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ANNUAL CERTIFICATION MUST BE COMPLETED ON OR BEFORE SEPTEMBER 1 OF EACH CALENDAR YEAR.

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SECTION 1
INTRODUCTION

The "New Economy" . . . More Coverage Denials?

In the coming years, insurance professionals may need to brace for a wave of coverage denials and even the outright voiding of insurance policies . . . also known as ***rescissions***.

One explanation for the change is the need for insurers to find better ways to control losses and improve bottom lines. Add in low interest rates, recent natural disasters, high healthcare costs and choppy markets and you have a recipe for depleted coffers at nearly every U.S. insurer. Paying fewer and necessary claims will be the watchword. In addition, a scaling back of government budgets will mean less detection and enforcement of insurance fraud . . . the State of California is among many states announcing major cutbacks in fraud division budgeting. With fraud detection back in the lap of the carriers, every tool will need to be utilized to combat the bad guys. Look for more denial of a claims and / or voidance of insurance policies based on misrepresentations of insureds and outright fraud.

Denial of Coverage Is Different From Rescission

Denial of coverage is nothing new as claims are routinely denied for a variety of reasons:

- *Improper filing of a claim (missing information)*
- *An exclusion of a treatment or benefit . . . it is simply not covered by the policy, e.g., an experimental medical procedure, a business owner is robbed of his personal property he kept at his business, etc*
- *Treatment or repair sought without prior authorization*
- *Proceeds denied because of a misrepresentation on the application, e.g., a known smoker claimed he did not smoke on his application, an undisclosed preexisting medical condition,etc.*
- *A requirement of coverage is not met, e.g., a shopkeeper did not have his alarm connect to a central reporting agency as required by his policy, a boatowner sailed in prohibited waters, an insured participated in a dangerous hobby, a commercial property owner allowed a tenant to reside in his building . . . a specific violation of the policy, a contractor working on a mold restoration job without mold coverage loses his general liability coverage, etc.*

For these reasons and more, an insurer can deny a claim. Many claims are denied yet policy coverage continues in other areas of the policy. Insurance rescission, however, is a whole new ball game. For a variety of reasons explained in the course that follows, insurers have the absolute right to return all premiums paid by an insured and void the policy as thought it never existed. In the process, there are instances where innocent victims, who may have been entitled to an insurance claim, may not be paid. Or, if payment to such third parties is demanded by the State to be paid, the insurer ends up suing the insured of the policy just rescinded to recover losses.

There are many rules, technicalities and procedures involved in the rescission process and insurance agents and adjusters play a role.

More About Rescission [1]

Rescission of an insurance policy is serious business. Such action could result in serious financial difficulties to insureds, especially if it occurs after a major loss. Furthermore, costly and protracted litigation to contest the rescission almost inevitably follows.

Fortunately, insureds and their brokers can minimize the potential for rescission by simply exercising greater care to ascertain the accuracy of underwriting information, and by providing all material information to insurers. Also, rescission decisions are made by insurers only if they are convinced that they have adequate justification for them.

An insurer may rescind its policy in the event of material misrepresentation or concealment of a fact by the insured. Misrepresentation is false statement of a fact by the insured. Concealment is the neglect to reveal a fact that the insured knows and ought to communicate to the insurer.

Misrepresentation or concealment is material if it affects the underwriting decision of the insurer. For example, the premium would have been higher had the insurer been aware of the true and complete facts.

Policies typically include conditions pertaining to the subject of rescission, such as:

- The policy is issued in reliance upon the truth of representations made by the insured.
- The policy is void if the insured intentionally conceals or misrepresents a material fact.
- The insured, by accepting the policy, agrees that the statements in the policy declarations are accurate and complete.

In most cases, ***rescission is based*** on materially misrepresented facts in the policy application, or in underwriting information provided by the insured or its broker. However, unless there is a satisfactory answer to each of the following questions, the rescission is not justifiable:

- Is the fact known only to the insured?

If the insurer possesses a fact that differs from what the insured had provided, then it must attempt to reconcile it before proceeding further with consideration of rescission.

- Is it false?

The insurer must have incontrovertible evidence to demonstrate that the fact obtained from the insured is false.

- Is the falsity material in nature?

[1] Akos Swierkiewicz, CPCU

Materiality is determined within the context of probable and reasonable influence on the insurer by the false fact. Consequently, if the insurer's underwriting decision is not affected, then the falsity cannot be deemed material.

- Is it reasonable to rely on it?

The insurer cannot reasonably rely on a fact received from the insured alone if it is aware of a conflicting fact.

- Did the insurer rely on it?

There must be clear evidence to demonstrate that the insurer did rely on materially false facts when making its underwriting decision.

State insurance codes and legal precedents also have an impact on the insurer's decision-making process concerning rescission.

For example, the California Insurance Code allows policy rescission even in cases of unintentional misrepresentation or unintentional concealment, and it provides that materiality is to be determined solely by the probable and reasonable influence of the facts on the insurer.

Also, case law precedent prevents insurers from relying solely on representations contained in the policy application or underwriting information if an inspection of the insured's property is conducted.

A policy may be rescinded even after a loss that would otherwise be covered by the policy. Since rescission could have severe negative financial impact on the insured, the insurer must be certain that the reasons for rescission are based on solid grounds and able to withstand potential legal challenge.

In a 2001 case, an insurer rescinded their policy following a major fire loss, alleging material misrepresentation and concealment by the insured, pertaining to several matters, including square footage of the premises.

The pre-trial discovery proceedings included examination of ambiguous questions contained in the insurer's application form, and the accuracy of the inspection report provided by an independent inspection company retained by the insurer.

Major weaknesses emerged in the insurer's justifications for its decision to rescind the policy, including:

- The insurer previously issued policies for a previous owner, covering the same premises, and therefore it had prior knowledge of the underwriting information, including square footage, which differed from what the insured had provided.
- Just because the square footage information provided by the insured differed from the prior information in the insurer's underwriting files, it was not sufficient for the insurer to conclude that the insured's statement is false, especially since its insurer failed to make any attempt to reconcile the difference.
- The square footage figures provided by the insured and its broker in the application was lower than the figure in the inspection report that was ordered by the insurer after

it issued the policy. In asserting materiality, the insurer disregarded another inspection report subsequently ordered by the insured, which confirmed the original figures in the application for the policy.

Based on the above points, it was not reasonable for the insurer to rely on the square footage information provided by the insured, and the insurer's contention that it did rely on the square footage data provided by the insured was questionable.

Although this case was resolved and the insured received payment for its claim, the pre-trial discovery process took over a year, with detrimental financial consequences to the insured. The lesson from cases like this is that all parties should take thorough measures to ensure the accuracy and completeness of underwriting information, and that conflicts or ambiguities are promptly resolved before coverage is bound.

Returning To Status Quo

As previously stated, rescission is a serious and complicated matter. Under the law, it's the ***primary purpose of rescission*** is to "to restore both parties to their former position as far as possible" and "to bring about substantial justice by adjusting the equities between the parties" despite thefact that "the status quo cannot be exactly reproduced". . . ." (Neptune Society Corp. v. Longanecker -- 1987)

However, restoring one's status quo is not always possible. In a case we will discuss later, a couple's health insurance was rescinded. While the family received their premiums back, more than $100,000 of health care bills remained unpaid. In addition, the husband now had a pre-existing condition that would prohibit him from obtaining new health insurance. It is impossible to return them to the "status quo" under any definition of the term.

Arbitration and Rescission

Many policies will have ***arbitration language t***hat determines how the parties to the insurance contract will settle their differences . . . including the rescission of the policy. Here is a sample of how this might read:

Any dispute or claim, of whatever nature, arising out of or related to this Plan, or breach or rescission thereof, must be resolved by arbitration.

An interesting argument is presented, however, where an insurer decides to rescind a policy. Without a contract, an arbitrator has no authority to act because the arbitration provision evaporated along with the rest of the contract. In essence, there is no contract to arbitrate.

This is exactly what happened in a case against Blue Cross (De Grezia v. Superior Court of Los Angeles County -- 2001). The insureds had a new baby and notified Blue Cross to add him to the policy within a day or so of birth. But, after significant health problems with the baby, and upon learning the insured had fertility challenges prior to the birth, Blue Cross rescinded the policy. Fertility problems, however, did not become the focus of this case. Rather, arbitration itself became the basis for a trial.

The insureds wanted a jury trial but Blue Cross referred to the arbitration clause in the contract. Based on the clause, Blue Cross initially won the right to force arbitration. A later court overturned this decision for the reason stated above . . . there is no contract to arbitrate. In the appeal, the court reversed the earlier decision stating that the question at

hand is whether the policy is actually rescinded. The court's direct the arbitrator to proceed with the arbitration on the merits if the arbitrator finds no rescission, but to decline to proceed with arbitration, and to return the matter to respondent court, if the arbitrator finds rescission.

Reformation of Insurance Contracts

Rescission is not the only remedy available to insurers wishing to limit claims. A reformation of the insurance contract is also possible. ***Reformation*** is when an otherwise valid insurance policy does not, as written, fully or accurately express the agreement of the ***insurer and the insured*** because of fraud, inequitable conduct, or mutual mistake. When the policy fails to accurately express the parties' intent in such instances, a court may reform the policy to express the actual nature of the agreement between the parties.

For example, if a consultant substantially understated his annual revenues on an application for professional liability coverage, an insurer could seek reformation of the insurance policy to more accurately reflect the consultant's revenues and therefore allow the insurer to charge a higher premium.

Deceitful conduct by the insured or insurer can also result in reformation. If one of these situations occurs, a court may order an insurance policy reformed so the policy will state the accurate details.

Reformation of almost every California health policy recently occurred when the Affordable Care Act mandated that policies after 9/23/10 must include lifetime benefits with no caps, extended coverage to an insured's child under age 26 and acceptance of insured's regardless of preexisting conditions. All California policies must "reform" to these guidelines.

SECTION 2: INSURANCE COMPANIES AND COVERAGE DENIAL

A LEGAL RIGHT

The ability of an insurer to void a policy is a ***legal right***. An insurance company is entitled to determine for itself what risks it will accept, and therefore to know all the facts relative to the risk insured. Insurers have the unquestioned right to select those whom it will insure and to rely upon him who would be insured for such information as it desires as a basis for its determination to the end that a wise discrimination may be exercised in selecting its risks (Imperial Casualty & Indemnity Co. v. Sogomonian - 1988).

To implement these rights, most insurance policies will contain a clause similar to this . . .

This entire policy shall be void if, whether before or after a loss the insured has concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof, or the interest of the Insured therein, or in the case of any fraud or false swearing by the Insured relating thereto.

Similar language might appears as follows . . .

In signing the application, the applicant attests to the accuracy and completeness of the responses, and acknowledges the insurance company may revoke coverage if the applicant furnishes false or incomplete information.

Another version reads as follows:

Insurer may terminate this Policy for cause immediately upon written notice for material information that is false or misrepresented on the enrollment application or given to the Plan.

Some policies fail to establish the right to rescind as seen in the words of this policy . . .

There will be a charge to the Policyholder or refund from the Insurer to adjust for past premium payments. This charge or refund will be equal to the difference between: (I) premiums previously billed; and (ii) the premiums that, based on the most current data, should have been billed.

Aside from retroactive premium adjustment, this policy does not expressly provide the insurer any remedy for misstatements regarding information provided by the applicant. There is no provision for rescission, and the termination section does not include misrepresentation as a basis upon which to cancel the policy.

Laws and Other Remedies

Insurers are duty bound to follow specific laws and procedures before they can legally void a policy. (We discuss many of the California statutes that apply in a later section.) But, even when the insurance company has forfeited its right to rescission by failing to make a required code investigation of risk, or simply choosing not to rescind, it is not without remedies. “The

insurer may still prosecute a cause of action against the insured for damages for wrongful misrepresentation, after satisfying the injured person's claim, or, in an action brought by the insured, after he has satisfied a judgment against him by the injured person, defend on the ground of misrepresentations in the application." (Barrera v State Farm Mutual – 1969)

When ***an insurer attempts to rescind a policy*** of insurance it needs to produce the following evidence:

- Proof of the representations made to the insurer to induce it to insure.
- Proof of the materiality of each representation presented by the underwriter who actually made the decision to rescind.
- Availability of evidence to establish that the insurer had no intent to waive any of its rights.

In certain cases, courts have protected the insurer from the fraud by rewriting or ***reforming*** the contract to be the contract that ***would have been*** entered had the truth been told. The insurer is protected from the risk it did not want to take had it known the truth and the insured is protected from other losses.

If it isn't clear by now, denial and rescission of coverage is not a black and white matter. Where coverage disputes have escalated to lawsuits, courts have made decisions that sometime favor insurers . . . sometime favor insureds. Results can vary on a case by case basis.

ISSUES OF RESCISSION AND DENIAL

Materiality

In general, ***a simple incorrect answer*** on an insurance application will not result in a rescission based on fraud, where the true facts, if known, would not have made the contract less desirable to the insurer. (Thompson v. Occidental Life Ins. Co. -- 1973) In Ransom v. Penn Mutual Life Ins. Co. (1954), for example, the insured died in an auto accident, but it was considered immaterial that he erroneously answered he had never had an electrocardiogram. The insurer did not claim that "'essentially normal'" EKG history, if known, would have influenced it to consider the risk less desirable.)

In a different case (Old Line Life Ins. Co. v. Superior Court), the insured misrepresented her smoking history on a life insurance application. The court held that an insurance company can rescind an insurance policy upon such a ***gross misrepresentation***. Likewise, in Imperial Casualty & Indemnity Co. v. Sogomonian, the applicants made numerous misrepresentations regarding their loss history, litigation and cancellation experience in an application for homeowner's insurance. The court found the misrepresentations material as a matter of law as they did in Cohen v. Penn Mut. Life Ins. Co. (1957) where the insured failed to reveal his cardiac condition; or in Standard Accident Ins. Co. v. Pratt (1955) where the insured misrepresented he had a valid driver's license in application for auto insurance. In De Campos v. State Comp. Ins. Fund (1954) the failure to name one partner to be covered by workers' compensation policy because he did not have good credit was also deemed a material misrepresentation.

In most cases, the ***materiality of a representation*** is a question of law. Materiality is to be ***determined solely by*** the ***probable and reasonable*** effect which truthful answers would have had upon the insurer (C.I.C 334); e.g., the insurer was misled into accepting a risk, fixing the premium of insurance, estimating the disadvantages of the proposed contract or

making or limiting inquiries. The fact that the insurer has demanded answers to specific questions in an application for insurance is in itself usually sufficient to establish materiality as a matter of law. (Imperial Casualty & Indemnity Co. v. Sogomonian (1988).

"'The ***purpose of the materiality inquiry*** is . . . to make certain that the risk insured was the risk covered by the policy agreed upon. If a fact is material to the risk, the insurer may avoid liability under a policy if that fact was misrepresented in an application for that policy whether or not the parties might have agreed to some other contractual arrangement had the critical facts been disclosed. . . . (Old Line Life Ins. Co. v. Superior Court (1991).

Willful Misrepresentation

Insurers often defend their decision to rescind a policy on the basis that the insured "willfully misrepresented" facts in his application.

The courts do not cite specific examples on what constitutes a willful misrepresentation by an insured. They do, however, tend to rule that a ***misrepresentation does NOT occur*** where the applicant failed to read an application filled out by an agent or did not understand the nature of questions being asked due to a language barrier or simple lack of knowledge.

Before an insurance company can void a policy, the courts often like to see that the insurer has made a ***reasonable effort to verify an application***. A decision varies from case to case, but a reasonable effort may go beyond making sure that no required fields in the application were left blank, to confirm that plaintiffs' application was accurate and complete. A risk assessment may also require a reasonable check on the information the insurer uses to evaluate the risk.

Concealment and Misrepresentation

Concealment is defined in section 330 of the California Insurance Code as neglect to communicate that which a party knows, and ought to communicate, and section 334 provides that "Materiality is to be determined not by the event, but solely by the probable and reasonable influence of the facts upon the party to whom the communication is due, in forming his estimate of the disadvantages of the proposed contract, or in making his inquiries."

Concealment and Fraud

Courts have determined that an insurer is allowed to rescind or void a policy where there is undisputed evidence showing the applicant concealed or misrepresented facts when seeking insurance coverage.

Concealment is defined in section CIC 330 as neglect to communicate that which a party knows, and ought to communicate.' In addition, section 332 states: `Each party to a contract of insurance shall communicate to the other, in good faith, all facts within his knowledge which are or which he believes to be material to the contract and as to which he makes no warranty, and which the other has not the means of ascertaining.

Section 359 of the CIC further provides: "`If a representation is false in a material point, whether affirmative or promissory, the injured party is entitled to rescind the contract from the time the representation becomes false".

Insurance fraud is any act committed with the intent to fraudulently obtain payment from an insurer. Insurance fraud can be classified as either hard fraud or soft fraud.

Hard fraud occurs when someone deliberately plans or invents a loss, such as a collision, auto theft, or fire that is covered by their insurance policy in order to receive payment for damages. Criminal rings are sometimes involved in hard fraud schemes that can steal millions of dollars.

Soft fraud, which is far more common than hard fraud, is sometimes also referred to as opportunistic fraud. This type of fraud consists of policyholders ***exaggerating*** otherwise legitimate claims. For example, when involved in a collision an insured person might claim more damage than was really done to his or her car. Soft fraud can also occur when, while obtaining a new insurance policy, an individual misreports previous or existing conditions in order to obtain a lower premium on their insurance policy.[

Bad Faith & Emotional Distress

Many disputes settle where the injured party is restored to his or her original condition. However, ***where bad faith or emotional distress can be proven***, the prevailing party may be entitled to substantial tort and punitive damages beyond their out-of-pocket expenses.

In the case of an insurance policy, an insurer's delay or denial in the payment of policy benefits may expose it to bad faith liability if "the insurer acted unreasonably or without proper cause." (Chateau Chamberay Homeowners v. Associated Insurance – 2001). The case goes on to say . . . "It is now settled law in California that an insurer denying or delaying the payment of policy benefits due to the existence of a ***genuine dispute*** with its insured as to the existence of coverage liability or the amount of the insured's coverage claim is not liable in bad faith even though it might be liable for breach of contract."

When does a delay in paying benefits constitute bad faith on the part of the insurer? Each case is different, but following is an example where the courts determined insurer bad faith:

After an accident, a health insurer became suspicious that the insured may have withheld information on their application relating to a medical condition in February 2001, but failed to notify the insured of a potential problem until it sent out its rescission letter almost four months later in June. The insured asserts they could have obtained healthcare coverage through her employer before the insured's accident had the carrier promptly notified them of a potential problem with their application. The insurance company's underwriting investigator testified the company referred approximately 1,000 claims a year to her for investigation of possible misrepresentations or omissions in the subscribers' applications. Yet, she testified she decides to rescind in less than one percent of the cases she investigates. These facts raise the specter that insurer does not immediately rescind health care contracts upon learning of potential grounds for rescission, but waits until the claims submitted under that contract exceed the monthly premiums being collected. Health care service plans may not adopt a "wait and see" attitude after learning of facts justifying rescission by continuing to collect premiums while keeping open its rescission option if the subscriber later experiences a serious accident or illness that generates large medical expenses. Accordingly, the courts concluded a triable issue of fact exists whether the insurer acted in bad faith.

Courts have rejected bad faith liability where, for example, the insurer simply delayed or denied insurance benefits, refused to accept a settlement demand within policy limits

(Isaacson v. California Ins. Guarantee Assn., failed to investigate a claim and accused the insured of “trying to put something over on’ the insurer (Ricard v. Pacific Indemnity Co. (1982), or violated its duties under Insurance Code section 790.03 by misleading the claimant as to the applicable statute of limitations and advising the claimant not to obtain the services of an attorney.

Conversely, in Fletcher v. Western National Life Ins. Co. (1970), the insurer engaged in ***outrageous behavior*** by seeking to limit, and later denying, disability benefits based on unfounded assertions the insured’s injury was the result of sickness or a birth defect. The insurer not only stopped payments without any supportable basis, but also threatened the insured with a lawsuit to recover previous payments and, knowing the insured was in dire financial straits, attempted to coerce him into surrendering his policy in exchange for $1,200. The court recognized the evidence demonstrated outrageous conduct because the insurer “embarked upon a concerted course of conduct to induce plaintiff to surrender his insurance policy or enter into a disadvantageous ‘settlement’ of a nonexistent dispute by means of false and threatening letters and the employment of economic pressure based upon his disabled and, therefore impecunious, condition, (the very thing insured against) exacerbated by [the insurer’s]malicious and bad faith refusal to pay plaintiff’s legitimate claim.” Similarly, in Hernandez v. General Adjustment Bureau (1988), a sales clerk submitted a claim for worker’s compensation benefits, based upon the psychological harm caused by crimes committed at the convenience store in which she had worked. The employee gave the insurance adjuster “medical records and reports detailing her serious medical and psychiatric problems which included major depression, nightmares, anxiety and repeated suicide attempts.” The claimant alleged the adjuster knew of her fragile emotional condition, and that she provided the sole economic support for her three children. Despite this knowledge, and the lack of any dispute as to the claimant’s entitlement to benefits, the adjuster consistently delayed disability payments. Based on these allegations, the trial court concluded the plaintiff stated a cause of action for intentional infliction of emotional distress.

The Fletcher case goes on to say: “Undoubtedly an insurance company is privileged, in pursuing its own economic interests, to assert in a permissible way its legal rights and to communicate its position in good faith to its insured even though it is substantially certain that in so doing emotional distress will be caused. Nevertheless, the exercise of the privilege to assert one’s legal rights must be done in a permissible way and with a good faith belief in the existence of the rights asserted. It is well established that one who, in exercising the privilege of asserting his own economic interests, acts in an ***outrageous manner may be held liable for intentional infliction of emotional distress***.”

In Hailey v. California Physicians Service (Blue Shield) (2007), the courts determined . . . “a plan acts in an ***outrageous manner*** if it obtains information entitling it to rescind, yet ***deliberately foregoes rescission*** until after the subscriber has suffered a serous illness or injury. By adopting a “wait and see” attitude, a plan not only risks bad faith liability, but liability for intentional infliction of emotional distress if the plan knows the subscriber “is peculiarly susceptible to emotional distress, by reason of some physical or mental condition or peculiarity.” As noted above, the facts alleged raise the specter that Blue Shield’s final decision to rescind the Haileys’ plan may not have come about because of omissions in the application, but because of the substantial medical bills resulting from Steve’s automobile accident. Accordingly, we conclude the complaint sufficiently alleged extreme and outrageous conduct necessary to plead a cause of action for intentional infliction of emotional distress.

APPLICATIONS

Applications are serious business where a mistake can void or decline a policy or claim and get an agent sued. As you will see below, there is a case for agents spending more time than they do now to make applications accurate and complete.

Applications are the lifeblood of the insurance business yet most agents regard them as a hassle. Agents have a ***legal duty*** to be sure that each application is completed ***fully without deceit*** of any nature. The information on all forms must be accurate to the best of your knowledge.

Following are instances where applications were the source of coverage denial or policy rescission:

Calculation errors can be bad news . . .

In a case against an auto transporter the insurer (Inscorp) argued that the insured's (Superior's) failure to list motor vehicles in the insurance application as one of the commodities hauled was a material misrepresentation and concealment that invalidated the policy. Inscorp cited allegations in Superior's original complaint that Superior routinely hauled "autos, dump trucks and other vehicles" and argued that those allegations showed that the failure to identify motor vehicles as one of the commodities hauled was a material misrepresentation and concealment.

The application form requested a list of "Commodities Hauled," the percentage that each commodity represented of the total haul, and the average and maximum value of each commodity. The application submitted by RSI, as Superior's broker, identified the commodities hauled as 30 percent "Produce," 40 percent "food goods & canned foods beer/wine," 10 percent "textiles," and 20 percent "paper products," totaling 100 percent. No other commodities were listed. Thus, the application represented that Superior hauled no other commodities. Representations in an insurance application prepared by an insurance broker on behalf of an insured are attributed to the insured as a matter of law. (LA Sound USA, Inc. v. St. Paul Fire & Marine Ins. Co. (2007)

A bad application can mean no insurance existed in the first place . . .

One Court of Appeal, for instance, found that charges by the insured of poor claims handling, bad faith and tortious breach of contract by the insurer could not be sustained because if rescission is proper there was never a policy of insurance. Without a contract of insurance there can be no tort of bad faith.

Facts and answers missing from an application can be hazardous . . .

In the Westphall v. Metropolitan (1915) case the application read in part, "I have never had any of the following complaints or diseases: Apoplexy . . . fits or convulsions . . . (naming a number of well-recognized diseases) varicose veins, except." Nothing was written by the applicant after the word "except" and it was held that his failure to note any exception constituted a positive representation that he had never had or suffered from any of the designated complaints or diseases.

In another case, the inquiry was: "What illnesses, diseases, or accidents have you had since childhood?" The applicant listed pneumonia but failed to list an injury occasioned by the kick of a mule. It was said that the answer, which omitted all mention of the accident, was in effect an answer that no accident had been sustained. A judgment on directed verdict for defendant was sustained on appeal, upon the ground that the applicant's answer constituted a fraudulent misrepresentation which voided the life insurance policy.

Unintentional errors . . .

"Most people are capable of ***forgetting facts*** at the time they apply for insurance, especially if those facts relate to a condition or event in the past which is no longer (and perhaps never was) deemed a problem by the applicant. Most insureds probably don't expect to lose their coverage for an unintentional misrepresentation." Given the likelihood of inadvertent error, accurate risk assessment requires a reasonable check on the information the insurer uses to evaluate the risk.

Insurers attempt to minimize the effect of unintentional errors by making applicants responsible for their applications. It is typical, for instance, for an insurer to send an applicant the following letter . . .

Thank you for your insurance application. Here is a copy for your files. Please make certain all questions have been answered accurately and completely. If, upon second review, you determine some answers were not correct, please notify us in writing within ten (10) days of receipt of the certificate. FAILURE TO DISCLOSE ACCURATE INFORMATION MAY RESULT IN A DENIAL OF BENEFITS OR RESCISSION OF COVERAGE."

Nothing here assures the right of the carrier to deny a claim or void a policy, but these kind of statements help assign some responsibility to the applicant information supplied is later determined to be lacking or inaccurate.

Reservation of rights . . .

An insured may respond to a claim or actually accept the defense of an insured using a reservation of rights notification. Basically, the ***insurer is notifying an insured*** that coverage for a claim may not apply. This allows the insurer time to investigate the claim without waiving its right to later deny coverage based on information revealed by the investigation.

Although the reservation of rights protects and insurer's interest, it is also serves to alert the insured to the fact that some elements of his claim may not be covered. The insured, can therefore take steps to protect its potentially uninsured interests.

Leaving well enough alone . . . insurers sometimes do the right thing . . .

Cases have occurred where an insurer defended an insured even though the insurer may have felt something was wrong in an application. In one specific case, the insurer defended an insured's company and arranged a settlement with a plaintiff. The plaintiff accepted the settlement but still pursued the insured individually. The insured sued the insurer for breaching its duty to defend.

This time around, the insurer fired back with a complete rescission of the policy based on misrepresentation in the policy (they said they did not participate in joint ventures when they

did) which eventually entitled them to get back everything they spent to settle and litigate the case. The insured's ended up owing them a huge sum as well as still liable against the plaintiff's claims.

Shoulda . . . Coulda . . .

Issues of rescission are never written in stone. Consider a case below where it may have been reasonable to assume the insurer might have investigated a response more than they did. The fact that an answer was incomplete or a response was overlooked does not prevent an insurer from winning a rescission.

Even if it be considered that defendant, upon receipt of the medical examiner's report, had knowledge that, as regards the treatment by Dr. Woods, plaintiff had not fully answered the questions in the application, it does not follow that defendant cannot resist recovery on the policy on account of other and serious representations which defendant thereafter learned to be false. The application and report of the medical examiner were forwarded to company headquarters where the officials of defendant company decided whether they cared to issue the policy. It was their right to reject the application if upon the information before them they desired to do so. The fact that they might have overlooked or considered as inconsequential an incorrect or incomplete answer contained in the application does not prevent their defense against fraudulent statements, the falsity of which was discovered after the issuance of the policy. The defendant had no knowledge at the time the policy was issued of the misrepresentations now relied upon to defeat recovery.

In Maggini v.West Coast Life Ins. Co., it is stated: 'But the evidence is clear that the appellant did not have any knowledge of the falsity of any of these misrepresentations except that relating to the illness of the insured five years prior to the date of the policies. This may have been sufficient to raise a suspicion as to the truth of other representations relied on; but cause for suspicion does not constitute knowledge. Hence there could be no estoppel of the insurer's right to "set up the fraud by way of defense to an action brought to enforce the apparent liability."' By referring to the language just quoted we do not mean to say that defendant had sufficient knowledge 'to raise a suspicion as to the truth of other representations relied on.'

Oops I forgot to mention a few things . . ..

Imperial Casualty v. Sogomonian (1988) a homeowner failed to include the following facts:

1. That in February of 1980 (within three years of their application to Imperial) defendants suffered landslide damages to their property which resulted in a legal action for $500,000 in damages filed against them by a downhill neighbor. This claim was submitted by the defendants to their then insurance carrier, Equitable General Insurance Company;

2. That in early 1981 defendants suffered an uninsured loss by theft of precious stones exceeding $100,000 in value;

3. That on December 12, 1981, Underwriters Insurance Company had cancelled a homeowner's policy which it had previously issued on the same property here involved;

4. That on March 29, 1982, defendants had presented a water damage claim to Blue Ridge Insurance Company with respect to this same property;

5. That, on April 5, 1982, over two months prior to the submission of the application to Imperial, the defendants had been notified by Blue Ridge Insurance Company of the nonrenewal of the homeowner's insurance policy which that company had theretofore issued. Subsequently, on July 19, 1982, just a few days after the issuance of Imperial's policy, defendants were informed that the reason for such nonrenewal was substandard property maintenance by defendants of the same property here involved. Defendants did not ever provide such information to Imperial;

6. That at the time of the application, there was pending a lawsuit with Equitable Life Assurance Society, wherein that company sought to rescind a health policy on the grounds that defendants had made material misrepresentations and omissions in the application for that policy;

7. That at the time the application was made to Imperial defendants had a second mortgage on their property with Alliance Bank (the existence of a first mortgage with American Savings & Loan Association was disclosed; however, the total owed on the home was approximately $425,000 of which nearly one-half, or $200,000, was secured by the undisclosed second trust deed). Imperial also offered the deposition testimony of one of its former underwriters who was responsible for making the decision to issue the subject policy. She testified that she relied on defendants' application and had she known the "true facts" she would not have approved the issuance of the policy.

In their response to the summary judgment defendants did not dispute that the aforesaid statements in the application were untrue or incomplete and they effectively conceded that the described omissions had occurred. However, they contended that such statements and omissions were either irrelevant or immaterial, or claimed that the "true facts" were known to Derian who, defendants claim, was the agent of Imperial rather than defendants. In short, defendants presented no serious dispute as to the accuracy of Imperial's factual claims. Indeed, in their brief before this court defendants make clear that, apart from their arguments on materiality, there is no real dispute as to the truth of Imperial's claim of concealment. The court upheld the insurer's request to void the policy.

I'm just unlucky. . .

In yet another case (CIGNA Property and Casualty Insurance Co. v. Polaris Pictures Corp. -- 1998) the insured also failed to disclose a rather ***checkered loss history***. When his brand new yacht sank under suspicious conditions, an investigation uncovered other losses he failed to mention, including:

- Two previously owned yacht's sank in bizarre scenarios
- 1970 Rolex watch stolen from $1,150 unattended vehicle in Madrid
- Personal items and jewelry $2,000 taken from an unattended taxicab in Sydney, Australia
- 1971 Baggage stolen from unattended more than vehicle in Barcelona, (several $20,000 identical claims against different combined insurers)
- 1974 Missing Jensen-Healy automobile unknown
- 1981 Baggage lost by airline $10,000
- 1990 Baggage lost while traveling $9,000 in Europe
- 1991 Baggage lost while traveling $10,000 in Europe
- 1992 Paintings and personal property $700,000 stolen from home
- 1993 other losses resulting from 1992 undisclosed theft settlement with second insurer

The insured's bad luck extended beyond the loss of mere personal property. He also filed twenty-nine insurance disability claims between 1976 and 1990. In a 1990 claim, he sought $11,000 per month because of a "bipolar personality disorder." The insurer, Monarch Insurance Company (Monarch), sought to rescind the insurance contract alleging the insured had misrepresented and concealed material information in the application. However, after the applicant filed a counterclaim asserting breach of contract, bad faith, negligence, fraud, and negligent infliction of emotional distress, Monarch settled the claim for $550,000.

Since a full disclosure of these losses would have resulted in a denial of coverage at the time of application; and, with a yacht sinking under strange circumstances, a full rescission of the policy was approved by the court. Beyond that, a later trial resulted in the insured's conviction and sentencing for conspiracy, mail fraud, wire fraud, and perjury. The government alleged that the same insured participated in a scheme to defraud by purchasing a yacht, inflating its value through a series of sham transactions, obtaining insurance on the yacht at the inflated value, scuttling it off the coast of Italy, and attempting to collect the insurance proceeds, in part by lying about the cause of the sinking during civil litigation with the yacht's insurer.

Just a few things wrong . . .

During the policy period, a building was destroyed by arson. The arsonist, an acquaintance of insured, perished in the fire. In the ensuing investigation, insurer (United National) discovered several purported misrepresentations in the insured (Mitchell's) application for insurance, rescinded the policy, and offered to return Mitchell's premium. Mitchell refused to accept the return of his premium and filed and action.

The application stated that (1) the property to be insured consisted of a 3,420 square foot commercial building; (2) the building was to be used by Mitchell as a "video production studio and offices"; (3) the business to be conducted in the building had $20,000 in payroll and generated $300,000 in receipts; (4) there was no existing insurance on the building; (5) the building had no uncorrected fire code violations; (6) the building had a burglar alarm; and (7) Records & Records & Filmworks, Inc. (later changed to James E. Mitchell) was the purchaser of the building.

In fact, (1) the building was less than 2,000 square feet, (2) the business conducted in the building had no officers or employees, was used only to film a music video for two days in May or June of 2000, and was leased to a tenant who operated a garment business; (3) the business in the building generated approximately $6,500 in receipts fromFebruary 2000 to the time of the fire; (4) the building was insured by the California FAIR Plan, an insurer of "last resort"; (5) the building was subject to a City of Los Angeles abatement order stating that the building could not be occupied without a clearance or repaired without a permit and contained such deficiencies as being open to unauthorized entry, littered with combustible debris, excessive dry weeds or vegetation, broken windows, damaged or missing doors, damaged exterior wall covering, damaged interior wall and ceiling covering, and deteriorated flooring (and no permit had been obtained for corrective work on these deficiencies); (6) the building had no burglar alarm; and (7) the building was owned by the Mitchell Family Trust.

Mitchell admitted that the application for insurance submitted to United National "contained inaccuracies" that caused United National to rescind the policy, but claimed that those inaccuracies were not material and were solely the fault of his insurance brokers.
Based on material misrepresentations in his application for insurance and that United National was entitled, under Insurance Code sections 331 and 359, to rescind the policy.

LACK OF INSURED'S COOPERATION

Once a claim is filed, it is widely known that an ***insured's cooperation*** in the claim investigation is instrumental to ***resolving*** the claim it self. Lack of cooperation can lead to denial of a claim. A typical policy condition might read as follows:

". . . Upon the company's request, the insured and every claimant hereunder shall submit to examination by the company, subscribe the same, under oath if required, and produce for the company's examination all pertinent records, all at such reasonable times and places as the company shall designate, and shall cooperate with the company in all matters pertaining to loss or claims with respect thereto."

But what if an insured fails to cooperate by refusing to file a proof of loss in the form and manner required by defendant or by refusing to answer questions asked of her by defendant's representative? Or, worse, willfully making incorrect statements respecting her claim. Is the policy void?

Consider Robinson v. National Automobile and Casualty Insurance Co. (1952). When the insured was interrogated, the following occurred:

"Did you list in your schedule of assets any of the jewelry that you had?"

Upon advice of her counsel plaintiff replied, "I refuse to answer." In the same examination plaintiff refused to answer questions as to when, if at all, she acquired a safe deposit box. With reference to her claim that about the month of March, 1953, she had sold some jewelry to one Harold Frank and that about August she repaid Mr. Frank $800 and that the jewelry was returned to her, plaintiff was asked,

"Where did you get the cash?" (which she paid to Mr. Frank).

Upon advice of counsel she again refused to answer. Finally, plaintiff was asked "Did you fully, fairly and truthfully, disclose in your bankruptcy proceedings all of your assets?"

Again, on advice of counsel an answer was refused.

In view of the foregoing it can hardly be said that plaintiff complied with the "cooperation" clause of her contract. On the contrary, it is evident that by her conduct the insured deprived the insurer of its right to a full disclosure of the true facts, in disregard of the plain provisions of her contract. Here is the court's statement:

Neither can it be questioned that the refusal of the insured to answer material questions at an examination under oath (provided for in the policy), shows a failure to give to the insurer that degree of cooperation required by the provisions of the policy her under consideration, and is a violation of the agreement of the insured to submit to such examination under oath.

