IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

LINDA MOORE	:	
	:	
v.	:	
	:	
HEWLETT-PACKARD CO.	:	CIVIL NO. 99-2928

MEMORANDUM

Giles, C.J. April ___, 2000

This is an action arising under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 et seq., in which Linda Moore ("Moore") alleges that she was wrongfully denied disability benefits under the Hewlett-Packard Company's ("HP") Employee Benefits Organization Income Protection Plan and not given adequate notice of the denial. The court now considers HP's Motion for Summary Judgment, or in the alternative, Partial Summary Judgment on the ERISA claims against it. For the reasons that follow, HP's Motion for Summary Judgment is granted.

BACKGROUND

Material Facts

Moore, age 46, suffers from fibromyalgia[1] and connective tissue disease. She was last employed by HP as a computer sales associate. The primary function of an HP computer sales associate is to provide sales, marketing, order filling, and administrative account

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[1] Fibromyalgia, sometimes called fibrositis, is a condition that is associated with widespread aching, stiffness and fatigue, and originates in muscles and soft tissues. People with fibromyalgia are found to have multiple tender points in specific muscle areas. Most individuals complain of aching and stiffness in areas around the neck, shoulders, upper back, lower back and hip areas. American College of Rheumatology, *Fibromyalgia Fact Sheet* (visited March 15, 2000) <http:// www.rheumatology.org/patients/factsheet/fibromya.html.

management services to HP trade customers as part of an account management team. Over the course of a normal eight-hour day, a computer sales associate is required to: (1) sit seven hours; (2) bend ¼ hour; (3) walk ½ hour; (4) stand ¼ hour; (5) carry a notebook computer weighing five pounds; and (6) carry a briefcase weighing ten pounds.

HP's Income Protection Plan

HP adopted the Employee Benefits Organization Income Protection Plan (the "Plan") to provide a stream of income to eligible employees who become disabled. The Plan is sponsored by the HP Employee Benefits Organization (the "Organization") and is independently administered by Voluntary Plan Administrators, Inc. ("VPA"), pursuant to an administrative services contract. All employees on HP's United States payroll who work at least thirty (30) hours per week are "Members" of the Organization and are therefore eligible to participate in the Plan.

VPA, as the claims administrator, is vested with the exclusive authority to approve or deny members' claims for benefits. (Plan § 4(f) p. 13.). VPA is compensated based on a flat quarterly fee, and not on the number of claims processed, approved or denied. The Plan is entirely funded by HP; consequently, benefits are paid from the Plan's trust and not by VPA or an insurance company.

For VPA to approve a claim for benefits under the Plan, a Member must establish that she is "totally disabled" as defined by the Plan. Under the Plan, the phrase "totally disabled" applies both to short-term benefit applications and long-term disability applications. A Member seeking short-term disability benefits must show that "following the onset of the injury or sickness, [she] is continuously unable to perform each and every duty of . . . her Usual

Occupation.[2]" (Plan § 2(q) p. 6.). "Usual Occupation" is defined as "the normal work assigned to the Member" by HP. (Plan § 2(u) p. 9).

VPA must make determinations of total disability on the basis of "objective medical evidence." (Plan § 2(q) p. 6.). The Plan describes "objective medical evidence" as "evidence establishing facts or conditions as perceived without distortion by personal feelings, prejudices or interpretations." (Id.). This "objective evidence" must be provided to VPA by the Member seeking benefits as she is "solely responsible for submitting the claim form and any other information or evidence on which [she] intends the Claims Administrator to consider in order to render a decision on the claim." (Plan § 7(b) p. 25-26.). Similarly, if the Member appeals a VPA decision, she is "solely responsible for submitting a written request for review of the claim" and any additional documentation that she would have the Claims Administrator consider in order to render a decision on review. (Plan § 8(b) p. 28.).

Even if a Member initially qualifies for benefits, VPA has the right to "reassess the [Member's] eligibility for benefits based on the diagnosis, prognosis, treatment plan, adequacy of documentation submitted" and any other factors "consistent with Claims Administrator's standard procedures." (Plan § 7(b) p. 26.).

Moore's Claim for Short-Term Benefits

On February 6, 1998, Moore suffered an attack of fibromyalgia and went out on sick leave. Pursuant to the terms of the Plan, she began receiving short-term benefits of approximately $540 per week (75% of her salary) on February 13, 1998. At the same time, VPA

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[2] Likewise, a Member seeking long-term benefits must demonstrate that after thirty-nine weeks from the onset of the injury or sickness she remains "continuously unable to perform each and every duty of . . . her Usual Occupation." (Plan § 2(q) p. 6.).

started gathering information necessary to assess Moore's continued entitlement to benefits.

