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

DEBORAH A. BONENFANT,

Plaintiff,

No. CIV S-10-0361 KJM-KJN

vs.

STANDARD INSURANCE  
COMPANY, a corporation; and DOES  
1 through 30, inclusive,

Defendant.

ORDER

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This matter comes before the court on defendant Standard Insurance Company's motion for summary judgment on plaintiff Deborah Bonenfant's claim for breach of the duty of good faith and fair dealing. (ECF 23.) The court heard oral argument on the motion on July 13, 2011; Linda Lawson appeared for defendant and Robert Scott appeared for plaintiff. For the following reasons, defendant's motion for partial summary judgment is hereby GRANTED.

I. PROCEDURAL HISTORY AND UNDISPUTED FACTS

Plaintiff filed her complaint in Placer County Superior Court on December 9, 2009 alleging two causes of action: breach of contract and breach of the duty of good faith and fair dealing. (ECF 2-1.) Defendant removed the action to this court on February 11, 2010. (ECF 2.) Defendant filed the present motion for summary judgment on May 6, 2011. (ECF 23.)

1 Plaintiff filed her opposition on May 25, 2011 (ECF 25) and an amended opposition on June 29,  
2 2011. (ECF 27.)<sup>1</sup> Defendant filed its reply on June 30, 2011. (ECF 28.)

3 Defendant issued plaintiff an individual disability income insurance, policy  
4 number C7445470 (“the policy”), which became effective on April 10, 1997. (Def.’s Statement  
5 of Undisputed Facts ¶ 1, ECF 23-2 (hereinafter, “ECF 23-2”); Pl.’s Responsive Statement of  
6 Undisputed Facts ¶ 1, ECF 25-1 (hereinafter, “ECF 25-1”).) The policy defines “Total  
7 Disability/Totally Disabled” as the following:

8 Because of Your Injury or Sickness:

- 9 1. You are unable to perform the substantial and material  
10 duties of Your Regular Occupation; and
- 11 2. You are not engaged in any other gainful occupation; and
- 12 3. You are under the regular care of a Physician appropriate  
13 for Your Injury or Sickness.

14 (Not. of Removal, Compl. Ex. 1, ECF 2-1 at 24.) The policy defines “Regular Occupation” as  
15 “your occupation at the time Disability begins” “[u]ntil You have received 60 monthly payments  
16 for a Continuous Disability” after which time it is “any occupation for which You are reasonably  
17 fitted by education, training and experience.” (*Id.*) Plaintiff notified defendant that she was  
18 submitting a claim for benefits on April 11, 2007. (ECF 23-2 ¶ 5; ECF 25-1 ¶ 5.)

19 On her Insured’s Statement, plaintiff listed her occupation title as “manager” and  
20 listed her job duties as “at computer typing notes from meetings, doing reports”; “business  
21 meetings”; “telephone conversations”; and “administrative staff, coach, mentor.” (Nickelson  
22 Decl., Ex. 3, ECF 23-14.) Plaintiff indicated she became unable to work on February 26, 2007,

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23 <sup>1</sup> Plaintiff’s briefs ignore the standing orders of the previously-assigned district judge  
24 (ECF 6) and the undersigned, placing a limit of twenty (20) pages on oppositions. Counsel is  
25 cautioned to strictly comply with the Federal Rules of Civil Procedure, Local Rules and the  
26 court’s standing order in the future. Counsel also is cautioned that failure to obtain the court’s  
permission prior to filing documents in excess of court-mandated page limits is sanctionable in  
accordance with Local Rule 110 and can result in an order striking documents with leave to  
refile compliant documents or in the court’s ignoring all excess pages. In this instance, given  
that more than nine pages of the memorandum are a copied and pasted segment of David  
Peterson’s Declaration, which is in the record (ECF 25-3 at 11-25), the court disregards these  
pages of the memorandum. (ECF 27-1 at 15-25.)

