An Unwillingness to Live With Ambiguity

A CRITICAL REVIEW OF SOME RECENT FIFTH CIRCUIT INSURANCE COVERAGE DECISIONS

By Jeffrey E. Dahl*

INTRODUCTION

This article will examine some recent insurance coverage decisions by the Fifth Circuit, which are similar in that well-established rules of insurance contract interpretation were either not utilized or were trumped by the court's own interpretation of the terms at issue. The purpose of this article is to 1) analyze the particular decisions, and, in the process, 2) review some basic rules of insurance contract interpretation.

A. HOMEOWNER'S INSURANCE

The decision that is the most familiar of those discussed in this paper is *Sharp v. State Farm Fire and Cas. Ins. Co.,* concerning homeowner's coverage for damage caused by plumbing leaks.[1] The issue presented in *Sharp* was whether loss caused by plumbing leaks which caused soils under residential foundations to contract and expand, which in turn caused damage to the foundation and often the interior of the house, was a covered loss under the standard homeowners' policy (sometimes referred to as the HOB policy or the Form B policy).

The Form B policy provided two types of coverage for property loss: Coverage A insured the dwelling itself and Coverage B insured the homeowner's personal property. Coverage A was followed by Coverage B in the policy. Coverage A provided as follows: "We insure against all risks of physical loss to the (dwelling) unless the loss is excluded in Section I Exclusions."[2] The relevant exclusion read as follows:

> **1(h).** We do not cover loss under Coverage A (Dwelling) caused by settling, cracking, bulging, shrinkage, or expansion of foundations, walls, floors, ceilings, roof structures, walks, drives, curbs, fences, retaining walls or swimming pools. We do cover ensuing loss caused by collapse of a building or any part of the building, water damage or breakage of glass which is part of the building if the loss would otherwise be covered under this policy.[3]

The personal property coverage section, Coverage B, did not cover all risks but rather protected the homeowner from loss from twelve enumerated perils.[4] The enumerated peril at issue in the *Sharp* decision was the following:

> Accidental Discharge, Leakage or Overflow of Water or Steam from within a plumbing, heating, or air conditioning system or household appliance. A loss resulting from this peril includes the cost of tearing out and replacing any part of the building necessary to repair or replace the system or appliance. But this does not include loss to the system or appliance from which the water or steam escaped. *Exclusions I(a) through I(h) under Section I Exclusions do not apply to loss caused by this peril.*[5]

The principal argument levied by State Farm in response to the Sharp's foundation claim was that exclusion I(h) clearly and unambiguously excluded loss to the dwelling caused by "settling, cracking, bulging, shrinkage or expansion of foundation...."[6] The primary argument of the homeowners was that the "accidental discharge" peril provided coverage for plumbing leaks causing dwelling damage because there was an exception to exclusion I(h), sometimes referred to as the "repeal provision", for the enumerated peril "accidental discharge".[7] Since exclusion I(h) was repealed in regards to the enumerated peril, any loss, whether it was dwelling loss or personal property loss, was covered when it was caused by an "accidental discharge" from a plumbing system, i.e. a plumbing leak.[8]

The Fifth Circuit ruled in favor of State Farm, stating:

> The Sharp's policy clearly and unambiguously divides dwelling losses and personal property losses into two separate coverages. It therefore would appear nonsensical, and a rejection of the obvious structure of the policy, to reach into text that applies solely to Coverage B (Personal Property) and determine the extent of coverage provided under Coverage A.[9]

The Texas Supreme Court, corrected this error the following year in *Balandran.*[10] Examining the identical policy and the same type of claim, a plumbing leak which caused

foundation damage, the Court found coverage for the homeowner and rejected the reasoning of *Sharp*. The first basic rule of construction employed by the Texas Supreme Court in correcting the decision in *Sharp* was whether the contract was ambiguous, a question of law.[11]

If an insurance contract is susceptible to two or more reasonable interpretations, it is ambiguous.[12] If the disputed terms within the insurance contract are found by the court to be ambiguous, the uncertainty must be resolved by adopting the construction that most favors the insured.[13] The court in *Balandran* found ambiguity, that is, it found that the homeowners had a reasonable argument that there was coverage, and did not buy into the narrow argument that no reasonable interpretation of the policy could bridge the gap between Coverage A and Coverage B. As the Texas Supreme Court noted, if all losses were to be covered that were caused by the enumerated peril, "accidental discharge", it made the most sense to draft the Form B policy in the manner in which it was drafted, in other words, to place the repeal provision next to the enumerated peril, rather than to place it out of context somewhere in the Coverage A portion of the policy.

The Texas Supreme Court noted that if the *Sharp* reasoning was adopted, the repeal of exclusion I(h) in the "accidental discharge" peril was rendered meaningless.

Further, the Texas Supreme Court applied a second basic rule of contract construction that was not employed in *Sharp*: an interpretation of a contract should not render terms within the contract meaningless.[14]

The Texas Supreme Court noted that if the *Sharp* reasoning was adopted, the repeal of exclusion I(h) in the "accidental discharge" peril was rendered meaningless, as that exclusion on its face applies only to dwelling damage, and therefore does not need to be repealed in the "accidental discharge" peril if "accidental discharge" only applies to personal property loss.[15]

B. COMMERCIAL CRIME POLICIES

Two cases involving commercial crime policies were decided by the Fifth Circuit in 2002, in which well-settled insurance contract construction was dismissed in favor of the court's own interpretation of the disputed terms. The following policy terms were at issue in both cases:

II. Forgery or Alteration

> We will pay for loss resulting directly from "Forgery" or alteration of, on, or in "Covered Instruments" that are:
> 1. Made or drawn by or drawn upon you; or
> 2. Made or drawn by one acting as your agent;
>
> or that are purported to have been so made or drawn.
>
> ****
>
> "Covered Instruments" means checks, drafts, promissory notes or similar written promises, orders, or directions to pay a sum certain in "Money".[16]
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> ****
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> "Forgery" means the signing of the name of another person or organization with intent to deceive; it does not mean a signature which consists in whole or in part of one's own name signed with or without authority, in any capacity for any purpose.[17]

The first decision was *Parkans*, in which the Fifth Circuit reversed a substantial judgment for the insured.[18] The insured, Parkans, had agreed to purchase scrap metal from a company called Adusa Export.[19] Payment was to be made by an irrevocable letter of credit that Parkans established at its bank of choice, Marine Midland, which was to be confirmed by a bank of Adusa's choice, Wells Fargo.[20] Payment was to occur on the letter of credit upon presentation of certain non-negotiable documents by Adusa.[21] Adusa submitted fraudulent documents to Wells Fargo upon which Wells Fargo, relied and paid under the letter of credit, even though the scrap metal was never delivered to Parkans.[22] Marine Midland withdrew funds (almost a million dollars) from Parkans' account to pay Wells Fargo.[23] Parkans claimed loss under its commercial crime policy, but Zurich denied coverage.[24] Parkans won on summary judgment as to coverage under the policy in the trial court, and also obtained a substantial tort verdict against Zurich, as the jury found that Zurich knowingly committed unfair and deceptive practices in dealing with Parkans.[25]

The Fifth Circuit reversed and rendered in favor of Zurich, finding that the letter of credit was not a "covered instrument" as that term was defined in the policy, because it was not "drawn by or drawn upon" the insured, *i.e.* Parkans, as the policy required, but rather was drawn upon Marine Midland (even though the money was ultimately drawn from Parkans' account and it was Parkans that incurred the loss).[26] The court found it significant that the letter of credit named Marine Midland as the drawee, not Parkans, and found that Marine Midland did not act as Parkans' agent when honoring the letter of credit by paying Wells Fargo.[27] The court stated as follows:

> A contextual analysis of the contract is the proper approach to determine the meaning of contractual terms. (cite omitted). The policy uses the term "drawn" in the context of the specific listed instruments and "similar... promises, orders, or directions to pay." In the commercial paper context the phrases "drawn by" and "drawn upon" are not ambiguous and have a definite legal meaning. A contract term that can be given a definite or certain legal meaning is not ambiguous.[28] We will not therefore interpose multiple dictionary usages.[29]

The court chose to define the terms in this technical manner, despite the fact that the policy did not state that the terms were to be defined in a "commercial paper" context, nor did it state that the terms were to be defined in accordance with U.C.C. definitions.

Judge Dennis sharply dissented, stating in part as follows:

> To the detriment of the insured, the majority gives the terms of this insurance policy their technical, rather than popular meaning. Because this method of interpretation contravenes established canons of Texas insurance law, I respectfully dissent…. The majority interpretation conflicts with basic principles of Texas insurance law. When interpreting an insurance contract, Texas courts will read its terms in their plain, ordinary, and popular sense unless the policy defines a term in some other way.[30] Texas courts disfavor interpretations that limit coverage, and they construe ambiguities in favor of the insured.[31] Under these principles, Parkans was covered for its loss.[32]

The Fifth Circuit compounded this error in *Travelers*.[33] Baptist Health System had incurred losses of over $800,000.00 by payment to vendors upon forged invoices.[34] Under the

hospital's payment procedures, it would pay invoices by vendors once they were approved by certain officers of Baptist Hospital.[35] The officers would approve payment by signing or initialing the invoice, which would then indicate to the accounts payable department to pay the invoice.[36] The vendor forged the signatures of the officers who had authority to approve payment and dropped the bogus invoices in the baskets of the accounts payable clerks.[37] This mixing of bogus, forged invoices with good invoices occurred for a couple of years before it was detected by the hospital. [38]

Baptist sued Travelers after Travelers denied coverage under Baptist's commercial crime policy for the loss.[39] The policy terms at issue were the same terms at issue in *Parkans*.[40] The trial court granted summary judgment in favor of Baptist, finding ambiguity and finding that it was a reasonable interpretation of the policy that the forged invoices were both directions to pay and promises to pay, making them covered instruments under the policy.[41] Further, the district court found the signed invoices were drawn by or upon or upon Baptist, since Baptist was the source of funds from which payment on the forged invoices was drawn.[42]

The Fifth Circuit reversed and rendered judgment for Travelers, relying upon the technical interpretation of the terms "drawn by" and "drawn upon" handed down in Parkans rather than the plain meaning of the terms.[43] Again, the decision to give the terms at issue their technical meanings rather than plain meanings was a decision generated by the panel without reliance upon any specific language within the policy that stated technical definitions were to be used. The court stated in part:

> The forged invoices were not made, drawn by, or drawn upon [Baptist] as those terms are used in the commercial paper context or under the Uniform Commercial Code. The addition of the forged signatures to the invoices did not create instruments on which a party could demand payment from a bank. In the commercial context, [Baptist] is not a "maker" or "drawer" of the forged invoices.[44]

By narrowly interpreting "drawn by" or "drawn upon," the court violated another cannon of contract construction. It rendered some of the terms within the "covered instruments" section meaningless.[45] Despite the absence of language in the policy that a covered instrument meant a negotiable instrument, the panel felt it was essential to coverage that the instrument be a negotiable instrument. The court cited as crucial that the forged invoices could not be taken to a bank and cashed.[46]

By this narrow and technical interpretation, the court rendered part of the definition of "covered instruments" in the policy superfluous. One of the enumerated "covered instruments" was a "direction to pay" a certain sum of money.[47] In the UCC context and the commercial context that the panel embraced, there was and is no such thing as a "direction to pay."[48]

C. COMMERCIAL GENERAL LIABILITY POLICIES

In *Bailey*, the Fifth Circuit held that there was no duty to defend or indemnify a church or its associate ministers for negligence claims relating to the hiring and retention of a minister who engaged in various acts of sexual misconduct.[49] Although the claims against the associate ministers and the United Methodist Church of Fort Worth were negligence claims, the Fifth Circuit rejected the insured's argument for coverage.[50] The court held all of the allegations against the associate ministers were interdependent on the intentional conduct of the minister. A Sexual Action Exclusion within the policy it was clearly excluded the minister's intentional conduct.[51] The court relied upon a number of previous Fifth Circuit decisions and a previous district court decision, stating that, under Texas law, where a third party's liability is related to and interdependent on other tortuous activities, the ultimate issue is whether the underlying tortuous activities are encompassed within the definition of occurrence.[52] The minister's intentional conduct was clearly not an occurrence, so the church and associate ministers did not have coverage, as the claims against them were interdependent upon the tortuous acts of the minister.[53]

In *King v. Dallas Fire Ins. Co.*, the Texas Supreme Court decided the issue of whether negligent acts of associates or a supervisor could be an occurrence under a CGL policy, even though the negligent acts were interdependent upon excluded, intentional conduct.[54] The intentional conduct was an assault by one of King's employees.[55]

The Texas Supreme Court focused on the separation of insured's clause and the intentional acts exclusion in the standard CGL policy. The terms at issue were as follows:

> "Separation of Insureds. Except with respect to the Limits of Insurance, and any rights and duties specifically assigned in this Coverage Part to the first Named Insured, this insurance applies: a. As if each Named Insured was the only Named Insured; and b. Separately to each insured against whom claim is made or suit is brought. Exclusions. This insurance does not apply to: a. Expected or Intended Injury Bodily injury or property damage expected or intended from the standpoint of the insured."[56]

In arguing the case before the Texas Supreme Court, the carrier relied heavily upon *Bailey* and the predecessor opinions of the Fifth Circuit that established the related and interdependent rule.[57] The Texas Supreme Court disagreed and found for the insured, stating that "we conclude the Fifth Circuit's rule (the negligent conduct is related to and interdependent of the excluded intentional conduct-therefore, coverage excluded) improperly imputes the actor's intent to the insured."[58] Further, it reviewed the history of the CGL policy, and noted that the related to and interdependent rule violates a cannon of insurance contract interpretation.[59] Specifically, the language within the exclusion "expected or intended from the standpoint of the insured" is rendered meaningless if all claims that revolve around intentional conduct are to be excluded from coverage, regardless of whether the insured is alleged to have negligently hired, trained, or retained the actor who committed the intentional acts.[60]

D. DISABILITY INSURANCE POLICIES

A recent Fifth Circuit opinion, *Ellis v. Liberty Life Assurance Co. of Boston*, could prove to have a devastating effect upon insureds litigating disability claims.[61] Although the plaintiff sued regarding the Employee Retirement Income Security Act of 1974 ("ERISA") benefits, a disability policy underwritten and administered by Liberty Life was at issue.[62] Liberty appealed after the trial court granted the insured's summary judgment, finding that Liberty as plan administrator abused its discretion in terminating the insured's long-term disability benefits.[63] As in any disability claim, the definition of disability within the policy was crucial to considering whether the insured was wrongly denied disability benefits.[64] The applicable definition of disability within the policy was as follows:

> [Long-term disability] benefits are payable during the first 24 months to covered employee who is 'unable

to perform all of the material and substantial duties of his occupation on an Active Employment basis because of an injury or sickness.[65]

Taken in isolation, this definition is ambiguous. The trial court granted summary judgment on the reasonable interpretation, that if an employee cannot perform one or more of the material and substantial duties of his or her employment, he or she is disabled.[66] If one cannot perform one or more of the material and substantial duties of his or her occupation, one is precluded from being able to perform all of the material and substantial duties of his or her occupation. Liberty asserted on appeal the definition means to be disabled one must not be able to perform *any* of the material and substantial duties of his or her occupation.[67] This interpretation is unfair to the insured. Under this interpretation, an employee who cannot perform two-fifths or four-fifths of the material duties of the job may lose his or her job due to disability, yet not be covered under the policy. Although unfair, this is a reasonable interpretation of the definition.

As an ERISA case, the Fifth Circuit's task was to analyze whether Liberty, as administrator of benefits, gave the legally correct interpretation to the policy.[68] Importantly, even though this was an ERISA matter, the fundamental rules of insurance contract interpretation still apply.[69] Despite this requirement, the court made this careless pronouncement regarding the policy's definition of disability:

> The District Court erred when it interpreted the phrase "unable to perform all" the language in the policy-as synonymous with "not able to perform any one." We interpret "unable to perform all" as synonymous with "not able to perform every." In other words, "unable" is synonymous with "not able" and "all" is synonymous with "every".[70]

Considering a strikingly similar coverage clause in which the word "each" was at issue instead of "all," a prior Fifth Circuit panel correctly applied basic rules of insurance contract construction when considering a very similar ERISA disability claim. In *Lain,* the court reviewed a disability policy that defined disability as "the insured cannot perform each of the material duties of her regular occupation."[71] The insured argued disability meant that if she could not perform one or more of her material duties, she was disabled.[72] Like *Ellis*, the insured argued the definition meant that she was disabled only if she could not perform any of the material duties of her occupation.[73] The Fifth Circuit upheld the district court's judgment in favor of the insured, adopting the insured's interpretation of the definition of disability, stating that, even if the term is ambiguous (i.e., even if the insurer has a reasonable interpretation), under Texas law it is well settled that ambiguities in insurance policies are construed against the insurer.[74] Regarding these competing interpretations in *Lain*, the court went on to say the Unum claims adjuster handling the administrative appeal "incorrectly interpreted the terms of the Policy and held Lain to a higher standard by requiring her to prove that she was unable to perform all of the material duties of her regular occupation. Accordingly, we find that UNUM'S interpretation is inconsistent with a fair reading of the Policy".[75] Oddly, despite these striking similarities, the *Lain* case is not even mentioned in the *Ellis* decision.

In *Ellis*, the Fifth Circuit may have made the right decision regarding the coverage issue, but it did so in the wrong way, potentially harming future claimants by failing to use basic cannons of insurance contract interpretation. As stated previously, taken in isolation the disability definition in *Ellis* should have been construed as ambiguous. However, in deciding whether insurance contract terms are ambiguous, it is fundamental that the entire policy be reviewed, and that the court strives to give meaning to every sentence, clause, and word to avoid rendering any portion inoperative.[76] In the disability policy at issue in *Ellis*, there was an additional provision for partial disability, which stated that Partial Disability shall mean that the covered person is able to perform one or more, but not all, of the material and substantial duties of his own or any other occupation on an Active Employment or part-time basis.[77] Assuming that this is the entire definition and there are not additional qualifications for partial disability coverage, the partial disability clause is rendered superfluous if one adopts the insured's interpretation of the definition of total disability as "not being able to perform one or more duties of the insured's occupation."

If the same result regarding coverage may have been achieved through traditional insurance contract analysis, where is the harm in the majority opinion in *Ellis*? The harm is created by the majority opinion not engaging in the ambiguity analysis, which it had previously followed in *Lain* and was required to follow. One gets the impression from reading the opinion that even if the partial disability coverage were not part of the policy, the court would have still found the only ressonable interpretation to be the interpretation adopted by the insurer. The definition "unable to perform all of the material and substantial duties of ones occupation" is in many disability policies, which this author has reviewed, which do not also contain the same partial disability definition. Are those insureds or plan beneficiaries going to be denied coverage because they cannot perform each and every one of the material and substantial duties of their occupation? *Ellis* provides the argument for the insurers and the plan administrators, no matter how unfair the result and how contrary to traditional insurance contract interpretation. Had the court analyzed it with some discipline, it would have engaged in an ambiguity analysis and determined that the total disability definition is ambiguous when taken in isolation, but when it is construed with the partial disability definition, only the reasonable interpretation of the total disability definition adopted by the insurer makes sense.[78] Importantly, the court would have confined the decision to that particular policy.

Judge Pickering, who dissented in *Ellis*, saw the harm in the majority's interpretation regarding the definition of disability. Judge Pickering summarized the definition given by the majority as "unable to perform all of the material and substantial duties of his occupation" can only mean unable to perform each and every one of the material and substantial duties of an occupation; if an employee can perform even one material and substantial duty of his or her occupation, the employee is not disabled.[79] He found the definition of total disability to be ambiguous, and reiterated the rule that such ambiguities are to be construed against the insurer. He noted, however, that because of the definition of partial disability later in the policy, the insured's interpretation created an internal inconsistency within the policy.[80] Although Judge Pickering may be technically wrong in concluding that the total disability definition remains ambiguous, as the rules of construction required that the phrase seen initially, be reviewed as ambiguous, but then be examined in light of other language in the policy, the fact that he recognized the ambiguity of the definition when taken in isolation at least avoids the potential harm created by the majority opinion.

CONCLUSION

The purpose of this paper is not to criticize the Fifth Circuit, but to criticize certain opinions in which the court has either not engaged in traditional insurance contract construction or superceded the rules of construction with the Court's own interpretation of the terms at issue. An insured is in a precarious spot if he or she cannot rely upon the court's employment of well-settled rules of insurance contract construction and interpretation. Further, because the court is often dealing with standard policies, if a contract term or phrase is interpreted carelessly or without giving appropriate deference to the established rules of insurance contract construction, there can be a significant and unfortunate impact upon how future claims are interpreted, handled, and finally decided by the courts. Many of these rules of construction and interpretation, especially the rule that ambiguity is to be resolved in favor of the insured, were adopted to protect the insured. Insureds cannot afford the erosion of these fundamental rules.

[*] Jeffrey Dahl is a partner at Harkins, Latimer & Dahl, P.C. in San Antonio, Texas.
1. 115 F.3d 1258 (5th Cir. 1997).
2. *Id.* at 1264.
3. *Id.* at 1265.
4. *Id.*
5. *Id.* at 1264. (emphasis added).
6. *Id.* at 1265.
7. *Id.* at 1263.
8. *Id.* at 1265.
9. *Id.* at 1263.
10. Balandran v. Safeco Ins. Co. of America, 972 S.W.2d 738 (Tex. 1998).
11. *Balandran*, 972 S.W.2d at 741, (citing Nat'l Union Fire Ins. Co. v. CBI Indus., 907 S.W.2d 517, 520 (Tex. 1995)).
12. *Id.*
13. Ramsey v. Maryland Am. Gen. Ins. Co., 533 S.W.2d 344, 349 (Tex. 1976).
14. *Balandran*, 972 S.W.2d at 741 (citing United Serv. Auto Ass'n v. Miles, 161 S.W.2d 1048, 1050 (Tex. 1942)).
15. *Id.*
16. Parkans Int'l LLC v. Zurich Ins. Co., 299 F.3d 514, 516 (5th Cir. 2002).
17. Findlaw Definitions: http://dictionary.lp.findlaw.com, (last visited on April 2, 2005).
18. *Parkans*, 299 F.3d at 516.
19. *Id.* at 515.
20. *Id.*
21. *Id.*
22. *Id.*
23. *Id.*
24. *Id.*
25. *Id.* at 516.
26. *Id.* at 517.
27. *Id.*
28. *Id.* (citing *National Union Fire Ins. Co.*, 907 S.W.2d at 520).
29. *Id.*
30. *Id.* at 520, (citing Puckett v. U.S. Fire Ins. Co., 678 S.W.2d 936, 938 (Tex. 1984)).
31. *Id.* (citing *Puckett*, 678 S.W.2d at 938).
32. *Id.* at 520-21.
33. Travelers v. Baptist Health Sys., 313 F.3d 295 (5th Cir. 2002). The author represented Baptist Health System in both the trial court and before the Fifth Circuit.
34. *Id.* at 296.
35. *Id.*
36. *Id.*
37. *Id.*
38. *Travelers*, 313 F.3d at 297.
39. *Id.*
40. *Id.* at 299. *See Parkans*, 299 F.3d at 517.
41. *Travelers*, 313 F.3d. at 298.
42. *Id.*
43. *Id.* at 299; *Parkans*, 299 F.3d at 517.
44. *Travelers*, 313 F.3d at 299.
45. *Id.*
46. *Id.*
47. *Id.* at 298.
48. Definitions that fall in line with common commercial use include: A "maker" is "a person who signs or is identified in a note as a person undertaking to pay." Tex. Bus. & Comm. Code §3.103(a)(5) (Vernon Supp. 2002). A "drawer" is "a person who signs or is identified in a draft as a person ordering payment." Tex. Bus. & Comm. Code §3.103(a)(3). A "drawer" is "one who directs a person or entity, usually a bank, to pay a sum of money stated in an instrument-for example, a person who writes a check; the maker of a note or draft." Black's Law Dictionary 510 (7th Ed. 1999).
49. *Am. States Ins. Co. v. Bailey*, 133 F.3d 363 (5th Cir. 1998).
50. *Id.* at 370.
51. *Id.*
52. *Id.* at 371. The Court relied upon New York Life Ins. Co. v. Travelers Ins. Co., 92 F.3d 336 (5th Cir. 1996) (citing Cornhill Ins. PLC v. Valsamis, Inc., 106 F.3d 80 (5th Cir. 1997), Old Republic Ins. Co. v. Comprehensive Health Care Assoc., Inc., 786 F. Supp. 629 (N.D. Tex. 1992), *aff'd on other grounds*, 2 F.3d 105 (5th Cir. 1993).
53. *Id.* at 372.
54. King v. Dallas Fire Ins. Co., 85 S.W.3d 185 (Tex. 2002).
55. *Id.* at 197.
56. *Id.* at 188.
57. *Id.* at 190-91.
58. *Id.* at 191.
59. *Id.* at 188.
60. *Id.* at 192.
61. 394 F.3d 262 (5th Cir. 2004) .
62. *Id.* at 267.
63. *Id.*
64. *Id.* at 269-70.
65. *Id.* at 266.
66. *Id.* at 267.
67. *Id.* at 266.
68. Lain v. UNUM Life Ins. Co. of Am., 279 F.3d 337, 344 (5th Cir. 2002), (citing Tolson v. Avondale Indus.., 141 F.3d 604, 608 (5th Cir. 1998)).
69. *Id.* at 345-46.
70. *Ellis*, 394 F.3d at 270.
71. *Lain*, 279 F.3d at 346.
72. *Id.*
73. *Ellis*, 394 F.3d at 272.
74. *Lain*, 279 F.3d at 345 (citing Jarvis Christian Coll. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa., 197 F.3d 742, 746 (5th Cir. 1999)).
75. *Id.* at 346.
76. *Balandran*, 972 S.W.2d at 741 (citing United Serv. Auto. Ass'n v. Miles, 161 S.W.2d 1048, 1050 (1942)).
77. *Ellis*, 394 F.3d at 271-72.
78. This assumes that the qualifications of total disability and partial disability are otherwise in parity. This author has not reviewed the policy at the issue but relies upon the characterization of the policy given by the Court.
79. *Ellis*, 394 F.3d 278.
80. *Id.*