On February 20, 1998, VPA received Moore's application for short-term benefits. In the form she described her "disability" in terms of symptoms which included "fever, chest pains, lymph nodes swelling, [fatigue], and pain." (HP Employee Claim Form at 1.). In conjunction with her Employee Claim Form ("Claim Form"), Moore provided VPA with a Physician's Certification of Disability Form, completed by her family physician, Dr. Lucy E. Hornstein ("Dr. Hornstein"). In the form, Dr. Hornstein indicated that Moore was being treated for fibromyalgia and estimated Moore's return-to-work date to be May 1, 1998. Although the form specifically requested "Objective Findings in Support of [the] Diagnosis/ Disability, [*e.g.*,] tests, X-rays, or clinical findings," Dr. Hornstein wrote "N/A" in that section of the form. (Physician's Form § 2). Moore provided VPA with a Daily Activities Questionnaire ("Questionnaire") on March 11, 1998. In the Questionnaire, Moore stated that her condition caused her to take both a morning and an afternoon nap, and that this sleep pattern, along with her muscle pain, prevented her from sleeping well at night. (Questionnaire p. 1.). She also stated that she: (a) had no trouble taking care of her personal needs (*e.g.*, grooming herself); (b) prepared and cooked her own meals; © went grocery shopping (although she needed help lifting the packages); (d) was able to do housework with the aid of her husband; and (e) continued to drive a car. (Questionnaire p. 1-2.).

On March 2, 1998, VPA requested that Dr. Hornstein forward copies of all Moore's medical records dating back to February 2, 1998. Dr. Hornstein responded by providing one page of notes which showed no more than that Moore had been examined on February 2, 1998 and February 18, 1998, and that medication had been prescribed. On April 3, 1998, VPA

again wrote Dr. Hornstein. On this occasion, VPA specifically requested, all "[m]edical documentation including all the medical evidence, such as lab test results, X-rays, consulting physician's reports, or physical therapy results for the period of February 3, 1998 through the present." (Letter from VPA to Dr. Hornstein of 4/3/98, at 1.). In response, Dr. Hornstein furnished VPA with an additional page of notes regarding a March 11th examination of Moore as well as the results of a blood test which confirmed the diagnoses.

On April 21, 1998, Dr. Hornstein submitted a Continuation of Disability Form ("Continuation Form") to VPA. Although this form again requested "medical evidence, such as lab test results, X-rays, consulting physician's reports, or physical therapy results," (Continuation Form of 4/21/98), Dr. Hornstein simply indicated that she was still treating Moore for fibromyalgia which rendered her unable to work due to "pain and fatigue." Moore's return-to-work date was set at July 13, 1998. Subsequently, at VPA's request, Dr. Hornstein provided records which showed additional office visits on April 8, 1998 and April 21, 1998. VPA then requested all of Moore's medical records from January 1, 1996 forward. On June 25, 1998, Dr. Hornstein did provide these records to VPA along with a new Continuation Form. In the form, she stated that she last saw Moore on June 16, 1998 and that she still estimated Moore could return to work on July 13, 1998. (Continuation Form of 6/24/98)

On July 28, 1998, VPA mailed to Moore its initial denial of her claim for short-term benefits. In the letter, VPA outlined the provisions of the Plan under which Moore's claim was evaluated. The letter stated that Moore would have to be determined to be "continuously unable to perform each and every duty of . . . her Usual Occupation" based on a review of "objective medical evidence." (Letter from VPA to Moore of 7/28/98, at 1.). It further stated

that "objective medical evidence" means "evidence establishing facts or conditions as perceived without distortion by personal feelings, prejudices or interpretations." (Id.). VPA's letter then stated that, because Moore failed to provide VPA with "objective medical evidence to support disability," her claim was denied. (Letter from VPA to Moore of 7/28/98, at 2.). VPA's letter also explained the appeals process.

