

**IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION**

LIBERTY CORPORATE CAPITAL LTD.,)	
and AMTRUST AT LLOYD’S LTD.,)	
)	
Plaintiffs,)	Case No. 4:16-cv-816
)	
v.)	
)	
ROCHELLE G. CATUS,)	
)	
Defendant.)	

COMPLAINT FOR DECLARATORY JUDGMENT

COME NOW, Liberty Corporate Capital Limited and AmTrust at Lloyd’s Limited (collectively, “Plaintiffs” or “Underwriters”) subscribing to Individual Insurance Certificate No. 13396V13149A-003 (the “Policy”) and file their Complaint for Declaratory Judgment against Rochelle G. Catus (“Dr. Catus” or the “Insured”) seeking a declaration of non-coverage as described herein. In support thereof, Underwriters allege as follows:

JURISDICTION AND VENUE

1. Policy No. 13396V13149A-003 provides certain coverage to Dr. Catus, subject to the Policy’s terms, conditions, limitations, and exclusions, for the period August 15, 2013, through August 14, 2018. A true and correct copy of the Policy is attached hereto as Exhibit “A.”

2. Liberty Corporate Capital Limited (“Liberty”) is a corporation organized and existing under the laws of England and Wales with its principal place of business at 20 Fenchurch Street, London, United Kingdom EC3M 3AW. For the purposes of diversity, Liberty is a citizen of the United Kingdom.

3. AmTrust at Lloyd’s Limited (“AmTrust”) is a corporation organized and existing under the laws of England and Wales with its principal place of business at 1 Great Tower Street,

London, United Kingdom EC3R 5AA. For purposes of diversity, AmTrust is a citizen of the United Kingdom.

4. Defendant Catus is a citizen of Missouri, and may be served with process at her place of residence, located at 57 Frontenac Estates, Frontenac, Missouri 63131.

5. The Court has personal jurisdiction over Defendant because Defendant has sufficient minimum contacts with the state of Missouri.

6. The Court has subject matter jurisdiction over each of the claims on diversity grounds. Pursuant to 28 U.S.C. § 1332, the Court has jurisdiction based on diversity of citizenship because Underwriters are diverse from Defendant and the amount in controversy exceeds \$75,000.00.

7. Venue is proper pursuant to 28 U.S.C. § 1391 because Defendant resides in this district.

8. This action is brought pursuant to 28 U.S.C. § 2201 and seeks declaratory relief as to Underwriters' obligations under the policy of insurance issued to Rochelle G. Catus for the policy period August 15, 2013 to August 14, 2018.

9. Underwriters are uncertain as to their duties, rights, and obligations and file this declaratory judgment action to resolve questions of coverage under the insurance policy. An actual and justiciable dispute over those duties, rights, and obligations exists between the parties.

BACKGROUND FACTS

10. Underwriters repeat and reallege each of the foregoing paragraphs as if fully set forth herein.

11. Prior to her disability, the Insured worked as a self-employed OB/GYN who saw obstetrics patients for the first six months of pregnancy and performed certain gynecological surgeries and/or procedures. She has since closed her practice.

12. In the early 1990s, twenty years before she applied for permanent and total disability insurance, the Insured experienced tingling in her hands and feet and urinary incontinence.

13. On June 13, 2013, one month before applying for disability insurance, the Insured saw Dr. Sherry Ma, a neurologist, for the specific symptoms of tingling in her hands and feet; urinary incontinence; tingling and numbness in her chest and abdomen; trouble walking; and neck and shoulder stiffness.

14. At that appointment with Dr. Ma, the Insured was prescribed Gabapentin, a medication commonly used to treat the symptoms of multiple sclerosis (“MS”).

15. On June 18, 2013, 24 days before applying for the Policy, the Insured underwent an MRI of her cervical spine.

16. On June 26, 2013, 16 days before applying for the Policy, the Insured underwent an MRI of her brain, which noted brain abnormalities, including white matter lesions suggestive of demyelinating disease.

17. Dr. Ma’s records from June 26, 2013 state, “demyelinating disease is a serious consideration in this patient.” MS is the most common form of demyelinating disease.

18. On July 12, 2013, the Insured applied for permanent and total disability insurance. A true and correct copy of the Application for Permanent and Total Disability Insurance is attached hereto as Exhibit “B.”

19. The very next day, on July 13, 2013, the Insured again saw Dr. Ma, and they went over the results of her MRIs.

20. At this appointment, the Insured recalled to Dr. Ma tingling of her hands and feet and urinary incontinence in the early 1990's. Dr. Ma believed these may have been the Insured's first symptoms of MS.

21. On August 15, 2013, the Policy went into effect. Exhibit A.

22. The Insured was officially diagnosed with MS on December 4, 2013.

23. On or about April 30, 2015, Hanleigh Management, Inc. ("Hanleigh") received a Proof of Loss statement signed by the Insured, dated April 10, 2015. A true and correct copy of the Proof of Loss is attached hereto as Exhibit "C."

24. The Proof of Loss states that the Insured became permanently and totally disabled on October 15, 2014 due to MS.

25. Attached to the Proof of Loss was neurologist Barbara Green's attending physician's statement. According to Dr. Green's statement, she first consulted with the Insured for the Insured's MS on December 14, 2013.

26. Dr. Green's statement states that the Insured's symptoms first appeared in 1991 or 1992, dissipated for nearly twenty years, then reappeared in October 2013.

27. Dr. Green's statement also shows that the Insured apparently met the criteria for diagnosis of MS in September 2013, approximately one month after the inception of the Policy.

28. According to Dr. Green, the Insured became permanently and totally disabled on approximately September 30, 2014.

29. Following receipt of the Proof of Loss, Hanleigh retained claims adjuster George Rodolakis (“Mr. Rodolakis”) to investigate the Insured’s claim.

30. The Insured provided Mr. Rodolakis with certain of her medical records to verify her diagnosis of MS and her subsequent disability.

31. These medical records confirm the allegations contained in Paragraphs 11, 12, 13, 14, 15, 16, 18, 19, and 21, above. This information was not known to Underwriters at the time the Policy was underwritten, and it was not disclosed by the Insured.

32. On January 5, 2016, following the investigation of the Insured’s claim and review of her provided medical records, Underwriters denied the claim. A true and correct copy of the January 5, 2016 denial letter is attached hereto as Exhibit “D.”

33. On or around January 20, 2016, the Insured requested an informal review of her claim.

34. On January 29, 2016, Mr. Rodolakis had a telephone call with the Insured and her attorney. On that call, the Insured stated that in July 2014, she began experiencing cognitive function problems, and was subsequently diagnosed with cognitive dysfunction. She states that she has not specifically treated for this condition.

35. On February 11, 2016, Mr. Rodolakis again spoke to the Insured and her attorney about her claim. Following this call, at the Insured’s request, Mr. Rodolakis presented the Insured’s appeal of her denial to the claims committee.

36. On March 17, 2016, following the appeal, a second denial letter was issued to the Insured. A true and correct copy of the March 17, 2016 denial letter is attached hereto as Exhibit “E.”

37. On March 29, 2016, following receipt of the second denial letter, the Insured's counsel sent Mr. Rodolakis a letter requesting a formal review of the denials of the Insured's claim.

THE INSURING AGREEMENT

38. Underwriters subscribed to Policy No. 13396V13149A-003 for the period of August 15, 2013 through August 14, 2018. Exhibit A.

39. The Policy contains a choice of law provision which states that "[t]he Certificate is governed by the laws of the state of the Owner as listed on the schedule page." Policy, p. 1 of 10.

40. The Policy provides coverage to the Insured for permanent and total disability, subject to the Policy's terms, conditions, exclusions, and endorsements. If coverage exists, the Policy provides a \$1,500,000 lump-sum benefit for qualifying permanent and total disability. Policy, p. 3 of 10.

41. The Policy states that for coverage to be triggered, there must be a "loss due to Injury and/or Sickness." Policy, p. 1 of 10.

42. The Policy defines "Sickness" in two ways:

Sickness means any sickness, illness or disease that: (1)(a) is diagnosed or treated by a Physician while this Certificate is in force; and (b) is not a Pre-Existing condition as defined above; or (2) is a Pre-existing Condition but: (a) is declared on the Application for this certificate; and (b) is not excluded from coverage by name or specific description.

Policy, p. 7 of 10.

43. The Policy defines "Pre-Existing Condition" as follows:

PRE-EXISTING CONDITION means a sickness or accidental injury for which you:

- Received medical treatment, consultation, care or services;

- Took prescription medication or had medication prescribed; or
- Had symptoms or conditions that would cause a reasonably prudent person to seek diagnosis, care or treatment in the 12 months before your insurance or any increase in the amount of insurance under this certificate takes effect.

Policy, p. 7 of 10.

44. Disability due to Sickness must result from a Sickness that manifests itself during the Policy period. Policy, p. 1 of 10.

45. The Sickness must cause total disability to commence within one year of a covered Sickness. Policy, p. 1 of 10.

46. The Policy defines “Permanently and Totally Disabled” as follows:

Permanently and Totally Disabled means, as a result of a covered Injury or Sickness, the Insured is totally unable to perform the substantial and material duties of his or her regular occupation as shown on the Schedule for the entire Elimination Period and is not expected to recover for the remainder of his or her life. The Insured must also be under the regular care of a physician that is appropriate for the condition causing the disability.

Policy, Benefit Coverage Insert, p. 1 of 1.

47. The Policy contains a Pre-Existing Condition Limitation, which states,

Pre-Existing Condition Limitation

This Certificate does not provide benefits for a loss due to a Pre-Existing Condition as defined in the Certificate unless: (1) the loss begins more than 1 year after the Effective Date Shown in the Schedule; or (2) We have underwritten and agree to cover such condition.

We will not pay benefits, or increase in benefit amount due to an elected increase in the amount of your insurance for a disability that results from a Pre-existing condition, if you have been actively at work for less than 12 consecutive months after the date your Disability insurance or the elected increase in the amount of such insurance takes effect under this certificate.

Policy, p. 1 of 10.

48. The Policy also contains an endorsement, Rider #1, which sets forth the following conditions:

In event of a claim against this policy it will be necessary for the insured person to show that he/she has satisfied the underwriting eligibility requirements which are the following:

1. For a period of time commencing 180 days prior to risk attaching under this policy the insured person has been continuously at work on a full-time basis (30 or more hours per week) in the usual and customary manner performing the duties of his/her occupation and has not been homebound or admitted to a medical facility due to injury or sickness;
2. The insured person is not suffering from a pre-existing condition as defined in the policy (unless specifically approved and accepted by underwriters);
3. The insured person has not been in receipt of any form of disability benefit in the period of five (5) years preceding the date risk attached under this policy.

Rider, p. 1 of 1.

CAUSES OF ACTION

COUNT I – DECLARATORY JUDGMENT

**THE INSURED’S MS IS A PRE-EXISTING CONDITION
NOT COVERED BY THE POLICY**

49. Underwriters repeat and reallege each of the foregoing paragraphs as if fully set forth herein.

50. The Insured’s MS is a Pre-Existing Condition under the Policy because it meets all three alternative bases of the Policy’s definition of a Pre-Existing Condition, as stated below:

PRE-EXISTING CONDITION means a sickness or accidental injury for which you:

- Received medical treatment, consultation, care or services;
- Took prescription medication or had medication prescribed;
or

- Had symptoms or conditions that would cause a reasonably prudent person to seek diagnosis, care or treatment in the 12 months before your insurance or any increase in the amount of insurance under this certificate takes effect.

Policy, p. 7 of 10.

