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**UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA**

DENISE JUMP,

Plaintiff,

v.

UNUM LIFE INSURANCE
COMPANY OF AMERICA,

Defendant.

Case No. 5:22-cv-01812-SSS-SHKx

**ORDER GRANTING
DEFENDANT’S MOTION FOR
JUDGMENT AS A MATTER OF
LAW [Dkts. 37, 39] AND DENYING
PLAINTIFF’S MOTION FOR
JUDGMENT AS A MATTER OF
LAW[Dkt. 35]**

1 Before the Court are Plaintiff Denise Jump’s (“Jump”) and Defendant
2 Unum Life Insurance Company of America’s (“Unum”) cross-motions for
3 judgment as a matter of law. [Dkts. 35;37; 39]. Both motions were opposed.
4 [Dkt. 40; Dkt. 42]. The motions were taken under submission without a hearing
5 on March 18, 2024. [Dkt. 43]; *see* Fed. R. Civ. P. 78; L.R. 7-15.

6 For the reasons set forth below, Unum’s motion is **GRANTED** and
7 Jump’s motion is **DENIED**.

8 I. LEGAL STANDARD

9 A. Federal Rule of Civil Procedure Rule 52

10 This matter is properly before the Court pursuant to Federal Rule of Civil
11 Procedure 52. Rule 52 motions for judgment are “bench trial[s] on the record,”
12 and the Court “make[s] findings of fact under Federal Rule of Civil Procedure
13 52(a).” *Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1095 (9th Cir. 1999) (en
14 banc).

15 B. Standard of Review

16 The Court reviews this matter *de novo*. Under a *de novo* standard of
17 review, “[t]he court simply proceeds to evaluate whether the plan administrator
18 correctly or incorrectly denied benefits.” *Abatie v. Alta Health & Life Ins. Co.*,
19 458 F.3d 955, 963 (9th Cir. 2006). That is, the Court “determines in the first
20 instance if the claimant has adequately established that he or she is disabled
21 under the terms of the plan.” *Muniz v. Amec Constr. Mgmt., Inc.*, 623 F.3d
22 1290, 1295-96 (9th Cir. 2010). In doing so, the Court must focus on the
23 rationale given to the claimant when benefits are denied, and it must determine
24 whether the administrator’s decision is supported by the record. *Collier v.*
25 *Lincoln Life Assurance Co. of Bos.*, 53 F.4th 1180, 1182 (9th Cir. 2022).

26 C. Burden of Proof

27 Jump bears the burden of establishing by a preponderance of the evidence
28 her entitlement to benefits (i.e., that she was totally disabled under the Policy

1 definition during the relevant time period). *Armani v. Nw. Mut. Life Ins. Co.*,
2 840 F.3d 1159, 1163 (9th Cir. 2016); *Muniz*, 623 F.3d at 1294. To do so, Jump
3 must establish that she was more likely than not “disabled” under the terms of
4 the Policy at the time her benefits were denied. *See, e.g., Hart v. Unum Life Ins.*
5 *Co. of Am.*, 253 F. Supp. 3d 1053, 1074 (N.D. Cal. 2017); *Porco v. Prudential*
6 *Ins. Co. of Am.*, 682 F. Supp. 2d 1057, 1072 (C.D. Cal. 2010).

7 **D. Evidence Considered by the Court**

8 The Court is generally limited in its review to “the evidence that was
9 before the plan administrator at the time [the] determination [was made].”
10 *Opeta v. Northwest Airlines Pension Plan*, 484 F.3d 1211, 1217 (9th Cir. 2007).
11 Evidence before the Court need not be admissible under the Federal Rules of
12 Evidence; instead, it “may be considered so long as it is relevant, probative, and
13 bears a satisfactory indicia of reliability.” *See Tremain v. Bell Indus., Inc.*, 196
14 F.3d 970, 978 (9th Cir. 1999).

15 In a trial on the record, the court “can evaluate the persuasiveness of
16 conflicting testimony and decide which is more likely true.” *Kearney*, 175 F.3d
17 at 1095 (9th Cir. 1999); *see Schramm v. CNA Fin. Corp. Insured Grp. Benefits*
18 *Program*, 718 F. Supp. 2d 1151, 1162 (N.D. Cal. 2010) (noting that, in
19 reviewing the administrative record, “the Court evaluates the persuasiveness of
20 each party’s case, which necessarily entails making reasonable inferences where
21 appropriate”).

22 Here, both parties request judicial notice of additional evidence that was
23 not considered during the administrative process. A court may take judicial
24 notice of matters that are either generally known within the trial court’s
25 territorial jurisdiction or can be accurately and readily determined from sources
26 whose accuracy cannot reasonably be questioned; however, to the extent any
27 facts in documents subject to judicial notice are subject to reasonable dispute, a
28 court will not take judicial notice of those facts. Fed. R. Evid. 201(b).

1 Unum requests the Court to take judicial notice of an order on cross-
2 motions for judgment issued in *Sanders v. Metropolitan Life Ins. Co.*, No. 3:22-
3 cv-00499-RBM, Dkt. 42 (S.D. Cal. 2022). [Dkt. 38]. This Court may take
4 judicial notice of the existence of the *Sanders* order. *Cal. ex rel. RoNo, LLC v.*
5 *Altus Fin. S.A.*, 344 F.3d 920, 931 (9th Cir.2003). However, Federal Rules of
6 Evidence Rule (“Rule”) 201 does not permit a trial court to take judicial notice
7 of any facts found by a court in another judicial proceeding. *Wyatt v. Terhune*,
8 315 F.3d 1108, 1114 (9th Cir.2003), *overruled on other grounds by Albino v.*
9 *Baca*, 747 F.3d 1162 (9th Cir. 2014) (citing *M/V Am. Queen v. San Diego*
10 *Marine Constr. Corp.*, 708 F.2d 1483, 1491 (9th Cir.1983)). Although the
11 Court can take judicial notice of the existence of the *Sanders* order itself, the
12 existence of the *Sanders* order alone is not relevant here and therefore the Court
13 will not consider the order as evidence. Accordingly, Unum’s request for
14 judicial notice is **MOOT** due to its irrelevance.

15 Jump requests the Court to take judicial notice of Jump’s Social Security
16 Administration (“SSA”) disability benefits award notice dated March 29, 2023,
17 because the administrative process was closed when Unum issued its final
18 decision of Jump’s administrative appeal on October 4, 2022, and this action
19 was filed on October 14, 2022. [Dkt. 36]. Although a district court’s review is
20 generally limited to the evidence presented to the plan administrator, the Ninth
21 Circuit is clear that “new evidence may be considered under certain
22 circumstances to enable the full exercise of informed and independent
23 judgment.” *Mongeluzo v. Baxter Travenol Long Term Disability Ben. Plan*, 46
24 F.3d 938, 943 (9th Cir. 1995); *see also O’Neal v. Life Ins. Co. of N. Am.*, 10 F.
25 Supp. 3d 1132, 1136 (D. Mont. 2014) (a need for evidence beyond the
26 administrative record includes additional evidence that the claimant could not
27 have presented during the administrative process). District courts have
28 considered an SSA award where the claimant could not have presented it in the

1 administrative process. *See Schramm*, 718 F. Supp. 2d at 1165 (considering
2 October 2009 SSA determination after the administrator’s final decision in
3 March 2009); *Oldoerp v. Wells Fargo & Co. Long Term Disability Plan*, 12 F.
4 Supp. 3d 1237, 1254 (N.D. Cal. 2014) (considering July 2008 SSA
5 determination after the administrator’s final decision in June 2008). The Court
6 **GRANTS** Jump’s request for judicial notice of the SSA award notice itself. *See*
7 *Neff v. Colvin*, No. 1:14-CV-03090-VEB, 2015 WL 2185836, at *1 (E.D. Wash.
8 May 11, 2015) (granting plaintiff’s motion for judicial notice of an SSA award
9 notice without opposition).

10 **E. Analyzing Medical Evidence**

11 A mere diagnosis is not dispositive of the issue of disability. *See*
12 *Matthews v. Shalala*, 10 F.3d 678, 680 (9th Cir. 1993) (“The mere existence of
13 an impairment is insufficient proof of a disability A claimant bears the
14 burden of proving that an impairment is disabling.”) (internal quotation marks
15 and citation omitted).

16 In performing a *de novo* review, the Court is not required to accept the
17 conclusion of any particular treatment provider or medical file review. For
18 instance, the Court does not accord special deference to the opinions of treating
19 physicians based on their status as treating physicians. *Black & Decker*
20 *Disability Plan v. Nord*, 538 U.S. 822, 834 (2003). Instead, medical opinions
21 “must . . . be accorded whatever weight they merit.” *Jebian v. Hewlett-Packard*
22 *Co. Employee Benefits Org. Income Prot. Plan*, 349 F.3d 1098, 1109 n.8 (9th
23 Cir. 2003) (citing *Nord*).

24 The Court may give greater weight to a treating physician’s opinion
25 where it is evident a particular physician has had “a greater opportunity to know
26 and observe the patient than a physician retained by the plan administrator” who
27 conducts a file review. *Id.* (internal quotation marks omitted). However, where
28 a treating physician lacks expertise in a particular area, and the plan’s retained

1 expert is a specialist in that area, it may be appropriate for a court to give greater
2 weight to the specialist who merely conducts a file review. *See Nord*, 538 U.S.
3 at 832.

4 Moreover, in cases such as this one, courts have noted an apparent tension
5 between treating physicians, who may tend to favor an opinion of “disabled” in
6 a close case, and physicians who are routinely hired by plan administrators, who
7 may favor a finding of “not disabled” in the same case. *See id.* It is therefore
8 incumbent upon the Court to carefully assess and weigh all the evidence in light
9 of the issues before the Court. The Court does so below.

10 II. FINDINGS OF FACT

11 On the record before it, the Court makes the following findings of fact.

12 A. Jump’s Employment

13 Jump worked as a senior underwriter at Amtrust Financial Services
14 (“Amtrust”) for 14 years. [Dkt. 32-1, at 284]. As described by a vocational
15 rehabilitation consultant, Jump’s occupational duties require “mostly sitting,
16 may involve standing or walking for brief periods of time, lifting, carrying,
17 pushing, pulling up to 10 pounds occasionally (up to 1/3 of the time).
18 Occasional reaching at desk level. Frequent (1/3 to 2/3 of the time)
19 fingering/keyboarding, handling, talking, and hearing. Constant (more than 2/3
20 of the time) near acuity (referring to clarity of vision at 20 inches or less). The
21 duties of this occupation would allow for changes in position for brief periods of
22 time throughout the day.” [Dkt. 32-2, at 401]. Further, the mental and
23 cognitive demands of Jump’s occupation “along with memory, concentration,
24 and attention involve attaining precise set limits, tolerances, and standards,
25 dealing with people, and making judgements and decisions.” [Dkt. 32-2, at
26 401]. In March 2021, Jump stopped working due to her alleged disability and
27 has not returned to work since. [Dkt. 32-1, 34–38].
28

1 **B. Long-Term Disability Policy**

2 At the time she stopped working, Jump was covered as a participant of
3 Unum’s long-term disability plan (“LTD Plan”) by virtue of her employment
4 with Amtrust. [Dkt. 32-4, at 61–112]. The LTD Plan benefits were funded by a
5 group insurance policy (the “Policy”) issued by Unum to Amtrust. [Dkt. 32-4,
6 at 61]. The Policy is governed by the Employee Retirement Income Security
7 Act of 1974 (“ERISA”). [Dkt. 32-4, at 71]. The Policy provides long-term
8 disability (“LTD”) benefits when a covered person is continuously disabled for
9 the longer of 180 days or when short-term disability payments end. [Dkt. 32-4,
10 at 64, 76]. To receive long-term disability benefits, the covered person must
11 satisfy the Policy’s definition of “disabled.” [Dkt. 32-4, at 76].

12 Under the Policy, someone is “disabled” when Unum determines that
13 they “are limited from performing the material and substantial duties of [their]
14 regular occupation due to [their] sickness or injury,” and “have a 20% or more
15 loss in [their] indexed monthly earnings due to the same sickness or injury.”
16 [Dkt. 32-4, at 76]. To prove disability, the Policy requires Jump to show,
17 among other things, “that [she is] under the regular care of a physician,” “the
18 date [her] disability began,” “the cause of [her] disability,” and “the extent of
19 [her] disability, including restrictions and limitations preventing [her] from
20 performing [her] regular occupation.” [Dkt. 32-4, at 66].

21 The Policy further provides that after “24 months of payments,” the
22 participant is “disabled when [Unum] determines that due to the same sickness
23 or injury, they are unable to perform the duties of any **gainful occupation** for
24 which [they] are reasonably fitted by education, training or experience.” [Dkt.
25 32-4, at 76 (emphasis in original)]. Unum will stop sending payments and
26 terminate the participant’s claim when the participant is “no longer disabled
27 under the terms of the [policy].” [Dkt. 32-4, at 76].

1 **C. The Motor Vehicle Accident**

2 Jump was involved in a motor vehicle accident (“MVA”). [Dkt. 32-1, at
3 228–37]. According to the Traffic Collision Report (“TRC”), Jump was
4 suddenly hit from behind by a vehicle going an estimated 65 miles per hour.
5 [Dkt. 32-1, at 235]. The airbags in Jump’s vehicle did not deploy. [Dkt. 32-1,
6 at 234]. The impact was so great that Jump’s shoes fell off and flew forward.
7 [Dkt. 32-1, at 235]. After the collision, Riverside County Fire Department
8 (“RCFD”) personnel arrived within seconds. [Dkt. 32-1, at 235]. Jump then
9 moved her vehicle to the right shoulder and shut off her engine. [Dkt. 32-1, at
10 235]. At the scene, Jump complained of slight dizziness and pain to her neck
11 and back. [Dkt. 32-1, at 234]. Notably, Jump was in shock from the collision
12 and could not fully recall all the details. [Dkt. 32-1, at 235].

13 Jump was treated at Inland Valley Medical Center (“IVMC”)
14 immediately following the MVA for neck pain and forearm pain, Jump raised
15 no other complaints at the time. [Dkt. 32-2, at 491]. At IVMC, she had
16 multiple imaging studies completed that did not reveal any injuries or
17 abnormalities. [Dkt. 32-2, at 493]. Those reports consisted of a negative
18 cervical spine CT scan, a negative chest x-ray, a negative left shoulder x-ray, a
19 negative left forearm x-ray, and a negative head/brain CT scan. [Dkt. 32-2, at
20 493]. The reason for the head/brain CT scan was for a head injury with
21 headache and loss of consciousness or amnesia. [Dkt. 32-1, at 316]. As
22 discussed in Section III below, the MVA resulted in subsequent medical
23 treatment and a basis to the alleged disability.

24 **D. Medical Evidence**

25 The administrative record in this case is voluminous, spanning about
26 eight years, and totaling almost 1,500 pages. Because the only relevant
27 determination is whether Plaintiff was disabled as defined by the Policy, not all
28 the medical evidence is summarized here. Instead, historical medical evidence

1 is discussed only to the extent relevant to the Court’s analysis. The most
2 relevant medical evidence is summarized below by medical provider.

3 Dr. Pervaiz Channah, M.D. of Channah Pervaiz and Associates:

- 4 • 01/11/2017 to 06/26/2019: Jump’s pre-MVA diagnoses by Dr.
5 Channah include chronic anxiety, depression, insomnia, bronchitis,
6 and obesity. [Dkt. 32-2, at 480–90].
- 7 • 08/13/2019: Appointment following the MVA and ER visit at
8 IVMC. [Dkt. 32-3, at 255]. Dr. Channah noted that Jump had
9 concussion and neck sprain, and that the CT scan of the brain was
10 unremarkable. [Dkt. 32-3, at 255].
- 11 • 08/22/2019: Jump complained of fuzzy headaches and lack of
12 concentration. [Dkt. 32-3, at 253]. Assessment included
13 concussion with loss of consciousness, sequela. [Dkt. 32-3, at
14 253]. Jump requested one month off work due to inability to travel
15 and work on computer due to worsening of her neck pain. [Dkt.
16 32-3, at 253].
- 17 • 09/25/2019 to 07/14/2021: Jump periodically met with Dr.
18 Channah about every month. [Dkt. 32-3, at 228–52]. Dr.
19 Channah’s progress notes generally discuss Jump’s neck pain with
20 radicular symptoms, follows her neurologist appointments for
21 traumatic brain injury (“TBI”), and chiropractic treatment. [Dkt.
22 32-3, at 228–52]. Notably, Jump did not raise any concerns of
23 headaches or vision problems throughout this period. [Dkt. 32-3,
24 at 228–52]. On December 21, 2020, Dr. Channah notes that Jump
25 experienced COVID, but that she was testing negative at this point.
26 [Dkt. 32-3, at 236]. On March 19, 2021, Dr. Channah noted that
27 Jump possibly had COVID longhauers syndrome and that she
28 complained of an “inability to concentrate due to fogginess of the

1 head causing increase stress at work” following COVID and the
2 MVA. [Dkt. 32-3, at 233]. That same appointment, Jump
3 requested one month of work excuse due to inability to
4 concentrate. [Dkt. 32-3, at 233].

- 5 • 11/09/2021: Noting that Jump was dealing with chronic headaches
6 status post Botox injections. [Dkt. 32-3, at 223]. Dr. Channah also
7 noted that Jump was seeing a neurologist and an infectious disease
8 specialist. [Dkt. 32-3, at 223].
- 9 • 11/09/2021: In an LTD claim form to Unum, Dr. Channah wrote
10 that Jump was unable to physically work full time from March 29,
11 2021 to that present moment because she was unable to sit at the
12 computer to read emails and manage duties as required. [Dkt. 32-
13 1, 102–3]. Dr. Channah conclude that Jump’s functional capacity
14 is impacted by TBI, PTSD, long-haul COVID symptoms,
15 insomnia, anxiety, major depressive disorder, neck sprain, and
16 sequela. [Dkt. 32-1, 102]. Behavioral health restrictions include
17 “concentration, memory, functions, anxiety, unable to read
18 documents without skipping lines.” [Dkt. 32-1, 103].
- 19 • 02/03/2022: Dr. Channah signed a form that agreed with Unum’s
20 physicians that Jump was not precluded from working in her
21 sedentary occupation as of September 8, 2021. [Dkt. 683–85].
- 22 • 08/22/2022: In a letter with Dr. Channah’s signature stamp and
23 letterhead Cynthia Cox, RNPC, stated that “the disability paper
24 should specify [Jump] is unable to work at all. She is under the
25 care of specialists, requiring ongoing care for chronic conditions,
26 resulting in permanent disability. Please feel free to contact the
27 office with any further questions.” [Dkt. 32-3, at 471].

28 Dr. Martha Castro, D.C. of Cornerstone Spine Institute:

- 1 • 08/09/2019 to 01/06/2020: Jump was treated by Dr. Castro on a
2 near weekly basis, with constant complaints of severe sharp neck
3 pain, sharp mid-back pain, low back pain, headaches, stiffness,
4 soreness, pain in the tailbone, lower leg pain, severe left arm pain,
5 decreased mobility, and difficulty lifting. [Dkt. 32-2, at 493–99;
6 Dkt. 32-3, at 1–9]. She presented with an antalgic right lean of her
7 neck. [Dkt. 32-2, at 493]. Dr. Castro opined that the pain Jump
8 experienced was the direct result of the MVA. [Dkt. 32-3, at 9].

9 Dr. Dae Lee, D.C. of Lee Chiropractic:

- 10 • 01/10/2020 to 07/09/2020: Jump was treated by Dr. Lee on a near
11 weekly basis. [Dkt. 32-3, at 9–42]. Jump consulted with Dr. Lee
12 for headache pain, radiating neck pain, radiating low back pain,
13 middle back pain, forgetfulness, and dizziness. [Dkt. 32-3, at 9].
14 Her symptoms fluctuated throughout treatment. [Dkt. 32-3, at 9–
15 42]. In Jump’s last visit, Dr. Lee noted that Jump “continue[d] to
16 have signs of occasional foggy thoughts and forgetfulness and
17 continued neck and back pains.” [Dkt. 32-3, at 42].

18 Dr. Stanley Eosakul, M.D. and PA Saema Sial, PA-C of American Spine:

- 19 • 01/20/2020: The notes reflect that Jump reported loss of
20 consciousness as a direct result of the MVA. [Dkt. 32-3, at 12].
21 Other complaints by Jump included radiating neck, mid back, and
22 low back pain, and neurological symptoms such as weakness and
23 numbness in the arms and legs—including balance problems. [Dkt.
24 32-3, at 12].
- 25 • 05/18/2020: PA Sial noted similar symptoms from the initial visit.
26 [Dkt. 32-3, at 28–29]. During that visit, PA Sial recommended
27 cervical epidural steroid injections to reduce pain and
28 inflammation, noting that Jump may need to repeat the procedure.

1 [Dkt. 32-3, at 29]. Notably, PA Sial found that Jump “has neck
2 pain and radicular symptoms in the arms as well as neurologic
3 deficits on physical exam. Imaging studies reveal disc protrusions
4 and neuroforaminal narrowing. The patient has reached a plateau
5 in the improvement with less invasive therapies (chiropractic
6 therapy and anti-inflammatory pain medications). “Nerve injury is
7 clearly evident.” [Dkt. 32-3, at 29].

- 8 • 01/26/2021 and 03/08/2021: Jump continued to complain of
9 similar issues with her neck, neurological symptoms, and low back
10 pain. [Dkt. 32-1, at 479–90]. Among other things, Dr. Eosakul
11 noted that Jump underwent a cervical epidural steroid injection on
12 May 30, 2020, for her neck pain that resulted in 20% pain relief for
13 a few weeks and cervical medical branch blocks on August and
14 September 2020 resulting in 50% pain relief for 8 hours and 2 to 3
15 hours. [Dkt. 32-1, at 482, 488]. Jump also “underwent a lumbar
16 epidural steroid injection on [July 15, 2020] resulting in 50% pain
17 relief for 4 weeks, but continues to have bilateral low back pain
18 with left-sided radicular symptoms with pain on lumbar extension.”
19 [Dkt. 32-1, at 482, 488]. Dr. Eosakul’s diagnoses included cervical
20 disc displacement at C4-C5 and C5-C6 levels and the high cervical
21 region, injury of the nerve root of both the cervical and lumbar
22 spine, sequela, stenosis of the cervical neural canal, disc
23 displacement in lumbar and lumbosacral region, and the thoracic
24 region, traumatic spondylopathy in the cervical regions, and
25 concussion with loss of consciousness (of 30 minutes or less,
26 sequela). [Dkt. 32-1, at 482, 488]. Jump denied any vision
27 problems. [Dkt. 32-1, at 480, 486].
28

1 Dr. Yuvraj Grewal, M.D. of the Advanced Center for Neurology and
2 Headache:

- 3 • 05/28/2020: Jump consulted with Dr. Grewal in relation to
4 “headaches, neck pain, lower back pain, dizziness, cognition and
5 memory difficulties, changes in mood, fatigue and sleep-wake
6 cycle changes.” [Dkt. 32-3, at 156]. Jump reported a significant
7 memory loss surrounding the MVA and that she lost consciousness
8 until the paramedics arrived. [Dkt. 32-3, at 156]. Dr. Grewal
9 diagnosed Jump with concussion/TBI, post concussive syndrome
10 and post concussive headaches. [Dkt. 32-3, at 159]. Jump denied
11 any changes in vision. [Dkt. 32-3, at 158].
- 12 • 02/25/2021: Dr. Grewal concluded that Jump’s signs and
13 symptoms were caused by the MVA. [Dkt. 32-3, at 148]. After
14 reviewing an MRI of the brain without contrast (performed on
15 April 14, 2020), Dr. Grewal noted that “a posttraumatic etiology is
16 a consideration with a clinical history of trauma.” [Dkt. 32-3, at
17 148]. He then explained that the finding of “mild enlargement of
18 several perivascular spaces . . . can represent normal variant
19 anatomy in a patient of this age,” but that “association with
20 traumatic brain injury is a consideration in the appropriate clinical
21 setting.” [Dkt. 32-3, at 148]. Dr. Grewal’s opinion of the
22 EMG/MCV study of the upper extremities (performed on January
23 28, 2021) is that it was an abnormal study with electrophysiologic
24 evidence of bilateral C6 radiculopathy and bilateral carpal tunnel
25 syndrome. [Dkt. 32-3, at 148]. Dr. Grewal’s diagnoses, again,
26 included concussion/TBI, post concussive syndrome and post
27 concussive headaches. [Dkt. 32-3, at 148]. Jump “has history and
28 imaging consistent with the diagnosis of traumatic brain injury.

1 Since she was last seen in the neurology clinic, she has had an MRI
2 brain study performed. This study did show evidence of dilated
3 perivascular spaces that can be seen in the context of [TBI]. As
4 such, the patient does have clinical history as well as objective
5 imaging consistent with the diagnosis of [TBI]. Given the duration
6 of time that has elapsed since onset of symptomatology, her deficits
7 in terms of cognition are likely a permanent issue. Unfortunately,
8 treatment will be primarily supportive. She also has had
9 electrodiagnostic testing of the upper extremities performed. This
10 testing is consistent with MRI cervical spine study and shows
11 evidence of bilateral C6 radiculopathy.” [Dkt. 32-3, at 149]. No
12 visual symptoms were reported. [Dkt. 32-3, at 147].

13 Dr. Vrijesh Tantuwaya, M.D. of Neurological and Spinal Surgery:

- 14 • 07/08/2020: Jump’s chief complaints related to headaches, neck
15 pain, bilateral arm pain, thoracic pain, low back pain, and left leg
16 pain. [Dkt. 32-1, at 466–67]. At that point, she did not have any
17 formal work activity restrictions or limitations. [Dkt. 32-1, at 468].
18 The report notes that Jump had balance difficulties and poor vision.
19 [Dkt. 32-1, at 468, 470]. Dr. Tantuwaya’s studies found an overall
20 normal-appearing MRI scan of the brain and thoracic spine. [Dkt.
21 32-1, at 474]. He did not detect any focal or lateralizing
22 neurological deficits, and an MRI scan of the brain showed no clear
23 evidence of structural brain injury. [Dkt. 32-1, at 451–52]. His
24 review of the MRI scan of the lumbar spine (performed on April
25 14, 2020) shows “near-complete collapse of the disc” at the L4-L5
26 and the L5-S1 levels, as well as a “facet arthropathy in a broad-
27 based disc protrusion” at L4-L5, severe bilateral foraminal stenosis
28 and severe facet arthropathy. [Dkt. 32-1, at 474]. Importantly, Dr.

1 Tantuwaya concluded that Jump suffers from post-concussional
2 syndrome and post-traumatic headaches because of the MVA
3 where she lost consciousness for several minutes, and further
4 recommended a neuropsychological consultation and
5 comprehensive TBI evaluation with Dr. Lisa Davidson. [Dkt. 32-1,
6 at 476–77].

- 7 • 10/14/2020 and 12/10/2020: Confirming previous diagnoses.
8 [Dkt. 32-1, 444–54, 455–63]. Notably, since the initial
9 examination, Jump felt the same and expressed that she was
10 experiencing extreme physical and mental fatigue. [Dkt. 32-1, at
11 451–52]. MRI scan of the brain without contrast (performed on
12 April 14, 2020) appeared normal. [Dkt. 32-1, at 449–50]. An MRI
13 scan of the cervical spine (performed on October 27, 2020) reveals
14 a significant loss of cervical lordosis, multi-level disk protrusions
15 at C3-C4, C5, C5-C6 and C6-C7 and broad-based disc protrusion at
16 C4-C5. [Dkt. 32-1, at 450]. Notably, a mental status exam found
17 that Jump’s “attention span and concentration are normal. Recent
18 and emote memories are intact. Fund of knowledge is adequate.”
19 [Dkt. 32-1, at 449].

20 Dr. Lisa A. Davidson, PH.D., a clinical psychologist/neuropsychologist:

- 21 • 04/15/2021: Dr. Davidson’s report states that she evaluated Jump
22 on January 26, February 4 and 12, and March 2, 2021. [Dkt 32-1,
23 at 331]. Dr. Davidson concluded that there is ample evidence of a
24 TBI. [Dkt 32-1, at 340]. The MVA, where she experienced loss of
25 consciousness, resulted “in confusion and probable ability loss
26 (Low Average IQ Index scores, impaired WAIS-IV subtest scores),
27 significant memory difficulties (Low Average and Borderline
28 WMS-IV Index scores, impaired subtest scores), and SCT scores

1 indicating significant difficulties in the areas of problem solving,
2 organizing mental information, making judgments, and
3 discriminating significant from insignificant details in her
4 environment. These factors affect Jump’s visual and auditory
5 memory, with impairment in immediate (short-term) memory. She
6 also has problems making transitions and/or shifting from one task
7 to another, as well as having visual-perceptual-motor difficulties.”
8 [Dkt 32-1, at 340]. Notably, Jump told Dr. Davidson that she was
9 “written up at work for making a mistake after 34 years of success.
10 I don’t respect my boss. She is not supportive of me and what I’ve
11 been through.” [Dkt. 32-1, at 336]. “Ms. Jump’s test results show
12 that she is now experiencing processing speed issues which are
13 particularly sensitive to brain injury. It is important to note that her
14 previous career required accurate, fast, processing speed and
15 attention to detail which are now at a minimum for Ms. Jump.
16 Also, it appears that when Ms. Jump was violently hit from behind
17 in her car, she suffered a coup contrecoup brain injury which
18 means that her brain bounced inside her skull causing a diffuse
19 axonal injury. Specifically impacted are her immediate/delayed
20 memory and auditory memory which are causing her distress in her
21 daily life. In conclusion, the [MVA] has left permanent effects for
22 Ms. Jump in her brain functioning.” [Dkt. 32-1, at 340].

- 23 ● 02/15/2022: Dr. Davidson informed Unum that Jump is precluded
24 from working due to headaches and sequelae of TBI, specifying
25 that her setbacks are not related to behavioral health conditions
26 such as anxiety or depression. [Dkt. 32-2, at 236].
- 27 ● 07/10/2022: In response to Unum’s request for further information
28 on Jump’s health condition, Dr. Davidson completed a medical

1 certification. [Dkt. 32-3, at 391–93]. The medical certification
2 states that as of March 29, 2022 (but likely meant 2021) due to
3 TBI, cervical and lumbar issues and post-concussive headaches,
4 Jump “cannot work at this time” and the nature of her work
5 restrictions are “all/permanent.” [Dkt. 32-3, at 1392–93].

- 6 • 07/22/2022: Dr. Davidson confirmed in a letter to Jump’s attorney
7 that Jump is totally disabled. [Dkt. 32-3, at 389]. Dr. Davidson
8 opined that “[Jump] has [temporomandibular joint (“TMJ”)] and
9 cervical spine-issues secondary to her accident which are not
10 resolving well Ms. Jump suffers with a closed head injury
11 with concussion, post-concussion syndrome, probable convergence
12 insufficiency, left tempo mandibular joint syndrome, cervical
13 radiculopathy and lumbar radiculopathy, all of which produce
14 constant and permanent effects which render Ms. Jump totally
15 disabled.” [Dkt. 32-3, at 389]. He also stated that long-haul
16 COVID exacerbated Jump’s TBI. [Dkt. 32-3, at 389].
- 17 • 09/02/2022: Dr. Davidson again confirmed Jump’s total disability,
18 describing her medical conditions as “traumatic brain injury, post-
19 concussive migraines daily, cervical spine issues, vision/vestibular
20 issues, memory problems, low stamina/fatigue, low frustration
21 tolerance.” [Dkt. 32-3, at 486].

22 Dr. Donald Janiuk, O.D. of the College of Optometrists in Vision
23 Development:

- 24 • 10/30/2020: Jump’s chief complaint was blurred vision in both
25 eyes. [Dkt. 32-3, at 58]. Dr. Janiuk reports that “[t]he blurred
26 vision at computer distance and at al[l] distances with pain. The
27 blurred vision is moderate in severity. The blurred vision has been
28

1 present for 1 year and 2 months. Accident rear ended knocked
2 unconscious symptoms.” [Dkt. 32-3, at 58].

- 3 • 04/12/2021: In a visual sensory motor evaluation, Dr. Janiuk found
4 that: “Jump’s Fixations were 87 on the left eye and 99 on the right.
5 Her Regressions were at 10 left eye and 13 on the right eye. Span
6 of Recognition 1.15 on the left and 1.01 on the right. Duration of
7 Fixations were at 0.34 on the left eye and 0.30 on the right. Her
8 Reading Rate was 200 words per minute with 80%
9 Comprehension.” [Dkt. 32-1, at 328]. Jump had difficulty tracking
10 across a page, with a loss of binocular vision 12 times while
11 reading only 100 words. [Dkt. 32-1, at 328]. “The grade level
12 equivalent of the findings range from 2nd grade for duration of
13 fixation to 14th grade for regressions.” [Dkt. 32-1, at 328]. He
14 found recovery of clear, single vision was poor once coordination
15 was lost and she experienced slow eye movements, both saccadic
16 and pursuit. [Dkt. 32-1, at 328]. He recommended a program of
17 24 optometric vision therapy sessions. [Dkt. 32-1, at 328].
- 18 • 07/24/2021: Dr. Janiuk’s Visual Evoked Potential (“VEP”) report,
19 an examination of the brain’s response to a repetitive visual
20 stimulus, reflects that Jump’s vision was 20/20 in each eye and that
21 her visual field test results were normal. [Dkt. 32-2, at 260]. He
22 found no sign of post-trauma syndrome in this context. [Dkt. 32-2,
23 at 260].
- 24 • 02/18/2022: In an LTD disability claim form to Unum, Dr. Janiuk
25 stated that Jump has extremely low and inaccurate eye movements,
26 and she is unable to track across the page, causing frustration and
27 anxiety. [Dkt. 32-2, at 203]. He recommended near-odyometric
28

1 vision therapy and that she should not do any work until there is
2 improved visual function. [Dkt. 32-2, at 203].

- 3 • 09/18/2022: In a letter to Unum, Dr. Janiuk wrote that Jump
4 started a neuro-optometric vision therapy on October 14, 2021, and
5 “while there was some symptom reduction, she is still unable to
6 maintain her visual concentration for long enough to work
7 effectively.” [Dkt. 32-3, at 163].

8 Dr. Charles A. Moss, M.D. of the Moss Center for Integrated Medicine:

- 9 • 05/04/2021: Jump filled out an intake form for Dr. Moss, and her
10 chief concerns were long-haul COVID related symptoms, which
11 included cognitive dysfunction, fatigue, runny nose, taste and smell
12 disorder, tinnitus, muscle pain, and headache pain. [Dkt. 32-1, at
13 319–22].
- 14 • 05/18/2021, 07/28/2021, and 12/22/2021: Records reflect that Dr.
15 Moss attended to Jump for long-haul COVID. [Dkt. 32-1, at 386–
16 91]. Dr. Moss also stated that effective March 30, 2021, Ms. Jump
17 should have been restricted from “computer work, interact[ing]
18 with clients, sitting at desk, lifting.” [Dkt. 32-1, at 388].
- 19 • 01/17/2022: Dr. Moss had “no opinion” as to whether Jump could
20 perform the physical and cognitive requirements of her occupation,
21 and instead, he deferred to Dr. Davidson. [Dkt. 32-2, 134].

22
23 Dr. Ian Purcell of the Senta Clinic, Division of Neurology:

- 24 • 09/08/2021, 10/19/2021, and 11/19/2021: Jump consulted Dr.
25 Purcell regarding TBI. [Dkt. 32-3, at 82–84, 89–91, 93–95]. When
26 discussing the MVA, Jump reported that she hit her head on the
27 driver’s side window and loss consciousness for 5 minutes. [Dkt.
28 32-1, at 438]. Dr. Purcell confirmed her traumatic brain injury,

1 chronic migraines which were worsening over time, dizziness, lack
2 of coordination, and cognitive difficulties. [Dkt. 32-3, at 82–84,
3 89–91, 93–95]. Dr. Purcell’s review of Jump’s October 2021 MRI
4 was “unremarkable.” [Dkt. 32-1, at 431, 433]. Jump complained
5 of blurred vision, vertigo, cognitive difficulties described as
6 forgetfulness, headaches, tinnitus, emotional lability, and daytime
7 fatigue. [Dkt. 32-1, at 431, 433].

- 8 • 12/27/2021: Given the severity of Jump’s complaints, and lack of
9 control/relief of symptoms, Dr. Purcell advised that Jump should
10 “continue to refrain from work as that type of environment and
11 demand will exacerbate her condition and further worsen her
12 prognosis.” [Dkt. 32-1, at 427]. Again, Dr. Purcell describes
13 Jump’s October 2021 MRI as “unremarkable.” [Dkt. 32-1, at 427].
- 14 • 04/27/2022: Dr. Purcell reiterated Jump’s continued inability to
15 work. [Dkt. 32-3, at 215].

16 Dr. Andrew Blumenfeld, M.D. of the American Board of Psychiatry and
17 Neurology:

- 18 • 06/29/2022: Dr. Blumenfeld opined that Jump has post-traumatic
19 syndrome because of the MVA. The history of Jump’s injury
20 includes loss of consciousness for about 5 minutes. [Dkt. 32-2, at
21 477]. “Recovery from concussion is a slow process. The brain
22 connections need to re-establish. The course is dependent on the
23 extent of brain damage and often concussion recovery is prolonged;
24 leading to depression and anxiety which further complicates the
25 situation. The symptoms can persist for many months or even for
26 several years. Every person and every concussion are different.”
27 [Dkt. 32-3, at 97]. Dr. Blumenfeld’s mental status exam found that
28 Jump was alert with normal attention and her “[c]ognitive function

1 shows adequate recent and remote recall as well as attention span.”
2 [Dkt. 32-3, at 95–96]. Additionally, Dr. Blumenfeld found that:
3 “Visual fields are full to confrontation testing. Extra-ocular
4 movements are full. There is no nystagmus or diplopia [i.e., no
5 double vision]. Pupils are equal and reactive.” [Dkt. 32-3, at 96].
6 Dr. Thomas Schweller, M.D. Diplomate American Board of Psychiatry
7 and Neurology:

- 8 • 04/13/2022: Dr. Schweller completed a neurological independent
9 medical evaluation of Jump. [Dkt. 32-3, at 100–20]. Jump
10 reported to Dr. Schweller that she lost consciousness and woke up
11 with emergency personnel around her. [Dkt. 32-3, at 100]. After
12 conducting a full physical exam and reviewing Jump’s medical
13 records, Dr. Schweller diagnosed her with a closed head injury
14 with concussion, post-concussion syndrome, probable convergence
15 insufficiency, left TMJ and cervical and lumbar radiculopathy.
16 [Dkt. 32-3, at 100–20]. His physical examination of Jump found,
17 among other things, that she remembered 3/3 objects after 5
18 minutes, remembered part of the street address, her affect was
19 appropriate, her communication skills were in tack, balance
20 difficulties, blurred vision from 3 feet, motor strength was 5/5,
21 sensory decrease in left arm and leg, and neck and lumbar spine
22 tenderness. [Dkt. 32-3, at 119]. He concluded that Jump was
23 unable to compete in the open labor due to her ongoing disability
24 related to the residual effects of her TBI. [Dkt. 32-3, at 120].
25 Jump’s work “environment and demand will exacerbate her
26 condition and further worsen the prognosis.” [Dkt. 32-3, at 119].
27
28

1 **E. JUMP’S DECLARATION**

2 In her declaration in support of claim for LTD benefits, Jump mentions
3 that she was involved in the MVA, where she lost consciousness as a result.
4 [Dkt. 32-3, at 394]. Jump asserts that she is disabled and unable to work
5 because of: TBI; post-concussion syndrome; spinal damage, low back and
6 neck; concussion; long-haul COVID-19 symptoms from multiple COVID
7 infections; Type 2 diabetes mellitus; and post-traumatic stress disorder,
8 secondary to the above conditions. [Dkt. 32-3, at 394]. She states that her
9 disabilities are permanent and have become worse over time, and that she is
10 actively seeking medical treatment to address her disabilities. [Dkt. 32-3, at
11 394]. Further, she states that she was first diagnosed with COVID in December
12 2020 and has since experienced multiple infections, leading to long-haul
13 COVID symptoms including fatigue, brain fog, cognitive dysfunction, and
14 runny nose. [Dkt. 32-3, at 394]. Some of the effects from Jump’s medical
15 condition(s) include: TBI preventing her from reading anything except short
16 emails and texts; trouble balancing as she experiences dizziness triggered by
17 fatigue; vision difficulties due to eye pain, eye redness, and blurry/double
18 vision; daily migraines with constant pain; and memory deficits, with difficulty
19 with forgetfulness. [Dkt. 32-3, at 395–96].

20 **F. JUMP’S APPLICATION AND APPEAL FOR LONG-TERM**
21 **DISABILITY BENEFITS**

22 In October 2021, Jump submitted (via telephone call) a claim for LTD
23 Benefits. [Dkt. 32-1, at 34–38]. At that time, Jump identified her disabling
24 condition as “spinal nerve damage and traumatic brain injury.” [Dkt. 32-1, at
25 35]. Unum denied Jump’s long-term disability (“LTD”) benefits on March 16,
26 2022. [Dkt. 32-2, at 400–409]. Unum’s denial letter explains the reasons
27 underlying Unum’s decision, citing to Jump’s medical records submitted and
28 explaining that Unum’s reviewing physicians “found no support beyond

1 September 8, 2021, for restrictions that would have prevented [Jump] from
2 performing the full-time activities required in [her] occupational duties.” [Dkt.
3 32-2, at 402–03]. Unum’s physicians were Dr. Elizabeth Belanger, M.D., board
4 certified in internal medicine and infectious diseases, and Dr. Michael Chilungu,
5 M.D., board certified in neurology. [Dkt. 32-2, at 130, 389]. Because Jump’s
6 disability began on March 30, 2021, her elimination period ended on September
7 25, 2021. Thus, since Jump’s disability allegedly ended prior to September 25,
8 2021, she did not satisfy the elimination period and therefore was not approved
9 for benefits.

10 Jump filed an administrative appeal on August 22, 2022, with
11 supplemental evidence that was not before Unum during Jump’s initial
12 application. [Dkt. 32-2, at 459–70]. Unum again denied Jump’s LTD benefits
13 on October 4, 2022. [Dkt. 32-4, at 44–53].

14 **III. CONCLUSIONS OF LAW**

15 The only issue before the Court is whether Unum’s denial of Jump’s LTD
16 benefits was correct for Jump’s 24-month own occupation period as her claim
17 did not establish her inability to perform the duties of any gainful occupation for
18 which she was reasonably fitted by education, training or experience.

19 20 **A. Unum’s File Reviewers Identified Reasons to Find That Jump Was** 21 **Not Totally Disabled**

22 Unum had two physicians review Jump’s file when deciding her initial
23 application and a separate reviewing physician for the appeal. Their opinions
24 are discussed in further detail below.

25 Reviewing Dr. Belanger opined that Jump’s file did not support that she
26 was precluded from performing her occupational demands on a full-time basis
27 as of September 8, 2021, because of the “demonstrated capacity, inconsistent
28 and largely benign exams, inconsistently reported activities, and low intensity of

1 management reflected in the file.” [Dkt. 32-2, at 127, 130]. Among other
2 things, Dr. Belanger pointed out that: Jump’s neurology office visits
3 consistently described Jump as lucid without neglect or inattention; the April
4 2020 MRIs of the brain and thoracic spine and the October 2021 MRI of the
5 brain are interpreted as overall normal appearing scans; no confusion, difficulty
6 with word finding, memory or comprehension was noted in any submitted
7 exams; and an October 2020 optometry evaluation documents Jump as reporting
8 blurry vision for a year and 2 months, but she was able to work. [Dkt. 32-2, at
9 125–30, 402–03]. Dr. Belanger also highlighted that even though Jump’s
10 cognitive difficulties were abnormal during 2020 neurosurgery visits, exams
11 from those visits document her as being alert and oriented with a normal
12 attention span and concentration. [Dkt. 32-2, at 125–30, 402–03]. Further, Dr.
13 Belanger notes that the April 2021 optometry evaluation specified that Jump’s
14 saccadic and pursuit movements were normal though slower and documented a
15 corrected visual acuity of 20/20, and that the July 2021 VEP report described no
16 sign of post trauma vision syndrome. [Dkt. 32-2, at 125–30, 402–03].

17 Reviewing Dr. Chilungu agreed that Jump was able to work on a full-time
18 basis as of September 8, 2021. [Dkt. 32-2, at 387–89]. Dr. Chilungu’s findings
19 and opinions are summarized, in part, as follows: “[The medical information],
20 while descriptive of an individual suffering from recurrent headaches, dizziness,
21 and cognitive concerns in the aftermath of a concussive head injury[,] fails to
22 contain consistent, independent, objective examination data that supports the
23 assertion that the claimant is neurologically impaired and incapable of
24 performing the regular, unrestricted duties of the claimant’s occupation as
25 outlined above. There is no robust physical or cognitive examination data . . .
26 that validates the claimant’s claimed level of incapacitation. The claimant
27 demonstrates consistently near normal to completely unremarkable neurological
28 examinations throughout the medical record[.]” [Dkt. 32-2, at 388].

1 Appeal reviewing Dr. Steven Winkel, D.O., who is board certified in
2 internal medicine, concluded that Jump was able to work on a full-time basis as
3 of September 8, 2021. [Dkt. 32-3, at 494–500]. Dr. Winkel opined that since
4 the MVA: “[T]he insured has had extensive evaluations and treatments with her
5 primary care provider, neurology, neurosurgery, neuropsychology,
6 ophthalmology, and pain management. The serial examinations with the
7 providers have noted the insured to be awake, alert, and oriented x4. The
8 insured has had normal thought content, judgment, speech, comprehension, and
9 no cognitive deficits were noted on the serial examinations. The providers have
10 noted no word searching difficulty or speech abnormalities I believe these
11 findings would not preclude the insured from performing sedentary occupational
12 demands. Despite the injuries sustained in the motor vehicle accident and
13 COVID-19 infection, the insured has continued to work full-time without
14 restrictions until 3/30/2021. The medical records do not document evaluations
15 for the COVID-19 infection or complications The serial MRI scans of the
16 cervical and lumbar spines have not documented herniated discs. Bulging discs
17 and neuro-foraminal stenosis have been documented. EMG/NCV study of the
18 upper extremities noted left carpal tunnel syndrome and left C6 radiculopathy.
19 The medical records do not document referrals to orthopedics for carpal tunnel
20 syndrome or occupational hand therapy. These findings would not preclude the
21 insured from performing the sedentary occupational demands.” [Dkt. 32-3, at
22 494].

23 **B. Jump Has Not Shown by a Preponderance of the Evidence That She**
24 **Was Disabled at the Time of the Denial of Benefits**

25 Although Jump’s medical providers, including Drs. Channah, Purcell,
26 Davidson, Schweller, and Janiuk, concluded that she was disabled and could not
27 return to work, the record is conflicting with regard to Jump’s symptoms and
28 her medical provider’s objective findings. Accordingly, as discussed below, the

1 Court concludes that Jump has not met her burden to show it is more likely than
2 not that she was disabled during the entire elimination period from her
3 occupation under the terms of the Policy.

4 **1. Jump’s Ability to Work Post-MVA and Post-COVID**

5 As a preliminary matter, the Court addresses Unum’s contentions that
6 Jump’s disability claim is at odds with the fact that she was able to work post-
7 MVA and post-COVID. [Dkt. 39, at 6:20–23, 22:22–24, 24:26–27]. Although
8 the argument has superficial appeal, the fact that Jump found a way to continue
9 to work does not preclude a finding of disability. *See, e.g., Hawkins v. First*
10 *Union Corporation Long-Term Disability Plan*, 326 F.3d 914, 918 (7th Cir.
11 2003) (there is no “logical incompatibility between working full time and being
12 disabled from working full time” as “a desperate person might force himself to
13 work despite an illness that everyone agreed was totally disabling”); *Wilcox v.*
14 *Sullivan*, 917 F.2d 272, 277 (6th Cir. 1990) (a claimant “should not be penalized
15 because he had the courage and determination to continue working despite his
16 disabling condition”); *see also Cooper v. Bowen*, 815 F.2d 557, 561 (9th Cir.
17 1987) (“Disability does not mean that a claimant must vegetate in a dark room
18 excluded from all forms of human and social activity.”) (quoting *Smith v.*
19 *Califano*, 637 F.2d 968, 971 (3d Cir. 1981)). Accordingly, there is little merit to
20 Unum’s contentions regarding Jump’s ability to work prior to her alleged total
21 disability, and the Court analyzes the arguments below with that in mind.

22 **2. Self-Reported Symptoms**

23 The Court is cognizant of the issue pertaining to self-reported symptoms
24 and the need for objective testing. A disability determination *may* be based on
25 self-reported symptoms if said reporting is credible. *See Demer v. IBM Corp.*
26 *LTD Plan*, 835 F.3d 893, 905–06 (9th Cir. 2016) (finding that an administrator
27 abused its discretion in denying LTD benefits based on claimant’s failure to
28 provide objective evidence of disability where claimant provided subjective

1 complaints corroborated by his treating physicians). But where self-reported
2 symptoms are not entirely credible and the evidence of disability is primarily
3 derived from the treating physician’s recording of the patient’s self-reported
4 symptoms, courts have repeatedly recognized that this evidence alone does not
5 support a finding that the claimant has a disabling condition where those self-
6 reports are not supported. *See e.g., Sanchez v. Hartford Life & Accident Ins.*
7 *Co.*, No. 2:20-cv-03732-JWH-JEM, 2022 WL 4009176, *6 (C.D. Cal. Sept. 2,
8 2022), *appeal dismissed*, 2023 WL 2754769 (9th Cir. Feb. 23, 2023) (“treating
9 physician’s diagnosis can be discounted when it lacks supportive evidence, it is
10 contradicted by other statements and assessments of medical condition, and it is
11 based upon subjective descriptions of pain or limitations”); *McCool v. Life Ins.*
12 *Co. of N. Am.*, No. 2:17-07766-RGK-JEM, 2018 WL 6137163, *5 (C.D. Cal.
13 Nov. 9, 2018) (“whether there is evidence of a disability, the court looks to the
14 objective medical evidence rather than relying solely on a claimant’s subjective
15 reports of pain”); *see also Bratton v. Metropolitan Life Ins. Co.*, 439 F. Supp. 2d
16 1039, 1052 (C.D. Cal. 2006) (“a finding of disability based on mere subjective
17 complaints would open the Plan up to malingering and would greatly hamper
18 [the insurance company] from exercising its fiduciary role of scrutinizing
19 requests for benefits”). Therefore, the Court appropriately weighs the subjective
20 and objective evidence when reviewing the administrative record.

21 **3. Misrepresentations of the MVA to Jump’s Medical Providers**

22 One of Unum’s overarching arguments is that the findings of Jump’s
23 medical providers are premised on false representations pertaining to the
24 circumstances of the MVA, specifically that she lost consciousness. [Dkt. 39, at
25 10:27–12:6]. Jump represented to Dr. Purcell and Dr. Blumenfeld that she lost
26 consciousness for 5 minutes, [Dkt. 32-1, at 427; 32-2, at 977], and she
27 represented to Dr. Tantuwaya that she lost consciousness for several minutes,
28 [Dkt. 465, 451]. Indeed, Jump asserted that she lost consciousness in her

1 declaration in support of her claim for benefits to Unum. [Dkt. 32-3, at 394].
2 The Court is dubious of the assertion that Jump was unconscious for several
3 minutes considering that RCFD was at the scene within seconds of the collision
4 and the TRC makes no mention of Jump’s loss of consciousness. [Dkt. 32-1, at
5 235]. But that is not to say that Jump did not experience loss of consciousness,
6 her claim that she endured a concussion is consistent throughout the record—
7 even if her loss of consciousness lasted seconds or minutes. [See Dkt. 32-3, at
8 100] (Jump reported to Dr. Schweller that she lost consciousness and woke up
9 with emergency personnel around her); [Dkt. 32-3, at 156] (Jump reported to
10 Dr. Grewal that she lost consciousness until the paramedics arrived). Although
11 Jump’s representations to her medical providers may not have been entirely
12 accurate, the Court will not dispose of the diagnoses of her medical providers as
13 she has been treated for a concussion throughout the past 5 years. Indeed,
14 Unum’s reviewers do not dispute the actual occurrence of a concussion. But the
15 Court will appropriately weigh those diagnoses based on Jump experiencing
16 loss of consciousness for several minutes. As to other alleged
17 misrepresentations raised, the Court finds those to be immaterial for the
18 purposes of this case.

19
20 **4. Spinal Nerve Damage**

21 As discussed above, Jump’s LTD claim identified her disabling condition
22 as “spinal nerve damage and traumatic brain injury.” [Dkt. 32-1, at 35]. The
23 administrative record is clear that, since the MVA, Jump has experienced neck
24 pain, mid and low back pain, lower leg pain, stiffness, numbness and tingling in
25 her hands, and persistent pain in her left arm and shoulder. [Dkt. 32-2, at 493–
26 500; Dkt. 32-3, at 1–42]. Her subjective complaints of pain are consistent with
27 MRIs and imaging which disclose numerous abnormalities in her cervical and
28 lumbar spine. [Dkt. 32-1, at 448, 450; Dkt. 32-2, at 510–511; Dkt. 32-3, at 22–

1 26, 71, 151–52]. PA Sial found that nerve injury was “clearly evident.” [Dkt.
2 32-3, at 29].

3 Unum argues that none of the physicians responsible for treating Jump for
4 her orthopedic complaints declared her disabled from those conditions. [Dkt.
5 42, at 18:8–9]. Notably, Dr. Davidson concluded that “[Jump] has TMJ and
6 cervical spine-issues secondary to her accident which are not resolving well . . .
7 . Ms. Jump suffers with a closed head injury with concussion, post-concussion
8 syndrome, probable convergence insufficiency, left tempo mandibular joint
9 syndrome, cervical radiculopathy and lumbar radiculopathy, all of which
10 produce constant and permanent effects which render Ms. Jump totally
11 disabled.” [Dkt. 32-3, at 389]. Although Unum argues that Dr. Davidson is not
12 qualified to offer an opinion regarding impairment due to orthopedic conditions,
13 [Dkt. 42, at 18 n.6], a neuropsychologist evaluation involves gathering
14 information such as a patient’s medical conditions to understand how the
15 patient’s brain is working.¹ The Court recognizes that Jump’s orthopedic
16 conditions alone are not disabling (nor do any of Jump’s medical providers
17 attribute disability to her orthopedic conditions alone), and instead her spinal
18 nerve damage could be a piece to the conclusion of total disability. Thus, the
19 Court turns Jump’s cognitive deficiencies to determine whether, in part with her
20 spinal nerve damage or even without it, she is disabled.

21 **5. Cognitive Deficiencies**

22 **a. Jump’s Vision**

23 Unum argues that Jump fails to prove she is disabled, even in part, by
24 vision problems. [Dkt. 42, at 19:5–20:21]. The Court agrees.

25 _____
26
27
28 ¹ Smitha Bhandari, M.D., *What Is a Neuropsychologist?*, WEBMD (June 24, 2024), <https://www.webmd.com/mental-health/what-is-a-neuropsychologist>

1 Jump first presented to Dr. Janiuk in October 2020, reporting that she
2 experienced blurred vision in both eyes since the MVA, in moderate severity.
3 [Dkt. 32-3, at 58]. Jump also complained about blurred vision to Drs. Purcell
4 and Tantuwaya. [Dkt. 32-1, at 431, 433, 468, 470]. In her declaration in
5 support of her LTD claim, Jump mentions that she has “vision difficulties due to
6 eye pain, eye redness, and blurry/double vision; daily migraines with constant
7 pain; and memory deficits, with difficulty with forgetfulness.” [Dkt. 32-3, at
8 396].

9 Unum highlights, among other things, that Dr. Janiuk’s July 2021 VEP
10 report reflects that Jump’s vision was 20/20 in each eye and that her visual field
11 test results were normal. [Dkt. 32-2, at 260]. Unum also points out that Dr.
12 Blumenfeld’s findings refute that Jump’s vision precluded her from working
13 because he noted that: “Visual fields are full to confrontation testing. Extra-
14 ocular movements are full. There is no nystagmus or diplopia [i.e., no double
15 vision]. Pupils are equal and reactive.” [Dkt. 32-3, at 96]. And although Dr.
16 Schweller recorded that Jump had “blurred vision from 3 feet” on April 13,
17 2022, he did not indicate how this was determined. [Dkt. 32-3, at 119].

18 Jump asserts that Unum disregards Dr. Janiuk’s evaluations and opinions.
19 First, Dr. Janiuk’s April 2021 visual sensory motor evaluation found that
20 “[Jump’s Fixations were 87 on the left eye and 99 on the right. Her Regressions
21 were at 10 left eye and 13 on the right eye. Span of Recognition 1.15 on the left
22 and 1.01 on the right. Duration of Fixations were at 0.34 on the left eye and
23 0.30 on the right. Her Reading Rate was 200 words per minute with 80%
24 Comprehension.” [Dkt. 32-1, at 328]. Jump had “difficulty tracking across a
25 page, with a loss of binocular vision 12 times while reading only 100 words.
26 The grade level equivalent of the findings ranges from 2nd grade for duration of
27 fixation to 14th grade for regressions.” [Dkt. 32-1, at 328]. Both saccadic and
28 pursuit movements without comprehension were normal. [Dkt. 32-1, at 328].

1 Dr. Janiuk concluded that Jump’s recovery of clear, single vision was poor once
2 coordination was lost and that she experienced slow eye movements (both
3 saccadic and pursuit) and recommended a program of 24 optometric vision
4 therapy sessions. [Dkt. 32-1, at 328]. On February 8, 2022, Dr. Janiuk
5 confirmed that Jump continued (since October 30, 2020) to suffer from
6 “extremely low and inaccurate eye movements. She is unable to track across the
7 page which causes frustration and anxiety.” [Dkt. 32-2, at 203]. He
8 recommended near-odyometric vision therapy and that she should not do any
9 work until there is improved visual function. [Dkt. 32-2, at 203]. On
10 September 18, 2022, after Jump’s completion of the recommended treatment,
11 Dr. Janiuk stated that despite some symptom reduction, Jump was “still unable
12 to maintain her visual concentration for long enough to work effectively.” [Dkt.
13 32-3, at 163].

14 The Court credits Dr. Janiuk’s conclusions. *See Shaw v. Life Ins. Co. of*
15 *N. Am.*, 144 F. Supp. 3d 1114, 1130 (C.D. Cal. 2015) (courts give great weight
16 to those doctors whose specialty relates to the alleged disability). Separately,
17 although Unum’s argument that Dr. Janiuk found Jump to have 20/20 vision is
18 persuasive, the Court is not entirely moved because 20/20 vision does not
19 always mean that one’s eyesight is perfect.² The Court’s analysis does not end
20 with Dr. Janiuk.

21 Importantly, Jump did not report vision difficulties when evaluated by
22 several other physicians, who specifically examined and/or asked about her
23 eyes. [Dkt. 32-1, at 488; 32-3, at 96, 147, 148, 228–52]. And the record does
24 not contain a clear explanation as to Jump’s subjective inconsistencies to her
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28 ² *See Whitney Seltman, O.D., What Is Acuity of Vision?*, WEBMD (July 10, 2023), <https://www.webmd.com/eye-health/what-is-acuity-of-vision>.

1 other providers. Notably, Jump does not address Dr. Blumenfeld’s finding of
2 no blurry vision on June 29, 2022, which is particularly troublesome. *See*
3 *generally* [Dkts. 35, 42]. Moreover, Dr. Schweller’s finding of blurry vision
4 appears to be based solely on Jump’s self-report. Finally, the Court notes that
5 “[f]or functional tests of the visual field, which require a subject to actively
6 respond to a stimulus, lower motivation could reduce reliability because it could
7 adversely affect attention and concentration.”³ Indeed, Dr. Davidson
8 documented Jump’s statement that she does not respect her boss, indicating the
9 possibility of low motivation during her evaluations. [Dkt. 32-1, at 336].

10 Unum further contends that Jump’s visual difficulties are at odds with the
11 fact that she delayed starting vision therapy until October 2021 (after Dr. Janiuk
12 recommended the treatment in April 2021). [Dkt. 39, 23:6–8]. Jump’s delay or
13 failure to comply with Dr. Janiuk’s recommended treatment plan does not
14 necessarily preclude her from demonstrating that she was disabled and entitled
15 to benefits. Rather, her delay or failure to comply is factored into assessing
16 credibility and carries more or less weight depending on her diagnosis and her
17 reasons for failing to follow recommended treatments. *Shaw*, 144 F. Supp. 3d at
18 1133 (collecting cases). Although no explanation as to Jump’s delay is within
19 the record, the Court notes that Jump eventually complied with the
20 recommended treatment and Dr. Janiuk opined that her visual difficulties
21 continued. [Dkt. 32-3, at 163].

22 In summary, the Court finds that Jump has not met her burden of proof
23 that she is visually disabled as the record is conflicting—specifically with regard
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27 ³ Stuart K. Gardiner & Shaban Demirel, *Assessment of Patient Opinions of*
28 *Different Clinical Tests Used in the Management of Glaucoma*, 115
Ophthalmology 2127, [p. 2] (2008).

1 to her subjective complaints and provider documentation finding no vision
2 difficulties. Although Dr. Janiuk’s opinion holds weight, the Court considers
3 Jump’s delay in seeking therapy and possible low motivation on her evaluations.
4 Accordingly, those diagnoses that rely in part or in whole on Jump’s vision
5 deficiencies, such as Dr. Janiuk, for a finding of disability cannot be accredited
6 their full weight unless they separately find that other medical conditions
7 rendered Jump disabled.

8 **b. COVID and Long-Haul Symptoms**

9 Jump first contracted COVID in December 2020. [Dkt. 32-3, at 236].
10 She asserts that she endured multiple COVID infections, [Dkt. 32-3, at 394], but
11 the dates of those other infections are unclear. Jump claims that she continues
12 to have symptoms associated with COVID, including brain fog, cognitive
13 dysfunction, fatigue, runny nose, taste and smell disorder, tinnitus, dizziness,
14 muscle pain and headache pain. [Dkt. 32-2, at 467]. On May 4, 2021, Jump
15 filled out a general intake form for Dr. Moss, and her chief concerns were her
16 long-haul COVID related symptoms. [32-1, at 320]. Dr. Moss attended Jump
17 for long-haul COVID on May 18, 2021, July 28, 2021, and December 22, 2021.
18 [Dkt. 32-1, at 386–91]. Dr. Moss stated that effective March 30, 2021, Jump
19 should have been restricted from “computer work, interact with clients, sitting at
20 desk, lifting.” [Dkt. 32-1, at 388]. However, Dr. Moss told Unum he had “no
21 opinion” as to whether Jump could perform the physical and cognitive
22 requirements of her occupation and deferred to Dr. Davidson. [Dkt. 32-3, 134].

23 Unum and Dr. Winkel point out that Jump’s medical records do not
24 document evaluations for the COVID infections or complications. [Dkt. 42, at
25 1:10–12; Dkt. 32-3, at 494]. Unum argues that Dr. Moss’ treatment records
26 consist only of nondescript documents and the new patient forms completed by
27 Jump in which she self-reported various symptoms. [Dkt. 42, at 16:27–17:2].
28 Additionally, Unum avers that no other physician verified that Jump

1 experienced long-haul COVID symptoms and/or limitations from that condition
2 at any time relevant to her claim for LTD benefits. [Dkt. 42, at 17:6–8].

3 The Court finds that Jump is not disabled solely due to COVID (nor does
4 any provider find otherwise), but that COVID could have exacerbated her other
5 medical conditions. Dr. Channah, in March 2021, noted that Jump possibly had
6 COVID long-haulers syndrome before she met with Dr. Moss. [Dkt. 32-3, at
7 233]. In fact, Dr. Davidson opined that long-haul COVID exacerbated Jump’s
8 TBI. [Dkt. 32-3, at 389]. Moreover, unlike her vision difficulties, the record is
9 consistent that Jump experienced COVID and related long-haul symptoms. For
10 instance, symptoms of brain fog were consistently reported with Dr. Channah,
11 Dr. Eosakul, and Dr. Lee. [Dkt. 32-3, at 14, 69, 75]. While the Court
12 recognizes that a diagnosis of long-haul COVID is inherently based on Jump’s
13 subjective complaints, the record is consistent with Jump’s complaints and her
14 diagnosis by Dr. Moss. Accordingly, the Court will consider Jump’s long-haul
15 COVID in combination with her other cognitive deficiencies and diagnoses.

16 **c. Remaining Cognitive Deficiencies**

17 Drs. Channah, Purcell, Davidson, and Schweller, all concluded that Jump
18 was precluded from performing her occupational duties and lacked the
19 functional capacity to do so. However, the Court finds that the record is not
20 consistent with these diagnoses and therefore—despite Jump’s spinal issues and
21 potential exacerbation by long-haul COVID—she has not shown by a
22 preponderance of the evidence that she is disabled.

23 **i. Dr. Channah**

24 First, Dr. Channah’s primary diagnosis is that Jump’s functional capacity
25 is impacted by TBI, PTSD, long-haul COVID symptoms, insomnia, anxiety,
26 major depressive disorder, neck sprain, and sequela. [Dkt. 32-1, 102]. Those
27 medical conditions restrict/limit Jump’s concentration, memory, anxiety, and
28 ability to read documents without skipping lines. [Dkt. 32-1, 102]. Notably, on

1 February 3, 2022, Dr. Channah signed a form that agreed with Unum’s
2 physicians that Jump was not precluded from working in her sedentary
3 occupation as of September 8, 2021. [Dkt. 32-2, 183–85]. But then, in a
4 contradictory follow-up letter to Unum, Dr. Channah stated that “the disability
5 paper should specify [Jump] is unable to work at all. She is under the care of
6 specialists, requiring ongoing care for chronic conditions, resulting in
7 permanent disability. Please feel free to contact the office with any further
8 questions.” [Dkt. 32-3, at 471].

9 Unum asserts that Dr. Channah primarily monitored Jump’s complaints,
10 treatment by other providers, and her medications. [Dkt. 42, at 9:5–10]. And
11 that neither Dr. Channah, nor any other physician, ordered or advised Jump to
12 stop working; instead, she unilaterally chose to stop working when she
13 presented to Dr. Channah on March 19, 2021. [Dkt. 42, at 9:11–14]. Unum
14 also argues that Dr. Channah’s records lack any indication that he independently
15 verified Jump’s purported TBI or administered any tests to confirm the TBI and
16 concussion diagnoses. [Dkt. 42, at 9:15–17]. Further, Unum highlights that Dr.
17 Channah’s notes do not note any cognitive impairments demonstrated by Jump
18 after the MVA (including impaired attention or focus, speech or word-finding
19 difficulties, memory difficulties, etc.). [Dkt. 42, at 9:22–10:2].

20 The Court agrees with Unum that Dr. Channah’s diagnoses is mainly
21 based on subjective complaints and monitoring of Jump’s treatment by other
22 providers. But the Court will not completely dispose of Dr. Channah’s
23 conclusion as treating physicians “have an obligation to record the symptoms
24 complained of by their patients” and “are more or less required to accept the
25 representations of their patients.” *Seleine v. Fluor Corp. Long-Term Disability*
26 *Plan*, 598 F. Supp. 2d 1090, 1102 (C.D. Cal. 2009), *aff’d* 409 Fed. App’x 99
27 (9th Cir. 2010). That said, Dr. Channah’s notes may serve as corroborative
28 evidence to other provider opinions discussed in further detail below.

1 Similarly, although he concluded that Jump has TBI, Dr. Purcell did not record
2 any neurological problems in five post-COVID interactions with Jump (besides
3 those reported by her) even though his exam findings template the following
4 categories: “Intact recent & remote memory”; “Normal attention
5 span/concentrate”; “Normal language functions”; “Normal fund of knowledge,”
6 and; “No neglect or inattention.” [Dkt. 32-1, at 434]. Instead, for each visit, he
7 summarized the neurologic findings as follows: “Patient appears lucid and
8 appropriate on exam.” [Dkt. 32-1, 426, 430, 432, 434; Dkt. 32-3, at 214]. On
9 June 29, 2022, Dr. Blumenfeld’s mental status exam found that Jump was alert
10 with normal attention and her “[c]ognitive function shows adequate recent and
11 remote recall as well as attention span.” [Dkt. 32-3, at 95–96]. Again, although
12 Jump’s medical providers “are more or less required to accept the
13 representations of their patients,” *Seleine*, 598 F. Supp. 2d at 1102, the Court
14 questions why such symptoms were not documented by Jump’s medical
15 providers individually, aside from the mere subjective complaints.

16 Next, Unum highlights that Drs. Tantuwaya and Purcell, both found that
17 MRI scans of Jump’s brain to be overall normal appearing. Dr. Purcell’s review
18 of Jump’s October 2021 MRI was “Unremarkable.” [Dkt. 32-1, at 427, 431,
19 433]. Dr. Tantuwaya, who concluded that Jump suffers from post-concussional
20 syndrome and post-traumatic headaches, reviewed the April 2020 MRI scan and
21 did not detect any focal or lateralizing neurological deficits. [Dkt. 32-1, at 474].
22 Indeed, the MRI scan of the brain was overall normal-appearing and showed no
23 clear evidence of structural brain injury. [Dkt. 32-1, at 449–50, 474]. In
24 contrast, Dr. Grewal, who concluded that Jump suffers from TBI, post-
25 concussional syndrome, and post-traumatic headaches, reviewed the April 2020
26 MRI scan and found that Jump “has history and imaging consistent with the
27 diagnosis of traumatic brain injury.” [Dkt 32-3, at 148–49]. Although Unum’s
28 argument is appealing, the mere fact that Jump’s MRI scans appeared normal

1 does not dispose the findings of TBI, post-concussion syndrome, and post-
2 traumatic headaches.⁴ However, the Court does not find the diagnoses of TBI,
3 post-concussion syndrome, and post-traumatic headaches to be particularly
4 reliable given the number of inconsistencies throughout the administrative
5 record pertaining to Jump’s symptoms. Thus, Jump has not met her burden of
6 proof.

7 **iii. Credibility of Unum’s Medical Consultant’s**

8 Unum’s medical consultants, Drs. Belanger, Chilungu, and Winkel, never
9 conducted an in-person examination. Because the opinions of Unum’s medical
10 consultants are not based on personal knowledge and observations, but rather on
11 a review of paper records, and thus the Court did not accord the same weight as
12 the opinions of Jump’s treating physicians. *See generally* [Dkt. 32]; *see also*
13 *Salomaa v. Honda Long Term Disability Plan*, 642 F.3d 666, 676 (9th Cir.
14 2011) (finding medical opinions rendered following in-person examination
15 more persuasive than contrary opinions from an administrator’s paper-only
16 review); *Backman v. Unum Life Ins. Co. of Am.*, 191 F.Supp.3d 1053, 1066
17 (N.D. Cal. 2016) (“[C]ourts generally give greater weight to doctors who have
18 actually examined the claimant versus those who only review the file, especially
19 when they are employed by the insurer.”). Although the Court did not lean on
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27 ⁴ A. Leum Lee, *Advanced Brain Imaging in Traumatic Brain Injury: Helping Us*
28 *Understand What We Do Not Know or What We Are Missing*, 16 KOREAN J. OF
NEUROTRAUMA 1 (2020).

1 Unum’s medical consultant for their ultimate diagnoses, the opinions were
2 helpful to spot important inconsistencies in the administrative record.

3 **IV. CONCLUSION**

4 Jump has not provided evidence showing it is more likely than not that
5 she was disabled during the entire elimination period from her occupation under
6 the terms of the Policy. Although Jump’s subjective evidence, including reports
7 by Drs. Channah, Purcell, Davidson, Schweller, and Janiuk, concluded that she
8 was disabled and could not return to work, the record is conflicting with regard
9 to Jump’s symptoms and her medical provider’s objective findings.

10 Accordingly, the Court concludes that Jump has not met her burden by a
11 preponderance of the evidence.

12 As such, the Court hereby **GRANTS** Unum’s motion for judgment as a
13 matter of law [Dkts. 37 and 39] and **DENIES** Jump’s motion for judgment as a
14 matter of law [Dkt. 35].

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16 **IT IS SO ORDERED.**

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18 Dated: December 6, 2024



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20 SUNSHINE S. SYKES
21 United States District Judge
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