering the shareholders in a professional association where, at the time that some of the policies were issued, one of the shareholders was an employee without any ownership interest.

Issue Four: Whether disability insurance policies that are issued to a shareholder in a professional association can be part of the same ERISA plan that provides various types of insurance coverage to the association's shareholders and employees.

A. The Policies Are Governed by ERISA.

Independent of the foregoing, the trial court correctly entered summary judgment in Provident's favor because Knott's claims related to an employee welfare benefit plan governed by ERISA. The Professional Association provided various types of insurance coverage to its employees as part of an "employee welfare benefit plan," which is defined as:

... any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer ... to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, [or] disability ...

29 U.S.C. § 1002(1). For the Professional Association's plan to satisfy this definition, the Court must find that a plan "(1) exists; (2) falls outside the safe-harbor provisions established by the Department of Labor; and (3) satisfies the primary elements of an ERISA 'employee benefit plan'--establishment or maintenance by an employer intending to benefit employees."

Meredith v. Time Ins. Co., 980 F.2d 352, 355 (5th Cir. 1993). As the trial court correctly held, all of these elements were met.

1. A Plan Existed. First, in determining whether a plan existed, the Court must determine whether a reasonable person could ascertain the intended benefits, beneficiaries, sources of financing, and procedures for receiving benefits. Id. (citing Donovan v. Dillingham, 688 F.2d 1367, 1373 (11th Cir. 1982)). "A formal document designated as 'the Plan' is not required to establish that an ERISA plan exists." Memorial Hosp. Sys. v. Northbrook Life Ins. Co., 904 F.2d 236, 241 (5th Cir. 1990). Here, Knott, Kuhne, and McGinnis (who was at the time an employee with no ownership interest) all purchased disability policies from Provident. These policies were all made a part of the same risk group, and in the Salary Allotment Agreement, the Professional Association agreed to remit the premiums for such policies to Provident and, as a result, obtained a 10% discount.¹⁸ In the present case, these policies set forth descriptions of benefits, classes of beneficiaries, sources of financing, and procedures for receiving benefits, thus confirming that the Professional Association maintained an ERISA plan with respect to the provision of disability insurance.

As the Court of Appeals correctly pointed out (Opinion at 4), ERISA does not apply to a plan that covers only owners or partners. According to Knott, ERISA is inapplicable because McGinnis was at all times a shareholder in (rather than an employee of) the

¹⁸The Salary Allotment Agreement indicated that the Professional Association was responsible for remitting the premiums for all five policies to Provident and making appropriate payroll deductions (CR 246, 328), thus rebutting Knott's assertion that a reasonable person could not ascertain the source of funding for the Policies.

Professional Association. Knott conveniently ignores, however, that the records from the early 1970s in Provident's underwriting files pertaining to Knott, Kuhne, and McGinnis confirmed that McGinnis was an employee without any ownership interest at the time of his application to Provident. Compare CR 337, 339, 342, 349-50 (characterizing Knott and Kuhne as partners and/or self-employed) with CR 356, 358 (stating that McGinnis was employed by the Professional Association). Knott's testimony "[t]o his knowledge" and "[a]s he recall[ed]" (CR 48) does not prevent summary judgment. See Campbell v. Fort Worth Bank & Trust, 705 S.W.2d 400, 402 (Tex. App.--Fort Worth 1986, no writ) ("We reject and do not consider those statements in appellant's affidavit which are based upon the best of his knowledge.").

The mere fact that McGinnis subsequently became a shareholder in the Professional Association does not change this result. By its terms, ERISA applies to "any plan ... or program ... established or maintained by an employer...." 29 U.S.C. § 1002(1); see also Peterson v. American Life & Health Ins. Co., 48 F.3d 404, 408 (9th Cir.) (recognizing the disjunctive nature of this provision), cert. denied, 516 U.S. 942 (1995). Thus, regardless of whether McGinnis subsequently became a shareholder, the Professional Association's remitting of the necessary premiums and other involvement with the Provident policies confirm that it had established an ERISA-regulated plan during the time that he was an employee of which the Policies were part.¹⁹ The Court of Appeals' narrow focus effectively