51. First, prior to the Policy going into effect, the Insured received medical treatment, consultation, care or services for her MS.

52. As early as 1991 or 1992, the Insured sought medical attention for certain symptoms, indicative of MS, including tingling in hands and feet and an overactive bladder.

53. On June 13, 2003, the Insured saw Dr. Sherry Ma, a neurologist, for ongoing symptoms including tingling in her hands and feet, urinary incontinence, tingling and numbness in her chest and abdomen, trouble walking, and neck and shoulder stiffness.

54. On June 18, 2013, at her neurologist's direction, the Insured underwent an MRI of her cervical spine. On June 26, 2013, again at her neurologist's direction, the Insured underwent an MRI of her brain.

55. The Insured's June 13, 2003 appointment with Dr. Ma, the Insured's cervical spine MRI, and the Insured's brain MRI all constitute medical consultation, care, and/or services for the Insured's MS.

56. The Insured therefore received medical treatment, consultation, care or services for her MS, satisfying the first of three independent bases under the Policy for having a pre-existing condition.

57. Second, prior to the Policy going into effect, the Insured was prescribed or took medication for her MS.

58. On or around June 13, 2003, Dr. Ma prescribed Gabapentin to the Insured to treat her sensory symptoms.

59. The Insured therefore was prescribed, or took, medication for her MS, satisfying the second of three independent bases under the Policy for having a pre-existing condition.

60. Third, in the 12 months before the Policy went into effect, the Insured had symptoms or conditions that would cause a reasonably prudent person to seek diagnosis, care or treatment.

61. In the 12 months before the Policy went into effect, the Insured complained of the following symptoms: tingling in her hands and feet, urinary incontinence, tingling and numbness in her chest and abdomen, trouble walking, and neck and shoulder stiffness.

62. The symptoms described above are symptoms or conditions that would cause a reasonably prudent person to seek medical care or treatment. Indeed, these symptoms did cause the Insured to seek treatment with Dr. Ma on June 13, 2013, two months before the Policy went into effect.

63. The Insured's symptoms or conditions therefore satisfy the third of the three independent bases under the Policy for having a pre-existing condition.

64. Underwriters are thus entitled to a declaration that the Insured's MS is a Pre-Existing Condition under the Policy under any or all of the Policy's three independent bases for defining a Pre-Existing condition.

COUNT II – DECLARATORY JUDGMENT

THERE IS NO LOSS DUE TO INJURY OR SICKNESS
UNDER THE POLICY

65. Underwriters repeat and reallege each of the foregoing paragraphs as if fully set forth herein.

66. Under the Policy, to trigger coverage, there must be a “loss due to Injury and/or Sickness.” Policy, p. 1 of 10. The Insured’s disability is not a loss due to Injury and/or Sickness according to the Policy’s terms.

67. The Policy defines “Sickness” in two ways:

Sickness means any sickness, illness or disease that: (1)(a) is diagnosed or treated by a Physician while this Certificate is in force; and (b) is not a Pre-Existing condition as defined above; or (2) is a Pre-existing Condition but: (a) is declared on the Application for this certificate; and (b) is not excluded from coverage by name or specific description.

Policy, p. 7 of 10.

68. The Insured’s MS is not a “Sickness” under either of these definitions.

69. First, a “Sickness” is a sickness, illness or disease that (a) is diagnosed or treated by a Physician while this Certificate is in force; and (b) is not a Pre-Existing condition as defined by the Policy. Policy, p. 7 of 10.

70. The Insured was diagnosed with MS by her physician and began treatment for her MS on December 4, 2013, which is during the Policy period.

71. The Insured’s MS, however, is a Pre-Existing Condition, as established in Count I, under any of the Policy’s three independent definitions of a “Pre-Existing Condition.”

72. The Insured’s MS therefore is not a “Sickness” under the first definition because although it is a disease that was formally diagnosed or treated by a physician during the Policy period, it also is a Pre-Existing Condition under the Policy.

73. Second, a “Sickness” is a Pre-Existing Condition that: (a) is declared on the Application for this certificate; and (b) is not excluded from coverage by name or specific description. Policy, p. 7 of 10.

74. The Insured’s MS is a Pre-Existing Condition, as established in Count I.

75. The Insured did not declare her MS on her Application for insurance. Exhibit B.

76. As the Insured did not declare her Pre-Existing Condition on her Application, her MS is not a “Sickness” under the second definition of “Sickness” as provided by the Policy.

77. As the Insured’s MS is not a “Sickness” under the Policy, there can be no loss due to Sickness, as required by the Policy for coverage.

78. Underwriters are thus entitled to a declaration that no coverage exists for the Insured’s claim because no loss due to Injury or Sickness occurred under the Policy.

COUNT III – DECLARATORY JUDGMENT

THE PRE-EXISTING CONDITION LIMITATION BARS COVERAGE

79. Underwriters repeat and reallege each of the foregoing paragraphs as if fully set forth herein.

80. The Policy’s Pre-Existing Condition Limitation places certain additional limitations on coverage for a loss due to a pre-existing condition.

81. As the Insured has a Pre-Existing Condition, the Policy only provides coverage in two situations: (1) if the loss begins more than one year after the Policy’s effective date; or (2) if the Underwriters agreed to cover the Pre-Existing Condition. Policy, p. 1 of 10.

82. The Policy does not provide coverage for the Insured’s disability as the Insured’s loss does not satisfy the Pre-Existing Condition Limitation’s requirements.

83. To be covered, the Insured’s loss must have begun “more than 1 year after the Effective Date shown in the Schedule.” Policy, p. 1 of 10. The Policy’s effective date is August 15, 2013. Therefore, the Insured’s loss must have begun *after* August 15, 2014.

84. The Insured’s loss, in fact, actually began *before* August 15, 2014.

85. The following symptoms or events happened prior to August 15, 2014: (1) the Insured experienced tingling in her hands and feet, urinary incontinence, trouble walking, and neck and shoulder stiffness; (2) the MRI of her brain noted abnormalities suggestive of

demyelinating disease; (3) the Insured was officially diagnosed with MS; (4) the Insured began treatment for her MS; and (5) the Insured noted cognitive issues that made it impossible for her to keep up with job as a doctor.

86. These events demonstrate that the Insured's loss began prior to August 15, 2014, and, therefore, the Insured does not satisfy the provisions of the Pre-Existing Condition Limitation.

87. Underwriters are thus entitled to a declaration that no coverage exists for the Insured's claim as the Pre-Existing Condition Limitation precludes coverage because the Insured's loss began more than one year after the Policy's effective date.

COUNT IV – DECLARATORY JUDGMENT

RIDER #1 BARS COVERAGE FOR THE INSURED'S CLAIM

88. Underwriters repeat and reallege each of the foregoing paragraphs as if fully set forth herein.

89. The Policy's endorsement, Rider #1, sets forth additional conditions for coverage.

Rider #1 states:

In event of a claim against this policy it will be necessary for the insured person to show that he/she has satisfied the underwriting eligibility requirements which are the following:

1. For a period of time commencing 180 days prior to risk attaching under this policy the insured person has been continuously at work on a full-time basis (30 or more hours per week) in the usual and customary manner performing the duties of his/her occupation and has not been homebound or admitted to a medical facility due to injury or sickness;
2. The insured person is not suffering from a pre-existing condition as defined in the policy (unless specifically approved and accepted by underwriters);
3. The insured person has not been in receipt of any form of disability benefit in the period of five (5) years preceding the date risk attached under this policy.

Rider, p. 1 of 1.

90. Underwriters do not dispute that the Insured satisfies requirements #1 and #3, above.

91. Coverage is barred for the Insured's claim under Rider #1, however, because the Insured does not comply with the endorsement's second requirement.

92. The existence of a non-disclosed Pre-Existing Condition bars coverage under requirement #2, above.

93. The Insured's MS is a non-disclosed Pre-Existing Condition.

94. The Insured did not disclose her Pre-Existing Condition, and so Underwriters did not have the opportunity to approve or accept her Pre-Existing Condition prior to subscribing to the Policy.

95. The Insured therefore does not comply with Rider #1, as she has a pre-existing condition that was not specifically approved or accepted by Underwriters.

96. Underwriters are thus entitled to a declaration that no coverage exists for the Insured's claim as the Insured's Pre-Existing Condition was not disclosed to Underwriters, and therefore was never specifically approved or accepted by Underwriters, and, as such, does not comply with Rider #1.

COUNT V – DECLARATORY JUDGMENT

THE INSURED'S MS DID NOT MANIFEST ITSELF WHILE THE POLICY IS IN FORCE AND HER TOTAL DISABILITY DID NOT COMMENCE WITHIN 1 YEAR OF A COVERED SICKNESS

97. Underwriters repeat and reallege each of the foregoing paragraphs as if fully set forth herein.

98. The Policy requires that “[d]isability due to Sickness must result from a Sickness that manifests itself while the Certificate is in force and causes Total Disability to commence within 365 days of a covered Sickness.” Policy, p. 1 of 10.

99. First, the Insured’s Sickness did not manifest itself during the Policy period as the Insured exhibited multiple symptoms of MS and received medical care or services for her MS prior to the Policy’s August 15, 2013 inception.

100. Second, the Insured’s Total Disability did not commence within 365 days of a covered Sickness.

101. The Insured’s MS is not a covered Sickness, precluding coverage under the Policy.

102. Even if the Insured’s MS is a covered Sickness, the Insured’s Total Disability commenced *after* 365 days of her covered Sickness.

103. The Insured states in her Proof of Loss that her illness began in October 2013. Exhibit C. Underwriters dispute that the Insured’s illness began this late, as she received significant medical care or services for her MS as early as June 2013.

104. The Insured states that she became totally and permanently disabled on October 15, 2014. Exhibit C.

105. Even if the Insured’s illness began in October 2013, the Insured’s permanent and total disability did not commence within 365 days of her illness.

106. Therefore, the Insured’s Total Disability does not commence within 365 of a covered Sickness.

107. Underwriters are thus entitled to a declaration that no coverage exists for the Insured's claim as the Insured's MS did not manifest itself while the Certificate is in force and her Total Disability did not commence within 365 days of a covered Sickness.

WHEREFORE, Plaintiffs pray for:

- (1) The Court to declare that Dr. Catus's MS is a Pre-Existing Condition under the Policy;
- (2) The Court to declare that no coverage exists for Dr. Catus' claim as there is no loss due to Injury and/or Sickness under the Policy;
- (3) The Court to declare that no coverage exists for Dr. Catus' claim as the Policy's Pre-Existing Condition Limitation precludes coverage;
- (4) The Court to declare that no coverage exists for Dr. Catus' claim as the Policy's Rider #1 precludes coverage;
- (5) The Court to declare that no coverage exists for Dr. Catus' claim as her MS did not manifest itself while the Policy is in force and her total disability did not commence within one year of a covered sickness;
- (6) The Court to enter judgment in Underwriters' favor and against Dr. Catus on any and all grounds set forth in this Complaint;
- (7) Plaintiffs recover their costs; and
- (8) Such other relief as the Court deems just.

Respectfully submitted,

/s/ Bradley R. Hansmann

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Attorneys for Plaintiffs

#13008272

Exhibit “A”



Individual Insurance Certificate

Certificate Number: 13396V13149A-003

Insured's Name: Rochelle G Catus

Owner's Name: Rochelle G Catus

Effective Date: August 15, 2013

Signed by Hanleigh Management, Inc., Lloyd's Correspondent

A handwritten signature in black ink, appearing to read "Graham Southall", written over a horizontal line.

