STATE OF MICHIGAN

COURT OF APPEALS

PARKER HANNIFIN CORPORATION GROUP INSURANCE PLAN and PARKER HANNIFIN CORPORATION,

Plaintiffs-Appellees,

v

TITAN INSURANCE COMPANY,

Defendant,

and

BRISTOL WEST INSURANCE COMPANY,

Defendant/Cross-Plaintiff-Appellant,

and

AUTO OWNERS INSURANCE COMPANY,

Defendant/Cross-Defendant.

UNPUBLISHED
February 20, 2007

No. 263303
Allegan Circuit Court
LC No. 03-034446-CK

Before: Sawyer, P.J., and Neff and White, JJ.

PER CURIAM.

This case involves a priority dispute between a no-fault insurer, defendant Bristol West Insurance Company, and a group health plan, plaintiff Parker Hannifin Corporation Group Insurance Plan (Parker Plan), for medical expenses incurred by Jason Smith ("Smith"), who was catastrophically injured in an automobile accident in October 2002. The Parker Plan is a self-funded employee benefit plan under the Employee Retirement Income Security Act (ERISA), 29 USC 1001 *et seq*., and is administered by plaintiff Parker Hannifin Corporation (Parker Hannifin). Defendant appeals as of right, challenging the trial court's rulings that its coverage is primary to the Parker Plan for medical expenses incurred between January 1, 2003, and December 31, 2003, and that plaintiffs have no further liability for coverage after December 31, 2003. We affirm.

I. Underlying Facts

At the time of Smith's accident, he was insured under a no-fault policy issued by defendant to Smith's father, Richard Smith. Richard Smith was also an employee of Parker Hannifin and a participant in the Parker Plan. At the time of the accident, Smith was 22 years old. At that time, dependent children aged 19 to 23 years old were covered under the Parker Plan "as long as they remain unmarried and are dependent on you [the employee] for more than one-half of their support and maintenance." Parker Hannifin, through the Parker Plan's eligibility review committee, determined that Smith was covered under the plan at the time of the accident and, therefore, the Parker Plan was liable for Smith's medical expenses through December 31, 2002.

Effective January 1, 2003, however, the Parker Plan's eligibility requirements for dependents aged 19 to 23 years changed. The new plan provided coverage for these dependents "as long as they remain unmarried, are full-time students . . . and you [the employee] are eligible to claim them on your federal income tax return." Parker Hannifin notified all of its employees of this impending change in August 2002.

Because Smith was not a full-time student at the end of 2002, Parker Hannifin determined that he was no longer eligible for dependent coverage. In January 2003, Parker Hannifin sent notices to those dependents who were no longer eligible, including Smith, informing them of their right to continued coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA), 29 USC 1161 *et seq*. Smith elected the COBRA coverage, and defendant paid his premiums.

The Parker Plan also has a coordination of benefits provision that in 2003 stated, in part, "If the claimant is a COBRA participant in this plan, this plan will always be secondary." The provision further provided:

> If the claimant is an active employee or dependent of an active employee and has Medicare or Medicaid coverage, this plan normally will be primary, however, this plan will be secondary to: Medicare after 30 months if the person has End Stage Renal Disease.
>
> If the other coverage is through any auto insurance including no-fault: When coverage is provided through an automobile policy required by a state's automobile no-fault coverage or personal injury protection coverage, the Plan will coordinate as follows:
>
> If the automobile policy <u>does not</u> have a coordination of benefits provision, then the automobile policy will be primary for any auto-related injuries.
>
> If the automobile policy does have a coordination of benefits provision, this Plan will be primary for any auto related injuries and will coordinate benefits with coverage provided through the automobile insurance policy.

Under the above provision, Parker Hannifin concluded that when the question of priority involved a COBRA participant, the COBRA clause superceded the other clauses in the coordination of benefits provision, because it stated that in such cases, the Parker Plan would "always" be secondary. Thus, Parker Hannifin determined that the Parker Plan was secondary to defendant's coverage for Smith's medical expenses after January 1, 2003.

Effective January 1, 2004, the Parker Plan increased the monthly COBRA premium for all participants, including Smith, from $279.42[1] to $311.10. Parker Hannifin notified Smith of the increase and sent him new remittance coupons. Defendant was unaware of the increase and continued to remit monthly payments of $279.42. On March 15, 2004, Parker Hannifin terminated Smith's COBRA coverage because the premium payments were late and insufficient. Thus, Parker Hannifin determined that it had no liability for Smith's medical expenses incurred after January 1, 2004.