¹⁹Further support for this conclusion may be found in the numerous cases holding that ERISA governs the conversion of a policy under an ERISA plan to an individual policy. See, e.g., Painter v. Golden Rule Ins. Co., 121 F.3d 436, 439-40 (8th Cir. 1997), cert. denied, 523 U.S. 1074 (1998); White v. Provident Life & Acc. Ins. Co., 114 F.3d 26, 28 (4th Cir.), cert. denied, 522 U.S. 950 (1997); Jones v. Georgia Pac. Corp., 90 F.3d 114, 116 (5th Cir. 1996); Glass v. United of Omaha Life Ins. Co., 33 F.3d 1341, 1346-47 (11th Cir. 1994); Greany v. Western Farm Bureau Life Ins.

rendered meaningless Congress's express intent that ERISA governs plans "established" by employers.

The Court of Appeals also erred in ignoring the various other types of insurance coverage that the Professional Association provided to its employees. By its terms, ERISA applies to "any plan, fund, or program ... established or maintained by an employer ... to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants ... medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment." See Opinion at 3 (quoting 29 U.S.C. § 1002(1)). The Court of Appeals then observed, without citation to any authority, that "[t]he arrangement presented in this case involves disability insurance." (Id.) Nothing in the text of ERISA, however, required the Court of Appeals to separately analyze each type of insurance coverage that the Professional Association provided to its employees. Rather, the Court of Appeals ignored the numerous cases holding that an employer can create an ERISA plan by the purchase of different types of insurance from different insurers covering different sets of employees. See, e.g., Peterson, 48 F.3d at 407 (concluding that a health insurance policy covering only a partner was a component of the employer's ERISA plan); Salameh v. Provident Life & Acc. Ins. Co., 23 F. Supp. 2d 704, 710 (S.D. Tex. 1998) (finding that a professional association established an ERISA plan that included disability coverage for its physicians, life insurance for its physicians and staff, group health insurance for its physicians, and a profit-sharing plan for its staff); Bellisario v. Lone Star Life Ins., 871

Co., 973 F.2d 812, 817 (9th Cir. 1992); see also Gabner v. Metropolitan Life Ins. Co., 938 F. Supp. 1295, 1302 n.11 (E.D. Tex. 1996) (collecting cases).

F. Supp. 374, 377-79 (C.D. Cal. 1994) (holding that a disability policy purchased for a sole shareholder and not covering any employees was nonetheless part of an ERISA plan); see also Brundage-Peterson v. Compcare Health Servs. Ins. Corp., 877 F.2d 509, 511 (7th Cir. 1989) ("The fact that in this case the employer offered a choice of plans rather than a single plan can make no difference, for it is commonplace to offer employees benefit options.").

As the Bellisario court observed:

The Court agrees with defendants that the plan at issue here is comprised of both the disability insurance policy and the group medical insurance policy. Plaintiff cites to no cases or regulations that require insurance policies to be analyzed separately under ERISA. To the contrary, the ERISA statute specifically provides that an "employee benefit plan" can be a "plan, fund, or program" which presumably may contain more than one insurance policy from more than one insurance company. In fact, many employers provide a set of benefits for their employees under different policies and by different insurance carriers.

871 F. Supp. at 377 (emphasis in original). Even if they are considered without reference to the disability coverage of Kuhne and McGinnis, the Policies were part of the same ERISA plan that provided various employees with health coverage, provided Knott with overhead expense coverage, and paid some (if not all) of the premiums for such policies. The Professional Association's involvement in these coverages was "substantial evidence that a plan, fund, or program [was] established." See Kidder v. H&B Marine, Inc., 932 F.2d 347, 353 (5th Cir. 1991).