Graham Southall, Lead Underwriter

LLOYD'S

Individual Insurance Certificate

This Certificate is attached to and forms part of certificate provisions (Form SLC-3 USA).

This is a legal contract between the Underwriters (We, Our, or Us), and the Owner (You or Your). This Certificate is issued in consideration of the attached Schedule, Application and other attached papers and the payment of the required Premium due.

WHAT THIS CERTIFICATE PROVIDES

This Certificate provides Individual Disability Insurance coverage for loss due to Injury and/or Sickness. We will pay the benefits shown on the Benefit Schedule to the Beneficiary named in the Benefit Schedule after We receive satisfactory proof that the Insured has sustained a covered loss. Disability due to Sickness must result from a Sickness that manifests itself while the Certificate is in force and causes Total Disability to commence within 365 days of a covered Sickness. Disability due to Injury must result from an injury which occurs while this Certificate is in force and causes Total Disability to begin within 365 days of a covered Accident. No dividends are payable. This insurance is subject to the terms, conditions, and limitations of this Certificate. Your applicable coverage is shown on the attached Schedule. Read Your Certificate carefully.

RENEWAL PROVISION

This Certificate is not renewable. The Certificate is in force for the full Term for which the Premium has been paid, subject to Our limited right to terminate coverage as set forth in the provision entitled "When Your Coverage Ends".

10 DAY RIGHT TO EXAMINE CERTIFICATE

This Certificate can be returned for any reason within ten (10) days after You receive it. You can return the Certificate by mail or in person to Us or to the agent who sold it. We will refund any Premium paid and treat the Certificate as if it were never issued.

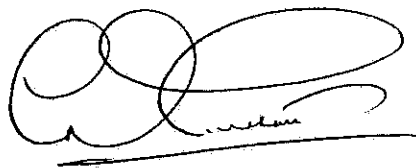
PRE-EXISTING CONDITION LIMITATION

This Certificate does not provide benefits for a loss due to a Pre-Existing Condition as defined in the Certificate unless: (1) the loss begins more than 1 year after the Effective Date Shown in the Schedule; or (2) We have underwritten and agreed to cover such condition.

The Certificate is governed by the laws of the state of the Owner as listed on the schedule page.

Signed by Hanleigh Management, Inc., Lloyd's Correspondent

Hanleigh Management, Inc.
50 Tice Blvd. – Suite 122
Woodcliff Lake, New Jersey 07677



Graham Southall, Lead Underwriter

THIS CERTIFICATE IS NON-RENEWABLE. PLEASE READ THE CERTIFICATE CAREFULLY.

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SCHEDULE

The data entered below is subject to the applicable Provisions of the Certificate in accordance with the Benefit Coverage provided.

Certificate:	13396V13149A-003	Premium Mode:	Annual
Term:	Five Years Less One Day	Termination Date:	August 14, 2018
Effective Date:	August 15, 2013		
Name of Insured:	Rochelle G Catus	Occupation:	Physician - OBGYN
Name of Owner:	Rochelle G Catus	Name of Beneficiary:	Same as Insured
Address:	C/O Missouri Professionals Mutual (MPM) 287 N. Lindbergh Blvd.		
City, State and Zip:	Saint Louis, MO 63141		

BENEFIT SCHEDULE

Coverage is provided for the following benefits. If no coverage is provided, the word "No" will be checked, and "NIL" will appear in the appropriate space.

Total Disability for Accident & Sickness Benefit: Yes No

GSI Monthly Benefit	NIL	This is evidence of insurance procured and developed under the Missouri Surplus Lines Laws. It is NOT covered by the Missouri Insurance Guaranty Association. This insurer is not licensed by the state of Missouri and is not subject to its supervision.
Excess Monthly Benefit	NIL	
Benefit Period	NIL	
Elimination Period	NIL	
Term of Insurance	NIL	
		Name of Licensee: Philip Stephen Hagan

Residual Disability Benefit: Yes No
(only available if Total Disability Benefit is selected)

Permanent Total Disability for Accident & Sickness Benefit: Yes No

GSI Lump Sum	\$1,500,000
Excess Lump Sum	NIL
Elimination Period	12 Months
Term of Insurance	Five Years Less One Day

Accidental Death Benefit: Yes No

Principal Sum	NIL
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Accidental Death and Dismemberment Benefit: Yes No

Principal Sum	NIL
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Aggregate Limit: \$1,500,000

Exclusions Deleted: Refer to Policy

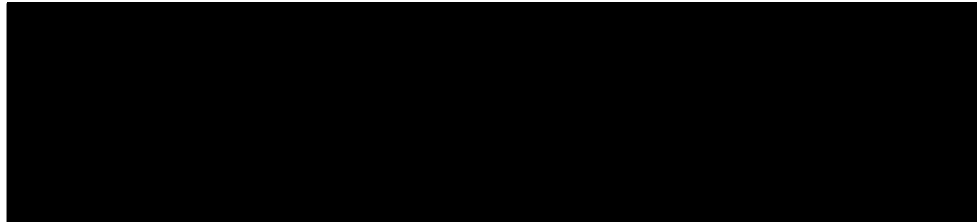
Pre-existing Conditions Covered: Refer to Policy

Forms Attached at Issuance: LL-AH-12994 - (06.13), LL-AH-12978, Rider #1, Security List, LSW1135B, Multi Life Disability Income Insurance Enrollment Form.

PREMIUM SCHEDULE

Due Dates: Aug 15, 2013 Aug 15, 2014 Aug 15, 2015 Aug 15, 2016 Aug 15, 2017

Premium
MO Surplus Lines Tax @ 5%
Certificate Fee
Total
Total Due after MPM's Discount



Surplus Lines Taxes to be filed by Hanleigh, Woodcliff Lake, New Jersey.

PREMIUM PROVISIONS

The following provisions are provided for Annual and Installment premiums only. Premium must be paid on or before the Premium Due Dates shown above, and are not subject to change.

Grace Period: After the first Premium is paid, We will allow a Grace Period of 31 days for the payment of each subsequent Premium amount due. During the Grace Period this Certificate will stay in force.

Unpaid Premium: Upon the payment of a claim under this Certificate, any Premium due and unpaid will be deducted from such benefit payment.

Waiver of Premium: In the event the Insured qualifies for benefits under this policy, any premium installments due while the Insured is disabled and receiving benefits will be waived. Furthermore, if the Insured qualifies for benefits under this policy and subsequently returns to his or her occupation, any premium installments which are due within the ninety (90) day period following the Insured's return to his or her occupation will also be waived. Any premium installments which are due after the Insured has returned to his or her occupation for ninety (90) days will be due and payable.

SECURITY

Security: Insurance is effective with Certain Underwriters at Lloyd's of London (See attached security allocation)

Several Liability Notice (LL-LSW1001 Insurance): The subscribing insurers' obligations under contracts of insurance to which they subscribe are several and not joint and are limited solely to the extent of their individual subscriptions. The subscribing insurers are not responsible for the subscription of any co-subscribing insurer who for any reason does not satisfy all or part of its obligations.

Applicable Law (USA) (LMA5021): This Insurance shall be subject to the applicable state law to be determined by the court of competent jurisdiction as determined by the provisions of the Service of Suit Clause (U.S.A.).

SERVICE OF SUIT (LL-LMA5020)

This Service of Suit Clause will not be read to conflict with or override the obligations of the parties to arbitrate their disputes as provided for in any Arbitration provision within this Policy. This Clause is intended as an aid to compelling arbitration or enforcing such arbitration or arbitral award, not as an alternative to such Arbitration provision for resolving disputes arising out of this contract of insurance (or reinsurance).

It is agreed that in the event of the failure of the Underwriters hereon to pay any amount claimed to be due hereunder, the Underwriters hereon, at the request of the Insured (or Reinsured), will submit to the jurisdiction of a Court of competent jurisdiction within the United States. Nothing in this Clause constitutes or should be understood to constitute a waiver of Underwriters' rights to commence an action in any Court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another Court as permitted by the laws of the United States or of any State in the United States.

It is further agreed that service of process in such suit may be made upon

MENDES & MOUNT
750 Seventh Avenue
New York, New York 10019-6829
U S A

and that in any suit instituted against any one of them upon this contract, Underwriters will abide by the final decision of such Court or of any Appellate Court in the event of an appeal.

The above-named are authorized and directed to accept service of process on behalf of Underwriters in any such suit and/or upon the request of the Insured (or Reinsured) to give a written undertaking to the Insured (or Reinsured) that they will enter a general appearance upon Underwriters' behalf in the event such a suit shall be instituted.

Further, pursuant to any statute of any state, territory or district of the United States which makes provision therefor, Underwriters hereon hereby designate the Superintendent, Commissioner or Director of Insurance or other officer specified for that purpose in the statute, or his successor or successors in office, as their true and lawful attorney upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of the Insured (or Reinsured) or any beneficiary hereunder arising out of this contract of insurance (or reinsurance), and hereby designate the above-named as the person to whom the said officer is authorized to mail such process or a true copy thereof.

WHEN YOUR COVERAGE BEGINS

All periods of insurance begin and end at 12:01 a.m. Local Standard Time, at the Owner's address as last shown on Our records. The Insured's coverage will be in force upon completion of both of the following: (1) Our receipt of the Insured's Premium; and (2) Our approval at Our Administrative Offices of the Insured's signed Application and any other forms or attachments that We request the Insured to sign or that We may require for Our approval. The Effective Date of coverage is shown on the attached Schedule.

WHEN YOUR COVERAGE ENDS

Coverage will end when one of the following occurs: (1) the date the Insured dies; (2) the date the Aggregate Limit, as defined in this Certificate, is reached; (3) the date You request to end coverage; (4) on the Termination Date shown in the Schedule; (5) at the end of the period for which Premium is paid; (6) the date Insured terminates employment {or contract} and (7) the date insurable interest between the Owner and the Insured ceases to exist (if applicable).

PORTABILITY OPTION

At the option of the Insured, protection provided by this policy (certificate) may continue if the insured leaves employment of the owner /plan sponsor provided he/she remains actively employed in their insured profession and continues payment of premium payments for the remainder of the policy period. At the end of the policy period any ongoing coverage will be subject to individual underwriting at terms and conditions applicable to age, health and occupation at that time.

Should the Insured leave service of the owner / plan sponsor and not be immediately actively employed in his /her insured profession, protection provided by this policy (certificate) may be continued for the 90 days immediately following their departure from the owner / plan sponsor upon request by the Insured to Underwriters and upon payment of premiums by the insured for the period of 90 days. Any claim for benefits by the insured while not actively at work in their insured profession are not guaranteed and are subject to Underwriters review and approval.

PREMIUMS/REFUNDS

The Premium due must be paid in full before coverage will start. The Premium due is shown on the Schedule. If the required Premium is not paid, the Certificate will not take effect. Certificates issued greater than 12 months, if the Certificate is terminated before the Termination Date shown on the Schedule, we will provide a refund of any unearned Premium paid, less Certificate Fee. For Certificates issued less than 12 months, premium is fully earned at inception and will not be refunded.

Small Additional or Return Premiums (LL-NMA1168): Notwithstanding anything to the contrary contained herein and in consideration of the premium for which this Insurance is written, it is understood and agreed that whenever an additional or return premium of \$2 or less becomes due from or to the Assured on account of the adjustment of a deposit premium, or of an alteration in coverage or rate during the term or for any other reason, the collection of such premium from the Assured will be waived or the return of such premium to the Assured will not be made, as the case may be.