The parties filed cross motions for summary disposition. The trial court held that Parker Hannifin properly determined that Smith was no longer eligible for coverage after January 1, 2003, and that the COBRA coverage was secondary, and that Smith's COBRA coverage was properly terminated, effective January 1, 2004. Accordingly, it granted plaintiffs' motion for summary disposition and denied defendant's motion under MCR 2.116(C)(10).

II. Standard of Review

This Court reviews de novo a trial court's decision on a motion for summary disposition. *Corley v Detroit Bd of Ed*, 470 Mich 274, 277; 681 NW2d 342 (2004). Summary disposition may be granted under MCR 2.116(C)(10) when there is no genuine issue as to any material fact, and the moving party is entitled to judgment or partial judgment as a matter of law. A motion under this subrule tests the factual sufficiency of the complaint. *Corley*, *supra* at 278. A court must consider the pleadings, affidavits, depositions, admissions, and other documentary evidence submitted by the parties in the light most favorable to the nonmoving party to determine whether the moving party is entitled to judgment as a matter of law. *Scalise v Boy Scouts of America*, 265 Mich App 1, 10; 692 NW2d 858 (2005).

The Parker Plan is a self-funded benefit plan under ERISA that grants discretionary authority to Parker Hannifin to determine claimant eligibility and construe the plan's language. Therefore, Parker Hannifin's decision that Smith's COBRA coverage was only secondary is reviewed under the arbitrary and capricious standard, taking into consideration any conflict of interest it may have had as the plan administrator. *Firestone Tire & Rubber Co v Bruch*, 489 US 101, 115; 109 S Ct 948; 103 L Ed 2d 80 (1989); *Davis v Kentucky Finance Cos Retirement Plan*, 887 F2d 689, 694 (CA 6, 1989). The arbitrary and capricious standard is "extremely deferential" and is "the least demanding form of judicial review." *McDonald v Western-Southern Life Ins Co*, 347 F3d 161, 172 (CA 6, 2003). "'When it is possible to offer a reasoned explanation, based

[1] The record indicates a discrepancy in the amount of the premium due, that paid by defendant, and that represented by the parties. Because the parties and the trial court have consistently relied on the $279.42 figure, we will disregard any discrepancy for purposes of this appeal.

on the evidence, for a particular outcome, that outcome is not arbitrary or capricious.'" *Calvert v Firstar Financial, Inc*, 409 F3d 286, 292 (CA 6, 2005) (internal quotation marks and citations omitted).

Defendant asserts that in its application of the arbitrary and capricious standard of review, the trial court erroneously found that Parker Hannifin did not have a conflict of interest. The trial court specifically found, however, that a conflict of interest existed, given the structural relationship between Parker Hannifin and the Parker Plan, but that it was not entitled to significant weight in this case. We agree with the trial court that the mere fact that Parker Hannifin had a financial interest in denying benefits is insufficient to find that its decisions were financially motivated. Defendant was required to present some evidence that the conflict of interest affected Parker Hannifin's decisions or that Parker Hannifin otherwise acted in bad faith. See *Peruzzi v Summa Medical Plan*, 137 F3d 431, 433 (CA 6, 1998); see also *Davis, supra* at 695. The trial court found persuasive plaintiffs' assertion that the potential remaining liability for Smith's medical expenses ($1.63 million)[2] was small compared to Parker Hannifin's 2004 net sales of $7 billion and gross profits of $1.3 billion.

Defendant asserts that it is "ridiculous" to conclude that the decision to terminate Smith's benefits was not financially motivated and suggests a scenario of mass destruction where multiple catastrophic claims could total Parker Hannifin's annual gross profits. We agree with plaintiffs, however, that defendant may not rely on hypothetical circumstances to conclude that Parker Hannifin acted in a self-interested manner with regard to this particular case involving this particular beneficiary. Defendant presented no actual evidence to suggest that Parker Hannifin's decisions regarding Smith's eligibility were financially motivated or that Parker Hannifin otherwise acted in bad faith. Therefore, we conclude that the trial court properly weighed the conflict of interest factor.

III. Smith's Eligibility Under the Parker Plan

Defendant argues that the trial court erred in determining that Parker Hannifin's decision that Smith was no longer eligible for benefits after January 1, 2003, was not arbitrary and capricious. We disagree.