1 that her illness was “ruptured cervical disks,” and that her symptoms include “neck pain, severe  
2 headaches, tingling & numbness in arms & hands.” (*Id.*) She listed her attending physicians as  
3 Dr. Ernest Agresti, Dr. Pasquale Montesanto, and Dr. Elvert Nelson. (*Id.*) Plaintiff also  
4 submitted an Attending Physician’s Statement (“APS”) from Dr. Agresti dated April 20, 2007,  
5 which identified plaintiff’s primary condition as cervical disc herniation with a secondary  
6 diagnosis of cervicgia and other diagnoses of hypothyroid, hypertension, hyperlipidemia,  
7 gastro esophageal reflux spasm, pain, numbness, tingling, weakness and osteoarthritis.  
8 (Nickelson Decl., Ex. 4, ECF 23-15.) Dr. Agresti further indicated that plaintiff’s functional  
9 capacity was severely limited and that she had the following physical limitations, which he  
10 anticipated would impair plaintiff until September 10, 2007: standing/sitting/walking;  
11 bending/stooping; lifting/carrying; and use of hands. (*Id.*)

12           On May 2, 2007, one of defendant’s employees spoke with plaintiff, at which  
13 time plaintiff indicated that she sat most of the work day. (Nickelson Decl., Ex. 5, ECF 23-16.)  
14 Also on May 2, 2007, defendant requested records from Dr. Agresti, Dr. Montesanto and Dr.  
15 Nelson (Nickelson Decl., Ex. 6, ECF 23-17)<sup>2</sup> and referred plaintiff’s claim to a vocational  
16 consultant, Don Earwood, to review plaintiff’s “regular occupation.” (ECF 23-2 ¶ 19; ECF 25-1  
17 ¶ 19.)<sup>3</sup> On May 8, 2007, Earwood reviewed plaintiff’s Insured’s Statement, resume and notes of  
18 the May 2, 2007 phone call. (Nickelson Decl., Ex. 7, Earwood Report Mem., ECF 23-18.)

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20 <sup>2</sup> On August 16, 2007, Dr. Agresti submitted another APS to defendant. (Nickelson Decl.  
21 Ex. 12, ECF 23-23.) On October 3, 2007, defendant also received medical records from Dr.  
22 Orisek. (ECF 23-2 ¶ 33; ECF 25-1 ¶ 33.) On January 30, 2008, defendant received another APS  
23 from Dr. Agresti. (ECF 23-2 ¶ 36; ECF 25-1 ¶ 36.) On July 17, 2008, defendant requested  
24 medical records from Drs. Agresti, Hankins and Schaefer. (ECF 23-2 ¶ 49; ECF 25-1 ¶ 49.)  
25 Defendant requested updated medical records again on January 28, 2009. (ECF 23-2 ¶ 62; ECF  
26 25-1 ¶ 62.) Defendant received another APS from Dr. Agresti on July 17, 2009. (ECF 23-2 ¶  
84; ECF 25-1 ¶ 84.)

<sup>3</sup> Plaintiff disputes “that [Earwood] reviewed Bonenfant’s regular occupation properly or  
at all” (ECF 25-1 ¶ 19) but cites only to the Peterson declaration, in which Peterson states that  
Earwood’s conclusion regarding the classification of plaintiff’s job “was unreasonable.”  
(Peterson Decl. at 11, ECF 25-3.) This declaration is inadmissible, as will be discussed below,  
and plaintiff provides no other evidence for her position in this regard.

1 Relying on the U.S. Department of Labor’s Dictionary of Occupational Titles, Earwood  
2 determined that the “Manager, Office” occupation best described the duties of plaintiff’s regular  
3 occupation. (*Id.*) This occupation is described as “sedentary strength, [requiring] the exertion of  
4 force ‘to 10 lbs. occasionally, or a negligible amount of force frequently to lift, carry, push, pull,  
5 or move objects.’” (*Id.*) Defendant further submitted plaintiff’s medical records to Dr. David  
6 Waldram, a physician consultant board certified in orthopedic surgery, for review. (ECF 23-2 ¶  
7 24; ECF 25-1 ¶ 24.) Dr. Waldram found support for limitations and restrictions being placed on  
8 plaintiff from February 23, 2007 to August 2007; specifically, that plaintiff should avoid  
9 “prolonged sitting, moving neck & can’t do repetitive bending or lifting.” (Nickelson Decl., Ex.  
10 9, ECF 23-20.)