CANCELLATION (LL-NMA 1331) – Rev 01/21/2013

Notwithstanding anything contained in this Insurance to the contrary this Insurance may be cancelled by the Assured at any time by written notice or by surrendering of this Contract of Insurance. This Insurance may also be cancelled by or on behalf of the Underwriters by delivering to the Assured or by mailing to the Assured, by registered, certified or other first class mail, at the Assured's address as shown in this Insurance, written notice stating when, not less than 10 days thereafter, the cancellation shall be effective. The mailing of notice as aforesaid shall be sufficient proof of notice and this Insurance shall terminate at the date and hour specified in such notice. Notice of Cancellation by the Underwriters shall be given only for non-payment of premium, fraudulent misrepresentation by the Insured, intentional non-disclosure of information which might have caused the Underwriters to impose special terms or the Insured having committed a criminal or felonious act.

If this Insurance shall be cancelled by the Assured the Underwriters shall retain the customary short rate proportion of the premium hereon, except that if this Insurance is on an adjustable basis the Underwriters shall receive the Earned Premium hereon or the customary short rate proportion of any Minimum Premium stipulated herein whichever is the greater.

If this Insurance shall be cancelled by or on behalf of the Underwriters the Underwriters shall retain the pro rata proportion of the premium hereon, except that if this Insurance is on an adjustable basis the Underwriters shall receive the Earned Premium hereon or the pro rata proportion of any Minimum Premium stipulated herein whichever is the greater.

Payment or tender of any Unearned Premium by the Underwriters shall not be a condition precedent to the effectiveness of Cancellation but such payment shall be made as soon as practicable.

If the period of limitation relating to the giving of notice is prohibited or made void by any law controlling the construction thereof, such period shall be deemed to be amended so as to be equal to the minimum period of limitation permitted by such law

TRANSPLANT BENEFIT

If, after the Certificate has been in force for six (6) months, the Insured gives a part of his/her body to another person, the condition will be deemed a Sickness. Disability benefits will be paid in the same way as for any other Sickness.

PRESUMPTIVE DISABILITY

You will be presumed to be totally disabled, if due to accident or sickness while this coverage is in force, you have totally lost: the use of both hands, or both feet, or one hand and one foot, or the sight of both eyes, or the hearing of both ears, or the ability to speak. The Elimination Period will be waived. Regular medical care is not required. The covered monthly benefits will be paid as long as the loss exists, up to the Maximum Benefit Period.

DEFINITIONS

ACCIDENT means a sudden, unexpected event that results in Injury to an Insured. To be covered under the Certificate, an Accident must occur while coverage is in force for an Insured and must result in a loss or Injury covered by the Certificate for which benefits are payable.

AGGREGATE LIMIT means the combined maximum amount of benefits payable under all sections of this Certificate and shall not exceed the Aggregate Limit stated on the schedule.

DEFINITIONS (cont'd)

COMPLICATIONS OF PREGNANCY means: (1) conditions requiring hospital stays (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, and shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and (2) nonelective caesarean section, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy, that occurs during a period of gestation in that a viable birth is not possible.

ELIMINATION PERIOD means the period of time shown on the Schedule during which the Insured must be continuously disabled before benefits may be payable.

IMMEDIATE FAMILY means a person who is related to the Insured in any of the following ways: spouse; brother-in-law; sister-in-law; son-in-law; daughter-in-law; mother-in-law; father-in-law; parent (includes stepparent); brother or sister (includes stepbrother or stepsister); or child (includes legally adopted stepchild).

INJURY means bodily injury. It must be caused by an Accident occurring while the Certificate is in force. It must be a direct result of an Accident, independent of all other causes and/or Pre-Existing Conditions.

OWNER if other than the Insured, means the person who applies for insurance on behalf of, and in conjunction with, the Insured. The Owner will pay the required Premium. A valid insurable obligation must exist between the Owner and the Insured, as evidenced by an executed contract or other documentation defining such insurable interest.

PHYSICIAN means a legally licensed practitioner of the healing arts acting within the scope of his or her license and not the Insured, a member of the Insured's Immediate Family or a person residing with the Insured.

CERTIFICATE FEE is an administrative charge for initiating and maintaining the Certificate; it is shown in the Certificate Schedule

PRE-EXISTING CONDITION means a sickness or accidental injury for which you:

- Received medical treatment, consultation, care or services;
- Took prescription medication or had medication prescribed; or
- Had symptoms or conditions that would cause a reasonably prudent person to seek diagnosis, care or treatment in the 12 months before your insurance or any increase in the amount of insurance under this certificate takes effect.

We will not pay benefits, or increase in benefit amount due to an elected increase in the amount of your insurance for a disability that results from a Pre-existing Condition, if you have been actively at work for less than 12 consecutive months after the date your Disability insurance or the elected increase in the amount of such insurance takes effect under this certificate.

SICKNESS means any sickness, illness or disease that: (1) (a) is diagnosed or treated by a Physician while this Certificate is in force; and (b) is not a Pre-Existing Condition as defined above; or (2) is a Pre-Existing Condition but: (a) is declared on the Application for this Certificate; and (b) is not excluded from coverage by name or specific description. Sickness includes Complications of Pregnancy.

AGGREGATE LIMIT

In no event will Our total liability for all benefits payable under the Certificate exceed the Aggregate Limit amount shown on the Schedule.

EXCLUSIONS

This Certificate does not cover any loss caused by, in whole or in part, or as a result of:

1. The Insured being under the influence of narcotics or intoxicants, unless taken under the advice of a Physician other than yourself or a member of Your immediate family; or
2. Any psychosis, neurosis, or neuropsychiatric illness including, but not limited to, any emotional anxiety or depression illness for which any form of psychiatric or psychological therapy is indicated or received.
3. Normal Pregnancy
4. Suicide, attempted suicide or intentionally self-inflicted injury;
5. Travel or flight on or in (including getting in or out, on or off) any vehicle for aerial navigation, if:
 - A. the vehicle is being used: (1) for test or experimental purposes; or (2) by or for any military authority (including aircraft flown by the U.S. Military Airlift Command (MAC) or a similar service of another country); or
 - B. the Insured is: (1) serving as a pilot or crew member (or student taking a flying lesson); or (2) riding as a passenger in a vehicle without a valid airworthiness certificate;
6. The Insured's participation in a riot or civil insurrection; or service in the military of any nation (upon notice to Us of entrance into active military service), We will provide a pro-rata refund of Premium in accordance with the Refunds or Military Service section of this Certificate;
7. Committing or attempting to commit a felony.
8. Any losses directly or indirectly arising out of, contributed to or caused by, or resulting from or in connection with, any act of nuclear, chemical, biological terrorism (as defined below) regardless of any other cause or event contributing concurrently or in any other sequence to the loss.

For the purpose of this exclusion:

"Nuclear, Chemical, Biological Terrorism" shall mean the use of any nuclear weapon or device or the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous Chemical agent and/or Biological agent during the period of this insurance by any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious, ideological or ethnic purposes or reasons including the intention to influence any government and/or to put the public, or any section of the public, in fear.

"Chemical" agent shall mean any compound which, when suitably disseminated, produces incapacitating, damaging or lethal effects on people, animals, plants or material property.

"Biological" agent shall mean any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which cause illness and/or death in humans, animals or plants.

If the Underwriters allege that by reason of this exclusion any loss is not covered by this insurance, the burden of proving the contrary shall be upon the Insured.

9. Nuclear reaction, nuclear radiation or radioactive contamination.

WAR AND TERRORISM

Unless specifically excluded elsewhere in this insurance this Certificate **covers** the Insured Persons against bodily injury or sickness caused by or attributable to war, invasion, acts of foreign enemies, hostilities or warlike operations (whether war be declared or not), civil war, rebellion, revolution, insurrection, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power, or any act of terrorism provided that the Insured Person is not taking an active part therein.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES. This Certificate, including the Application, riders, endorsements and any attached papers, constitutes the entire contract between You and Us. No change in this Certificate can be made until it is approved by an authorized officer of the Underwriter. The approval must be noted on or attached to this Certificate. No agent or other person has the authority to change this Certificate or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES. After two (2) years from the Effective Date of applicable coverage, only fraudulent misstatements made in the Application may be used to void the Certificate or deny any claim for loss. In the event of any contest, the Insured will be furnished a copy of the instrument in question. No claim for loss incurred after 1 year from the Effective Date will be reduced or denied because a Sickness or physical condition not excluded by name or specific description before the date of loss existed before the Effective Date.

NOTICE OF CLAIM. Written notice of claim must be given within sixty (60) days after a covered loss occurs or as soon thereafter as reasonably possible. The notice must be given to Us or Our agent. Notice should include Your name and the Certificate number.

CLAIM FORMS. When We receive the notice of claim, We will send the Insured forms for filing proof of loss. If these forms are not given to the Insured within fifteen (15) days, he or she may meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss section of this Certificate.

PROOFS OF LOSS. Written proof of loss must be given within ninety (90) days after such loss. If it is not reasonably possible to give written proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one (1) year from the date of loss unless the claimant was legally incapacitated. From time to time, We will require the Insured to provide continued proof of loss, satisfactory to Us, for benefits to continue to be payable.

TIME OF PAYMENT OF CLAIM. All benefits payable under this Certificate for any loss will be paid in accordance with the Schedule upon receipt of due written proof of loss.

PAYMENT OF CLAIMS. We will pay the Owner of this Certificate any benefits due unless a Beneficiary other than the Owner has been properly designated to receive such proceeds.

CLAIMANT COOPERATION PROVISION. Failure of a claimant to cooperate with Us in the administration of a claim may result in the termination of a claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

RECOVERY OF OVERPAYMENT. If benefits are overpaid, or paid in error, We have the right to recover the amount overpaid, or paid in error, by any or all of the following methods:

1. A request for lump sum payment of the amount overpaid, or paid in error.
2. Reduction of any proceeds payable under the Certificate by the amount overpaid, or paid in error.
3. Any other legal means.

LEGAL ACTION. No legal action may be brought to recover on this Certificate within sixty (60) days after written proof of loss has been given as required by this Certificate. No such action may be brought after three (3) years from the time written proof of loss is required to be given. For purposes of this provision, proof of loss means the initial proof required for payment of a claim.

MISSTATEMENT OF AGE. If the age of the Insured has been misstated, We will pay the amount of benefit that the Premium paid would have purchased at the true age.

ASSIGNMENT. This Certificate may be assigned. We are not bound by any Assignment until received by and approved by Us on a form acceptable to Us. We assume no responsibility or liability for the validity of any Assignment.

GENERAL PROVISIONS (cont'd)

CHANGE OF OCCUPATION. If the Insured is Injured or contracts a Sickness after having changed his/her occupation to one classified by Us as more hazardous than that stated in the Application for this Certificate, We will pay only such portion of the benefit provided by this Certificate as the premium paid would have purchased at the rates and within the limits fixed by Us for the more hazardous occupation. However, benefits will not be payable and coverage will immediately terminate if: (1) the new occupational class under Our then current underwriting guidelines would not be acceptable to Us in accordance with Our then usual and customary underwriting practices for this Certificate; or (2) the Owner of the Certificate is not the Insured and such Change in Occupation negates the underlying insurable interest that existed when such Certificate was issued. If coverage is terminated, it will end on the date of such Change of Occupation.

If the Insured changes his/her occupation to one classified by Us as less hazardous than that stated in the Application for this Certificate, upon receipt of proof of such Change of Occupation, We will reduce the premium rate and will return the excess pro-rata unearned premium from the date of the Change of Occupation. However, if the Owner of the Certificate is not the Insured, and a Change of Occupation negates the insurable interest that existed when the Certificate was issued, coverage will be terminated on the date of such Change of Occupation.