Parker Hannifin's decision was based on two separate determinations: (1) Smith was no longer eligible for benefits under the Parker Plan after December 31, 2002, because he was not a full-time student, and (2) Smith was not eligible for extended coverage available to a disabled child because Richard Smith never applied for this coverage.

Effective January 1, 2003, a dependent aged 19 to 23 years old was required to be a full-time student to be eligible for coverage under the Parker Plan. Defendant does not dispute that Smith was not a full-time student in 2003. Instead, defendant asserts that Parker Hannifin's decision that Smith was no longer eligible for coverage was arbitrary and capricious because

[2] Under the Parker Plan, Smith had a lifetime maximum benefit of $2 million. The plan had already paid approximately $370,000 in medical expenses on Smith's behalf.

plaintiffs never previously investigated whether Smith met eligibility requirements, and did so after the accident only because they were facing a large potential liability. We find no merit to this argument. Plaintiffs had no obligation to investigate whether employees were enrolling dependents who did not meet eligibility requirements.

Further, defendant presented no evidence suggesting that Smith's coverage was terminated at the end of 2002 only because of his accident, not because he failed to meet the changed eligibility requirements. It is undisputed that he did not meet the new eligibility requirements, and that the new requirements were adopted, and communicated to eligible employees in August 2002, well before Smith's accident.

Defendant also argues that Parker Hannifin's decision was arbitrary and capricious because it interpreted the plan inconsistently with its own past practices. Defendant asserts that it was inconsistent for Parker Hannifin to deny Smith benefits for not meeting the eligibility requirements in 2003, when he did not meet the requirements before then, but was nevertheless afforded coverage. The record does not support this argument. There is no evidence that Smith was not eligible for coverage under the Parker Plan after he turned 19 years old, and plaintiffs explicitly found that he was eligible for coverage in 2002.

Defendant also argues, in effect, that the trial court erred in finding that Parker Hannifin's decision that Smith was not eligible for continued coverage under the Parker Plan as a disabled child was not arbitrary and capricious. We disagree.

The Parker Plan provides that in order to be considered for such continued coverage, an application must be filed within 60 days of the date coverage otherwise would end. There is no dispute that Smith, or anyone on his behalf, never filed an application. Further, the parties do not dispute that plaintiffs had no obligation under the Parker Plan to notify Smith of his right to disabled child coverage or to COBRA coverage at the time he became ineligible under the plan in 2003.

Defendant asserts, however, that plaintiffs steered Smith into electing COBRA coverage, rather than continued coverage available to a disabled child, by notifying him of his COBRA rights, but not notifying him of his right to continued coverage as a disabled child. Defendant contends that this selective notification shows that Parker Hannifin's decision that Smith was not eligible for disabled child coverage was arbitrary and capricious because Parker Hannifin followed the plan's language when it was in its financial interest to do so and disregarded the plan when it was not. We find this conclusion unsupported by the record.

The evidence discloses that when plaintiffs changed the eligibility requirements, they notified *all* dependents who were no longer eligible of their COBRA rights. The notification was not personal to Smith only. There is no evidence that this across-the-board notification was an attempt to dissuade Smith from applying for disabled child coverage. Under these circumstances, Parker Hannifin's decision that Smith was not eligible for continued coverage as a disabled child because he did not submit the required application was not arbitrary and capricious. Accordingly, the trial court did not err in determining that Smith was not eligible for continued coverage under the Parker Plan after December 31, 2002.

IV. Priority Between Defendant and the Parker Plan in 2003

Defendant argues that Parker Hannifin's decision that the COBRA coverage was secondary to defendant's coverage was arbitrary and capricious. We disagree.

Parker Hannifin's decision is consistent with the coordination of benefits provision in the Parker Plan, which states, in part, "If the claimant is a COBRA participant in this plan, this plan will always be secondary." "'When it is possible to offer a reasoned explanation, based on the evidence, for a particular outcome, that outcome is not arbitrary or capricious.'" *Calvert, supra* at 292.

Nonetheless, defendant asserts that the coordination of benefits provision, of which the COBRA clause is a part, is ambiguous and, therefore, should be construed against plaintiffs. Defendant contends that the trial court erroneously found that the provision was unambiguous. However, the trial court did not find the provision was unambiguous, but rather held that it was inappropriate to apply the rule of contra proferentem (ambiguities are construed against the drafter), and that Parker Hannifin offered a rational interpretation of the provision.

In deciding this issue, the trial court cited *Moos v Square D Co*, 72 F3d 39, 42 (CA 6, 1995), and *Davis, supra* at 695. In *Moos, supra* at 42, the court stated, "We grant plan administrators who are vested with discretion in determining eligibility for benefits great leeway in interpreting ambiguous terms." The court found that the administrator's interpretation of ambiguous terms in a plan was "within the range of the Administrator's discretion," and therefore, not arbitrary and capricious. *Id*. In *Davis*, the court held that under the arbitrary and capricious standard, the committee's interpretation of the plan should be deferred to, even where an ambiguity in the plan language exists, unless it is shown that the interpretation renders the plan internally inconsistent, the decision was made in bad faith, or there is some other ground for calling the decision into question. *Davis, supra* at 694-695. However, neither of these cases specifically mentions the applicability of the rule of contra proferentem.

Plaintiffs assert that the rule does not apply in this case, relying on *Kimber v Thiokol Corp*, 196 F3d 1092, 1100 (CA 10, 1999), in which the court stated that under the arbitrary and capricious standard, "[w]hen a plan administrator is given authority to interpret the plan language, and more than one interpretation is rational, the administrator can choose any rational alternative." The court specifically rejected the application of the rule of contra proferentem, adopting the Seventh Circuit Court's reasoning in *Morton v Smith*, 91 F3d 867 (CA 7, 1996).

> Courts invoke [contra proferentem] when they have the authority to construe the terms of a plan, but this authority arises only when the administrators of the plan lack the discretion to construe it themselves. Therefore, it is only used when courts undertake a de novo review of plan interpretations. When the administrators of a plan have discretionary authority to construe the plan, they have the discretion to determine the intended meaning of the plan's terms. In making a deferential review of such determinations, courts have no occasion to employ the rule of contra proferentem. Deferential review does not involve a construction of the terms of the plan; it involves a more abstract inquiry--the construction of someone else's construction. Because this case engages us in this

> more abstract exercise, we will not apply the rule. [*Kimber, supra* at 1100, quoting *Morton, supra* at 871 n 1 (citations omitted).]

The *Kimber* court noted that the majority of other courts have held that the rule of contra proferentem is applicable only in the context of de novo review of ERISA plans, not arbitrary and capricious review. *Kimber, supra* at 1100-1101.

Defendant cites *Regents of the Univ of Michigan v Employees of Agency Rent-A-Car Hosp Ass'n*, 122 F3d 336 (CA 6, 1997), in support of its position that the rule applies in this case. In *Regents of the Univ of Michigan*, the court stated, "The federal common law as expressed by other circuits requires that the terms of an ERISA plan be interpreted in an ordinary and popular sense, and that any ambiguities in the language of the plan be strictly construed against the drafter of the plan." *Id*. at 339-340, citing *Phillips v Lincoln Nat'l Life Ins Co*, 978 F2d 302, 307-308 (CA 7, 1992). However, *Phillips* involved a de novo standard of review, *id*. at 307, and the court specifically discussed the propriety of applying the rule under that standard of review, *id*. at 311-312. Notably, subsequent to the *Phillips* decision, the Seventh Circuit Court issued its decision in *Morton*.[3]

The parties have presented no decision of the Sixth Circuit Court addressing this issue, and we find none. In *Univ Hospitals of Cleveland v Emerson Electric Co*, 202 F3d 839, 845-846 (CA 6, 2000), the court used the arbitrary and capricious standard, but also noted that the rule of contra proferentem applied, citing *Perez v Aetna Life Ins Co*, 150 F3d 550, 555 n 7 (CA 6, 1998) (en banc). But the court found no ambiguity, *id*. at 850, and, therefore, its statement regarding the rule is dicta. In addition, *Perez* does not stand for the proposition that the rule applies to ERISA plans reviewed under the arbitrary and capricious standard. The primary issue in *Perez* was whether the de novo or the arbitrary and capricious standard applied. *Perez, supra* at 555. In making this determination, the plaintiff urged the court to apply the rule of contra proferentem. The court declined to do so because it found no ambiguity in the plan language regarding whether the plan vested discretion in the administrator. *Id*. at 557 n 7. The court ultimately held that the arbitrary and capricious standard applied.[4] *Id*. at 558.

One federal district court in this circuit has addressed this issue. In *Peach v Ultramar Diamond Shamrock*, 229 F Supp 2d 759, 765-766 (ED Mich, 2002), the district court declined to follow the *University Hospitals* court's dicta and concluded that the doctrine was inapplicable "to ERISA plans which are reviewed under an arbitrary and capricious standard, as in this case." The court stated that while the rule may be applicable under a de novo standard of review, it was

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[3] It appears that *Regents of the Univ of Michigan* was also decided under a de novo standard of review, because the court gave no deference to the plan's interpretation.

[4] Notably, the Circuit Court affirmed the district court's decision after remand holding that, despite several ambiguities in the plan language, the administrator's interpretation of the plan was entitled to deference and was not arbitrary and capricious. *Perez v Aetna Life Ins Co (After Remand)*, unpublished opinion of the Sixth Circuit Court, issued February 10, 2000 (Docket No. 95-1111).

inconsistent with a deferential standard of review in which the plan administrator is given great latitude in interpreting plan language. *Id*. at 766.[5]

In light of the foregoing case law, we agree that the rule of contra proferentem is inapplicable to ERISA plans where the standard of review is arbitrary and capricious. Thus, the trial court properly refused to apply the rule in this case. Accordingly, we conclude that Parker Hannifin's determination that the COBRA coverage was secondary was not arbitrary and capricious.[6]

V. Estoppel[7]

Defendant argues that the trial court erred in finding that it could not sustain its equitable estoppel claims. First, defendant asserts that plaintiffs should be estopped from using their investigation as a basis for Parker Hannifin's decision that Smith was ineligible for benefits under the Parker Plan as of January 1, 2003.

> The elements of equitable estoppel are:
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> 1) conduct or language amounting to a representation of material fact;
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> 2) awareness of the true facts by the party to be estopped;
>
> 3) an intention on the part of the party to be estopped that the representation be acted on, or conduct toward the party asserting the estoppel such that the latter has a right to believe that the former's conduct is so intended;
>
> 4) unawareness of the true facts by the party asserting the estoppel; and

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[5] On appeal, the Sixth Circuit Court affirmed the decision in *Peach* in an unpublished opinion. One of the issues the plaintiff raised on appeal was whether the district court erred in refusing to apply the rule of contra proferentem. The court affirmed the district court's holding without specifically discussing the appeal issues because it found that the district court's reasoning sufficiently addressed the issues raised in the appeal and a detailed opinion would have been duplicative. *Peach v Ultramar Diamond Shamrock*, unpublished opinion of the Sixth Circuit Court, issued July 29, 2004 (Docket No. 02-2392).

[6] Although defendant asserts that the trial court erred in finding that Parker Hannifin's interpretation of the coordination of benefits provision was reasonable, it presents no argument in support of this claim. An appellant may not merely announce its position and leave it to this Court to discover and rationalize the basis for its claim. *Peterson Novelties, Inc v City of Berkley*, 259 Mich App 1, 14; 672 NW2d 351 (2003). Thus, we decline to consider this issue further.

[7] At oral argument, counsel for defendant withdrew this claim. However, we address it here because of the very contentious nature of this litigation.

> 5) detrimental and justifiable reliance by the party asserting estoppel on the representation. [*Armistead v Vernitron Corp*, 944 F2d 1287, 1298 (CA 6, 1991).]

Defendant contends that Richard Smith clearly relied on plaintiffs' failure to investigate whether Smith met the dependent eligibility requirements as evidenced by the fact that he continued to elect coverage for him each year. Defendant argues that plaintiffs should therefore be estopped from using its investigation as a basis for determining that Jason Smith was no longer eligible for coverage. Defendant presented no evidence of Richard Smith's reliance, however, and Richard's own deposition testimony fails to support defendant's contention. In his deposition, Richard Smith testified that he was surprised that Jason was covered under the Parker Plan at the time of his accident.

Moreover, Smith was denied coverage, effective January 1, 2003, because he did not meet the new eligibility requirements. Equitable estoppel is unsustainable in situations where the plan language is unambiguous. *Sprague v Gen Motors Corp*, 133 F3d 388, 404 (CA 6, 1998). Defendant's contention that the coordination of benefits provision is ambiguous is irrelevant because that provision had nothing to do with Parker Hannifin's decision that Smith was ineligible for benefits under the Parker Plan as of January 1, 2003.