The court upheld the denial of the claim.

UNDERWRITING

In rescission litigation cases, company underwriters are often asked to testify. They are asked to assess if they would have accepted a certain risk had they known all the facts.

Here is the testimony of an underwriter where risk evaluation was key to the policy being voided:

St. Paul's senior underwriter testified to the misrepresentation's materiality. She explained joint ventures pose increased risks, require additional underwriting, and warrant charging "an additional premium" before St. Paul will cover them. Thus, the misrepresentation is also material because it affected St. Paul's evaluation of risk and the amount of the premium charged. Contrary to plaintiffs' claim, St. Paul had no obligation to produce the specific underwriter who reviewed the application. Materiality may be shown by the effect of the misrepresentation on the "'likely practice of the insurance company'" - "'the test is the effect which truthful answers would have had upon the insurer.'" The senior underwriter's testimony regarding St. Paul's practices for insuring joint ventures sufficiently shows the material effect that truthful answers about the joint venture would have had upon St. Paul.

The courts allowed the rescission of the policy.

In a similar case the underwriter testified that she issued an insurance policy for a building based on the representations contained in the application for insurance. She declared that had she known that there were uncorrected fire code violations, that the building was substantially smaller than had been represented in the insurance application, and that the property was not to be used as applied for, she either would have underwritten the policy differently or declined to underwrite it altogether. She also stated that the existence of prior insurance coverage under the California FAIR Plan was an important underwriting consideration because such coverage indicated past problems in acquiring insurance as the California FAIR Plan is an insurer of "last resort," affording coverage to property owners who have been rejected by traditional insurance carriers and who are unable to obtain insurance in the normal market. She stated that she would have undertaken further investigation had she known the property was insured under the California FAIR Plan. Based in part on her testimony, the courts agreed the insurance company had right to rescind the policy based on these misrepresentations.

BINDERS

Liability policies may be issued with binding authority. This authority is sometimes the reason an insurer rescinds a policy. Take the case of National Emblem Insurance Co. v. Rios (1969). A small used car dealer was issued a policy and temporarily bound through his insurance agent. However, the binder did not detail the conditions under which the coverage was afforded nor did it specify the exclusions; it merely indicated the subject matter, the coverage period, the rate and the amount of insurance.

A customer of the car dealer was driving a care she wished to purchase and was involved in a nasty accident. The dealer's company refused to issue the policy it had bound. The customer's insurance company also refused coverage on the ground that she made material misrepresentations in her application. It also sought to escape liability under the policy by alleging that the dealer's policy was the primary insurer and was required to protect the customer under the coverage it had extended to the dealer under its binder.

After court trial the judge found that the dealer was indeed covered under the binder of January 7, 1966, and on the date of the accident had automobile insurance within the limits of $500,000 to $1,000,000 as applied for in its application. However, they also determined that the binder did not provide any coverage for permissive users of the insured's automobiles if such users were covered by other valid and collectible insurance. Further, the

courts decreed that the customer's insurance company was ***not*** entitled to rescind the automobile insurance policy it issued to her prior to the accident, and that she was covered by valid and collectible insurance at the time of the accident and hence was not protected by the binder.

The lesson learned here? "Where the preliminary oral contract or binding slip does not specify the terms and conditions, it is a general rule that the ***parties will be presumed*** to have contemplated a form of policy containing such conditions and limitations as are usual in such cases, not the highest form of coverage which could be obtained but one reasonably suited to plaintiff's situation. The principle that in the absence of express agreement the enforcement of insurance binders is generally governed by the terms and conditions of the policies ordinarily used to cover such risks has been applied to automobile insurance binders generally."

In another binder case (Rallod Transportation Co. v. Continental Insurance Co – 1984), a cargo carrier was ***verbally bound*** by an agent. Before the policy was issued, a claim occurred and the insurer rescinded the policy on the basis that Rallod (the cargo carrier) had a duty to disclose it had financial difficulties previous to being bound. These same financial issues eventually led to the claim the insurer was asked to defend.

Under California law an insurer may rescind an insurance policy if the insured conceals material facts (C.I.C 331). However, rescission is permitted only when the insured conceals facts that he is under a ***duty to disclose***. Absent such a duty, there can be no actionable concealment. Thus, for this case it was important to determine when Rallod's duty to disclose ceased.

The court found that Rallod continued under a duty to disclose until the date the policy was issued: February 14, 1979. They held that Rallod's duty to disclose terminated when the insurance contract was formed: February 13, 1979 at noon. The ***difference between a binder policy and one with no binder*** is that the ***contract is formed*** when the binder is issued. Once issued, the insured is under no further obligation to disclose material facts. In non-bindable policies, the insured's duty to disclose would continue until the contract is accepted. In the Rallod case, his contract was formed the day his insurance agent said he was ***bound***.

WARRANTIES & OTHER CONDITIONS

Insurance policies are ***contracts under the law***. As such, they can include conditions that must be met before (conditions precedent) and after (conditions subsequent) a policy is delivered. An applicant not fulfilling these conditions subjects his policy to rescission or claim to denial.

For example, in the West Coast Life Insurance Co. V. Ward (2005) case, it was determined that a condition of the policy was that the applicant drop her life insurance policy with another company in favor of a new one with West Coast life. This did not happen before the insured died leading the insurer to rescind the policy on the basis the condition had not been met.

A ***warranty*** in an insurance policy is a promise by the insured party that statements affecting the validity of the contract are true. Most insurance contracts require the insured to make certain warranties. Policies can be rescinded for a variety of warranty violations:

- A marine policy, for instance, might specifically exclude a yacht traveling in Colombian and Nicaraguan waters or require that the vessel be stored on land for six months out of

the year. A breach of this ***cruising warranty*** will immediately terminate (coverage) and the policy or certificate of insurance will be null and void.

- To obtain a health insurance policy, an insured party may have to warrant that he does not suffer from a terminal disease.
- A commercial building policy might prohibit a tenant from "living" on premises. If the tenant's occupancy results in some form of building damage, the policy might be might be declined or the policy might be voided.
- A general contractor, working to restore a mold-ridden office building, accidentally burns down the building. His general liability insurance is void because he breached a warranty in his policy by working on a mold infested building (mold remediation requires specialized coverage).

Not all misstatements made by an insured party give the insurer the right to cancel a policy or refuse a claim. Only misrepresentations on conditions and warranties in the contract give an insurer such rights. To ***qualify as a condition or warranty***, the statement must be expressly included in the contract, and the provision must clearly show that the parties intended that the rights of the insured and insurer would depend on the truth of the statement.

Warranties in insurance contracts can be divided into two types: affirmative or promissory. An ***affirmative warranty*** is a statement regarding a fact at the time the contract was made. A ***promissory warranty*** is a statement about future facts or about facts that will continue to be true throughout the term of the policy. An untruthful affirmative warranty makes an insurance contract void at its inception. If a promissory warranty becomes true, the insurer may cancel coverage at such time as the warranty becomes untrue. For example, if an insured party warrants that property to be covered by a fire insurance policy will never be used for the mixing of explosives, the insurer may cancel the policy if the insured party decides to start mixing explosives on the property. Warranty provisions should contain language indicating whether they are affirmative or promissory.

Many states have created laws that protect insureds from cancellations due to misrepresented warranties. Courts tend to favor insureds by classifying indefinite warranties as affirmative. Many state legislatures have created laws providing that no misrepresented warranty should cancel an insurance contract if the misrepresentation was not fraudulent and did not increase the risks covered by the policy.

INCONTESTABILITY CLAUSES

Life, health or disability policies in California are mandated (C.I.C 10350.2) to include an incontestability clause that reads something like this:

We may not contest this policy after it has been in force for 2 years during your lifetime. This excludes any period of disability related to a misrepresentation in your application. We won't use any misstatements in your application to deny a claim for benefits if your disability begins after a like 2 year period.

It is important to know that the incontestability clause in the policy and section 10350.2 of the Insurance Code address the conditions under which an insurer may no longer contest a claim, including the unilateral right of rescission. These provisions, however, do not define or restrict rights while the policy is still contestable.

In Harrison v. Connecticut Mutual (1992) a letter of rescission was sent within the policy's

contestable period upon learning the applicant had symptoms of AIDs before applying for a health insurance policy. The Insurance Code contemplates insurance companies having the right to rescind a contract upon the discovery of fraud or misrepresentations.

Courts have consistently recognized the right of insurers to rescind contracts upon the provision of proper notice DURING THE CONTESTABLE PERIOD. If a party, "promptly upon discovering the facts which entitle him to rescind," gives notice and offers to "restore to the other party everything of value which he has received from him under the contract," then the contract is rescinded. Under such circumstances, an insured may contest the rescission by challenging the premise underlying the exercise of the right, i.e. the existence of a material misrepresentation, etc.

After the contestable period ends, the courts have routinely enforced the insured's rights to receive benefits even if fraud was used to procure the policy. Clearly, the burden is placed in the insurer to investigate and discover possible fraud during the contestable period. This has been the law in this state for more than 80 years.

There is a slight exception regarding disability policies. Although insurers are required to include incontestability clauses in disability policies, the insurer is permitted to exclude fraudulent misstatements made in the application from the incontestability bar, or if the policy is noncancelable, to exclude any period during which the insured is disabled from the contestable period. In contrast, the incontestability clause required to be in life insurance policies does not provide for such exclusions or tolling periods.

ERISA SAVINGS CLAUSE

Under ERISA, The Employee Retirement Income Security Act, an insured employee who believes he has been wrongfully denied benefits may sue in federal court. With certain exceptions, ***ERISA laws preempt*** "***any and all state law*** insofar as they may not or hereafter relate to any [covered] employee benefit plan." On the surface, this could spell disaster for an insurer attempting to deny coverage or rescind a policy involving health or disability insurance for employees of a company. However, the ***savings clause*** saves from preemption any state law that regulates insurance, banking, or securities. In essence, the savings clause retains the state's right to regulate insurance issues. So, someone cannot use ERISA as a defense to block an insurer's decision to deny coverage or void a policy.

To fall under the ***savings clause***, a regulation must meet a ***two prong test***. First, the regulation must be specifically directed toward the entities engaged in insurance. Second, the regulation must substantially affect the risk pooling arrangement between the insurer and the insured.

INNOCENT PARTIES

Often times, courts will view a policy rescission in light of innocent parties that may be affected if a claim is denied. In the case of auto liability, the courts take a public policy viewpoint ruling that auto insurance is issued for the public good. Therefore, in an auto claim where a third party is injured, the courts typically force the insurer to pay third parties, even though the insurer has a rock solid case to rescind the policy.

In generally liability claims, however, the courts may take the opposite view: Take the case of Homestore, a publicly traded company, is an internet-based provider of residential real

estate listings and related content. Homestore appeared to be performing well during fiscal year 2000 and the first quarter of 2001. However, in December 2001 Homestore announced the audit committee of its board of directors had begun an inquiry into the company's accounting methods and it would restate certain of its financial statements. Soon after Homestore's announcement shareholders began filing federal securities class-action and derivative liability lawsuits against Homestore and many of its current and former officers and directors. The plaintiffs alleged, among other things, Homestore had materially overstated its revenues and its financial statements were materially inaccurate and misleading.

In September 2002 the United States Attorney for the Central District of 17. California Insurance Code 2071. California filed a criminal information alleging a scheme to commit securities fraud and naming Homestore's former chief financial officer, Joseph Shew, and two other former Homestore officers. Shew pleaded guilty to one count of conspiracy to commit securities fraud and admitted that from March through December 2001 he had conspired to overstate Homestore's advertising revenue and filed false Form 10-Qs (quarterly financial reports) with the Securities and Exchange Commission.

TIG's first clause advises non- signing officers and directors with knowledge of misrepresentations they will not be covered. The second clause adds to that declination of coverage by providing no one will be covered if one of the officers or directors who actually signed the application had knowledge of the misrepresentation.

"Most courts hold that material misrepresentations by any applicant justify the insurer's rescission of the policy as a whole. The insurer can thus avoid responsibility for losses claimed even by officers and directors who knew nothing of the misrepresentation.

While this result may seem unfair to those defendants who find themselves without coverage through no fault of their own, an equally unjust result would occur if the insurance company were required to supply coverage for a risk it never intended to insure."

"While we sympathize with movant's position, and recognize that innocent officers and directors are likely to suffer if the entire policy is voidable because of one man's fraudulent response, it must be recognized that plaintiff insurers are likewise innocent parties."

OTHER OPTIONS

As previously mentioned, even when the insurance company has forfeited this right of rescission by failing to make such an investigation, it is not without remedies.

Litigation

The insurer may still prosecute a cause of action against the insured for damages for wrongful misrepresentation***, after satisfying*** the injured person's claim, or, in an action brought by the insured, after he has satisfied a judgment against him by the injured person, defend on the ground of misrepresentations in the application.

Subrogation

With insurance subrogation, there are three parties involved: the insured; the insurer; and the tortfeasor (the party who is responsible for the damages). ***Under subrogation***, the insurance company assumes the right to sue the tortfeasor for the amount of the ***damages reimbursed to the insured***. An indemnity insurer has two distinct types of subrogation

rights. Firstly, they have the classic type of subrogation used in the example above; viz. the insurer is entitled to take over the remedies of the insured against another party in order to recover the sums paid out by the insurer to the insured and by which the insured would otherwise be overcompensated. Secondly, the insurer is entitled to recover from the insured up to the amount which the insurer has paid to the insured and by which the insured is overcompensated. The latter situation might arise if, for example, an insured claimed in full under the policy, but then started proceedings anyhow against the tortfeasor, and recovered substantial damages. We will discuss more subrogation in a later section.

SECTION 3:

SPECIAL POLICY ISSUES

Certain policies include special “triggers” or protections under the law regarding rescissions. An insurer may be blocked or limited in rescinding these types of policies.

LIFE

Life policy disputes typically focus on whether an actual contract of insurance has been made. Most life policies are sold with a ***conditional receipt*** that indicates coverage will be provided immediately, so long as the applicant meets health requirements and has paid the initial premium. Here is a legal interpretation of this process:

If the first premium is paid in full in exchange for the attached receipt signed by the Company’s agent when this application is signed the insurance shall be in force, subject to the terms and conditions of the policy applied for, from the date of this application, whichever is the later, provided the Company shall be satisfied that the Proposed Insured was at that date acceptable under the Company’s rules for insurance upon the plan at the rate of premium and for the amount applied for, but that if such first premium is not so paid or if the Company is not satisfied as to such acceptability, no insurance shall be in force until both the first premium is paid in full and the policy is delivered while the health, habits, occupation and other facts relating to the Proposed Insured are the same as described in this application and in any amendments thereto.

Some application give the applicant a choice of either paying his first premium when he signs the application, in which event the insurance shall be in force . . . from the date . . . of the application, or of paying upon receipt of the policy, in which event ‘no insurance shall be in force until . . . the policy is delivered.

It is important to mention that the ***conditional receipt is NOT the policy*** . . . it merely defines when coverage begins, witness this statement by the courts:

While the conditional receipt may govern the date coverage commences, it is not a policy. Plaintiff has cited no authority, and we know of none, that considers a conditional receipt to be a policy of life insurance. While the receipt may trigger the commencement of coverage, it is not the policy.

So, how is coverage ultimately determined where the insured dies prematurely? Again the courts chime in with the following viewpoint:

The understanding of an ordinary person is the standard which must be used in construing the contract, and such a person upon reading the application would believe that he would secure the benefit of immediate coverage by paying the premium in advance of delivery of the policy.

Life policies have been legally rescinded when applicants lie or misrepresent facts on their applications, e.g., saying they are not a smoker when they really are.

Insurers have also been ***blocked*** from a rescinding a life policy where an agent slightly modified the application leading the applicant to believe he was covered (as though the policy was issued and delivered) even though the insurer's conditions were not met.

Likewise, ***both*** insurers and insureds have been denied their case when asserting that coverage is not effective if the application is not attached to the policy. While this may be true for other types of insurance, e.g., health policies, it does not apply to life contracts.

AUTO

The law seems clear that where the insured has secured a policy of automobile liability insurance through fraud, breach of warranty, or material misrepresentation, the insurer can rescind the policy as of its inception, notwithstanding the existence of any rights in third parties who were injured by the acts of the insured which occurred before the rescission." (Allstate Ins. Co. v. McCurry).

This does not mean insurers have unlimited powers witness the following court statement:

Unless it has conducted a reasonable investigation as to the insurability of its insured, an insurance company may not rescind an automobile insurance policy based upon the material misrepresentations of its insured after the insured injures a third party. (Barrera v. State Farm Mut. Automobile Ins. Co. (1969)

The Barrera case laid a foundation for more auto policy rules that establish the "***quasi-public" nature of auto insurance:***

Because of the "quasi-public" nature of the insurance business and the relationship between the insurer and the insured, the rights and obligations of the insurer cannot be determined solely on the basis of rules pertaining to private contracts negotiated by individual parties of relatively equal bargaining strength. In the case of the standardized contract prepared by the economically powerful entity and the comparatively weak consumer we look to the reasonable expectation of the public and the type of service which the entity holds itself out as ready to offer.

More comments establish the contention that the courts view auto as a slightly different coverage:

With respect to an insurance policy voidable under the Insurance Code, if an automobile liability insurer can perpetually postpone the investigation of insurability and concurrently retain its right to rescind until the injured person secures a judgment against the insured and sues the carrier, then the insurer can accept compensation without running any risk whatsoever. Such a rule would permit an automobile liability insurer to continue to pocket premiums and take no steps at all to probe the verity of the application for the issued policy unless and until the financial interest of the insurer so dictated. Furthermore, under such a rule, the carrier would be permitted to deal with the insured as though he were insured, and thus to lead him to believe that he was in fact insured.

A rule which would permit an automobile liability insurer indefinitely to postpone determination of the validity of a liability policy and to retain its right to rescind the policy in the absence of the filing of a suit against it by a judgment creditor of the insured, defeats not only the public service obligations of the insurer but also the basic policy of the Financial Responsibility Law. That law aims "to make owners of motor vehicles financially responsible

to those injured by them in the operation of such vehicles." (Wildman v. Government Emp. Ins. Co.(1957) Thus we have uniformly held that "the entire automobile financial responsibility law must be liberally construed to foster its main objective of giving monetary protection to that ever changing and tragically large group of persons who while lawfully using the highways themselves suffer grave injury through the negligent use of those highways by others.'" (Interinsurance Exchange v. Ohio Cas. Ins. Co. (1962)

Quoting from Continental Cas. Co. v. Phoenix Constr. Co. (1956)

"The pattern is clearly discernible: a desire on the part of the judiciary and the Legislature to not only prevent the astronomical accident toll in this state, but also to provide compensation for those injured through no fault of their own."

A rule permitting an automobile liability insurer indefinitely to postpone its investigation of insurability until such time as it is financially opportune to do so directly thwarts a chief purpose of the Financial Responsibility Law which was enacted to:

"provide compensation for those injured through no fault of their own." Automobile liability insurance differs from ordinary indemnity insurance, which primarily protects the insured and which may not be available to an applicant if the carrier decides he is not an insurable risk. As the Financial Responsibility Law and the several cases construing it demonstrate, the state has provided legislative protection for those who suffer injury or death on the highway from financially irresponsible drivers. That policy is evidenced also by the Assigned Risk Plan (Ins. Code, § 11620 et seq.) which assures liability insurance, although at higher rates, for any automobile owner who would be required to furnish proof of financial responsibility by section 16430 of the Vehicle Code. This policy of protecting the public by an assurance of financially responsible automobile owners finds further expression in the requirement that liability policies must contain a provision that the insolvency or bankruptcy of the insured will not release the insurer from liability under the policy. Johnson v. Holmes Tuttle Lincoln-Mercury, Inc. (1958).

We therefore cannot accept a construction of the statute governing rescission of insurance policies, insofar as it applies to automobile liability insurers, which would serve only the financial interest of the insurer and directly thwart that public policy. State Farm's alleged practice of postponing its investigation of insurability until after the assertion of a "significant" claim produces the dangerous condition that owners of cars will be driving on the streets and highways in the erroneous belief that they are insured and that the public generally will utilize these streets and highways with the frustrated expectation that insurance companies would conduct their business in such a way as to fulfill, not thwart, the basic purposes of the Financial Responsibility Law. This latter expectation can only be fulfilled, however, by recognition of the duty of the automobile liability insurer to under take within a reasonable time from issuance of the policy a reasonable investigation of insurability and by penalizing the breach of that duty by loss of the right of rescission.

California has developed a line of decisions imposing a duty upon all insurers to act promptly upon an application for insurance. The rationale underlying the ***extra-contractual imposition*** of this duty parallels the philosophy underlying the Financial Responsibility Law and related statutory and judicial rules governing automobile liability insurance. The rule that an insurer must act promptly finds its source in the quasi-public nature of the insurance business and the reasonable expectation of the applicant and the general public. "Since insurance companies are held to a broader legal responsibility than are parties to purely private contracts, having solicited and obtained an application for insurance. and having

received payment of a premium, they are bound either to furnish indemnity or decline to do so within a reasonable time."

Courts clearly want auto insurers to be responsible to the public . . .

The requirement that the carrier act promptly to ***determine insurability after issuance of an automobile liability*** insurance policy inures primarily to the benefit of those members of the public who suffer injury from negligent motorists and seek recovery against the responsible tortfeasors. The duty arises from the public policy that protects the innocent victim of the careless use of automobiles from an inability to sue a financially responsible defendant. This duty, which the insurer incurs with the issuance of an automobile liability policy, therefore runs directly to the class of potential victims of the insured. Consequently, when the insurer breaches that duty, it may not defeat recovery by the injured person, who has recovered a judgment against the insured, by relying on an untimely attempt to rescind.

In another case, State Farm Insurance argues against the "rule" that an injured person "***stands in the shoes of***" the insured bars the injured person's recovery against the insurer when the insured procured the policy through misrepresentation. In its case with Alveses, State Farm feels it could not be compelled to pay them if they had satisfied the judgment obtained by plaintiff, and that therefore plaintiff lacks any basis upon which to sue it on the policy.

The courts responded as follows:

State Farm's contention overlooks the fact that the automobile liability insurer's duty to conduct a reasonable investigation of insurability with due diligence inures directly to the benefit of persons such as the plaintiff who may be injured by the insured's use of his automobile. Upon the imposition of analogous duties in other contexts, we have held that the real beneficiary of such a duty cannot lose his remedy merely because the party whose relationship with the defendant gave rise to the duty would be barred from recovery.

In Heyer v. Flaig (1969) we considered a case in which the intended beneficiaries of a will sought to recover losses incurred because the defendant-attorney breached a duty owed them when he negligently failed to fulfill the testamentary directions of his client. We recognized such a duty in Lucas v. Hamm, supra, 56 Cal. 2d 583, and noted that the duty ran directly in favor of the intended testamentary beneficiaries. In Heyer, the defendant invoked the rule that a third party is subject to the same statute of limitations as the promisee to the contract.

The purpose of the imposition of such a duty is to reduce the number of motorists on our highways who are, in fact, financially irresponsible; the goal is to protect the motoring public generally against the inability to recover compensation for death or injuries caused by automobile accidents. Prompt notice to the insured of the revocation of his policy of insurance will most certainly impel him to seek other means of compliance with the potential requirements of the Financial Responsibility Law.

The Assigned Risk Plan provides a guarantee that such means will be available. If the insurer does undertake a reasonable investigation of insurability, it retains the statutory right granted in section 650 of the Insurance Code to declare the rescission of the policy because of a material misrepresentation of the insured. When the insurer fails, however, to conduct such a reasonable investigation it cannot assert such a right of rescission. The insurer

cannot complain of the denial of the statutory right, when its conduct is culpable and directly contributes to the presence on the highway of a financially irresponsible motorist.

Other remedies . . .
Even when the insurance company has forfeited this right of rescission by failing to make such an investigation, it is not without remedies. "The insurer may still prosecute a cause of action against the insured for damages for wrongful misrepresentation, after satisfying the injured person's claim, or, in an action brought by the insured, after he has satisfied a judgment against himby the injured person, defend on the ground of misrepresentations in the application." Moreover, the insurance company may be able to cancel the existing policy.

In Philadelphia Indemnity v. Montes-Harris a driver rented a car using a false driver license. He injured a 3rd party and the insurer was allowed to rescind where the court concluded:

When, with the minimal investigation found acceptable is conducted, later discovery of deception is sufficient to establish grounds for declaring the policy void.

The case above is reason insureds should have sufficient uninsured motorist coverage.

PROPERTY & CASUALTY

Mold & The Universal Exclusion

Lurking in many commercial and contractors policies is a provision that can spell disaster for insureds, agents and adjusters alike . . . it's called the ***universal mold exclusion***. In a nutshell, if contractors remediate mold, come in contact with mold, or their work causes or has allegedly caused mold growth ***in any amount***, this exclusion voids out all GL coverage including the defense cost coverage. This excerpt emphasizes just how far reaching the exclusion is. ***Mold only has to be involved or allegedly involved in a loss, not be the cause of the loss, for this exclusion to take effect over the entire GL policy.*** This means that all contractors who "assess or respond to mold or bacteria in any way" have NO General Liability coverage. So, if he burns down the house or cause bodily injury while responding to or assessing mold, there is potentially NO General Liability coverage to respond to the claim, i.e., ***coverage denied!***

To manage the risk of performing water, drying and mold work, or even general contracting work, it is important for all the parties to realize:

1. That the mold and bacteria exclusion kicks in as soon as the insured sets foot on the property.
2. The entire GL policy is voided out even if only a very small part of the loss is "related to" any amount of mold. In theory, a single mold spore triggers the exclusion.
3. Purchasing a separate Contractors Pollution Liability policy to cover mold is only a partial solution to the insurance coverage gap created by this far reaching exclusion in the General Liability policy.

The most common mold or bacteria exclusion found in a General Liability policy reads as follows:

This insurance does not apply to:

Fungi or Bacteria

a. *"Bodily injury" or "property damage" which would not have occurred,* ***in whole or in part****,* ***but for the*** *actual, alleged or* ***threatened*** *inhalation of, ingestion of, contact with, exposure to,* ***existence*** *of, or presence of,* ***any "fungi"*** *or bacteria on or within a building or structure, including its contents,* ***regardless of whether any other cause, event, material or product contributed concurrently or in any sequence*** *to such injury or damage.*

b. *Any loss, cost or expenses arising out of the abating, testing for, monitoring, cleaning up, removing, containing, treating, detoxifying, neutralizing, remediating or disposing of,* ***or in any way responding to, or assessing the effects of*** *"fungi" or bacteria, by any insured or by any other person or entity.*

This exclusion is so broad it essentially voids out the GL policy entirely as soon as any insured party is in any way "related to" a mold project. he GL policy is voided out even if the only activity of an insured party is evaluating the "threatened existence of mold or bacteria." Since mold spores are omnipresent, it is impossible to interpret what the threatened existence of mold may mean; mold spores will always exist in the built environment.

Let's explore how the universal model exclusion can result in a denial of coverage [2]:

The contractor while removing moldy materials accidentally starts a fire that destroys the building and severely injuries several tenants. As a result of the loss, the building owner and property manager sue the contractor and the tenants sue the contractor, building owner and property manager.

- *Can the contractor's GL insurer deny the entire loss from the fire citing the mold exclusion?*
- *Can the building owner's and property manager's GL insurers deny the tenants' claims by citing the mold exclusion?*

The consultant, while less exposed, could still be sued by the damaged parties for the fire loss; can his GL insurer deny the claim citing the exclusion?

The answer could be yes to all three questions. Although we doubt this is the intent of the exclusion, the insurance company has the option to deny all these claims because of it.

A couple of years ago, we contacted several GL insurers who we had regularly found insuring fire/water contractors and restoration contractors. Our effort was to find GL insurers willing to offer insurance to our book of restoration contractors. However, to our surprise, nearly all the GL insurers at the home office director of underwriting level had one of the following responses:

- Fire/water and restoration contractors are a class of business their underwriters are prohibited from insuring.
- Their insurance company was in the process of non-renewing all such contractors because of the loss exposure to mold. Or they denied their insurance company was actually selling

[2] The balance of this section is excerpted from the article ***General Liability and Mold*** by *Paul Duggan, ERM, and David Dybdahl, CPC -- Insurance brokers specializing in mold and restoration contractors insurance at American Risk Management Resources Network, LLC. Visit www.armr.net for more information*

GL insurance to restoration contractors. Yet we find these same carriers suspiciously continuing to insure restoration contractors today.

The possible explanations for this include:

- Insurance agents may misclassify fire/water and restoration contractors as “janitors” when they submit their applications to the insurance company. The result is the insurer may be unaware they are even insuring a restoration contractor. Where paying the insurance rates of a janitor saves on the premium, the policy will not be a good value for a restoration contractor if a claim is denied due to insurance fraud.

- Underwriters may be ignorant about their own underwriting guidelines until there is a loss.
- Individual underwriters may agree to insure businesses submitted to them by their best agents by stretching their company’s underwriting guidelines.

The interplay between universal mold exclusions and naive underwriting could be very detrimental for contractors in a claim situation. The insurance company may not like the idea of having to pay a large claim on a risk they never intended to insure. Therefore, the insurer’s claims personnel are likely to look for any conceivable reason to deny coverage. The universal mold exclusion gives them a ready made reason to deny the entire claim if they so choose anytime there is a speck of mold involved in the loss.

Other Coverage Solutions

Purchasing a CPL policy separately to cover mold does not fix the problem because the mold exclusion in the GL excludes more than the broadest CPL policy can cover. This is because the universal exclusion basically voids out the GL policy if mold in any quantity is even remotely involved with a loss.

On the other hand, all CPL polices only insure claims that are a result of the emission, discharge, release or escape of mold. A classic example that illustrates the coverage gap between these policies would be if a contractor starts a fire while performing a mold remediation. In theory, the GL is voided out for the entire job because the job was “related to” mold. The CPL would not engage for the fire loss either because there was no emission discharge, release or escape of mold. So there is no coverage in either of these separate insurance policies for the fire loss.

One ***solution to filling this coverage gap*** is to purchase GL and Contractors Pollution Liability (CPL), including coverage for mold, from the same insurer. There are several insurers providing good quality package insurance policies to restoration contractors. This solution addresses many of the concerns raised including:

1. These specialized insurers understand the business of restoration contractors and want to insure them.
2. It is very unlikely these insurers could use the mold exclusion to deny a GL claim when they also insure the CPL. This is because the CPL policy requires that the insured complete an application detailing their services. The policy specifically lists these services as “covered services.” These insurers know that fire/water/restoration contractors may come in contact with mold and will not be able to use the “we were told the firm was a janitor” argument to deny a loss. Having the same insurer on the GL and CPL prevents two well intentioned but adversarial insurance companies from using the classic “It’s not

my job" argument for each policy. A coverage stalemate between these insurance policies could take years to work out.

Experts mention that another solution to fill the coverage gap between General Liability and Contractors Pollution Liability is to purchase these coverages through a package policy, these can also include Professional Liability coverage.

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HEALTH

A typical health policy starts with an application and wording similar to the following:

"THIS APPLICATION made to the ABC Life Insurance Company of California is the basis and a part of a proposed contract of insurance, subject to the charter of the company and the laws of the State of California. I hereby agree that all the following statements and answers, and all those that I make to the company's medical examiner, in continuation of this application, are by me warranted to be true, and are offered to the company as a consideration of the contract, which I hereby agree to accept, and which shall not take effect unless and until the first premium shall have been paid, during my continuance in good health, and unless also the policy shall have been signed by the president and secretary and countersigned by the registrar of the company and issued during my continuance in good health; unless a binding receipt has been issued as hereinafter provided."

Policies also include language reading something like this . . .

"This policy and the application here for, copy of which is indorsed hereon or attached hereto, constitutes the entire contract between the parties hereto. All statement smade by the insured shall, in the absence of fraud, be deemed representations and not warranties, and no such statement of the insured shall avoid or be used in defense to a claim under this policy unless contained in the written application herefor, a copy of which is indorsed hereon or attached hereto." "Agents are not authorized to modify this policy or to extend the time for paying a premium."

While it would appear that with iron-clad language as this health insurers are "holding all the cards" where an insured answers incorrectly to fraudulently, there are many consumer laws favoring consumers.

Health care plans are governed by a different set of statutes and regulations than insurers, both are equally bound by the duty of good faith and fair dealing. (Sarchett v. Blue Shield of California -- 1987).

To protect the public from unscrupulous carriers, California passed legislation (1389.3) prohibiting "***post claims underwriting***" practices . . . the rescinding, canceling, or limiting of a plan contract due to the failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the plan contract. Insurers have been known to ignore suspicious answers or ask only a few. When a claim is filed, the questionable answers are used as justification to rescind the policy.

Courts frown on any post claims activity for the following reason: "The insurer controls when the underwriting occurs. . . . If the insured is not an acceptable risk, the application should [be] denied up front, not after a policy is issued. This allows the proposed insured to seek other coverage with another company since no company will insure an individual who has suffered serious illness or injury." (Lewis v. Equity Natl. Life Ins. Co. (1994)

In California, the law is clear, a health carrier in that wishes to rescind a health care service plan must:

- Prove an intentional misrepresentation or concealment of material fact.
- Make a reasonable effort to make sure the client's application was complete and accurate.

The courts do not cite specific examples on what constitutes a willful misrepresentation by an insured. They do, however, tend to rule that a ***misrepresentation does NOT occur*** where the applicant failed to read an application filled out by an agent or did not understand the nature of questions being asked due to a language barrier or simple lack of knowledge.

A reasonable effort on the part of the insurer may go beyond making sure that no required fields in the application were left blank, to confirm that plaintiffs' application was accurate and complete. A risk assessment also requires a reasonable check on the information the insurer uses to evaluate the risk.

Health policies in California are also mandated to include a ***incontestability provision*** which stipulates a given period of time (usually two years) that an insurer may contest an insured's application and benefits. Once the incontestability period expires, the insurer ***cannot use any misstatements in an application to deny a claim for benefits if the disability begins after a like 2 year period.***

Health Applications Are Important

A very complicated area of the law involves applications that are endorsed or attached to policies. An insurer who fails to follow proper procedure here may be prohibited from rescinding a health policy. Yes, insured's who have misrepresented their health condition have successfully barred their insurer from voiding their policies simply because an application was not attached or endorsed per CIC 10113 and 10381.5.

Insurers, on the other hand, have prevailed in policy rescissions, even when the application was not attached, where they proved fraud or the insured made representations to people verbally, outside the application, that they were "healthy", when, in fact, they were not.

Consider the landmark Hailey v. California Physicians case of 2007.

Plaintiffs Cindy and Steve Hailey challenged a judgment entered after the trial court granted summary judgment in favor of defendants California Physicians' Service, doing business as Blue Shield of California (Blue Shield) on the Haileys' claims for breach of contract and breach of the covenant of good faith and fair dealing, and awarded $104,194.12 in damages to Blue Shield on its cross-complaint for rescission of the health services contract it had previously agreed to provide the Haileys.

The Haileys contend, Health and Safety Code section 1389.3 precludes Blue Shield from rescinding unless it can prove the Haileys willfully misrepresented the condition of Steve's health at the time they applied for coverage. Because evidence of whether the Haileys' misrepresentations were willful presents a triable issue of fact, they contend the trial court erred in granting summary judgment. They also contend Blue Shield's rescission of their health services plan constituted extreme and outrageous behavior sufficient to state a cause of action for intentional infliction of emotional distress.

The court concluded . . .

Section 1389.3 precludes a health services plan from rescinding a contract for a material misrepresentation or omission unless the plan can demonstrate (1) the misrepresentation or omission was willful, or (2) it had made reasonable efforts to ensure the subscriber's application was accurate and complete as part of the precontract underwriting process.

According to Cindy, she believed she provided all of the information requested on the application. Nonetheless, she mistakenly believed the form sought information relating only to her health, and not that of her husband, Steve, or their son. Although she noted on the application matters concerning her own health, she omitted any health information regardingher husband or son. She also incorrectly listed Steve's weight as 240 pounds instead of his actual weight of 285 pounds.

In its probe, Blue Shield obtained Steve's medical records, which revealed a history of undisclosed health issues, including obesity, hypertension, difficulty swallowing, and gastroesophageal reflux disease. Based on the information obtained from Steve's medical providers and Blue Shield's underwriting guidelines, Crary determined the Haileys intentionally misrepresented and concealed Steve's medical information. On March 19, 2001, an automobile accident left Steve completely disabled. He remained hospitalized until May 31, 2001, when he was released and sent home with instructions for additional home nursing care and physical therapy. Before his discharge, Blue Shield authorized healthcare providers to provide surgery, treatment, care, and physical therapy in an amount exceeding $457,000.

On June 1, 2001, Blue Shield sent the Haileys a letter informing them their health insurance coverage had been cancelled retroactively to December 15, 2000, the date Blue Shield issued the policy. Blue Shield based its cancellation on the Haileys' failure to disclose medical information Blue Shield had received from Los Alamitos Medical Center, which disclosed that in October 2000, Steve had been seen "for dysphagia, stricture/stenosis of the esophagus, essential hypertension, and a reported weight of 285 lbs." The letter noted the total amount of claims submitted during the period of February 6, 2001 to May 14, 2001 was $457,163.30. The letter demanded the Haileys pay Blue Shield $60,777.10, the difference between the amount Blue Shield had paid for Steve's medical care, and the premiums the Haileys had paid for their health insurance.

After Blue Shield cancelled the policy, the Haileys could no longer afford nursing care or physical therapy for Steve. In addition, third party medical providers demanded the Haileys pay for medical care previously provided. Blue Shield's rescission of the health care plan contract caused Steve delays in obtaining necessary medical care. Steve subsequently lost the use of his bladder, which he contends is permanently nonfunctional. Steve also asserts the lack of physical therapy has impaired his ability to walk, increased his pain, and resulted in further surgery and medication.

The Haileys sued Blue Shield, alleging in their second amended complaint causes of action for breach of contract, breach of the implied covenant of good faith and fair dealing, and intentional infliction of emotional distress. Blue Shield demurred to the intentional infliction of emotional distress cause of action, which the trial court sustained without leave to amend. Blue Shield also filed a cross-complaint seeking a declaration it legally rescinded its health care contract with the Haileys and was entitled to recover the money it spent on Steve's medical care before the rescission.

The trial court granted Blue Shield's summary judgment motion on the Haileys' complaint, determining that the Haileys' misrepresentations and omissions justified rescission, and entered judgment for Blue Shield on its cross-complaint in the amount of $104,194.12. The Haileys appealed and later filed a petition for writ of supersede as to stop Blue Shield from executing on its judgment.

In an appeal by the Hailey's, however, the court found Part 3 of the application, requests medical information for "you or any applying family member . . . ." Moreover, the medical information checklist in part 3 did not provide separate questions for each family member, but required the applicant to answer each question as to herself and each family member. The form, although understandable upon close examination and reflection, is no model of clarity, and lends credence to Cindy's explanation of her omission of Steve's health information. Her belief that Steve's medical information was unnecessary in obtaining health insurance also negates an inference that her understatement of Steve's weight on the application was willful. Similarly, Steve's misplaced reliance on Cindy to accurately complete the application also negates an inference of willfulness. Accordingly, we conclude the Haileys have demonstrated a triable issue of fact whether they willfully misrepresented Steve's medical history.

Blue Shield performed its risk assessment on the assumption the application contained no errors. Upon receiving a hospitalization claim under the plan, however, Blue Shield launched an investigation in which it obtained extensive medical records.

Postclaim eligibility investigation v. Postclaim underwriting

Postclaims investigation and postclaims underwriting involve a common activity: Research into a subscriber's precontract health after a claim is made to determine whether to rescind the plan due to misrepresentations or omissions in the original application. The ***distinction*** between postclaims investigation and postclaims underwriting thus lies primarily in the quality of the underwriting process undertaken before the policy is issued.

Courts have determined that an ***insurer does not participate in postclaims underwriting*** where it is has properly completed its underwriting process and resolved all reasonable questions arising from the information provided by appellant. Insurers are not compelled to do more if there is nothing in the application to alert them that the appellant's responses were false. Courts may also play "what if" to determine if additional inquiries would have resulting in evidence to suggest that it would have learned of appellant's undisclosed condition and treatment. If not, there is no postclaims underwriting taking place.

The facts presented here raise an inference Blue Shield may have acted in bad faith by delaying its decision to rescind the policy. Specifically, Blue Shield first became suspicious that the Haileys may have withheld information relating to Steve's medical condition in February 2001, but failed to notify the Haileys of a potential problem until it sent out its rescission letter almost four months later in June. Cindy asserts they could have obtained healthcare coverage through her employer before Steve's accident had Blue Shield promptly notified her of a potential problem with her application.

Moreover,BlueShield's underwriting investigator testified the company referred approximately 1,000 claims a year to her for investigation of possible misrepresentations or omissions in the subscribers' applications. Yet, she testified she decides to rescind in less than one percent of the cases she investigates. These facts raise the specter that Blue Shield does not immediately rescind health care contracts upon learning of potential grounds for rescission, but waits until the claims submitted under that contract exceed the monthly premiums being collected. In other words, a health care services plan may not adopt a "wait and see" attitude after learning of facts justifying rescission by continuing to collect premiums while keeping open its rescission option if the subscriber later experiences a serious accident or illness that generates large medical expenses. Accordingly, under the facts presented, we conclude a triable issue of fact exists whether Blue Shield acted in bad faith.

SECTION 4: PROTECTIONS FOR THE INSURED

In combating denial of coverage, consumers have several weapons of choice. Chief among them is the threat of bad faith. Sanctions of many types, including punitive damages, are an incentive to insurers to avoid bad faith claims from their customers. Attorneys also have great success with estoppel clauses in insurance contracts that prevent companies from adopting a position that is not consistent with a position it took previously . . . especially if it would result in an injury to the insured. An insurer that can be estopped from certain actions needs to be fair from dealing with customers. Finally, insurance policies are contracts of adhesion . . . they are written by one party (the insurer). Where insureds can make the case that policy language is ambiguous and can be interpreted in different ways, the courts typically favor the insureds.

MISTAKES BY THE INSURED

Sections 331 and 359 of the California Insurance Code provide that material misrepresentations or concealments in an application for insurance are grounds for rescission of the policy. However, a ***false statement*** in an application for insurance does not void a policy unless the false statement was made with the ***intent to deceive***, or the statement did not materially affect either the acceptance of the risk or the hazard assumed by the insurer. Cal. Ins. Code 10380.

Moreover, the signature of the insured on the application for insurance does not mean the insured is destined to have his policy cancelled if it can be shown that the insured simply failed to recall the facts represented or to appreciate their significance. (Thompson v. Occidental Life Ins. Co. (1973).

An ***insured under California law has a duty*** "to read the contract and the application in accordance with her representations and to report to the company any misrepresentations or omissions, (Telford v. New York Life Ins. -- 1937). However, an insurance company may not rescind a policy if the insured in good faith gives truthful answers to application questions, and the answers "owing to the fraud, mistake, or negligence of the agent filling out the application are incorrectly transcribed." (Boggio v. California-Western States Life Ins. Co. -- 1952).

DISCRETIONARY CLAUSES

A discretionary clause is any provision in an insurance policy..."that purports to confer on the carrier sole discretionary authority to determine eligibility for benefits or to interpret the terms or provisions of the policy or contract. Insurers with this authority can deny claims and/or rescind policies at will. However, The California Insurance Commissioner has the authority to prohibit discretionary clauses but it is not an "express" authority with the standing power of a statute, i.e., violations may result in a trial or negotiation. A 2010 bill (AB 1868) to correct this was vetoed by the Governor but a 2011 version is being proposed as of the writing of this report.

The use of “discretionary clauses” in insurance policies has been and remains controversial. Opponents of the clauses argue that their elimination would mitigate the conflict of interest present when a claims adjustor also pays the benefit. The opponents also argue that use of the discretionary clause may result in an insurer engaging in inappropriate claims practices. Proponents of the clauses argue that they keep insurance costs manageable and that eliminating them will lead to increased per-case costs.

Relief Actions

Section 1692 states: “When a contract has been rescinded in whole or in part, any party to the contract may seek relief based upon such rescission by (a) bringing an action to recover any money or thing owing to him by any other party to the contract as a consequence of such rescission or for any other relief to which he may be entitled under the circumstances or (b) asserting such rescission by way of defense or cross-complaint

Social impact: The law would have a favorable impact on consumers. In a court case, the 'de novo' standard of review would ensure that cases could be completely reviewed and patients would have a better chance of receiving the benefits promised in their policies. Carriers would no longer have free rein to interpret the policies as they wish. ("Prohibition of Discretionary Clauses" by Actuarial Services, New Jersey Department of Banking and Insurance, Division of Insurance, 2006)

Economic Impact: Consumers will likely receive benefits for claims which would have been denied before. This means that carriers may be paying out more in claims than they did before. Having a uniform policy of banning discretionary clauses will economically benefit carriers since if will improve the efficiency of form presentation and of the filing process. Also, with the 'de novo' standard of review in place, insurance carriers are more apt to approve claims and avoid possible court cases which they are more likely to lose. (Andalman, 31 Aug. 2006)

Impact on small businesses: Some claims will be paid that would not have been paid had a discretionary clause been in place, so self-funded groups may pay a little more in claims. However, a study by the Maryland Insurance Administration determined that a ban on discretionary clauses would have little impact on small business. ("Fiscal and Policy Note" by Alexandra M. Rzasa, Insurance Administration, Maryland, 26 Feb. 2008) A 2005 study by Milliman, Inc. suggested that, for disability policies, premiums would rise 3 to 4 percent. Milliman points out that increases "appear modest and seem a small price to pay for fairness in claim adjudication and protection promised by the ERISA statute." ("Discretionary Clauses and Insurance" by Mark D. DeBofsky, Adjunct Professor of Law, John Marshall Law School, 2006) Besides, the insurer already reserves for claims and avoids the costs of litigation by paying according to the contract. (Andalman, 31 Aug. 2006)

VOCABULARY CONFLICTS

Insurance contracts are contracts of adhesion meaning one party is responsible for writing the contract. For this reason, courts lean toward the insured if a term or definition is ***ambiguous***.

In the Superior v. Inscorp case, Superior argued that there was no misrepresentation or concealment as to the commodities it hauled. Superior presented evidence that Inscorp’s inspector had reported that Superior hauled “100% container freight.” Superior argued that

the terms “container freight” and “containerized freight” as used in the industry could include anything in or on a container. Superior successfully argued that Inscorp’s knowledge that Superior hauled “100% container freight” showed that Inscorp understood that the containers could contain anything and that Inscorp was not misled by the listing of commodities hauled in the insurance application.

Statute of Limitations on Insurance Contracts

Q: What is the statute of limitations in a bad faith case?
A: In most cases, a one-year statute for personal injuries (emotional distress) is applied. (C.C.P. section 340.) A two-year statute governing actions “upon a[n] . . . obligation or liability not founded upon an instrument of writing” (C.C.P. section 339(1)) may also apply. (Smyth v. USAA Property and Casualty Ins. Co. (1992) 5 Cal.App.4th 1470, 7 Cal.Rptr.2d 694.) **CAUTION** If the insurance policy contains a contractual statute of limitations clause see question 52 below.

Q: Is an insurance policy clause limiting the time “within which the insured must bring an action to recover on the policy” (e.g., one year), enforceable, and if so, how is the time period computed?
A: This issue is complex. The wording of the policy and the facts of the case are important factors. Some insurance policies attempt to require insured to file actions on the policy within a specified period from the occurrence, rather than from the time the claim is denied. (Lawrence v. Western Mutual Ins. Co. (1988) and Abari v. State Farm Fire & Casualty Co. (1988)

In Prudential – LMI Commercial Insurance v. Superior Court, supra, 51 Cal.3d 674, the California Supreme Court held that the time limitation in the policy was enforceable, but tolled between the period of time that the insured gives notice of the loss and the time the claim was denied. For example: a loss occurs on January 1, 1991 and is reported to the insurer on February 1, 1991; it is denied by the insurer on March 1, 1992. The insured must file suit prior to February 1, 1993. The one month that elapsed between the loss and the notice to the insurer counts toward the limitations period. Based on the length of the delay in reporting the loss, the insured will have only and additional eleven months after denial to file the lawsuit. (Prieto v. state Farm Fire & Casualty Co. (1990)

Q: When does the statute of limitations begin to run on an action to compel and insurer to abide by an arbitration clause?
A: The limitations period begins to run when the insurer refuses to arbitrate. (Spear v. California State Auto. Assn. (1992)

FAIR CLAIMS

Regulations enacted by the Department of Insurance require certain disclosures by insurers in connection with claims presented. We discuss this issue in much greater detail in a later section. Basically, the State ***requires an insurer to notify*** its insured claimant of contractual limitations provisions and other policy provisions that may apply to the claim.

Section 2695.4: Every insurer shall disclose to a first party claimant or beneficiary, all benefits, coverage, time limits or other provisions of any insurance policy issued by that

insurer that may apply to the claim presented by the claimant." The term "first party claimant" is d efined as "any person asserting a right under an insurance policy as a named insured, other insured or beneficiary under the terms of that insurance policy, and including any person seeking recovery of uninsured motorist benefits." Thus, the term includes not only insureds making claims under first party policies, but also insureds making claims under third party, liability policies.

Section 2695.7, subdivision (f) requires an insurer to notify a claimant of any statute of limitations and any "other time period requirement upon which the insurer may rely to deny a claim." (Ibid.) Section 2695.7, subdivision (f) states in pertinent part: "Except where a claim has been settled by payment, every insurer shall provide written notice of any statute of limitation or other time period requirement upon which the insurer may rely to deny a claim. Such notice shall be given to the claimant not less than sixty (60) days prior to the expiration date; except, if notice of claim is first received by the insurer within that sixty days, then notice of the expiration date must be given to the claimant immediately. . . . This subsection shall not apply to a claimant represented by counsel on the claim matter." The term "claimant" is defined to include both a "first party claimant," defined above, and a "third party claimant," which is defined as "any person asserting a claim against any person or the interests insured under an insurance policy."

MATERIALITY & UNDERWRITING

Insurance Code section 332 requires ***each party*** to an insurance contract to disclose, "in good faith, all facts within his knowledge which are or which he believes to be material to the contract . . . ." The disclosure obligations imposed by these statutes are directed specifically at the formation of the insurance contract. Insurance Code section 334 states: "Materiality is to be determined not by the event, but solely by the probable and reasonable influence of the facts upon the party to whom the communication is due, in forming his estimate of the disadvantages of the proposed contract, or in making his inquiries." (Ins. Code, § 334, italics added.) Insurance Code section 356 provides: "The completion of the contract of insurance is the time to which a representation must be presumed to refer."

Requiring full disclosure at the inception of the insurance contract and granting a statutory right to rescind based on concealment or material misrepresentation at that time safeguard the parties' freedom to contract. "[An insurance company] has the unquestioned right to select those whom it will insure and to rely upon him who would be insured for such information as it desires as a basis for its determination to the end that a wise discrimination may be exercised in selecting its risks." (***Robinson v. Occidental Life Ins. Co. -- 1955***)

Insurer's Duty

Some insureds claim the insurer should investigate weird things on their applications. The fact is: Insurers have no obligation to verify the accuracy of the representations. (Robinson v. Occidental Life Ins. Co.) In connection with an insurance application "it was not incumbent upon [insurer] to investigate [insured's] statements made to them". This does not apply to auto insurance because of financial responsibility laws.

Applications

The materiality of a misrepresentation is determined by its probable and reasonable effect upon the insurer. (C.I.C 334.) The misrepresentation need not relate to the loss ultimately claimed by the insured. (Torbensen v. Family Life Ins. Co. (1958) The ***test for materiality*** is

whether the information would have caused the underwriter to reject the application, charge a higher premium, or amend the policy terms, had the underwriter known the true facts. (Old Line Life Ins. Co. v. Superior Court (1991).

This is demonstrated further here . . . "The most generally accepted test of materiality is whether or not the matter misstated could reasonably be considered material in affecting the insurer's decision as to whether or not to enter into the contract, in estimating the degree or character of the risk, or in fixing the premium rate thereon" (Holz Rubber Co., Inc. v. American Star Ins. Co. (1975).

And, again here . . . "Materiality is determined by the probable and reasonable effect that truthful disclosure would have had upon the insurer in determining the advantages of the proposed contract. Essentially, we must decide whether the insurer was misled into accepting the risk or fixing the premium of insurance. This is a subjective test; the critical question is the effect truthful answers would have had on [the insurer], not on some `average reasonable' insurer." (Cummings v. Fire Ins. Exchange (1992)

An authority has written that "courts are split on whether the insured's answers to questions in the insurance application must be regarded as material as a matter of law, or whether their materiality is a question of fact in each case." (Ransom v Penn.Mutual Life Ins. Co. -- 1954).

"An incorrect answer on an insurance application is not grounds for rescission where the true facts, if known, would not have made the contract less desirable to the insurer" (Thompson v. Occidental Life Ins. Co. . . . "the trier of fact is not required to believe the `post mortem' [post loss] testimony of an insurer's agent that insurance would have been refused had the true facts been disclosed"

In Cohen v. Penn Mut. Life Ins. Co. (1957) . . . "The fact that defendant put the questions in writing and asked for written answers was itself proof that it deemed the answers material". Yet, in another case, the court suggested that the issue of materiality of a misrepresentation in an insurance application may be one of law by stating, "`The fact that the insurer has demanded answers to specific questions in an application for insurance is in itself usually sufficient to establish materiality as a matter of law." " The court also stated when there is undisputed evidence that false information was given in an application for insurance and the insurer issued a policy in reliance upon this information, the materiality of a misrepresentation or concealment may be established as a matter of law.

Yet, the court gave some indication of possible factual issues in a determination of materiality by stating, "Defendants offer us no evidentiary assistance on this point [materiality], but content themselves with the naked argument that since a jury might `disbelieve' all of the uncontradicted evidence presented by [the insurer], they are entitled to a trial on the question of materiality." The court went on to say that materiality was established by "the nature of the insurance coverage which defendant sought, the quality and quantity of the information which was not disclosed," in addition to the fact that the insurer "specifically requested the information on its application and therefore relied upon it in issuing the policy."

Incorrect Answers . . .

It seems unreasonable to conclude that an incorrect answer to any question on an insurance application automatically would constitute a material misrepresentation for purposes of rescission. For example, there might be instances when the question on the application is not relevant to an underwriting decision or the answer is such that the insurance company could

not have relied upon it. Thus, we can conceive of situations when the issue of materiality might be a factual one.

Applicant Did Not Understand . . .

Rescissions of an insurance policy have been ***denied*** because the ***applicant did not understand the application question*** or did not comprehend the significance of an answer. In Thompson v. Life (1973), for example, the courts determined " there is no breach of the duty to disclose [a previous injury or medical condition] if the applicant, acting in good faith, does not understand the significance of the information he fails to disclose." Thus, a lay person might be excused for his failure to relay certain information if, for example, he did not understand the meaning of a medical diagnosis. In Paul Revere Life Insurance Co. v. Dennis P. Steigerwald (1992), however, the circumstances were different. The insured, a licensed chiropractor, who is necessarily quite familiar with back injuries, was fully aware of the fact that he had suffered a cervical sprain and other injuries should have understood the significance they played in a claim against his disability policy. In yet another case, Life Ins. Co. of North America v. Capps (1981) the insurer was able to rescind a policy because the insured knew she had a heart condition, even though she may not have appreciated its significance.

Less Than A Full Answer . . .

In the Turner v. Redwood Mutual Life Ass'n, case, the insured (later deceased). One question was, "From what illnesses have you suffered during the last three years? A. droppage of bladder (fully recovered)." The insured had had a diseased organ near the bladder and the court held that here was a substantial disclosure sufficient to put the insured on inquiry of an illness in that region.

Another question was, "Have you ever had an operation? Answer: Operation for small rupture in 1921." Here the inquiry was only whether insured ever had "an" operation, not how many, and here the answer was truthful. We take this California case to hold that if there be specific inquiries concerning health affecting the risk, it is sufficient if these be substantially answered, and no further disclosures are required. However, in the case at bar the specific question as to the three-year experience was not answered by a statement substantially true. It was untruthfully answered in such a way as to persuade the insurer the risk was an exceptionally good one, whereas the applying corporation had had a very bad experience. In Frederick v. Federal Life Ins. Co, a case decided just after Turner v. Redwood Mutual Life Ass'n., the exact question here presented was decided. There the applicant for life insurance made a statement concerning his health of which the insurer had information from which it might be inferred that it was not a full answer. There were other matters material to the risk which were false, but of which the insurer had no knowledge of their falsity.

BAD FAITH

An insurance company has many duties to its policyholders. The kinds of applicable duties vary depending upon whether the claim is considered to be "first party" or "third party." A common ***first party context*** is when an insurance company writes insurance on property that becomes damaged, such as a house or an automobile. In that case, the company is required to investigate the damage, determine whether the damage is covered, and pay the proper value for the damaged property. Bad faith in first party contexts often involves the insurance carrier's improper investigation and valuation of the damaged property (or its refusal to even acknowledge the claim at all). Bad faith can also arise in the context of first

party coverage for personal injury such as health insurance or life insurance, but those cases tend to be rare. Most of them are preempted by ERISA.

Third party situations break down into at least two distinct duties, both of which must be fulfilled in good faith. First, the insurance carrier usually has a ***duty to defend*** a claim (or lawsuit) even if some or most of the lawsuit is not covered by the insurance policy. Unless the policy is expressly structured so that defense costs "eat away" at the policy limits, the default rule is that the insurer must cover all defense costs regardless of the actual limit of coverage. In one of the most famous decisions of his career, Justice Stanley Mosk wrote: "[W]e can, and do, justify the insurer's duty to defend the entire 'mixed' action prophylactically, as an obligation imposed by law in support of the policy. To defend meaningfully, the insurer must defend immediately. To defend immediately, it must defend entirely. It cannot parse the claims, dividing those that are at least potentially covered from those that are not."

Second, the insurer has a, which is the duty to pay a judgment against the policyholder, up to the limit ***duty of indemnification*** of coverage, but only if the judgment is for a covered act or omission. As a result, most insurance companies exercise a great deal of control over litigation.

Bad faith can occur in either situation—by improperly refusing to defend a lawsuit or by improperly refusing to pay a judgment or settlement of a covered lawsuit.

In some jurisdictions, like California, third party coverage also contains a third duty, the duty to settle a reasonably clear claim against the policyholder within policy limits, in order to avoid the risk that the policyholder may be hit with a judgment in excess of the value of the policy (which a plaintiff might then attempt to satisfy by writ of execution on the policyholder's assets). If the insurer breaches in bad faith its duties to defend, indemnify, and settle, it may be liable for the *entire* amount of any judgment obtained by a plaintiff against the policyholder, even if that amount is in excess of policy limits. This was the holding of the landmark *Comunale* case.

Bad faith is a fluid concept and is defined primarily by court decisions in case law. ***Examples of bad faith*** include undue delay in handling claims, inadequate investigation, refusal to defend a lawsuit, threats against an insured, refusing to make a reasonable settlement offer, or making unreasonable interpretations of an insurance policy.

In some cases, the tort or the governing state statute allows punitive damages against insurance companies as a mechanism to prevent future behavior.

In California, the plaintiff in a bad faith action may be able to recover some of its attorneys' fees *separately* and in addition to the judgment for damages against a defendant insurer, but *only* up to the extent that those fees were incurred in recovering *tort* damages (for breach of the implied covenant) as opposed to contractual damages (for breach of the terms of the insurance policy). The allocation of attorneys' fees between those two categories is usually a question of fact (meaning it usually goes to the jury).

SECTION 5: INSURANCE AGENTS AND POLICY RESCISSION

The actions of an agent can result in a client's policy rescission or claim denial. The result might be the agent being sued or involved in a costly and drawn out litigation.

APPLICATIONS

The roots of most rescissions can be found in the application.

Agent Modifications . . .

Agents need to be careful how they modify an application. Doing so could place the agent in the role of the insurer, not the agent. Take the case of ***Thompson v Occidental Life*** (1973). The agent slightly modified the insurer's standard life application causing the applicant to believe he had full and immediate coverage. Of course, the insurer believed otherwise and denied the claim for double indemnity life insurance when the applicant died in a sudden accident.

Occidental supplied its agent with standard applications with the following disclaimer:

"No waiver or modification shall be binding upon the Company unless in writing and signed by the President or a Vice President and the Secretary or an Assistant Secretary."

Despite this clause, the agent ***modified the contract*** form by changing the "mode of premium payment" from "annual" to "monthly," scratching out "C.O.D." (which evidently meant "collect premium on delivery of policy") and substituting "$205" as "payment with application."

The record indicates that Occidental allowed both Kelly (agent) and Thompson (insured) to believe that Kelly possessed the authority to act as he did. Kelly was Occidental's Oakland manager, had been employed by Occidental since 1952, and had previously received insurance applications and collected premium payments with the applications, or shortly thereafter, without any instructions from Occidental as to limitations on his authority in such transactions.

The changes by the agent, however, led the applicant (Thompson) to believe he would secure the benefit of immediate coverage by paying the premium in advance of delivery of the policy. The insurer's condition of coverage, on the other hand, was that Thompson agree to a medical examination before the policy could be issued. Of course, this never happened since Thompson died prematurely.

The claim for $200,000 was initially denied by the insurer on the basis that the agent did not have authority to make the changes above. This is how the court responded:

"We cannot accept Occidental's position, for to do so would place undue burdens upon the applicant for insurance to inquire of soliciting agents regarding their authority and to verify the

facts by independent inquiry with the company involved. Certainly the language of the application did not expressly deny the agent's authority to make the modifications at issue, for the agent might have been one of the designated officers."

In addition, Occidental believed that an insurance contract did not take place since the policy was never delivered prior to Thompson's death. To this, the courts responded:

" . . . a contract of insurance arose upon Thompson's payment of the first premium following his completion of the application and initialmedical examination.Neither the language in the application and receipt nor the "explanation" given by Kelly was clear and unambiguous, and an ordinary man in Thompson's position might well assume that payment would bring immediate protection, at least until the insurer had notified him that he was uninsurable."

Eventually, the courts sided with Thompson and his heirs were awarded $200,000 plus interest. No actions against the agent were discussed in the court proceedings, however, it is within the insurer's right to sue its own agent or rescind his agency agreement.

Agent Authority

Agents represent the insurer and have implied authority. This authority is summed up Under Civil Code section 2315 et seq. an agent has (1) such authority as his principal intentionally confers upon him or intentionally or by want of ordinary care allows him to believe he possesses (§ 2316 – actual authority), or (2) such authority as the principal intentionally or by want of ordinary care causes or allows a third person to believe the agent possesses (§ 2317 – ostensible authority). The record indicates that Occidental allowed both Kelly and Thompson to believe that Kelly possessed the authority to act as he did.Kelly was Occidental's Oakland manager, had been employed by Occidental since 1952, and had previously received insurance applications and collected premium payments with the applications, or shortly thereafter, without any instructions from Occidental as to limitations on his authority in such transactions. "If a principal by his acts has led others to believe that he has conferred this authority upon his agent, he cannot be heard to assert, as against third persons who have relied thereon in good faith, that he did not intend to confer such power."

Agent Advice . . .

In ***O'Riordan v. Federal Kemper Life*** (2005), an agent ***advised a client*** how to answer the application in a less than truthful manner. An applicant for a life insurance policy applied for a non-smoker rate. Events in this case point to the ***agent having knowledge*** the applicant smoked.

The insurance applications had a medical questionnaire, which asked these two questions: (1) "Have you smoked cigarettes in the past 36 months?," and (2) "Have you used tobacco in any other form in the past 36 months?" According to plaintiff, his wife, Amy, had smoked for many years but quit in 1991, five years before submitting her application. Amy told agent Hoyme that she had been a smoker and that her previous life insurance policy was a smokers' policy. She also mentioned that she "might have had a couple of cigarettes in the last couple of years." Hoyme replied: "That's not really what they're looking for. They're looking for smokers." He explained that the O'Riordans would have to undergo blood and urine tests to determine whether their bodies contained any traces of smoking. Someone -

the record does not say whether it was Hoyme or Amy - checked the boxes marked “No” next to the two questions at issue. A doctor, approved and paid for by Kemper, examined Amy and took blood and urine samples, which showed no traces of nicotine.

Although Hoyme [the agent] testified in his deposition that he did not recall Amy telling him that she had smoked two cigarettes during the 36 months preceding the application, he did remember having “some conversation [withAmy] or a question . . . about, you know, having, you know, a cigarette . . . in the past, you know, at a special function or something like that . . . .” He also said that he often told applicants that “if you have one [cigarette] once or twice a year, then it’s probably not a big deal.”

When plaintiff sought to collect on Amy’s life insurance policy, Kemper conducted an investigation and learned that in July 1995, less than a year before Amy applied for the policy, Amy had asked her physician for, and received, a nicotine patch. The physician’s report stated that although Amy had quit smoking several years previously, “recently, due to some stressors, she did start to smoke a little bit again, but is not smoking as much as she smoked previously.” Based primarily on this information, Kemper concluded that Amy had falsely answered the application’s questions pertaining to her smoking. It denied plaintiff’s claim, and it rescinded the policy it had issued to Amy.

Agent Responsibility . . .

In Century Surety v. Crosby Insurance (2004) the insurer sued its own agent for fraud and deceit arising out of an application for insurance. The agent unsuccessfully argues that only the insured is responsible for any misrepresentation in the application made by the broker. Of course, he was relying on a line of cases in which California courts that held that an insured was responsible for the acts of the agent, including misrepresentations in an insurance application, when the issue was the insurer’s liability to the insured:

> ***Solomon v. Federal Ins. Co. (1917),*** the plaintiff hired an insurance broker to obtain insurance for a used 1907 automobile he had purchased for $2,500. The agent filled out an application for insurance, stating that the automobile was a 1909 model purchased for $3,500. Relying on the application, Federal Insurance Company (Federal) issued an insurance policy to the plaintiff. After the plaintiff’s car was destroyed by fire, the plaintiff sought to recover under the insurance policy, but Federal disclaimed liability on the ground that the destroyed car did not match the car described in the application. The trial court found for the plaintiff, but the Supreme Court held that the misrepresentations in the application entitled Federal to rescind the policy. In response to the plaintiff’s argument that the misrepresentations had been made by the broker, not by the plaintiff, the court stated: “It is well settled that where, in circumstances such as are presented here, an insurance agent requests insurance from a company which he does not represent, he is acting for the insured, who is responsible for misrepresentations in the application made out by the broker.” (Solomon, supra, 176 Cal. at p. 138.
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> ***Purcell v. Pacific Automobile Ins. Co. (1937)*** reached a similar conclusion on similar facts, “Ordinarily one who procures another to obtain insurance for him thereby makes such person his agent and assumes full responsibility for his acts.”

The common element of these cases is that they address the ***insurer’s liability to the insured*** when an insurance policy was issued in reliance on misrepresentations in the application made by the broker or agent. However, ***these cases do not address the***

insurer's potential recovery from the broker when the insurer has incurred costs in defending an insured whose policy was later shown to have been obtained in reliance on the broker's misrepresentations.

The broker was not named as a defendant in Solomon or Purcell, and no issue was raised in those cases as to any potential liability of the broker to the insurer for the broker's misrepresentations. Thus, Solomon and Purcell do not create any rule that exempts insurance brokers from the consequences of their own fraud. Indeed, it would be an unreasonable, if not perverse, result if the law allowed an insurer no remedy against a broker who has, as is alleged in the cross-complaint, actively forged documents to support an insurance application. (Calif. Civ. Code 1709) "One who willfully deceives another with intent to induce him to alter his position to his injury or risk, is liable for any damage which he thereby suffers." And, California Civ. Code 1668 "All contracts which have for their object, directly or indirectly, to exempt anyone from responsibility for his own fraud, . . . are against the policy of the law."

We observe that courts in other jurisdictions have imposed liability on an insurance broker in an insurer's action to recover for losses incurred as a result of the broker's fraud. (Midland Ins. Co. v. Markel Serv. Inc (1977) holding that substantial evidence supported the jury's finding that an insurance broker misrepresented the facts to the insurer concerning the limits of the insured's primary liability coverage, that such misrepresentations were material, and that the insurer's reliance on the misrepresentations resulted directly in the loss to the insurer]; And, Putnam Resources v. Pateman (1992) holding that an insurer was required to establish a claim of intentional misrepresentation against an insurance broker by clear and convincing evidence]; and Westfield Ins. v. Yaste, Zent & Rye Agency (2004) 806 holding that questions of material fact precluded summary judgment on an insurer's claim against a broker for actual fraud].

One source has stated the principles as follows: "Since a broker that is not the insurer's agent owes no fiduciary duty to the insurer, the broker is not liable for an alleged failure to reveal known facts. However, a broker will be held liable in tort to an insurer that issued a policy based on fraudulent material misinformation or the withholding of facts, where the broker knew, or reasonably should have known, that disclosure of the truth would have resulted in the insurer rejecting the application." ***In essence, California case law does not provide any basis for exempting an insurance broker from the consequences of its own fraud.***

The Insured's Responsibility . . .

In Century Surety v. Crosby Insurance (2004) an agent was sued for not disclosing material information and misrepresenting information to the insurer. The agent argued that the Insurance Code charges the insured, not the broker, with the duty to disclose material information and with the responsibility for misrepresentations made to the insurer. Crosby's role in the transaction was alleged to be that of an insurance broker, not an agent. An insurance broker is defined by statute as "a person who, for compensation and on behalf of another person, transacts insurance other than life insurance with, but not on behalf of, an insurer." (Ins. Code, 33, 1623.) "Put quite simply, insurance brokers, with no binding authority, are not agents of insurance companies, but are rather independent contractors, . . ." (Marsh & McLennan of Cal. Inc. v. City of Los Angeles (1976).

Crosby cites a number of cases in support of the proposition that the insurance broker's only duty is toward the insured. For example, in Kurtz, Richards,Wilson&Co. v. Insurance

Communicators Marketing Corp. the court held that when an insurance agent intentionally misrepresents facts on an application for insurance presented on behalf of a client who is unaware of those misrepresentations, the agent breaches the duty of reasonable care owed to the client. The court was not called upon, however, in Kurtz or in the other cases Crosby has cited, to determine the liability of a broker to the insurer when the broker intentionally misrepresents facts in an application for insurance. Thus, those cases do not stand for the proposition that an insurer has no remedy against an insurance broker for intentional misrepresentations. Again, we conclude that California case law does not provide any basis for exempting an insurance broker from the consequences of its own fraud.

In fact, the court found that agent Crosby had a legal duty toward the insurer (Century) “to properly prepare and process the insured’s application for insurance in an honest, truthful and accurate manner, by fully divulging in good faith to CENTURY all facts within their knowledge material to the contract which CENTURY had no means of ascertaining.

CROSBY also owed a duty not to defraud CENTURY by intentionally, carelessly, and/or negligently failing to prepare and process the application by failing to fully and truthfully divulge to CENTURY BAROCO’s (the insured’s) true and accurate loss history.”

California courts have not ruled on the duty an insurance broker owes to an insurer under circumstances similar to those of the Crosby case, however, the Supreme Court has set forth the factors for determining when a party to a transaction owes a duty to a third party. In Biakanja v. Irving (1958) the intended beneficiary under an invalid will sued the notary public whose negligence had caused the will to be refused admittance to probate. The trial court entered judgment in favor of the plaintiff beneficiary, and the notary public appealed. The Supreme Court held that to sue for negligence, a plaintiff need not prove privity of contract with the defendant. The court also announced the standard for determining whether a duty of care is owed: “The determination whether in a specific case the defendant will be held liable to a third person not in privity is a matter of policy and involves the balancing of various factors, among which are the extent to which the transaction was intended to affect the plaintiff, the foreseeability of harm to him, the degree of certainty that the plaintiff suffered injury, the closeness of the connection between the defendant’s conduct and the injury suffered, the moral blame attached to the defendant’s conduct, and the policy of preventing future harm.”

In Roberts v. Ball,Hunt,Hart, Brown&Baerwitz (1976), the court extended the Biakanja rule to hold that a lawyer owed a duty of care to a third party when the lawyer provided a document, which contained a negligent misrepresentation, to a principal with the intent that the document be relied upon by the third party. The court explained, “Defendants undertook, on behalf of their clients, to assist in securing loans from various persons, including plaintiff, for the benefit of BBC. The defendants’ opinion concerning the status of the partners was rendered for the purpose of influencing plaintiff’s conduct, and harm to him was clearly foreseeable. We have no difficulty, therefore, in determining that the issuance of a legal opinion intended to secure benefit for the client, either monetary or otherwise, must be issued with due care, or the attorneys who do not act carefully will have breached a duty owed to those they attempted or expected to influence on behalf of their clients.”

Here, likewise, the factors set forth in Biakanja support finding a duty on the part of an insurance broker toward an insurer under the circumstances alleged in the second amended complaint. First, the transaction of applying for an insurance policy is intended to benefit the insurer as well as the insured and is designed to influence the insurer’s conduct in issuing an insurance policy. Second, harm from misrepresentations in an insurance application, such as

the precise harm alleged to have occurred in this case, is easily foreseeable. Third, injury is certain in that the insurer incurred costs in defending an insurance claim on a policy that would not have issued but for the misrepresentations in the application. Fourth the misrepresentations in the application were material to the insurer's decision to issue the policy and thus were closely connected to the ensuing injury. Fifth, under the circumstances alleged, the factor of moral blame supports a finding of duty. Finally, imposing liability on insurance brokers for misrepresentations in insurance applications would act as a deterrent in preventing future harm.

We conclude that policy reasons support imposing a duty on insurance brokers to exercise reasonable care in preparing insurance applications under the facts alleged in the cross complaint. We emphasize that our holding should not be construed as treating an insurance broker as a guarantor of information in an insurance application or as imposing a duty on a broker to independently investigate information provided by the insured. However, when the broker knows of actual misstatements, the broker may be held liable for transmitting those misrepresentations in an insurance application knowing the insurer will reasonably rely on them.

Agent Filled out Application . . .

In Cole v. Calaway A doctor applied for malpractice insurance but the agent filled out the entire application on his behalf. A claim led to an investigation which revealed prior malpractice claims not disclosed in the application. The insurer rescinded the policy and the agent was involved in a lawsuit.

In his application, the doctor recites: "No claims or suits for professional services rendered, or which should have been rendered have been made against me except as follows: Instrument broke during tonsilectomy several years ago. No payment made." Defendant secured a reduction of 15 per cent in his insurance premium because his application showed that no suits had been filed nor claims made against him for malpractice.

The insurer, however, alleges that said warranties were untrue in that "defendant had had several claims and/or suits filed against him, alleging acts of malpractice upon his part; that if plaintiffs would have known of these facts previous to the issuance of said insurance certificates, no certificate of insurance would have been issued by plaintiffs to defendant"; that "said warranties were made to and did induce plaintiffs to issue the same through" Pacific, a surplus lines broker. Upon learning of these suits, the insurer gave defendant a written notice of rescission of said certificates of insurance along with the return of all moneys paid by defendant as premiums; that plaintiffs claim all obligations on their part, as therein provided, have terminated, which defendant disputes, and plaintiffs having elected to terminate said insurance certificates, desire a declaration of their rights and duties in the premises, including a declaration that said insurance certificates are and were null and void.

Defendant answered and claimed that the proposal form was filled out by the insurance agent for Pacific and that defendant signed it without reading it. He denied he wilfully made any false statements with the intent of inducing plaintiffs to issue said certificates. He admitted he then knew of the fourmal practice suits which had previously been filed against him, as alleged, but denied generally the other allegations of the amended complaint.

The court found generally that plaintiffs were underwriters authorized to engage in the insurance business at Lloyd's London; that Pacific was licensed in this state to carry on business as a surplus line broker and authorized to enter into and execute the certificates of

insurance on behalf of plaintiffs, “subject to the rules and regulations of plaintiffs”; that defendant was a practicing physician and on December 13, 1950, signed the completed “proposal form and declaration for malpractice insurance,” and submitted it to the agent of Pacific, requesting the issuance of a policy; that it is untrue that the soliciting agent was an agent of plaintiffs, and untrue that Pacific was the agent of plaintiffs except to the extent specifically authorized. It then found that defendant, at the time of the application, knew that four lawsuits had been filed against him alleging acts of malpractice and did not disclose them, and that if disclosed plaintiffs would not have issued the insurance certificates; that Pacific had no authority to issue said certificates had such information been disclosed, without having first submitted the proposal to plaintiffs, and that plaintiffs relied solely upon the warranties of defendant; that plaintiffs tendered the $169.28 premium paid on the policy to defendant, who refused it, and plaintiffs deposited said sum with the county clerk, subject to the order of the court; that there was a notice of rescission of the certificates of insurance given on July 3, 1953, and, due to the breach of warranty, no liability of plaintiffs attached to the risk and the certificates were, accordingly, void from their inception; that there was no unreasonable delay in giving the notice of rescission and that the affirmative defenses claimed by defendant were untrue.

INSURANCE ETHICS

In the cases above, it appears that a dose of ethics may have prevented some nasty surprises. Let’s explore some ethics issues:

Do We Need A Moral Code?

Possessing a moral code is not all that is needed to set an insurance professional apart from a layman. However, maintaining a Code of Ethics can inspire us to do better — especially if the breach of the code means we will lose our membership or be scrutinized by our peers.

Having ***high ethical standards***, or more simply being honest, can be more important than being right because honesty ***reflects character*** while being right reflects a ***level of ability***. Unfortunately, the insurance industry, for the most part, still rewards ability. There are, for example, plenty of "million dollar" production winners and "sales achievement awards"; but few, if any, "Ethics & Due Care" certificates.

Being ethical is indeed professional but the gesture goes beyond the mere compliance with law. It ***means*** being completely honest concerning ALL FACTS. It means more than merely NOT telling lies because an incomplete answer can be more deceptive than a lie. It means more than being silent when something needs to be said, because saying nothing can be the same as a lie. For example, is it the duty of an adjuster to warn a first party insured of mold contamination and possibility of health risks discovered in a building under claim. While the legal issue gained steam in a famous ***Melinda v. Fire Insurance Exchange Case*** ($32 million – later appealed and settled for an undisclosed amount) most adjusters are coming to the realization that the duty of good faith and fair dealing obligate warnings be given to the insured. And, the adjuster should also include covered mold remediation in the scope of damages, including Additional Living Expenses necessary.

But, does the obligation stop at a simple warning? When handling water damage should the insurance professional be pro-active concerning mold? What about third party claimants, e.g., other occupants near an infected unit? Responsibility is not only based on the sense of duty of one human being to another, it’s accepted claims practice, professional and ethical, to take action. And, not doing so could be a breach of the Unfair Claims Practice regulations

or a possible tort/criminal liability. The story doesn't end here either. Notification alone may not be enough because part of your training concerns the proper use of experts. An insurance pro who may occasionally see or smell mold should know that it may also exist behind walls and other inaccessible locations. The presence of mold may also be indicated by unexplained illnesses, i.e., when the situation warrants, you may have the obligation to seek out the liability exposures to properly evaluate the claim. Testing for mold by a professional could be required.

Adjusters, agents and insurers may feel uncomfortable in disclosing potential health dangers where their client / claimant may suffer the wrath of potential new claims. However, failure to disclose such dangers to first or third parties could result in the building owner / policyholder being sued for damages in excess of the available policy limits. If that happen, who do you think the property owner might be looking to make up the difference? Policyholders might also have a bad faith claim against the insurer for failing to protect the property. In essence, as a practical matter, full disclosure may be cheaper in the long run.

Could lack of a health disclosure result in criminal charges? In the Melinda Case above, child endangerment criminal charges were filed against some insurance company personnel but later dropped in a settlement.

Instilling Ethics

Someday, it may be real important for a court and jury to hear that you have a history of serving claimants without consideration for how much you made or how busy you were, i.e., you are a person with good ethics.

Instilling ethics is a process that must start ***long before*** a person chooses insurance as a career. It is probably part of the very fiber that is rooted in lessons parents teach their children. So, preaching ethics in a forum like this course of study may not be incentive enough to sway adjusters to stay on track. It may be easier to explain that honesty and fair play could mean greater sales and lessen the possibility of lawsuits.

Ethics Defined

Just what is ethics? A simplified definition of ethics is a ***set of values*** that constantly guides our values. These values are typically ***aligned*** with what society considers correct and positive behavior within legal boundaries. Ethics is also the ***balancing*** of an individual's good with the good of the whole. Let's say you develop a seminar series on "mold detection". At the event, you have a person pass around a clipboard asking people if they would like to be informed of future seminars. The real purpose of this exercise, however, is to create a mailing list to market your adjuster services. Smart marketing? Or, breach of ethics? Are you really concerned with your clients education (the whole) or only what you will get out of their business (the one)?

Balancing the good of the one with the good of the whole is not as easy any more. The whole that we have to consider is everybody, not just a competing adjuster down the street or in the next town. Survival is important, but not at any cost. True survival requires long-term, successful relationships with customers and companies, as well a co-workers and competitors. When people do not understand their role in the "whole" and are completely self and survival oriented, it throws the ethical system we once knew out of whack.

How can you stay on track? Most important is that you know your personal core values and the values that your company stands for and then live and work congruently and consistently with those values. The people will know you as a person of integrity. And, with integrity comes trust.

The authentically ethical person in our seminar example would have simply disclosed the purpose of the clipboard or simply buy a mailing list from someone else. Respect for privacy would be honored and remembered.

Shades of Grey

One of the problems with ethics today is that we have so many different mores or values that guide our society. The values that guide each individual and/or company can vary tremendously, therefore an individual or company may be ***ethical*** according to their values and not to yours or the definition above. Several major shifts in right or wrong standards means that we are faced with more and more gray areas in our personal and professional lives. The shifts are occurring at such a pace that they may even hinder our ability to cope and process the changes.

Moral and Market Values

The American economy depends on ethical standards upheld by responsible business leaders. Unfortunately, this unwritten rule was violated in recent ethics scandals occurring in many corporate boardrooms. Respected companies lost credibility and innocent investors lost millions in the late 1990's and early 2000's. Cheating became rampant because it was the norm. It was no longer seen as wrong. In fact, at the peak of the problem, much of our economy resembled a giant pyramid scheme, taking in money from new suckers to pay those who invested earlier. A so-called ***bubble economy*** developed where businessmen willing to gamble with other people's money were rewarded handsomely. Stock prices were rising so fast that if you cut corners to meet projected numbers, you probably thought you were doing your shareholders a favor. And, there was always new money pouring in to make up the difference.

In insurance as well as the corporate world, people who rely on your word can be sucked in during times of sensitivity. Take the recent example of some less than ethical public adjusters who were contacting consumers late at night as they awaited treatment in a hospital emergency room following a disaster in their homes. An adjuster could easily take advantage of their tragedy.

Will tougher laws and even prison sentences be a deterrent. It can't hurt. But, the fact is bubbles burst quicker than a business climate can change. If a crooked practice doesn't pay off, a lot fewer people will take the risk of using them. So, the real challenge is to create a new business culture that matches the market. Think about a system that rewards and reinforces the honest and careful adjusters and businessmen just like the bubble economies made heroes out of the gamblers.

Moral Compass

During times of fundamental change, values that were previously taken for granted may be strongly questioned. These are the times when the attention to business ethics is critical. Leaders, workers and adjusters must sensitize their actions -- they must maintain a strong moral compass.

John Kennedy Jr's last flight went wrong because he lost sight of land. In the growing dark around him, the horizon line became blurred and he became disoriented eventually flying his place right into the ocean.

When nothing is stable or dependable, you also can lose your own sense of moral direction. When it happens, you start accepting ambiguity as real. You begin making up your own rules. You cut corners. This is exactly how things started going bad at Enron. Accountants simply made-up their own accounting standards. They lied, cheated and waffled because it was to their economic advantage. Over time, they began justifying their unethical behavior as acceptable.

How can you keep this from happening to you? You can have a strong, unfailing sense of what is right and stay focused on it at all times. It's called ***integrity***. When you have it, it allows others to trust you, even when things go bad. Kim Cameron, Professor of Organizational Behavior at the University of Michigan, says that it is not enough to simply encourage ethical behavior, honesty and integrity because these concepts in themselves imply an ***absence of harm***. A strong moral compass means that you strive for ***virtuousness*** where your actions rise to doing good, honoring others, taking a positive stance -- i.e., . . . "behaving in ways where ***self-interest is not the driving motivation***." Too soft and fuzzy for you? Well take note, Kim's research proved that businesses with high scores on virtuousness significantly outperformed those with low scores. ***It pays to have a strong moral compass!***

Truly honest and ethical people live by the choice to do what is right, even when it is not pleasurable. This is how reputations are built. And, regarding reputations, ***Alan Greenspan*** summed it up quite nicely . . "Your reputation is your stock and trade. If you do something to undermine that, then you very well may not have a company any more."

Moral Distress

Have you ever thought about why people make bad decisions? One reason is dissatisfaction with work or near impossible objections. When either one of these occurs, a person experiences growing pressure to engage in unethical behavior. You are left in a situation where every decision must weigh your own survival against the care and attention you give your client. The end results is that shortcuts will be taken or you become frustrated, resentful, angry or guilty about your bad decisions. What can you do?

Stakeholders: Experts suggest that, among other things, one should adopt a long-term stakeholder mentality, and, to be ethical under social justice theories you should be fair to all ***stakeholders***. What does this mean? A ***stakeholder*** is anybody that can be ***affected by your actions***. Your client is a stakeholder in that he depends on you and your insurance products to protect is economic well-being. Your insurer is a stakeholder in you representing product fairly and within the scope of the law. The shareholders who have invested in the insurance company are also stakeholders and when it comes down to it, you are a stakeholder yourself. That's right! You owe it to yourself to survive in your chosen field. And, as we have already described, the best way to do this is long-term, with integrity and respect for others and all stakeholders. ***Remember***, customers ultimately pay your salary and commissions, and insurers enable you to make a living. That's something that should be important to you. So, how could you be a bystander and watch either of them be injured in any way by your actions?

Pace Yourself: Another way to reduce moral distress is to operate at a reasonable pace. We have already explained that when you cut corners it promotes unethical practices. For instance, if you fail to budget time to read a policy coverages, they go out without being reviewed raising ethical questions and moral distress. What about when you forgot to get a first party's signature. It's awful tempting to sign it yourself when you know they will approve it anyway rather than drive 30 miles back out to meet them a second time. Again, moral distress raises its ugly head. Of course, the solution is to allow more time the first time out. But, this will mean less production which creates economic stress. At times like this, you have to assure yourself that you are in this for the long-term. Being genuine and ethical means that you live by the choice to do what is right, even when it is not pleasurable.

A Tolerance For Problems: When you succeed at something, it's normally because you are doing something that other people do not want to do. In a sense, you have to "tune-up" your instincts to be ***satisfied*** at meeting objectives that others find hard to take or when people don't want you to succeed. What does this have to do with moral distress. A lot, because you can reduce your level of moral distress by increasing your tolerance for problems. Think about it. You can convince yourself that external forces are never-ending anyway, so there is no reasons to sweat it so much. The fact is, you're in the problem solving business and you're a pro! Just remember the immortal words of Saturday Night Live's Rosanna Rosanna Danna -- "It's always something!"

Integrity

While many agents believe that "integrity" is a characteristic of choice, many state laws set minimum agent standards to follow, such as:

Qualifications

Insurance Commissioners have been known to suspend or revoke an insurance agent's license if it is determined that he or she is not properly qualified to perform the duties of a person holding the license. Qualification may be interpreted to be the meeting of minimum licensing qualifications (age, exam scores, etc) or beyond.

Lack of Business Skills or Reputation

Licenses have been revoked where the agent is NOT of good business reputation, has shown incompetency or untrustworthiness in the conduct of any business, or has exposed the public or those dealing with him or her to danger of loss. In Goldberg v. Barger - 1974, an application for an insurance license was denied by one state on the basis of reports and allegations in other states involving the applicant's violations of laws, misdealing, mismanagement and missing property concerning "non-insurance" companies.

Activities Circumventing Laws

Agent licenses have been revoked or suspended for activities where the licensee (1) did not actively and in good faith carry on as a business the transactions that are permitted by law; (2) avoids or prevents the operation or enforcement of insurance laws; (3) knowingly misrepresents any terms or the effect of a policy or contract; or (4) fails to perform a duty or act expressly required of him or her by the insurance code. In Hohreiter v. Garrison - 1947, the Commissioner revoked a license because the agent misrepresented benefits of policies he was selling and had entered false answers in applications as to the physical condition of the applicants. In Steadman v. McConnell - 1957, a Commissioner found a licensee guilty of

making false and fraudulent representations for the purpose of inducing persons to take out insurance by misrepresenting the total cash that would be available from the policies.

Dishonesty

Agents have lost their license because they have engaged in fraudulent practices or conducted any business in a dishonest manner. A licensee is also subject to disciplinary action if he or she has been convicted of a public offense involving a fraudulent act or an act of dishonesty in acceptance of money or property. Furthermore, most Insurance Commissioners will discipline any licensee who aids or abets any person in an act or omission which would be grounds for disciplinary action against the persons he or she aided or abetted. In McConnell v. Ehrlich - 1963, a license was revoked after an agent made a concerted effort to attract "bad risk business" from drivers who licenses had been suspended or revoked. The Commissioner found that the agent had sent out deceptive and misleading solicitation letters and advertising from which it could be inferred that the agents could place automobile insurance at lower rates than could others because of their “volume plan”. If this wasn’t bad enough, the letters appeared to be official correspondence of the Department of Motor Vehicles. Clients would be induced to sign contracts with the agents where the agent would advance the premiums to the insurance company. The prospective insured would agree to repay the agents the amount of the premium plus “charges” amounting to an interest rate of 40 percent per annum. The interest rates charged were usurious and violated state law.

Catchall Category

In addition to the specific violations above, most states establish that agent responsibilities MUST NOT violate the “public interest”. This is obviously a catchall category that has been used where agents have perpetrated acts of mail fraud, securities violations, RICO (Criminal) violations, etc.

Professional Ethics Are Not Laws

Many believe that professional ethics and the law are the same. It is important to realize that ***professional ethics are not laws***, ***yet they can be guided by laws***. Proof of this exists in the fact that you can be unethical yet still operate within limits of the law. A perfect example of this is the insurance client who fears he has physical problem because he is experiencing shortness of breath, yet he is allowed to withhold disclosing it on an application. He has no duty to disclose his "fears" of a medical condition. It's legal, but not too ethical.

Laws in the United States are abundant, growing in numbers every day. The courts attempt to legislate protections from those without values or with values in opposition to what most of us would consider right and wrong. We have more laws than any one lawyer can ever know. And more and more lawyers seem to be necessary to handle the litigation that results from what seems to be a trend in "making others pay".

Ethical Decision-Making

Before the Enron fiasco, Arthur Anderson had a steadfast reputation. When big organizations wanted him to falsify their accounting he said . . . "No, we'll find other ways to make our money". The point is, to maintain ethical standards, you have to be able to think around problems, cultures and differences. Here are some ways to accomplish this:

Get The Facts: The Makkula Center for Applied Ethics suggests you find the relevant facts about a situation. This means identifying the individuals or groups who have an important stake in the outcome. Some may have a greater stake because they have special needs or because you have a special obligation to them.

An example might be elderly claimants. Due to their status or cognition, they may need to rely more on your advice than other claimants. Your ethical standards may have to be raised in matters that concern them.

Sizing Up The Problem: Michigan University Business Ethics Professor Tim Fort suggest you ask the following questions when faced with an ethical decision:

What's the moral issue?
Who has been harmed? Or who could be harmed?
In what ways?
What are the alternatives that exist?
What facts need to be known to make a reasoned decision?
What are the personal impacts on the person making the decision?

Working within a format like this helps bring the issues away from your own self-interests over the interests of others.

Pursuasion: If an ethical dilemma arises between you and a peer or claimant, why not solve the problem with your powers of persuasion. Be convincing. Have convictions. The influence you exert may very well change their mind.

Taking Risks: The more you are paid, the more complex the decisions you must make. Things are rarely "black and white" and a lot of your decisions will challenge your integrity. But, these are the risks you must be prepared to assume in a sometimes difficult world. You must constantly weigh ***short-term results*** with ***long-term consequences***.

Evaluate Alternative Actions: Which option will produce the ***most good*** and do the ***least harm***? Which option respects the rights and dignity of all stakeholders? Will everyone be treated fairly? Which option will promote the ***common good***. Which option will enable the deepening or development of the core values you share with your company? Your profession? Your personal commitment?

Reflect on Your Decision: Was you position defensible? Would you do it again? How did it turn out for all concerned? Was your decision successful for both you and your client?

Confronting Unethical Conduct

In a lot of ways, we have become a ***no-fault society***. Popular thinking dictates that as long as you don't own the problem you don't need to get involved. A crucial shift is needed to avoid this bystander mentality. People need to think of themselves as members of a community. And, their life in this community entails ***mutual obligations*** and ***interdependence***. In other words, be part of the solution, not part of the problem.

How can this be accomplished. Well, you can learn to help solve ethical dilemmas rather than walk away or simply ignore them. Here are a couple ways to do this:

State Your Position: Ask those who want you to perform an unethical task to ***state their position clearly***. This forces them to make an ethical choice. If your manager wants you to fudge a value, for example, pose the following question: Are you asking me to lie in this claim? It is probably a safe bet that he will back away from his unethical request.

Present A Case: Many ethical dilemmas result because someone has taken a short cut. You can sometimes turn their thinking around by presenting things statistically or in an organized manner. Take the manager who wants you to submit an inaccurate claim. If you use some of your CE materials or Google, you could probably find where an adjuster did a similar thing and faced a huge penalty and loss of license. When presented this way, it would be hard to ignore the correct path.

Don't Ratify Unethical Actions: One of the easiest ways to become entangled in the wrong deeds of someone else is to ratify their behavior. Not only is it unethical, but it can come back to haunt you in the form of rather large lawsuit. ***Ratification*** generally occurs where, under the particular circumstances, the employer demonstrates an intent to adopt or approve oppressive, fraudulent, or malicious behavior by an employee in the performance of his job duties. The issue commonly arises where the employer or its managing entity is charged with ***failing to intercede in a known pattern of workplace abuse***, or ***failing to investigate or discipline*** the errant employee once such misconduct became known. Corporate ratification in the punitive damages context requires actual knowledge of the conduct and its outrageous nature."

A Moral Company Climate

If you ***don't*** create an company culture that reinforces values and ethics, other adjusters and employees will only do what is right so many times and then they will either leave or give in to outside pressures to cut corners, lie, fudge, etc.

In order to reinforce this theme, you can't punish people for taking actions they need to take. You have to ***support*** good, moral decisions, even at the ***cost of production***.

What happens if no one else cooperates? You must continue to forge forward, even if you are the only one doing the right thing. Why? It's a fundamental choice you are making to be an ethical leader. And, it will pay off in time.

Privacy

Protecting a client's privacy is an ethical responsibility and an area of increasing liability. The concern by clients is that highly personal health and financial information you collect in the process of adjusting a claim will get in the hands of groups who might use this data to exploit them.

It may seem obvious and oversimplified, but the information in the claim file is extremely confidential and all efforts to make it secure should be practiced. Remember, ***agent and adjuster files are accessible by an insurance company and / or a plaintiff's attorney***. Then again, always check with your errors and omissions carrier before turning over any documents with client information.

Your attention to privacy issues is particularly important where electronic files are concerned. The problem is two-fold: You can unintentionally send records (e-mails, files, etc) to the wrong party -- E-mail users often hit the "enter" key which could send a message to a wrong

party. Just as likely, you could “delete” something you do not want someone to know about your client and a plaintiff’s attorney, with help from a programmer, could recover it from your computer.

Ways To Minimize Privacy Conflicts

The best approach to guard client information is to ***establish guidelines*** for handling files and communications (including e-mail). It also goes without saying that since others have access to your files, it would be wise to NEVER make a written derogatory comment or reveal some personal information about a client. Either could be damaging to you and your client. Extremely sensitive information on your computer may need to be encrypted to protect it from being accidentally transmitted. Software that uses passwords is always recommended. And, it is probably a law in your state, or soon to be, that your entire system be protected by a ***firewall*** to prevent unauthorized access.

Better Service

There are a thousand ways to make your service better. Here's a few of the more important ones you need to know:

- Always be positive. This means always trying to create a situation where your customer can be satisfied. If you don’t handle a particular coverage, go the extra mile and find someone who will. Take the attitude that nothing is impossible and that no effort is too much.

- Keep your word. Don't make promises you can't keep.

- Don't argue. If a problem develops between you and your customer, always remember, the customer is "king". It doesn't make sense to debate an issue to death. Even if you are right, it doesn't matter. It is the customer's perception that you are wrong that counts. In his mind, you goofed. It is better to look at it as an opportunity to fix the problem and satisfy the customer. As we saw earlier, a dissatisfied customer can cost you a lot of money and time. And they're sure to complain to ten other people. Just give him some attention and assure him it will be fixed. Then make sure you do it!

- It's ok to acknowledge your mistakes. Unless a lawsuit is at risk, don't be too proud. Let the customer know that a mistake has been made. Apologize and set in place a solution to fix it.

Handling Tough Customers

No matter how you try, you will encounter tough customers who always believe they are right and you are wrong. Here are a number of ways to handle them:

- Negotiate. Always try and find a middle ground.
- Keep you cool. Make sure you and your employees understand that it is not personal. It's business. Keep a soft tone of voice and solve the problem.
- Listen to the customer. Since they usually think they are right and you are wrong, make sure you let them know that you are aware of the problem and you are concerned that it be solved as soon as possible. You can diffuse the situation somewhat by actually taking the customer's side and agreeing with them (to some extent).

- Set a policy. While there is never an excuse for poor behavior or lack of manners, you need to develop a policy for handling problem customers and stick to it. If you are too soft, then customers can easily pick up that you are an easy mark and they will always complain. Using a database or contact manager, you can document conversations with clients to ferret the chronic complainers. As long as you are fair, you can be firm with these customers. They may not win every time, but at least they may come to respect you.

Elements of Good Service

Following are the elements of good service.

- Reliability. Consistent service the customer can rely on.
- Quality performance. Make sure you do things well.
- Worthwhile outcome for the customer.
- Overall service. The ability to provide good service in ***all*** your dealing with clients.

Poor Service

You already know that poor service will drive your customers away. The trouble is that you may not even know about until it's too late. Why? Because a lot of people will never complain about poor service, they'll just move on to the next adjuster. Worst yet, when they have the chance, they'll complain to friends, family and others that your service was poor.

It is also important to realize that good service extends to everyone you deal with, not just paying customers. Providing poor service to people because they are not paying customers is a definite way to ensure that they will not want to do business with you in the future. Like others, they will also probably complain to their friends.

Principles of Communication

Whatever mode of communication used by your or your clients, there are certain general principles you need to follow to make sure you are meeting client needs and eliminating potential confusion.

Clear communication is always your goal. For instance, when handling a ***client's instruction*** or request, it would be wise to ***repeat your understanding*** to the other person. Let's say that Mr. Dean called your office and advised you to adjust the settlement amount on a boat. You might respond by saying . . . "Mr. Dean, as I understand it, you want to adjust your settlement on your boat . . . "

If you are making a recommendation, you need to thoroughly explain the client's ***options and consequences***. For example . . . "Mr. Brighten, we recommend that you investigate other units in the complex for possible mold remediation. Even though you will being paying extra costs, your potential claims could be lower in the long run".

Always confirm that you are ***meeting client needs***. "Mr. Smith, have I given you all the information you need to make a decision?" Does this policy make sense to you"? "Is there anything else I can answer for you to assure you that this is the right solution based on your needs?"

Be sure that your client always understand his ***current insurance coverage status***. "Mrs. Johnson, do you understand that mold is not covered in your policy?"

When you and your client are satisfied that you are BOTH communicating on the same wavelength you still need to ***document what was said, what was done and what needs to be done***. For instance, it would be smart to follow-up a phone conversation with a letter outlining your understanding of the matter.

Telephones

For the not-too-distant-future, it is unlikely that the telephone will be totally replaced with alternative forms of communication. Instead of complicated e-mail, Internet or fax transmissions, a healthy portion of your clients will always prefer to simply dial you up with their problems and needs

One of the most important things to remember about phone calls is that they are not a permanent record of your communication with a client like letters, e-mail or faxes. There are lawsuits, and as many judgement awards against adjusters, where there were no "notes to the file" to verify the basis of a client/adjuster discussion. Your ***standard operating procedure*** should include a system to immediately document client phone calls, inbound and outbound, between you, clients and your staff. Every call should be logged into the client's file or, better yet, a ***contact management system*** to document what was said and the result of the conversation. Where needed, a follow-up letter documenting the basis of the phone call can be sent to the client.

As far as improving your phone calls consider the following advice:

- Call your company and ask for yourself or have someone do it for you. Try different times of the day and listen closely to the general demeanor of your employees. Are they courteous, helpful, enthusiastic, accurate?
- Call your company and pose as an existing customer or pose as a new one. Ask for different departments, voice a complaint or leave a message for a call back. Being passed from one wrong person to another can make a client feel unimportant and frustrated. Th initial contact should determine who best to handle the call and solve the problem.
- Make sure that all incoming calls are answered before the third ring. Always ASK if it is OK before you put someone on hold before you do. A good phone system will let you know if the caller has been on hold too long. Offer to call ask if necessary and find out when this will be convenient.
- Take complete and accurate messages. Incomplete phone messages or lost scraps of paper are not acceptable procedures.
- Return all messages within one business day or less. If you promise to call someone back by a certain time make sure you do . . . even if you still don't have an answer for his question. It is important to do what you say you are going to do every time.
- If your company has a menu of options, listen to it carefully. Does it make sense. Does it work?
- Try NOT to use a speaker phone unless you really need to because a caller may feel as though their conversations are less than private.
- Call new clients to make sure that their policy or information you sent them arrived.
- Call existing clients on a regular basis, just to say hello, or tell them about a new offering.
- If you leave a voice mail message for someone, speak slowly and clearly. Give the purpose for the call and a good time for them to call you back.

- If calls are taken at home, make sure family members understand the rules on message taking.
- Unlicensed people in your office need to know the proper procedures and what they can and can't say to clients.
- Hire customer service people who have insurance knowledge and a pleasant phone voice. Clients are more likely to trust a friendly, confident person on the other end of the line over one who is abrupt, uninterested or combative.

Cell Phones

Cellular phones are a modern-day marvel and a potential E&O tragedy. There are concerns about privacy and the basic inability to reach the intended party when needed. Equally important is the fact that calls are taking place outside the office where it is much more difficult to document the conversation.

Automated Messaging

Answering machines and voice mail systems are inexpensive methods to take calls in your absence. Newer systems are capable of documenting the time and date a call was received. However, all such systems are capable of breaking down when you most need them and/or distorting. Answering machines in an agency should not take messages. They should be limited to listing hours and an emergency number if needed. If you use one, your outgoing message should clearly state that your machine does not take messages. Claims and coverage issues must ONLY be handled during normal business hours with a "live" person.

Fax Messaging

Your fax machine is an incredibly useful part of your call center. One of the most important issues in handling faxes is to make sure they are delivered to the appropriate person and responded to in the same manner as a letter.

Here are some more things to keep in mind concerning faxes:

- Most states accept fax signatures and documents as good as the original. However, the paper on some fax machines (thermal paper) is know to fade over time. For this reason and others, it is always a good idea to not rely solely on faxes. Try and get the original in your file as soon as possible.
- Faxes are not a 100% reliable delivery system. For unknown reasons, they sometimes don't get to their destination even when your machine shows a confirmation that the message was received. For important documents, it is always wise to call and confirm delivery.
- Confidential information should not be faxed without the approval of the parties involved. It is best to call the intended receiver before the fax it sent.
- Faxes you receive should be date stamped and filed.

Online Communications

The Internet is a rich component for customer service. The challenge for adjusters is to bring the same level of excellence they have placed on traditional call center systems to their websites.

Online communications are evolving rapidly. Unfortunately, customer care is moving at a much slower pace. Recent studies, for example, have found that only a small percentage of customers who sent an e-mail regarding an inquiry or purchase receive a follow-up e-mail. The same customer who telephoned their adjuster would be outraged to NOT receive a return call. To avoid this, your ***e-mails should be treated like a phone call.*** Check them often and return them promptly.

Online customers today are expecting more from e-commerce sites than just e-mail. Those who use the Internet often like the control it gives them. They can seek information, contact you and even complete transactions without ever speaking to a single person. If your site is primarily being used to advertise your services, it is recommended that you advise customers that they will have to call or write you to receive process claims.

E-Practices

*The passing of federal and state **e-signature laws** grant electronic signatures the same legal status as a handwritten signature for any legal document or transaction – including insurance. Combine this event with the electronic commerce explosion, and you will see why adjusters and insurers need to develop a digital strategy. One of the most significant elements of this strategy is a responsible approach to selling and servicing clients on the Internet – we call it **e-conduct** -- the responsibility you **chose to uphold** to make online insurance information or transactions better, more secure and usable for your clients.*

*At present, the insurance industry is not really **leading** the charge in the development and innovations in electronic commerce, in fact, some would say they are **lagging behind**.*

When it happens, the consumer will be the ultimate beneficiary with greater convenience, access and control. The Web will increase their knowledge, choices and product offerings. Positive side effects might be lower prices and improved service.

If we are indeed destined to be a significant Internet force, it is even more important to develop an ***e-conduct approach***.

E-Code

As of yet, there are no Internet police so it is up to you to abide by standards of ethics and reason when using the Internet for claims-related transactions or communication. An ***E-Code*** is a foundation of e-commerce procedures you may wish to adopt.

Changes to your E-Code will also occur from the regulatory arena where new laws and the eventual codification of Internet insurance transactions will require new and different approaches to e-commerce compliance. For example, California passed a law requiring agents to include their license number on all ***printed materials***, including business cards, advertisements, premium quotes, etc. In coming years, look for the law to be modified to include all Internet advertising and websites. Or, look for so-called ***clean-up*** regulations like those passed in Arkansas where a new statute allows the Insurance Commissioner to interpret the words “print” or “printed” to include electronic printing. Additional legislation, like various state and federal ***electronic signature acts***, pave the way for legalizing online purchases, including insurance, that formerly required hand-written signatures. Any of these events change your E-Code.

COMPLIANCE & BUSINESS ISSUES

There are at present many challenges to the sale of insurance on the Internet. Some of a business nature; some of a legal nature. Following is a discussion to help you understand the issues at hand.

Legality of Internet Transactions. Still unanswered is the question of whether insurance commerce conducted on the Internet is an insurance transaction regulated under the McCarran-Ferguson Act, or an interstate electronic transmission to be federally regulated under the Commerce Clause.

Lack of Commonality. Insurance industry participants in e-commerce will, for the moment, experience difficulty in sharing data and systems due to an absence of common technology or languages. Many data transfers within the industry, for example, are still done by mail or fax. In addition, electronic data interaction is still limited by the fact that only a few players have sufficient technology and transfer mechanisms. An example is the simple fact that many insurance agents are still not linked to insurance carriers. Likewise, other parts of the chain, such as insurer to reinsurer, have virtually no systematic links.

Consumer interpretations. A California adjuster's web site is just as likely to be read by a consumer in Florida. Insurance law between these two states is clearly different. Without a significant disclosure of same, consumers can all too easily request quotes or fill-in an application for coverage you cannot provide.

License Jurisdiction. In certain states, you may merely "trigger" an activity that requires licensing. For example, providing quotes or referring business may be considered actions requiring a producer license in some states. Adjusters wanting multi-state access to clients will need to review and ensure compliance with producer licensing in all states in which he intends to "farm" web interest.

Situs Problems. Since the Internet knows NO geographic boundaries, it is unclear as to the physical location where a sale or solicitation occurred. Did the transaction occur in the state where the adjuster is physically locate, or the state where the client visited the web site?

Signature Problems. Until electronic signatures become workable on a widespread basis, most state insurance laws require a "wet" signature accompany insurance transaction documents, including applications, added endorsements, release forms, changes in beneficiary or policy limits, product disclosures, etc. This is currently difficult to accomplish with "paperless" Internet transactions.

SOLUTIONS

Be solutions-based in your approach to helping clients. This means more than performing a task. It means providing solutions to their insurance dilemmas by knowing needs and financial objectives. It means ***listening*** to clients, ***discussing*** exactly what the product will do for them and be sure they ***understand*** the information you are presenting.

Some of the most frequent complaints that insurers and regulators receive stem from purchases where clients did not know exactly what they were buying; thought they were ***fully covered***; thought the coverage was for more than the limits allowed; did not know there were surrenders, penalty charges or taxes associated with the product; and / or the product simply was not appropriate for their needs.

Solutions create ***satisfied customers*** which minimizes conflicts and prevents problems like these from ever starting. Further, if a problem does develop, you will be better prepared to respond.

Of course, before you can offer solutions, you must engage in a fact-finding process to gather information on the client's current insurance / financial needs and goals. Each client's needs are unique; based on individual circumstances and goals. You will need to consider age, health, education, employment, dependents, income, assets, debt, standard of living, new worth, tax status, financial experience, current financial status, retirement plans and risk tolerance to mention a few.

Finally, and just as important, you need to understand your products; which one is appropriate for the client and explain to them exactly how they work. For your own protection, it is also important that you document all analyses and conversations so that if questions arise later they can be effectively answered. To accomplish this, you should keep all records pertaining to information about your client, information on their needs and the matching of appropriate product as well as your explanation on how the product works to meet their needs.

STANDARD PROCEDURES

If you don't already have standard operating procedures, develop them ***now***! Every client deserves to be treated equally and given the same level of service. It is also the best way to establish evidence and protect you in a liability suit. The best standard procedures involve the establishment of ***office protocol and operations manuals*** that:

- Create consistent and comprehensive steps for every sale. The offer of a special endorsement or rider, for example, should be offered to everyone and their acceptance or denial noted.
- Reduce oral agreements, scattered notes and conversations to a formal writing as soon as possible.
- Use automated equipment with database capabilities for up-to-date documentation and "date stamping" features.
- Note and file client needs and requests.
- Create a "follow-up" or "hot list" system for notifying clients about important dates, renewals and endorsements.
- Lay out set procedures for handling and logging phone messages, faces, copies, e-mails, photographs, microfilm, proof of mailing receipts, records storage, etc.
- Review policies received to be sure they are meeting client needs.
- Complies with application and cancellation procedures with the ability to track notices sent.
- Provide quick, easy access to claim processing and claim procedures.

BEST PRACTICES

In any given industry, someone is compelled to document the strategies and tactics employed by highly admired companies. These companies are not particularly the "best-in-class" in every area -- such a company may not exist at all. Rather, due to their nature of competition and drive for excellence, the ***practices*** they have implemented and honed place them among the most admired, the most profitable and the keenest competitors in the business.

In the early 1990's the Independent Insurance Agents of America began researching ways to reverse tough market conditions present at the time. They formed a commission to identify the most successful agencies and find out what they were doing that set them apart. A series of interviews, on-site visits and conversations among 800 offices revealed a set of common practices consistent with the most successful agencies. These common business methods became known as the basis of ***Best Practices***.

In reality, best practices may not be revolutionary or new ideas; they are just ***good, sound business practices***. They may be things you already know, but having them broken down helps to bring attention and use them easier.

The IIAA Best Practice survey resulted in nine guidelines to maximize potential and improve agency operations:

1. ***Focus on customer service and satisfaction***. This means not only providing good service but looking into what the customer needs and expects.
2. ***Maintain good customer contact***. Best Practice agencies use customer contacts to educate the customer, serve as the client's advocate and problem solver, and make every transaction as easy as possible. They also tend to be pro-active on pricing and introducing new products
3. ***Valued staff***. Agencies' staff are continuously provided education, training and tools to do a good job. The expectation of high performance and professional growth is often rewarded with recognition, better salaries and better benefits.
4. ***Participatory management***. Top managers are very active in day-to-day operations. Managers regularly seek employee input, especially about planning and budgeting processes. Fiscal information is not a secret and profit expectations are clear.
5. ***Vision***. Best Practice agencies have a very clear vision of where they are and where they intend to go in the future.
6. ***Win/Win supplier relationships***. Successful agencies seek to do business with companies that have a vision and embrace values like theirs. A Best Practice agency engages in joint planning.
7. ***Efficiency***. Though not all agencies are completely automated, use of efficient processes and systems is common. Bets Practice agencies strive to improve work flows t add value for their customers.
8. ***Total account development***. Best Practice agencies seek to grow through total account development. They are looking to develop a larger share of the customers' accounts.
9. ***Continuous improvement***. These agencies constantly work to improve themselves. They measure and compare themselves to peers and their own past performances.

Agents who follow best practices typically use them as a benchmark to see how they measure up with other agencies -- where they excel and where they can improve. Benchmarking is a common practice among many industries. The mission is simple: observe, learn and copy practices that lead to success. As the old adage goes: ***Success breeds success***. Product or the type of agency (life, casualty, health, etc) is irrelevant. The bottom line is that these are tools and skills the agent can use to change or improve his practice.

SECTION 6: CALIFORNIA CODES AND COVERAGE DENIAL

There are many California statutes enacted to enforce the right of insurers to rescind insurance policies. An equal number, exist to protect consumers from having their policies rescinded. Here are a few examples:

California Insurance Code

Section 330: Neglect to communicate that which a party knows, and ought to communicate, is concealment.

Section 331: Concealment, whether intentional or unintentional, entitles the injured party to rescind insurance.

Section 332: Each party to a contract of insurance shall communicate to the other, in good faith, all facts within his knowledge which are or which he believes to be material to the contract and as to which he makes no warranty, and which the other has not the means of ascertaining.

Section 333: Neither party to a contract of insurance is bound to communicate information of the matters following, except in answer to the inquiries of the other:

1. Those which the other knows.
2. Those which, in the exercise of ordinary care, the other ought to know, and of which the party has no reason to suppose him ignorant.
3. Those of which the other waives communication.
4. Those which prove or tend to prove the existence of a risk excluded by a warranty, and which are not otherwise material.
5. Those which relate to a risk excepted from insurance, and which are not otherwise material.

Section 334: Materiality is to be determined not by the event, but solely by the probable and reasonable influence of the facts upon the party to whom the communication is due, in forming his estimate of the disadvantages of the proposed contract, or in making his inquiries

Section 336: The right to information of material facts may be waived, either (a) by the terms of insurance or (b) by neglect to make inquiries as to such facts, where they are distinctly implied in other facts of which information is communicated.

Section 337: Information of the nature or amount of the interest of one insured need not be communicated unless in answer to an inquiry, except as prescribed by section 381, or by the provisions of the insurance contract if such provisions are prescribed by this code as part of a standard form.

Section 338: An intentional and fraudulent omission, on the part of one insured, to communicate information of matters proving or tending to prove the falsity of a warranty, entitles the insurer to rescind.

Section 339: Neither party to a contract of insurance is bound to communicate, even upon inquiry, information of his own judgment upon the matters in question.

Section 350: A representation may be oral or written.

Section 351: A representation may be made at the time of, or before, issuance of the policy.

Section 354: A representation cannot qualify an express provision in a contract of insurance; but it may qualify an implied warranty.

Section 355: A representation may be altered or withdrawn before the insurance is effected, but not afterwards.

Section 357: When an insured has no personal knowledge of a fact, he may nevertheless repeat information which he has upon the subject, and which he believes to be true, with the explanation that he does so on the information of others; or he may submit the information, in its whole extent, to the insurer. In neither case is he responsible for its truth, unless it proceeds from an agent of the insured, whose duty it is to give the information.

Section 359: If a representation is false in a material point, whether affirmative or promissory, the injured party is entitled to rescind the contract from the time the representation becomes false.

Section 650: Whenever a right to rescind a contract of insurance is given to the insurer by any provision of this part such right may be exercised at any time previous to the commencement of an action on the contract. The rescission shall apply to all insureds under the contract, including additional insureds, unless the contract provides otherwise.

Section 651: Whenever an insurer gives notice of rescission of an automobile liability policy, upon request of the driver, the insurer, within 15 days of receipt of the request, shall furnish to the insured a statement setting forth the ground or grounds upon which the notice of rescission is based. There shall be no liability on the part of, and no cause of action shall arise against, any insurer or authorized representative, or its licensed investigative sources, for any statements made by them in a written notice required to be given pursuant to this section. If the insurer fails to comply with the provisions of this section, the insured may apply to the commissioner for a certificate of the facts or information desired. Any such request shall be made in accordance with Article 3 (commencing with Section 12950) of Chapter 2 of Division 3, and the commissioner shall exercise any power conferred upon him by that article as may be necessary to ensure compliance with this section.

Section 1900: In marine insurance each party is bound to communicate, in addition to what is required in the case of other insurance:

(a) All the information which he possesses and which is material to the risk, except such as is exempt from such communication in the case of other insurance.
(b) The exact and whole truth in relation to all matters that he represents or, upon inquiry assumes to disclose.

Section 1904: In marine insurance, if a representation by the insured is intentionally false in any respect, whether material or immaterial, the insurer may rescind the entire contract.

Section 10115: When a payment is made equal to the full first premium at the time an application for life insurance other than group life insurance is signed by the applicant and either (1) the applicant received at that time a receipt for said payment on a form prepared by the insurer, or (2) in the absence of such a receipt the insurer receives the said payment at its home office, branch office, or the office of one of its general agencies, and in either case the insurer, pursuant to its regular underwriting practices and standards, approves the application for the issuance by it of a policy of life insurance on the plan and for the class of risk and amount of insurance applied for, and the person to be insured dies on or after the date of the application, on or after the date of the medical examination, if any, or on or after any date specially requested in the application for the policy to take effect, whichever is later, but before such policy is issued and delivered, the insurer shall pay such amount as would have been due under the terms of the policy in the same manner and subject to the same rights, conditions and defenses as if such policy had been issued and delivered on the date the application was signed by the applicant. The provisions of this section shall not prohibit an insurer from limiting the maximum amount for which it may be liable prior to actual issuance and delivery of the policy of life insurance either to (1) an amount not less than its established maximum retention, or to (2) fifty thousand dollars ($50,000), if a statement to this effect is included in the application.

Section 10381.5: The insured shall not be bound by any statement made in an application for a policy unless a copy of such application is attached to or endorsed on the policy when issued as a part thereof. If any such policy delivered or issued for delivery to any person in this State shall be reinstated or renewed, and the insured or the beneficiary or assignee of such policy shall make written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall within 15 days after the receipt of such request at its home office or any branch office of the insurer, deliver or mail to the person making such request, a copy of such application. If such copy shall not be so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action or proceeding based upon or involving such policy or its reinstatement or renewal.

California Civil Code

Section 1691: To effect a rescission a party to the contract must, promptly upon discovering the facts which entitle him to rescind if he is free from duress, menace, undue influence or disability and is aware of his right to rescind: (a) Give notice of rescission to the party as to whom he rescinds; and (b) Restore to the other party everything of value which he has received from him under the contract or c) offer to restore the same upon condition that the other party do likewise, unless the latter is unable or positively refuses to do so.

When notice of rescission has not otherwise been given or an offer to restore the benefits received under the contract has not otherwise been made, the service of a pleading in an action or proceeding that seeks relief based on rescission shall be deemed to be such notice or offer or both.

Section 1693: When relief based upon rescission is claimed in an action or proceeding, such relief shall not be denied because of delay in giving notice of rescission unless such delay has been substantially prejudicial to the other party.

A party who has received benefits by reason of a contract that is subject to rescission and who in an action or proceeding seeks relief based upon rescission shall not be denied relief because of a delay in restoring or in tendering restoration of such benefits before judgment unless such delay has been substantially prejudicial to the other party; but the court may make a tender of restoration a condition of its judgment.

California Code of Civil Procedure

Section 340: There is a one-year statute of limitation on written insurance contracts to file a personal injury action. Two years if nothing is in writing.

California Health & Safety Code

Section 1389.21: (a) A health care service plan shall not rescind a plan contract, or limit any provisions of a plan contract, once an enrollee is covered under the contract unless the plan can demonstrate that the enrollee has performed an act or practice constituting fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the contract.

(b) If a plan intends to rescind a plan contract pursuant to subdivision (a), the plan shall send a notice to the enrollee or subscriber via regular certified mail at least 30 days prior to the effective date of the rescission explaining the reasons for the intended rescission and notifying the enrollee or subscriber of his or her right to appeal that decision to the director pursuant to subdivision (b) of Section 1365.

(c) Notwithstanding subdivision (a), Section 1365 or any other provision of law, after 24 months following the issuance of a health care service plan contract, a plan shall not rescind the plan contract for any reason, and shall not cancel the plan contract, limit any of the provisions of the plan contract, or raise premiums on the plan contract due to any omissions, misrepresentations, or inaccuracies in the application form, whether willful or not. Nothing in this subdivision shall be construed to alter existing law that otherwise applies to a health care service plan within the first 24 months following the issuance of a health care service plan contract.

Section 1389.3 : No health care service plan shall engage in the practice of post claims underwriting. For purposes of this section, "post claims underwriting" means the rescinding, canceling, or limiting of a plan contract due to the plan's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the plan contract. This section shall not limit a plan's remedies described in subdivision (a) of Section 1389.21.
An insurer can rescind a fire insurance policy based on an insured’s negligent or unintentional misrepresentation of a material fact in an insurance application, notwithstanding the willful misrepresentation clause included in the required standard form fire insurance policy.

Section: 1389.6: Compensation of a person or entity employed by, or contracted with, a health care service plan shall not be based on, or related in any way to, the number of contracts that the person or entity has caused or recommended to be rescinded, canceled, or limited, or the resulting cost savings to the health plan. A health care service plan shall not set performance goals or quotas, or provide compensation to any person or entity employed by, or contracted with, the health care service plan, based on the number of persons whose

coverage is rescinded or any financial savings to the health care service plan associated with rescission of coverage.

Section 1378.7 Every health care service plan that offers, issues, or renews individual plan contracts shall offer to any individual, who was covered under an individual plan contract that was rescinded, a new individual plan contract, without medical underwriting, that provides equal benefits. A health care service plan may also permit an individual, who was covered under an individual plan contract that was rescinded, to remain covered under that individual plan contract, with a revised premium rate that reflects the number of persons remaining on the plan contract.

Section 1389.8: (a) Notwithstanding any other provision of law, an agent, broker, solicitor, solicitor firm, or representative who assists an applicant in submitting an application to a health care service plan has the duty to assist the applicant in providing answers to health questions accurately and completely.

(b) An agent, broker, solicitor, solicitor firm, or representative who assists an applicant in submitting an application to a health care service plan shall attest on the written application to both of the following:

(1) That to the best of his or her knowledge, the information on the application is complete and accurate.

(2) That he or she explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and that the applicant understood the explanation.

(c) If, in an attestation required by subdivision (b), a declarant willfully states as true any material fact he or she knows to be false, that person shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars ($10,000). Any public prosecutor may bring a civil action to impose that civil penalty. These penalties shall be paid to the Managed Care Fund.

(d) A health care service plan application shall include a statement advising declarants of the civil penalty authorized under this section.

SECTION 7:
THE NATURE OF CLAIMS

Introduction

To help understand why claims are denied, it is important to understand the claims process.

Notification of a loss to an insurance company by a policyholder or a third person constitutes a claim for payment. Before satisfaction of any claim, a carrier will require an investigation of the facts and circumstances underlying the situation which gave rise to a claim. The adjustment of losses in the industry is probably most significant in property insurance because of the partial nature of such damages and the difficulty of measuring the extent of such losses. This concern does not normally affect life insurance since the loss is complete and the amount of the payment is always a certain sum, the face value of the policy.

One of the ***first steps*** in the ***investigation of a claim*** is to ascertain if the ***insurance carrier is responsible*** for payment of a loss. Infrequently, a claimant will file a claim with the wrong company or describe property that is not the subject of a policy. Other claims may be filed after a policy has expired or when the time for the payment of a premium or premiums has expired. Some losses, such as damage due to floods, may have been specifically excluded from coverage. In a few cases, coverage may not be forthcoming because an applicant filed a fraudulent claim.

Once a carrier has determined it is liable to pay for a loss, the company must then determine the actual amount of damages done. If a carrier and a policyholder can agree on the amount of coverage, the claim will be settled. If not, arbitration proceedings may be warranted. A carrier must take care not to reduce payments for legitimate losses below a level which would constitute an unfair settlement of a claim. If a claimant is willing to settle for less than what the insurer thinks the claim is worth, it would be a show of good faith for the company to pay the reasonable value of a claim.

Once a claim is accepted and agreed upon, it will be paid promptly by a carrier. If a claim is denied or if a claimant thinks the proposed settlement amount is insufficient, the insured can secure the services of a lawyer and sue the carrier.

Claims as an Insurance Company Expense

An insurance carrier is in the business of handling many risks, and the business does not come cheaply. Most insurance companies are significantly large entities, bureaucratic institutions that operate with very substantial amounts of overhead, including rent, utilities, salaries, company vehicles, legal costs, sales commissions and expenses resulting from the settlement of claims. All of such costs are included in calculating what amount of premiums to charge. Such expenses also include the costs of frivolous, exaggerated and fraudulent claims.

People have been known to burn down buildings and fake their own deaths in order to recover under both property and life insurance policies. Some insurance companies are owned by private investors and others by policyholders. In either case, claims are paid from funds attributable to premiums collected and from income from investing such premiums.
Parties Involved in an Insurance Claim

The parties involved in an insurance claim can involve an insured, a carrier, a beneficiary, a third party who may have suffered losses, a staff claims adjuster, an independent adjuster, a specialized investigator, a mediator, an arbitrator, a lawyer and the state insurance department. An agent who sold an insurance contract to a policyholder may also be useful in reporting the claim directly to the carrier, keeping the policyholder advised of the investigation and the resolution and disposition of the claim.

Elements of a Valid Claim

In order for a casualty or a loss to be covered by insurance, a few basic elements must exist:

- Losses must be fortuitous—Except for death, a loss which is covered by a certain situation is not a valid basis for an insurance claim, since a policy insures against a risk. Losses covered by normal wear and tear or deterioration are the result of a known condition, and therefore are not covered, even if an insurance policy did not specifically exclude such losses.
- Losses must be occasioned by an extraneous factor—If a loss is caused by an inherent physical condition rather than an external agent, coverage will not apply. For example, a policyholder decided to paint her old airplane with a polyethylene paint, necessitating removal of the old paint with a special solvent and the application of an undercoat. A week after she finished applying the paint, it began to chip. The owner of the aircraft consulted an aircraft paint shop on the field where she hangars her plane. The owner of the shop concluded that either the undercoat was applied improperly or there was a defect in the composition of the undercoat. There is no insurable loss because it was not occasioned by an extraneous cause.
- Damages caused by intentional actions of a policyholder—If an empty building in the middle of an enormous vacant field is destroyed by a surrounding grass fire, coverage would be applicable. If, on the other hand, the owner dropped a match intentionally onto a pile of kerosene soaked rags he placed behind the building, not only would he be guilty of arson, but he would not be able to recover from his carrier for any losses to the building because it is against public policy to insure a loss which is caused by the intentional act of a policyholder.
- Only legal property can be the subject of a valid claim—Illegal property cannot be the subject of a valid binding contract. A policyholder cannot store contraband in his or her garage or house and then make a claim for the loss of stolen property if the garage or house burns down.
- A loss must be sustained—The mere happening of a perilous or catastrophic occasion involving insurable property cannot be the subject of a valid claim unless an actual loss has been sustained. If property that has no value is stored in a building that is damaged, there can be no recovery for such worthless property since no loss has been sustained.
- There must be an "***insurable interest***" in the property—A policyholder must have some degree of ***legal or equitable interest*** in the property which is the subject of an insurance claim. If an antique car dealer had an insurance policy on a classic auto that he shipped to a buyer in another state and the car was stolen just after the buyer took delivery, the seller could not file a valid claim on the stolen vehicle simply because he still had a policy covering the car, because at the time of the theft he was no longer the owner.

- Rights of a Claimant
- One of the most significant laws that provides protection to consumers while impacting investigation, evaluation and settlement of claims on the part of an insurance carrier is the "Model Unfair Claim Settlement Practices Act," which has been adopted in one form or another by a substantial number of states. The enumeration of such rights is not by any means exclusive as other legal rights of policyholders that have been established both by legislation and by case law. Also, such rights may serve as a guideline to some courts when confronted with the question of an unfair settlement practice.

Below are some practices involving an insured or a claimant that are illegal under the ***Model Uniform Claim Settlement Practices Act***.

- Failure to adopt and maintain sound criteria for the investigation and processing of claims.
- Misstating policy terms or relevant facts that affect coverage.
- Failure to provide for prompt and equitable settlement of claims when liability is relatively certain.
- Using advertising material that would lead a reasonable person to believe that a claim could be settled for one amount and then refusing to settle for such amount.
- Failing to inform the insured, upon request, under which part of a policy a claim has been paid.
- Failure or refusal to provide an explanation of the reasons relied on in a policy or under the laws for either compromising or denying a claim.
- Misrepresenting the statute of limitations.
- Delaying the investigation or payment of a claim by using multiple forms to obtain the same information relative to a claim.
- Failure to act promptly upon notification of a claim arising under a policy.
- Forcing an insured to sue to recover for a loss by offering to settle a claim for significantly less than what is ordinarily recovered in a suit for like claims.

The Insurance Claims Process & The law

The ***claims process*** is a method of translating the rights provided to a policyholder under an insurance policy into a ***remedy***. Several decades ago, there were only a few laws that applied specifically to insurance claims which were subject to the ordinary rules of interpretation affecting contract performance and breach, resulting in protection to carriers from liability for special damages for failure to defend or settle claims as required by a policy. When an insurer was sued, the only penalty that was ordinarily incurred was a judgment in which the carrier was ordered to satisfy the very claim it sought unsuccessfully to avoid. Insurers had a significant strategic advantage since there was little incentive to promptly and fully settle claims.

In the past 20 to 30 years, a growing body of statutes, rules and regulations, and judicial decisions have arisen, creating new responsibilities on the part of carriers where few had previously existed, resulting in the playing field between carriers and policyholders being more balanced. Growing statutory and case laws have proved in many instances to be quite onerous, and curiously have had an unexpected side effect in that carriers have been encouraged to pay invalid or exaggerated claims just to avoid burdensome litigation.

There are three sets of developments that have resulted in the imposition of extraordinary burdens on insurance companies—the extra-contract or judicially-imposed liability for failure

to pay a first-party claim, the creation of a duty or obligation to settle claims and the elaboration of a carrier's duty to defend an insured liability. Underlying all of these developments has been a failure on the part of those who prepare insurance policies to specify clearly the corresponding rights and obligations of both the carrier and the policyholder. As a result, carriers have had an abundance of discretion in determining whether and how to settle claims and how to satisfy other contractual obligations. Some courts have managed to limit this discretion through an equitable, economic application of insurance laws.

When the terms and conditions of an insurance policy are not crafted with a great amount of specificity, sufficient detail must be provided by legislation or by case law. One method of achieving this is to tailor the terms and conditions in such a fashion as the parties would have done if they would have agreed upon the inclusion of such details in the policy. An adjuster can minimize the possibility of legal or judicial intervention on this basis by not abusing the discretion delegated to it by interpreting the policy or taking actions inconsistent with the expectations of a policyholder. Adjusters should be aware that failure to do so may constitute "bad faith" from a legal perspective. The elements of evil intent or deliberate wrongdoing are not necessarily inherent in the legal concept of bad faith. Exceeding the discretion allowed by a contract is frequently enough to constitute bad faith on the part of a carrier. It must be recognized that the term "bad faith" varies from one setting to another as well as from one jurisdiction to another.

One significant development in the legal regulation of claims that has occurred over the past several decades is the evolution of a new cause of action for the bad faith refusal of a carrier to pay claims of first parties. Prior to that, a policyholder could only recover an amount of damages equal to the policyholder's losses under conventional contract law. The measure of damages, being only what the carrier would have otherwise been obligated to pay, did virtually nothing to deter a carrier from breaching a policy. And since the policy was the product of a carrier, the inequitable situation could not be alleviated by including a fuller measure of damages in the insurance contract. More and more, courts are now awarding damages that are not contemplated by the insurance contract, such as legal fees, consequential damages, pain and suffering and exemplary or punitive damages. The great majority of bad-faith cases involve defective investigation of insurance claims which results in an inappropriate denial of claims. Unlimited recovery of damages not provided by the terms and conditions of a policy can lead to overcaution on the part of the insurance industry, similar to the degree of safeguards adopted by the medical profession in overdiagnosing and overtreating to avoid liability. Several states have attempted to stem this development by passing laws that allow recovery of reasonable legal fees and a modest amount of punitive damages in bad-faith cases.

Generally, ***punitive damages*** can only be recovered in bad-faith litigation upon proof by the claimant of an intention on the part of an insured to inflict injury or damages. Liability often turns on the intent of the denial. A simple but erroneous conclusion that one is not entitled to coverage would probably be less than a sufficient basis for punitive damages. If denial was made with flagrant disregard of the necessity to investigate, punitive damages may be appropriate. A claim that an adjuster may initially refuse to investigate may be only one of negligence, but a stubborn and willful continuance to refuse to investigate can turn quickly into a case involving bad faith. The appropriate test for determining the existence of bad faith should be whether a carrier took improper advantage of its strategic position with respect to a claimant. Because of the new measure of liability for denial of claims, it is possible that more fraudulent, exaggerated and frivolous claims will be filed in the future.

At the same time, another body of case law has arisen with respect to an insurer's duty to settle third-party claims against the insured that has impacted the entire procedure of claims investigation, evaluation and settlement. A first review of an ordinary insurance policy would have the reader conclude that a carrier has near complete discretion about whether to settle or litigate third-party claims. A standard provision appearing in an insurance policy typically provides that, "the insurer shall defend any suit against the insured in which the claimant alleges property damage or bodily injury and seeks damages payable under the terms and conditions of this policy, notwithstanding that the allegations may be false, fraudulent or groundless. The company may at its own discretion conduct such investigation and settlement of any suit or claim as it shall deem appropriate."

Such discretion has frequently led to disagreements and serious conflicts between a carrier and a policyholder. The problem becomes most obvious in a situation where policy coverage is set at one amount and a claimant asserts liability in excess of that amount. If a claimant offers to settle for the limits of coverage and the carrier refuses, the insured is left with the possibility of threatened litigation and, ultimately, a judgment in excess of the policy coverage amounts. Some courts have held that a carrier owes a policyholder equal consideration when weighing the relative interests of its own with those of a policyholder, hoping to establish a deterrence against carriers making institutional decisions to create a reputation for being tough on settlements. The problem with this approach is it places a burden on a carrier to entertain a settlement offer as though there were no policy limitations on coverage, when the penalty for failing to settle a reasonable offer is liability for the entire claim on the part of the carrier. The imposition of a duty to settle reasonable claims has resulted in part in protection for the carrier against liability for coverage exceeding the limitations set forth in a policy.

The extent of a carrier's duty to defend litigation brought against the insured by a third party is also in flux. Under traditional circumstances, carriers had less motive to breach their duty to defend a policyholder against third-party liability claims than they did to refuse to settle reasonable offers, since in the first instance the insurer was typically liable only for the amount of the reasonable settlement. Bad faith was not ordinarily involved in a decision not to defend, but rather the driving force was an unbridled contractual provision in a policy which limited the duty to defend to circumstances in which the carrier could reasonably expect to have to pay the costs of the defense.

The more contemporary cases involving bad faith have effected a realignment of the balance between a policyholder and a carrier with respect to relative advantages enjoyed by both. Regulation is justified on the theory that both parties become adversaries, potential courtroom foes, immediately upon the filing of a claim. The insurer's interest is set aside if it has no ultimate duty to cover the loss of the policyholder. On the other hand, the policyholder is assured a defense in almost every case when it can be reasonably expected that one will be necessary. The readjustments do not necessarily create a mandatory obligation on the part of the insured; rather, they impose liabilities for acting unreasonably.

SECTION 8:

CLAIM EVALUATION & INVESTIGATION

Investigation of a Claim

Generally, the burden of proving the existence of a loss is upon a policyholder. An insurer does not have a legal duty to prove that a loss that is the subject of a claim has not been sustained by a policyholder unless and until the claimant has met his or her initial burden of proof. Although these relative obligations on the part of a policyholder and an insurance carrier are not stated in a policy, they are accepted throughout the insurance industry and are recognized by the judicial system. Notwithstanding the general rule about the burden of proving the existence of a loss, in situations where it is extremely difficult for an insured to demonstrate a loss, a carrier must accept the policyholder's word concerning facts surrounding a loss unless it is able to obtain conflicting evidence. A carrier has a legal right to require a policyholder to prove that the value of a claimed loss is as stated in the notice to the carrier or the proof of loss. The financial burden of demonstrating a loss, including the cost of an appraisal or an estimation of repairs or replacement, is upon the claimant.

Procedural Reasons for Denying a Claim or Terminating a Policy

When an insurance company receives a claim from a policyholder, it assumes a duty to carry out a thorough and competent investigation of the claim to determine what coverage for the underlying loss is applicable and which benefits are payable under the policy. Once a policyholder has filed a claim for insurance, the company will assign the claim to an adjuster, who is the person in charge of investigation, negotiation, evaluation and settlement of a claim. The initial task of an adjuster is to see if the policy in question is in full force and effect. If there are exclusions that apply or if premiums have not been paid timely as required under the terms and conditions of the policy, coverage may not be forthcoming. Another set of circumstances which may enable a carrier to avoid coverage is the existence of fraudulent conduct on the part of a policyholder, either at the time an application for insurance coverage was taken or when the claimant prepared the notice or proof of loss. An adjuster must also satisfy him/herself that the claimant complied with any duties imposed upon him or her by the policy that apply after a loss.

Following is a typical clause in an insurance policy that allows a carrier to nullify coverage in the event of fraud, misrepresentation or concealment:

Concealment or Fraud.

The entire policy will be ***void*** if whether before or after a loss, an "insured" has:

- Intentionally concealed or misrepresented any material fact or circumstance.
- Engaged in fraudulent conduct.
- Made false statements relating to this insurance.

Concealment

Concealment involves a failure to divulge facts to a carrier which, if otherwise known, would have affected the decision of the carrier to grant coverage or honor a claim. For example, a policyholder represented in an application for health insurance that he never had surgery, when in fact he had a craniotomy. If the carrier had known of his neurosurgical history, it would have designated his condition as a "preexisting condition," either limiting or denying coverage for that situation. Sometime after the policy was issued, the insured began having seizures which resulted from residual trauma.

When the policyholder filed a claim for medication that was prescribed by his physician to control seizures, an astute claims adjuster examined the medical records of the policyholder to see if there was any medical evidence indicating the existence of seizures or any other condition that might have been the basis for convulsions. After it was determined that the policyholder intentionally withheld information about his neurological condition, the policy was canceled.

Misrepresentation

Misrepresentation, as opposed to concealment, is a misstatement of a fact that is material to the underwriting decision, which can also lead to denial of a claim or termination of a policy. If an applicant for a homeowners policy represented to the carrier that there were functioning smoke detectors on the property and the property was destroyed by fire after the applicant was accepted for coverage, in all probability the carrier would deny coverage for the policyholder’s loss or terminate the insurance policy.

Duties of an Insured in the Event of a Loss

Virtually every insurance policy involving the loss of property contains a provision providing what steps must be taken by a policyholder in the event of a loss. If an insurance claims adjuster determines that the policyholder failed to comply with such conditions, he or she may recommend denial of the claim to the carrier.

Review and Examination of a Claim

The next step in the investigation of a claim is a thorough review and examination of the allegations set forth in the notice provided by the claimant to the insurance company. The adjuster should ask the claimant to document the losses detailed in a claim. If a claimant asserted that his or her wheelchair was stolen, the adjuster should require proof that the policyholder did in fact purchase the wheelchair. Independent verification of the facts stated in the claim may be accomplished by reviewing any reports that were filed with the police or by conducting interviews with witnesses. The adjuster will probably want to verify that the policyholder did nothing to worsen the condition of any damaged property or that he or she contributed to the situation which brought about the losses.

CLAIM EVALUATION

The evaluation of an insurance claim involves assessing the damages or the extent of losses surrounding real and personal property, personal injury or loss of life. In complicated cases, the process can often be quite lengthy. The first step in an evaluation of a loss set forth in an

insurance claim actually occurs when a carrier sends an adjuster for an on-site inspection, investigation and estimation of damages. The adjuster should attempt to verify that losses are covered by the policy in question. In the case of damage or losses to property, an adjuster's task is facilitated if a claimant has not made any repairs other than those essential to preservation of the property, and if he or she has been able to secure maximum cooperation from the claimant during the investigation and evaluation of the claim. Dollar losses are then calculated by taking inventory of the damages claimed. Each specific item of damage or loss is assigned a value, using either an assessment made by a claimant or a determination by an adjuster who employs external sources, such as established indexes of value or the estimates of a repair shop or a professional appraiser.
Repair estimates, receipts, service charges and repair bills are evaluated to arrive at an estimation of the amounts which will eventually constitute a settlement. All information bearing on the evaluation of a claim presented by a claimant to an adjuster will be considered. Inadequate or irrelevant information may lead to an undervalued claim.

Disputes About Evaluation of a Claim

Disputes between an insurer and a claimant about the value of a claimed loss constitute one of the most frequent disagreements between a policyholder and an insured. During the processing of a claim, one of the most difficult tasks confronting an insurance adjuster is determining what a claim is worth. Inherent in such determination is placing an accurate value upon the subject of an insurance claim so that every claim can be reduced to a specific dollar amount. Placing the value on a life in the event of death is at best arbitrary. The benefits of future earnings that certain of the survivors would have been entitled to, funeral expenses and medical costs are amenable to quantification, but such other aspects as loss of consortium and companionship are not capable of being reduced to a dollar amount. Another problematic area involves the evaluation of personal property losses. Items such as family heirlooms and antiques have an intrinsic value to a claimant that can never be replaced. In situations where a claimant has lost everything, such as in a fire or a tornado, it may be impossible to provide a evidence of ownership of and complete or adequate inventory of every piece of personal property that was owned before the disaster.

Use of an Independent Expert

In the event of a property loss, an insurance adjuster frequently uses the services of an independent expert to evaluate a loss. A claimant who has had damages to a house or a roof might employ the services of an independent contractor to make necessary repairs, but a carrier is not legally bound to pay the contractor for his or her services at any price. In reality, a contractor works for the claimant. Because it is difficult for one adjuster to be intimately familiar with the costs of repairs and replacements involving every conceivable type of property, it is frequently necessary for a carrier to use the services of an expert to assist an appraiser in establishing a value for a recommended settlement. There are a number of independent experts whose professional training and experience are frequently employed by carriers to assist in the investigation and evaluation of claims, including engineers, meteorologists, doctors, chemists, aircraft and aviation specialists, marine personnel, jewelry dealers, photographers, detectives, private investigators, safety engineers and vibration consultants. One very expensive aspect of the operation of an insurance company is the defense of claims in court. There are large numbers of attorneys who specialize in such practice, and most are outside lawyers, not associated with the legal staff of an insurance carrier.

Actual Cash Value

One of the most arduous tasks of an adjuster is a balancing act involving the assignment of a value to items that are the subject of a claim while performing his or her responsibility of reducing a claim to a dollar amount. An ordinary insurance policy covering personal or real property provides that benefits payable for damaged or lost property are the "actual cash value" of such property at the time of loss. A typical provision might be as follows:

The market value of an article or piece of property is the price which it might be expected to bring if offered for sale in a fair market; not the price which might be obtained on a sale at public auction or sale forced by the necessity of the owner, but such a price as would be fixed by negotiation and mutual agreement, after ample time to find a purchaser, as between a vendor who is willing (but not compelled) to sell and a purchaser who desires to buy (but is not compelled) a particular article or piece of property.

By establishing the actual cash value as the price that one might anticipate an article or piece of property to bring if offered for sale in a fair market where there is a willing seller and a willing buyer, a forced sale or a price obtained at a public auction would be excluded as determinative of market value. The term "actual cash value" is defined under the laws of some states, and, in other jurisdictions, customary definitions have come into use because of court definitions.

When a market exists for used goods like the kind in question which may have been stolen or destroyed, the value can be measured against the price it would have brought in the open used market. An adjuster cannot reduce a claim to a dollar amount unless he or she knows what items have been lost or damaged. An adjuster will ask a claimant to prove ownership of an item which is the basis of a claim, and may be suspicious if a policyholder asserts that he or she purchased a large amount of items for cash. When there is no public market for a used item, the actual cash value may be determined by taking the acquisition cost of a new item and subtracting an amount reflecting the used component of the item, which is called depreciation.

Depreciation

Depreciation is calculated by an insurance carrier using the rule of thumb that an item loses value every year over its expected life. Since property generally depreciates more rapidly in the earlier years, this method of computing depreciation can be quite generous to an insured. Many carriers employ depreciation tables in evaluating what dollar amount to place on damaged property. Placing a dollar value on used personal property is quite subjective. Some insurance companies insist that the starting point for placing a value on a used item of personal property is the original cost, even though it may only be a fragment of the cost of replacement.

Replacement Cost

When old property is involved, the deduction for depreciation might reduce the settled amount to a level below the actual replacement cost. In such a case, a carrier may allow an insured to pay additional premiums for an endorsement that substitutes replacement cost for actual cash value. Under replacement cost coverage, settlement is conditioned upon a

claimant actually replacing the damaged or lost property. If the claimant elects not to replace the property, the settled amount is limited to actual cash value.

Another exception to an actual cash value policy is a "***stated value***" policy, in which the insurer and the carrier agree at the time of issuing a policy that the property in question has a ***specific value***. The carrier must then pay the stated value rather than the actual cash value.

Evaluation of Extraordinary Items

Certain items of personal property are not susceptible to replacement value coverage and should be insured separately if coverage is available. There is no rate book that an adjuster can turn to for determining the value of a loss of an extraordinary object, such as an expensive lithograph, a quilt from the Revolutionary War era or a two-carat diamond inlaid in a customized setting. ***A reputable certified appraiser should have been consulted*** before the item in question was insured, but if that was not the case, one will have to be used by an adjuster. Other items which may be included as extraordinary for purposes of coverage include furs, vintage automobiles, boats and aircraft, antiques, guns and certain articles of clothing. An appraiser may seek information about whether the item has depreciated in determining the amount of the settlement.

Evaluating Minor Personal Injury Claims

In the event of a minor personal injury, a claim may be filed by the insured or a third party who was on the insured's premises during the time of an injury or may have been injured while a passenger in a vehicle belonging to the insured. Frequently, in determining how much to allow in a claim for minor personal injury, an adjuster may be bound by the consensus of what other carriers allow as well as applicable case law. In an evaluation of a minor personal injury claim, an examiner or adjuster will take the following factors into consideration:

- Determination of which carrier will cover a claim—In certain instances, such as the destruction of a house by a tornado, there is no question that if coverage applies it will be extended by the carrier which provided a homeowners policy to the owner of the property. In other cases, such as a multi-car pileup, it may not be obvious which carrier must cover the accident, and, frequently, protracted litigation may be necessary to determine which company or companies must pay. In an event where multiple carriers may be involved, an examiner will determine from police reports and statements whether another carrier should have been notified of the underlying event.
- Medical expenses—Medical expenses are reviewed carefully to determine reasonableness and the possibility of double coverage. If a claimant has both personal medical insurance and automobile coverage, it must be determined who will be the primary carrier. If a claimant was working at the time of an accident, it will also be necessary to determine if workers' compensation is applicable.
- Loss of earnings—Wage-loss information is analyzed for lost income or earnings capacity. An insurance examiner will compare wage statements provided on a W-2, a 1099, or a recent federal or state income tax return. If a claimant presents lost wages from a job which he or she was about to begin, but was prevented from doing so by an accident, an examiner will ask the prospective employer to verify such claimed wage losses.

- Disability—An examiner will evaluate the underlying facts upon which a claim for disability is based. Medical reports and the nature of the underlying treatment will be examined. In the case of an absence of medical treatment, an adjuster will look to see if there is other surrounding evidence to prove or disprove a claim of disability.

Death Due to an Accident

In a claim involving death due to an accident, ***"wrongful death" statutes*** may apply in many states. Under such statutes, a surviving spouse, parents or children of the deceased may ***recover damages from the party*** responsible for the death. In such a case, one who could so recover becomes the claimant.

One of the first factors which must be determined is whether the deceased contributed by his or her own negligence to his or her death. Were his or her actions the sole causative factor or was there another party whose negligence resulted in the underlying death? The answers determine the amount of the damages which an insurance company may have to pay. Another factor to be considered in calculating damages is whether the deceased survived for any period of time after the accident occurred and if the deceased incurred pain and suffering. An examiner must determine if the deceased was conscious before his or her death for any amount of time.

An adjuster must obtain a copy of the death certificate to verify the cause of death. Traces of alcohol or drugs in the blood of the deceased may confirm contributory negligence. Police investigations and witness statements are useful in this determination and other matters affecting the cause of death.

Settlement of a Claim

The vast majority of insurance claims are paid promptly and without the involvement of a great deal of complexity. Many cases are settled or disposed of through negotiation between a claimant and an adjuster. Insurance adjusters should know that compromise is the basis of a successfully negotiated claim and that non-reciprocal compromises may constitute an invitation to litigation. Negotiations must be made in good faith for an offer to be fair and reasonable. Successful dispositions of an insurance claim, based upon a compromised settlement, must also be based upon a consideration of all of the underlying facts. Reasonable demands or concessions made at inappropriate times have an adverse impact on a settlement. Unreasonable offers should be refused. Settlement agreements should not be signed unless an adjuster and a claimant are reasonably satisfied with the terms and conditions of the proposed settlement.

Release

No matter what the type of claim, a release is the ultimate objective of an insurance company. A release is a legally-binding document which provides that the person who executed it settled the claim for a valuable consideration, and did so knowingly. After a release is signed, and notarized, if required, the insurance company dispenses a check to the party affected by the release. Once a ***settlement release is signed***, the company ican then rely on representations by an insured that the claim is settled, and knows that no additional claims will be made which arose out of the same accident or set of facts.

Following are some of the more important aspects of a release:

- Reading the release—A release must be in readable form and should have been reviewed and understood by the insured. A lawyer should be involved if the release cannot be understood by the parties involved.
- Good faith—A release should be obtained in good faith. Material misinformation on the part of an adjuster or an insurance company may lead to a release being set aside by a court. In the event of a personal injury, a medical statement should be obtained from a qualified physician before a release is signed.
- Waiting period—In a number of states, there is a legally-prescribed waiting period that must by observed before a release can be executed. The waiting period protects an insured or an injured party from receiving inadequate medical treatment or sums insufficient to remedy property damage. It also deters a carrier from avoiding its obligations under a policy. Some states require a waiting period to be 30 days in duration. If signed in less than the requisite time, a release may be invalid.
- Expenses—A release typically covers all expenses, whether past, present or future, paid or unpaid. If any third parties paid expenses on behalf of the insured, those payments should be included in a release.
- Assets of a Carrier—These must be sufficient to cover a release.
- Other Carriers—If additional carriers are involved, they should be apprised of the release.

Negotiating a Settlement

The negotiation of a settlement is a business transaction between a policyholder and an insurance adjuster who is acting on behalf of a carrier. Personal feelings and emotions should be kept out of the negotiating environment. Objectivity should prevail. There should be no insistence on the part of either party to bend or mold contractual provisions or legal precedents. Both parties should be able to detach themselves from personal prejudices which either may hold about the other party. Threats to cancel a policy on the part of either party are out of place.

Negotiation does not have to be a win-or-lose proposition. A fair and equitable disposition or settlement leaves both the policyholder and the carrier feeling like winners. A claim settled within reasonable limits is one in which an adjuster can feel that he or she has done a satisfactory job both for the insured and his or her employer. Adjusters should expect a policyholder to approach the negotiating process with a proposed settlement that is on the high side. By being creative and doing a little extra work in approaching a claim, it is possible for an adjuster to arrive at an amount which is fair and equitable to both the insured and the carrier.

Appraisal

A method which is frequently used to settle a claim between a carrier and a claimant is an appraisal. The standard appraisal provision that is contained in an insurance policy is required under the laws of some states and is a normal provision in a policy covering personal or real property. Either party to an insurance policy has the right to demand an appraisal. The appraisal method, used infrequently because most claimants are not aware of the process, can be employed to determine the value of real and personal property. Most of the time it is used to settle disagreements that develop over the expenses of restoring commercial, industrial or residential property destroyed by fire. Appraisals are only

appropriate when there is a significant amount of money in controversy. In order to satisfy the requirements of a competent appraiser, the one selected should have impressive credentials in a given area. Licensed contractors specializing in reconstruction of burned properties or an established art dealer when the property involved is a rare painting would probably satisfy the "competent" requirement. In actual practice, an umpire is rarely used to resolve a dispute between two appraisers. The appraisal award is binding on both parties.

Reduction and Denial of Claims

Most reductions or denials of claims result from clauses or phrases in a policy which exclude certain property or transactions from insurance coverage. In order for an exclusion to be valid it must be set forth in a policy in plain, concise and clear language, and the burden is generally on the carrier to prove that the exclusion is both clear and understandable and is applicable to the situation underlying a claim.

If a ***policy exclusion is vague***, unclear or not capable of being understood, a court will ordinarily construe the language in favor of the claimant. This trend follows a 200 year-old judicial practice that if language in a policy is capable of being interpreted in two different ways, that which favors a policyholder will be upheld. When a claim is filed, an adjuster will conduct his or her examination with a view to whether or not it is payable. If a policy is not in force, if it has expired and premium payments have not been satisfied, the company may deny coverage. Many policies contain a grace period during which a policy can be reinstated if an insured brings all of the delinquent payments up to date. Another issue that must be resolved, especially where a health care claim is involved, is whether the claimant is covered under the policy. Certain medical checkups are excluded from coverage, so it becomes necessary to determine if a visit to a physician was routine or the result of an existing medical condition, disability or disease.

If an insurance application has not been filled out completely and accurately, anything which was not included may be used by a carrier to limit or deny coverage. In the worst possible case, a policy may be canceled. Inflated, overly-exaggerated, frivolous, fraudulent and deceptive claims may also result in the denial of coverage or cancellation of a policy. Claimants are entitled to a written explanation containing the reasons for the denial of a claim. Most state laws require that such an explanation be provided in writing, and failure on the part of the carrier to do so may constitute an unfair claims practice. A claimant’s rights are governed to a large extent by the phrases and words included in the governing insurance policy. Claims may be denied for something as trivial as failing to follow the company’s specific requirements for filing out claim forms or for failing to file such a claim in a timely manner.

Litigation

"Bad-faith" litigation can be an expensive way to settle a claim for a carrier. A lawsuit in which a carrier is charged with having handled a claim in bad faith or making an unreasonable refusal to pay a valid claim is costly and onerous to a carrier. ***Bad faith*** can encompass a carrier’s failure to investigate, evaluate and settle a claim adequately or within a reasonable amount of time. Recovery will entitle a claimant at the very least to the amount of benefits explicitly provided for within the policy and, depending upon the nature of the circumstances, may lead to the recovery of incidental damages, economic loss, future damages, amounts for mental distress or punitive damages. Punitive damages are provided for by law to deter a carrier from engaging in bad faith practices. The California Supreme Court has held that

insurance carriers have a relationship of trust with their clients which underlie the interest of the public. Taking advantage of that relationship, public policy dictates imposing punitive damages on a carrier and an attempt to restore the contractual relationship between the carrier and a policyholder. Some states that do not allow punitive damages provide for other kinds of damages or penalties. There are some recent judicial guidelines which must be satisfied before an award of punitive damages would be appropriate. They include:

- An ongoing practice of nonpayment of claims by a carrier.
- A constant and unremedied pattern of egregious practices by an insurer.
- Malicious disregard of the rights of a policyholder.
- The absence of any reasonable basis for the alleged misconduct.
- Actions which constitute more than just a mistake of law or fact, an honest error of judgment, over-zealousness, simple negligence, witlessness, bureaucratic inertia or human failing.

Although no dissertation on the rights of a consumer is intended, it is prudent for an adjuster to have a general awareness of what guidelines a court might use in assessing some of the factors set forth above as the basis for an award of punitive damages. In particular, with regard to the rights of a policyholder, the ones included as specific terms and conditions under a policy will be evaluated, but there are additional ones to be considered. Although it does not have the force of a law, the National Association of Professional Insurance Agents and Consumer Insurance Interest Group has adopted an Insurance Consumer's Bill of Rights and Responsibilities, which can serve as a judicial guide as to what constitutes equitable insurance practices and reliable representation by an insurance agent. Some of the items included are:

- The right to a voice—A consumer should have a vote in any significant decisions which affect him or her, including the right to a response to any suggestions or inquiries made by a consumer.
- The right to safeguards—A consumer is entitled to be advised of his or her rights as well as his or her obligations which arise under an insurance policy.
- The right to a remedy—Claims must be handled and settled in a timely and equitable fashion. Mediation, appraisal and arbitration procedures, and an appeal to the state insurance department or commission must be available.

Although a consumer's rights are emphasized, an adjuster should also be aware that the Insurance Consumer Bill of Rights and Responsibilities imposes concurrent obligations on a consumer, including a duty to timely and accurately file claims, to read the policy before purchase and to seek professional help to aid in understanding terms and conditions, to minimize risks and losses, to report any fraudulent conduct to law enforcement authorities and regulatory agencies, to maintain accurate records and inform the insurance company of any changes, and to comply with policy provisions concerning claims and payment of premiums.

One of the most significant consumer protection laws (which was discussed briefly before), serving as another set of judicial guidelines when the appropriateness of punitive damages is at issue, is the ***Model Unfair Claim Settlement Practices Act***, which has been adopted in one form or another by many states. Following are some unfair claims practices under this act:

- Failing to adopt and maintain sound criteria for the investigation and processing of claims.

- Misstating policy terms or relevant facts that affect coverage.
- Failing to provide for prompt and equitable settlement of claims when liability is relatively certain.
- Using advertising material that would lead a reasonable person to believe that a claim could be settled for one amount and then refusing to settle for such amount.
- Failing to inform the insured, upon request, under which part of a policy a claim has been paid.
- Failing or refusing to provide an explanation of the reasons relied on in a policy or under the laws for either compromising or denying a claim.
- Misrepresenting the statute of limitations.
- Delaying the investigation or payment of a claim by using multiple forms to obtain the same information relative to a claim.
- Failing to act promptly upon notification of a claim arising under a policy.
- Forcing an insured to sue to recover for a loss by offering to settle a claim for significantly less than what is ordinarily recovered in a suit for similar claims.
- Failing to deny or confirm coverage within a reasonable period of time after proof-of-loss requirements have been satisfied by an insured.
- Settling on the basis of a claim form that was altered by the insurer without permission of or notice to the insured or his or her representative.
- Using the threat of appealing awards or claims to force an insured to accept a lesser amount in settlement of a claim.
- Advising the insured not to obtain legal advice.

Since insurance policies are contracts, a wrongful denial of a claim can give rise to a breach of a contract cause of action as well. Under a breach of contract case, all a claimant has to prove is that he or she was entitled to recover. The motives or conduct on behalf of the carrier or the claimant is not at issue. If a claimant can prove a carrier issued a policy with no intention to pay claims, there may be cause for fraud. Other legal causes of action might include intentional infliction of emotional distress, malicious prosecution, negligence or conspiracy, depending on the underlying circumstances. Courts have held that under certain circumstances, an insurance company owes a special duty to an insured because the company stands in a special relationship with such party. Insurance companies must respond to settlement offers from third parties in a reasonable manner, and failing to respond to such an offer or rejecting a reasonable offer may result in liability on the part of a carrier for bad faith. Under a bad faith claim, an insured can recover damages, which could include the amount of an excessive judgment against a claimant. Some courts have held that the insurer is under a legal obligation to settle claims a claimant has against its own carrier as well or be liable for first-party bad faith claims.

Small Claims Court

If a disagreement between a carrier and a claimant cannot be resolved and involves a small amount of damages, typically no more than $5,000, a claimant may elect to pursue the matter in small claims court. Since some courts will not allow a defendant to employ a lawyer to appear on his or her behalf, an adjuster may have to represent the carrier. If nobody from the insurance company makes an appearance, a claimant will be entitled to a default judgment. Adverse judgments usually can be appealed to the next highest trial court, which will result in a new trial.

Subrogation

Under the laws of most states, an insurance company which pays an insured for a loss occasioned by a third party is entitled to be subrogated or substituted in place of the insured with respect to the insured's rights to sue such third party. By way of illustration, if a pilot swerved off a taxi way and ran into a restaurant near the end of the field, the pilot would probably be liable for any damages to the restaurant. If the owner of the restaurant filed a claim with his or her insurance carrier and the carrier paid for losses to the owner's property, the restaurant owner's carrier would be entitled to be subrogated to the restaurant owner's rights against the pilot. An insurance company cannot avoid payment by insisting that an insured must first attempt to collect directly from a third party or its insurance carrier. On the other hand, the restaurant owner could not legally collect from both his or her carrier and the pilot or the pilot's insurance carrier. If the restaurant owner waived his or her right to collect for damages from the pilot or the pilot's carrier, he or she would also be waiving the right of his or her insurer to sue the pilot. In that case, the restaurant owner would be estopped from collecting damages from his or her own carrier. Subrogation does not exist with respect to life insurance policies, since such coverage is not a contract of indemnity. Following is a typical subrogation provision found in an insurance policy:

Our Right to Recover Payment

If we make a payment under this policy, and the person to or for whom payment was made has a right to recover the damages from another, we shall be subrogated to that right. That person shall do:

- Whatever is necessary to enable us to exercise our rights.
- Nothing after loss to prejudice them.

If we make a payment under this policy and the person to or for whom payment is made recovers damages from another, that person shall:

- Hold in trust for us the proceeds of the recovery.
- Reimburse us to the extent of our payment.

SECTION 9: SUBROGATION & SALVAGE

SUBROGATION

Subrogation, in the insurance industry, is the term used to describe the right of an insurance carrier who has paid a claim as a result of an accident of loss covered under a policy, to recover from a wrongdoer for the damage caused, up to the amount paid by the insurer. In other words, the insurer is substituted for the insured for the purpose of making a claim against the third party wrongdoer to recover the money paid under the policy.

Subrogation plays a very important part in claims work. Proper handling of this phase of insurance can make the difference between a profitable and an unprofitable operation. Every dollar recovered after expenses is pure profit. Unlike the premium dollar, there are normally no commissions or other fees that must be deducted.

While the right of ***subrogation*** does not arise until after payment has been made to or for the insured by his insurance carrier, the ***claims person must be alert*** to the possibilities of subrogation from the very ***inception of the claim*** and must prepare his or her investigation accordingly. The right of subrogation may arise in law as a matter of equity or by contractual agreement. We are, of course, particularly concerned with the rights arising out of insurance policies.

Most casualty policies, where subrogation is a factor, contain a subrogation condition which reads as follows:

"In the event of any payment under this policy, the company shall be subrogated to all the insured's rights of recovery therefore against any person or organization and the insured shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The insured shall do nothing after loss to prejudice such rights."

Exactly the same condition appears in the workers' compensation policies. Many of the state insurance statutes incorporate this or similar wording in their workers' compensation laws. Where subrogation rights are asserted under the conditions of the policy, such conditions become the sole measure of the insurer's rights. The insurer is limited to the rights of the insured and only to the extent of the amount paid by the insurer.

Subrogation may apply to the following kinds of insurance policies or bonds:

- Motor Vehicle
- Workers' Compensation
- Marine and Inland Marine
- Fire
- Fidelity-Surety

The basic principle of subrogation is the same in each instance. The insurer is substituted for the insured in any right of recovery against a wrongdoer. In workers' compensation claims, subrogation rights are subject to the laws of the various states. While these may differ in their requirements for bringing actions against the wrongdoer, their purpose is uniform in

attempting to deny double recovery to the injured and in protecting whatever subrogation rights an insurer may have. The right of subrogation does not apply to life insurance or to accident and health policies unless the latter contain a specific subrogation clause, which is rare.

In all first party claims involving a third party wrongdoer, the insured has a choice of recovery, either under his or her first party policy, or against the third party wrongdoer, or his or her carrier. Recovery, however, can only be made once. Therefore, if the insured chooses to press the claim against the third party, and makes recovery without the consent of the insurer, he or she relinquishes his right to make a claim under the first party policy.

In the event that the insured recovers under the first party policy, he or she loses the right to recover against the wrongdoer to the extent of the amount paid him by the first party insurer. Accordingly, if settlement is made under a first party policy, the claims person should be certain that the insured is advised that he or she must not try to recover against the third party for the same damage. If recovery is made from the third party (or the third party carrier) after the claim has been paid under the first party policy, the first party carrier is entitled to repayment from the insured, assuming that such recovery is made without the knowledge or consent of the insurer.

On the other hand, the wrongdoing third party could remain liable to the first party insurer if he or she knew of the first party insurer's rights of subrogation at the time the latter settled the claim. It is therefore obvious that the company must notify the third party and his or her carrier of its interest in the matter as soon as possible after receiving a report of an accident. A release given by an insured ordinarily voids the right of subrogation unless a lien or some notice has been filed with the wrongdoer.

It has been held that the mere sending of a lien letter in advance of payment of a claim is not sufficient to hold the third party wrongdoer or his or her insurance carrier in double jeopardy unless the carrier with the subrogation rights notifies the wrongdoer or his carrier that payment has actually been made on the claim. The court held in that case that the plaintiff's right to subrogation did not actually arise until the claim had been paid and since the lien letter preceded any payment made, and did not give the amount of any expected payment, it was ineffective.

Accordingly, the letter notifying the wrongdoer or the carrier of subrogation rights should be followed by a notification that payment has been made including the amount of such payment. It is just as essential that the claims person keep possible subrogation involvement in mind when making a sizable property damage settlement. As we have indicated, payment of such a claim to a third party claimant where notice of subrogation rights has been received could put the company in a position of double jeopardy.

No single form can be devised to fit all situations. The following letter therefore is given as an example only.

"John J. Jones, insured under [Insurance Co.] Policy No. ____ has made claim or damage to the [automobile] caused by the negligent operation of your car resulting from the accident which occurred on [date of accident] at [place of accident]. The [Insurance Co.], because of its subrogation rights, hereby makes claim against you for the amount [state amount if known] which it has been or will be required to pay and requests prompt settlement of this claim. If, at the time of this accident, you were insured against loss arising out of claims of this kind, we suggest that you forward this letter to your insurance company without delay.

Please let us know when this has been done and send us the name and address of your insurance company. We shall appreciate it if you will let us hear from you by return mail."

Subrogation rights are not necessarily limited to first party (collision, fire, theft, etc.) or workers' compensation policies only. They may arise because of vicarious liability imposed upon a third party insured under a financial responsibility statute or in some instances because of agency. For example, if payment is made under a non-ownership policy because of the negligence of the driver-owner of the automobile, the carrier may bring an action to recover the amount paid against the driver-owner.

In subrogation actions, suits may be brought in the name of the insured or may be required to be brought in the name of the carrier, depending upon the law of the jurisdiction involved, and the nature of the action being brought. In either event, investigation should be completed as soon as possible and action to recover should be taken without too much delay after payment has been made.

Any defense which a wrongdoer could ordinarily get away with can also be asserted against the insurer in a subrogation action. The insurer does not lose its right of subrogation by waiving any of its rights of subrogation or by waiving any of its policy defenses for breach of policy conditions such as late notice or failure to cooperate. However, the wrongdoer can defend a subrogation action against the insurer on the grounds that there was no coverage in the first place or that coverage was specifically excluded.

Subrogation rights do not extend to voluntary payments made by the insurer. Payment of a claim properly covered by an insurance policy is not construed as a voluntary payment. It is merely the fulfillment of a legal or contractual obligation. If the insurer chooses to pay a claim that is not covered, with full knowledge of this fact, he thereby becomes a mere volunteer and is not entitled to subrogation rights.

An insurer may waive his right of subrogation either by express agreement or by failure to act. If an insurer pays a claim with full knowledge of a settlement that has already been made between the insured and the wrongdoer, he waives his right of subrogation. In addition, if he induces the insured to make settlement with the third party, he loses his right of subrogation. Furthermore, if an insurer unreasonably delays a settlement, knowing that the insured has financial need, he may waive his right to subrogation in the event that settlement does not take care of the complete obligation under the policy.

Loan Receipt

An action against the wrongdoer, ordinarily brought under a subrogation clause, is usually brought in the name of the insured although, in some other instances, it may be brought in the name of the insurance company. A loan receipt is sometimes obtained for the purposes of:

- Permitting the insurer to bring an action against the wrongdoers in the name of the insured where this might otherwise be contested.
- In order to enable the insurer to pay the claim promptly because third party liability has been established.
- To further protect the insurer's rights of subrogation.

After a first party claim has been paid by an insurance case recovery against the wrongdoer, it becomes a primary concern of the insurer. Since the insured cannot make double recovery,

it is obvious that his or her interest in any further action is greatly diminished, if it is not altogether extinguished. In view of the fact that the insurance company now becomes—under the laws of most states—the real party in interest, action must be prosecuted against the wrongdoer in its own name.

Judgment must be used in determining whether or not to press any subrogation rights that the company may have. If the amount involved is small and the liability doubtful, it would be patently unwise to press subrogation rights when by so doing an otherwise quiescent claim for bodily injury or extensive property damage may be activated. Even if the amount involved is substantial, it is sometimes inadvisable to press subrogation rights if this might result in a retaliatory claim for serious bodily injury on a case of doubtful liability. Any question about the advisability of asserting subrogation rights should ordinarily be discussed with the claims manager or home office before taking any definite action.

Factors Relating to Subrogation

Some factors which should be given consideration before making a final decision concerning subrogation are:

- ***The amount recoverable***—A substantial amount will warrant the expenditure of more time and effort than will a nominal amount.
- ***Expense***—The effort and expense involved in an attempt to recover should be warranted by the amount recoverable. It is not common sense to spend $20 worth of time in an effort to recover $10. This does not mean that no effort should be made to collect claims involving small amounts if this can be done through minimal efforts and without undue expense. Some effort should always be extended to make recovery by mail, telephone or personal contact when warranted. Expense factors to be considered are:
  - Cost of investigation in both time and money.
  - Legal fees.
  - Suit expenses such as reimbursement for witnesses' testimony and so forth.
- ***Insurance***—An attempt should always be made to find out whether the wrongdoing third party carries insurance and if so with what company and to what extent.
- ***Identity of the third party***—It is essential to establish the exact identity of the wrongdoer and determine whether he is an agent or an individual, co-partnership, corporation or whatever.
- ***Financial responsibility***—If the individual or his principal did not have insurance, an investigation should be made, in cases that warrant it, to determine the extent of financial responsibility of both the individual and his principal. This can be done fairly easily through one of the companies that specialize in this sort of work. There is little point in spending time and money to obtain a worthless judgment.
- ***Potential antagonisms***—The claims person should check with the insured to determine whether there will be any business repercussions if an action is brought against the wrongdoer. In some instances, the insured's right may arise out of a manufacturer-wholesaler, manufacturer-retailer, or similar relation-ship, in which the goodwill of the wrongdoer may be important to the insured in a business way. Although this should not be the determining factor in the final analysis, as far as the claims department is concerned, it is always good business practice to discuss such matters with the underwriting department so that they can have the opportunity to decide whether any possible recovery would be worth the antagonism that might be created.
- Retaliation—Give primary consideration to the possibility that prosecution of subrogation rights might provoke a retaliatory property damage or bodily injury claim.

- Liability—Even though other factors prove favorable to pressing a subrogation action, lack of liability on the part of the third party can of course defeat all other considerations. It is usually inadvisable to spend the time, effort and money to press a subrogation claim unless it is felt that the chances of success are at least 50-50 or better.

The ***right of subrogation*** arises normally through common law, but as we have previously stated, is reaffirmed in the policy provisions. Actually a subrogation receipt adds nothing to the subrogation clause already provided for in the policy. In the event that the claims person may encounter the unusual circumstances in which there is no subrogation provision in the policy, he would be wise to obtain a subrogation receipt. Such receipt may be worded as follows:

"Received from [insured] through [insurer] ____ Dollars in full satisfaction, compromise and discharge all claims for loss and expense sustained to property insured under Policy No. ____ by reason of [describe the accident] which occurred [date] and in consideration of which the undersigned hereby assigns and transfers to the said company each and all claims and demands against any person, persons, corporation or property arising from or connected with such loss or damage and the said company is subrogated in the place of and to the claims and demands of the undersigned against the said person, corporation or property in the premises to the extent of the amount above named."

"Knock for Knock Agreements"

Agreements whereby the insurer does not press subrogation rights against another insurer as a matter of reciprocity are prevalent in the British Commonwealth of Nations and are known as "Knock for Knock Agreements." Such agreements assume that in the long run, the subrogation rights which an insurer may have are equalized by the claims which might be made against it as a result of which both parties avoid the time and expense necessary to press subrogation rights against each other.

There are several kinds of "Knock for Knock Agreements" that operate in various parts of the world. Sometimes in the United States, the idea is sponsored by local claim associations of various kinds.

A claim executives' association in Wisconsin designed a subrogation agreement that would apply to insurers who had claims against each other. This agreement outlines some thirteen specific instances which illustrate applicability of subrogation rights and the percentages of recovery in each instance. The same agreement or others patterned after it were adopted by other claim organizations. The advantage of these agreements is obvious in that it not only avoids unnecessary time and expense of individual collections, but also avoids cluttering the courts with numerous property damage claims that are disposed of without the necessity of litigation.

One of the programs sponsored by the American Insurance Association is the Inter-Company Arbitration Agreement. The purposes of this agreement are to improve claims service, to afford relief to the courts and to prevent litigation of disputes between member companies as much as possible, thereby enhancing the confidence of the public in the insurance industry.

The vast majority of inter-company cases can and are quickly resolved by arbitration. These comprise, for the most part, property damage claims, usually in relatively small amounts, that

would otherwise tend to clog the court calendars unnecessarily. There is also arbitration machinery that avoids legal expense and tends to lessen misunderstandings and friction among companies in the insurance industry, in addition to other advantages previously mentioned.

Practically all motor vehicle policies today covering collision losses are written on a deductible basis. Ordinarily, an insurer has no right to represent an insured in pressing the insured's claim against the third party. As a practical matter, the deductible feature of the policy is usually the smallest part of the claim and is tied in with the subrogation claim of the insurer. The general practice is for both carriers to treat the claim as a unit and dispose of the insured's (as well as the insurer's) claims in any settlement negotiations.

Where recovery for the deductible amount has been made, the amount due to the insured is to be determined by the general practice followed in any particular locality. In some areas, legal fees involved in the recovery are apportioned. In others, the insured will receive a proportionate share in the settlement and, by agreement in some jurisdictions, the insured's deductible is paid first and the remainder kept by the insurance company. The amount involved is so small that there is no legal precedent to follow. It becomes a matter of business and public relationships in each particular area.

Ordinarily, any recoveries made by a carrier under a subrogation action would make the excess carrier whole first. Under a district court decision in New York, the court permitted first recovery by the primary insurer because the primary insurer had taken a loan receipt. The court stated that the position of the excess insurer is no better than that of the insured. The decision gave no weight to the "custom" in the insurance industry for the proceeds of a subrogation recovery to be applied first to the payment made by the excess underwriter.

SALVAGE

As a ***result of paying a claim*** under an insurance policy, the ***property*** insured may rightfully ***belong to the insurer***. Such property is commonly known as ***salvage***. Properly handled, it can be an important source of revenue for an insurance company. Despite the fact that an article may be considered a total loss for settlement purposes, more often than not, the damaged article has some monetary value. It sometimes takes a little ingenuity to find a market for some articles, but it can ordinarily be done with the use of a little imagination and effort.

Salvage is a matter to be considered not only in the disposition of first party claims but in the settlement of third party claims as well. The claims person will often find that a claimant may be willing to settle a claim for a lesser amount if permitted to keep the article that the company is paying for. In such an event, it is usually more practical and economical to permit the claimant to retain the salvage if adequate deduction is being made for the value of the property in its damaged condition. Automobile salvage is a highly specialized field in which there is usually some buyer available whether the market be high or low at the time. It must become part of a claim person's routine to become acquainted with dealers in wrecked cars so that he or she can always obtain a number of competitive bids on automobile salvage.

If the salvage involves a large object like an automobile, make sure that it is protected from weather damage as well as from theft. It is, of course, important that the claims person arranges for economical storage until such time as he can dispose of the article so that the eventual amount recovered will at least be more than the storage charges. For this reason, it

is also advisable to dispose of salvage as soon as possible after having carefully explored the available market.

CONTRIBUTION

Although the subject of contribution does not properly belong in the category of subrogation or salvage, proper attention to it can be an important item of possible financial gain to a company. This is reason enough to make some mention of it here. The good claims person should always be conscious of the possibility that someone else's responsibility for the payment of a loss may be equal to his company's or even greater than it. In many instances, the automobile and public liability policies may overlap—the claims person must be awake to the possibility of such a situation. For example, an insured's automobile may have been involved in an accident while on the premises of the insured.

Ordinarily (excluding the operation of guest statutes), a passenger involved in a two-vehicle accident has a right of action against the owner and driver of the car in which he was a passenger as well as the owner and driver of the opposing car. Sometimes two cars will collide and injure a pedestrian or damage property belonging to someone else. Occasionally, there will be two similar policies covering the same insured. There may be other instances, as well as these mentioned, in which it is advisable to check the possibility of contribution. This should be prominent in the thinking of the claims person during the investigation of any casualty claim.

SECTION 10:
FAIR PRACTICE LAW

PURPOSE OF FAIR CLAIMS LEGISLATION

The insurance industry is heavily regulated. The basic thrust and ***purpose*** of all such regulation is to maintain the solvency of insurers. A second goal is to promote the equitable, moral and legal interests of policyholders. This applies to both purchasing insurance, the settlement claims and policy rescissions. This portion of the course deals specifically with the fair handling of claims in California. However, there are certain reasons that claims legislation is enacted regardless of origin. They are:

Misrepresentation Issues

Under most Unfair Claims Settlement Practices Acts, an insurance company may not *knowingly* misrepresent material facts or relevant policy provisions in connection with a claim. It may not attempt to enforce policy provisions that were altered by the company without notice to a policyholder without knowledge or consent.

Undue Influence

Where fair claims legislation is enact, a company may not drag out the settlement of a claim under one portion of a policy where liability and the amount of the loss are reasonably clear, so as to influence settlements under a different portion of a policy. For example, auto insurer can't refuse to pay bills under the medical coverage in a policy so that the policyholder will settle an uninsured motorist claim.

Acknowledging Claims

An insurance company must acknowledge and act promptly in response to a communication about a policyholder's claim, i.e., the insurance company must respond within a certain time frame, such as 15 days.

Prompt Claims Processing

Insurers must implement standards for promptly investigating and processing claims. Otherwise, an unethical insurance company could endlessly stonewall by saying it is still investigating a claim.

Control Delays

An insurer may not delay an investigation or payment of claims by requiring unnecessary or repetitive reports and proof-of-loss forms.

Satisfaction Without Lawsuits

A company may not force a policyholder to go to court in order to recover amounts due under an insurance policy by offering substantially less than the money ultimately recovered. Otherwise, an insurance company with lots of lawyers on the payroll could just say, "Sue us!"

and make claimants go to court. Obviously, that would discourage many individuals with small claims.

Lack of Appeal

An insurance company ***may not exploit the legal system*** by appealing almost all of the arbitration awards in favor of policyholders as a way to ***force a settlement*** or compromise of claims. The insurance company is allowed to appeal, but appeals can't be a standard business practice aimed at forcing policyholder's to take less than they're owed on a claim.

Unreasonable Delays

An insurance company may not refuse to pay claims or delay payment without a valid reason. It must promptly provide a reasonable explanation why a claim was denied or why a compromise settlement was offered. The insurer is required to make a good faith attempt to process a prompt, fair, and equitable settlement of claims in which liability is reasonably clear.

NON-COMPLIANCE

Market Conduct & Claims

The claims end of insurance is probably one of the industry's biggest market conduct issues. Claim infractions subject insurers to frequent criticisms, with issues ranging from timely claim-handling issues to the remitting of the proper amount to the claimant. Providing required reasons for claim denials and specific notices, such as the bill of rights in an automobile claims process, also appear to be problematic for insurers. Apart from these timeframe and complete claim issues, insurers are also frequently cited for using unlicensed claim adjusters or appraisers.

Claims compliance violations result in internal resources being used to deal with examiner inquiries and corrective action plans, not to mention the direct out-of-pocket cost of assessed fines and per diem examiner fees.

Repercussions for noncompliance include potentially significant monetary fines and restitution orders designed to make claimants whole, with accompanying negative publicity when the repercussions are made public. Additionally, noncompliance findings during the exam can result in extended periods of time for the examiners to be on-site, resulting in higher overall exam costs, and increasing the probability of more frequent re-exams to determine if corrective actions were implemented.

California market conduct examiners will cite insurer violations in a manner such as this: "In 65 instances, the company failed to provide the insured with the Auto Body Repair Bill of Rights, either at the time of application for automobile insurance, at the time a policy was issued, or following an accident. Specifically, in 40 of these instances, the Auto Body Repair Bill of Rights was not sent. In 15 instances, the Company sent an Auto Body Repair Bill of Rights letter containing incorrect language. The Department alleges these acts are in violation of CCR §2695.85."

Some companies are more sensitive to these market conduct "black eyes" than others. It's bad for business. For these companies, adjusters probably do a little better job of evaluating the entire claim as opposed to just punching the information into the computer to see what

spits out. And, their in-house attorneys may be a tad more reasonable in settling, especially where a bad faith action is at stake.

Non-Compliance With Fair Practice Law

The California case of ***Moradi-Shalal v. Firemen's Fund*** (1988) virtually eliminated private lawsuits for violations of the fair practices act, overruling the ***Royal Globe Insurance vs Superior Court*** (1979). Thus, the enforcement of insurance codes has been with the insurance commissioner leading to legislation such as the present Fair Claims Practices.

In the ensuing years, insureds have attempted to circumvent the *Moradi-Shalal* ruling by bringing actions for unfair business practices. Another approach has been to pursue a common law bad faith claim based on evidence of violations of the Insurance Code and the Commissioner's regulations.

Jordan vs Allstate (2007) may change this. A precedent may have again been set whereby insureds may once again be able to collect on bad faith issues resulting in large punitive damages. In this case, the insured presented testimony from an expert on insurance industry claims settlement practices. The expert opined that Allstate's conduct violated provisions of Section 790.03(h). Among the alleged "violations" were ***failing to disclose all insurance policy benefits, failing to have a copy of the Commissioner's Regulations in the insurer's claim manual, and failing to provide the claimant with a statement listing all of the grounds for the denial of the claim***.

The trial court in the *Jordan* case ruled that the expert testimony was relevant and admissible. The Court of Appeal agreed. It held that the insured was not "seeking to recover on a claim based on a violation" of Section 790.03(h). Rather, the Court stated, "her claim was based on a claim of common law bad faith arising from Allstate's breach and the implied covenant of good faith and fair dealing, which she is entitled to pursue." The Court affirmed that it was proper for the insured to use the expert opinion as evidence to support the bad faith claim. The Court held that, "this is a *proper* use of evidence of an insurer's violations of the statute and the corresponding regulations."

The *Jordan* case raises a practical question: Is a claim based on evidence of violations of the statute and the regulations materially different from the old *Royal Globe* cause of action? Particularly in a jury trial, evidence of violations of the Fair Claims Handling Practices regulations can have a dramatic impact. Whereas the point of the *Moradi-Shalal* decision was to leave enforcement of the regulations to the Insurance Commissioner, not the courts, the Jordan decision arguably puts that enforcement back in the hands of a judge or jury.

For insurers, the *Jordan* decision highlights the importance of making a continuous effort to comply with claims regulations. Most of the regulations address matters that insurers would already follow as part of their regular practices. Yet, when placed in evidence in the trial of a bad faith case, an otherwise innocuous violation of a regulation may be the deciding factor in the outcome of the case. The admission of "expert" testimony to a jury about how the insurer does not "follow the rules" could be the difference between a defense verdict and a finding of bad faith.

FAIR CLAIMS TIME LINE RULES

A large part of claims compliance is following mandated timelines. Following is a chart to help claims professionals understand the timelines under the California Fair Claims Settlement Law.

TIME LIMIT	ACTION REQUIRED	CODE
Within 15 calendar days or sooner after receiving a notice of claim or legal action	Acknowledge receipt of the claim (unless paid) and begin any necessary investigations. Provide reasonable assistance and forms. Specify information claimant must provide for proof of claim.	2695.5
Within 15 calendar days or sooner of any client communication where a response is required	Reply to claimant (unless the claim is a notice of legal action).	2695.5
Within 21 calendar days or sooner of receipt of inquiry regarding a claim from the Dept of Insurance	Furnish DOI with a written response	2695.5
Every 30 days after a 30-day extension	Notify claimant of insurer's inability (if any) to make a determination regarding acceptance or settlement.	2695.7
Within 30 days or sooner after settlement and provision of release	Insurer must tender settlement payment after affirmation of coverage	2695.7
Within 40 calendar days or sooner after receipt of a proof of claim	Accept or reject the claim, in whole or in part and affirm or deny liability unless fraud is involved.	2695.5
At least 60 days before expiration of the statute of limitations applicable to the claim	Insurer must notify the claimant of the expiration of the statute of limitations in writing.	2695.7
Annually, before Sept 1	Certify under penalty of perjury that all adjusters have read and understand fair claims regs, keep a copy in the adjuster claims manual and have clear instructions on procedures for compliance.	2695.6

INSURER COMPLIANCE

Insurers are routinely examined by the California Department of Insurance to test compliance with their claims practices and procedures, including conformance with the Fair Claims Settlement Practices Act. Market conduct violations are often discovered and corrective action required to remedy any infractions. Following are actual cases where companies were found to be non-compliant and the procedures they enacted to comply with the law. The hope is this will be instructive to adjusters and others needing to better understand the law and the importance the Department of Insurance places on compliance.

1. A Company failed to properly document claim files. Specifically, a company failed to maintain claim data that was accessible, legible and retrievable for examination . . . a violation of CCR §2695.3(a).

Summary of Company Response: The Company acknowledges that it failed to document within the claim file that a policyholder was being provided an auto body repair bill of rights document. The Company states that the proper mailing of the consumer bill of rights document had been a clerical duty, but has modified its procedure such that the file examiner will mail the vehicle owner a copy of the auto body bill of rights with a notation placed within the claim file. The Company has submitted documentation to evidence this procedural modification for the Department's records.

2. A Company failed to advise the claimant that he or she may have the claim denial reviewed by the California Department of Insurance. The Company failed to include a statement in their claim denial that should the claimant believe that the claim had been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance. This is a violation of CCR §2695.7(b)(3).

Summary of Company Response: The Company acknowledges that all denials of coverage and/or benefits to policyholders and/or claimants must reference the California Department of Insurance, its address and telephone number. The Company modified its general form and specific denial correspondence to include the California Department of Insurance reference, its address and telephone number to comply with the subject regulation. The Department reviewed this modified form to ensure compliance. Additionally, the modified procedure and forms have been added to the Company's training manual.

3. A Company failed to include, in the settlement, all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the comparable automobile. The Company failed to include in the settlement, all applicable taxes, license fees and any other fees incident to transfer of evidence of ownership of the comparable automobile. The Department alleges these acts to be in violation of CCR §2695.8(b)(1).

Summary of Company Response: The Company acknowledges that a new total loss notification procedure was needed to communicate all itemized deductions to policyholders and claimants. The Company implemented the following corrective procedures:

A. In the event of a determined total loss, a modified form will be sent to the insured regarding the return of, if appropriate, vehicle license fees or VLF fees. The name of the owner of the vehicle will be shown as the party to whom the return should be directed. When the signed form is received from the owner, it will be sent to the DMV for them to return any monies due. A copy of the signed form will be placed in the claim file. Language confirming this procedure shall be included in the form correspondence to the vehicle owner. The Department reviewed this form for accuracy and to ensure that it is in compliance with the subject regulation.

B. Following this examination, the Company commenced a file by file review of all prior total loss settlements. On those files where the transfer or tag fee was allowed at $10.00, as opposed to $15.00, the difference has been returned to the vehicle owner. Any other variances inuring to the benefit of the vehicle owner have also been returned. Further, on any files not showing a VLF request form, the forms are being filled out and sent to the DMV for reimbursement. The accurate payment of sales tax had been reviewed and corrected prior to this examination by Company to ensure that sales tax was not paid

twice and that the proper tax rate was utilized. Accordingly, Company is paying sales tax at 8.5% on all vehicular total losses. The Department reviewed the aforementioned forms for accuracy and to ensure that each is in compliance with the subject regulation.

4. A Company failed to provide a written basis for the denial of the claim. Here, the Company failed to provide a written basis for the denial of the claim. The Department alleges these acts to be in violation of CCR §2695.7(b)(1).

Summary of Company Response: The Company acknowledges that it failed to state, in writing, a factual basis for the denial. The Company has developed and implemented a modified form to be utilized by staff for all denials of coverage and/or benefits to policyholders and/or claimants. Further, the staff is being trained to provide a denial communication, in writing, which offers a clear and concise basis for the denial. In cases where specific policy language is applicable, a copy of the policy evidencing the subject language will be included in the denial.

5. A Company failed to begin investigation of the claim within fifteen calendar days.
A Company failed to begin investigation of the claim within fifteen calendar days. The Department alleges these acts to be in violation of CCR §2695.5(e)(3).

Summary of Company Response: The Company acknowledges that it failed to begin investigation in a timely manner. In an effort to ensure that its staff is more familiar with California regulations, the Company began a California specific training seminar in2002 for its claims staff. All participating staff received California Fair Claims Settlement Practices Certification. Moreover, during the first quarter of 2003, the Company has hired new supervisors and examiners in addition to a new Senior Vice President of Claims. The Company has also established a new Special Investigations Unit (SIU). Finally, a copy of the California Fair Claims Settlement Practices document has been given to each examiner for their reference when handling a California claim.

6. A Company failed to provide necessary forms, instructions and reasonable assistance within fifteen calendar days. The Company failed to provide the necessary forms, instructions and reasonable assistance within fifteen calendar days. The Department alleges these acts to be in violation of CCR §2695.5(e)(2).

Summary of Company Response: The Company acknowledges that it failed to provide the necessary forms, instruction and reasonable assistance to the claimant within a timely manner. In an effort to ensure that its staff is more familiar with California regulations, the Company began a California specific training seminar for its claims staff. All participating staff received California Fair Claims Settlement Practices Certification. Moreover, the Company hired new supervisors and examiners in addition to a new Senior Vice President of Claims. The Company has also established a new Special Investigations Unit (SIU). Finally, a copy of the California unfair claim practices document has been given to each examiner for their reference when handling a California claim.

7. A Company failed to acknowledge notice of claim within fifteen calendar days.
The Company failed to acknowledge notice of claim within fifteen calendar days. The Department alleges these acts to be in violation of CCR §2695.5(e)(1).

Summary of Company Response: The Company acknowledges that it failed to acknowledge notice of claim within a timely manner. In an effort to ensure that its staff is more familiar with California regulations, the Company began a California specific training

seminar for its claims staff. All participating staff received California Fair Claims Settlement Practices Certification. Moreover, the Company has hired new supervisors and examiners in addition to a new Senior Vice President of Claims. The Company has also established a new Special Investigations Unit (SIU). Finally, a copy of the California Fair Claims Settlement Practices document has been given to each examiner for their reference when handling a California claim.

8. A Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims. The Company failed to issue notices or issue notices timely or issue notices that included all required benefit information. The Company failed to adhere to standard of prompt investigation and processing of claims. The Department alleges these acts to be in violation of CIC. §790.03(h)(3).

Summary of Company Response: The Company acknowledges that in the above-cited matters its investigation, processing and/or payment of an insured's claim was severely delinquent. Training and seminar sessions now include a greater emphasis on prompt investigations, processing and payments of claims. Regular file reviews by management is also designed to ensure claim handling quality and compliance.

9. A Company failed to accept or deny the claim within forty calendar days. The Company failed upon receiving proof of claim, to accept or deny the claim within forty calendar days. The Department alleges these acts to be in violation of CCR §2695.7(b).

Summary of Company Response: The Company acknowledges that it failed upon receipt of proof of claim to accept or deny the claim within forty calendar days. In an effort to ensure that its staff is more familiar with California regulations, the Company began a California specific training seminar for its claims staff. All participating staff received California Fair Claims Settlement Practices Certification. Moreover, the Company has hired new supervisors and examiners in addition to a new Senior Vice President of Claims. The Company has also established a new Special Investigations Unit (SIU). Finally, a copy of the California Fair Claims Settlement Practices document has been given to each examiner for their reference when handling a California claim.

10. A Company failed to provide written notice of the need for additional time ever thirty calendar days. The Company failed to provide written notice of the need for additional time every thirty-calendar days. The Department alleges these acts to be in violation of CCR §2695.7(c)(1).

Summary of Company Response: The Company acknowledges that it failed to provide written notice to the claimant to request additional time to evaluate the matter. In an effort to ensurethat its staff is more familiar with California regulations, the Company began a California specific training seminar for its claims staff. All participating staff received California Fair Claims Settlement Practices Certification. Moreover,during the first quarter of 2003, the Company has hired new supervisors and examiners in addition to a new Senior Vice President of Claims. The Company has also established a new Special Investigations Unit (SIU). Finally, a copy of the California Fair Claims Settlement Practices document has been given to each examiner for their reference when handling a California claim.

11. A Company required the use of non-original equipment manufacture replacement crash parts. The Company required the use of non-original equipment manufacture replacement crash parts. The Department alleges these acts to be in violation of CCR §2695.8(g)(3).

Summary of Company Response: The Company acknowledges that it failed to warrant that non-original equipment manufacturer replacement crash parts were of like, kind, quality, safety, fit, and performance as original replacement crash parts. In an effort to ensure that its staff is in compliance with the subject regulation, it has forwarded correspondence to all licensed California independent appraisers who are currently being employed by the Company.
The subject correspondence mandates that all of the appraiser's estimate forms must list all part variances as required by the subject regulation. The Department has reviewed the Company's offered correspondence for accuracy and compliance with the subject regulation.

12. A Company persisted in seeking unnecessary information. The Company persisted in seeking information not reasonably required for or material to the resolution of a claim dispute. The Department alleges these acts to be in violation of CCR §2695.7(d).

Summary of Company Response: The Company acknowledges that it failed to request additional time, in writing, from the subject claimants to evaluate the matter. In an effort to ensure that its staff is more familiar with California regulations, the Company began a California specific training seminar for its claims staff. All participating staff received California Fair Claims Settlement Practices Certification. Moreover, the Company has hired new supervisors and examiners in addition to a new Senior Vice President of Claims. The Company has also established a new Special Investigations Unit (SIU). Finally, a copy of the California Fair Claims Settlement Practices document has been given to each examiner for their reference when handling a California claim.

13. A Company failed to document the determination of value. The Company failed to document the determination of value. Any deductions from value, including deductions for salvage, must be discernible, measurable itemized, and specified as well as be appropriate in dollar amount. The Department alleges these acts to be in violation of CCR §2695.8(b)(1)(C).

Summary of Company Response: The Company acknowledges that a new total loss notification procedure was needed to communicate all itemized deductions to policyholders and claimants. The Company has implemented the following corrective procedures:

A. In the event of a determined total loss, a modified form will be sent to the insured regarding the return of, if appropriate, vehicle license fees or VLF fees. The name of the owner of the vehicle will be shown as the party to whom the return should be directed. When the signed form is received from the owner, it will be sent to the DMV for them to return any monies due. A copy of the signed form will be placed in the claim file. Language confirming this procedure shall be included in the form correspondence to the vehicle owner. The Department has reviewed this form for accuracy and to ensure that it is in compliance with the subject regulation.

B. Following this examination, the Company commenced a file by file review of all prior total loss settlements. On those files where the transfer or tag fee was allowed at $10.00, as opposed to $15.00, the difference has been returned to the vehicle owner. Any other variances inuring to the benefit of the vehicle owner have also been returned. Further, on any files not showing a VLF request form, those forms are being filled out and sent to the DMV for reimbursement. The accurate payment of sales tax had been reviewed and corrected prior to this examination by the Company to ensure that sales tax was not paid twice and that the proper tax rate was utilized. Accordingly, the Company is 10 paying sales tax at 8.5% on

all vehicular total losses. The Department has reviewed the aforementioned forms for accuracy and to ensure that it is in compliance with the subject regulation.

14. Upon acceptance of the claim the Company failed to tender payment within thirty calendar days. Upon acceptance of the claim the Company failed to tender payment within thirty calendar days. The Department alleges these acts to be in violation of CCR §2695.7(h).

Summary of Company Response: The Company acknowledges that it failed to tender payment to the claimant within thirty calendar days upon acceptance of the claim. In an effort to ensure that its staff is more familiar with California regulations, the Company began a California specific training seminar in November 2002 for its Georgia claims staff. All participating staff received California Fair Claims Settlement Practices Certification. Moreover, the Company has hired new supervisors and examiners in addition to a new Senior Vice President of Claims. The Company has also established a new Special Investigations Unit (SIU). Finally, a copy of the California Fair Claims Settlement Practices document has been given to each examiner for their reference when handling a California claim.

15. A Company failed to respond to communications within fifteen calendar days. The Company failed to respond to communications within fifteen calendar days. The Department alleges these acts to be in violation of CCR §2695.5(b).

Summary of Company Response: The Company acknowledges that it failed to respond to communications from the claimant within fifteen calendar days. In an effort to ensure that its staff is more familiar with California regulations, the Company began a California specific training seminar for its claims staff. All participating staff received California Fair Claims Settlement Practices Certification. Moreover, the Company has hired new supervisors and examiners in addition to a new Senior Vice President of Claims. The Company has also established a new Special Investigations Unit (SIU). Finally, a copy of the California Fair Claims Settlement Practices document has been given to each examiner for their reference when handling a California claim.

16. A Company failed to provide written notification to first party claimant as to whether the insurer intends to pursue subrogation. The Company failed to provide written notification to a first party claimant as to whether the insurer intends to pursue subrogation of the claim. The Department alleges these acts to be in violation of CCR §2695.8(i).

Summary of Company Response: The Company acknowledges that it failed to provide written notification to a first party claimant that it would pursue the subrogation of the subject claim. In an effort to ensure that its staff is more familiar with California regulations, the Company began a California specific training seminar for its claims staff. All participating staff received California Fair Claims Settlement Practices Certification. The Company also hired new supervisors and examiners in addition to a new Senior Vice President of Claims. The Company has also established a new Special Investigations Unit (SIU). Finally, a copy of the California Fair Claims Settlement Practices document has been given to each examiner for their reference when handling a California claim.

17. A Company attempted to settle a claim by making a settlement offer that was unreasonably low. The Company attempted to settle a claim by making settlement offer that was unreasonably low. The Department alleges this act to be in violation of CCR §2695.7(g).

Summary of Company Response: The Company acknowledges that it attempted to effectuate an unreasonably low settlement based on unsubstantiated deductions, which have been reimbursed to the insured. In an effort to ensure that its staff is more familiar with California regulations, the Company began a California specific training seminar in November 2002 for its claims staff. All participating staff received California Fair Claims Settlement Practices Certification. Finally, a copy of the California Fair Claims Settlement Practices document has been given to each examiner for their reference when handling a California claim.

Note: To meet the DOI required Annual Fair Claims Certification you must read and understand the rules below, keep a copy of these rules, with claims procedures from your carrier, in your adjuster manual. Part of our certification process involves answering specific questions (using the exam that came with this course) correctly.

CALIFORNIA FAIR CLAIMS SETTLEMENT

CALIFORNIA CODE OF REGULATIONS, TITLE 10. CHAPTER 5
FAIR CLAIMS SETTLEMENT PRACTICES REGULATIONS

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Section 2695.1. Preamble

(a) Section 790.03(h) of the California Insurance Code enumerates sixteen claims settlement practices that, when either knowingly committed on a single occasion, or performed with such frequency as to indicate a general business practice, are considered to be unfair claims settlement practices and are, thus, prohibited by this section of the California Insurance Code. The Insurance Commissioner has promulgated these regulations in order to accomplish the following objectives:

(1) To delineate certain minimum standards for the settlement of claims which, when violated knowingly on a single occasion or performed with such frequency as to indicate a general business practice shall constitute an unfair claims settlement practice within the meaning of Insurance Code Section 790.03(h);

(2) To promote the good faith, prompt, efficient and equitable settlement of claims on a cost effective basis;

(3) To discourage and monitor the presentation to insurers of false or fraudulent claims; and,

(4) To encourage the prompt and thorough investigation of suspected fraudulent claims and ensure the prompt and comprehensive reporting of suspected fraudulent claims as required by Insurance Code Section 1872.4.

(b) These regulations are not meant to provide the exclusive definition of all unfair claims settlement practices**.** Other methods, act(s), or practices not specifically delineated in this set of regulations may also be unfair claims settlement practices and subject to California Insurance Code Section 790.03(h) and/or California Insurance Code Section 790.06. These regulations are applicable to the handling or settlement of all claims subject to Article 6.5 of Division 1, Part 2, Chapter 1 of the California Insurance Code, commencing with Section 790**,** except as specifically provided below:

(1) Workers' compensation insurance;

(2) Liability insurance for the professional malpractice of health care providers as defined in California Code of Civil Procedure Section 364(f)(1);

(3) Self insured or self funded plans which are bona fide Employee Retirement Income Security Act ("ERISA") plans which are not also multiple employer welfare arrangements, to the extent that these ERISA plans are not covered by insurance;

(4) Any other self funded or self insured plan, to the extent it is not covered by insurance, which is lawfully conducting business in this state.

(c) In recognition of both the unique relationship which exists under a surety bond between the surety, the obligee or beneficiary, and the principal, and the fact that the processing of surety claims is subject to the Unfair Practices Act, beginning with California Insurance Code Section 790, only sections 2695.1 through 2695.6, inclusive, section 2695.10, and sections 2695.12, 2695.13 and 2695.14, inclusive, shall apply to the handling or settlement of claims brought under surety bonds**.**

(d) These regulations apply to home protection contracts and home protection companies defined in California Insurance Code Section 12740.

(e) All licensees, as defined in these regulations, shall have thorough knowledge of the regulations contained in this subchapter.

(f) Policy provisions relating to the investigation, processing and settlement of claims shall be consistent with or more favorable to the insured than the provisions of these regulations**.**

(g) The California Insurance Code provides the commissioner with access to all records of an insurer and the power to examine the affairs of every person engaged in the business of insurance to determine if such person is engaged in any unfair or deceptive act or practice. California Insurance Code Section 790.03(h) requires all persons engaged in the business of insurance to effectuate prompt, fair and equitable settlements of claims and to otherwise process claims in a fair and reasonable manner.

The Department considers the use of reliable information to be an essential element of the fair and equitable settlement of claims. The fact that information, data or statistical methods used or relied upon by a licensee to process or establish the value of insurance claims is obtained through a third party source shall not absolve the licensee of its legal

responsibility to comply with these regulations or to effectuate prompt, fair and equitable settlements of claims. Failure of a licensee to provide the commissioner with requested information sufficient to examine the licensee's claims handling practices may justify a finding that the licensee was in non-compliance with these regulations or other applicable insurance code provisions. Any and all information received pursuant to the Department's request shall be given confidential treatment, as provided in California Insurance Code section 735.5 and California Government Code Section 11180 et seq. When processing or establishing the value of a claim, a licensee shall not be responsible for the accuracy of information provided by a governmental entity, unless the licensee has discovered or been notified of the inaccuracy and has continued to use the information.

NOTE: Authority cited: Sections 790.034, 790.10, 1871.1, 12340 - 12417, inclusive, 12921 and 12926 of the California Insurance Code and Sections 11342.2 and 11152 of the California Government Code. Reference: Sections 790.03, 790.04, 735.5 and 12740 of the California Insurance Code, and Section 11180 et seq. of the California Government Code.

Section 2695.2. Definitions

As used in these regulations:

(a) "Beneficiary" means:

(1) for the purpose of life and disability claims, the party or parties entitled to receive the proceeds or benefits occurring under the policy in lieu of the insurer
or,

(2) for the purpose of surety claims, a person who is within the class of persons intended to benefit from the bond;

(b) "Calendar days" means each and every day including Saturdays, Sundays, Federal and California State Holidays, but if the last day for performance of any act required by these regulations falls on a Saturday, Sunday, Federal or State Holiday, then the period of time to perform the act is extended to and including the next calendar day which is not a Saturday, Sunday, or Federal or State holiday;

(c) "Claimant" means a first or third party claimant as defined in these regulations, any person who asserts a right of recovery under a surety bond, an attorney, any person authorized by operation of law to represent the claimant, or any of the following persons properly designated by the claimant in the manner specified in subsection 2695.5(c): an insurance adjuster, a public adjuster, or any member of the claimant's family.

(d) "***Claims agent***" means any person employed or authorized by an insurer, to conduct an investigation of a claim on behalf of an insurer or a person who is licensed by the Commissioner to conduct investigations of claims on behalf of an insurer. The term "claims agent", however, shall not include the following:

1) an attorney retained by an insurer to defend a claim brought against an insured; or,

2) persons hired by an insurer solely to provide valuation as to the subject matter of a claim.

(e) "Extraordinary circumstances" means circumstances outside of the control of the licensee which severely and materially affect the licensee's ability to conduct normal business operations;

(f) "***First party claimant***" means any person asserting a right under an insurance policy as a named insured, other insured or beneficiary under the terms of that insurance policy, and including any person seeking recovery of uninsured motorist benefits;

(g) "***Gross settlement amount***" means the amount tendered plus the amount deducted as provided in the policy in the settlement of an automobile total loss claim;

(h) "Insurance agent" means:

(1) the term "insurance agent" as used in section 31 of the California Insurance Code; or,

(2) the term "life agent" as used in section 32 of the California Insurance Code; or,

(3) any person who has authority or responsibility to notify an insurer of a claim upon receipt of a notice of claim by a claimant; or,

(4) an underwritten title company.

(i) "Insurer" means a person licensed to issue or that issues an insurance policy or surety bond in this state, or that otherwise transacts the business of insurance in the state, including reciprocal and interinsurance exchanges, fraternal benefit societies, stock and mutual insurance companies, risk retention groups, California county mutual fire insurance companies, grants and annuities societies, entities holding certificates of exemption, non-profit hospital service plans, multiple employer welfare arrangements holding certificates of compliance pursuant to Article
4.7 of the California Insurance Code, and motor clubs, to the extent that they transact the business of insurance in the State. The term **"**insurer" for purposes of these regulations includes non-admitted insurers, the California FAIR Plan, the California Earthquake Authority, those persons licensed to issue or that issue an insurance policy pursuant to an assignment by the California Automobile Assigned Risk Plan, home protection companies as defined under California Insurance Code Section 12740, and any other entity subject to California Insurance Code Section 790.03(h). The term "insurer" shall not include insurance agents and brokers, surplus line brokers and special lines surplus line brokers.

(j) "Insurance policy" or "policy" means the written instrument in which any certificate of group insurance, contract of insurance, or non-profit hospital service plan is set forth. For the purposes of these regulations the terms insurance policy or policy do not include "surety bond" or "bond".

For the purposes of these regulations the term insurance policy or policy includes a home protection contract or any written instrument in which any certificate of insurance or contract of insurance is set forth that is issued pursuant to the California Automobile Assigned Risk Plan, the California Earthquake Authority, or the California FAIR Plan;

(k) "Investigation" means all activities of an insurer or its claims agent related to the determination of coverage, liabilities, or nature and extent of loss or damage for which

benefits are afforded by an insurance policy, obligations or duties under a bond, and other obligations or duties arising from an insurance policy or bond.

(l) "***Knowingly committed***" means performed with actual, implied or constructive knowledge, including, but not limited to, that which is implied by operation of law.

(m) "Licensee" means any person that holds a license or Certificate of Authority from the Insurance Commissioner, or any other entity for whom the Insurance Commissioner's consent is required before transacting business in the State of California or with California residents. The term "licensee" for purpose of these regulations does not include an underwritten title company if the underwriting agreement between the underwritten title company and the title insurer affirmatively states that the underwritten title company is not authorized to handle policy claims on behalf of the title insurer.

(n) "***Notice of claim***" means any written or oral notification to an insurer or its agent that reasonably apprises the insurer that the claimant wishes to make a claim against a policy or bond issued by the insurer and that a condition giving rise to the insurer's obligations under that policy or bond may have arisen. For purposes of these regulations the term "notice of claim" shall not include any written or oral communication provided by an insured or principal solely for informational or incident reporting purposes.

(o) "Notice of legal action" means notice of an action commenced against the insurer with respect to a claim, or notice of action against the insured received by the insurer, or notice of action against the principal under a bond, and includes any arbitration proceeding;

(p) "Obligee" means the person named as obligee in a bond;

(q) "Person" means any individual, association, organization, partnership, business, trust, corporation or other entity;

(r) "Principal" means the person whose debt or other obligation is secured or guaranteed by a bond and who has the primary duty to pay the debt or discharge the obligation;

(s) "***Proof of claim***" means any evidence or documentation in the possession of the insurer, whether as a result of its having been submitted by the claimant or obtained by the insurer in the course of its investigation, that provides any evidence of the claim and that reasonably supports the magnitude or the amount of the claimed loss.

(t) "***Remedial measures***" means those actions taken by an insurer to correct or cure any error or omission in the handling of claims on the part of its insurance agent as defined in subsection 2695.2(h), including, but not limited to:

(1) written notice to the insurance agent that he/she is in violation of the regulations contained in this subchapter;

(2) transmission of a copy of the regulations contained in this subchapter and instructions for their implementation;

(3) reporting the error or omission in the handling of claims by the insurance agent to the Department of Insurance;

(u) "***Replacement crash part***" means a replacement for any of the nonmechanical sheet metal or plastic parts which generally constitute the exterior of a motor vehicle, including inner and outer panels;

(v) "Single act" for the purpose of determining any penalty pursuant to California Insurance Code Section 790.035 is any commission or omission which in and of itself constitutes a violation of California Insurance Code Section 790.03 or this subchapter;

(w) "Surety bond" or "bond" means the written instrument in which a contract of surety insurance, as defined in California Insurance Code Section 105, is set forth;

(x) "***Third party claimant***" means any person asserting a claim against any person or the interests insured under an insurance policy;

(y) "Willful" or "Willfully" when applied to the intent with which an act is done or omitted means simply a purpose or willingness to commit the act, or make the omission referred to in the California Insurance Code or this subchapter. It does not require any intent to violate law, or to injure another, or to acquire any advantage;

NOTE: Authority cited: Sections 132(d), 790.10, 12340 - 12417, inclusive, 12921 and 12926 of the California Insurance Code**,** Section 995.130 of the Code of Civil Procedure and Sections 11342.2 and 11152 of the California Government Code. Reference: Sections 31, 32, 101, 106, 675.5(b), (c) and (d), 676.6, 790.03(h) and 10082 of the California Insurance Code.

Section 2695.3. File and Record Documentation

(a) Every licensee's claim files shall be subject to examination by the Commissioner or by his or her duly appointed designees. These files ***shall contain all documents***, notes and work papers (including copies of all correspondence) ***which reasonably pertain to each claim*** in such detail that pertinent events and the dates of the events can be ***reconstructed*** and the licensee's actions pertaining to the claim can be determined;

(b) To assist in such examination all insurers shall:

(1) ***maintain claim data*** that are accessible, legible and retrievable for examination so that an insurer shall be able to provide the claim number, line of coverage, date of loss and date of payment of the claim, date of acceptance, denial or date closed without payment**.** This data must be available for all open and closed files for the current year and the four preceding years**;**

(2) ***record in the file the date*** the licensee received, date(s) the licensee processed and date the licensee transmitted or mailed every material and relevant document in the file; and

(3) ***maintain hard copy files*** or maintain claim files that are accessible, legible and capable of duplication to hard copy; files shall be maintained for the current year and the preceding four years.

(c) The requirements of this section shall be satisfied where the licensee provides documentation evidencing inability to obtain data, nonexistence of data, or difficulty in obtaining clear documentary support for actions due to catastrophic losses, or other unusual

circumstances providing the licensee establishes to the satisfaction of the Commissioner that the circumstances alleged by the licensee do exist and have materially affected the licensee's ability to comply with this regulation. Any licensee that alleges an inability to comply with this section shall establish and submit to the Commissioner a plan for file and record documentation to be used by such licensee while the circumstances alleged to preclude compliance with this subsection continue to exist.

NOTE: Authority cited: Sections 790.04, 790.10, 12340 - 12417, inclusive, 12921 and 12926 of the California Insurance Code and Sections 11342.2 and 11152 of the California Government Code. Reference: Section 790.03(h) of the California Insurance Code.

Section 2695.4. Representation of Policy Provisions and Benefits

(a) Every insurer shall disclose to a first party claimant or beneficiary, all benefits, coverage, time limits or other provisions of any insurance policy issued by that insurer that may apply to the claim presented by the claimant. When additional benefits might reasonably be payable under an insured's policy upon receipt of additional proofs of claim, the insurer shall immediately communicate this fact to the insured and cooperate with and assist the insured in determining the extent of the insurer's additional liability.

(b) ***No insurer shall misrepresent or conceal benefits***, coverages, time limits or other provisions of the bond which may apply to the claim presented ***under a surety bond***.

(c) No insurer shall deny a claim on the basis of the claimant's failure to exhibit property, unless there is documentation in the file (1) of reasonable demand by the insurer, and unfounded refusal by the claimant, to exhibit property, or (2) of the breach of any policy provision providing for the exhibition of property.

(d) Except where a time limit is specified in the policy, no insurer shall require a first party claimant under a policy to give notification of a claim or proof of claim within a specified time.

(e) No insurer shall:

(1) request that a claimant sign a release that extends beyond the ***subject matter*** which gave rise to the claim payment unless, prior to execution of the release**,** the legal effect of the release is ***disclosed and fully explained*** by the insurer to the claimant in writing. For purposes of this subsection, an insurer shall not be required to provide the above explanation or disclosure to a claimant who is represented by an attorney at the time the release is presented for signature;

(2) be precluded from including in any release a provision requiring the claimant to waive the provisions of California Civil Code Section 1542, provided that**,** prior to execution of the release**,** the legal effect of the release is disclosed and fully explained by the insurer to the claimant in writing. For purposes of this subsection, an insurer shall not be required to provide the above explanation or disclosure to a claimant who is represented by an attorney at the time the release is presented for signature.

(f) No insurer shall issue checks or drafts in ***partial settlement of a loss or claim*** that contain or are accompanied by language ***releasing the insurer***, the insured, or the principal on a surety bond from total liability unless the policy or bond limit has been paid, or there has been a ***compromise settlement*** agreed to by the claimant and the insurer as to coverage and amount payable under the insurance policy or bond.

(g) No insurer shall require a first party claimant or beneficiary to submit duplicative proofs of claim where coverage may exist under more than one policy issued by that insurer.

NOTE: Authority cited: Sections 790.10, 12340 - 12417, inclusive, 12921 and 12926 of the California Insurance Code and Sections 11342.2 and 11152 of the California Government Code. Reference: Section 790.03(h)(1), (3) and (4) of the California Insurance Code.

Section 2695.5. Duties upon Receipt of Communications

(a) Upon receiving any written or oral ***inquiry from the Department of Insurance*** concerning a claim, every licensee shall immediately, but in no event more than ***twenty one (21) calendar days of receipt*** of that inquiry, furnish the Department of Insurance with a ***complete written response*** based on the facts as then known by the licensee. A complete written response addresses all issues raised by the Department of Insurance in its inquiry and includes copies of any documentation and claim files requested. This section is not intended to permit delay in responding to inquiries by Department personnel conducting a scheduled examination on the insurer's premises.

(b) Upon receiving any ***communication from a claimant***, regarding a claim, that ***reasonably suggests that a response*** is expected, every licensee shall immediately, but in no event more than ***fifteen (15) calendar days*** after receipt of that communication, furnish the claimant with a complete response based on the facts as then known by the licensee. This subsection shall not apply to require communication with a claimant subsequent to receipt by the licensee of a notice of legal action by that claimant.

(c) The designation specified in subsection 2695.2(c) shall be in writing, signed and dated by the claimant, and shall indicate that the designated person is authorized to handle the claim. All designations shall be transmitted to the insurer and shall be valid from the date of execution until the claim is settled or the designation is revoked. A designation may be revoked by a writing transmitted to the insurer, signed and dated by the claimant, indicating that the designation is to be revoked and the effective date of the revocation.

(d) Upon receiving ***notice of claim***, every licensee or claims agent shall immediately transmit notice of claim to the insurer.

(e) Upon receiving notice of claim, every insurer shall immediately, but in no event more than fifteen ***(15) calendar days later***, do the following unless the notice of claim received is a notice of legal action:

(1) ***acknowledge receipt*** of such notice to the claimant unless payment is made within that period of time. If the acknowledgment is not in writing, a notation of acknowledgment shall be made in the insurer's claim file and dated. Failure of an insurance agent or claims agent to promptly transmit notice of claim to the insurer shall be imputed to the insurer except where the subject policy was issued pursuant to the California Automobile Assigned Risk Program.

(2) ***provide to the claimant necessary forms***, instructions, and reasonable assistance, including but not limited to, specifying the information the claimant must provide for proof of claim;

(3) ***begin*** any necessary ***investigation*** of the claim.

(f) An insurer may not require that the notice of claim under a policy be provided in writing unless such requirement is specified in the insurance policy or an endorsement thereto.

NOTE: Authority cited: Sections 790.04, 790.10, 12340 - 12417, inclusive, 12921, 12926 of the California Insurance Code and Sections 11342.2 and 11152 of the California Government Code. Reference: Sections 790.03(h)(2) and (3) of the California Insurance Code.

Section 2695.6 Training and Certification

(a) Every insurer shall adopt and communicate to all its claims agents written standards for the prompt investigation and processing of claims, and shall do so within ninety (90) days after the effective date of these regulations or any revisions thereto.

(b) All licensees shall provide thorough and adequate training regarding these regulations to all their claims agents. Licensees shall certify that their claims agents have been trained regarding these regulations and any revisions thereto. However, licensees need not provide such training or certification to duly licensed attorneys.

A licensee shall demonstrate compliance with this subsection by the following methods:

(1) where the licensee is an individual, the licensee shall annually certify in writing under penalty of perjury that he or she has read and understands these regulations and any and all amendments thereto;

(2) where the licensee is an entity, the annual written certification shall be executed, under penalty of perjury, by a principal of the entity as follows:

(A) that the licensee's claims adjusting manual contains a copy of these regulations and all amendments thereto; and,

(B) that clear written instructions regarding the procedures to be followed to effect proper compliance with this subchapter were provided to all its claims agents;

(3) where the licensee retains insurance adjusters as defined in California Insurance Code Section 14021, the licensee must provide training to the insurance adjusters regarding these regulations and annually certify, in a declaration executed under penalty of perjury, that such training is provided. Alternately, the insurance adjuster may annually certify in writing, under penalty of perjury, that he or she has read and understands these regulations and all amendments thereto or has successfully completed a training seminar which explains these regulations;

(4) a copy of the certification required by subsections 2695.6(b) (1), (2) or (3) shall be maintained at all times at the principal place of business of the licensee, to be provided to the Commissioner only upon request.

(5) the annual certification required by this subsection shall be completed on or before September 1 of each calendar year.

NOTE: Authority cited: Sections 790.10, 12340 - 12417, inclusive, 12921 and 12926 of the California Insurance Code and Sections 11342.2 and 11152 of the California Government Code. Reference: Section 790.03(h)(3) of the California Insurance Code.

Section 2695.7. Standards for Prompt, Fair and Equitable Settlements

(a) No insurer shall discriminate in its claims settlement practices based upon the claimant's age**,** race, gender, income, religion, language, sexual orientation, ancestry, national origin, or physical disability, or upon the territory of the property or person insured.

(b) Upon receiving proof of claim, every insurer, except as specified in subsection 2695.7(b)(4) below, shall immediately, but in no event more than forty (40) calendar days later, accept or deny the claim, in whole or in part. The amounts accepted or denied shall be clearly documented in the claim file unless the claim has been denied in its entirety.

(1) Where an insurer denies or rejects a first party claim, in whole or in part, it shall do so in writing and shall provide to the claimant a statement listing all bases for such rejection or denial and the factual and legal bases for each reason given for such rejection or denial which is then within the insurer's knowledge. Where an insurer's denial of a first party claim, in whole or in part, is based on a specific statute, applicable law or policy provision, condition or exclusion, the written denial shall include reference thereto and provide an explanation of the application of the statute, applicable law or provision, condition or exclusion to the claim. Every insurer that denies or rejects a third party claim, in whole or in part, or disputes liability or damages shall do so in writing.

(2) Subject to the provisions of subsection 2695.7(k), nothing contained in subsection 2695.7(b)(1) shall require an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the subject claim is being investigated as a suspected fraudulent claim.

(3) Written notification pursuant to this subsection shall include a statement that, if the claimant believes all or part of the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance, and shall include the address and telephone number of the unit of the Department which reviews claims practices.

(4) The time frame in subsection 2695.7(b) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the California Insurance Code, disability income insurance subject to Section 10111.2 of the California Insurance Code or mortgage guaranty insurance subject to Section 12640.09(a) of the California Insurance Code, and shall not apply to automobile repair bills arising from policies of automobile collision and comprehensive insurance subject to Section 560 of the California Insurance Code. All other provisions of subsections 2695.7(b)(1), (2), and (3) are applicable.

(c)(1) If more time is required than is allotted in subsection 2695.7(b) to determine whether a claim should be accepted and/or denied in whole or in part, every insurer shall provide the claimant, within the time frame specified in subsection 2695.7(b), with written notice of the need for additional time. This written notice shall specify any additional information the insurer requires in order to make a determination and state any continuing reasons for the insurer's inability to make a determination. Thereafter, the written notice shall be provided every thirty (30) calendar days until a determination is made or notice of legal action is

served. If the determination cannot be made until some future event occurs, then the insurer shall comply with this continuing notice requirement by advising the claimant of the situation and providing an estimate as to when the determination can be made.

Subject to the provisions of subsection 2695.7(k), nothing contained in subsection 2695.7(c)(1) shall require an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the claim is being investigated as a possible suspected fraudulent claim.

(d) Every insurer shall conduct and diligently pursue a thorough, fair and objective investigation and shall not persist in seeking information not reasonably required for or material to the resolution of a claim dispute.

(e) No insurer shall delay or deny settlement of a first party claim on the basis that responsibility for payment should be assumed by others, except as may otherwise be provided by policy provisions, statutes or regulations, including those pertaining to coordination of benefits.

(f) Except where a claim has been settled by payment, every insurer shall provide written notice of any statute of limitation or other time period requirement upon which the insurer may rely to deny a claim. Such notice shall be given to the claimant not less than sixty (60) days prior to the expiration date; except, if notice of claim is first received by the insurer within that sixty days, then notice of the expiration date must be given to the claimant immediately. With respect to a first party claimant in a matter involving an uninsured motorist, this notice shall be given at least thirty (30) days prior to the expiration date; except, if notice of claim is first received by the insurer within that thirty days, then notice of the expiration date must be given to the claimant immediately. This subsection shall not apply to a claimant represented by counsel on the claim matter.

(g) No insurer shall attempt to settle a claim by making a settlement offer that is unreasonably low. The Commissioner shall consider any admissible evidence offered regarding the following factors in determining whether or not a settlement offer is unreasonably low:

(1) the extent to which the insurer considered evidence submitted by the claimant to support the value of the claim;

(2) the extent to which the insurer considered legal authority or evidence made known to it or reasonably available;

(3) the extent to which the insurer considered the advice of its claims adjuster as to the amount of damages;

(4) the extent to which the insurer considered the advice of its counsel that there was a substantial likelihood of recovery in excess of policy limits;

(5) the procedures used by the insurer in determining the dollar amount of property damage;

(6) the extent to which the insurer considered the probable liability of the insured and the likely jury verdict or other final determination of the matter;

(7) any other credible evidence presented to the Commissioner that demonstrates that (i) any amount offered by the insurer in settlement of a first-party claim to an insured not represented by counsel, or (ii) the final amount offered in settlement of a first-party claim to an insured who is represented by counsel or (iii) the final amount offered in settlement of a third party claim by the insurer is below the amount that a reasonable person with knowledge of the facts and circumstances would have offered in settlement of the claim.

(h) Upon acceptance of the claim in whole or in part and, when necessary, upon receipt of a properly executed release, every insurer, except as specified in subsection 2695.7(h)(1) and (2) below, shall immediately, but in no event more than thirty (30) calendar days later, tender payment or otherwise take action to perform its claim obligation. The amount of the claim to be tendered is the amount that has been accepted by the insurer as specified in subsection 2695.7(b). In claims where multiple coverage is involved, and where the payee is known, amounts that have been accepted by the insurer shall be paid immediately, but in no event more than thirty (30) calendar days, if payment would terminate the insurer's known liability under that individual coverage, unless impairment of the insured's interests would result. The time frames specified in this subsection shall not apply where the policy provides for a waiting period after acceptance of claim and before payment of benefits.

(1) The time frame specified in subsection 2695.7(h) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the California Insurance Code, disability income insurance subject to Section 10111.2 of the California Insurance Code, or of mortgage guaranty insurance subject to Section 12640.09(a) of the California Insurance Code, and shall not apply to automobile repair bills subject to Section 560 of the California Insurance Code. All other provisions of Section 2695.7(h) are applicable.

(2) Any insurer issuing a title insurance policy shall either tender payment pursuant to subsection 2695.7(h) or take action to resolve the problem which gave rise to the claim immediately upon, but in no event more than thirty (30) calendar days after, acceptance of the claim.

(i) No insurer shall inform a claimant that his or her rights may be impaired if a form or release is not completed within a specified time period unless the information is given for the purpose of notifying the claimant of any applicable statute of limitations or policy provision or the time limitation within which claims are required to be brought against state or local entities.

(j) No insurer shall request or require an insured to submit to a polygraph examination unless authorized under the applicable insurance contract and state law.

(k) Subject to the provisions of subsection 2695.7(c), where there is a reasonable basis, supported by specific information available for review by the California Department of Insurance, for the belief that the claimant has submitted or caused to be submitted to an insurer a suspected false or fraudulent claim as specified in California Penal Code Section 550 or California Insurance Code Section 1871.4(a), the number of calendar days specified in subsection 2695.7(b) shall be:

(1) increased to eighty (80) calendar days; or,

(2) suspended until otherwise ordered by the Commissioner, provided the insurer has complied with California Insurance Code Section 1872.4 and the insurer can demonstrate to the Commissioner that it has made a diligent attempt to determine whether the subject

claim is false or fraudulent within the eighty day period specified by subsection 2695.7(k)(1).

(l) No insurer shall deny a claim based upon information obtained in a ***telephone conversation*** or personal interview with any source ***unless*** the telephone conversation or personal interview is ***documented in the claim file*** pursuant to the provisions of Section 2695.3.

(m) No insurer shall make a payment to a provider, pursuant to a policy provision to pay medical benefits, and thereafter seek recovery or set-off from the insured on the basis that the amount was excessive and/or the services were unnecessary, except in the event of a proven false or fraudulent claim, subject to the provisions of Section 10123.145 of the California Insurance Code.

(n) Every insurer requesting a medical examination for the purpose of determining liability under a policy provision shall do so only when the insurer has a good faith belief that such an examination is reasonably necessary.

(o) No insurer shall require that a claimant withdraw, rescind or refrain from submitting any complaint to the California Department of Insurance regarding the handling of a claim or any other matter complained of as a condition precedent to the settlement of any claim.

(p) Every insurer shall provide written notification to a first party claimant as to whether the insurer intends to pursue subrogation of the claim. Where an insurer elects not to pursue subrogation, or discontinues pursuit of subrogation, it shall include in its notification a statement that any recovery to be pursued is the responsibility of the first party claimant. This subsection does not require notification if the deductible is waived, the coverage under which the claim is paid requires no deductible to be paid, the loss sustained does not exceed the applicable deductible, or there is no legal basis for subrogation.

(q) Every insurer that makes a subrogation demand shall include in every demand the first party claimant's deductible. Every insurer shall share subrogation recoveries on a proportionate basis with the first party claimant, unless the first party claimant has otherwise recovered the whole deductible amount. No insurer shall deduct legal or other expenses from the recovery of the deductible unless the insurer has retained an outside attorney or collection agency to collect that recovery. The deduction may only be for a pro rata share of the allocated loss adjustment expense.

This subsection shall not apply when multiple policies have been issued to the insured(s) covering the same loss and the language of these contracts prescribe alternative subrogation rights. Further, this subsection shall not apply to disability and health insurance as defined in California Insurance Code Section 106.

NOTE: Authority cited: Sections 553, 554, 790.03(h)(5), 790.03(h)(12), 790.10, 1861.03(a), 10350.10, 10111.2, 11580.2(k), 12340 - 12417, inclusive, 12921 and 12926 of the California Insurance Code and Sections 11342.2 and 11152 of the California Government Code**;** *Egan v. Mutual of Omaha Insurance Company* (1979) 24 Cal.3d 809 [169 Cal.Rptr. 691]; *KPFF, Inc. v. California Union Insurance Company* (1997) 56 Cal.App.4th 963 [66 Cal.Rptr.2d 36] (certified for partial publication); *Betts v. Allstate Ins. Co.* (1984) 154 Cal.App.3d 688 [201 Cal.Rptr. 528]. Reference: Section 790.03(h) (2), (3), (4), (5) (13) and

(15), and 1872.4 of the California Insurance Code**,** Section 6149.5 of the California Business and Professions Code and California; and Penal Code Section 550.

Section 2695.8. Additional Standards Applicable to Automobile Insurance

(a) This section enumerates standards which apply to adjustment and settlement of automobile insurance claims.

(1) the words "automobile" and "vehicle" are used synonymously**.**

(b) In evaluating automobile total loss claims the following standards shallapply:

(1) The insurer may elect a cash settlement that shall be based upon the actual cost of a “comparable automobile” less any deductible provided in the policy. This cash settlement amount shall include all applicable taxes and one-time fees incident to transfer of evidence of ownership of a comparable automobile**.** This amount shall also include the license fee and other annual fees to be computed based upon the remaining term of the loss vehicle’s current registration. This procedure shall apply whether or not a replacement automobile is purchased.

(A) If the insured chooses to retain the loss vehicle or if the third party claimant retains the loss vehicle, the cash settlement amount shall include the sales tax associated with the cost of a comparable automobile, discounted by the amount of sales tax attributed to the salvage value of the loss vehicle. The cash settlement amount shall also include all fees incident to transfer of the claimant’s vehicle to salvage status. The salvage value may be deducted from the settlement amount and shall be determined by the amount for which a salvage pool or a licensed salvage dealer, wholesale motor vehicle auction or dismantler will purchase the salvage. If requested by the claimant, the insurer shall provide the name, address and telephone number of the salvage dealer, salvage pool, motor vehicle auction or dismantler who will purchase the salvage. The insurer shall disclose in writing to the claimant that notice of the salvage retention by the claimant must be provided to the Department of Motor Vehicles and that this notice may affect the loss vehicle’s future resale and/or insured value.

The disclosure must also inform the claimant of his or her right to seek a refund of the unused license fees from the Department of Motor Vehicles.

(2) A “comparable automobile” is one of like kind and quality, made by the same manufacturer, of the same or newer model year, of the same model type, of a similar body type, with options and mileage similar to the insured vehicle. Newer model year automobiles may not be used as comparable automobiles unless there are not sufficient comparable automobiles of the same model year to make a determination as set forth in Section 2695.8(b)(3), below. In determining the cost of a comparable automobile, the insurer may use either the asking price or actual sale price of that automobile. Any differences between the comparable automobile and the insured vehicle shall be permitted only if the insurer fairly adjusts for such differences. Any adjustments from the cost of a comparable automobile must be discernible, measurable, itemized, and specified as well as appropriate in dollar amount and so documented in the claim file. Deductions taken from the cost of a comparable automobile that cannot be supported shall not be used. The actual cost of a comparable automobile shall not include any deduction for the condition of a loss vehicle unless the documented condition of the loss vehicle is below average for that particular year, make and model of vehicle. This

subsection shall not preclude deduction for prior and/or unrelated damage to the loss vehicle. A comparable automobile must have been available for retail purchase by the general public in the local market area within ninety (90) calendar days of the final settlement offer. The comparable automobiles used to calculate the cost shall be identified by the vehicle identification number (VIN), the stock or order number of the vehicle from a licensed dealer, or the license plate number of that comparable vehicle if this information is available. The identification shall also include the telephone number (including area code) or street address of the seller of the comparable automobile.

(3) Notwithstanding subsection (2), above, upon approval by the Department of Insurance, an insurer may use private sales data from the Department of Motor Vehicles, or other approved sources, which does not contain the seller's telephone number or street address. Approval by the Department of Insurance shall be contingent on the Department's determination that reasonable steps have been taken to limit the use of private sales data that may be inaccurately reported to the Department of Motor Vehicles or other approved sources.

(4) The insurer shall take reasonable steps to verify that the ***determination of the cost of a comparable vehicle*** is accurate and representative of the market value of a comparable automobile in the local market area. Upon its request, the department shall have access to all records, data, computer programs, or any other information used by the insurer or any other source to determine market value. The cost of a comparable automobile shall be determined as follows and, once determined, shall be fully itemized and explained in writing for the claimant at the time the settlement offer is made:

(A) when comparable automobiles are available or were available in the local market area in the last 90 days, the ***average cost of two or more*** such comparable automobiles; or,

(B) when comparable automobiles are not available or were not available in the local market area in the last 90 days, the ***average of two or more quotations*** from two or more licensed dealers in the local market area; or,

(C) the cost of a comparable automobile as determined by a ***computerized automobile valuation service*** that produces statistically valid fair market values within the local market area; or

(D) if it is not possible to determine the cost of a comparable automobile by using one of the methods described in subsections (b)(3)(A)**,** (b)(3)(B) and (b)(3)(C) of this section, the cost of a comparable automobile shall otherwise be supported by documentation and fully explained to the claimant. Any adjustments to the cost of a comparable automobile shall be discernible, measurable, itemized, and specified as well as appropriate in dollar amount and so documented in the claims file. Deductions taken from the cost of a comparable automobile that cannot be supported shall not be used.

(5) In ***first party automobile total loss claims***, the insurer may elect to offer a ***replacement automobile*** which is a specified ***comparable automobile*** available to the insured with all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile paid by the insurer at no cost other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the insurer's claim file. A replacement automobile must be in as ***good or better*** overall

condition than the insured vehicle and ***available for inspection*** within a reasonable distance of the insured's residence.

(6) Subsection 2695.8(b) applies to the evaluation of third party automobile total loss claims, but does not change existing law with respect to the obligations of an insurer in settling such claims with a third party.

(c) In first party automobile total loss claims, every insurer shall provide notice to the insured at the time the ***settlement payment*** is sent or final settlement offer is made that if notified by the insured within ***thirty-five (35) calendar days*** after the insured receives the claim payment or final settlement offer that he or she cannot purchase a comparable automobile for the gross settlement amount, the insurer will reopen its claim file**.** If subsequently notified by the insured the insurer shall reopen its claim file and utilize the following procedures:

(1) The insurer shall locate a comparable automobile for the gross settlement amount determined by the company at the time of settlement and shall provide the insured with the information required in (c)(4), below, or offer a replacement vehicle in accordance with section 2695.8(b)(4). Any such vehicle must be available in the local market area; or,

(2) The insurer shall either pay the insured the difference between the amount of the gross settlement and the cost of the comparable automobile which the insured has located, or negotiate and purchase this vehicle for the insured; or,

(3) The insurer shall invoke the appraisal provision of the insurance policy.

(4) No insurer is required to take action under this subsection if its documentation to the insured at the time of final settlement offer included written notification of the identity of a specified comparable automobile which was available for purchase at the time of final settlement offer for the gross settlement amount determined by the insurer. The documentation shall include the telephone number (including area code) or street address of the seller of the comparable automobile and:

(A) the vehicle identification number (VIN) or,

(B) the stock or order number of the vehicle from a licensed dealer, or

(C) the license plate number of such comparable vehicle.

(d) No insurer shall, where liability and damages are reasonably clear, recommend that the ***third party claimant*** make a claim ***under his or her own policy*** to avoid paying the claim under the policy issued by that insurer.

(e) ***No insurer*** shall:

(1) require that an automobile be repaired at a specific repair shop; or,

(2) ***suggest or recommend*** that an ***automobile be repaired at a specific repair shop***, unless all of the requirements set forth in California Insurance Code Section 758.5 have been met [***prominently disclose such requirement at time the insurance is applied for***].

(3) require a claimant to travel an unreasonable distance either to inspect a replacement automobile, to conduct an inspection of the vehicle, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.

(f) If ***partial losses*** are settled on the basis of a written estimate prepared by or for the insurer, the insurer shall supply the claimant with a copy of the estimate upon which the settlement is based. The estimate prepared by or for the insurer shall be of an amount which will allow for repairs to be made in a workmanlike manner. If the claimant subsequently contends, based upon a written estimate which he or she obtains, that necessary repairs will exceed the written estimate prepared by or for the insurer, the insurer shall:

(1) ***pay the difference*** between the written estimate and a higher estimate obtained by the claimant; or,

(2) if requested by the claimant**,** promptly ***provide the claimant*** with the name of ***at least one repair shop*** that will make the repairs for the amount of the insurer's written estimate. The insurer shall cause the damaged vehicle to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy or as otherwise allowed by law. The insurer shall maintain documentation of all such communications; or,

(3) ***reasonably adjust*** any written estimates prepared by the repair shop of the claimant's choice and provide a copy of the adjusted estimate to the claimant.

(g) No insurer shall require the use of ***non-original equipment manufacture*** replacement crash parts in the repair of an automobile unless:

(1) the ***parts are at least equal*** to the original equipment manufacturer parts in terms of kind, quality, safety, fit, and performance;

(2) insurers specifying the use of non-original equipment manufacturer replacement crash parts shall pay the cost of any modifications to the parts which may become necessary to effect the repair; and,

(3) insurers specifying the use of non-original equipment manufacture replacement crash parts ***warrant that such parts are of like kind, quality, safety, fit, and performance*** as original equipment manufacturer replacement crash parts; and,

(4) all original and non-original manufacture ***replacement crash parts***, manufactured after the effective date of this subchapter, when supplied by repair shops ***shall carry sufficient permanent, non-removable identification*** so as to identify the manufacturer. Such identification shall be accessible to the greatest extent possible after installation**;** and,

(5) the use of non-original equipment manufacturer replacement crash parts is disclosed in accordance with section 9875 of the California Business and Professions Code.

(h) No insurer shall require an insured or claimant to supply parts for replacement.

(i) When the ***amount claimed*** is adjusted because of betterment or depreciation, all justification shall be ***contained in the claim file***. Any adjustments shall be discernable, measurable, itemized, and specified as to dollar amount, and shall accurately reflect the

value of the betterment or depreciation. This subsection shall not preclude deduction for prior and/or unrelated damage to the loss vehicle. The ***basis for any adjustment shall be fully explained*** to the claimant in writing and shall:

(1) ***reflect a measurable difference*** in market value attributable to the condition and age of the vehicle, and

(2) ***apply only to parts*** normally subject to repair and replacement during the useful life of the vehicle such as, but not limited to, tires, batteries, et cetera.

(j) In a first party partial loss claim, the expense of labor necessary to repair or replace the damage is not subject to depreciation or betterment unless the insurance contract contains a clear and unambiguous provision permitting the depreciation of the expense of labor.

(k) After a covered loss under a policy of automobile collision coverage or automobile physical damage coverage as defined in California Insurance Code Section 660, where towing and storage are reasonably necessary to protect the vehicle from further loss, the insurer shall pay reasonable towing and storage charges incurred by the claimant. The insurer shall provide reasonable notice to the claimant before terminating payment for storage charges so that the claimant has time to remove the vehicle from storage. This subsection shall also apply to a third party claim filed under automobile liability coverage as defined in California Insurance Code section 660, however, payment to a third party claimant may be prorated based upon the comparative fault of the parties.

NOTE: Authority cited: Sections 790.10, 12921 and 12926 of the California Insurance Code, Section 3333 of the California Civil Code and Sections 11342.2 and 11152 of the California Government Code. Reference: Sections 758.5, 790.03(c) and 790.03(h)(3) of the California Insurance Code and Section 9875 of the California Business and Professions Code.

Section 2695.85. Auto Body Repair Consumer Bill of Rights

(a) Every insurer that issues automobile liability or collision insurance policies shall provide the named insured(s) with an Auto Body Repair Consumer Bill of Rights either at the time of application for an automobile insurance policy, at the time a policy is issued, or following an accident or loss that is reported to the insurer. If the insurer provides the insured with an electronic copy of a policy, the bill of rights may also be transmitted electronically. If the insurer provides the bill of rights following an accident or loss, the insurer shall also provide the bill of rights to the particular insured filing the insurance claim. If the insurer provides the bill of rights at the time of application or policy issuance, all named insureds that have not previously received the bill of rights shall be provided with a copy upon renewal of the policy.

(b) The requirements set forth in subsection 2695.85(a), above, shall apply to all automobile liability and collision insurance policies issued in California including commercial automobile, private passenger automobile, and motorcycle insurance policies.

(c) The Auto Body Repair Consumer Bill of Rights shall be a separate standardized document and plainly printed in no less than ten-point type. An insurer may distribute the form using its own letterhead, but the language of the Auto Body Repair Consumer Bill of Rights shall be developed by the California Department of Insurance and shall read as follows:

AUTO BODY REPAIR CONSUMER BILL OF RIGHTS

A CONSUMER IS ENTITLED TO:

1. SELECT THE AUTO BODY REPAIR SHOP TO REPAIR AUTO BODY DAMAGE COVERED BY THE INSURANCE COMPANY. AN INSURANCE COMPANY SHALL NOT REQUIRE THE REPAIRS TO BE DONE AT A SPECIFIC AUTO BODY REPAIR SHOP.

2. AN ITEMIZED WRITTEN ESTIMATE FOR AUTO BODY REPAIRS AND, UPON COMPLETION OF REPAIRS, A DETAILED INVOICE. THE ESTIMATE AND THE INVOICE MUST INCLUDE AN ITEMIZED LIST OF PARTS AND LABOR ALONG WITH THE TOTAL PRICE FOR THE WORK PERFORMED. THE ESTIMATE AND INVOICE MUST ALSO IDENTIFY ALL PARTS AS NEW, USED, AFTERMARKET, RECONDITIONED, OR REBUILT.

3. BE INFORMED ABOUT COVERAGE FOR TOWING AND STORAGE SERVICES.

4. BE INFORMED ABOUT THE EXTENT OF COVERAGE, IF ANY, FOR A REPLACEMENT RENTAL VEHICLE WHILE A DAMAGED VEHICLE IS BEING REPAIRED.

5. BE INFORMED OF WHERE TO REPORT SUSPECTED FRAUD OR OTHER COMPLAINTS AND CONCERNS ABOUT AUTO BODY REPAIRS.

COMPLAINTS WITHIN THE JURISDICTION OF THE BUREAU OF AUTOMOTIVE REPAIR
Complaints concerning the repair of a vehicle by an auto body repair shop should be directed to:

Toll Free (800) 952-5210
California Department of Consumer Affairs
Bureau of Automotive Repair
10240 Systems Parkway
Sacramento, CA 95827

The Bureau of Automotive Repair can also accept complaints over its web site at:
www.autorepair.ca.gov

COMPLAINTS WITHIN THE JURISDICTION OF THE CALIFORNIA INSURANCE COMMISSIONER. Any concerns regarding how an auto insurance claim is being handled should be submitted to the California Department of Insurance at:

(800) 927-HELP or (213) 897-8921
California Department of Insurance
Consumer Services Division
300 South Spring Street
Los Angeles, CA 90013

The California Department of Insurance can also accept complaints over its web site at:
www.insurance.ca.gov

NOTE: Authority cited: Sections 790.10, 1874.85, 1874.87 of the California Insurance Code. Reference: Sections 790.03(c), 790.03(h)(3), and 1874.87 of the California Insurance Code;

Sections 9884.8, 9884.9 of the California Business and Professions Code; and California Code of Regulations, Title 10, Chapter 5, Subchapter 7.5, Section 2695.8(j).

Section 2695.9. Additional Standards Applicable to First Party Residential and Commercial Property Insurance Policies

(a) When a residential or ***commercial property insurance*** policy provides for the adjustment and settlement of first party losses based on replacement cost, the following standards apply:

(1) When a loss requires repair or ***replacement of an item or part [replacement cost]***, any consequential physical damage incurred in making the repair or replacement not otherwise excluded by the policy shall be included in the loss. The ***insured shall not have to pay for depreciation*** nor any other cost except for the applicable deductible.

(2) When a loss requires replacement of items and the replaced items do not match in quality, color or size, the insurer shall replace all items in the damaged area so as to conform to a reasonably uniform appearance.

(b) No insurer shall require that the insured have the property repaired by a specific individual or entity.

(c) ***No insurer*** shall ***suggest or recommend*** that the insured have the property repaired by a specific individual or entity unless:

(1) the ***referral is expressly requested*** by the claimant; or

(2) the claimant has been informed in writing of the right to select a repair individual or entity and, if the ***claimant accepts the suggestion or recommendation***, the insurer shall cause the damaged property to be restored to no less than its condition prior to the loss and repaired in a manner which meets accepted trade standards for good and workmanlike construction at no additional cost to the claimant other than as stated in the policy or as otherwise allowed by these regulations.

(d) If losses are settled on the basis of a written scope and/or estimate prepared by or for the insurer, the insurer shall supply the claimant with a copy of each document upon which the settlement is based. The estimate prepared by or for the insurer shall be in accordance with applicable policy provisions, of an amount which will restore the damaged property to no less than its condition prior to the loss and which will allow for repairs to be made in a manner which meets accepted trade standards for good and workmanlike construction. The insurer shall take reasonable steps to verify that the repair or rebuilding costs utilized by the insurer or its claims agents are accurate and representative of costs in the local market area. If the claimant subsequently contends, based upon a written estimate which he or she obtains, that necessary repairs will exceed the written estimate prepared by or for the insurer, the insurer shall:

(1) pay the difference between its written estimate and a higher estimate obtained by the claimant; or,

(2) if requested by the claimant, promptly provide the claimant with the name of at least one repair individual or entity that will make the repairs for the amount of the written estimate. The insurer shall cause the damaged property to be restored to no less than its

condition prior to the loss and which will allow for repairs in a manner which meets accepted trade standards for good and workmanlike construction at no additional cost to the claimant other than as stated in the policy or as otherwise allowed by these regulations; or,

(3) reasonably adjust any written estimates prepared by the repair individual or entity of the insured's choice and provide a copy of the adjusted estimate to the claimant.

(e) Once the appraisal provision under an insurance policy is invoked, the appraisal process shall not include any legal proceeding or procedure not specified under California Insurance Code Section 2071. Nothing herein is intended to preclude separate legal proceedings on issues unrelated to the appraisal process.

(f) When the amount claimed is adjusted because of betterment, depreciation, or salvage, all justification for the adjustment shall be contained in the claim file. Any adjustments shall be discernable, measurable, itemized, and specified as to dollar amount, and shall accurately reflect the value of the betterment, depreciation, or salvage. Any adjustment for betterment or depreciation shall reflect a measurable difference in market value attributable to the condition and age of the property and apply only to property normally subject to repair and replacement during the useful life of the property. The basis for any adjustment shall be fully explained to the claimant in writing.

(1) Under a policy, subject to California Insurance Code Section 2071, where the insurer is required to pay the expense of repairing, rebuilding or replacing the property destroyed or damaged with other of like kind and quality, the measure of recovery is determined by the actual cash value of the damaged or destroyed property, as set forth in California Insurance Code Section 2051. Except for the intrinsic labor costs that are included in the cost of manufactured materials or goods, the expense of labor necessary to repair, rebuild or replace covered property is not a component of physical depreciation and shall not be subject to depreciation or betterment.

NOTE: Authority cited: Sections 790.10, 2051, 2051.5, 2071, 12921 and 12926 of the California Insurance Code**,** Section 7109 of the California Business and Professions Code and Sections 11342.2 and 11152 of the California Government Code**;** Reference: Sections 790.03(h)(3), (5) and (7) of the California Insurance Code.

Section 2695.10 Additional Standards Applicable to Surety Insurance

(a) No insurer shall base or vary its ***claims settlement practices***, or its standard of scrutiny and review, upon the claimant's***, age, race, gender, income, religion, language, sexual orientation, ancestry, national origin, or physical disability***, or upon the territory of the property or person insured.

(b) As soon as possible, but in no event later than ***forty (40) calendar days*** after receipt by the insurer of ***proof of claim***, and provided the claim is not in litigation or arbitration, the insurer shall ***accept or deny the claim***, in whole or in part, and affirm or deny liability. Every insurer that denies or rejects a claim in whole or in part, or disputes liability or damages, shall provide to the claimant a written statement listing all bases for such rejection or denial, and the factual and legal bases for each reason given for each rejection or denial, which are within the insurer’s knowledge. If an insurer’s denial of a claim in whole or in part is based on a specific statute or specific bond provisions, the denial shall include reference thereto and provide an explanation of the application of the statute or bond provision to the claim. Written

notification pursuant to this subsection shall also include a notification that the claimant may have the matter reviewed by the California Department of Insurance and shall provide the address and telephone number of the unit of the Department which reviews complaints regarding claims practices.

(1) A principal's absence, non-cooperation, or failure to meet the bonded obligation shall not excuse unreasonable delay by the insurer in determining whether a claim should be accepted or denied.

(2) While an insurer may consider all information provided by a principal**,** absent reasonable factual and/or legal bases for denying a claim, no insurer shall deny a claim based solely upon a principal's protest of a claim or denial of liability for a claim.

(c) In the event an insurer requires more time than is allotted in subsection 2695.10(b) to determine whether a claim should be accepted and/or denied, in whole or in part, the insurer shall provide the claimant with written notice of the need for such ***additional time [extension]*** within the time specified in subsection 2695.10(b). Such written notice shall specify the reasons for the need for such additional time, including specification of any additional information the insurer requires in order to make such determination. The insurer shall provide the claimant with written notice as to the continuing reasons for the insurer's inability to make such a determination. Except in cases where extraordinary circumstances are present which materially affect the insurer's ability to comply, such written notice shall be provided within ***30 calendar days*** of the date of the initial notification, and ***every 30 calendar days*** thereafter until such determination is made or notice of legal action is received. If the determination cannot be made until some event, process, or third party determination is made, then the insurer shall comply with this requirement by advising the claimant of the situation and provide an estimate as to when the determination can be made.

(d) No insurer shall fail to pursue diligently an investigation of a claim, or persist in seeking information not reasonably required for or material to resolution of a claim dispute.

(e) No insurer shall deny a claim upon information obtained in a telephone conversation or personal interview with any source unless the telephone conversation or personal interview is documented in the claim file pursuant to the provisions of section 2695.3.

(f) Where the ***claim is to be settled*** by payment, and where neither the claim nor the amount is in dispute, such payment shall be tendered (1) within ***15 calendar days*** following affirmation of liability where the insurer does not require the claimant to execute a release, or (2) ***within 15 calendar days*** following the insurer's ***receipt of a release*** properly executed by the claimant, where such release is required by the insurer. Such release shall be provided to the claimant within ten (10) calendar days following affirmation of liability. Where multiple claimants are involved, payment shall be made pursuant to this subsection, provided such payment shall not increase the insurer's liability, or impair the rights of other claimants under the bond.

(g) Except where a claim has been settled by payment, every insurer shall provide written notice of any statute of limitations or other time period requirement upon which the insurer may rely to deny a claim. Such notice shall be given to the claimant no less than sixty (60) days prior to the expiration date. If notice of claim is first received by the insurer within sixty (60) days of the expiration date and such date is known to the insurer, then notice of the expiration date must be given to the claimant immediately. This subsection shall not apply to

a claimant represented by counsel on the claim matter or to a claim already time barred when first received by the insurer.

(h) No insurer shall attempt to settle a claim by making a ***settlement offer*** that is ***unreasonably low***. The Commissioner shall consider any admissible evidence offered regarding the following factors in determining whether or not a settlement offer is unreasonably low:

(1) ***the extent*** to which the insurer considered evidence submitted by the claimant to support the ***value of the claim***;

(2) the extent to which the insurer considered ***legal authority*** or evidence made known to it or reasonably available;

(3) the ***procedures*** used by the insurer in determining the dollar amount of damages;

(4) any other ***credible evidence*** presented to the Commissioner that demonstrates that the final amount offered by the insurer in settlement of a claim is below the amount that a reasonable person with knowledge of the facts and circumstances would have offered in settlement of the claim.

NOTE: Authority cited: Sections 790.10, 12921, 12921.1 and 12926 of the California Insurance Code. Reference: Sections 790.03(h)(3), (4) and (15), 12921.3 of the California Insurance Code, and California Civil Code Section 2807.

Section 2695.11. Additional Standards Applicable to Life and Disability Insurance Claims

(a) No insurer shall seek reimbursement of an overpayment or withhold any portion of any benefit payable as a result of a claim on the basis that the sum withheld or reimbursement sought is an adjustment or correction for an overpayment made under the same policy unless:

(1) the insurer's files contain clear, documented evidence of an overpayment and written authorization from the insured or assignee, if applicable, permitting such the reimbursement or withholding procedure, or

(2) the insurer's files contain clear, documented evidence pursuant to section 2695.3 of all of the following:

(A) The overpayment was erroneous under the provisions of the policy.

(B) The error which resulted in the payment is not a mistake of the law.

(C) The insurer notifies the insured within six (6) months of the date of the error, except that in instances of error prompted by representations or nondisclosure of claimants or third parties, the insurer notifies the insured within fifteen (15) calendar days after the date of discovery of such error. For the purpose of this subsection, the date of the error shall be the day on which the draft for benefits is issued.

(D) Such notice states clearly the cause of the error and states the amount of the overpayment.

(E) The procedure set forth above in (a)(2)(A) through (D) above may not be used if the overpayment is the subject of a reasonable dispute as to facts.

(b) With each claim payment, the insurer shall provide to the claimant and assignee, if any, an explanation of benefits which shall include, if applicable, the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits.

(c) An insurer may not impose a penalty upon any insured for noncompliance with insurer requirements for precertification of benefits unless such penalties are specifically and clearly set forth in writing in the policy or certificate of insurance.

(d) An insurer that contests a claim under California Insurance Code Section 10123.13 shall subsequently affirm or deny the claim within thirty (30) calendar days from the original notification. In the event an insurer requires additional time to affirm or deny the claim, it shall notify the claimant and assignee in writing. This written notice shall specify any additional information the insurer requires in order to make a determination and shall state any continuing reasons for the insurer's inability to make a determination. This notice shall be given within thirty (30) calendar days of the notice (required under Insurance Code Section 10123.13) that the claim is being contested and every thirty (30) calendar days thereafter until a determination is made or legal action is served. If the determination cannot be made until some future event occurs, the insurer shall comply with this continuing notice requirement by advising the claimant and assignee of the situation and providing an estimate as to when the determination can be made.

(e) When a policy requires ***preauthorization of non-emergency medical services***, the preauthorization must be given immediately but in no event more than ***five (5) calendar days*** after the request for preauthorization. The preauthorization shall be communicated or confirmed in writing to the insured and the medical service provider, and shall ***explain the scope*** of the preauthorization and whether the preauthorization is or is not a guarantee of acceptance of the claim. In the event the preauthorization is denied, ***the reason(s) for the denial shall be communicated in writing*** to the insured and the medical service provider.

(f) No preauthorization shall be required by an insurer for emergency medical services.

(g) An insurer shall reimburse the insured or medical service provider for reasonable expenses incurred in copying medical records requested by the insurer.

NOTE: Authority cited: Sections 790.10, 12921 and 12926 of the California Insurance Code and Sections 11342.2 and 11152 of the California Government Code. Reference: Section 790.03(h)(1), (2), (3), (5) and (13) and Section 10123.13 of the California Insurance Code.

Section 2695.12. Penalties

(a) In determining whether to assess penalties and, if so, the appropriate amount to be assessed, the Commissioner shall consider admissible evidence on the following:

(1) the existence of extraordinary circumstances;

(2) whether the licensee has a good faith and reasonable basis to believe that the claim or claims are fraudulent or otherwise in violation of applicable law and the licensee has complied with the provisions of Section 1872.4 of the California Insurance Code;

(3) the complexity of the claims involved;

(4) gross exaggeration of the value of the property or severity of the injury, or amount of damages incurred;

(5) substantial mischaracterization of the circumstances surrounding the loss or the alleged default of the principal;

(6) secreting of property which has been claimed as lost or destroyed.

(7) the relative number of claims where the noncomplying act(s) are found to exist, the total number of claims handled by the licensee and the total number of claims reviewed by the Department during the relevant time period;

(8) whether the licensee has taken remedial measures with respect to the noncomplying act(s);

(9) the existence or nonexistence of previous violations by the licensee;

(10) the degree of harm occasioned by the noncompliance;

(11) whether, under the totality of circumstances, the licensee made a good faith attempt to comply with the provisions of this subchapter;

(12) the frequency of occurrence and/or severity of the detriment to the public caused by the violation of a particular subsection of this subchapter;

(13) whether the licensee's management was aware of facts that apprised or should have apprised the licensee of the act(s) and the licensee failed to take any remedial measures; and

(14) the licensee’s reasonable mistakes or opinions as to valuation of property, losses or damages.

(b) This section shall not bar, obstruct or restrict any right to administrative due process an insurer may be afforded under California Insurance Code Sections 790.05, 790.06, and 790.07.

NOTE: Authority cited: Sections 790.035, 790.07, 790.08, 790.09, 790.10, 1872.4, 12340 - 12417, inclusive, 12921, 1065, 704, 780-784, 1011, 11690, 12926 and 12928.6 of the California Insurance Code and Sections 11342.2 and 11152 of the California Government Code. Reference: Section 790.03(h), 790.035 (a), 790.04, 790.05, 790.06, 790.08, 790.10 of the California Insurance Code.

Section 2695.13. Severability

If any provision or clause of this rule or the application thereof to any person or situation is held invalid, such invalidity shall not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

NOTE: Authority cited: Sections 790.10, 12340 - 12417, inclusive, 12921 and 12926 of the California Insurance Code and Sections 11342.2 and 11152 of the California Government Code. Reference: Section 790.03(h) of the California Insurance Code.
2695.14 Compliance Date

(a) Any amendments to these regulations shall be complied with within ninety (90) calendar days after they are filed with the Secretary of State.

(b) Prior to the ***compliance date*** of these regulations, ***licensees*** shall, pursuant to Section 2695.6, adopt and communicate to their claims ***agents standards*** for the prompt investigation and processing of claims, and provide ***training and instruction on these regulations***.

(c) These regulations shall apply to any claims handling that takes place on or after the compliance date set forth under subsection 2695.14(a).

NOTE: Authority Cited: Sections 790.10, 12921 and 12926 of the California Insurance Code and Section 11343.4 of the California Government Code. Reference: Section 790.03(h) of the California Insurance Code.

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