For this Change of Occupation provision, the classification of occupational risk and the premium rates shall be those that were last filed by Us with the appropriate regulatory agency, if required, prior to the occurrence of the loss for which We are liable or prior to the date of the Change of Occupation in the state where the Insured resided at the time this Certificate was issued. If such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by Us in such state prior to the occurrence of the loss or prior to date of Change of Occupation.

If coverage is terminated under this Change of Occupation provision, We will refund the excess pro-rata unearned premium from the date of the Change of Occupation.

PHYSICAL EXAMINATION. We, at Our expense, have the right to have the Insured examined by a Physician of Our choice as often as reasonably necessary while a claim is pending.

CONFORMITY WITH STATE LAW. Any provision of this Certificate that, on its Effective Date, is in conflict with the laws of the state of the Owner on that date, shall be deemed amended to conform to the minimum requirements of such laws.

ARBITRATION CLAUSE: As part of the proof of **Permanent Total Disability** there must be included a certification from a physician that the Insured Person has suffered **Permanent Total Disability** as defined in the Certificate. In the event that Underwriters determine that it has not been demonstrated the Insured Person is **Permanently Totally Disabled**, then the question of **Permanent Total Disability** will be subject to the approval of two independent referees.

One referee shall be an independent legally qualified physician* or surgeon, chosen by the Underwriters and the second referee shall be an independent expert of recognised standing in the occupation (as stated in the Schedule) of the Insured Person, and shall be chosen by the Assured.

The referees shall have the authority to decide solely whether the Insured Person's **Total Disability** is **Permanent** as defined in this Certificate. The referees are not to decide any other aspect concerning the validity of the claim. The decision of the two referees will be binding upon all parties.

In the event that the two referees fail to agree, then they will appoint an Umpire (determined and agreed to by both parties prior to commencement of the arbitration procedure) whose decision will be final and binding upon all parties.

Any physicians, medical advisors and/or use of referees and umpire shall be domiciled in the country where the certificate was issued.

Each party shall be responsible for their own respective costs, except for those incurred as a result of the involvement of the final umpire where additional costs shall be shared equally.

**Physician means a legally qualified physician or surgeon other than a physician or surgeon who is related to the Insured Person by blood or marriage.*

Benefit Coverage Insert

LLOYD'S

CERTIFICATE NUMBER: 13396V13149A-003

PERMANENT TOTAL DISABILITY FOR ACCIDENT AND SICKNESS BENEFIT

We will pay the Permanent Total Disability Benefit shown on the Schedule for a periodic loss of income if:

1. The Insured becomes Permanently and Totally Disabled as defined below as a direct result of:
 - (a) an Injury which occurs while this benefit is in force and causes Permanent Total Disability due to the injury to begin within 365 days of a covered Accident; or
 - (b) a Sickness which manifests itself while this benefit is in force and causes Permanent Total Disability to commence within 365 days of a covered Sickness; and
2. The Insured satisfies the Elimination Period shown on the Schedule; and
3. The Insured is under the regular care of a Physician that is appropriate for the condition causing the disability.

“PERMANENTLY AND TOTALLY DISABLED” means, as a result of a covered Injury or Sickness, the Insured is permanently and totally unable to perform the substantial and material duties of his or her regular occupation as shown on the Schedule for the entire Elimination Period and is not expected to recover for the remainder of his or her life. The Insured must also be under the regular care of a Physician that is appropriate for the condition causing the disability.

No benefit will be paid prior to the completion of the Elimination Period. In no event will We pay more than the Aggregate Limit shown in the Schedule.

This provision is subject to all Certificate Term, conditions and limitations.

Rider #1

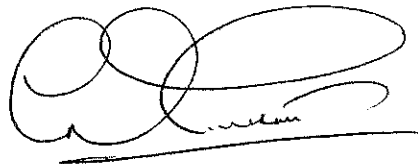
CERTIFICATE NUMBER: 13396V13149A-003

In event of a claim against this policy it will be necessary for the insured person to show that he/ she has satisfied the underwriting eligibility requirements which are the following:-

1. For a period of time commencing 90 days prior to risk attaching under this policy the insured person has been continuously at work on a full-time basis (30 or more hours per week) in the usual and customary manner performing the duties of his / her occupation and has not been homebound or admitted to a medical facility due to injury or sickness;
2. The insured person is not suffering from a pre-existing condition as defined in the policy (unless specifically approved and accepted by underwriters);
3. The insured person has not been in receipt of any form of disability benefit in the period of five (5) years preceding the date risk attached under this policy.

This rider takes effect on **August 15, 2013**, 12:01 a.m. Local Standard Time at **Saint Louis, Missouri**, and expires concurrently with the Certificate and is subject to all of the provisions, definitions, limitations and conditions of the Certificate not inconsistent herewith.

Signed by Hanleigh Management, Inc., Lloyd's Correspondent



Graham Southall, Lead Underwriter

Security List



CERTIFICATE NUMBER: 13396V13149A-003

Disability/Other

Section 2

Signed (%)

Pseudonym

Syndicate No.

28.5715

LIB

4472

22.8571

SAL

1206

14.2857

TAL

1183

14.2857

CNP

4444

2.8571

CHN

2015

2.8571

ASP

4711

7.1429

ANV

1861

7.1429

TRV

5000

100.0000%

TOTAL

Privacy Policy Statement

CERTIFICATE NUMBER: 13396V13149A-003

UNDERWRITERS AT LLOYD'S, LONDON

The Certain Underwriters at Lloyd's, London want you to know how we protect the confidentiality of your non-public personal information. We want you to know how and why we use and disclose the information that we have about you. The following describes our policies and practices for securing the privacy of our current and former customers.

INFORMATION WE COLLECT

The non-public personal information that we collect about you includes, but is not limited to:

- A. Information contained in applications or other forms that you submit to us, such as name, address, and social security number;
- B. Information about your transactions with our affiliates or other third-parties, such as balances and payment history;
- C. Information we receive from a consumer-reporting agency, such as credit-worthiness or credit history.

INFORMATION WE DISCLOSE

We disclose the information that we have when it is necessary to provide our products and services. We may also disclose information when the law requires or permits us to do so.

CONFIDENTIALITY AND SECURITY

Only our employees and others who need the information to service your account have access to your personal information. We have measures in place to secure our paper files and computer systems.

RIGHT TO ACCESS OR CORRECT YOUR PERSONAL INFORMATION

You have a right to request access to or correction of your personal information that is in our possession.

CONTACTING US

If you have any questions about this privacy notice or would like to learn more about how we protect your privacy, please contact the agent or broker who handled this insurance. We can provide a more detailed statement of our privacy practices upon request.

Exhibit “B”

Lloyds of London**LLOYD'S****Multi-Life Disability Income Insurance Enrollment Form**

I hereby apply to Lloyd's of London for insurance based upon the following representations:

1. EMPLOYER/AFFILIATION MPM		3. REQUESTED EFFECTIVE DATE (MO./DAY/YR.) 08/01/2013	
2. INSURED/OWNER NAME (FIRST, MIDDLE INITIAL, LAST) Rochelle G CATUS			
4. RESIDENCE ADDRESS (NUMBER & STREET, CITY, STATE, ZIP CODE) 57 Frontenac Estates Frontenac MO 63131			
5. RESIDENCE PHONE #: [REDACTED]		6. WORK PHONE #: [REDACTED]	
7. EMAIL: rgcatusinc@aol.com			
8. DATE OF BIRTH (MO./DAY/YR.): [REDACTED]			
9. OCCUPATION: Physician		9A. SPECIALTY: OBGYN	
10. ANNUAL INCOME GREATER THAN \$100,000: Yes _____		11. BENEFIT AMOUNT REQUESTED: 1500000	
12. FOR THE PERIOD OF TIME COMMENCING 180 DAYS PRIOR TO THE DATE OF THIS APPLICATION:			
(a) ARE YOU NOW AND HAVE YOU BEEN CONTINUOUSLY AT WORK ON A FULL-TIME BASIS IN THE USUAL AND CUSTOMARY MANNER PERFORMING ALL OF THE DUTIES OF YOUR OCCUPATION; AND ... YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
(b) HAVE YOU BEEN HOMEBOUND OR HOSPITALIZED DUE TO AN ACCIDENT OR SICKNESS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> IF (A) IS ANSWERED "NO" AND/OR (B) IS ANSWERED "YES", GIVE DETAILS. _____ _____ _____			
13. HAVE YOU BEEN PAID DISABILITY BENEFITS FROM ANY SOURCE DURING THE PAST 5 YEARS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> IF ANSWERED "YES" PLEASE PROVIDE DETAILS. _____ _____			
TO THE BEST OF MY KNOWLEDGE AND BELIEF ALL OF THE FOREGOING STATEMENTS OF THIS APPLICATION ARE TRUE, COMPLETE AND CORRECTLY STATED. THEY ARE OFFERED TO LLOYD'S OF LONDON AS THE BASIS FOR ANY INSURANCE ISSUED ON THIS APPLICATION. I UNDERSTAND AND AGREE THAT ANY POLICY ISSUED BY LLOYD'S OF LONDON WILL BE CONDITIONED UPON THE ACCURACY OF THE ABOVE ANSWERS.			
SIGNATURE OF PROPOSED INSURED X Rochelle CATUS		PRINT LICENSED AGENT'S OR BROKER'S NAME Mike Zimmerman	
SIGNED AT (CITY, STATE) Frontenac, MO			
TODAY'S DATE: 7/12/2013			

Exhibit “C”

Proof of Loss



MAIL TO:

Hanleigh Management Inc.

50 Tice Blvd.; Suite 122; Woodcliff Lake, New Jersey 07677
Phone: (201) 505-1050 or (800) 443-2922 / Facsimile: (201) 505-1051
www.hanleighinsurance.com

PART I - DISABILITY CLAIM FORM

POLICY NUMBER: _____ **CERTIFICATE NUMBER:** 13396V13149A-0

Insured's Full Name: ROCHELLE G. MATUS, MD

Street Address: 57 FRONTENAC ESTATES DR **Telephone:** _____

City: ST. LOUIS **State:** MO **Zip:** 63131

Date of Birth: _____ **Marital Status:** _____ **Height & Weight:** 5'7" & 255lb

Occupation prior to Disablement:

Duties: OBSTETRICS and GYNECOLOGY - Patient care, physical exam-
inations, gyn SURGICAL PROCEDURES

Monthly Earnings: ~10,000 **Weekly Earnings:** _____

- Give full description of injury or disease from which you are now suffering. Sickness Injury
If an injury, tell when, where, and how it occurred.
I have been diagnosed with Multiple Sclerosis and am
no longer able to perform gyn surgeries nor do
patient examinations. My symptoms will not
improve and my neurologist has me on medication to
try to keep my symptoms from getting worse. I am on perma
- (A) Have you ever had this or a similar condition in the past? Yes No *disability*
(B) If "Yes," state the nature of the condition, dates of treatment and names and addresses of treating doctors, hospitals and clinics:
Condition(s): _____ **Dates:** _____ **Treating Physician and Address:** _____
NOT applicable
- (A) Give exact date when illness began or injury occurred: **Date:** 10/2013
(B) When did you first consult physician for this condition? **Date:** 12/2013
(C) When did you become totally disabled (unable to work)? **Date:** 10/15/14
(D) When were you able to again perform part of your occupational duties? **Date:** NOT applicable

4. Hospitals: (Give complete names, addresses and dates of confinement):

Hospital Names: Addresses: Dates:

NOT applicable

5. (A) Give names, addresses and telephone numbers of all attending physicians:

Names:	Addresses:	Telephone:
DR BARBARA GREEN	1176 TOWN and COUNTRY COMMONS, CHESTERFIELD	(636) 893-1266
DR AMY RAUCHWAY	" " " " " "	" " " "

(B) Give name, address and telephone number of usual family physician:

Name:	Address:	Telephone:
DR CAMI WATKINS	12255 DEPAUL DR BRIDGETON, MD 63044	(314) 209-512

6. What other accident, sickness or disability insurance do you have in place? Please name the insurance carrier.

Carrier Name & Address:	Policy No.:	Benefit:
EQUITABLE	89702197	\$1,500/MONTH
GENERAL AMERICAN	8464037	\$5,000/MONTH

7. List names, addresses of all treating physicians and hospitals during the past 5 years and the reason and date of treatment:

Physician/Hospital:	Address:	Dates and Reasons for Treatment:
DR BARBARA GREEN	1176 TOWN + COUNTRY COMMONS, CHESTERFIELD, MD 63	5/2014 - Begin MS ME.
DR AMY RAUCHWAY	1176 TOWN + COUNTRY COMMONS, CHESTERFIELD, MD	12/2013 REVIEW TEST RES.
DR JOHN D. WRIGHT	615 S NEW BALLAS RD	10/2014 NEUROPSYCH EVALUATION CREVE COEUR, MD 63141

8. Names and address of Employers and length of Employment with each?

Names	Addresses	From To
ROCHELLE G. CATVS, INC	12255 DEPAUL DR #705 BRIDGETON, MD 63044	7/2/1999 - 10/15/2014

PART II - ATTENDING PHYSICIAN'S STATEMENT - HEALTH INSURANCE DISABILITY CLAIM

The following information is to be completed by the Attending Physician.