On August 13, 1998, Dr. Hornstein wrote a letter to VPA expressing disagreement with its decision to deny benefits on the basis that Moore's claim was unsupported by objective medical evidence. On October 2, 1998, Moore submitted a written request for an appeal of VPA's July 28th decision. As a part of the appeals process, VPA requested that Dr. Hornstein provide all Moore's records from July 24, 1998 forward. When received, Dr. Hornstein's records revealed that Moore had an MRI done on September 3, 1998, which was normal, and that she had been referred to a specialist, Dr. Larry Leventhal ("Dr. Leventhal") whom she was to see on October 19, 1998. Dr. Hornstein also submitted a new Continuation of Disability form which stated that Moore continued to suffer from "fatigue, back/joint/muscle pain." (Continuation Form of 7/24/98). Moore's return-to-work date was revised to October 1, 1998. VPA then requested that Dr. Leventhal provide all of his medical records on Moore.

On October 26, 1998, VPA forwarded all of Moore's medical records to Dr. James Schroeder ("Dr. Schroeder"), a Board Certified Rheumotologist at Northwestern Medical Facility Foundation in Chicago, Illinois. He was engaged to provide a diagnosis based on the records, and render an opinion as to the extent of any work limitations or restrictions should be placed on Moore. (Letter from VPA to Schroeder of 10/26/98, at 1.). Although Dr. Schroeder agreed with Moore's diagnosis of fibromyalgia and acknowledged that Moore suffers from

fatigue and muscle pain, he opined that based on Moore's medical records there was "no objective basis for an assertion of disability or specifically any inability to work." (Letter from Schroeder to VPA of 12/5/98, at 1.).

After Dr. Schroeder had rendered this opinion, VPA received a copy of Dr. Leventhal's records regarding Moore's October 19, 1998 visit. Dr. Leventhal's opinion was consistent with the opinions of Dr. Hornstein and Dr. Schroeder that Moore suffered from fibromyalgia and connective tissue disease. However, he did not opine whether Moore's conditions rendered her unable to work. VPA sent Dr. Leventhal's evaluation of Moore to Dr. Schroeder to review and revise his opinion, if appropriate. In response, Dr. Schroeder noted that although Dr. Leventhal's records clarified Moore's diagnosis, they did nothing further to "substantiate any physical disability or impairment" that would prevent Moore from working. (Letter from Dr. Schroeder to VPA of 1/11/99, at 1.).

On January 28, 1999, VPA communicated its final decision on Moore's appeal. The letter outlined the necessary duties of Moore's computer sales associate position. As was done in Moore's initial denial of benefits letter, VPA detailed the applicable Plan provisions under which it was required to evaluate Moore's claim, including the requirement that, in order to find Moore "totally disabled," there had to be "objective medical evidence" that she was "continuously unable to perform each and every duty of . . . her Usual Occupation." (Letter from VPA to Moore of 1/28/99, at 1-2.). The letter stated that VPA considered Dr. Hornstein's office visit notes, Dr. Leventhal's report, and Dr. Schroeder's evaluation. Finally, the letter stated that, although VPA realized that Moore's condition caused her great discomfort, they were "unable to authorize benefits under the Plan" due to the lack of "objective documentation . . . support[ing]

work related restrictions." (Letter from VPA to Moore of 1/28/99, at 2.)

On June 9, 1999, Moore filed this suit alleging that she was wrongfully denied benefits by HP, by and through VPA, in violation of § 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1). Moore's Complaint further asserted that HP, by and through VPA, incorrectly concluded that her medical records failed to show objective medical evidence. In doing so, Moore claimed that HP failed to describe properly the materials necessary to perfect her claim in violation of ERISA's notice provision, 29 U.S.C. § 1133.[3] HP argues that Moore's denial of benefit was appropriate under the Plan and that Moore, by suing HP and not VPA, sued the wrong party. HP further argues that it provided Moore with adequate notice of what it required to complete her application for benefits. The court agrees with HP and grants summary judgment in its favor.

DISCUSSION

[3] In an Order dated October 25, 1999, this court dismissed with prejudice Counts III and IV of Moore's Complaint which were preempted by ERISA and struck Moore's Demand for Jury Trial. See Pane v. RCA Corp., 868 F.2d 631, 636 (3d Cir. 1989) (holding that private actions under § 1132(a)(1)(B) are equitable and carry no right to a jury trial).

Statement of Jurisdiction

This court has federal question jurisdiction over this matter pursuant to 28 U.S.C. § 1331 as the claims arise under ERISA, a law of the United States.