Second, defendant argues that plaintiffs should be estopped from preventing Richard Smith the opportunity of submitting an application for disabled child coverage for Jason. Defendant contends that plaintiffs steered Smith into electing COBRA coverage by notifying him of his COBRA rights, but not of his right to extended coverage as a disabled child. Defendant argues that plaintiffs' actions intentionally deceived Richard Smith by concealing the fact that disabled child coverage was available.[8]

However, plaintiffs presented evidence that all employees were provided with the plan documents at open enrollment. Richard Smith never stated that he did not receive these documents or that the benefits available were otherwise concealed from him. Although defendant states that Richard Smith was unaware of the benefit, it presented no evidence to support this assertion. Accordingly, the trial court properly rejected defendant's estoppel arguments.

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[8] Defendant's reliance on *Zittrouer v Uarco Inc Group Benefit Plan*, 582 F Supp 1471 (ND Ga, 1984), is misplaced because that case is factually distinguishable. In *Zittrouer*, an exclusion was omitted from the summary plan description (SPD). The plaintiff relied on the SPD's lack of this exclusion. *Id*. at 1474-1475. Here, there is no dispute that the plan summary contained the information regarding the disabled child coverage, including how and when to apply for it.

VI. The Parker Plan's Liability in 2004[9]

Defendant argues that although its 2004 premium payments for Smith's COBRA coverage were short, they were sufficient under 26 CFR 54.4980B-8 A-5(d).[10] However, defendant also concedes that its payments were short of the amount deemed sufficient under the regulation.[11] Therefore, defendant's monthly payments were "significantly less" than the amount required to be paid and plaintiffs were entitled to terminate Smith's COBRA coverage. 26 CFR 54.4980B-8 A-1.

Nevertheless, defendant asserts that it was entitled to notice of its deficiency and an opportunity to cure because it substantially complied with the regulation, the difference between its payment and the amount deemed sufficient under the regulation being only 57 cents. Defendant relies on *Peckham v Gem State Mut of Utah*, 964 F2d 1043 (CA 10, 1992). In *Peckham*, the plaintiff asserted that she was entitled to coverage for her newborn child because she substantially complied with the terms of her policy. *Id*. at 1052. The *Peckham* court held that the state law doctrine of substantial compliance was not preempted by ERISA. *Id*. We find *Peckham* distinguishable, however, because the plaintiff there was asserting the doctrine in relation to her ERISA plan. Here, defendant is relying on the doctrine to argue substantial compliance with a federal regulation pertaining to COBRA. Defendant cites no authority that the doctrine is applicable in this context. Moreover, the regulation explicitly provides that "[a]n amount is not significantly less than the amount the plan requires to be paid for a period of coverage *if and only if* the shortfall is no greater than the lesser of the following two amounts: (1) Fifty dollars . . . ; or (2) 10 percent of the amount the plan requires to be paid." 26 CFR 54.4980B-8 A-5(d) (emphasis added).

Because defendant may not rely on the doctrine of substantial compliance, there is no dispute that its payments were insufficient under the law. Defendant was not entitled to notice of its deficiency and an opportunity to cure because those rights are only required if the payment is not "significantly less" than the required amount. 26 CFR 54.4980B-8 A-5(d). Accordingly, we conclude that plaintiffs did not improperly terminate Smith's COBRA coverage and the trial court did not err in finding that plaintiffs had no liability for Smith's medical expenses incurred on or after January 1, 2004.

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[9] Given our ruling that the trial court correctly ruled that the COBRA coverage was secondary, this issue is moot. While defense counsel agreed the issue would be moot if we so ruled on the priority issue, we address this issue nevertheless in light of the nature of this litigation.

[10] Defendant's argument that its payments were timely is immaterial because the trial court agreed that the February payment was timely, but found that it was nonetheless insufficient. Additionally, we do not address defendant's statement that plaintiffs failed to notify it of the premium increase despite knowing that defendant was paying the premiums on Smith's behalf. Defendant does not contend that plaintiffs were obligated to provide it notice, and cites no authority in support of such a proposition. *Peterson Novelties, supra* at 14.

[11] For defendant's payments to be sufficient under 26 CFR 54.4980B-8 A-5(d) in this case, the monthly shortage could not be greater than $31.10. Both parties represent that defendant's payments were deficient by $31.68.

The trial court properly granted plaintiffs' motion for summary disposition and denied defendant's motion for summary disposition.

Affirmed.

/s/ David H. Sawyer
/s/ Janet T. Neff