Patient's Name and Address ROCHELLE G. CATVS
57 FRONTENAC ESTATES DR
ST. LOUIS, MO 63131

Age: 59

1. (A) Diagnosis and current condition (If fracture or dislocation, describe nature and location):

multiple sclerosis

patient has reached maximum medical improvement.

Disease is stable e present.

(B) Is condition due to injury or sickness arising out of patient's employment?
If yes, explain:

Yes No

2. (A) When did symptoms first appear or accident occur?

Date: 10/2013

(B) When did patient first consult you for this condition?

Date: 12/4/2013

(C) Has patient ever had same or similar condition?

Yes No

If "Yes" to (C), state when and describe: Diagnosis 2013. Symptoms occurred 1991-92, Then dissipated and did not return until 2013. In 9/2013 she met criteria for diagnosis of MS

3. (A) Nature of surgical procedure, if any (describe fully):

NA

(B) If performed in a hospital, give name of hospital:

Inpatient

Outpatient

4. What other services, if any, did you provide the patient? Itemize giving dates and fees:

Regular follow up appointments every 4-6 months and PRN. Physical therapy may be ordered as needed. Medications treat symptoms. Lifelong diagnosis

5. Is patient still under your care for this condition? Yes No
If "No," give date services terminated: Date:

6. (A) How long was or will patient be continuously totally disabled? (Unable to work?) *permanent disability* From: *9/30/14* Thru: *---*

(B) How long was or will patient be partially disabled? *full disability* From: Thru:

(C) Was house confinement necessary? If "Yes," give dates: Yes No
From: Thru:

7. To your knowledge, does patient have other health insurance or health plan coverage? If "Yes," identify: Yes No

unknown

REMARKS

Barbara Green MD

Print Name of Physician

Barbara Green

Signature of Physician

Neurology

Specialty

4/24/15

Date

176 Town & Country Commons

Street Address

636-893-1260

Telephone

Chesterfield

City or Town

MO

State

63017

Zip

PART III: AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: ROCHELLE G. CATUS

Date of Birth: [REDACTED]

Social Security No.: [REDACTED]

1. I authorize the use or disclosure of the above named individual's health information as described below:

2. The following individual or organization is authorized to make the disclosure:

Name: DR BARBARA GREEN
Address: 1176 TOWN + COUNTRY COMMONS
CHESTERFIELD, MO 63017

3. The type and amount of information to be used or disclosed is as follows:

ENTIRE RECORD - Copies of all medical information, including, but not limited to, psychiatric or psychological records, drug or alcohol abuse records, detoxification or rehabilitation records, charts, diagnostic tests, diagnostic records and/or reports, discograms, myelograms, CT scans, x-rays and x-ray reports, opinion letters, surgical reports, laboratory records or reports, pathology records or reports, pharmaceutical records, consent forms, admission and discharge forms and records, financial records showing charges and payments for services rendered, and for any other medical information which you may have concerning treatment to me for any purpose and at any time.

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization for the purpose of **processing an insurance claim - Lloyd's of London; C/O Hanleigh; 50 Tice Blvd. - Suite 122 Woodcliff Lake, NJ 07677.**

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at the conclusion of my claim. Since I have elected for this release to expire at the termination of my claim, I specifically acknowledge that my claim may be ongoing for several years and acknowledge that this release may be used for several years after the date noted hereinbelow.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. This release shall be valid for two years from the date signed below.

8. **A PHOTOCOPY OF THIS ORIGINAL WILL SERVE AS AN ORIGINAL.**

Rochelle Catus, MD
Signature
Jessica Schutte, RN
Witness

4/23/15
Date
4/23/15
Date

PART IV – INSURED CERTIFICATION

BY SIGNING BELOW, I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

<i>Roshelle G. Catrus, MD</i>	<i>4/10/15</i>
Signature of Insured	Date

FRAUD WARNING: "IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT."

Exhibit “D”



January 5, 2016

P. O. Box 25
Bloomfield, CT 06002

Rochelle G. Catus, MD
57 Frontenac Estates Dr.
St. Louis, MO 63131

(800) 722-9680
(860) 769-6976
(860) 769 6986 Fax

Email: kquinn@dispec.com

RE: Certificate Number: 13396V13149A-003
Claim Number: 13396V13AAA

Dear Dr. Catus,

We are writing to you regarding your claim for disability benefits under the above-captioned insurance Certificate with Lloyd's of London.

We have completed our review of your claim and it is our determination that the condition for which you are claiming benefits did not manifest itself while your Certificate/Policy was in force. As such, no benefits are payable on your claim.

To review, you have claimed disability effective 10/15/14, from your occupation as a physician in the field of Ob/Gyn due to multiple sclerosis (MS). Your insurance became effective on 08/15/13.

The Certificate defines Permanent Total Disability as follows:

"We will pay the Permanent Total Disability Benefit shown on the Schedule for a period loss of income if:

1. *The Insured becomes Permanently and Totally Disabled as defined below as a direct result of:*
 - (a) *an Injury that occurs while this benefit is in force and causes Permanent Total Disability due to the injury to begin within 365 days of a covered Accident; or*
 - (b) *Sickness that manifests itself while this benefit is in force and causes Permanent Total Disability to commence within 365 days of a covered Sickness; and*
2. *The Insured satisfies the Elimination Period shown on the Schedule; and*
3. *The Insured is under the regular care of a Physician that is appropriate for the condition causing the disability.*

'PERMANENTLY AND TOTALLY DISABLED' means, as a result of a covered Injury or Sickness, the Insured is permanently and totally unable to perform the substantial and material duties of his or her regular occupation as shown on the Schedule for the entire Elimination Period and is not expected to recover for the remainder of his or her life. The Insured must also be under the care of a Physician that is appropriate for the condition causing the disability."

The Certificate defines Sickness as follows:

"SICKNESS means any sickness, illness or disease that: (1) (a) is diagnosed or treated by a Physician while this Certificate is in force; and (b) is not a Pre-Existing Condition as defined above; or (2) is a Pre-existing Condition but: (a) is declared on the Application for this Certificate; and (b) is not excluded from coverage by name or specific description. Sickness includes Complication of Pregnancy."

1. Disability Claim Form completed by you and dated 04/10/15;
2. Attending Physician's Statement-Health Insurance Disability Claim form completed by Dr. Barbara Green and dated 04/24/15;
3. Copy of your 2012, 2013, and 2014 1040 US Individual Income Tax Return;
4. Copy of your 2011 and 2012 1120 US Corporation Income Tax Return for Rochelle G. Catus, Inc.;
5. Copy of medical records from Dr. Barbara Green for the period from 12/04/13-06/29/15;
6. Copy of medical record from Dr. John D. Wright dated 10/10/14;
7. Copy of medical records from Dr. Sherry MA for the period from 06/13/13-07/17/13;
8. CPT production reports for procedures personally performed by you for the period from 01/01/13-10/15/14;
9. Copy of your Social Security Disability Award letter dated 04/06/15;

The file reflects that you filed a claim with a date of disability of 10/15/14 due to Multiple Sclerosis (MS). Your Policy became effective on 08/15/13. Your condition of MS did not manifest itself while your coverage was in force. Dr. Green documented on the Attending Physician's Statement dated 04/24/15 that you have had the same or similar condition in the past. She reported that the diagnosis was in 2013. She reported that symptoms occurred in 1991-1992, then dissipated and did not return until 2013. On 06/13/13 you sought treatment with Dr. Ma for tingling and numbness in your hands and feet for about 10 days. Dr. Ma documents that your chief complaint was sudden onset of left hand tingling and numbness, then on the right hand, and recently both feet tingling sensation. You had tingling and numbness of your chest and abdominal region also. Your walking was/is affected and you step more carefully. Your bladder control was/is poor, and you have urinary urgency. There was no history of neck injury, no falling, and no trauma. You have/had chronic neck and shoulder stiffness. On 06/18/13 you underwent a Cervical MRI per Dr. Ma's orders, which revealed the following: *"There are two high T2 weighted signal intensity lesions in the cervical cord, one at the C2 level and one at the C6-7 level. A differential diagnosis would include a primary or metastatic cord lesion, inflammatory or infectious process involving the cervical cord, infarction, however, not in the typical location; demyelinating process, B12 deficiency, or cervical myelopathy. Less likely, syringomyelia or normal pressure hydrocephalus should be considerations."* On 06/26/13 you underwent a MRI of the brain with and without contrast per Dr. Ma's orders, which revealed the following: *"1. Multiple small foci of increased signal intensity in the T2 weighted images in the periventricular white matter bilaterally. These may be due to lacunar infarcts or demyelinating disease.*
2. No acute hemorrhage or mass effect identified.
3. In view of the abnormal foci in the cervical spinal cord seen on the MRI of the cervical spine of 06/18/13, demyelinating disease is a serious consideration in this patient."

On 07/13/13 you followed-up with Dr. Ma and reviewed the MRI of the brain, which showed multiple periventricular white matter changes, and some perpendicular to the lining of ventricle system. At this point Dr. Ma recorded that you recalled that you did have one episode of tingling of your feet, urinary urgency about 20 years ago, and evaluation showed "white matter changes on the MRI of brain" and your symptoms subsided and you did not pursue further testing. In light of the abnormal MRI of the brain and c-spine, Dr. Ma documented the medical record that this was suggestive of demyelinating disease considering that you did have one episode of paresthesia and urinary urgency, and it subsided but the MRI of the brain was abnormal then. Dr. Ma documented that this could have been the first episode of your demyelinating disease and current symptoms, the second episode. As such you treated for your sickness prior to the Certificate being in force.

Based on the terms, provisions, and definition of Permanently and Totally Disabled as referenced above and in your Policy and the documents and information contained in your claim file taken as a whole, we are denying your claim for Permanently and Totally Disabled Disability Benefits.

Nothing contained in this letter should be construed as a waiver of any rights or defenses under the Certificate/Policy. This determination has been made in good faith and without prejudice under the terms and conditions of the contract, whether or not specifically mentioned herein.