11 Defendant approved plaintiff’s application for disability benefits on June 12,  
12 2007. (Nickelson Decl., Ex. 10, ECF 23-21.) Defendant continued to receive periodic updates  
13 from plaintiff and her doctors. *See, e.g.*, note 2 *supra*. On July 15, 2008, plaintiff left defendant  
14 a voice message stating she had not been receiving State Disability as of February 2008 and that  
15 she applied for social security disability and was denied, which decision she appealed, which  
16 appeal was denied. (Nickelson Decl., Ex. 20, ECF 23-31.) On November 5, 2008, Dr. Waldram  
17 reviewed plaintiff’s medical records and indicated that plaintiff “could have returned to  
18 sedentary work with no overhead use of either extremity” as of August 2007 through to the date  
19 of an April 11, 2008 surgery, and that she could have returned to work after that surgery on June  
20 26, 2008. (Nickelson Decl., Ex. 24, ECF 23-35.) On April 28, 2009, Dr. Waldram again  
21 reviewed plaintiff’s medical records and indicated that she could have returned to work after her  
22 December 31, 2008 surgery, with limitations. (Nickelson Decl., Ex. 30, ECF 23-41.) However,  
23 on May 5, 2009, Dr. Waldram indicated that based on records from April 2009 “it was still  
24 reasonable at this time that [plaintiff] has not gone back to work” and told defendant to obtain  
25 her most recent medical records. (Nickelson Decl., Ex. 31, ECF 23-42.) On May 5, 2009,  
26 defendant contacted Dr. Schaefer and asked if plaintiff could go back to work; on May 6, 2009,

1 Dr. Schaefer sent defendant a letter stating that plaintiff could return to work as long as she did  
2 not perform overhead work or lift more than ten pounds. (Nickelson Decl., Ex. 32, ECF 23-43.)  
3 On May 26, 2009, Dr. Waldram stated he agreed with Dr. Schaefer that plaintiff could return to  
4 work restricted to no overhead work or lifting over ten pounds. (Nickelson Decl., Ex. 33, ECF  
5 23-44.) On June 4, 2009, defendant referred plaintiff's file to a vocational consultant, Jan  
6 Cottrell, for clarification as to the requirements of plaintiff's regular occupation; Dr. Cottrell  
7 concluded that overhead reaching is not required for plaintiff's occupation, nor is exerting over  
8 ten pounds of force. (ECF 23-2 ¶ 79; ECF 25-1 ¶ 79; Nickelson Decl., Ex. 34, ECF 23-45.) On  
9 September 30, 2009, defendant notified plaintiff that it had determined she no longer met the  
10 policy's definition of disability. (Nickelson Decl., Ex. 37, ECF 23-48.) This notification letter  
11 indicates that Dr. Waldram reviewed plaintiff's complete medical file, including updates  
12 received from her various physicians, and concluded that she was able to return to work in her  
13 sedentary position. (*Id.* at 6-7.)

14 II. OBJECTIONS TO EVIDENCE<sup>4</sup>

15 Defendant objects to the Peterson declaration "because his opinion testimony  
16 constitutes improper legal conclusions which usurp the function of the Court and jury" and on  
17 the grounds of lack of foundation, speculation, improper opinion testimony, improper legal  
18 conclusion, the best evidence rule, hearsay, relevance and mischaracterizing the evidence.  
19 (Def.'s Obj. Evid. at 4-41, ECF 28-2.) The court sustains defendant's objection for the following  
20 reasons and hereby strikes the Peterson declaration in its entirety. As a preliminary matter, this  
21 declaration is inadmissible as it is not signed. Furthermore, the court finds an utter lack of  
22 foundation explaining how Peterson, plaintiff's proffered "expert," came by any of his  
23 underlying facts, such as his contention that Earwood was never provided with plaintiff's  
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25 <sup>4</sup> The court generally addresses only those objections to evidence upon which it relies. In  
26 this section, however, the court addresses those objections to evidence upon which plaintiff  
heavily relies, as it has determined not to consider this evidence.

1 resume. (Peterson Decl. at 11). See *Rodriguez v. Airborne Express*, 265 F.3d 890, 902 (9th Cir.  
2 2001) (“This circuit has held that self-serving affidavits are cognizable to establish a genuine  
3 issue of material fact so long as they state facts based on personal knowledge and are not too  
4 conclusory.”). “An affidavit or declaration used to . . . oppose a motion must be made on  
5 personal knowledge, set out facts that would be admissible in evidence, and show that the affiant  
6 or declarant is competent to testify on the matters stated.” FED. R. CIV. P. 56(c)(4). The  
7 Peterson declaration does not meet any of these criteria. In addition, Peterson’s declaration does  
8 not serve to “assist the trier of fact to understand the evidence or to determine a fact in issue,”  
9 FED. R. EVID. 702, but consists of purely conclusory statements. *Hernandez v. City of Napa*,  
10 2011 U.S. Dist. LEXIS 28757, at \*30 (N.D. Cal. Mar. 21, 2011) (quoting *Soremekun v. Thrifty*  
11 *Payless, Inc.*, 509 F.3d 978, 984 (9th Cir. 2007)) (“Conclusory, speculative testimony in  
12 affidavits and moving papers is insufficient to raise genuine issues of fact and defeat summary  
13 judgment.”). Moreover, Peterson’s statements consist of opinions on ultimate issues of law,  
14 which are inadmissible. *Mukhtar v. Cal. State Univ.*, 299 F.3d 1053, 1066 n.10 (9th Cir. 2002).  
15 Furthermore, much of Peterson’s declaration consists of inadmissible hearsay, offered to prove  
16 the truth of the matter asserted. FED. R. EVID. 801. In addition, portions of the declaration are  
17 directly contradicted by plaintiff’s statement of undisputed facts and other facts in the record.  
18 (*E.g., compare* ECF 25-1 ¶ 20 *with* Peterson Decl. at 11:23.)

19 Defendant also objects to Exhibit I to the Scott Declaration, contending that it has  
20 not been properly authenticated. (Def.’s Obj. to Evid. at 2-3.) The court sustains this objection  
21 and hereby strikes Exhibit I in its entirety, as well as any references to Exhibit I in plaintiff’s  
22 opposition. Moreover, counsel for plaintiff admitted both in his declaration and at the motion  
23 hearing that this exhibit was not filed and served electronically. (Scott Decl. ¶ 10, ECF 25-2.)  
24 Local Rule 133(a) expressly states: “Unless excused by the Court or by the electronic filing  
25 procedures set forth in these Rules, attorneys shall file all documents electronically pursuant to  
26 those Rules.” Local Rule 260(b) states: “The opposing party shall be responsible for the filing

1 of all evidentiary documents cited in the opposing papers.” Moreover, Federal Rule of Civil  
2 Procedure 56(c)(1)(A) provides that parties may support their assertions by “citing to particular  
3 parts of materials in the record . . .”; however, Exhibit I is not “in the record” and plaintiff’s  
4 reliance on the unfiled, unserved Exhibit I is in contravention of the Local Rules, Federal Rule of  
5 Civil Procedure 56, and established common law. *See, e.g., Nicholson v. Hyannis Air Serv.*, 580  
6 F.3d 1116, 1127 (9th Cir. 2009) (documents that are not filed do not become part of the record).

7 III. ANALYSIS

8 A. Standard

9 A court will grant summary judgment “if . . . there is no genuine dispute as to any  
10 material fact and the movant is entitled to judgment as a matter of law.” FED. R. CIV. P. 56(a).  
11 The “threshold inquiry” is whether “there are any genuine factual issues that properly can be  
12 resolved only by a finder of fact because they may reasonably be resolved in favor of either  
13 party.” *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 250 (1986).<sup>5</sup>

14 The moving party bears the initial burden of showing the district court “that there  
15 is an absence of evidence to support the nonmoving party’s case.” *Celotex Corp. v. Catrett*, 477  
16 U.S. 317, 325 (1986). The burden then shifts to the nonmoving party, which “must establish that  
17 there is a genuine issue of material fact . . . .” *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*,  
18 475 U.S. 574, 585 (1986). In carrying their burdens, both parties must “cit[e] to particular parts  
19 of materials in the record . . . ; or show [] that the materials cited do not establish the absence or  
20 presence of a genuine dispute, or that an adverse party cannot produce admissible evidence to  
21 support the fact.” FED. R. CIV. P. 56(c)(1); *see also Matsushita*, 475 U.S. at 586 (“[the  
22 nonmoving party] must do more than simply show that there is some metaphysical doubt as to  
23 the material facts”). Moreover, “the requirement is that there be no *genuine issue of material*

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25 <sup>5</sup> Rule 56 was amended, effective December 1, 2010. However, it is appropriate to rely  
26 on cases decided before the amendment took effect, as “[t]he standard for granting summary  
judgment remains unchanged.” FED. R. CIV. P. 56, Notes of Advisory Comm. on 2010  
amendments.

1 fact . . . . Only disputes over facts that might affect the outcome of the suit under the governing  
2 law will properly preclude the entry of summary judgment.” *Anderson*, 477 U.S. at 247-48  
3 (emphasis in original).

4 In deciding a motion for summary judgment, the court draws all inferences and  
5 views all evidence in the light most favorable to the nonmoving party. *Matsushita*, 475 U.S. at  
6 587-88; *Whitman v. Mineta*, 541 F.3d 929, 931 (9th Cir. 2008). “Where the record taken as a  
7 whole could not lead a rational trier of fact to find for the non-moving party, there is no ‘genuine  
8 issue for trial.’” *Matsushita*, 475 U.S. at 587 (quoting *First National Bank of Arizona v. Cities*  
9 *Service Co.*, 391 U.S. 253, 289 (1968)).

10 B. Application

11 Defendant contends it is entitled to summary judgment on plaintiff’s cause of  
12 action for breach of the covenant of good faith and fair dealing due to California’s “genuine  
13 dispute doctrine.” (Def.’s Mot. at 13.) Defendant contends that its “investigation and its denial  
14 of additional disability benefits were indisputably reasonable, in good faith, and due to a genuine  
15 dispute as to Bonenfant’s eligibility for such benefits.” (*Id.* at 14.) It further maintains that “the  
16 undisputed evidence in this case establishes, at a minimum, a genuine dispute regarding  
17 Bonenfant’s eligibility for further benefits.” (*Id.* at 17.) Plaintiff asserts that defendant cannot  
18 rely on the genuine dispute doctrine because its “conduct was below the standard of care when it  
19 acted unreasonably in investigating plaintiffs’ [sic] claim.” (Pl.’s Opp’n at 7.) Plaintiff contends  
20 that defendant did not “thoroughly investigate Plaintiff’s claim,” that its investigation of  
21 plaintiff’s claim was “below industry standards,” it “misapplied, misstated, misrepresented and  
22 at all times failed to even advise Plaintiff of the correct California definition of ‘total disability’  
23 in its correspondence,” and it “put its own financial interests above Plaintiff’s.” (*Id.* at 9, 10, 12  
24 & 13.)

25 The covenant of good faith and fair dealing “obligates the insurer: (1) to make a  
26 thorough and prompt investigation of the insured’s claim for benefits; and (2) not to

1 unreasonably delay or withhold payment of benefits.” *Casey v. Metropolitan Life Ins. Co.*, 688  
 2 F. Supp. 2d 1086, 1098 (E.D. Cal. 2010) (citing *Silberg v. California Life Ins. Co.*, 11 Cal. 3d  
 3 452, 461-62 (1974)). The covenant is breached where the insurer acts unreasonably or without  
 4 proper cause, *id.*; “[t]he mere denial of benefits . . . does not demonstrate bad faith.” *Hanson v.*  
 5 *The Prudential Ins. Co. of Am.*, 783 F.2d 762, 766 (9th Cir. 1985). Unreasonable in this context  
 6 means “without any reasonable basis for its position.” *Casey*, 688 F. Supp. 2d at 1098.  
 7 Accordingly, “bad faith liability does not exist for a legitimate dispute of an insurer’s liability  
 8 under the policy.” *Id.* “A genuine dispute exists only where the insurer’s position is maintained  
 9 in good faith and on reasonable grounds,” and its existence can be decided as a matter of law  
 10 “[p]rovided there is no dispute as to the underlying facts.” *Id.* at 1098-99; *see Bosetti v. United*  
 11 *States Life Insurance Co.*, 175 Cal. App. 4th 1208, 1237 (2009) (“The ‘genuine dispute’ . . .  
 12 doctrine . . . enables an insurer to obtain summary adjudication of a bad faith cause of action by  
 13 establishing that its denial of coverage, even if ultimately erroneous and a breach of contract,  
 14 was due to a genuine dispute with its insured.”).

15 ““An insurer’s good or bad faith must be evaluated in light of the totality of the  
 16 circumstances surrounding its actions.”” *Gentry v. State Farm Mut. Auto. Ins. Co.*, 726 F. Supp.  
 17 2d 1160, 1169 (E.D. Cal. 2010) (quoting *Wilson v. 21st Century Ins. Co.*, 42 Cal. 4th 713, 723  
 18 (2007)). Among other contentions, most notably regarding defendant’s alleged breaching of the  
 19 “industry standard,” plaintiff presents the following as the total circumstances: “1) Standard’s  
 20 consulting physician, Dr. Waldram, merely reviewed Plaintiff’s medical records; 2) Standard’s  
 21 adjuster, Ethel Sly, denied Plaintiff’s claim for disability benefits without actually knowing  
 22 either the definition of Plaintiff’s conditions or definition of the medication Plaintiff was taking  
 23 to treat the conditions;<sup>6</sup> 3) Standard failed to conduct an independent medical review of  
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25 <sup>6</sup> Plaintiff provides no evidence to support this second contention, nor is this conclusory,  
 26 self-serving statement an accurate description of defendant’s decision to deny plaintiff’s claim.  
 The court will not consider this contention.

1 Plaintiff's medical records; 4) Standard failed to conduct an independent medical exam to  
2 determine if Plaintiff was disabled; 5) Standard failed to apply the correct standard for total  
3 disability in California; and 6) Standard rejected Plaintiff's claim for disability benefits based on  
4 Plaintiff's problems with her shoulders when the main cause of her disability was the debilitating  
5 pain in her neck due to three-levels of cervical herniation."<sup>7</sup> (Pl.'s Opp'n at 26.)

6 Plaintiff's contention that it was unreasonable for Dr. Waldram to review  
7 plaintiff's records without speaking with any of plaintiff's physicians, and instead of defendant's  
8 conducting an independent medical exam of plaintiff (Pl.'s Mem. at 15), ignores the totality of  
9 the circumstances standard. As is set forth in a case relied on by plaintiff, California law does  
10 not require the insurer to have its own doctors examine the insured; rather, as previously stated,  
11 "[a]n insurer's good or bad faith must be evaluated in light of the totality of the circumstances  
12 surrounding its actions. [ ] In some cases, review of the insured's medical records might reveal an  
13 indisputably reasonable basis to deny the claim without further investigation." *Bosetti*, 175 Cal.  
14 App. 4th at 1240 n.27 (finding insurer's failure to have insured examined by its own doctors was  
15 not unreasonable as a matter of law quoting *Wilson v. 21st Century Ins. Co.*, 42 Cal. 4th at 723.  
16 In *Callahan v. Northwestern Mutual Life Insurance Company*, 2010 U.S. Dist. LEXIS 17232, at  
17 \*20 (N.D. Cal. Feb. 26, 2010), the Northern District found "[a]n insurance company is not  
18 always obligated to engage in an independent medical examination before denying benefits," and  
19 found the plaintiff's contention that the denial of benefits was unreasonable because the  
20 insurance company did not conduct an independent medical examination was not compelling.  
21 Here, as in *Callahan*, as is clear from the extensive review performed by defendant and  
22 discussed above in Section I, "there is no factual dispute regarding how [the insurance company]  
23 handled [plaintiff's] claim and made its determination that [plaintiff] was not entitled to

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25 <sup>7</sup> This sixth contention also will not be considered further except to state that it is clear  
26 from the letter in which defendant informed plaintiff of its decision to cancel benefits that  
plaintiff's condition in its entirety was considered in reaching said decision. (Nickelson Decl.,  
Ex. 37, ECF 23-48.)

1 benefits.” *Id.* In both cases, the insurance company sought medical records and medical  
2 opinions in making this determination and “no reasonable jury could find that there was no  
3 genuine dispute over [plaintiff’s] entitlement to disability benefits.” *Id.* at 21.

4           In ultimately denying plaintiff benefits, as discussed above, defendant relied on a  
5 variety of findings. *See* pages 2-5 *supra*; *see also* Nickelson Decl., Ex. 37, ECF 23-48. On May  
6 6, 2009, as previously stated, Dr. Schaefer, the orthopedic surgeon plaintiff originally contacted  
7 when she tore her rotator cuff, indicated in response to questions from defendant that plaintiff  
8 could return to work restricted to “no overhead work or lifting more than 10 pounds.”  
9 (Nickelson Decl., Exs. 31 & 32, ECF 23-42 & 23-43; ECF 25-1 ¶ 35.) On July 6, 2009, in  
10 contrast, Dr. Agresti, plaintiff’s family doctor, indicated that plaintiff was completely disabled  
11 and “unable to perform any work.” (Nickelson Decl., Ex. 35, ECF 23-46.) At the motion  
12 hearing, defendant informed the court that at the time of the denial, Drs. Agresti and Schaefer  
13 were plaintiff’s treating doctors. In addition, defendant contends it was reasonable to assume Dr.  
14 Schaefer knew about plaintiff’s other conditions. Plaintiff responded that Dr. Schaefer did not  
15 know about any of plaintiff’s conditions other than the shoulder problems he treated. However,  
16 as the doctor treating plaintiff’s neck was Dr. Picetti, an orthopedic surgeon, it is reasonable that  
17 in the face of conflicting opinions, defendant would place greater weight on the opinion of  
18 another orthopedic surgeon, especially as it was supported by defendant’s own consultant, Dr.  
19 Waldram. (*See* Nickelson Decl., Ex. 37.) Moreover, in ultimately reaching its decision,  
20 defendant considered all the evidence it had collected, including records from plaintiff’s doctors,  
21 conversations with plaintiff, and the opinions of Dr. Waldram and vocational consultants. (*Id.*)  
22 In this way, the situation here is unlike that in *Amadeo v. Principal Mutual Life Insurance*  
23 *Company*, in which the Ninth Circuit found that plaintiff had “presented sufficient evidence from  
24 which a jury could conclude that [defendant insurer’s] denial of benefits to [plaintiff] was based  
25 on a bad faith interpretation of its policy and an inadequate investigation into the basis of  
26 [plaintiff’s] claim.” 290 F.3d 1152, 1156 (9th Cir. 2002). In *Amadeo*, the plaintiff presented