2. The Plan Was Not Within the Safe Harbor. Moreover, the trial court also correctly found that the Professional Association's plan did not fall within the safe harbor. To prove that the Policies were not part of an employee welfare benefit plan, Knott must

establish that (1) the Professional Association did not pay any of the premiums, (2) participation by employees was voluntary, (3) the Professional Association's role was limited to collecting and remitting premiums, and (4) the Professional Association received no profit from the plan. 29 C.F.R. § 2510.3-1(j)(1)-(4) (1992). This was a burden that Knott failed to meet. Here, the Professional Association (1) paid all of the health insurance premiums for its employees, paid all of the overhead expense premiums for Knott's overhead expense policy, and remitted (and may well have paid) the premiums for the Policies,²⁰ (2) automatically provided health insurance to all of its employees and disability coverage to its shareholder-employees, (3) took an active role in establishing and maintaining the plan, including (a) bearing some or all of the premium costs and (b) providing administrative services, such as paying the premiums, handling the related bookkeeping, and assisting Knott in the claim process with Provident, and (4) received, through use of the Salary Allotment Agreement, a 10% discount on the Provident coverage. ERISA thus governed Knott's claims under the Policies. See McNeil, 205 F.3d at 189-90 & n.17 (applying ERISA to an owner's claims where the plan also covered one non-owner employee); Vega v. National Life Ins. Servs., Inc., 188 F.3d 287, 291 (5th Cir. 1999) (en banc) (finding an ERISA plan that covered

²⁰The mere fact that Knott, Kuhne, and McGinnis might have reimbursed the Professional Association for some of the disability insurance premiums does not, standing alone, sail the Policies into the safe harbor. See Hansen v. Continental Ins. Co., 940 F.2d 971, 973, 977-78 (5th Cir. 1991) (finding an ERISA plan even though "the employees paid all of the premiums themselves, by means of payroll deductions"); McNeil v. Time Ins. Co., 977 F. Supp. 424, 428-30 (N.D. Tex. 1997) (finding ERISA applicable to a claim brought by a partner in a medical partnership where the partner's funds were used to pay his premiums), aff'd, 205 F.3d 179 (5th Cir. 2000), cert. denied, 531 U.S. 1191 (2001). Of course, Knott's claim that he reimbursed the Professional Association is questionable in light of his statements to Provident in both 1985 and 1996 that his employer paid 100% of his premiums. (CR 254, 295.)

the owners and one employee). Having long enjoyed the benefits of the Professional Association's involvement, Knott cannot now avoid its impact.

3. The Professional Association Intended to Benefit Its Employees. Finally, the Professional Association intended to benefit its employees through the establishment and maintenance of the plan. The Professional Association paid all the health insurance premiums for its employees, all of the overhead expense premiums for Knott, and possibly some (if not all) of the premiums for the Provident coverage. Moreover, the Professional Association assumed the responsibility of remitting the premium payments on time for the health insurance, overhead expense, and Provident coverage, handled the bookkeeping for the payments that it made, and provided assistance during the claim process. Finally, the Professional Association's involvement benefitted McGinnis (who was at the outset an employee) by virtue of the 10% discount that he received on his Provident coverage. The Professional Association's involvement in its employees' insurance affairs confirmed its intention to benefit its employees. See Hansen, 940 F.2d at 977-78; McNeil, 977 F. Supp. at 427 (finding ERISA applicable where the partnership's "administrative activity" consisted of receiving premium notices, paying premiums, and canceling the coverage of an ex-employee). All told, the trial court correctly held that the Policies constituted at least part of an employee welfare benefit plan.

Indeed, Salameh v. Provident Life & Acc. Ins. Co., 23 F. Supp. 2d 704 (S.D. Tex. 1998), one of the cases relied upon by Knott before the trial court and the Court of Appeals, supports the applicability of ERISA in virtually all respects. Salameh was an action brought

by a shareholder in a professional association for benefits under a Provident disability income policy. Salameh and Garcia, who at the time each owned one-half of the professional association, obtained disability policies from Provident. About three months later, Hurwitz joined the professional association as an employee and obtained coverage from Provident as well. All three policies became part of the same risk group, thereby reducing the premiums for these policies by 10%, and the professional association began paying the premiums for these policies. Hurwitz later became a one-third owner of the professional association. Salameh sought benefits under his policy, and after Provident denied his claim, he filed suit in state court against Provident, which removed the action to federal court and asserted that his policy was part of an ERISA plan. In concluding that ERISA applied, the Salameh court made a number of holdings that are fatal to Knott's position:

- the professional association established an ERISA plan that included the disability coverage for its physicians, life insurance for its physicians and staff, group health insurance for its physicians, and a profit-sharing plan for its staff, with the professional association's office manager providing administrative assistance and the professional association taking a deduction for "employee benefits" and "retirement benefits" on its corporate tax return (23 F. Supp. 2d at 710);
- the safe harbor was inapplicable because the professional association paid some (if not all) of the premiums for these coverages (id.);
- although a plan covering only partners is not an ERISA plan, ERISA governs a plan covering one or more common-law employees, in addition to self-employed individuals²¹ (id. at 711);

²¹Since the Professional Association's plan covered both its employees and its shareholders, the Professional Association did not maintain a separate plan for each group of individuals, and McGinnis was an employee at the time that he obtained his Provident policy, Knott's reliance on Robertson v. Alexander Grant & Co., 798 F.2d 868 (5th Cir. 1986), cert. denied, 479 U.S. 1089 (1987), is misplaced.

- the provision of coverage to Hurwitz, who was an employee, meant that Salameh's policy was part of an ERISA plan (id. at 715);
- Salameh was a "beneficiary" with standing under ERISA, notwithstanding his ownership interest in the professional association (id. at 715-16); and
- ERISA preempted all of Salameh's state-law claims (id. at 717-18).

Salameh thus confirms the applicability of ERISA to the Policies.

4. Knott Was Both a Participant and a Beneficiary in the Plan. Moreover, once the trial court determined that an ERISA plan existed, it was clear that Knott was both a participant and a beneficiary in such plan, notwithstanding his status as a shareholder. Numerous courts (including the Fifth Circuit) have held that an owner-employee may be a participant or a beneficiary in an ERISA plan. See, e.g., Vega, 188 F.3d at 294 (holding that a shareholder and his spouse were participants in an ERISA plan where the corporation maintained a plan covering at least one common-law employee); Engelhardt v. Paul Revere Life Ins. Co., 139 F.3d 1346, 1351 (11th Cir. 1998); In re Baker, 114 F.3d 636, 639 (7th Cir. 1997); Salameh, 23 F. Supp. 2d at 716.

5. ERISA Preempted Knott's Claims. In addition, the trial court correctly found that ERISA preempted all of Knott's claims and his request for statutory and exemplary damages. ERISA preempts and supersedes any and all state laws insofar as they may now or hereafter "relate to" an employee benefit plan. 29 U.S.C. § 1144(a). Congress used the words "relate to" in their broadest sense and intended to eliminate the threat of conflicting and inconsistent state and local regulations. Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 98 (1983). ERISA thus preempted Knott's common-law claims for breach of contract and breach of the duty of good faith and fair dealing. See Pilot Life Ins. Co. v. Dedeaux, 481

U.S. 41, 47-48 (1987); Harris v. Blue Cross & Blue Shield of Tex., Inc., 729 F. Supp. 49, 52 (N.D. Tex. 1990). Similarly, ERISA preempted Knott's claims under the DTPA and the Texas Insurance Code. See Hogan v. Kraft Foods, 969 F.2d 142, 144-45 (5th Cir. 1992); Ramirez v. Inter-Continental Hotels, 890 F.2d 760, 763 (5th Cir. 1989); Worthington v. Metropolitan Life Ins. Co., 688 F. Supp. 298, 300 (S.D. Tex. 1987); Cathey v. Metropolitan Life Ins. Co., 805 S.W.2d 387, 390 (Tex.), cert. denied, 501 U.S. 1232 (1991).

6. Provident Did Not Abuse Its Discretion. Knott never pled a proper claim under ERISA. The trial court properly held, however, that even if he had done so, Provident would nonetheless have been entitled to summary judgment because a review of Provident's claim file demonstrated that the process by which it made its decision was rational and its ultimate determination that Knott was not entitled to any additional benefits was not an abuse of discretion. As set forth above, both Knott and his physician advised Provident that his disability began after his 65th birthday, thus entitling him to no more than the 24 months of benefits that he received. Moreover, by virtue of his continuing work activities, Knott was not totally disabled, as he can to this day perform most (if not all) of his pre-plane crash duties. This constituted more than substantial evidence to support Provident's determination, and the trial court correctly held that Provident was entitled to summary judgment on all of Knott's claims.

B. The Remand Order Does Not Have Preclusive Effect.

Moreover, the Order entered by United States District Judge Solis remanding this case to the trial court does not have preclusive effect on the applicability of ERISA. Admittedly,

Judge Solis determined that Provident had not met its burden, as the removing party, of establishing subject-matter jurisdiction. As numerous courts (including the Court of Appeals) have recognized, however, such a remand order was not binding on the trial court and did not have preclusive effect. See Opinion at 3; Linton v. Airbus Industrie, 30 F.3d 592, 597 (5th Cir.) (observing that the district court's finding regarding the applicability of federal law was a jurisdictional finding that "can be reviewed by the state court upon remand" and has "no preclusive effect on the state courts"), cert. denied, 513 U.S. 1044 (1994); Soley v. First Nat'l Bank of Commerce, 923 F.2d 406, 410 (5th Cir. 1991) ("[B]ecause we interpret the remand order as jurisdictional, the state court will have the opportunity to consider the appellants' preemption defense and the district court's order will have no preclusive effect."); Sanchez v. Johnson & Johnson Medical, Inc., 860 S.W.2d 503, 512 n.3 (Tex. App.--El Paso 1993) ("Moreover, a federal court's decision to remand an action to state court does not control (and may not even address) the substantive question of preemption."), aff'd in part and rev'd in part, 924 S.W.2d 925 (Tex. 1996). As one federal district court observed:

The court emphasizes, however, that the above conclusions have been reached based on limited evidence, mainly by affidavit and without the benefit of live testimony at a trial, and go only to the question of the subject-matter jurisdiction of this court and not to the merit of the defense that [the plaintiff's] state-law claims are preempted by ERISA. This court's conclusions are therefore not binding on the state court. [The defendants] may still pursue the ERISA-preemption defense after remand to state court, and, indeed, after further development of the facts, including an evidentiary hearing, the state court may still find the defense has merit. For example, the state court, after hearing live testimony, may reach a different conclusion with regard to the factual circumstances under which [the plaintiff] obtained an individual policy with [the defendant insurer] and a different conclusion with regard to the relationship between [the defendant agent] and [the defendant insurer].

McDonald v. Professional Ins. Corp., 946 F. Supp. 943, 945-46 (M.D. Ala. 1996) (citations omitted).

In addition, application of preclusion principles would be unjust because Provident never had an opportunity to appeal the Order. Doctrines such as collateral estoppel or law of the case are applied to bar the relitigation of previously addressed issues. One factor considered in applying these doctrines is whether the losing litigant ever had an opportunity to appeal the finding that the prevailing party is seeking to use offensively. See Winters v. Diamond Shamrock Chem. Co., 149 F.3d 387, 395 (5th Cir. 1998) ("It is clear that fairness considerations weigh heavily against binding a party whose ability to appeal is precluded by a prohibition of law."), cert. denied, 526 U.S. 1034 (1999). Here, Provident could not seek appellate review of the Order. See 28 U.S.C. § 1447(d) ("An order remanding a case to the State court from which it was removed is not reviewable on appeal or otherwise...."). Accordingly, both the trial court and the Court of Appeals correctly concluded that the Order from Judge Solis did not have preclusive effect.

PRAYER

Provident respectfully requests that the Court reverse the Court of Appeals' ruling on Knott's breach of contract claim and affirm the trial court's summary judgment in favor of Provident in all respects.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing document has been sent by hand delivery to counsel for Knott, Mr. Ben C. Martin, Law Offices of Ben C. Martin, 2100 McKinney Avenue, Suite 1975, Dallas, Texas 75201, and by certified mail, return receipt requested, to counsel for Townley, Mr. Patrick Frank, Fiedler, Akin, Frank & Carlton, P.C., North Central Plaza Three, 12801 N. Central Expressway, Suite 450, Dallas, Texas 75243, on this 8th day of November, 2002.

Andrew C. Whitaker

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