Should you not agree with the claim determination, the Certificate states the following:

“GRIEVANCE PROCEDURES

Should you be dissatisfied with any claim or administration issue, the following steps apply. Notwithstanding any other item set forth herein, the parties hereby agree that any dispute which arises shall follow these procedures:

- 1) *General Inquiry: At any time You have the right to communicate with Us, either directly or through a representative, to seek clarification and assistance on any issue.*
- 2) *Informal Review: Should You not be satisfied with the response from Your General Inquiry, You have the right to request an Informal Review. This Informal Review should be requested in writing, but may be verbally requested. The Informal Review should be requested within sixty (60) days following the claim or administrative decision, but in no case before such claim or administrative decision. We shall respond within a reasonable amount of time.*
- 3) *Formal Review: Should You still not be satisfied with the response You receive through an Informal Review, then You have the right to request a Formal Review. Please provide a written summary of the issue and any items which may be useful for Us to review. A Formal Review must be requested no more than ninety (90) days following an informal review. We shall respond to Your request in a reasonable amount of time.*
- 4) *Legal Action; No legal action may be brought to recover under the insurance described in this Certificate until after the response of a Formal Review. No action may be brought more than one year after the date of the original claim or administrative decision. Legal Action shall not take place prior to a Formal Review.”*

If you have any additional questions regarding this matter please feel free to contact me at the numbers noted below.

Sincerely,



George A. Rodolakis
Disability Insurance Specialists LLC
Claims Management Services Unit
1-800-959-9379 ext 3091

Exhibit “E”



March 17, 2016

P. O. Box 25
Bloomfield, CT 06002

(800) 722-9680
(860) 769-6976
(860) 769 6986 Fax

Rochelle G. Catus, M.D.
57 Frontenac Estates Dr.
St. Louis, MO 63131

Email: postmaster@dispec.com

Re: Certificate Number: 13396V13149A-003
Claim Number: 13396V13AAA

Dear Dr. Catus:

This letter is in reference to your request for an informal review of the denial of your claim for benefits under the above captioned insurance Certificate with Lloyd's of London.

We have completed our review of your claim and it is our determination that the condition for which you are claiming disability benefits did not manifest itself while your benefit was in force. As such, no benefits are payable and the decision to deny your claim is being upheld.

The Certificate outlines the following:

"We will pay the Permanent Total Disability Benefit shown on the Schedule for a periodic loss of income if:

1. *The Insured becomes Permanently and Totally Disabled as defined below as a direct result of:
(a) and Injury which occurs while this benefit is in force and causes Permanent Total Disability due to the injury to begin within 365 days of a covered Accident; or
(b) a Sickness which manifests itself while this benefit is in force and causes Permanent Total Disability to commence within 365 days of a Covered Sickness; and*
2. *The Insured satisfies the Elimination Period shown on the Schedule; and*
3. *The Insured is under the regular care of a Physician that is appropriate for the condition causing the disability.*

'PERMANENTLY AND TOTALLY DISABLED' *means, as a result of a covered Injury or Sickness, the Insured is permanently and totally unable to perform the substantial and material duties of his or her regular occupation as shown on the Schedule for the entire Elimination Period and is not expected to recover for the remainder of his or her life. The Insured must also be under the regular care of a Physician that is appropriate for the condition causing the disability.*

SICKNESS *means any sickness, illness or disease that (1) (a) is diagnosed or treated by a Physician while this Certificate is in force; and (b) is not a Pre-Existing Condition as defined above; or (2) is a Pre-Existing Condition but: (a) is declared on the Application for this Certificate; and (b) is not excluded from coverage by name or specific description. Sickness includes Complications of Pregnancy.*

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“A. During the Elimination Period and your Own Occupation Period, **Disability and Disabled** mean you are, as a result of Physical Disease, Injury, Mental Disorder, Substance Abuse, or Pregnancy, unable to perform a majority of the Material Duties of your Own Occupation.

B. After your Own Occupation Period ends, **Disability and Disabled** mean you are, as a result of Physical Disease, Injury, Mental Disorder, Substance Abuse, or Pregnancy, unable to perform a majority of the Material Duties of Any Occupation...

Elimination Period means the period of time that you must be continuously Disabled before LTD Benefits become payable. No LTD Benefits are payable during the Elimination Period. Your Elimination Period is specified in the ‘Schedule of Benefits.’”

Your Individual Insurance Certificate indicates that Certificate number 13396V13149A-003 was effective August 15, 2013.

Our file reflects that you have claimed to be disabled from your occupation as a Physician as of October 15, 2014, due to symptoms associated with Multiple Sclerosis (MS). The Attending Physician’s Statement (APS), which was completed by Barbara Green, MD, Neurologist, on April 26, 2015, indicates that you were diagnosed with MS in 2013. Dr. Green notes that symptoms occurred in 1991-1992, then dissipated and did not return until 2013. In September 2013, you met the criteria for diagnosis of MS.

Your claim was denied on January 5, 2016, as it had been determined that you treated for your Sickness prior to your Certificate in-force date.

In a letter dated January 13, 2016, you requested an Informal Review. You stated that your sickness did not manifest itself prior to your obtaining the policy. You indicated that neither you nor your physician knew that you had MS at the time you obtained this insurance. You stated that you were not diagnosed with MS until December of 2013. You reported that prior to that time, you and your physicians considered other diagnoses. You indicated that before you applied for this insurance, you were doing testing, and “MS” never came up. You stated that there was nothing incorrectly stated on your enrollment form, and added that you were not asked about medical care or sickness, nor was there any place on the form to indicate or disclose treatment unless you had been homebound or hospitalized. You indicated that you had not been either of these.

During telephone conversations on January 29, 2016, February 11, 2016, and February 17, 2016, you contended that your disabling diagnosis of MS should be considered a Sickness as defined by the Certificate, because you were not diagnosed with MS until December 4, 2013, after your Certificate was in force. You indicated that an MRI is a diagnostic tool, and not a form of treatment. You stated that “treatment” would be therapy, medication, and surgery, none of which you had for your disabling condition of MS prior to August 15, 2013. You indicated that when you saw Dr. Sherry Ma in June of 2013, for tingling of the hands, you thought you might have Carpal Tunnel Syndrome, or possibly Vitamin D toxicity.

The medical records in your file document that you treated with Dr. Sherry Ma on June 13, 2013, with a chief complaint of tingling and numbness in your hands and feet for about 10 days. You also reported tingling and numbness of your chest and abdominal region, and indicated that your walking was affected and you were stepping more carefully. You described poor bladder control with urinary urgency, as well as chronic neck and shoulder stiffness. Dr. Ma’s impression was paresthesia and sensory level at C5-6, and recommended MRI of the cervical spine without contrast and NCV and EMG studies of both upper limbs. You were to start Neurontin 100 mg for your sensory symptoms.

The MRI of the Cervical Spine, dated June 18, 2013, revealed “two high T2 weighted signal intensity lesions in the cervical cord, one at the C2 level and one at the C6-7 level. A differential diagnosis would include a

NCV/EMG studies of June 19, 2013 were normal.

You then obtained an MRI of the brain on June 26, 2013, which revealed multiple small foci of increased signal intensity in the T2 weighted images in the periventricular white matter bilaterally. The report indicates that these may be due to lacunar infarcts or demyelinating disease, and that in view of the abnormal foci in the cervical spinal cord seen on the MRI of the cervical spine of June 18, 2013, demyelinating disease is a serious consideration.

When you next saw Dr. Ma on July 17, 2013, she reviewed your MRI with you, and you recalled having had one episode of tingling of your feet and urinary urgency about 20 years ago, and reported that evaluation had shown “white matter changes on the MRI of the brain.” Your symptoms had subsided and you did not pursue further testing, such as CSF, blood test, etc, at that time. Dr. Ma’s assessment was that of abnormal MRI of the brain and cervical spine, suggestive of demyelinating disease, considering that you did have one episode of paresthesia and urinary urgency in the past, which subsided, but MRI of the brain was abnormal then. Dr. Ma suggested that this incident could have been the first episode of your demyelinating disease and your current symptoms the second episode. Her plan was to proceed with CSF for analysis. You were to proceed with CSF for analysis. Dr. Ma asked that you bring the previous MRI of the brain for review, and planned to start you with IV solumedrol for five days after CSF analysis.

You treated with Amy Rauchway, DO, on December 4, 2013. At that time, you provided a history of being well until 1991 or 1992, when you developed tingling and an overactive bladder after starting spinning class. You treated with your Primary Care Physician, who ordered brain MRI. Dr. Rauchway noted that this study apparently showed some white matter lesions. The tingling resolved, but the bladder issues recurred, so you started Toviaz in 2009, which you used occasionally thereafter. Dr. Rauchway indicated that you remained stable until 2013. She stated that in May, when driving home from out of town, you developed tingling affecting your hands, which had persisted. You were evaluated by Dr. Sherry Ma at the recommendation of a colleague, and underwent NCS/EMG, which was found to be negative, and MRI of the brain and cervical spine. Dr. Rauchway noted that these images were reported as showing lesions at the C6-C7 level. You were advised to undergo lumbar puncture. Dr. Rauchway indicated that this procedure was done on September 18, 2013, after which you were diagnosed with MS.

Additionally, when you treated with Dr. Barbary Green on June 26, 2014, she indicated that your complete history, as well as your neurologic history, was reviewed. Per that review, you indicated that your first neurologic symptom was Bell’s Palsy in 1979. Then in 1991 and 1992, you developed tingling paresthesias of the lower extremities associated with urinary urgency and urge incontinence. Dr. Green noted that an MRI scan of the brain at that time apparently showed some abnormalities, but a definite diagnosis was not reached. She added that over the years that followed, you continued to have bladder difficulties. In 2013, you developed tingling in both hands and over the chest wall, worse on the right side than the left. You saw Dr. Sherry Ma and were re-evaluated for the possibility of demyelinating disease. You then sought a second opinion in December of 2013 with Dr. Amy Rauchway, who proceeded with additional evaluation to rule out mimics of MS, including sarcoidosis, with a CT Scan of the chest. Dr. Green stated that diagnosis of MS was confirmed, and options for treatment were discussed in your follow up visit of April 2014.

However, even if your disabling condition of MS can be defined as a Sickness according to your Certificate, the Certificate states that a Permanent Total Disability Benefit will be paid if the Insured becomes Permanently and Totally Disabled as a direct result of a Sickness which manifests itself while this benefit is in force. The treatment records from Dr. Ma, Dr. Rauchway, and Dr. Green all provide a history of symptoms of MS, including tingling of hands and feet and urinary urgency, beginning as early as 1991-1992, with an abnormal MRI at that time. The MRI of the brain on June 26, 2013, documented white matter, with demyelinating

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disease a serious consideration. As a result of the findings on this MRI, you were referred for CSF analysis, after which you were diagnosed with MS. While you have indicated that you did not know that you had MS and were not officially diagnosed until December of 2013, the medical records from your treating providers, as well as the cervical spine MRI of June 18, 2013 and the brain MRI of June 26, 2013, all document that this condition did not manifest itself while your benefit was in force. Additionally, in the APS of April 26, 2015, Dr. Green indicates that that symptoms occurred in 1991-1992, then dissipated and did not return until 2013.

Based on all of the above information, you had documented symptoms of MS prior to your Certificate effective date of August 15, 2013. As such, your disabling condition of MS did not manifest itself while your benefit was in force, and the decision to deny your claim is being upheld, as we have determined that you are not eligible for Permanent Total Disability Benefits under the terms of the Certificate.