Analysis

I. HP is Entitled to Summary Judgment Because it is Not A Proper Party to This Suit.

A claim for benefits under ERISA, § 502(a)(1)(B) must be brought against the plan itself or the administrator with discretionary authority and responsibility for the denial of the claim, not the employer or sponsor. See 29 U.S.C. § 1132(d)(2); see also Curcio v. John Hancock Mut. Life Ins. Co., 33 F.3d 226, 233-35 (3d Cir. 1994) (stating that employer only a proper ERISA defendant if it is a fiduciary to the plan). ERISA makes clear that a fiduciary is one that maintains discretionary authority or discretionary responsibility in the administration of the plan. 29 U.S.C. § 1102(a). ERISA defines "administrator" as "the person specifically so designated by the terms of the instrument under which the plan is operated." 29 U.S.C. § 1002(16)(A)(I).

HP sponsors the Plan through its Employee Benefits Organization which has properly assigned its fiduciary duties and responsibilities to VPA pursuant to 29 U.S.C. § 1140. Thus, VPA, not HP, is the "Plan Administrator" for purposes of daily operation of the plan and is, therefore, the administrator for purposes of any liability determination. Because the named defendant, HP, is not the proper defendant for Moore's ERISA claim, summary judgment must be granted in favor of HP.

II. Summary Judgment is Appropriate on the Merits.

Even assuming HP were the proper defendant for Moore's suit, summary judgment should be granted to HP. An amendment of the complaint would be futile.

A. Moore's § 1132 Claim Fails As a Matter of Law.

1. The "Arbitrary and Capricious" Standard of Review Applies

Moore argues that this court should review her denial of benefits de novo because VPA, as the claim administrator, is an "agent" of HP and, as such, there is a "conflict of interest" which makes VPA's decisions suspect. (Pl.'s Answer to Def.'s Mot. For Summ. J. at. 15-16.). Specifically, Moore contends that because VPA and HP have contracted to have VPA act as the administrator of the Plan, the two have entered into a principal/agent relationship. (Pl.'s Sur-Reply in Opp'n to Def.'s Mot. for Summ. J. at 2-3.). Moore states that this alleged agency relationship imposes, "as a matter of law," a fiduciary duty upon VPA to act on the behalf of HP. (Id at 3.). HP contends that the court must apply the "arbitrary and capricious" standard of review because VPA, as fiduciary to the Plan, has been vested with the sole discretionary authority to determine benefits eligibility. (Def.'s Mot. For Summ. J. at. 11-15.).

a. No Conflict of Interest Exists Between VPA and HP.

Moore's argument, which is based on principles of common law agency, fails for two reasons. First, Moore confuses VPA's duties under its contract with HP. VPA is indeed a "fiduciary." However, as the claims administrator which has been vested with the exclusive authority to approve or deny Members' claims for benefits, it is a fiduciary to the Plan pursuant to §§ 1002(21)(A)(iii) and § 1140 of ERISA, and is not a fiduciary to HP under agency law. (Plan § 4(f) p. 13.). The burden of establishing that a conflict of interest exists where, as here, the Plan expressly vests the authority to interpret and administer is on the plaintiff. Kostrosits v.

GATX Corp. Non-Contributory Pension Plan for Salaried Employees, 970 F.2d 1165, 1173 (3d. Cir. 1992). Aside from relying on agency law as authority for asserting that the administration contract creates a conflict, and stating that administrative records are stamped "Received [date] HP," Moore has failed to produce any evidence of conflict. See Id. (noting that third circuit has found conflict where: (a) benefits come directly from sponsor's assets; and (b) plan contribution determined by the cost of satisfying plan liabilities in immediately preceding years). Indeed, Moore has not shown that HP incurs "direct expense[s] as a result of benefits, nor . . . benefit[s] directly from the denial or discontinuation of benefits." Id.

Even if Moore established that a conflict existed, the court would apply a heightened arbitrary and capricious standard of review, not a de novo review. The third circuit has concluded that once a "plaintiff has established the existence of sufficient facts" to prove a conflict of interest, then the court should a apply "modified arbitrary and capricious standard." Id.

b. Arbitrary and Capricious Standard Applies to VPA.

Where an ERISA-governed benefits plan grants discretionary authority to a plan administrator or fiduciary to determine eligibility for benefits under the plan, a court reviewing the plan administrator's actions should apply the arbitrary and capricious standard of review. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 114 (1989); Dewitt v. Penn-Del Directory Corp.,106 F.3d 514, 520 (3d Cir. 1997). The plan need not contain explicit language granting discretionary authority to the administrator in order for the arbitrary and capricious standard to apply. Luby v. Teamsters Health, Welfare, and Pension Trust Funds, 944 F.2d 1176, 1180 (3d Cir.1991). "However, if the plan is ambiguous as to whether the administrator has discretionary

authority, then, under the doctrine of contra profentum," the Court must exercise a de novo review. Heasley v. Belden & Blake Corp, 2 F.3d 1249, 1258 (3d Cir.1993).

The Plan states that: "The [Hewlett-Packard Co. Employee Benefits] Organization is the named fiduciary which has the discretionary authority to act with respect to any appeal from a denial of benefits . . . to determine eligibility for benefits and to construe the terms of the Plan." (Plan § 8(a) p. 28.). This language shows that the discretionary authority to decide claims is vested in the Organization.

The Plan, however, further delegates the Organization's discretionary authority to the Claims Administrator, VPA.[4] Under ERISA, a named fiduciary may properly delegate its fiduciary responsibilities:

> The instrument under which a plan is maintained may expressly provide for procedures . . . (B) for named fiduciaries to designate persons other than named fiduciaries to carry out fiduciary responsibilities (other than trustee responsibilities) under the plan.

29 U.S.C. § 1105(c)(1)

Where the ERISA plan expressly gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan, and a named fiduciary properly delegates its discretionary authority to another fiduciary, the "arbitrary and capricious" standard of review has been applied to the designated ERISA-fiduciary as well as to the named fiduciary. Madden v. ITT Long Term Disability Plan, 914 f.2d 1279, 1283-85 (9th

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[4] The Claims Administrator is given the authority to make the determination of "total disability," and is responsible for processing the claims and periodically reassessing its disability determinations. (Plan § 2(q) p. 6; § 4(f) p. 13; § 7(6) p. 25-26). The Administrator is also granted the discretionary power to construe the language of the Plan and make the review decisions for denied claim appeals. (Plan § 8© p. 29.).

Cir. 1990) (holding that where fiduciary properly delegates its discretionary authority to another fiduciary, arbitrary and capricious standard applies); Rodriguez-Abreu v. Chase Manhattan Bank, N.A., 986 F.2d 580, 584 (1st Cir. 1993) (citing to Madden for proposition that arbitrary and capricious standard applies to fiduciary whose authority is derived by delegation); see also Ladd v. ITT Indus., Inc., CIV.A.97-3380, 1997 WL 769460, at *6 (N.D. Ill. Dec. 9, 1997) (holding that arbitrary and capricious standard applicable where fiduciary properly delegated discretionary authority to another fiduciary).

Based on the holding in Firestone that the decisions of a fiduciary are due deference, and the rationale of the circuits that have extended such deference to an administrator whose fiduciary obligations are derived through delegation, this court holds that the decision of VPA to deny Moore's claim must be reviewed under the "arbitrary and capricious" standard.

2. VPA's Decision Was Not Arbitrary and Capricious

For the purpose of determining whether the administrator's decision was arbitrary and capricious, a reviewing court must confine its review to the evidence before the administrator at the time the challenged decision was made.[5] Mitchell v. Eastman Kodak Co., 113 F.3d 433, 440 (3d Cir. 1997). A Claims Administrator must make its determinations in accordance with the provisions of the governing documents and instruments of the ERISA-governed plan. 29 U.S.C. § 1104(a)(1)(D). Therefore, to be valid, VPA's decision must have been rendered in a manner consistent with HP's Plan, based upon the information that was before

[5] A court may determine whether the fiduciary's decision was an abuse of discretion using only the records before the fiduciary at the time of its determination. Therefore, the Declaration of Linda Moore filed in support of Plaintiff's Answer to Defendant's Motion for Summary Judgment cannot be considered since it was not part of the record upon which the decision was made.

it at the time.

The Plan specifies that a Member is entitled to benefits only if, based on "objective medical evidence" (*e.g.*, lab test results, X-rays, consulting physician's reports, or physical therapy results), it can be established that she is "continuously unable to perform each and every duty" of her usual position at HP. At the time it rendered its decision on Moore's request for benefits, VPA had in its possession: Moore's medical records dating back to January 1, 1996 from Dr. Hornstein; reports from Dr. Leventhal; two opinions from Dr. Schroeder; and the Questionnaire that Moore filled out herself.

Dr. Hornstein's records, which consist primarily of the doctor's examination notes, do not contain any "objective medical evidence" as described by the Plan. Although Dr. Hornstein's notes detail Moore's symptoms, complaints, and concerns, and give insight into the doctor's diagnosis, impressions, and proposed treatment options, there is nothing in those records that objectively supports a determination that Moore could not perform each and every function of her job at HP. There are no X-rays on record, no test reports, or any other data that could be considered objective evidence "perceived without distortion by personal feelings, prejudices or interpretations" as to Moore's inability to perform each and every facet of her job. Indeed, Dr. Hornstein's opinion about Moore's inability to work constitutes subjective evidence in support Moore's claim.

The reports of Dr. Leventhal, Moore's consulting specialist, also were devoid of any objective medical evidence of total disability. Although Dr. Leventhal confirmed objectively Moore's fibromyalgia diagnosis, he did not opine whether Moore's disease was such that she was completely unable to perform each and every duty required by her position at HP.

Although Dr. Schroeder was contracted by VPA to conduct an independent review of Moore's records, there was nothing improper about VPA's reliance on his opinion to aid it in making Moore's benefits determination. See Irvin v. Metropolitan Life Ins. Co., No. CIV.A.98-2909, 1998 WL 401690, at *9-11 (E.D. Pa. June 30, 1998) (Pollak, J.) (holding that it was not arbitrary and capricious for plan administrator to rely on opinion of independent specialist it engaged where opinions of claimant's physician and independent specialist conflicted). The Schroeder report is basically a diagnosis based solely on a review of Moore's medical records (primarily, examination notes). Although Dr. Schroeder agrees with Doctors Hornstein and Leventhal that Moore suffers from fibromyalgia and connective disease, and that those conditions cause her discomfort and pain, he concluded that, after a review of all of the data submitted in support of Moore's claim, there was insufficient information to show that Moore was fully unable to perform each and every duty of her job.

The Questionnaire that Moore submitted in support of her application for benefits was also part of the evidence before VPA when it made its decision. Because that questionnaire is by nature full of subjective information supplied by the claimant, it cannot be considered "objective medical evidence." A VPA denial of benefits based solely on the questionnaire would indeed be arbitrary and capricious. However, the record shows that such was not the case.

Based on a review of the evidence before VPA at the time it made its decision, it cannot be said that its decision that Moore was not totally disabled was arbitrary and capricious. Because there are no genuine issues of material fact for trial, summary judgment is appropriate.

B. Summary Judgment is Appropriate for HP on Moore's § 1133 Claim.

Moore also argues that HP, by and through VPA, did not adequately notify her

regarding the provision of further medical information to support her benefit claim. Under ERISA, adequate notice in writing must be provided to any participant whose benefit claim has been denied. 29 U.S.C. § 1133(1). The notice of denial must contain: (I) the specific reason(s) for the denial; (ii) specific reference to pertinent plan provisions on which denial is based; (iii) a description of additional material necessary to perfect the claim; and (iv) how to appeal the denial. 29 C.F.R. § 2560.503-1(f). Likewise, a decision on review shall be in writing and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, as well as specific references to the pertinent plan provisions on which the decision is based. 29 C.F.R. § 2560.503-1(h)(3). VPA's denial letters conform to these requirements.

The record shows that VPA promptly notified Moore of its decision to terminate her Plan benefits, stating that her claim was denied because there was no "objective medical evidence" to support her claim of total disability. The record also shows that VPA specifically requested Moore to submit any additional medical reports that would corroborate her claim on appeal but she submitted none. Moreover, despite the fact that the Plan's provisions placed the burden on Moore to gather and submit all pertinent objective medical evidence, VPA contacted her doctors directly seeking definitive data. The court concludes that the content and context of VPA's notice to Moore does not give rise to a genuine dispute of material fact as to adequacy.

An appropriate Order follows.

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF PENNSYLVANIA

LINDA MOORE,	:	CIVIL ACTION
Plaintiff	:	
	:	
	:	
v.	:	
	:	
	:	
HEWLETT-PACKARD COMPANY,	:	
Defendant	:	NO. 99-2928

JUDGMENT

AND NOW, this ___ day of April, 2000, upon consideration of the Defendant's Motion for Summary Judgment, or in the alternative, Partial Summary Judgment, and the opposition thereto, it hereby is ORDERED that the Defendant's motion is GRANTED. Judgment is ENTERED IN FAVOR of the Defendant.

All pending motions are DENIED AS MOOT.

BY THE COURT:

_____
JAMES T. GILES C.J.

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to