1 evidence from which a jury could conclude that the defendant insurance company's  
2 interpretation of its policy was pretextual and arbitrary where it did not conduct an adequate  
3 investigation and ignored contrary evidence. *See id.* at 1163-64. Besides conclusory allegations,  
4 plaintiff presents no evidence in this case that defendant's interpretation of the policy was  
5 pretextual or that defendant ignored any relevant evidence. (*See* Pl.'s Opp'n at 13-14 (plaintiff  
6 sets out the standard for making such a finding but does not cite to any evidence that defendant  
7 engaged in such conduct).)

8           Moreover, insofar as plaintiff disagrees with defendant's analysis of her job  
9 duties, the court notes that, as previously stated, plaintiff listed herself as a "manager" on her  
10 claim form and listed her job duties as "at computer, typing notes from meetings, doing reports  
11 . . . business meetings, making critical business decisions . . . telephone conversations . . .  
12 administrative staff, coach mentor." (Nickelson Decl., Ex. 3.) Plaintiff also admits elsewhere  
13 that she was "primarily a sedentary 'desk worker.'" (Pl.'s Opp'n at 4.) Thus, her claims that  
14 defendant was not reasonable or thorough in determining that her regular occupation was that of  
15 "Manager, Office" are unavailing. Even if "[t]he job also required Plaintiff to walk, bend, stoop,  
16 climb and haul equipment . . ." (*id.*), such activities were, by plaintiff's own admissions, not  
17 substantial and, in accordance with California law, an individual who is able to perform activities  
18 constituting a "substantial portion" of his or her duties is not "totally disabled." *See Erreca v.*  
19 *Western States Life Ins. Co.*, 19 Cal. 2d 388, 398 (1942) (citing *Dietlin v. Missouri State Life Ins.*  
20 *Co.*, 4 Cal. 2d 336 (1935)).

21           Likewise, plaintiff provides no support for her reliance on a purported "industry  
22 standard" with which defendant allegedly had to comply; it is unclear what this alleged "industry  
23 standard" is and why plaintiff references it. (Pl.'s Opp'n at 10.) At the motion hearing,  
24 plaintiff's counsel indicated his reliance on an industry standard is supported by his expert and  
25 the Ninth Circuit's decision in *Hangarter v. Provident Life & Accident Insurance Company*, 373  
26 F.3d 998 (9th Cir. 2004). In *Hangarter*, the Ninth Circuit only referred to industry standards

1 when citing a witness's testimony. *See Hangarter*, 373 F.3d at 1010 & 1011 n.7. It did not  
2 discuss the meaning of "industry standard" in this context, nor did it rely on the breach of an  
3 "industry standard" in reaching its decision; rather, the court clearly relied on a totality of the  
4 circumstances analysis. *See id.* at 1011 ("Viewing the evidence in Hangarter's favor, we  
5 conclude that the district court did not err in determining that the jury had substantial evidence  
6 before it to find that the Defendants engaged in a biased, and thus 'bad faith,' investigation." ).  
7 Ultimately, plaintiff conceded at hearing that the "industry standard" is part of the totality of the  
8 circumstances, but still presented no evidence regarding what the industry standard is. Similarly,  
9 plaintiff provides no support for her contention that defendant acted in bad faith because its

10 denial letter includes a vague and generic job which  
11 Standard feels Plaintiff could be employed as even though  
12 the company has no proof that such jobs: a) specifically  
13 and actually exist; b) are available to those who have  
14 disability symptoms; c) have an employer who would  
15 actually accommodate a disabled person who needs pain  
16 medication; d) would hire someone who would need  
17 routine breaks and regular rests lying down; e) would hire  
18 someone with the physical limitations and restrictions  
19 Plaintiff actually experiences and [sic] f) would tolerate an  
20 employee such as Plaintiff who might have to call in  
21 unpredictably having to miss work due to pain and  
22 weakness.

17 (*Id.* at 10-11.) Rather, plaintiff fails to point to any evidence to show defendant acted  
18 unreasonably by not addressing these issues because there in fact is no requirement that it do so.

19 Furthermore, plaintiff provides no support for her contention that defendant used  
20 the wrong definition for total disability. (Pl.'s Opp'n at 12.) As previously stated, defendant  
21 defines "total disability" as being "unable to perform the substantial and material duties of Your  
22 Regular Occupation." (Not. of Removal at 24.) This comports with the definitions for "total  
23 disability" provided by the cases plaintiff relies on. (Pl.'s Opp'n at 12 (citing, *e.g.*, *Erreca v.*  
24 *Western States Life Ins. Co.*, 19 Cal. 2d 388 (1942).) Indeed, precedent is clear that a court must  
25 not deviate from the policy's definition where the definition of "total disability" provided in the  
26 policy is occupation- and employee-specific. *See Hangarter*, 373 F.3d at 1006-07 ("California

1 courts have specifically upheld jury instructions in the occupational policy context that defined  
2 ‘total disability’ as the inability to perform the substantial and material duties of one’s *own*  
3 occupation.”). Moreover, the fact that another insurer – Metropolitan Life Insurance Company  
4 (“MetLife”) – and the Social Security Administration are currently paying plaintiff disability  
5 benefits (*id.* at 13) is irrelevant. Defendant was not required to reach a different conclusion  
6 based upon the decisions reached by these bodies, nor does plaintiff provide any support for such  
7 a contention. At hearing, plaintiff admitted that these determinations were not binding on  
8 defendant. In any event, plaintiff did not include either the MetLife policy or its determination  
9 in the record and they are therefore inadmissible as evidence; neither the letter referred to by  
10 counsel at the hearing submitted by plaintiff’s husband nor the deposition (which also is not part  
11 of the record) render this evidence admissible.

12           In addition, plaintiff’s contention that defendant’s “investigation was tailored to  
13 deny plaintiff’s claim for disability benefits” (Pl.’s Opp’n at 13) is conclusory and unsupported  
14 by the facts in the record. Likewise, contrary to plaintiff’s assertion (*id.* at 14), the  
15 circumstances of plaintiff’s denial are distinguishable from those of *Wilson v. 21st Century*  
16 *Insurance Company*, in which the court found summary judgment inappropriate where the  
17 insurer could not cite to any medical report or opinion to support its conclusion. *Wilson*, 42 Cal.  
18 4th at 721-22. Here, plaintiff received insurance payments from defendant for more than two  
19 years, during which time defendant conducted a thorough investigation that included contact  
20 with plaintiff herself and plaintiff’s physicians, consultations with a physician consultant, Dr.  
21 Waldram, and referrals to vocational consultants. *See* note 2 *supra* and accompanying text; *see*  
22 *also, e.g.*, Nickelson Decl., Exs. 7, 24, 30, 33, 34. A jury could not conclude that defendant  
23 acted unreasonably. *See Amadeo*, 290 F.3d at 1162.

24           Thus, plaintiff fails to state a claim for breach of the duty of good faith and fair  
25 dealing. Defendant did not act in bad faith. Rather, the evidence shows that defendant  
26 performed an extensive investigation and acted reasonably. *Bosetti*, 175 Cal. App. 4th at 1236

1 (reasonableness and good faith require the insurer to “fully investigat[e] the grounds for its  
2 denial” (internal quotation omitted)). Plaintiff’s contentions are conclusory and wholly  
3 unsupported by the record, which instead shows that defendant’s investigation was “full, fair and  
4 thorough.” *Id.* at 1237. As in *Bosetti*, “[t]here is nothing in this record to suggest that  
5 [defendant’s] investigation into [plaintiff’s] claim was in any way biased, inadequate, superficial  
6 or otherwise unworthy of reliance by an objectively reasonable insurer.” *Id.* at 1240. As a  
7 result, because plaintiff’s only remaining claim is for breach of contract, plaintiff’s punitive  
8 damages claim fails as a matter of law. *See Casey*, 688 F. Supp. 2d at 1102 (“Under California  
9 law, punitive damages are not available for breaches of contract no matter how gross or  
10 willful.” (quoting *Tibbs v. Great Am. Ins. Co.*, 755 F.2d 1370, 1375 (9th Cir. 1985))).

11 IV. CONCLUSION

12 For the foregoing reasons, defendant’s motion for summary judgment of  
13 plaintiff’s claims for breach of the duty of good faith and fair dealing and plaintiff’s request for  
14 punitive damages is hereby GRANTED.

15 IT IS SO ORDERED.

16 DATED: September 5, 2011.

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UNITED STATES DISTRICT JUDGE