Nothing contained in this letter should be construed as a waiver of any rights or defenses under the Certificate/Policy. This determination has been made in good faith and without prejudice under the terms and conditions of the contract, whether or not specifically mentioned herein.

Should you not agree with the claim determination, Lloyd's provides the following Grievance Procedures:

GRIEVANCE PROCEDURES

Should you be dissatisfied with any claim or administration issue, the following steps apply. Notwithstanding any other item set forth herein, the parties hereby agree that any dispute which arises shall follow these procedures:

- (1) General Inquiry: At any time You have the right to communicate with Us, either directly or through a representative, to seek clarification and assistance on any issue.
- (2) Informal Review: Should You not be satisfied with the response from your General Inquiry, You have the right to request an Informal Review. This Informal Review should be requested in writing, but may be verbally requested. The Informal Review should be requested within sixty (60) days following the claim or administrative decision, but in no case before such claim or administrative decision. We shall respond within a reasonable amount of time.
- (3) Formal Review: Should You still not be satisfied with the response You receive through an Informal Review, then You have the right to request a Formal Review. Please provide a written summary of the issue and any items which may be useful for Us to review. A Formal Review must be requested no more than ninety (90) days following an informal review. We shall respond to Your request in a reasonable amount of time.
- (4) Legal Action: No legal action may be brought to recover under the insurance described in this Certificate until after the response of a Formal Review. No action may be brought more than one year after the date of the original claim or administrative decision. Legal Action shall not take place prior to a Formal Review.

If you have any additional questions regarding this matter, please feel free to contact me at the telephone number below.

Sincerely,

Gloria Ungaro

Disability Insurance Specialists LLC
Claims Management Services Unit
1-800-722-9680 ext. 3043

JS 44 (Rev. 12/12)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. (SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)

I. (a) PLAINTIFFS
 LIBERTY CORPORATE CAPITAL LTD.,
 and AMTRUST AT LLOYD'S LTD.

(b) County of Residence of First Listed Plaintiff United Kingdom
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys (Firm Name, Address, and Telephone Number)
 Bradley R. Hansmann, Brown & James, 800 Market St., #1100
 St. Louis, MO 63101 (314-421-3400)

DEFENDANTS
 ROCHELLE G. CATUS

County of Residence of First Listed Defendant St. Louis County
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys (If Known)

II. BASIS OF JURISDICTION (Place an "X" in One Box Only)

1 U.S. Government Plaintiff

2 U.S. Government Defendant

3 Federal Question *(U.S. Government Not a Party)*

4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES (Place an "X" in One Box for Plaintiff and One Box for Defendant)

	PTF	DEF		PTF	DEF
Citizen of This State	<input type="checkbox"/> 1	<input checked="" type="checkbox"/> 1	Incorporated or Principal Place of Business In This State	<input type="checkbox"/> 4	<input type="checkbox"/> 4
Citizen of Another State	<input type="checkbox"/> 2	<input type="checkbox"/> 2	Incorporated and Principal Place of Business In Another State	<input type="checkbox"/> 5	<input type="checkbox"/> 5
Citizen or Subject of a Foreign Country	<input checked="" type="checkbox"/> 3	<input type="checkbox"/> 3	Foreign Nation	<input type="checkbox"/> 6	<input type="checkbox"/> 6

IV. NATURE OF SUIT (Place an "X" in One Box Only)

CONTRACT	TORTS	FORFEITURE/PENALTY	BANKRUPTCY	OTHER STATUTES	
<input checked="" type="checkbox"/> 110 Insurance <input type="checkbox"/> 120 Marine <input type="checkbox"/> 130 Miller Act <input type="checkbox"/> 140 Negotiable Instrument <input type="checkbox"/> 150 Recovery of Overpayment & Enforcement of Judgment <input type="checkbox"/> 151 Medicare Act <input type="checkbox"/> 152 Recovery of Defaulted Student Loans (Excludes Veterans) <input type="checkbox"/> 153 Recovery of Overpayment of Veteran's Benefits <input type="checkbox"/> 160 Stockholders' Suits <input type="checkbox"/> 190 Other Contract <input type="checkbox"/> 195 Contract Product Liability <input type="checkbox"/> 196 Franchise	PERSONAL INJURY <input type="checkbox"/> 310 Airplane <input type="checkbox"/> 315 Airplane Product Liability <input type="checkbox"/> 320 Assault, Libel & Slander <input type="checkbox"/> 330 Federal Employers' Liability <input type="checkbox"/> 340 Marine <input type="checkbox"/> 345 Marine Product Liability <input type="checkbox"/> 350 Motor Vehicle <input type="checkbox"/> 355 Motor Vehicle Product Liability <input type="checkbox"/> 360 Other Personal Injury <input type="checkbox"/> 362 Personal Injury - Medical Malpractice	PERSONAL INJURY <input type="checkbox"/> 365 Personal Injury - Product Liability <input type="checkbox"/> 367 Health Care/Pharmaceutical Personal Injury Product Liability <input type="checkbox"/> 368 Asbestos Personal Injury Product Liability PERSONAL PROPERTY <input type="checkbox"/> 370 Other Fraud <input type="checkbox"/> 371 Truth in Lending <input type="checkbox"/> 380 Other Personal Property Damage <input type="checkbox"/> 385 Property Damage Product Liability	<input type="checkbox"/> 625 Drug Related Seizure of Property 21 USC 881 <input type="checkbox"/> 690 Other LABOR <input type="checkbox"/> 710 Fair Labor Standards Act <input type="checkbox"/> 720 Labor/Management Relations <input type="checkbox"/> 740 Railway Labor Act <input type="checkbox"/> 751 Family and Medical Leave Act <input type="checkbox"/> 790 Other Labor Litigation <input type="checkbox"/> 791 Employee Retirement Income Security Act IMMIGRATION <input type="checkbox"/> 462 Naturalization Application <input type="checkbox"/> 465 Other Immigration Actions	<input type="checkbox"/> 422 Appeal 28 USC 158 <input type="checkbox"/> 423 Withdrawal 28 USC 157 PROPERTY RIGHTS <input type="checkbox"/> 820 Copyrights <input type="checkbox"/> 830 Patent <input type="checkbox"/> 840 Trademark SOCIAL SECURITY <input type="checkbox"/> 861 HIA (1395ff) <input type="checkbox"/> 862 Black Lung (923) <input type="checkbox"/> 863 DIWC/DIWW (405(g)) <input type="checkbox"/> 864 SSID Title XVI <input type="checkbox"/> 865 RSI (405(g)) FEDERAL TAX SUITS <input type="checkbox"/> 870 Taxes (U.S. Plaintiff or Defendant) <input type="checkbox"/> 871 IRS—Third Party 26 USC 7609	<input type="checkbox"/> 375 False Claims Act <input type="checkbox"/> 400 State Reapportionment <input type="checkbox"/> 410 Antitrust <input type="checkbox"/> 430 Banks and Banking <input type="checkbox"/> 450 Commerce <input type="checkbox"/> 460 Deportation <input type="checkbox"/> 470 Racketeer Influenced and Corrupt Organizations <input type="checkbox"/> 480 Consumer Credit <input type="checkbox"/> 490 Cable/Sat TV <input type="checkbox"/> 850 Securities/Commodities/Exchange <input type="checkbox"/> 890 Other Statutory Actions <input type="checkbox"/> 891 Agricultural Acts <input type="checkbox"/> 893 Environmental Matters <input type="checkbox"/> 895 Freedom of Information Act <input type="checkbox"/> 896 Arbitration <input type="checkbox"/> 899 Administrative Procedure Act/Review or Appeal of Agency Decision <input type="checkbox"/> 950 Constitutionality of State Statutes

V. ORIGIN (Place an "X" in One Box Only)

1 Original Proceeding 2 Removed from State Court 3 Remanded from Appellate Court 4 Reinstated or Reopened 5 Transferred from Another District (specify) 6 Multidistrict Litigation

VI. CAUSE OF ACTION Cite the U.S. Civil Statute under which you are filing (Do not cite jurisdictional statutes unless diversity):
28 U.S.C. 2201-2202

Brief description of cause:
Declaratory Judgment regarding rights and obligations of the parties pursuant to an insurance contract.

VII. REQUESTED IN COMPLAINT: CHECK IF THIS IS A CLASS ACTION UNDER RULE 23, F.R.Cv.P. **DEMAND \$** _____ CHECK YES only if demanded in complaint: **JURY DEMAND:** Yes No

VIII. RELATED CASE(S) IF ANY (See instructions): JUDGE _____ DOCKET NUMBER _____

DATE: 06/08/2016 SIGNATURE OF ATTORNEY OF RECORD: 

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI

LIBERTY CORPORATE CAPITAL LTD.
and AMTRUST AT LLOYD'S LTD.

Plaintiff,

v.

ROCHELLE G. CATUS

Defendant,

)
)
)
)
)
)
)
)
)
)
)

Case No. 4:16-cv-816

ORIGINAL FILING FORM

**THIS FORM MUST BE COMPLETED AND VERIFIED BY THE FILING PARTY
WHEN INITIATING A NEW CASE.**

THIS SAME CAUSE, OR A SUBSTANTIALLY EQUIVALENT COMPLAINT, WAS
PREVIOUSLY FILED IN THIS COURT AS CASE NUMBER _____
AND ASSIGNED TO THE HONORABLE JUDGE _____.

THIS CAUSE IS RELATED, BUT IS NOT SUBSTANTIALLY EQUIVALENT TO ANY
PREVIOUSLY FILED COMPLAINT. THE RELATED CASE NUMBER IS _____ AND
THAT CASE WAS ASSIGNED TO THE HONORABLE _____. THIS CASE MAY,
THEREFORE, BE OPENED AS AN ORIGINAL PROCEEDING.

NEITHER THIS SAME CAUSE, NOR A SUBSTANTIALLY EQUIVALENT
COMPLAINT, HAS BEEN PREVIOUSLY FILED IN THIS COURT, AND THEREFORE
MAY BE OPENED AS AN ORIGINAL PROCEEDING.

The undersigned affirms that the information provided above is true and correct.

Date: 06/08/2016

/s/ Bradley R. Hansmann
Signature of Filing Party

AO 440 (Rev. 12/09) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

Eastern District of Missouri

LIBERTY CORPORATE CAPITAL LTD., et al.

Plaintiff

v.

ROCHELLE G. CATUS

Defendant

Civil Action No. 4:16-cv-816

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* Rochelle G. Catus
57 Frontenac Estates
Frontenac, MO 63131

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are:

Mr. Bradley R. Hansmann
Brown & James, P.C.
800 Market Street, Suite 1100
St. Louis, MO 63101-2501

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: _____

Signature of Clerk or Deputy Clerk

AO 440 (Rev. 12/09) Summons in a Civil Action (Page 2)

Civil Action No. 4:16-cv-816

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____
was received by me on *(date)* _____.

I personally served the summons on the individual at *(place)* _____
_____ on *(date)* _____ ; or

I left the summons at the individual's residence or usual place of abode with *(name)* _____
_____, a person of suitable age and discretion who resides there,
on *(date)* _____, and mailed a copy to the individual's last known address; or

I served the summons on *(name of individual)* _____, who is
designated by law to accept service of process on behalf of *(name of organization)* _____
_____ on *(date)* _____ ; or

I returned the summons unexecuted because _____ ; or

Other *(specify)*:

My fees are \$ _____ for travel and \$ _____ for services, for a total of \$ _____ 0.00.

I declare under penalty of perjury that this information is true.

Date: _____

Server's signature

Printed name and title

Server's address

Additional information regarding attempted service, etc: