CALIFORNIA CLAIMS ADJUSTING

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Ethics & Adjusters

Do you think you're an ethical adjuster? Could you prove it to a jury? What would your mother say about your practices? In the end, how will you judge your career? By how much money you made? By how many customers you helped? By what you accomplished for your family and your community? The answer lies within you. And, you are not alone if you are not 100% sure. There are many people and industries trying to grapple with the solution.

The fact is, when large sums of money are involved, breaches in ethical and moral behavior are all too common and the industry of insurance claims adjusting is certainly no exception. There are many temptations for a claims adjuster since they have the ability to dictate the speed at which a claim is processed and the final settlement amount. That's a lot of power! Insureds have been known to offer a sum of cash in exchange for a quick claim resolution or desired claim amount. And, of course if one is paid based on the amount of the settled claim the temptation is even greater, but so is the potential penalty.

As a regulated “profession” a finding that an adjuster has violated a particular ethical provision may lead to a reprimand, suspension, or even revocation of the adjusting license. Second, it is not uncommon for insureds and their attorneys to contend that an adjuster's violation of his code of ethics is imputable evidence of the insurer's “bad-faith” claims handling. Third, not to be familiar with such codes of ethics may result in awkward and embarrassing moments for that adjuster at deposition and trial, which, in turn, may lead to negative consequences for both the adjuster and the insurer. Notwithstanding the above, prosecuting attorneys have been known to say it is dangerously common for adjusters and other claims professionals to be wholly ignorant, let alone conversant about, any adjuster's code of ethics.

Do We Need A Moral Code?

Possessing a moral code is not all that is needed to set a 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 adjuster be pro-active concerning mold? What about third party claimants, e.g., other occupants near an infected unit? An adjusters 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 the training of an adjuster concerns the proper use of experts. An adjuster 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, the adjuster has the obligation to seek out the liability exposures to properly evaluate the claim. Testing for mold by a professional could be required.

Adjusters 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 adjusting 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 as 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!"

**Ethics Are Not Laws**

Many adjusters believe that ethics and the law are the same. It is important to realize that **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".

**An Adjusters Code of Ethics**

With all these concepts and consequences in mind, let's look at a sample code of ethics for adjusters on the next few pages. These suggestions are a compilation of present-day professional and coded standards for guiding adjusters in their everyday ethical decision-making.
AN ADJUSTER’S CODE OF ETHICS

In all my professional relationships, I pledge myself to the following rules of ethical conduct:

- An adjuster shall not directly or indirectly refer or steer any claimant needing repairs or other services in connection with a loss to any person with whom the adjuster has an undisclosed financial interest, or who will or is reasonably anticipated to provide the adjuster any direct or indirect compensation for the referral or for any resulting business.
- An adjuster shall treat all claimants equally.
- An adjuster shall not provide favored treatment to any claimant.
- An adjuster shall adjust all claims strictly in accordance with the insurance contract.
- An adjuster shall not approach investigations, adjustments, and settlements in a manner prejudicial to the insured.
- An adjuster shall make truthful and unbiased reports of the facts after making a complete investigation.
- An adjuster shall handle every adjustment and settlement with honesty and integrity, and allow a fair adjustment or settlement to all parties without any remuneration to himself except that to which he is legally entitled.
- An adjuster, upon undertaking the handling of a claim, shall act with dispatch and due diligence in achieving a proper disposition of the claim.
- An adjuster shall promptly report to any conduct by any licensed insurance representative which violates any provision of the Insurance Code or Department rule or order.
- An adjuster shall exercise extraordinary care when dealing with elderly clients to assure that they are not disadvantaged in their claims transactions by failing memory or impaired cognitive processes.
- An adjuster shall not negotiate or effect settlement directly or indirectly with any third-party claimant represented by an attorney, if the adjuster has knowledge of such representation, except with the consent of the attorney. (The term “third-party claimant” does not include the insured or the insured's resident relatives).
- An adjuster is permitted to interview any witness, or prospective witness, without the consent of opposing counsel or party. In doing so, however, the adjuster shall scrupulously avoid any suggestion calculated to induce a witness to suppress or deviate from the truth, or in any degree affect the witness's appearance or testimony during deposition or at the trial. The witness shall be given a copy of the statement.
- An adjuster shall not advise a claimant to refrain from seeking legal advice, nor advise against the retention of counsel to protect the claimant's interest.
AN ADJUSTER’S CODE OF ETHICS (Cont)

In all my professional relationships, I pledge myself to the following rules of ethical conduct:

- An adjuster shall not attempt to negotiate with or obtain any statement from a claimant or witness at a time that the claimant or witness is, or would reasonably be expected to be, in shock or serious mental or emotional distress as a result of physical, mental, or emotional trauma associated with a loss.
- The adjuster shall not conclude a settlement when the settlement would be disadvantageous to, or to the detriment of a claimant who is in the traumatic or distressed state.
- An adjuster shall not knowingly fail to advise a claimant of the claimant's claim rights in accordance with the terms and conditions of the contract and of the applicable laws of this state.
- An adjuster shall exercise care not to engage in the unlicensed practice of law as prescribed by the California Bar.
- A company or independent adjuster shall not draft special releases called for by the unusual circumstances of any settlement or otherwise draft any form of release, unless advance written approval by the insurer can be demonstrated. A company or independent adjuster is permitted only to fill in the blanks in a release form approved by the insurer they represent.
- An adjuster shall not undertake the adjustment of any claim concerning which the adjuster is not currently competent and knowledgeable as to the terms and conditions of the insurance coverage, or which otherwise exceeds the adjuster's current expertise.
- No person shall, as a public adjuster, represent any person or entity whose claim the adjuster has previously adjusted while acting as an adjuster representing any insurer or independent adjusting firm.
- No person shall, as a company or independent adjuster, represent him- or herself or any insurer or independent adjusting firm against any person or entity that the adjuster previously represented as a public adjuster.
- A public adjuster shall not represent or imply to any client or potential client that insurers, company adjusters, or independent adjusters routinely attempt to, or do in fact, deprive claimants of their full rights under an insurance policy.
- No insurer, independent adjuster, or company adjuster shall represent or imply to any claimant that public adjusters are unscrupulous, or that engaging a public adjuster will delay or have other adverse effect upon the settlement of a claim.
- No public adjuster, while so licensed, shall represent or act as a company adjuster, independent adjuster, or general lines agent.
AN ADJUSTER’S CODE OF ETHICS (Cont)

In all my professional relationships, I pledge myself to the following rules of ethical conduct:

- No independent adjuster or company adjuster, while so licensed shall represent or act as a public adjuster.
- A public adjuster shall advise the insured and claimant in advance of the insured or claimant's right of counsel, and choice thereof, to represent the insured or claimant, and that such choice is to be made solely by the insured or claimant.
- The public adjuster shall notify the insured or claimant in advance of the name and location of any proposed contractor, architect, engineer, or similar professional, before any bid or proposal by any of these persons may be used by the public adjuster in estimating the loss or negotiating settlement. The insured or claimant may exercise veto power of any of these persons, in which case that person shall not be used in estimating costs.
- The public adjuster shall ensure that if a contractor, architect, engineer, or other professional is used in formulating estimates or otherwise participates in the adjustment of the claim, the professional shall be licensed.
- A public adjuster shall not prevent, or attempt to dissuade or prevent, a claimant from speaking privately with the insurer, company or independent adjuster, attorney, or any other person, regarding the settlement of the claim.
- A public adjuster shall not acquire any interest in salvaged property, except with the written consent and permission of the insured.
- A public adjuster shall not accept referrals of business from any person with whom the public adjuster may conduct business where there is any form or manner of agreement to compensate the person, whether directly or indirectly, for referring business to the public adjuster.
- Except as between licensed public adjusters, no public adjuster shall compensate any person, whether directly or indirectly, for the principal purpose of referring business to the public adjuster.
- A public adjuster's contract with a client shall be revocable or cancellable by the insured or claimant, without penalty or obligation, for at least 3 business days after the contract is executed. The public adjuster shall disclose to the insured that the insured has the right to cancel with prompt notice within the revocation period. If the insured elects to cancel the contract, prompt notice shall be provided to the adjuster. Nothing in the provision shall be construed to prevent an insured from pursuing any civil remedy after the 3 day cancellation period.
- A public adjuster shall not enter into a contract or accept a power of attorney which vests in the public adjuster the effective authority to choose the persons who shall perform repair work.
- A public adjuster shall ensure that all contracts for the public adjuster's services are in writing and set forth all terms and conditions of the engagement.
Better Adjuster Practices

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 adjuster’s file is extremely confidential and all efforts to make it secure should be practiced. Remember, **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 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.

**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 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. Here are some adjuster best practices we found:

- **Acknowledgement:** An email notification will be sent to the assigning Client representative within 24 hours noting the assignment has been received. The acknowledgement will include the handling adjusters name and contact information.
- **Contact:** Contact will be made with the insured within the first 24 hours of receipt of assignment. If the adjuster is unable to reach the insured, a contact letter will be sent
immediately. At time of contact, the adjuster will arrange inspection of the loss within five (5) business days, provided the insured is available. If not, the file will be noted accordingly.

- **Inspection:** The loss will be inspected within five (5) days of assignment and or contact with the insured.

- **Reporting:** The adjuster will prepare a full captioned report on all losses which will include: *Reserve* (on initial report) *Coverage Analysis* – Policy effective date, limits, deductible, any sub-limits, forms/endorsements that may pertain to the loss: (form number, title and edition date); any other information pertinent to the adjustment, i.e. loss location, schedule amounts, etc. *Insurance to Value (ITV)* Adequacy of limits will be commented on in the initial report. This caption is to include the type and percentage of applicable ITV clause. *Title and encumbrances* – Ownership/Insurable Interest, including Mortgagee, Lien Holder, Loss Payee. A records check can be provided at additional cost. *Investigation/Adjustment Facts; Cause of Loss; Subrogation/Salvage; Recommendations*

- **Initial Reserve Report:** The initial reserve report will be within 15 days from date of assignment. If the reserve is anticipated to be in excess of $50,000 a phone call will be made to the Client within 24 hours of inspection, followed by an initial reserve report.

- **Interim Reports:** All interim reports will be within 30 days from the date of the initial reserve report and on 30 day intervals from that date forward, unless noted otherwise by the assigning adjuster.

- **Final Report:** The final report will be generated within 10 business days of the adjuster receiving all necessary documents to conclude the adjustment of the loss.

- **Estimates:** The adjuster will prepare a detailed estimate of all covered damages utilizing a computer estimating program, which will reflect line item depreciation for application ACV/RCV adjustment. The adjuster will not prepare an estimate for non-covered damages, unless specifically requested by client.

- **Diagrams:** Diagrams will be provided on all roof claims. Additional diagrams will be included as necessary with insurance to value calculations.

- **Statements:** Statements may be taken under the following circumstances: Late or delayed notice of loss; Property is discovered to be Vacant or Unoccupied; The potential for subrogation exists; Facts of loss are unclear; Conflicting information is presented; Important circumstances need to be documented; Pertinent information may become lost or become “stale”

- **Photographs:** Photographs will be taken of all property alleged to be damaged, including: Photo of the front and back of every risk; Photos of all damages seen or claimed; If no damage is apparent to claimed property, photographic evidence will be provided

- **Insurance to Value (ITV):** Adequacy of limits will be commented on as indicated under the reporting section of this document. In the event the insured is underinsured, thus invoking the coinsurance clause or ACV clause under the policy, the adjuster will complete a detailed valuation of the insured property and include same with their report.

- **Experts:** Other than enlisting a salvor, the adjuster will contact the client for approval before making assignments to any experts. All assignments, once approved will only be made to experts on the clients approved vendor list.

- **Agreed Price:** The adjuster will always attempt to reach an agreed price with the insured or the contractor of their choosing.
• **Settlement:** The adjuster will not commit the client to any settlement without prior consent.

• **Denials:** All denials of coverage will be drafted by the client unless advised otherwise. The adjuster will also not prepare estimates for damages that are excluded under the policy unless specifically requested.

• **Proof of Loss:** A Proof of Loss will not be obtained unless specifically requested by the client.

• **Reservation of Rights:** All Reservation of Rights will be prepared by the client.

• **Non-Waiver Agreements:** Non-Waiver Agreements will be obtained upon request by client

Adjusters who follow best practices typically use them as a benchmark to see how they measure up with other adjusters -- 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 adjuster can use to change or improve his practice.

### 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 be 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 no 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. The 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 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. The suggestions that appear on the following page are organized under three categories: **Netiquette**, **Compliance** and the **10 Commandments of Computer Ethics**. Keep in mind, new technologies and changing consumer views will require constant E-Code revisions.

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 E-Sign Act**

This federal legislation provides the essential foundation for transacting insurance business electronically by endorsing the validity of electronic signatures and records.

Industry analysts like the NAIC, have said that this legislation will NOT view insurance information posted to a website as **transacting insurance** provided it does not solicit, sell or negotiate terms. Consequently, a website owner would not need to be licensed or registered as a producer.

Further, this same legislation proposes that states should not assert jurisdiction over a website where **reasonable access to information** is provided to the consumer indicating that advertised products are not available in a particular state where the appropriate licenses have NOT been obtained.
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.

**E-Conduct Code of Procedures**

How do the issues above effect your e-conduct? Well, until your state adopts specific guidelines, the preferred practices you are about to read are highly recommended.
NETIQUETTE

(The following is courtesy of Arlene H. Rinaldi, The Net: User Guidelines and Netiquette, 1998)

- I will never assume that e-mail can be read by no one except me; others may be able to read or access my e-mail or the electronic messages sent by my clients.

- I will never send or keep any e-mail that I wouldn’t mind seeing on the evening news.

- It is my responsibility when downloading programs, to check for copyright or licensing agreements. If the program is beneficial to my use, I will pay any authors registration fee. If there is any doubt, I won’t copy it.

- I understand that under United States law, it is unlawful "to use any telephone facsimile machine, computer, or other device to send an unsolicited advertisement" to any "equipment which has the capacity (A) to transcribe text or images (or both) from an electronic signal received over a regular telephone line onto paper." The law allows individuals to sue the sender of such illegal "junk mail" for $500 per copy. Most states will permit such actions to be filed in Small Claims Court. This activity is termed "spamming" on the Internet and I refuse to do it

- I will never give my userID or password to another person except authorized system administrators that need to access your account for maintenance or to correct problems.

- I will keep paragraphs and messages short and to the point to help avoid confusion and inconvenience to the recipient of my e-mails.

- I will focus on one subject per message and always include a pertinent subject title for the message, that way the user can locate the message quickly.

- I will include my electronic signature (name, position, company, e-mail address and phone) at the bottom of Email messages when communicating with people who may not know me personally or when broadcasting to a dynamic group of subscribers.

- I will capitalize words only to highlight an important point or to distinguish a title or heading. Capitalizing whole words that are not titles is generally termed as SHOUTING! *Asterisks* surrounding a word can be used to make a stronger point. Use the underscore symbol before and after the title of a book, i.e. The Wizard of Oz_.
NETIQUETTE (Continued)

• I will limit line length to approximately 65-70 characters and avoid control characters.

• I will never ever send chain letters through the Internet. Sending them can cause the loss of my Internet Access.

• Because of the International nature of the Internet and the fact that most of the world uses the following format for listing dates, i.e. MM DD YY, I will be considerate and avoid misinterpretation of dates by listing dates including the spelled out month: Example: 24 JUN 96 or JUN 24 96

• I will follow chain of command procedures for corresponding with superiors. For example, I won’t send a complaint via Email directly to the “top” just because I can.

• I will be professional and careful what I say about others: Email is easily forwarded.

• I will cite all quotes, references and sources and respect copyright and license agreements.

• I will not forward personal email to mailing lists without the original author’s permission.

• Attaching return receipts to a message may be considered an invasion of privacy if the party I’m sending to is not expecting the message.

• I will be careful when using sarcasm and humor. Without face to face communications a joke may be viewed as criticism. When being humorous, use emoticons to express humor. (tilt your head to the left to see the emoticon smile) :-) = happy face for humor

• Acronyms can be used to abbreviate when possible, however messages that are filled with acronyms can be confusing and annoying to the reader.

    Examples: IMHO= in my humble/honest opinion
              FYI = for your information
              BTW = by the way
              Flame = antagonistic criticism
NETIQUETTE (Continued)

- I will not include very large graphic images in your HTML documents. It is preferable to have postage sized images that the user can click on to "enlarge" a picture. Some users with access to the Web are viewing documents using slow speed modems and downloading these images can take a great deal of time.

- While it is not usually a requirement to ask permission to link to another’s site, out of respect for the individual and their efforts, I will send a simple email message stating that I have made a link to their site would be appropriate.

- When I include video or voice files, I will include next to the description a file size, i.e. (10KB or 2MB), so the user has the option of knowing how long it will take to download the file.

- If I create a website it shall always include my email address and a date of last revision - so users linking to the site can know how up to date the information has been maintained.

- Infringement of copyright laws, obscene, harassing or threatening materials my website can be in violation of local, state, national or international laws and can be subject to litigation by the appropriate law enforcement agency.
To be the best adjuster possible, in my Internet communications and transactions I will comply with the same high standards of ethics and market conduct I practice in my everyday business.

I understand that it is the burden of insurers and adjusters to meet all policy requirements, as mandated by the State, for any transaction, regardless of whether it is electronic or on paper.

I realize that all forms of communication with my client, including the Internet, is considered advertising, which is subject to intense and thorough state and federal regulations that may not distinguish the fact that communication is Internet-based versus other, more traditional mediums.

I will comply with any and all state guidelines concerning signatures, authenticity of signatures, delivery of policies, replacements, exchanges, etc. If my state does not except digital signatures it may mean that I must provide my client a combination of electronic forms and / or hard copies.

I will follow any and all state guidelines regarding claim forms, disclosures, etc

I will develop standard operating procedures to follow when handling inquiries, applications and other insurance-related transactions on the Internet to be sure my clients have been treated equally, fairly and with full disclosure.

I will comply with any and all business and insurance laws regulating the collection of premiums from my clients through electronic funds transfer or other electronic medium, including verification of payment to meet proof of payment requirements under existing statutes.

I will satisfy records retention requirements by being able to produce information or data which accurately represents a record of electronic client communications or electronic transactions.
COMPLIANCE & BUSINESS E-CODE (Cont)

• I will do whatever possible to protect my clients privacy by safeguarding outside access to any personal and financial information I have collected through the Internet by using a firewall or other acceptable device. Where security needs are at their highest, I will consider a system of encryption where only a specific sender and receiver of information is permitted access.

• I must also realize that computer crimes, such as embezzlement or planting of logic bombs, are normally committed by trusted personnel who have permission to use my computer system. Computer security, therefore, must also be concerned with the actions of trusted computer users.

• I will address consumer complaints through the Internet in the same efficient manner I would offline. Also, where it might be required, I will establish any hotlinks to allow a client direct access to the Department of Insurance consumer protection division for registering unresolved complaints or settlements.

• Since the Internet know no boundaries between states, I will make every effort to alert users of my website that my services and products are not available in states outside my licensing.

• Where products require special underwriting I will make every attempt to present these additional requirements on my website so that consumers coming to my site are not mislead into believing there are no special requirements.

• I will respect the intellectual property of others by not posting unauthorized, copyrighted information on my website. To do so would infringe the owner’s rights of public display.

• I will investigate the wishes of my carrier to learn rules and regulations regarding their company name, logos, trademarks, forms and other proprietary information used on my web site or transmitted via electronic means.

• I will provide consumers of my e-commerce system complete knowledge about the services I offer. Doing so puts them in charge of the flow of information, the widest possible choice, convenience, accuracy and speed in order to make better-informed decisions.

• To the extent possible, I will NOT restrict my consumer's ability to compare by limiting my e-commerce products. To this end, I will try to present a range of premium choices, a variety of carrier options and/or referrals in areas I cannot help.
THE 10 COMMANDMENTS OF COMPUTER ETHICS

By the Computer Ethics Institute

1) Thou shalt not use a computer to harm other people: If it is unethical to harm people by making a bomb, for example, it is equally bad to write a program that handles the timing of the bomb. Or, to put it more simply, if it is bad to steal and destroy other people's books and notebooks, it is equally bad to access and destroy their files.

2) Thou shalt not interfere with other people's computer work: Computer viruses are small programs that disrupt other people’s computer work by destroying their files, taking huge amounts of computer time or memory, or by simply displaying annoying messages. Generating and consciously spreading computer viruses is unethical.

3) Thou shalt not snoop around in other people's files: Reading other people’s e-mail messages is as bad as opening and reading their letters: This is invading their privacy. Obtaining other people’s non-public files should be judged the same way as breaking into their rooms and stealing their documents. Text documents on the Internet may be protected by encryption.

4) Thou shalt not use a computer to steal: Using a computer to break into the accounts of a company or a bank and transferring money should be judged the same way as robbery. It is illegal and there are strict laws against it.

5) Thou shalt not use a computer to bear false witness: The Internet can spread untruth as fast as it can spread truth. Putting out false "information" to the world is bad. For instance, spreading false rumors about a person or false propaganda about historical events is wrong.

6) Thou shalt not use or copy software for which you have not paid: Software is an intellectual product. In that way, it is like a book: Obtaining illegal copies of copyrighted software is as bad as photocopying a copyrighted book. There are laws against both. Information about the copyright owner can be embedded by a process called watermarking into pictures in the digital format.

7) Thou shalt not use other people's computer resources without authorization: Multiuser systems use user id's and passwords to enforce their memory and time allocations, and to safeguard information. You should not try to bypass this authorization system. Hacking a system to break and bypass the authorization is unethical.
8) Thou shalt not appropriate other people's intellectual output: For example, the programs you write for the projects assigned in this course are your own intellectual output. Copying somebody else's program without proper authorization is software piracy and is unethical. Intellectual property is a form of ownership, and may be protected by copyright laws.

9) Thou shalt think about the social consequences of the program you write: You have to think about computer issues in a more general social framework: Can the program you write be used in a way that is harmful to society? For example, if you are working for an animation house, and are producing animated films for children, you are responsible for their contents. Do the animations include scenes that can be harmful to children? In the United States, the Communications Decency Act was an attempt by lawmakers to ban certain types of content from Internet websites to protect young children from harmful material. That law was struck down because it violated the free speech principles in that country's constitution. The discussion, of course, is going on.

10) Thou shalt use a computer in ways that show consideration and respect: Just like public buses or banks, people using computer communications systems may find themselves in situations where there is some form of queuing and you have to wait for your turn and generally be nice to other people in the environment. The fact that you cannot see the people you are interacting with does not mean that you can be rude to them.
A Word On Unsolicited Online Advertising

Unsolicited advertising by e-mail, commonly referred to as spamming, is one of the web's most annoying problems. It is estimated that almost one-third of all in-box e-mails today is filled with spam. And it will approach 50% in a short time.

Despite today's sophisticated spam-killer programs, we are doomed to receive this unwanted e-mail. A recent North American survey of 1,000 consumers by Insight Express said 65 per cent of respondents spend more than 10 minutes a day dealing with spam. And 37 per cent of respondents get more than 100 spam e-mails a week.

Today, sophisticated spamming gets to many e-mail recipients by massive hit-and-miss deliveries, hitting popular online e-mail services first. Many Internet providers offer filtering services from their servers, but they can also block legitimate e-mail.

In the next chapter, we will be discussing privacy protection from spamming, including many new laws that prohibit its use.

California Adjuster Law & Related Rules

California Codes

CA Insurance Code Section 15027 -- Contracts

(a) No licensee shall, directly or indirectly, act within this state as a public insurance adjuster without having first entered into a contract, in writing, on a form approved by the insurance commissioner and executed in duplicate by the public adjuster and the insured or a duly authorized representative. One original contract shall be kept on file by the licensee, available at all times for inspection, without notice, by the commissioner or his or her duly authorized representative, and one original contract shall be given to the insured.

(b) The written contract between the licensee and the insured shall contain each of the following:

(1) Title of "Public Adjuster Contract."
(2) The name, business name, license number, telephone number, and address of the licensee.
(3) The name and address of the insured.
(4) A description of the loss and its location, if applicable.
(5) The name of the insurer and the policy number, if known.
(6) The full salary, fee, commission, or other consideration the licensee is to receive for services under the contract.
(7) A description of the services to be provided to the insured.
(8) Signatures of the licensee and the insured.
(9) The date the contract was signed by the licensee and the date the contract was signed by the insured.
(10) The following statement: "As a public adjuster, I am required by the California Insurance Code to post a surety bond in the sum of $20,000 to cover certain kinds of claims made by you, the insured. If you have any questions concerning the surety bond, you may contact the California Department of Insurance Producer Licensing Call Center at 1-800-967-9331 or www.insurance.ca.gov."
(11) A statement of the compensation to the licensee, including the percentage and base to which the percentage applies.
(12) A statement that the insured has the right to rescind the contract within three business days of signing it.

(c) A contract covered by this section shall not contain a contract term that does any of the following:

(1) Allows the licensee's fee to be collected when money is due from an insurer, but not paid, or allows a licensee to collect the entire fee from the first payment issued by an insurer, rather than as a percentage of each payment issued by an insurer.
(2) Requires the insured to authorize an insurer to issue a payment only in the name of the licensee.
(3) Imposes late fees or collection costs on the insured.

(d) No licensee shall solicit or attempt to solicit a client for employment during the progress of a loss-producing occurrence.

(e) No licensee or any other person or entity offering, for a fee, service regulated by this chapter shall solicit a client for employment or initiate any contact with a policyholder between the hours of 6 p.m. and 8 a.m.

(f) No licensee shall use any form of contract other than that approved by the commissioner and which contains each of the following:

(1) A provision allowing the client to rescind the contract by written notice sent or delivered by certified mail, return receipt requested, or other form of mailing which provides proof of mailing, to the licensee by midnight of the third business day after the day on which the client signs a contract which complies with this section. Each copy of the contract shall contain a completed form, captioned "Notice of Cancellation," which shall be placed at the end of the contract and be separated from the remainder of the contract by a printed line. Nothing shall be printed on the reverse side of the notice form. The notice form shall be completed by the licensee, and shall contain in type of at least 10-point the following statement written in the same language, e.g., Spanish, as used in the contract:

Notice of Cancellation

______________________________
(Date of Contract)

You may cancel this contract within three business days from the above date without any penalty or obligation to pay your public adjuster, other than for reimbursement of moneys paid by your public adjuster for out-of-pocket emergency expenses for you or on your behalf. If your public adjuster seeks reimbursement from you for out-of-pocket emergency expenses, your public adjuster shall provide you with an itemized statement of those emergency expenses advanced to you or on your behalf if the cancellation is made within the first three business days after the contract was initiated. Nothing in this contract permits your public adjuster to recover any costs, except for out-of-pocket emergency expenses advanced to you. If you cancel, any money or other consideration paid by you will
be returned within five business days following the receipt of your
cancellation notice, and any security interest arising out of the
transaction will be canceled.
To cancel this contract, mail or deliver by certified mail, return
receipt requested, or other form of mailing which provides proof of
mailing, a signed and dated copy of this cancellation notice, or any
other written notice, or send a telegram to:

__________________________________________________
(name of public adjuster)

__________________________________________________
at

__________________________________________________
(address of public adjuster's place of business)

not later than midnight of________________________
(Date)

I hereby cancel this contract_____________________
(Date)

__________________________________________________
(Client's signature)

(2) The statement "WE REPRESENT THE INSURED ONLY" prominently displayed in at
least 10-point type.

(3) A provision disclosing the percentage of the insured's claim, or other fee, that the licensee
will charge for his or her services. The licensee shall obtain the initials of the insured next
to this provision.

(4) A conspicuous statement in at least 10-point type in immediate proximity to the space
reserved for the client's signature, as follows: "You may cancel this contract at any time
before midnight of the third business day after the date of this contract. See the notice of
cancellation form at the end of this contract for an explanation of this right."

(g) No licensee shall knowingly make any false report to his or her employer or divulge to any
other person, except as he or she may be required by law to do so, any information acquired by
him or her except at the direction of the employer or a client for whom the information is
obtained.

(h) No licensee shall use a badge in connection with the official activities of the licensee's
business.

(i) No licensee shall permit an employee or agent in his or her own name to advertise, engage
clients, furnish reports, or present bills to clients, or in any manner whatever to conduct
business for which a license is required under this chapter.

(j) Pursuant to subdivisions (a) and (c) of Section 15006, the commissioner shall have the
authority to enforce the provisions of this chapter and prosecute violations thereunder
committed by unlicensed persons or entities that hold themselves out or act as public
insurance adjusters.

(k) For purposes of this section, "business day" shall have the same meaning given to that term
in subdivision (e) of Section 1689.5 of the Civil Code, as in effect on the operative date of this
statute.
(l) The contract and the notice of cancellation set forth in paragraph (1) of subdivision (f) shall be written in the same language, e.g., Spanish, as principally used in the negotiation of the contract.

(m) Within five business days after a contract has been canceled, the licensee shall tender to the client any payments made by the client and any note or other evidence of indebtedness, including an itemized statement of all amounts tendered to the client.

(n) The licensee is not entitled to compensation for services performed prior to cancellation, other than for reimbursement of moneys paid by the licensee for out-of-pocket emergency expenses for the client or on behalf of the client. If the licensee seeks reimbursement from the client for out-of-pocket emergency expenses, and if the cancellation is made within the first three business days after the contract was initiated, the licensee shall provide the client with an itemized statement of those emergency expenses advanced to the client or on behalf of the client by the licensee. Nothing in this subdivision shall permit the licensee to recover any costs, except for out-of-pocket emergency expenses advanced to the client. Any security interest shall be canceled upon cancellation of the contract.

(o) Notice of cancellation given by the client need not take the particular form specified in paragraph (1) of subdivision (f). Notice of cancellation, however expressed, is effective if it indicates the intention of the client not to be bound by the contract.

(p) Cancellation occurs when the client gives written notice of cancellation by certified mail, return receipt requested, or other form of mailing which provides proof of mailing, to the licensee at the address specified in the contract.

(q) Notice of cancellation, if given by mail, is effective when sent by certified mail, return receipt requested, or other form of mailing which provides proof of mailing, properly addressed with postage prepaid.

(r) Until the licensee has complied with this section, the client may cancel the contract.

(s) The contracts shall be executed in duplicate. The licensee shall retain one original contract, and shall provide the insured with an original contract.

(t) The licensee shall provide the client with an original contract and notice of cancellation at the time the client signs the contract.

(u) Any confession of judgment or waiver of the provisions of this chapter shall be deemed contrary to public policy and shall be void and unenforceable.

(v) Prior to the signing of the contract, the licensee shall provide the insured with a separate printed disclosure document if the following form that bears the name and license number of the licensee:

"DISCLOSURE

There are three types of insurance adjusters that could be involved in the processing of your insurance claim. The definitions of the three types are as follows:

(1) Public adjusters means the insurance adjusters who do not work for your insurance company. They work for you, the insured, to
assist in the preparation, presentation, and settlement of your claim. You hire them by signing a contract and agreeing to pay them a fee or commission based on a percentage of the settlement, or other method of compensation. Public adjusters are required to be licensed, bonded, and tested by the State of California to represent your interest only.

(2) Company adjusters means the insurance adjusters who are employees of your insurance company. They represent your insurance company and are paid by your insurance company. They will not charge you a fee and are not individually licensed or tested by the State of California.

(3) Independent adjusters means the insurance adjusters who are hired on a contract basis by your insurance company to represent the company in the settlement of the claim. They are paid by your insurance company. They will not charge you a fee.

You have the right, but are not required, to use the services of a public adjuster in the preparation and handling of your insurance claim.

Public adjusters cannot solicit your business while the loss is underway, or between the hours of 6 p.m. and 8 a.m.

Your "Public Adjuster Contract," with a public adjuster representing you, should clearly indicate the amount of the fee you will be paying to your public adjuster. Your contract, with this fee percentage, should be acknowledged by your initials on the "Public Adjuster Contract." The salary, fee, commission, or other consideration is to be paid by you (the insured), not the insurance company (insurer).

You have the right to cancel the contract with your public adjuster, without any penalty or obligation, within three business days from the date the contract is signed.

If you cancel the contract with your public adjuster, any money or other consideration paid by you will be returned within five business days following the receipt of your cancellation notice, and any security interest arising out of the transaction will be canceled.

To cancel the contract with your public adjuster, mail or deliver by certified mail, return receipt requested, or other form of mailing which provides proof of mailing, a signed and dated copy of the cancellation notice, or any other written notice, or send a telegram to the public adjuster at the address in the contract.

You have the right to, and may, communicate with your insurance company at any time if you feel the need during the claims process.

If you have any concerns or questions, the officers at the California Department of Insurance Consumer Hotline are there to help you. Please call them at 1-800-927-HELP (4357), or www.insurance.ca.gov."

(w) No later than three business days after the cancellation has expired, the public adjuster shall notify the insurer, its adjuster, or its attorney, that he or she has entered into a written contract with the insured.
(x) If the licensee misrepresents or conceals a material fact from the insured prior to execution of the contract, the insured is entitled to rescind the contract without time limit.

**California Insurance Code Section 15027.1 -- Disasters**

(a) A licensee shall not solicit a contract of engagement for residential properties under this chapter until seven calendar days have elapsed after the occurrence of a disaster.

(b) Subdivision (a) shall not apply if the licensee is contacted directly by the insured or the insured's representative.

(c) For the purposes of this section, "disaster" means a loss-producing event that damages or destroys more than 25 dwellings, or a "disaster" as that term is defined in subdivision (b) of Section 1689.14 of the Civil Code.

**California Insurance Code Section 15027.5 – Insurer Authority**

Any person acting as a public adjuster who has executed a contract as described in Section 15027 is the agent of the insured.

While acting under the authority of such a contract, a public adjuster may not receive any fees or other consideration, monetary or otherwise, from either the insured or any other source, in excess of the amount or percentage provided in the contract. Any compensation received by the public adjuster from any party or any other source connected to the claim adjustment, including any contractor, insurer, or vendor, shall be disclosed by the public adjuster to the insured.

The insured may rescind the contract if the adjuster fails to make the required disclosure or if the public adjuster's receipt of any compensation from a third party conflicts with the interests of the insured.

**California Insurance Code Section 15028 – Adjuster Actions**

No person licensed as a public insurance adjuster shall do any of the following:

(a) Use any misrepresentation to solicit a contract or agreement to adjust a claim.

(b) Solicit or accept remuneration from, or have a financial interest in, any salvage, repair or other firm which obtains business in connection with any claim he or she has a contract or agreement to adjust.

(c) Advance moneys to any potential client or insured in order to obtain business.

(d) Offer to pay a fee, commission, or other valuable consideration, exceeding one hundred dollars ($100), to a person for referring a loss unless he or she employs that person to so act for him or her and that person is licensed to act as an adjuster under the provisions of this chapter.

**California Insurance Code Section 15028.5 – Adjuster Records**

(a) A public insurance adjuster shall maintain a complete record of each of his or her transactions as a public insurance adjuster. The records shall include all of the following:

(1) The name of the insured.
(2) The date, location, and amount of the loss.
(3) A copy of the contract between the public insurance adjuster and the insured.
(4) The name of the insurer and the amount, expiration date, and number of each policy carried with respect to the loss.
(5) An itemized statement of the recoveries by the insured from the sources known to the public insurance adjuster.
(6) The total compensation received for the adjustment.
(7) An itemized statement of disbursements made by the public insurance adjuster from recoveries received on behalf of the insured.

(b) Records shall be maintained for at least five years after the termination of the transaction with the insured, and shall be open to examination by the commissioner.

**California Insurance Code Section 15028.6 – Claim Proceeds**

All funds received as claim proceeds by any person acting as a public insurance adjuster are received and held by that person in his or her fiduciary capacity. Any person who diverts or appropriates any fiduciary funds for his or her own use is guilty of theft and punishable for theft as provided by law. Every applicant for a license to act as a public insurance adjuster shall, as part of the application, endorse an authorization for disclosure to the commissioner of all financial records of any fiduciary funds as defined in this section, pursuant to Section 7473 of the Government Code. The authorization shall continue in force and effect for so long as the licensee continues to be licensed by the department.

**California Insurance Code Section 15028.7 – Fund Handling**

(a) A public adjuster who receives, accepts, or holds any funds on behalf of an insured towards the settlement of a claim for loss or damage shall deposit the funds in a non-interest-bearing escrow or trust account in a financial institution that is insured by an agency of the federal government in the adjuster's home state or the state where the loss occurred.

(b) All funds held in an escrow or trust account shall be the property of the insured and shall be held pursuant to a written contract signed by the insured and the public adjuster.

(c) A public adjuster who receives any fiduciary funds shall, within 15 business days of receipt, deposit the funds in the escrow account and provide a written statement to the insured showing the amount of funds received and deposited in escrow.

(d) A public adjuster who, after reasonable diligence, is unable to obtain the endorsements of all payees designated on any bank draft representing fiduciary funds, or who receives a written statement from the insured indicating that he or she does not wish to establish an escrow or trust account, shall be exempt from the requirements of subdivisions (a) to (c), inclusive.

(e) The endorsement by a payee designated on any bank draft representing fiduciary funds shall not be construed as a waiver of any potential right of the payee to dispute the public adjuster's entitlement to those funds or any portion thereof.

**California Insurance Code Section 14021 -- Investigations**

An insurance adjuster within the meaning of this chapter is a person other than a private investigator as defined in Section 7521 of the Business and Professions Code who, for any consideration whatsoever, engages in business or accepts employment to furnish, or agrees to
make, or makes, any investigation for the purpose of obtaining, information in the course of adjusting or otherwise participating in the disposal of, any claim under or in connection with a policy of insurance on behalf of an insurer or engages in soliciting insurance adjustment business or aids an insurer in any manner with reference to:

Crime or wrongs done or threatened against the United States of America or any state or territory of the United States of America; the identity, habits, conduct, business, occupation, honesty, integrity, credibility, knowledge, trustworthiness, efficiency, loyalty, activity, movement, whereabouts, affiliations, associations, transactions, acts, reputation, or character of any person; the location, disposition, or recovery of lost or stolen property; the cause or responsibility for fires, libels, losses, accidents, or damage or injury to persons or to property; or securing evidence to be used before any court, board, officer, or investigating committee.

Notwithstanding any other provision of law, this section is in no way intended to limit the ability of a duly licensed independent insurance adjuster to perform the duties of an independent insurance adjuster for any other entity.

California Insurance Code Section 14022.5 – Emergency Adjusters

(a) In the event of an emergency situation as declared by the commissioner, claims arising out of the emergency, catastrophe, disaster, or other similar occurrence may be adjusted by a nonlicensed adjuster upon registration with the commissioner if all of the following requirements are met:

(1) The work performed by the nonlicensed adjuster is under the active direction, control, charge, or management of a licensed adjuster or an insurer authorized to do business in this state.

(2) Registration with the commissioner is accomplished within 15 working days from the date on which the nonlicensed adjuster commences the claims adjusting activity in connection with the emergency situation.

(b) "Registration," within the meaning of this section, shall mean a written letter to the commissioner, submitted by the supervising licensed adjuster or admitted insurer, naming the nonlicensed adjusters, identifying their adjuster licenses held in other jurisdictions, and stating when their claims adjusting activity commenced.

(c) Registration under this section is valid for a period of 180 days from the date of the registration letter. Before the lapse of that period, the commissioner may grant further 180-day extensions as he or she deems appropriate upon written request from the supervising licensed adjuster or the admitted insurer.

California Code of Regulations, TITLE 10 -- Standards for Prompt, Fair and Equitable Settlements.

(a) No insurer shall discriminate in its claims settlement practices based upon the claimant's 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.
(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 policy provision, condition or exclusion, the written denial shall include reference thereto and provide an explanation of the application of the 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 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 Insurance Code [i.e. only those that cover hospital, medical, or surgical expenses, but NOTE: disability INCOME insurance IS subject to the requirements of IC 2695.7(b). DOI has been giving INCORRECT information about this to inquirers!], life insurance subject to Section 10172.5 of the Insurance Code, or mortgage guaranty insurance subject to Section 12640.09(a) of the 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 Insurance Code.

(c) 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, then, 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) No insurer shall 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.
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 timely 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.

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 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 the final amount offered in settlement of the 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.

Upon acceptance of the claim 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 of the amount of the claim which has been determined and is not disputed by the insurer. In claims where multiple coverage is involved, payments which are not in dispute and where the payee is known shall be tendered immediately, but in no event in 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. This subsection shall not apply where the policy provides for a waiting period after acceptance of claim and before payment of benefits.

Subsection 2695.7(h) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the Insurance Code, of life insurance subject to Section 10172.5 of the Insurance Code, of mortgage guaranty insurance subject to Section 12640.09(a) of the Insurance Code, or of fire insurance subject to Section 2057 of the
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 Insurance Code.

(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 Insurance Code Sections 1871.1(a) and 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 to pay medical benefits shall do so only when the insurer has a good faith belief that such an examination is necessary to enable the insurer to determine the reasonableness and/or necessity of any medical treatment.

(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.
California Insurance Code Section 1749.85 – Agents & Values

(a) The curriculum committee shall, in 2006, make recommendations to the commissioner to instruct fire and casualty broker-agents and personal lines broker-agents and applicants for fire and casualty broker agent and personal lines broker-agent licenses in proper methods of estimating the replacement value of structures, and of explaining various levels of coverage under a homeowners' insurance policy. Each provider of courses based upon this curriculum shall submit its course content to the commissioner for approval.

(b) A person who is not an insurer underwriter or actuary or other person identified by the insurer, or a licensed fire and casualty broker-agent, personal lines broker-agent, contractor, or architect shall not estimate the replacement value of a structure, or explain various levels of coverage under a homeowners' insurance policy.

(c) This section shall not be construed to preclude licensed appraisers, contractors and architects from estimating replacement value of a structure.

(d) However, if the Department of Insurance, by adopting a regulation, establishes standards for the calculation of estimates of replacement value of a structure by appraisers, then on and after the effective date of the regulation a real estate appraiser's estimate of replacement value shall be calculated in accordance with the regulation.

Consumer Protection

Rules and regulations vary from state to state. There are, however, widely accepted codes of behavior expected from licensed adjusters that fall under the category of consumer protection. Some of these laws live and breathe outside the venue of insurance codes. However, they are just as lethal and can't be ignored.

Conflicts that surface in the consumer protection area are usually the result of violations in advertising and deceptive or unfair trade practices. Adjusters in the real world find it near impossible to know each and every consumer statute, yet a single mistake could jeopardize a career and personal assets. Sometimes, it is the tiny indiscretions in business that create the problem. For example, placing a small and seemingly harmless “sub-title” on your letterhead that says “Public Adjuster” when you are not could hold you accountable for more than you bargained. Knowing what is expected of adjusters in the consumer protection arena is the best place to reduce and avoid these problems.

ADVERTISING

Insurance advertising is highly regulated with guidelines that differ from state to state. These guidelines determine what is communicated in an advertising message, how it is communicated, and how it looks. In fact, much of what adjusters communicate probably falls under the legal definition of advertising. Failure to comply with state laws could require the insurer and adjuster to cease doing business and incur penalties.

Advertising includes all materials designed to create public interest in an insurer.

Communication used purely for internal purposes and not intended for public use is not considered advertising, as well as policy holder communications that DO NOT encourage policy modifications.
The consequences of using nonapproved advertising are both severe and damaging. Insurance regulators concerned about an advertisement’s content may require that ALL future advertising for the entire company be submitted for prior state approval. This would be disruptive and time-consuming. Additionally, a violation in advertising may carry fines of $1,000 or more per violation. As an example, 1,000 misleading flyers could be assessed a fine of $1 million ($1,000 X 1,000). To avoid these kinds of conflicts advertising should comply on several fronts:

If advertising focuses on a specific company it is advised that the FULL NAME of the company be used along with the home office address (City and State). Initials or abbreviations are not acceptable to most companies or insurance regulators.

For specific product ads, the policy or contract type should be clearly and accurately identified.

As a general rule, the advertising piece, when examined as a whole, cannot lead a person of average intelligence to any false conclusions. These conclusions can be based on the literal meanings of words in the ad and impressions from pictures or graphics as well as materials and descriptions omitted from the advertising piece.

Never use or imply an endorsement or testimonial by a person or organization without their approval. Further, if a person or organization making an endorsement or analysis is an employee of or has a financial interest in the Company or receives any benefit, it should be prominently displayed.

**IDENTIFICATION & DEFAMATION**

Adjusters should clearly identify themselves as insurance adjusters promoting or selling an claims adjusting services.

Defamation violations occur where an adjuster is involved in making, publishing, disseminating, directly or indirectly, any oral or written statement, pamphlet, circular, article or literature which is false or maliciously critical of or derogatory to the financial condition of any insurer or which is designed to injure any person engaged in the business of insurance.

**COERCION**

Most states consider it unlawful for licensed adjusters to enter into any agreement or commit any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

**FALSE FINANCIAL STATEMENTS**

Restrictions are very clear that an adjuster violates the law when filing with any supervisor, public official or making, publishing, disseminating, circulating or delivering to any person, directly, or indirectly, any false statement of financial condition of an insurer with intent to deceive. This also includes making any false entry in any book, report or statement of any insurer with intent to deceive any agent, examiner or public official lawfully appointed to examine an insurer's condition or any of its affairs. Willfully omitting to make a true entry of any material fact pertaining to the business of such an insurer in any book, report or statement are similar violations.
**DISCRIMINATION**

An adjuster clearly violates insurance law in making or permitting any unfair discrimination between individuals of the same class and equal expectation. Similarly, there shall be no discrimination between individuals of the same class and of essentially the same casualty hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable under such contracts. Discrimination can also occur where individuals of the same class and of essentially the same hazards are subject to reduced coverage or canceled because of geographic location.

**DECEPTIVE NAME OR SYMBOL**

Adjusters shall not use, display, publish, circulate, distribute or caused to be used or distributed any letter, pamphlet, circular, contract, policy, evidence of coverage, article, poster or other document, literature bearing a name, symbol, slogan or device that is the same or highly similar to a name adopted and already in use. This includes ads designed to associate you with or resemble government notices.

**Deceptive or Unfair Business Practices**

In addition to specified insurance codes, insurance adjusters must answer to generalized consumer protection laws carrying titles such as "Deceptive Trade Practices" or "Unfair Trade Practices". Adjusters are also pursued under consumer protection laws because some insurance codes do not specifically address certain questionable acts by adjusters where the misrepresentation or fraud occurs outside the limits of insurance business. In such cases, the damaged insureds or policy owners were not considered to be "consumers". By including the purchase of insurance services as a consumer transaction, the additional protection of deceptive or unfair trade practices acts can be invoked.

**UNLAWFUL TRADE PRACTICES**

False, misleading or deceptive acts or practices in the conduct of any trade or commerce are unlawful and subject to action by the appropriate codes of consumer protection. Such acts, which may apply to insurance adjusters, include, but are not limited to the following:

- Passing off services as those of another.
- Causing confusion or misunderstanding as to the source, sponsorship, approval or certification of services offered.
- Causing confusion or misunderstanding as to affiliation, connection or association with another.
- Using deceptive representations or designations of geographic origin in connection with services.
- Representing that services have sponsorship, approval, characteristics or benefits which they do not have.
- Disparaging services or the business of another by a false or misleading representation of facts.
- Advertising services with intent not to sell them as advertised.
- Advertising services with intent not to supply a reasonable expectable public demand, unless the advertisements disclose a limitation on quantity.

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• Representing that an agreement confers or involves rights, remedies or obligations which it
does not have or involve, or which are prohibited by law.
• Misrepresenting the authority to negotiate the final terms or execution of a consumer
transaction.
• Failure to disclose information concerning services which was known at the time of the
transaction if such failure was intended to induce the consumer into a transaction which the
consumer would not have entered had the information been disclosed.
• Advertising under the guise of obtaining sales personnel when in fact the purpose is to first
sell a service to the sales personnel applicant.
• Making false or misleading statements of fact concerning the price or rate of services.
• Employing "bait and switch" advertising in an effort to sell services other than those
advertised on different terms or rates.
• Requiring tie-in sales or other undisclosed conditions to be met prior to selling the
advertised services.
• Refusing to take orders for the advertised services within reasonable time.
• Showing defective services which are unusable or impractical for the purposes set forth in
the advertisement.
• Failure to make deliveries of the services advertised within a reasonable time or make a
refund.
• Soliciting by telephone or door-to-door as a seller, unless, within thirty seconds after
beginning the conversation the adjuster identifies himself, whom he represents and the
purpose of the call.
• Contriving, setting up or promoting any pyramid promotional scheme.
• Advertising services that are guaranteed without clearly and conspicuously disclosing the
nature and extent of the guarantee, any material conditions or limitations in the guarantee,
the manner in which the guarantor will perform and the identification of the guarantor.

To recover under deceptive or unfair trade practice acts, it is the claimant's burden to prove all
elements of his cause of action and that he is a "consumer" within meaning of the act.

Whenever the courts or consumer protection division of an insurance department have reason
to believe that any person is engaging in, has engaged in, or is about to engage in any act or
practice that may violate a trade or practices act, and that proceedings would be in the public
interest, the division may bring action in the name of the state against the person to restrain by
temporary restraining order, temporary injunction, or permanent injunction the use of such
method, act or practice. In addition, there may be a request by the consumer protection
division, requesting a civil penalty for each violation, possibly $2,000, with a maximum total not
exceed an established amount (typically $10,000). These procedures may be taken without
notification to such person that court action is or may be under consideration. Usually, however,
there is a small waiting period, seven days or more, prior to instituting court actions.

Actions which allege a claim of relief may be commenced in the district court -- usually where
the person resides or conducts business. The Court may make such additional orders or
judgments as are necessary to compensate those damaged by the unlawful practice or act.
Usually, there is a statute of limitations, typically two years, to bring such action.

USING THE POSTAL SERVICE

The Postal Service has jurisdiction over situations where the mail is used to transfer money for
products or services. It administers a powerful law but has insufficient resources to deal with
the vast number of frauds it encounters.
Most mail-order schemes attempt to exploit people's fears. Their promoters are usually "hit-and-run" artists who hope to make a profit before the Postal Service stops their false ads. When a scheme is detected, postal inspectors can file a complaint or seek an agreement with the perpetrator. When a complaint is contested, a hearing is held by an administrative law judge. If the evidence is sufficient, this judge will issue a False Representation Order (FRO) enabling the Postal Service to block and return money sent through the mail in response to the misleading ads. Although the order can be appealed to the courts, very few companies do this. Each voluntary agreement and FRO is accompanied by a cease-and-desist order that forbids both the challenged acts and similar acts. Under the Mail Order Consumer Protection Amendments of 1983, if this order is violated, the agency can seek a civil penalty in federal court of up to $11,000 per day for each violation.

UNFAIR COMPETITION AND BUSINESS PRACTICES

Adents should know that the insurance companies they represent are also subject to the insurance and practice rules above, as well as to specific deceptive or misleading acts in the areas of advertising, settlement practices, reporting procedures, discrimination (by race, disability, rates, renewal, benefits), investment practices, reinsurance restrictions, liquidations and more.

Violations of consumer protection issues by insurers will be met with an array of fines and penalties ranging from hearings before the commissioner, public hearings, judicial hearings and review, additional periodic reporting (beyond annual statements), investigative audits, dollar penalties, civil penalties to the more severe cease and desist actions and revocation of an insurer's certificate of authority to conduct business.

The following are some areas of consumer protection violations by insurers that should alert adjusters:

Unauthorized Insurer False Advertising

The purpose of consumer protection laws in this area is obvious -- insurers not authorized to transact business in the state should not place, send or falsify any advertising designed to induce residents of the state to purchase insurance. This legislation is usually directed at "foreign or alien insurers" and defines advertising to include ads in the newspaper, magazine, radio, television and illustrations, circulars and pamphlets. Violations can also include the misrepresenting of the insurer's financial condition, terms and benefits of the insurance contract issued or dividend benefits distributed.

Unfair Settlement Practices

Insurers doing business in a state are subject to rules and regulations detailing unfair claim settlement practices such as:

- Knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages.
- Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies.
- Failing to adopt and implement reasonable standards for prompt investigation of claims arising under its policies.
• Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims submitted in which liability has become reasonably clear.

• Compelling policy holders to institute lawsuits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in the suits brought by these policy holders.

• Failures of any insurer to maintain a complete record of all the complaints which it has received during recent years (usually three years) or since the date of its last examination by the commissioner. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint.

**Discrimination by Handicap**

An insurer doing business in a state may not refuse to insure, continue to insure or limit the amount, extent, or kind of coverage available to an individual, or charge an individual a different rate for the same coverage solely because of handicap or partial handicap, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonable anticipated experience.

**Discrimination by HIV Testing**

In recent years, HIV-related testing in connection with an application for insurance has become commonplace. If an insurer requests or requires applicants to take an HIV-related test, he must do so on a nondiscriminatory basis. An HIV-related test may be required only if the test is based on the person's current medical condition or medical history or if the underwriting guidelines for the coverage amounts require all persons within the risk class to be tested. Additional stipulations require that an insurer may not make a decision to require or request an HIV-related test based solely on marital status, occupation, gender, beneficiary designation or zip code. Further, the uses that will be made of the test must be explained to the proposed insured or any other person legally authorized to consent to the test and a written authorization must be obtained from that person by the insurer.

An insurer may not inquire whether a person applying for insurance has already tested negative from a previous HIV test. The insurer may inquire if an applicant has ever tested positive on an HIV-related test or has been diagnosed as having HIV or AIDS. The results of an HIV test are considered confidential, and an insurer may not release or disclose the test results or allow the test results to become known, except where required by law or by written permission from the proposed insured. Then and only then can results be released, but only to the proposed insured, a licensed physician, an insurance medical information exchange, a reinsurer or an outside legal counsel who needs the information to represent the insurer in an action by the proposed insured.

**Discrimination in Rates or Renewal**

An insurer may not discriminate on the basis of race, color, religion, or national origin, and, to the extent not justified by sound actuarial principles on the basis of geographical location, disability, sex, or age, in the setting or use of rates or rating manuals or in the nonrenewal of policies.
**Benefits Protection**

Insurers are duty bound to protect all money or benefits of any kind, including policy proceeds and cash values to be paid or rendered to the insured or any beneficiary under a life insurance policy or annuity contract. In essence, these benefits must inure exclusively to the person designated in the policy or annuity contract. They must be exempt from attachment, garnishment or seizure to pay any debt or liability of the insured or beneficiary either before or after the money or benefits are paid. They are also exempt from demands of a bankruptcy proceeding of the insured or beneficiary.

**Health Policy Benefits**

In the health insurance industry, benefit payments are commonly assigned to a physician or other form of health care provider who furnishes health care services to the insured. An insurer may not prohibit or restrict the written assignment of benefits. When such an assignment is requested, the benefit payments shall be made directly by the insurer to the physician or health care provider and the insurer is relieved of any further obligation. Of course, the payment of benefits under an assignment does not relieve the covered person from any responsibility for the payment of deductibles and copayments. Further, a physician or health care provider may not waive copayments or deductibles by acceptance of an assignment.

**Contract Entirety**

Every policy of insurance issued or delivered within the state by any insurance company doing business in the state shall contain the entire contract between the parties. Furthermore, the application used to secure the insurance is usually made part of the contract.

**Insurer Mergers**

The conditions and regulations necessary for two insurance companies to merge or consolidate are well documented in state insurance codes. Concerning consumer protection, however, it is important to know that all policies of insurance outstanding against an insurer must be assumed by the new or surviving corporation on the same terms and under the same conditions as if the policies had continued in force with the original insurer.

**Reinsurance Assumptions**

A method used by one insurance company to insure or reinsure another insurance company is called stock assumption. Most insurance codes do not affect or limit the right of a reinsurer to purchase or to contract to purchase all or part of the outstanding shares of another insurance company doing a similar line of business for the purpose of reinsuring all of the business including the assumption of its liabilities.

Despite the practice of assumption reinsurance, some members of Congress in recent years have objected to the process, since there is no requirement to inform policy holders in advance that the insurance company behind their policy is relinquishing responsibility to another company, that is, the reinsurer. The reasoning behind their concern is that policy holders who have purchased coverage based on the financial condition and reputation of one company may suddenly find themselves insured by another company without warning or knowledge of the new company's abilities to pay their claims. To date, however, there is no definitive legislation passed to change reinsurance assumption.


*Adjuster Conduct Litigation*

Imagine that your everyday decisions were under constant scrutiny by an expert on insurance matters. Imagine again that the entire focus of a professional, trained in insurance litigation, was to critique the minute-by-minute actions you performed for a client on a specific day... two or three years back! Imagine further that a slight oversight in favor of your client's insurance claim is ultimately the basis of his malpractice claim against you. Can't happen? Think again.

You could be facing many of these same things as an adjuster on trial. Would you pass the muster at every juncture? How much would it cost to defend yourself? Could there are things you can do to reduce a negative outcome or major financial judgment against you?

As you will soon see, some legal problems are self-inflicted by adjusters themselves; some result by being in the path of the problem without a proper defense or procedure system in place; others are simply human error... they're part of the business... part of life.

NOTE: The purpose of citing court cases is not to scare the adjuster reader. Rather, it is to make one aware that adjusters CAN become part of a legal action even when they have done nothing wrong. In some cases this has to do with the “shotgun” approach by attorneys that names everyone involved in the matter. Of course, a dismissal of the adjuster from a case is welcome, but the stress and expense of trials can already have taken their toll. An adjuster can outlay $20,000 to $40,000 in their defense that may not be recoverable. Wrongdoing, on the other hand, can amount to much more and could become a tipping point for someone losing their business, home and other assets.

It is also important to note that the content in THIS COURSE DOES NOT CONSTITUTE LEGAL ADVICE. We leave that to trained legal professionals. Rather, the purpose of this course is to alert you to the flashpoints that boil to the surface when an insurance legal issue is pending

**AMERICAN CENTURY CASUALTY v. CARTER, AVERY, DUMAS (2009)**

*Source:* Lexisone

*Summary:* An adjuster accepted a settlement demand / release without consulting other parties to the action. Negligence and bad faith charges were leveled against the insurer and adjuster.

Tammy Carter drove her car off a road in Decatur, Georgia, and struck and killed John Dumas. Carter later pleaded guilty to driving under the influence of alcohol and [*2*] homicide by vehicle. At the time of the accident, Carter was insured by American Century through an automobile policy that provided coverage for bodily injuries of $25,000 per person and $50,000 per accident. Dumas's surviving spouse, Melissa, and daughter, Camille, sought to recover from Carter, and American Century assigned McMasters, an insurance adjuster, to resolve their claim.

The Dumases mailed to McMasters a settlement demand for Carter's policy limit of $25,000. The demand stated that, "In consideration for payment [of] [the] policy limits," the Dumases agreed to "sign a release of American Century Casualty Insurance Company, its heirs, assigns and affiliates, for the claims arising by virtue of the injuries to and death of John C. Dumas." The Dumases stated that they refused "to release Ms. Carter in exchange for the payment of her limits under [the] policy" and "[t]hey [would] execute no release that directly or indirectly release[d] Ms. Carter." The Dumases explained that they "simply [sought] to exhaust the funds available through [the] policy, thereby releasing [American Century] from liability, while reserving
any claims they may have against Ms. Carter." The Dumases [*3] demanded that American Century "specifically stipulate [in the release] that [the Dumas family] reserve[d] all claims they have or might have against . . . Tammy Renee Carter, her heirs or assigns."

McMasters "agree[d] to the terms of [the] demand" without contacting Carter or making a counteroffer. American Century tendered to the Dumases a $ 25,000 check and an agreement to release both American Century and Carter. The Dumases refused to execute the agreement and wrote to American Century that they refused to release Carter. The Dumases explained that "acceptance of [their] demand [did] not actually make much of a difference for American Century. . . . [because] [they] [were] not going to release Ms. Carter no matter whether the payment [was] made or not." American Century asserted that McMasters had agreed to the demand by mistake, and the Dumases sued American Century to enforce the terms of the settlement agreement. American Century agreed to pay the Dumases $ 25,000, and the Dumases dismissed their lawsuit.

The Dumases filed a complaint in a Georgia court alleging that Carter had caused the wrongful death of John Dumas. American Century retained counsel to represent Carter and [*4] defended her in the lawsuit for over a year. In the meantime, the Dumases offered to settle with Carter in exchange for her consent to a judgment and her assignment of her potential claims against American Century. Under the terms of the offer, the Dumases retained the right to collect from Carter if the lawsuit against American Century was unsuccessful, but Carter refused the offer. The Dumases and Carter later agreed to a settlement in which Carter consented to a four million dollar judgment and assigned to the Dumases her potential claims against American Century and the Dumases relinquished their right to collect from Carter.

American Century filed a complaint in federal court seeking a declaration that it was not liable to the Dumases as assignees of Carter. American Century alleged that Carter had breached her contractual duty as an insured to cooperate to resolve a claim. American Century also alleged that Carter had colluded with the Dumases to manufacture a claim against American Century.

The Dumases filed a complaint in a Georgia court that alleged American Century and McMasters had acted negligently and in bad faith by accepting the demand of the Dumases without requiring [*5] them to relinquish all claims against Carter. The Dumases sought as damages the difference between the consent judgment and Carter's policy limit.

American Century and McMasters removed the action filed by the Dumases to federal court based on diversity of citizenship. 28 U.S.C. § 1332. American Casualty and McMasters moved to dismiss McMasters and alleged that the Dumases had fraudulently joined McMasters to defeat diversity jurisdiction. The district court dismissed McMasters.

The district court consolidated the actions by American Century and the Dumases, and the parties agreed to submit a stipulation of facts to resolve the corresponding duties of American Century and Carter. The district court entered a judgment in favor of American Century. The district court concluded that American Century did not act in bad faith by failing to obtain a release for Carter because the Dumases had made clear they would not settle with Carter for the limits of her policy.

We review the decision to proceed with a declaratory judgment action for abuse of discretion. Guideone Elite Ins. Co. v. Old Cutler Presbyterian Church, Inc., 420 F.3d 1317, 1324 (11th Cir. 2005). "[W]hen employing [*6] an abuse of discretion standard, we will leave undisturbed a district court's ruling unless we find that the district court has made a clear error of judgment, or has applied the wrong legal standard." Id. at 1325.
The Dumases argue that American Century misused the process for obtaining a declaratory judgment by preempting a tort claim that should be resolved by a Georgia court, but we disagree. The district court was obliged to resolve an actual controversy within its jurisdiction. 28 U.S.C. § 2201; Scott-Burr Stores Corp. v. Wilcox, 194 F.2d 989, 990 (5th Cir. 1952).


The judgment in favor of American Century was AFFIRMED.

UNITED STATES OF AMERICA v. BRANDON KEITH DIAL.

Source: Lexisone September 11, 2008

Summary: An insurance adjuster was caught paying himself by filing false claims.

Brandon Dial appeals the sentence imposed after he pleaded guilty of mail fraud and uttering false securities. Dial was an insurance adjuster who defrauded his employer by paying himself and others for invalid insurance claims. He contends that the district court erred by increasing his offense level under U.S.S.G. § 3B1.3 for abusing a position of trust. He argues that he was merely a "run-of-the-mill" claims adjuster without significant professional or managerial responsibility.

Dial had discretionary authority to settle and pay claims of up to $10,000 and de facto discretion to settle and pay up to $25,000 for some property claims. That authority placed him in a posture to commit the offense superior to that of the general public, thereby putting him in a position of trust that he abused.

The judgment was AFFIRMED.


Source: Lexisone

Summary: An adjuster was sucked into a lawsuit due to insufficient papers and releases for settlement payments.

Mr. Woolridge's 1986 BMW was damaged in October of 1998, when a J.F.L. employee rear-ended it. J.F.L.'s insurance carrier, Fireman's Fund, tried to settle the claim by issuing three checks: The first, in the amount of $780.00, was payable to Savage BMW and bore the notation "FOR STORAGE ON VEHICLE FOR JFL RE: Woolridge Invoice # 10018." Two more checks were issued, payable to Woolridge. A $3,000 check bore the notation "For full and final
settlement for your injury." A $ 6,545 check bore the notation "For the total loss of your vehicle and advance car rental for 27 n2 per day for 44 days."

Accompanying the checks was a release form which Woolridge was instructed to sign and return. He did not sign the release, but he cashed both checks. The $ 3,000 check was cashed without reservation. Before cashing the $ 6,545 check, he wrote "partial payment" next to his endorsement, but he did not cross out the "full and final settlement" language on the face of the check.

After cashing the checks, Woolridge sued J.F.L. for additional sums he alleged J.F.L. still owed him. As noted above, J.F.L. succeeded in obtaining summary adjudication as to Woolridge’s claim for bodily injury damages, based upon evidence that he had cashed the $ 3,000 check without reservation. Because summary judgment was denied on the property damage and loss of use claims, these claims went to trial.

Mr. Woodridge testified that, in his opinion, his car was worth $ 15,000 before the accident, and the cost to repair would be $ 11,840.72. He alluded to an estimate from Arrow Glenn Appraisal, but a hearsay objection to that evidence was sustained. He also contended he was entitled to loss of use damages of $ 27 per day for 487 days.

Mr. Clark, the Fireman's Fund adjuster, disagreed with Mr. Woolridge's evaluation. He testified he had obtained a professional appraisal showing the cost to repair exceeded the car's market value and therefore the company considered the car a "total loss." He then explained how he had computed salvage value and arrived at the $ 6,545 settlement amount that Woolridge had received.

On the accord and satisfaction issue, while Mr. Woolridge admitted he cashed the check sent to him for property damage and loss of use, he contended he had rejected it as an accord and satisfaction. He attempted to place into evidence a letter to Mr. Clark in which he said he was not accepting the check as a full payment. Clark testified he never received the letter, possibly because it was addressed to a nonexistent post office box. The court sustained J.F.L.'s hearsay objection and excluded the letter from evidence.

Mr. Clark testified he had discussed settlement with Mr. Woolridge. Although at certain times during their discussions, Mr. Woolridge had disagreed with the value Clark was placing on his car, Clark said the check ultimately issued by the insurance company represented [*6] his understanding of the amounts for which Woolridge had agreed to settle. Mr. Woolridge denied having agreed to accept these amounts.

At the conclusion of testimony, the court took the matter under submission. Thereafter, the court gave judgment to defendant on the ground that the parties had reached accord and satisfaction on remaining claims. This appeal followed.

Viewed in this light, the record contains substantial evidence of an accord and satisfaction under California Uniform Commercial Code section 3311. It was undisputed that a bona fide dispute existed as to the amount respondent owed appellant for property damage and loss of use (Cal. U. Com. Code, § 3311, subd. (a)(2)). Respondent's witness, insurance adjuster Clark, testified that during telephone discussions with appellant, he obtained appellant's agreement to a settlement figure and, in reliance upon that agreement, mailed him the check for the settlement amount. Thus, the check was tendered in good faith. (id., § 3311, subd. (a)(1).) Appellant cashed the check. (id., § 3311 subd. (a)(3).) The check bore conspicuous statements
indicating it was tendered in full and final satisfaction of the claim. (Id., § 3311, subd. (b).) The statute was therefore satisfied and the court correctly found an accord and satisfaction had been reached. n5

Although the record does not indicate that the court considered California Uniform Commercial Code section 3311 in making its finding that the parties had reached an accord and satisfaction, we review results, not reasoning. "[A] ruling or decision, itself correct in law, will not be disturbed on appeal merely because given for a wrong reason. If right upon any theory of the law applicable to the case, it must be sustained regardless of the considerations which may have moved the trial court to its conclusion." (D'Amico v. Board of Medical Examiners (1974) 11 Cal. 3d 1, 19 [112 Cal. Rptr. 786, 520 P.2d 10].) Moreover, even if Civil Code section 1526 had not been superseded, so that it controlled here, we would affirm the trial court's judgment. When statutory language is clear and unambiguous there is no need for construction and courts should not indulge in it. (In re Waters of Long Valley Creek Stream System (1979) 25 Cal. 3d 339, 348 [158 Cal. Rptr. 350, 599 P.2d 656].) The plain statutory language of Civil Code section 1526 requires "striking out" or "otherwise deleting" the full and final payment language in order to opt out of an accord and satisfaction. Appellant did neither. Rather, he added language. Therefore, he did not satisfy the statute's requirements.

Subdivision (c) of California Uniform Commercial Code section 3311 provides exceptions to an accord and satisfaction being created by mere acceptance of a check (e.g., if a check is cashed inadvertently) but nothing in the record suggests that the exceptions apply.

The judgment was affirmed.

2004 Cal. App. Unpub. LEXIS 5087,*

JOSEPH F. HARBISON v. NORCAL MUTUAL INSURANCE COMPANY et al. (2004)

Source: Lexisone

Summary: An adjuster suspecting illegal cashing of a settlement check was sued for defamation.

Plaintiff Joseph Harbison appeals from orders granting special motions to strike and awarding attorney fees to defendants Norcal Mutual Insurance Company (Norcal) and Kirsten Garcia. Harbison filed a complaint for defamation against Norcal and Garcia, one of Norcal's claims adjusters, after Garcia filed a complaint with the State Bar against Harbison.

Harbison argues his complaint was not subject to an anti-SLAPP special motion to strike because it did not arise from protected activity and because he demonstrated a probability of prevailing on his claim. He also argues the trial court abused its discretion in awarding attorney fees to Garcia and Norcal.

Garcia is a claims supervisor for Norcal. Norcal provides malpractice insurance for physicians. Harbison is an attorney who handles medical malpractice cases. Garcia complained to the State Bar that Harbison had acted unethically in two cases, Neil v. Archer and Younker v. Hamilton, in which Norcal insured the defendants. She stated her concerns as follows.

On September 5, 2000, Norcal issued a check to Louella Neil and her attorneys, Wilcoxen, Montgomery & Harbison. Louella Neil was the guardian ad litem for Scott Neil, the plaintiff in Neil v. Archer. Approximately four months later, Archer's attorney contacted Garcia to ask about
the status of the check. Archer's attorney stated Mr. Wilcoxen, Harbison's partner, told him their firm had never received the check. Archer's attorney also told Garcia that Wilcoxen, Montgomery & Harbison were disbanding.

Garcia contacted Norcal's finance department and discovered the check had not been cashed. A few days later, the finance department called Garcia to inform her the check had been cashed. When Garcia received a copy of the processed check, she noticed the firm's name and bank account number had been crossed out, and Harbison had countersigned the check for deposit into a different account. Garcia believed Harbison might have deposited the check into a personal account. Garcia was suspicious because Wilcoxen was not aware Harbison possessed the check and because Garcia believed Harbison had acted unethically in another case in which Norcal was involved, *Younker v. Hamilton*.

Garcia believed Harbison had misrepresented the amount of a MediCare/Medi-Cal lien in his settlement discussions and pleadings in the *Younker v. Hamilton* case, thereby increasing the amount of payment from Norcal. Garcia provided information to the State Bar on the *Neil v. Archer* and *Younker v. Hamilton* cases.

The State Bar notified Harbison of the complaint on March 28, 2001, and requested a response. On May 15, 2001, the State Bar informed Harbison it had determined there were insufficient grounds for disciplinary action, and that the file was being closed.

On April 10, 2002, Harbison filed a complaint against Garcia and Norcal for negligence and defamation. Defendants brought a special motion to strike the complaint pursuant to section 425.16. The motion was calendared for October 23, 2002.

One of the grounds for the motion was that Garcia's statements to the State Bar were made in the context of an official proceeding and were privileged. Although the complaint was vague as to when the alleged defamatory statements were made or what they contained, a letter from Harbison indicated the complaint related to "the malicious statement to the State Bar . . . that [Harbison] had stolen a settlement check and placed it in his personal account and . . . that he had engaged in some improprieties in the matter of *Younker v. Hamilton* . . . ."

On September 24, 2002, before the hearing on defendants' anti-SLAPP motion, Harbison filed an amended complaint. The amended complaint contained a sole cause of action for defamation. The complaint alleged that after the State Bar closed its investigation, Garcia and Norcal continued to make false and unprivileged statements regarding Harbison's handling of the settlement check in *Neil v. Archer* and about his handling of the lien in *Younker v. Hamilton* to Norcal employees, "members of the legal community, plaintiff's peers, past and/or prospective clients of plaintiff, others in and around Sacramento where plaintiff practices law and other third persons who have no need or desire to know." The first amended complaint alleged these statements had been made inter alia to attorneys Matthew Evans and Michael Ubaldi, an insurance adjuster with whom Ubaldi worked and attorneys Philip Birney and John Silas. The amended complaint further alleged the statements were made from May 23, 2001, to the present. Norcal and Garcia filed answers, by way of general denial, and affirmative defenses on or about October 28, 2002.

On October 21, 2002, defendants [*6] filed separate anti-SLAPP motions to strike the amended complaint. They alleged the amended complaint "arose from acts in furtherance of Ms. Garcia's right of free speech in connection with a public issue . . . ." Garcia filed a declaration in support of the motion. She admitted filing a complaint with the State Bar and
averred that "all of the statements I made to the State Bar were based on my understanding of the facts." However, she did not deny making statements to persons unconnected with the State Bar investigation, either before or after the investigation was closed. Instead, her points and authorities asserted any statements she may have made regarding Harbison's professional conduct were issues of public interest and were protected by the anti-SLAPP statute whether or not they were made after the investigation terminated.

Harbison filed an unsworn declaration in opposition to the anti-SLAPP motion wherein he asserted he learned for the first time after the State Bar investigation was closed that the same sort of statements Garcia made to the State Bar had been published and republished to others who were not related to the State Bar inquiry. Harbison stated his amended [*7] complaint was not based on any statements to the State Bar, but on the publication of statements outside the State Bar process.

Harbison filed another sworn declaration. In it he stated that after the State Bar closed its investigation, he began to encounter colleagues not associated with the investigation who told him they had heard from Norcal adjusters, including Garcia, that Harbison stole client funds, lied about the amount of Medicare and Medi-Cal liens, and had acted in an unethical manner. He stated he learned on May 23, 2001, that false and unprivileged statements had been made to attorneys Matthew Evans, Michael Ubaldi and an insurance adjuster with whom Ubaldi was working, Philip Birney, and John Silas. He also stated Norcal had accused him "of lying about the amount of liens at every opportunity, including at every settlement conference [he] attended in which NORCAL was involved."

The trial court granted the anti-SLAPP motions to strike. It found the statements Garcia made to the State Bar were protected statements made in connection with a public issue as defined in section 425.16, subdivision (e). It also found the alleged republication of Garcia's statements to [*8] the State Bar to other members of the legal community and to Harbison's peers was also protected because the republication concerned matters of interest to the public. The trial court also found such republication was protected because it was "intertwined" with the complaint to the State Bar, thus itself was an act in furtherance of the right of petition or free speech.

The trial court found none of Harbison's evidence showed defendants made a defamatory statement after the conclusion of the investigation of the State Bar complaint. It found Harbison's unsworn declaration identifying the individuals to whom the republication was made was insufficient to avoid an order striking the complaint. The court found Harbison failed to provide admissible evidence to establish a probability of prevailing on the claim, and dismissed the action. The court ordered defendants to file a separate motion for attorney fees.

Garcia submitted an attorney fee motion pursuant to section 425.16, requesting attorney fees and costs in the amount of $38,631.50. Norcal submitted an attorney fee motion pursuant to section 425.16, requesting attorney fees and costs in the amount of $26,292.05.

The trial court granted Garcia's motion in part and denied it in part. It found Garcia's evidence with respect to attorney fees was deficient, and that the billing was excessive. It awarded Garcia $24,280.66, finding this amount to be reasonable.

The trial court found the rates charged by Norcal's attorney to be reasonable, but the time spent not reasonable. The court disallowed all amounts charged for matters not specifically related to the anti-SLAPP motion. The trial court awarded Norcal attorney fees and costs in the total amount of $24,071.05.
Harbison appealed the orders granting the anti-SLAPP motion and the attorney fee awards. The court concluded that where there are unrefuted allegations that a defendant in a defamation action made false and unprivileged statements regarding specific attorney misconduct, and the statements are unconnected to a State Bar investigation or any other official proceeding, the action is not subject to an anti-SLAPP motion on the ground attorney misconduct is a public issue or matter of public interest.

Since we have determined defendants did not meet their burden as to this threshold issue, we need not consider plaintiff's probability of success on the merits. In addition to reversing the motions to strike, we shall reverse the orders granting defendants' attorney fees.

The judgment (orders) was reversed. Appellant shall recover costs on appeal, i.e., the adjuster had to give back the attorney's fees.


Source: Lexisone

Summary: An adjuster's inexperience and alleged bad faith were used in an action against the insurer.

Dorothy Greene (appellant) sued Century National Insurance (CNI) and its parent Kramer-Wilson Company Insurance Services (collectively referred to as respondents), in connection with damages incurred to her three apartment buildings from the Northridge earthquake (the Northridge earthquake) of January 17, 1994. After a ten week-long bifurcated jury trial, the jury awarded her $2,210,000 in contract damages, $47,000 for breach of the covenant of good faith and fair dealing, and $1 million in punitive damages.

The court granted a motion for a judgment notwithstanding the verdict (JNOV), in part. It struck the compensatory damages for bad faith and the resulting punitive damages. It denied the motion with regard to the jury's award for breach of contract. It then granted respondents' motion for a new trial on the contract damages conditioned on appellant accepting remittitur to the sum of $700,000. Appellant did not accept remittitur and appealed from the judgment entered. Respondents cross-appeal.

We conclude the trial court erred in granting JNOV and the motion for new trial, and that respondent's cross-appeal is without merit. We reverse and remand for the trial court to enter judgment in favor of appellant.

Appellant owned three apartment buildings located at 5254, 5300 and 5500 Newcastle Avenue in Encino (hereinafter the Property). The apartment buildings had a combined total of 230 units. The day-to-day operations of the building were left in the hands of Bruce Harrison and his company, Beaumont Property Management.

In July 1993, appellant obtained an all-risk commercial insurance policy from CNI for all three buildings (the Policy). The Policy had a limit for each building of approximately $3 million, and a $100,000 deductible. Appellant paid an annual premium of $32,179.

Immediately after the earthquake, Los Angeles County inspectors determined the damage to
appellant's property was not sufficient to endanger the residents and they were allowed to remain.

Harrison contacted appellant's insurance agent, who in turn contacted CNI, which appointed an adjuster to investigate. The adjuster contacted Harrison and Harrison told CNI's adjuster that he believed the damages were only cosmetic and would not exceed the $100,000 per building deductible. Harrison indicated he would arrange to have repair work done. CNI closed the file without notifying appellant or any of her agents.

Later, appellant hired a public adjuster, who contacted CNI. As a result of the inquiries made by the public adjuster, CNI reopened appellant's file in October 1995, one year and nine months after the earthquake. Based on the further investigation by its adjuster, CNI paid appellant $1,087,000, the amount it determined to be undisputed. Appellant contended damages exceeded this amount.

Appellant filed suit for breach of contract and bad faith, seeking compensatory and punitive damages. Trial took place April through June 2000.

At trial, evidence was presented that CNI had virtually no previous experience in writing property and casualty claims and mostly wrote automobile policies. Its vice-president, Monty Holy, had no experience adjusting claims and delegated responsibility for appellant's claim to CNI adjuster James Arensdorf. Arensdorf, however, had very little experience adjusting and had no experience in earthquake claims at all. Arensdorf reported to Leslie Fleischman, CNI's supervising adjuster, who also had never evaluated an earthquake claim. CNI received only seven to eight claims for the Northridge earthquake and appellant's claim would turn out to be its largest claim.

Shortly after the earthquake, Los Angeles County engineer Calvin Wang inspected the property briefly and observed very little damage. He recommended a "green tag" for each of the buildings, which meant that the buildings could remain occupied. At this time, he was inspecting ten to twenty buildings per day.

William Crocker, who worked for David Morse & Associates, an independent adjusting firm which did business with CNI, was assigned by CNI to inspect the Property. He went to the site with Harrison on January 24, 1994, and took photographs and measurements. Harrison told him that he would have an engineer inspect the premises and would send the estimates to Crocker, but doubted that the estimates would exceed the deductible of $100,000. Crocker then prepared his own written estimate for 5500 and determined that the damages approximated $350,000. The other two buildings were not as badly damaged, so he estimated repairs for each of them at $10,000. He sent his estimates to Fleischman in February 1994. Harrison contacted him and told him that he had gotten a bid for $85,000, and Crocker assumed he did not need to do anything further. He never told Harrison about his own estimate. Fleischman closed the file after she saw Crocker's estimate. No one told Harrison that the file was closed.

On behalf of appellant, Harrison authorized $85,000 of cosmetic repairs on the building. He heard nothing at all from CNI for over a year.

Sometime in late 1995, appellant's son, Greg Greene (Greene) engaged the services of Alan Kapilow, a public insurance adjuster. Greene agreed to pay Kapilow's fee of one-third of any recovery. Kapilow contacted CNI and it reopened appellant's file.

Kapilow engaged estimator Enrico D'Argenzio, who had worked for Kapilow before and seemed
knowledgeable. D'Argenzio, however, was not a licensed contractor. Based on D'Argenzio's work, Kapilow submitted estimates to CNI of approximately $4 million. n1

Appellant's contractor, Michael Nedobity, testified he prepared estimates for $1.5 million of repairs for 5300, excluding asbestos work and $1.035 million for 5500, and that it would take 10 months to repair each building. Nedobity testified that he had inspected every room in the two buildings. Appellant also called as an expert witness Michael Vaughn, who was a licensed public adjuster with construction experience and who had estimated over $1 million in damages to 5254, excluding asbestos repairs.

CNI hired its own contractors and engineers. An adjuster who worked for CNI, John Kagie, prepared a preliminary estimate of $450,000 for 5300, $300,000 for 5254 and $200,000 for 5500. James Marsch, a contractor, estimated a total of $1.35 million for all three buildings, which included approximately $144,000 for asbestos repairs.

At appellant's request, Matthew Westrup estimated approximately $1.2 million to repair the asbestos damage to all of the buildings.

In July 1996, CNI paid appellant $300,000 on account, but only after demanding a full release, to which appellant did not agree. No one from CNI told Greene or the public accountant that a formal proof of loss or proof of claim had to be filed or that appellant was not in compliance with policy conditions in order to obtain payment on the claim.

At a meeting in July 1996 between Greene, Arensdorf, Harrison, D'Argenzio and Michael Chamberlain, the Vice-President and Claims Manager of CNI, Arensdorf contended that some of the damage to the Property was not due to the Northridge earthquake, but rather to aftershocks. Arensdorf suggested that since aftershocks caused the damage, three $100,000 deductibles per building, or a total of $900,000, would be imposed.

In December 1996, CNI made additional payments to appellant totaling $787,638. The December 1996 check did not categorize or put a limitation on the payment, but was accompanied by a letter describing the payment as an "undisputed" amount.

At a later point during pendency of the trial, Green learned that respondents were contending appellant's claim for asbestos removal damage was not covered and respondents threatened to seek rescission of the Policy if Greene tried to pursue a claim for asbestos damage.

It was not until 1999 that CNI performed asbestos testing. Its inspector, Ralph Szaras, testified that there was less than a tenth of one percent of asbestos in the exterior stucco and repairs were not necessary. Gustave Delgado, another asbestos expert, testified at trial that Szaras' report was accurate.

Appellant contends the court erred in granting the motions for new trial and JNOV. She also contends the court erred in granting CNI's motion in limine regarding damages for loss of income.

The Problem? CNI promptly closed its file after Harrison said he believed the claim would not be in excess of the deductible limits. CNI failed to disclose to appellant that it was closing the file and it also failed to disclose to appellant the fact that its independent adjuster had concluded the 5500 property incurred $350,000 in damage, $250,000 in excess of the deductible. This, by itself, was a violation of the insurer's duty of good faith and fair dealing. (Egan v. Mutual of Omaha Ins. Co., supra, 24 Cal.3d at p. 818.) In addition, CNI engaged in threatening and
coercive behavior -- threatening to impose multiple deductibles; it initially denied asbestos remediation coverage, threatening rescission of the Policy if appellant persisted with that portion of the claim; it conditioned payment of benefits on relinquishment of bad faith rights and withdrawal of the asbestos claim; and it requested a release of all claims when it offered to pay the initial $300,000, even though other claims remained disputed.

Because CNI improperly closed its file, appellant was required to retain an independent adjuster who was able to convince CNI to reopen the file. After the file was reopened, CNI paid more than $1 million in "undisputed" damages, a portion of which appellant was required to pay to the independent adjuster pursuant to the retainer agreement. These fees are damages appellant suffered beyond delay in payment. (See infra.) In addition, the jury awarded damages above the "undisputed" amount paid by CNI, apparently concluding CNI had failed to properly evaluate the claim. These damages did not result from the "mere delay" in payment, but from the carrier's mishandling of the claim.

The trial court concluded there was sufficient evidence of bad faith on behalf of CNI, a finding with which we agree. Respondent argues on appeal that there is no sufficient clear and convincing evidence to support the award of punitive damages. We disagree.

As previously noted, CNI closed the file with knowledge that the claim, at least with regard to the 5500 property, did exceed the deductible, and it failed to divulge this information to appellant despite its duty to do so. In addition, the jury could have found that respondent's adjuster, Arensdorf, in the presence of CNI's Vice-President and Claims Manager [*16] Michael Chamberlain, was guilty of bad faith constituting despicable conduct at the meeting in July 1996. At that meeting, Arensdorf told Greene that some of the claimed damage claimed was due to aftershocks, not the original earthquake, for which CNI would have to apply additional deductibles. At trial, Arensdorf testified that at no time did CNI ever attribute any of the claimed damage to an aftershock. The jury could easily have concluded Arensdorf's statement at the meeting was a sham intended to oppress Greene into settling for an amount less than due on the claims. Further, the jury learned that prior to the date appellant was represented by an attorney, CNI also demanded a full release for payment of the original $300,000 while additional claims remained disputed. Later, CNI made an additional payment of $787,000 in "undisputed" damages. CNI also took the position that if appellant did not drop her claim for asbestos remediation it would seek to rescind the entire Policy.

This evidence is sufficient to support the jury's conclusion that CNI, through its adjuster and with the knowledge of its Vice-President and Claims Adjuster, acted in conscious disregard of appellant's rights [*17] to justify the award of punitive damages. (Campbell v. Cal-Gard Surety Services (1998) 62 Cal.App.4th 563, 571.)

"1. In calculating the damage awards during deliberations, the jury decided to award approximately $765,000 in asbestos abatement damages.

"2. The jury also decided to award approximately $365,000 to pay for the public adjuster's fees.

"3. The remainder of the approximately $2.2 million in damages was awarded for repairs to the buildings on the Greene's property.

"4. The jury also awarded approximately $47,000 for bad faith damages by calculating 8% in prejudgment interest of the $350,000 original estimate (minus the $100,000 deductible) over 28 months. [*20] "

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The orders granting the motions for judgment notwithstanding verdict and for new trial are reversed. The matter is remanded to the trial court with directions to reinstate the jury's verdict and enter judgment accordingly. The judgment, as reinstated, is otherwise affirmed. The parties are to bear their own costs on appeal.

**KATRINA CLASS ACTION (2009)**

**Source:** Property Insurance Coverage Law Blog 6/6/09

**Summary:** Adjuster fees become the focus of a class action lawsuit.

Two Miami law firms have launched a lawsuit in Miami-Dade County Circuit Court against North Bay Village-based *Ameriloss Public Adjusting Corp.* over fees it charged for supplemental hurricane damage claims.

The complaint in the lawsuit seeks class action status and alleges Ameriloss overcharged some clients. Specifically, the suit alleges Ameriloss sought fees of 33.5 percent for adjusting a claim by Clyde Lightbourn related to Hurricane Katrina in 2005, when state law limited fees to 10 percent.

Lightbourn attorney Lance Harke, of *Harke & Clasby* in Miami, said his client argued with Ameriloss about the fee, but the company insisted a third was the “standard” amount, and Lightbourn was desperate to get additional money for needed repairs.

“It got us pretty angry to think someone in that situation could be taken advantage of in this way. It’s price-gouging,” said Adam Moskowitz, an attorney with *Kozyak Tropin & Throckmorton* in Coral Gables, who is handling the lawsuit with Harke.

Lightbourn received a favorable declaratory statement from the *Florida Department of Financial Services* dated Jan. 13 that said “the public adjusting firm [Ameriloss] could not properly charge a fee in excess of 10 percent under the specific facts of this case.”

Lightbourn filed a claim soon after Katrina and received $12,285. He later found additional damage and decided to pursue a larger claim, signing a contract with Ameriloss to adjust the claim in 2007. His contract said he would pay 33.5 percent.

But, a state law passed in 2006 requires that insurance adjusters limit their fees to 10 percent for claims stemming from official states of emergency.

Lightbourn received two supplemental insurance payments based on his Ameriloss-adjusted claims of $22,062 and $20,903, for a total insurance payout of $55,250, according to his petition to the Department of Financial Services. Ameriloss deducted a fee of $7,354 from the first supplemental payment, which already totaled 12.9 percent of the total payout. The adjuster then asserted a claim for an additional $6,960.

The lawsuit complaint alleges Ameriloss engaged in “unfair and deceptive practices” and charged “illegal fees.”

Given recent worries about the financial health of the insurance industry in Florida, the lawsuit is of particular concern to consumers, said Walt Dartland, executive director of *Consumer Federation of the Southeast*. 
“A class action over this should be a warning to others,” he said. “The bulk of consumers probably don’t realize it’s capped at 10 percent.”

When contacted about the lawsuit, Ameriloss attorney Avani Patel said: “Because it is a pending lawsuit, I can’t give you statement right now.”

Lightbourn’s attorneys say they are seeking a statewide class action.

“We’re investigating whether other companies were engaging in the same practices,” Moskowitz said.

State law allows for a five-year window to file supplemental claims after a natural disaster.

Nina Bannister, a spokeswoman for the Department of Financial Services’ Division of Consumer Affairs, said the department had handled many questions and complaints about adjusters’ fees.

She said the five-year window for filing supplemental claims on damages from Wilma or Katrina is still open, but insurance companies are scrutinizing such claims closely now.

**FOTI V. INSURERS (2009)**

**Source:** Claims-Portal.com

**Summary:** Insurers and a claims software company are alleged to conspire to price fix.

Attorney General Charles Foti filed a lawsuit in Orleans Parish Civil District Court late Wednesday alleging collusion, price-fixing and anti-trust violations by six major insurance companies - including Allstate and State Farm - as well as the firms that manufacture their claims-processing software, and the companies that offer them advice or collect their data.

The suit, filed in conjunction with several outside law firms deep in Katrina litigation, is based on the work of an ongoing investigation by the Louisiana Attorney General, who lost his re-election bid in the October 20 primary.

Charles Foti says that these groups conspired to manipulate commerce for their own enrichment “by rigging the value of policyholder claims and raiding the premiums held in trust by their companies” and that companies "coerced their policyholders into settling their claims of damages for less than their value by editing engineering reports, by delaying payment and by forcing policyholders to litigate claims to receive full value.”

Bob Hartwig, an economist who is president of the Insurance Information Institute trade group, said that Foti’s accusations are baseless.

"To allege that insurers act collusively in the settlement of claims is an accusation that has no merit whatsoever," Hartwig said. "Insurers operate independently from each other in settling claims. They do not consult with one another, and they adjust those claims according to their individual contracts with their customers."

In Louisiana, insurers paid out $28 billion on 1.2 million claims of all types from Hurricanes Katrina and Rita. "Those are very substantial numbers. Much of the rebuilding that's going on in
Louisiana today is being done with insurance money," Hartwig said.

The suit names State Farm Fire and Casualty Co. and Allstate Insurance Co., Louisiana's two largest residential insurers; Farmers Insurance Exchange, the state's fifth largest homeowners insurance company; Standard Fire Insurance Co, better known as Travelers, the state's seventh largest homeowners insurer; military insurer USAA Casualty Insurance Co., the eighth largest homeowners company and tiny Lafayette Insurance Co., a division of United Fire Group.

The suit also names Marshall & Swift/Boeckh LLC and Xactware Inc., companies that manufacture leading claims adjusting software; and Xactware's parent company, insurance data collector Insurance Services Office Inc. It also names McKinsey & Co., an international consulting firm which was the architect of claims handling practices used by many major insurance companies.

Many of the companies named in the suit could not be reached for comment Wednesday. McKinsey officials said the company doesn't comment on anything related to client work. Allstate and Travelers officials said they couldn't comment because they hadn't seen the suit, as did State Farm, which also said it stands by its claims-handling procedures.

"We haven't seen the suit. What I can say is that we handle each claim individually based on the merits of the claims based on our contracts with our policyholders," State Farm spokesman Fraser Engerman said. "We pay what we owe."

USAA spokesman David Snowden said that lawyers are reviewing the suit. "USAA’s claims practices are based on a foundation of ethics, fairness and integrity. Since Hurricane Katrina, we've worked with our members to individually resolve more than 20,000 claims in Louisiana," Snowden said. USAA is owned by its members, who are military personnel and their families.

The sweeping suit says that many insurance companies used the same consulting firm, McKinsey, to devise a strategy for reducing claims, and the success of those companies created financial pressure for everyone else in the industry to follow.

By using claims processing software manufactured by Marshall & Swift/Boeckh and Xactware, the industry has been able to standardize its tactics for low-balling claims, and create a "tainted" database of claims settlements figures which the industry uses to further depress estimates for what people need to repair their homes, according to the lawsuit. Meanwhile, all of this data is centralized by Xactware’s parent company, Insurance Services Office, better known as ISO, allowing companies to collude.

By using these outside vendors to unify "power and control," insurers systematically reduced the percentage of premium dollars that companies return to policyholders in the form of claims payments "under a shroud of secrecy." While the industry has historically paid 70 cents on every premium dollar collected back to policyholders in claims payments, in Katrina, they paid 50 cents for every premium dollar, the suit says.

Foti’s suit was filed in conjunction with Baton Rouge sole practitioner Joseph McKernan; New Orleans sole practitioner Mark Glago; and the New Orleans law firms of Herman, Herman, Katz & Cotlar and Capitelli & Wicker. Those firms are working with Jane Johnson, Louisiana’s assistant attorney general for anti-trust issues, without any guarantees earning legal fees.

The lawsuit relies heavily on the theories of New Mexico attorney David Berardinelli, who wrote a book about the McKinsey company's work for Allstate called "From Good Hands to Boxing
Gloves." The title of the book is taken from a McKinsey slide advising the company to don boxing gloves and pummel anyone who doesn't accept settlements for pennies on the dollar.

Prior to McKinsey's consulting work for the industry, insurance was viewed as a quasi-public trust in which insurance played a vital role in indemnifying the middle class against financial ruin. But McKinsey, in its quest to increase profits for its clients, ignored this unique function of the industry, and created a devastating strategy that rewards shareholders at the expense of policyholders that has spread throughout the industry, Berardinelli says.

Foti's suit says that insurance companies engaged in horizontal price-fixing "with the explicit approval of insurer management," and strategies to delay and deny claims. In the face of such strategies, homeowners are essentially buying insurance that will never adequately compensate them, meaning that they are overpaying on their premiums.

The suit takes note of the record profits achieved by the industry in 2005 and 2006, despite fielding the most expensive hurricane seasons ever in 2004 and 2005.

In alleging the conspiracy, Foti's suit notes the vast influence that the outside firms named in the suit have on insurance companies. McKinsey, for example, advises two-thirds of the nation's Fortune 1000 companies.

ISO brags in press releases that it has a searchable database of more than 500 million insurance claims, and its Xactware is used by 16 of the nation's top 20 property insurers. The company's software allows insurers to monitor what claims adjusters are doing through its XactAnalysis Quality Review and compare their work to the latest prices reported in the software's Industry Trend Reports, and allows insurers to assign reinspections.

Those trend reports allow insurers "to share the current prices being submitted by competitors, and thus, coordinate the horizontal price-fixing suppression, or attempted suppression, of the overall market in repair services at virtually every geographic level and price component," the suit says.

By December 2005, the cost of repairing a home had doubled since before the storm, and the cost of completely rebuilding a home had gone up by 50 percent, the suit says, yet the price lists of the insurers named in the suit had only increased by 15 percent to 20 percent by December 2005.

Once enough companies are onboard using a certain product others are under pressure to follow. Farmers, according to the suit, visited with a bunch of other leading insurance companies in 1998 and 1999, and when it saw the financial benefits of using the standard claims processing software, it started using Xactimate, too.

The suit cites quotes by Frank Coyne, chairman, chief executive and president of ISO, boasting that computerized claims software and aggregated data are changing how companies do business, while companies that don't follow are going out of business.

"In just a decade and a half, approximately a third of the insurers serving the United States vanished as escalating competition ate into top-line revenue growth and bottom-line profitability. But it isn't just the intensity of competition that's changing. . . . The nature of the competition is changing, too, as advances in predictive modeling and other analytical techniques enable leading insurers of all sizes to target their marketing, underwriting and pricing as never before."
Claims adjusters, the suit says, are pressured or required to accept the pricing database information from the Xactware or Marshall & Swift/Boeckh software in the estimates they write if the adjuster wants to be able to close the claim and get paid for the work.

While these companies purport to be providing an independent and objective benchmark for pricing, the suit says, "they intentionally devalue the market price in order to underpay their policyholders and/or artificially deflate, or attempt to deflate construction and repair costs in the affected market."

Meanwhile, the suit says that State Farm has testified under oath that it can modify Xactimate's price lists before adjusting claims. A pricing specialist conducts surveys building material suppliers for the latest prices and updated its New Orleans prices several times per quarter between 2005 and 2007. However, the suit says, a State Farm price list containing 10,000 different items was exactly the same as a Travelers price list on Nov. 15, 2005, something that would be "a statistical impossibility without collusion."

"This continuous arrangement gave insurers an unjust advantage over policyholder, which they took advantage of before, during and after the greatest disaster this country has ever suffered, by reaping huge profits from the misfortunes of persons whom they pledged to protect from risk of loss. They raised insurmountable odds against policyholders' ability to recover," the suit says.

The suit asks for all damages, including but not limited to, treble damages, attorneys fees and costs, injunctive relief and all equitable, declaratory and general relief.

Public Adjuster Without A License (9/29/08 – Business Wire)

Peter and Tanya Strojnik filed a lawsuit against Rob Rich of Rob Rich and Associates, a self proclaimed Senior Professional Public Adjuster. Mike Mehl of Royal Restoration was also listed as Defendant in the lawsuit.

The Strojnik Family suffered a catastrophic fire at their home. They thought it would be a good idea to hire a public adjuster to help them deal with the insurance company. They hired Rob Rich. They believed that he would protect their interests.

However, after hiring Rich, the Strojniks discovered that Rob Rich's public adjuster license was summarily suspended in 1999 when the Department of Insurance discovered that he was depositing insurance proceeds into his own account by fraudulently endorsing the insurance checks and deposited them into his own account.

Investigation also disclosed that the National Association of Public Insurance Adjusters, NAPIA, revoked Rich's accreditation as a Senior Professional Public Adjuster in 2003, but that Rich continued the use of this designation on his website.

On the other hand, Michael Mehl of Royal Restoration agreed to a debriefing session with Peter K. Strojnik, the attorney for the homeowners. Mr. Mehl disclosed that he was unaware of Rich's practice of fraudulently endorsing insurance checks and that he was not aware of the decertification of Rich by NAPIA. Mehl opined that Rich's conduct gives the entire industry a bad name, and offered to help in the prosecution and investigation of Rich. Mr. Mehl agreed to "cooperate in further investigations of Rich and to make himself available for additional debriefing and the execution of further Affidavits, Declarations, or other documents reasonably necessary in the prosecution of the Lawsuit against Rich." Based on the representations by Mehl, Strojnik agreed to dismiss Mehl from the case altogether.
"I feel relieved that we have been dismissed from the lawsuit," said Mrs. Mehl. "We only did what Rich told us; we were caught completely off guard," she said. In his Affidavit filed with the Court, Mr. Mehl stated that "Rich told me that I must pay him a 20% 'public adjusting' fee out of any moneys paid to me as a result of m services relating to the Loss." Rich also told Mehl that the "bill for (Mehl's) services would be paid for by the insurer."

"We are pleased with the dismissal," said the homeowner. "Mike Mehl and Linda Mehl are good people caught in a bad situation. We wish them well."

ISABEL FLOOD VICTIM SUIT (2005)

Source: Insurance Journal 6/9/05

Summary: Suit alleged that adjuster training for flood insurance claims was designed to low-ball victim claimants.

Tropical storm Isabel are suing Homeland Security Undersecretary Michael Brown, David Maurstad, who runs the National Flood Insurance Program, 17 insurance companies and others charging that these officials conspired and knowingly paid claimants far less they deserved to repair their flooded homes and properties.

The NFIP insureds' lawsuit, which also cites Computer Sciences Corporation and independent insurance adjusting firms, was filed June 8 in United States District Court in Greenbelt, Maryland, alleging that the group conspired to defraud thousands of catastrophe victims who had purchased flood insurance through the federal flood program.

As a result of the alleged failure of those running the flood program to properly compensate victims, families have been strained, marriages have failed, and some residents have been left living in campers without indoor plumbing when temperatures dropped below freezing, with no place for children to study or play, according to the suit.

The suit claims that many victims became "ill and debilitated from exposure to mold, sewage and fuel oil contamination stemming directly from the flooding of their properties" and it blames this situation on the federal officials for refusing to legitimately address the victims' claims.

The suit seeks more than $2 billion in damages.

The plaintiffs claim that CSC was training sales agents to tell policyholders they would be restored to their pre-flood condition, while simultaneously training flood loss adjusters to allow for only narrowly defined coverage in limited amounts.

"In fact, the CSC adjuster training teaches those persons authorized to adjust flood loss claims made under the SFIP (standard flood insurance policy), and persons authorized to train such adjusters, to employ and teach the employment of systematic 'low-balling' and high pressure tactics, as a result of which flood victim claimants, including plaintiffs herein, receive only a small fraction of the amount necessary to place their primary residences in their pre-flood conditions," the complaint states.

The complaint notes that CSC transacts billions of dollars of business with its insurance company clients, known as Write Your Own companies within the flood program.
The WYO insurer defendants in the suit are said to have participated in a conspiracy "which brought about and sustained the vast difference between the instruction of the marketers of the SFIP and the instruction of the insurance community segment dealing with claims adjustment." The insurance company defendants include Allstate, Harleysville Mutual, The Hartford, Liberty Mutual, Nationwide Mutual, State Farm, Travelers and USAA.

The complaint blasts Maurstad, acting NFIP director, for allowing the wrongful conduct to go on despite pleas from state officials and for also declaring at one point that the NFIP "is not insurance and never has been," referring to it instead as a form of government aid.

The adjusters cited in the complaint Allied American Adjusting Company, Bellmon Adjusters, CNC Resource, Insurance Claims Catastrophe Services, Jackson Adjustment Company, Pilot Catastrophe Services, Simsol Insurance Services, Valco-USA and Colonial Claims are accused of employing "high-pressure, low-ball claims tactics."

Among the adjusting practices questioned in the complaint are the use of new construction prices in lieu of costlier repair and renovations costs; the recognition of damage only where water had physically contacted property; and the denial of payments for debris removal and elevation of structures.

In February 2004, Steven Kanstoroom, a fraud detection expert, reported that many insurance adjusters were using software programs that relied upon inadequate pricing.

In March 2004, the Senate Banking Committee directed FEMA to reevaluate 24,000 victims' claims - the largest such event in FEMA's history. But rather than conduct an independent review, FEMA and CSC assembled a task force comprised of the identical management and many of the same adjusters or adjusting firms that low-balled the victims in the first place, the suit continues.

According to the complaint, the questionable claims tactics were supported by the WYO insurers and leaders in the property casualty insurance industry because they were concerned that if they fairly paid the flood claims it would set a precedent for their non-flood claims.

Plaintiff attorney Martin Freeman of Rockville, Md., said that similar actions for victims from a number of other states would likely be filed.

The complaint seeks relief requiring defendants to pay the shortfall, disgorgement of profits, damages for the devastating impact the defendants' actions have had on the flood victims, and punitive damages to deter the defendants from continuing the unauthorized conduct.

**FLORIDA ADJUSTERS LAWSUIT (2009)**


*Summary:* Adjusters in Florida ban to force the State of Florida to drop a required 48-hour solicitation ban and fee caps for public adjusters.

A lawsuit was filed by three public adjusting firms seeking to enjoin the State of Florida from enforcing the 48 hour solicitation ban and the fee caps public adjusters may charge to policyholders. The mastermind behind the lawsuit is lawyer turned public adjuster, Pat Catania.
of East Coast Public Adjusters. The lawsuit is not a surprise. Many public adjusters have been
complaining that their business has been significantly impacted by these laws as insurance
restoration companies act as surrogate public adjusters since the 48 Hour Ban does not prohibit
insurance contractors from actively soliciting work from policyholders immediately after a loss.
I have recently noted the concern that some insurance restoration contractors are acting as
surrogate public adjusters and not in the best interests of the policyholder in my posts, Are
Insurance Restoration Contractors Ripping Off Insurers and Policyholders? and Former
Restoration Insider Comes Out Swinging Against Florida’s Limitation of Public Adjuster
Solicitation.

The 48 hour solicitation ban was a coup of the insurance companies and Citizens Property
Insurance Corporation. I attended the Citizen’s Claims Review Task Force meetings. It was
obvious that Citizens claims managers and executives blamed many of their controversial
claims delays and underpayments on the involvement of public insurance adjusters. The
insurance industry used the Task Force as a vehicle to place before legislators a few examples
of how public adjusters solicit for business following a disaster. Door hangers and the lining up
of a dozen public insurance adjusters were suggested as being “unsavory” by many. I guess the
connotation is that those that get paid for professional help following a catastrophe must be
taking advantage of victims. From the insurance industry’s perspective, it was a “perfect storm”
to reduce the retention of pubic adjusters.

The 48 hour solicitation ban states:

A public adjuster may not directly or indirectly though any other person or entity initiate contact
or engage in face-to-face or telephonic solicitation or enter into a contract with any insured or
claimant under an insurance policy until at least 48 hours after the occurrence of an event that
may be the subject of a claim under the insurance policy unless contact is initiated by the
insured or claimant.

The lawsuit emphasizes the constitutional aspect of one’s freedom to speak and to contract.
8. By prohibiting the Plaintiffs from directly or indirectly initiating contact or engaging in face-to-
face or telephonic solicitation with any insured or claimant, or entering into a contract with an
insured or claimant in the first 48 hours after an event that has not been declared an
emergency, subsection 626.854(6) constitutes a prior restraint on protected speech in violation
of the First Amendment to the United States Constitutions and Article 1, Section 4 of the Florida
Constitution.

It also points out some of the practical reasons why the laws are objectionable:

39. Subsection 626.854(6) is not narrowly tailored to further a significant government interest,
and other less intrusive means are available to control or prevent any practices of public
adjusters which might be needed to adequately protect the public

40. Subsection 626.854(6) is overbroad, in that it restricts the speech of all public adjusters,
including Plaintiffs, who are competent, scrupulous, honest, and professional in their dealings
with the public

41. Subsection 626.854(6) denies significant business opportunities for Plaintiffs and other
public adjusters by denying property owners the services of a licensed public adjuster at the
time they are in most distress and have the greatest need.
42. By preventing public adjusters from contacting property owners immediately following a natural disaster, subsection 626.854(6) prevents public adjusters from having any contact with the most severely damaged property owners at the only time they can be located before moving to an unknown address.

43. Section 626.854(6) amounts to an impermissible restriction on the time, place, and manner of conducting the business of public adjusting, and unduly restricts Plaintiffs' freedom of speech. Pat Catania has done an excellent job assembling a great legal team and getting a case stated clearly. Using a Shakespearean phrase, he told me yesterday that "if they [the insurance industry] want a war, I'll show them the war." Pat is not a part of FAPIA or NAPIA. He is creative, bright, energetic, and I find him fun. I believe the lawsuit has a good chance of success. He asked me to let other public adjusters know that he would like to include others as plaintiffs in the lawsuit.

Catania is also a fantastic marketer and entrepreneur. He started two web sites, MySmartClaims.com and SmartClaimsPro.com which help policyholders and professionals regarding the estimating and submittal of property insurance claims. He is a passionate consumer advocate and tireless opponent. I predict he will prevail and many public adjusters will be thanking him for his efforts.

Catania also told me that his dream is to submit the final proof of loss State Farm will pay on before it leaves Florida. He considers State Farm completely unworthy to be in the insurance business because he asserts that most State Farm policyholders are not treated properly regarding claims. He has some inside information on that issue--his wife worked as a property insurance claims adjuster for State Farm.

STATE FARM v. ADJUSTERS (2008)

Source: The Sun Herald 4/27/08

Summary: Former adjusters became "whistle-blowers" regarding alleged insurer actions.

Two former insurance adjusters who accused State Farm insurance of shortchanging policyholders now find themselves the target of attacks.

In an exclusive interview with the Biloxi Sun Herald, Cori and Kerri Rigsby said the focus needs to return to the reason they risked their careers in the first place.

State Farm pressured engineers to change Hurricane Katrina damage reports, they said - and documents filed in lawsuits have indicated - minimizing what policyholders were owed. About two months into claims adjusting, the company cancelled damage reports that had not been completed, court records indicate. Claims managers thought, in some cases, that wind covered by company policies was being blamed for damage actually caused by water, covered by flood insurance.

"I guess they're going to get away with hiding the truth," Kerri Rigsby said. "That's what they've been trying to do the whole time. There is no justice.

"How is State Farm now the good guy?"

State Farm responds that the Rigsbys' allegations, aired nationwide on an ABC news program, have proven false. One report in question was supervised by Kerry Rigsby, they pointed out,
who later agreed in sworn testimony, as did the engineer whose report was changed, that the property suffered the flood damage documented.

"If two people came forward and very publicly - I'm talking '20/20', AP (The Associated Press), the Biloxi Sun Herald - impugned your reputation, called you frauds, said you were systematically cheating customers in Katrina-claims handling and the whole world saw it and the whole world reacted that way, wouldn't you wish to know what the actual truth was?" said State Farm spokesman Phil Supple.

"So to do that, as far as push so hard to question the sisters, we did what the legal world allows you to do, you have them deposed, you ask questions … We could have stood back and said, 'I guess you can make those accusations and we'll go to court.' Well, we've gone to court." The sisters said they were naive in February 2006 when they first reported in a meeting with policyholders' attorney Dickie Scruggs what they called underhanded tactics at the State Farm Catastrophe Office.

'It was a tough decision, but we just needed help and needed somebody to stop what was going on," Kerri Rigsby said. "We didn't know what we were getting into at the time.

"I would do it again. I wouldn't recommend it to anybody else. We just definitely didn't know what to do. I guess, in my wildest fantasy, I thought that Dick (Scruggs) would just fix it."

As it turns out, they didn't know what they were getting into with Scruggs or State Farm. With Scruggs, they unwittingly stepped into a political, legal and ethical minefield.

With State Farm, claims practices the sisters said they thought were limited to renegade employees in the local catastrophe office actually have been uncovered in previous lawsuits against the company.

State Farm had a duty, Supple said, to look into the sisters' allegations.

"We looked very closely at this," he said. "We obviously had an obligation to do that to find out what did go on. In the midst of this huge storm and the challenges that came with that, were mistakes made? Yes," Supple said. "Was it systematic? Absolutely not. There was nothing wrong with our business practices."

The Rigsbys have lost their careers and insurance company friends. Corporate attorneys have grilled them under oath, several times each, about their personal lives, tax returns and travel expenses.

Their former employer, the independent adjusting firm E.A. Renfroe, is suing them for money they say they do not have.

Cori Rigsby has been forced to put her house on the market. She can no longer afford it. Kerri Rigsby's wedding is on hold because she does not want her fiance saddled with potential legal judgments.

Still, they say, their greatest regret is that events have allowed Renfroe and State Farm to twist their motives.

The Rigsbys wish they had known what they were getting into. They found out after the fact that whistle-blowers suffer a common fate: retaliation, lost wages, stress and more stress.
The pressure from State Farm, they said, has been relentless.

The Rigsbys hoped to remain anonymous when they went to Scruggs, taking with them records from State Farm files. They had begun saving and copying the records in the fall of 2005. As events unfolded, they say they realized anonymity would be impossible.

The Rigsbys were at first unaware State Farm also had trouble with reports from a previous catastrophe. In Watkins v. State Farm, an Oklahoma jury found in May 2006 that State Farm "intentionally and with malice breached its duty to deal fairly and act in good faith" with policyholders in its use of vendors Haag Engineering Co. and E.A. Renfroe to adjust claims from a 1999 tornado.

The jury found State Farm treated policyholders with "reckless disregard," awarding the Watkinses actual and punitive damages of $13 million.

Damages still had to be determined for other plaintiffs in the class-action lawsuit, but State Farm quietly settled with policyholders in April 2007. As part of the settlement, the verdicts against State Farm were removed from the court record.

Both vendors offered State Farm their services after Katrina, which slammed the Gulf Coast on Aug. 29, 2005.

Haag Engineering's Katrina Damage Survey, completed about a month later, concluded storm surge arrived before peak winds and that there was no tornado damage along the Coast. It estimated Katrina's peak wind gusts at 115 mph in Bay St. Louis, the hardest-hit area, compared with later estimates of 145 miles per hour from NOAA's Hurricane Research Division in Miami.

Two or three months after Katrina, the Rigsbys said, State Farm used the Haag report for a Gulfport training session with claims personnel.

The report's conclusions about the timing of surge and wind dovetailed with a State Farm "wind-water protocol" vetted and edited by corporate executives and attorneys. The protocol, an internal company document dated Sept. 13, 2005, said "where wind acts concurrently with flooding to cause damage to the insured property, coverage of the loss exists only under flood coverage."

Oklahoma City policyholders' attorney Jeff Marr explored State Farm's Katrina claims-handling practices as part of his punitive damages case against State Farm. He wanted to show the company's bad conduct had continued.

"Let's go back to the records," Marr said in an interview. "The records are what they are. The way that State Farm utilized these engineering firms, that's already been determined. It was proven here and again down there . . . on the Mississippi Coast.

"It's exactly the same and I'm sure it's the same conduct we'll see again. The rewards outweigh the risks."

State Farm points out the Haag report was only one of many sources the company used to determine Katrina's impact. The insurance company has repeatedly denied any wrongdoing, maintaining the protocol was meant to guide claims employees after an unprecedented storm.
The only punitive damages verdict against State Farm on the Coast - $1 million assessed in federal court - was overturned on appeal when the 5th U.S. Circuit Court of Appeals found State Farm was not malicious or grossly negligent in adjusting the claim. The appellate court ordered another trial, but the case settled Friday on confidential terms.

As a result of the Oklahoma case, State Farm ordered an independent investigation of Haag and suspended work with the company. No results have been released, but Supple said Haag remains suspended at State Farm. The engineering firm has defended what it says is a proud history of unbiased expert consulting work.

After Katrina, less than 2 percent of properties State Farm insured were inspected by engineers. The company at first ordered the reports on all properties subjected to storm surge, the Rigsbys have said and other information indicates.

The Rigsbys said claims manager Lecky King soon began to question engineering reports that noted extensive wind damage, sending them back for revision. In mid-October, records show, the company began to cancel engineering assignments altogether.

The Rigsbys took their concerns to Scruggs because they thought he had the reputation - and money - to fight State Farm. He had forced tobacco companies into a multi-state settlement worth billions in 1998. But State Farm is not a tobacco company and Scruggs was not an insurance lawyer.

Those who have followed insurance litigation say he had no idea what he was getting into and was poorly equipped to steer the erstwhile whistle-blowers.

Scruggs soon introduced them to out-of-state attorneys who specialize in whistle-blower lawsuits. The Rigsbys were extremely reluctant to file a lawsuit, they said, especially when they learned it would eventually be unsealed and their identities revealed. The lawsuit, which entitles them to a portion of any taxpayer dollars recovered, was filed in April 2006.

The sisters said they acted on their own when, over a weekend in June 2006, they downloaded thousands of pages of records from State Farm computers. They used a State Farm engineering roster and a Scruggs client list to decide what records to download.

"I knew that as soon as we did the data dump, we would lose our jobs," Cori Rigsby said. "I knew we would lose our careers."

They told State Farm executives the following Monday what they had done and were soon out of work. Scruggs followed his tobacco playbook, offering them consulting salaries of $150,000 each to come to work for him on policyholder cases. He also planned to use them as witnesses in those cases.

The sisters had no familiarity with attorneys' rules of conduct. To pay witnesses is unethical. Again, following his tobacco game plan, Scruggs took the Rigsbys to the media and pursued political options to pressure State Farm. Meanwhile, Alabama-based Renfroe sued the Rigsbys for breach of their employment contract and violation of the state's Trade Secrets Act. That federal lawsuit is still pending.

State Farm agreed in November 2006 to settle 640 policyholder cases with Scruggs, earning his Scruggs Katrina Group of attorneys $26.5 million in legal fees that came through only after Attorney General Jim Hood, some say under pressure from Scruggs, agreed to drop his criminal investigation of State Farm.
A dispute over those legal fees proved to be Scruggs' undoing. He tried to bribe a North Mississippi judge for a ruling he wanted in the case. He faces a maximum five years in prison and must surrender his law license.

The Rigsbys' whistle-blower lawsuit is still pending against State Farm, but its future is uncertain. A judge has disqualified all attorneys associated with Scruggs from participating in cases against Renfroe and State Farm. The Rigsbys have been disqualified from testifying, or using any documents they took, in the cases. In issuing his but the problem's still there," concluded Gary T. Fye, an expert in the analysis of disputed insurance claims who lives in Nevada. "The people who have the next storm are going to have the same problems. It's a much bigger problem. They saw the elephant's toe."

**BURDEN v. FARMERS (2009)**

**Source:** January 16, 2009 by Houston Trial Lawyer

**Summary:** Up to 8 adjusters implicated in alleged delay and bad faith in a claim settlement. Texas Farmers Insurance has been accused of unfair practices in a hurricane insurance claims lawsuit filed by a Jefferson County couple as a result of supposed unethical practices to deny claims.

John and Tammie Burden's home in Beaumont, Texas suffered extensive property damage during Hurricane Humberto on September 13, 2007. The destruction included structural damage as well as interior and roof damage caused by rain and flooding. The Burdens, like many other policy holders filed claims with their insurer, Texas Farmers Insurance. They were shocked when the insurer, after sending eight adjusters to assess the damage, told them the property damage was not included in their policy.

The Burdens have now filed a lawsuit alleging Texas Farmer Insurance committed a breach of contract in refusing to pay out the claim. The lawsuit also names the 8 adjusters involved. As stated in the lawsuit, the company also failed to deny or affirm the claim within a reasonable period of time and failed to explain why the Burdens' claim was denied.

**McCARVER v. ALLSTATE (2007)**

**Source:** The Southeast Texas Recorder 8/30/07

**Summary:** Adjusters accused of alleged code violations and fraud.

With the two-year anniversary of Hurricane Rita approaching, Golden Triangle lawyers and area residents are scrambling to file policy claim lawsuits before the statute of limitations runs out.

In Orange, Felecia McCarver is the latest Rita victim to sue Allstate, and two of its adjusters, for refusing to pay a portion of her policy damage claim.

Through attorney Michael Ramsey of the Mostyn law firm, McCarver filed a breach of contract lawsuit against Allstate Texas Lloyd's and claims adjusters, Matthew Delahoussaye and William Mason, with the Orange County District Court on Aug. 27.
When she filed her suit, McCarver joined a lengthy list of local residents represented by the Moyston law Firm who are seeking to recover the full portion of their Rita claims.

According to the plaintiff's original petition, McCarver submitted a claim for windstorm damages and was "wrongfully" denied at least a portion of her claim.

The suit says McCarver asked the insurance company to cover the cost of repairs to her property but Allstate "misrepresented" the policy to her and denied at least a portion of her claim, "even though the damage was caused by a covered occurrence."

"Defendant failed to explain to plaintiffs the reasons for their offer of an inadequate settlement," the suit said, adding that Allstate and its adjuster refused to conduct a reasonable investigation and breached its contractual violation.

The suit faults Allstate for breaching its contract and duty of good faith and fair dealing, and also alleges the insurance company committed several violations of the Texas Insurance Code.

Furthermore, the suit says the adjusters are also guilty of several Insurance Code violations and accuses all defendants of committing fraud.

The plaintiff is suing for the unpaid claim, actual and compensatory damages, economic hardship, plus exemplary damages and damages for mental anguish.

The case has been assigned to the 163rd Judicial District.
SECTION 2:
INSURERS & ADJUSTERS

Divisions
The basic functions of most insurance companies are carried out among four corporate divisions—underwriting, marketing, finance and claims. The underwriting department is responsible for the evaluation of risks, determining which risks will be underwritten and setting premium rates. Tailoring policies to individual needs, directing sales and advertising are the functions of the marketing department. The finance department is responsible for corporate and financial activities, tax preparation, investments, annual reports and the preparation and filing of necessary reports with state and federal regulatory agencies. The claims department, perhaps the least favored department because of its perception of contributing to the shrinkage of the bottom line, handles the investigation, evaluation and settlement of claims.

Claims Departments
Within the claims division of a sizable insurance carrier, there may be a corporate office claims department which establishes claims procedures and practices for the entire carrier, a regional claims office which supervises branch claims offices within its jurisdiction, and branch claims offices which supervise claims representatives or adjusters as well as the investigation, evaluation and disposition of all but the largest and most troublesome claims presented to a carrier.

The head of a corporate office claims division is responsible for the following:

- The development and communication of procedures and practices for the investigation, evaluation, direction and settlement of claims and the audit of payments of claims to policyholders and other named insureds.
- Verifying that disbursements are proper and in conformity with contract provisions of insurance policies.
- Insuring that policyholders receive the benefits purchased, service and protection.
- Deterring of questionable, unreasonable, inflated, fraudulent or frivolous claims.
- The effective pursuit and supervision of reinsurance, subrogation and salvage recovery.
- Overseeing the establishment and maintenance of efficient and prompt processing and disposition of claims.
- Monitoring significant litigation.
- Discouraging unnecessary expense.
Branch Claims Office

The branch claims facility is the office to which most claims are directed. Most branch offices are located in significant population centers. The personnel within a branch claims office handle and supervise claims and issue the settlements.

The Adjuster

An insurance adjuster, sometimes referred to as a "claims representative," a "claims specialist," an "examiner," a "senior adjuster," a "general adjuster" or an "executive general adjuster," is a professional, trained in the examination, evaluation and dispensation of claims. In addition, a standard part of the responsibilities of any adjuster is to counteract exaggerated, fraudulent or frivolous claims that are brought against a carrier.

Some insurance carriers use both field adjusters, who spend substantial amounts of time at the site of an accident or a loss, and office adjusters, who for the most part remain in their offices handling claims by telephone under the direct supervision of a claims manager. Originally, office adjusters handled only small claims in which there was little or no liability. Presently, most claims are processed by an office adjuster over the telephone. If a claim is within elementary guidelines, many carriers will allow an office adjuster to settle the claim over the telephone without the intervention of an outside adjuster, thus reducing administrative and overhead expenses considerably for an insurer. Quick resolution of small claims also enables a carrier to establish a reputation for the effective handling of claims. Claims of a larger magnitude, or in which liability of a carrier is in dispute, may be assigned to a field examiner who makes personal contacts with both the claimant and witnesses and is responsible for the direct inspection of the subject or site of a loss.

Field adjusters also handle the investigation, evaluation, negotiation and settlement of claims. Many also take a considerable amount of criticism from claimants. A number of observers of the insurance industry believe that field adjusters are drastically underpaid and are perceived to be low on the corporate ladder, resulting in a high turnover in such personnel.

It is arguable that the extensive use of office examiners reduces carrier overhead since many of their investigations tend to be rather superficial and the claims get little more attention than satisfying proper documentation. Favorable performance ratings tend to be given to the office examiner who has stuffed his or her file with the most paperwork—police reports, newspaper articles, accident reports, estimates, receipts and medical records.

Adjusters, whether in the office or the field, must keep written progress reports about their investigation and disposition of claim files under their supervision and control. All telephone calls, instructions from supervisors and activities taken on each claim are recorded. Also, both field and office adjusters are, for legal purposes, agents of an insurance carrier. As a result, an insurance company is responsible for the actions of agents that are carried out in the ordinary course of business. Inadvertent or negligent acts or omissions can result in a carrier having to pay a claim it might not otherwise have intended to pay.

The professional loss claims adjuster must possess a substantial degree of expertise and knowledge to avoid imposing a settlement of unwarranted claims on a carrier. To that end, there are two legal principles that an adjuster must be extremely familiar with—"waiver" and "estoppel." The intentional abandonment of a known right is designated as a "waiver," and "estoppel" is the result of behavior that is incompatible with asserting a known right.
The successful assertion of either one of these legal defenses by a claimant could result in a carrier being saddled with liability it might have otherwise avoided. Suppose a policy contained a provision requiring the filing of a proof of loss within 30 days after a claim was filed. If the carrier waives its right to receive such proof of loss from the claimant, it would very well be estopped from demanding one on the thirty-first day, and, as a result, might not avoid coverage on that fact alone.

**Independent Adjusters**

A smaller insurance company that does not have branch offices may employ the services of an independent adjuster to provide claims services relative to the investigation, evaluation and settlement of claims. Independent appraisers are typically hired by carriers for several reasons. During certain times of the year, such as hurricane and tornado season or during the early spring when flooding is rampant, the needs of many carriers are increased such that a number of extra adjusters are required. The holidays and summer months are seasons when theft is at a peak, again requiring an increased staff of adjusters. In less densely populated areas, such as small towns and rural areas, the number of claims is not typically large enough to justify staffing a full-time office, so carriers look to independent adjusters to take care of the infrequent number of claims that are filed in such places.

An independent adjuster is self-employed, in some cases working for him/herself and in other instances associating with a large group of professional independent adjusters. An independent adjuster may have to pass exhaustive examinations provided by the state department of insurance to obtain a license. Typically, an independent adjuster receives remuneration on a case-by-case basis, charging an hourly rate and recouping expenses. Adjusters do not collect a certain percentage of settled amounts. Independent adjusters should be motivated to arrive at a fair and quick disposition of a claim to avoid being reported to the state insurance department for unethical or underhanded practices.

**Public Adjusters**

Sometimes referred to as a "loss consultant," a public adjuster also works independently of a carrier, but, unlike an independent adjuster, he or she is typically hired by a claimant. Many public adjusters have scanners in the fire and police departments. Unlike an independent adjuster, a public adjuster works on a percentage of the amount recovered. In some states, a public adjuster must be licensed before he or she can offer his or her services to the public. A competent public adjuster is a professional who handles all the paperwork involved with a claim and negotiates a settlement with the carrier on behalf of a claimant. On average, a public adjuster recovers at a minimum at least 17 percent more than a claimant could by acting on his or her own behalf.

Public adjusters are perceived by some carriers as ambulance chasers, and hiring one can result in a carrier giving a claimant a difficult time in processing and settling a claim. However, a legitimate and competent public adjuster is usually thoroughly grounded in the subtle provisions of a policy and the inner workings of the claims department of a carrier.

**Line Supervisors**

The direct responsibility for supervising adjusters is that of a line supervisor, who specializes in claims surrounding a line or specific type of insurance, such as liability, personal injury, theft, fire, collision, workers’ compensation or tort claims. Typically, a line supervisor has the final word on the disposition or settlement of a claim. A line supervisor usually reports directly to a claims manager who is in charge of a branch office and is rarely involved with a claim.
Claims Adjusting in Catastrophic Situations

Claims adjusting stands alongside marketing and underwriting as the three most important functions of an insurance company, especially since the final value of an insurance contract is only determined in a situation involving a loss.

One of the most remarkable trends in the development of insurance over the past several decades has been the organization of a team of insurance experts to deal effectively and swiftly with losses in major catastrophes. The result is immediate loss adjustment in an area of a disaster. Insurance professionals, including claims adjusters, sometimes use superhuman efforts investigating, evaluating and settling claims, often working long hours under very stressful conditions. The mobile operation may involve the use of sound trucks to advise policyholders of the availability of loss claims adjustment services. Temporary living facilities may be located. Cleanup crews may be made available. Also, the insurance team may assist the victims in securing lumber and other building supplies to begin needed repairs and reconstruction of their homes.

Interdependency Between the Claims Department and the Underwriters

One of the responsibilities of the claims department of an insurance company is to advise the underwriters about unfavorable laws, areas with an excessive incidence of claims, various cost items and other potentially burdensome items. In turn, the underwriters should advise the claims department about stressful situations developing between the company and any policyholders.

When a request for underwriting is submitted by an insurance company, the underwriter must rely on information about the carrier, much of which comes from the claims department. Information such as the length of the claims history, the number of occurrences and the desirability of an account is needed. Claims files assist an underwriter in determining what can go wrong through an evaluation of the costs of different kinds of losses and practices of maintaining reserves. The underwriter uses this information to price the insurance product and to predict the number and size of possible losses. Expenses involved in investigation and negotiation of claims and the cost of litigation can drive the general and administrative overhead and related expenses of an insurance company through the roof if there is little or no cooperation between the claims department of an insurance carrier and that company's underwriters.

Another area of invaluable input involves the clarity and meaning of language used in policies. When an underwriter fashions a policy, he or she may have one meaning in mind that is not consistent with that gleaned by the claims department in their experience with claims processing. New policies tend to carry phrases and words that have not been exposed to judicial determination and interpretation.

Serious losses are sometimes subjected to postmortem examination. Conferences between the underwriters and the claims departments can help minimize or prevent future problems.

Interdependency Between the Marketing and Claims Departments

One commonalty that exists between the marketing and claims departments of an insurance carrier is that both represent the carrier to the public. Nothing tests the performance quality of an insurance product more than a claim. An unsatisfactory resolution of a claim indicates that the insurance product has failed to perform its intended need and function. The claims department can measure the delivery end of a carrier for the marketing department. Many facts developed from experiences with claims can make for a better insurance product.
**Relationship Between the Claims and Loss-Control Departments**

A significant amount of information from a claims department can enhance a loss-control specialist’s knowledge of what to guard against in an attempt to reduce losses. Safety improvements and other changes may be warranted. Pre-claim activity should have as its goal the mitigation of losses. Necessary evidence should not be lost or misplaced after a loss. Claims and loss control should work together to prepare and maintain records that are invaluable following a loss. Such a system enhances quality control of the insurance product. The combined input of both departments can be provided to an underwriter to help in the decision about whether an insured’s potential loss is desirable.

Cooperation between loss control and claims is especially useful in the area of workers’ compensation. Loss control personnel may possess specialized information not well known to the claims staff, such as mechanical, technical and engineering matters. By their collaborative efforts, they can prevent and reduce losses and solve technical problems that go hand in hand with claims. Claims and loss control cooperation can develop practices and routines that help to minimize accidents in the workplace. In the investigation of claims, a loss-control department can provide information to the claims department such as standards, codes, technical opinions and laboratory assistance. Accurate information about losses is important to help emphasize to the carrier the trends in—and resulting costs of—accidents and their effects on premiums and rates and the need for a reliable safety program.
SECTION 3:
The Nature of Claims

Introduction

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 hangs 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 Impact of the Law on Insurance Claims

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 4:

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 signed, the company is entitled to rely on representations by an insured that the claim is settled, and 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 an 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.
Investigation Principles

The constant goal of a good investigator should be to strive to uncover evidence and valid facts. If he finds that the best information, evidence, photographs and testimonies rest with the insured, the sooner he will be able to work out settlement negotiations for the position of the case.

Due to excessive demands, lack of liability or settlements of a claim may not be consummated and may have to be tried in court. It then becomes most important to show the facts in some tangible form that can be presented as evidence in court. This is accomplished by means of signed statements, affidavits, reporters’ statements, photography, diagrams, specialists’ testimonies and, where possible, by actually producing the object which was involved in the accident or allegation. It may be true that a defective faucet broke in the claimant’s hands, causing his or her hand to be severely lacerated. An examination of the porcelain handle might reveal that it was struck by an object, such as a hammer, and for this reason the claims person can introduce the handle itself, as well as expert testimony concerning it in the trial. The object is naturally the best possible piece of evidence.

It is obvious that such a handle, or some similar evidence should be put in a place of safe keeping and properly identified so that someone will be able to testify at the trial that it was reserved intact and in exactly the same condition from the time immediately after the accident until the moment it is presented in court.

An effective investigation must be planned in advance and properly timed. There must be order and execution. There can be no set pattern in the investigation of a casualty claim because of the varied circumstances in each case which calls for individual handling.

A claims person need not be a politician or a press agent to be a successful investigator, but it helps to have some elements of both. By establishing friendly contacts with the various police agencies, hospital and motor vehicle clerks, and various officials on both high and low levels, he or she will not only obtain a great deal more information, but will get information more quickly. Once the claims person has established a good contact, a telephone call may save hours of travel and waiting time. The claims person should never antagonize those upon whom he or she may subsequently have to call for information, no matter how great the provocation. He should take the time to establish friendly relations with police sergeants, hospital officials or clerks, record clerks and others in similar positions upon whom he is calling for the first time. It will be time well spent. If certain rules or regulations require the investigator to obtain forms or go through red tape routines which he or she feels are cumbersome, he should follow the procedure in good grace and not request shortcuts that will embarrass the clerks who have to abide by those rules.

Friendly contacts are invaluable for picking up gossip or hearsay which may often lead to pertinent information.

The scope of an investigation is determined as it develops. If the case is one to settle and if the demands are within reason, all efforts should be bent upon disposing of the case and eliminating or avoiding any investigation which will serve no ultimate purpose. Over-investigation can be just as costly in the long run as under-investigation. This is particularly applicable in property damage claims of the average kind where the liability has been determined and the damages established.
If the claims person has decided that to see the claimant first is most advantageous in a certain case, he or she will usually find it advisable to get in touch with the insured by telephone and obtain an oral version of the accident before taking the signed statement. If the claims person cannot talk to the insured right away, he or she should see that the insured is notified to give no signed statement to anyone but his own company representative and to be cautious about any verbal information he may be forced to give in making a claim of his own against the other party. Unless a claims person is handling property damage, medical payments, or other run-of-the-mill claims, the investigation will be made by personal interviews. He or she will have to meet, question and take statements from insureds, claimants and witnesses. These people come from all economic groups and have various religious, cultural, economic and national backgrounds. The claim representative must be tolerant, in the accepted usage of this term. It is a broad term and has often been misused, but tolerance includes respecting differences in point of view, politics, dress, mode of life, and other such matters as well as race, religion and foreign background. A claims person must not show prejudices of any sort.

The claims person is usually the insured’s first contact with an employee of the company with which he or she is insured. Because of this the claims person’s job is to make every effort to see that the interview is pleasant, affable and as smoothly-running as possible. He or she should take all the time needed to get the information necessary to protect the insured’s interests, but should not drag out the interview to the point of a social visit, especially if he or she has interrupted the insured or is using time which the insured could spend profitably in some other manner.

In this interview it is best to give the insured a briefing on what may be expected of him in the event that settlement negotiations fail and the case has to be tried. If the matter is brought up by the insured, it is also well to acquaint him with those things the insurer cannot do for him. Some insureds, for example, expect the company claims person to press their claim against the third party. It must be tactfully explained that it would be both unlawful and improper to do so, unless there are subrogation rights involved.

The problem of representation before a criminal court or traffic hearing will also often come up. The same explanation must be given in this respect. If the adjuster is a company representative, he or she should remember that although he may be the local attorney of record for his company, he or she is not in the general practice of law, and it would be both improper and unwise to represent an insured in either a criminal matter, a traffic hearing, or an action against third parties not involving subrogation rights. The claims person may always attend such hearings as an observer, but to take responsibility for the outcome is inadvisable.

Unless a claims person has reached a point where it can be determined that a first-call settlement is possible, it is not advisable to make a definite commitment the first time he or she sees the claimant. Nor should the claims person decline the claim until he or she has completed the investigation. A claims person should not miss the opportunity to obtain from the claimant written permission to get the doctor’s and hospital records, whether he or she intends to use these immediately, or some time in the future. The claims person will have no better opportunity to get this permission than on the initial visit. Any attempt to get a signed statement or further information after the claimant has disclosed the fact that he is being represented by counsel is unethical and deceitful.

An investigator must remember that the control he maintains will depend upon the impression he makes upon the claimant. If he indicates by attitude and gesture, as well as by words, that he intends to act fairly and ethically within the limits set by the policy, his batting average on settlements will be pretty high. Each company has its own policy with reference to such
payments. They are becoming more prevalent and have generally helped to keep some serious cases under reasonable control. The claims person will learn the attitude of his or her company concerning such payments and act accordingly.

One question the investigator will probably ask more often than any other in the investigation of casualty claims is, "Do you know or have you heard of anyone who saw the accident?" He or she will also try to learn this from the insured, the claimant, police offices and many others as well as outside witnesses, and will scan the police and motor vehicle bureau reports to determine the names of any possible witnesses. The investigator will attend traffic hearings and criminal proceedings, and read the transcripts. He or she will interview coroners and read transcripts of the coroners inquests to determine the names of possible witnesses to an accident.

In serious cases where the effort is warranted, he will make neighborhood investigations, and if he wants the best results, will make them at the same hour of the day when the accident occurred, and as soon after the accident as possible. Making a neighborhood investigation requires common sense and a great deal of persistence and determination. First of all it means calling on every store in the immediate vicinity that was open at the time of the accident and finding out not only whether the proprietor or the sales people saw the accident, but also whether there were any customers in the store at the time. It also means checking with these people to determine whether they know of anyone else who saw the accident.

In addition to covering the houses in the immediate vicinity, it also normally means knocking on the door of every apartment that has a window facing onto the scene of the accident. Time after time, investigators have located witnesses who were looking out of an upper story window down onto the scene of an accident. The investigator must ask all of these people whether they know of anyone else who might have seen the accident. Sometimes this involves interviewing four or five people before he tracks down the witness. This individual may be merely described generally since no one may know his name or address.

Most people’s lives are set in a fairly well-defined pattern. If buses or trolley cars were present at the time of an accident, it is not unusual to find certain people in them at the same time and place on a subsequent day. Bus or trolley drivers can usually be interviewed through the company for whom they work. Very often the claim departments in these companies will do the preliminary interviewing for the investigator. A claims person may possibly learn that telephone linemen or outside workers of other kinds were present at the scene of the accident, and he will have to track them down. If it is warranted, he should check with delivery people who may have been working in the area at the time of the accident, including mailmen, parcel deliveries, newspaper delivery men and others. After a case has gone into suit, information may be obtained that may lead to the discovery of other witnesses, by means of interrogatories and depositions. If such information is obtained, it should be followed up immediately. Occasionally, in important cases, a catchy advertisement in a local paper will bring forth a witness. All of this presupposes the fact that the nature of the accident deserves this kind of attention.

If the investigator contacts the witnesses promptly, he should be sure to obtain from them the identifying information and the names and addresses of relatives and friends who have a permanent address, and follow this up with regular periodic checkups concerning their availability so that he will have no problems locating the witnesses when he needs them. There will be occasions, however, since no one is infallible, when he will find it necessary to locate a witness that he has lost track of because the witness no longer lives at the last address which the investigator has for him.
There are various "skip-trace" organizations that specialize in locating missing persons for a reasonable fee. All claims persons occasionally have use for such organizations. There will, however, be many instances when, because of the time element, or because other methods have been unsuccessful, a claims person may have to make every effort to locate a witness who has apparently disappeared. If so, he should know that there is no magic formula for locating a missing witness. Should the claims person use some ingenuity, imagination, and a good deal of tenacity, he will probably accomplish his object. It is very difficult for an individual in this country to disappear without leaving any trace whatsoever.

**Locating the Witness Checklist**

As a stimulant to the investigator's imagination, the following checklist is offered as leads for locating the missing witness:

- A registered letter, return receipt with address requested, sent to the last known address of the witness.
- Telephone directories.
- City directories.
- Interview with janitor or landlord at last known address for any possible leads, including:
  - Names and addresses of relatives or friends.
  - Names of company or collector on an industrial life insurance policy.
  - Names of credit or collection agencies or individuals.
  - Name of any federal, veterans’ or other organizations that the witness may have belonged to.
- Canvass of the neighborhood or building for any possible leads from friends, relatives or acquaintances. It is essential that such investigations be repeated several times since the investigator will almost never find everyone home the first time the canvass is made. There is also always the possibility that someone he saw before has since seen or heard from a missing witness.
- Business establishments, stores and banks in the immediate vicinity.
- Churches and church organizations.
- Local doctors and dentists who may have treated the witness at one time.
- Local parochial or public schools.
- Name of a moving firm whose vehicles may have been observed by the janitor or any of the neighbors.
- Any former employer of the witness or any member of his family. From this source, the investigator may obtain:
  - Union affiliations.
  - Names of references on employment records.
  - Type of work and employment.
  - Information from fellow workmen.
- Automobile or Motor Vehicle Bureaus may have information concerning the witness' address if an automobile has been registered in his name, or if a driver's or chauffeur's license has been issued to him.
- Local election records.
- Utility and telephone companies.
- Military service or veteran's administration records.
- Credit accounts at department stores.
- Welfare agencies.
- Police records.
- Tax records.
• Marriage, birth, or death records of the witness or his immediate family.
• Judgment records.
• Golf, tennis or other athletic clubs that the witness may have belonged to, including leads to any hobbies that the witness may have had.
• Credit card organizations.

Potential witnesses comprise a variety of individuals. An insured or a claimant is an interested witness because he is interested in the outcome. One who knows neither party and is not interested in the outcome, except as a matter of justice, is a disinterested witness. Witnesses are often designated as friendly or hostile, adverse or favorable. These terms are self-explanatory. In interviewing witnesses, a claims person’s approach must be one of genuine sincerity. He may have to explain to the witness why it is important to the insurance company to pay just and proper claims and to avoid time-consuming additional investigation and litigation expenses. However, if he can convince the average person that he is sincerely interested in seeing that justice is done, whether or not it affects the company adversely, he will usually get the witness’ cooperation and in most cases, a signed statement, without too much difficulty.

Occasionally, a witness will give an initial impression of hostility that is merely a defense mechanism on his part. He may believe that a version unfavorable to the claims adjuster will be received with antagonism. It is up to the claims person to avoid jumping to conclusions and break this false barrier down. He should not misrepresent himself, but should gain witness confidence by his honesty and fairness. Unless the circumstances are extraordinary, it is advisable to have seen both the insured and the claimant and to have visited the scene of the accident before interviewing the witnesses. This presumes that the claimant is not represented by counsel. It does not imply that there should be undue delay in interviewing the witnesses. They should be seen as soon as possible. Time can only dim their memory.

The claims person may wish to take a key witness on an important claim back to the scene of the accident so that he can refresh his memory and familiarize himself with distances and landmarks. While it is perfectly proper and often necessary to refresh the memory of the witness, the claims person should not try to lead him in any definite direction. If the witness is important to the case, the claims person should obtain not only his name and present address, but the name and address of someone such as a parent or other close relative who has a permanent residence and through whom the witness can always be located.

It is important that witnesses be interviewed under circumstances which are comfortable to them. The claims adjuster should not try to interview a witness at his place of business if such an interview might make him ill at ease. He should be seen at home if possible. He should take the time necessary to obtain a proper interview but he should not impose upon the witness. If there is no choice but to interview a witness at his place of employment, an attempt should be made to enlist the aid of his employer, but care must be used—it could boomerang. A good claim representative will try to find some common bond with a witness on which to establish a basis of friendship. If the witness is busy or has only a very short time to give the claims person, he should take whatever information he can, but prepare the way for an additional interview later when the witness is not so rushed. On a follow-up, the average witness will usually go overboard to give whatever information he can, since he feels responsible for the extra call.

Whenever a witness is interviewed, the claims person should obtain complete details and record them along with his impressions of that witness. Did he appear to be honest and sincere? Was he reluctant? Did he seem to be holding back any information? Did he give the impression that he was favoring either side? Was his manner of presentation such as to make him a good witness on the stand? Was his appearance favorable? Did he speak with an accent? Was he
hesitant, or straightforward and direct in presentation? Did he appear intelligent and well-educated, or slow, stupid or ignorant?

Was he opinionated, timid or hesitant? Was he uncertain or positive in his statements? Was he friendly or belligerent? Did he have any speech impediment? What was the overall impression of his credibility? What is his reputation? Does he have any physical deformities? Does he appear vindictive?

Whatever his reason, if a witness persists in refusing to give information about an accident which the claims person has reason to believe he has seen or knows something about, it is important to obtain his negative signed statement so that he may be impeached if he tries subsequently to testify for the claimant at a trial.

**Special Damages**

Special damages is a term used in the investigation of casualty claims to denote losses that can be measured in definite sums of money. Allegations of special damages should not be taken at face value. If the nature of the case or the amount involved warrants it, the items should be checked for authenticity. If special damages have been exaggerated, it is a good indication that other features of the claim may need careful scrutiny. It is also a lot easier to dispose of a claim for a fair value after the claimant has been confronted with proven exaggerations in his special damage allegations.

Special damages which are ordinarily encountered in casualty claim work may be listed as follows:

- **Lost time and earnings**—It must be borne in mind that the claimant is entitled to his take-home pay only, and that he suffers no loss as a result of tax or other deductions, unless he is called upon to make up some items, such as insurance or hospitalization.
  - **Where the employee is salaried:**
    - Check the employer’s payroll records. Do not be satisfied with a verbal corroboration made by some clerk. In some instances, even a written letter cannot be taken on face value.
    - Check the exact lost time
    - Check the exact lost earnings. The employer may have paid all or part of the employee’s salary.
    - Determine the amount of the regular salary.
    - Determine the amount of commissions and overtime, and obtain average salary for that particular time of the year.
    - Estimate tips and other gratuities, such as board and lodging.
    - Determine whether the injury has necessitated a change of job or employment.
    - Determine whether the injury has made it necessary for the claimant to obtain part-time work.
  - **Where the claimant is self-employed:**
    - Check income tax records, including federal, state and city, if any.
    - Social Security tax, if possible.
    - Unemployment tax.
    - Examine private books and accounts.

- **Property Damage**—The following items will be discussed in great detail when we consider automobile property damage losses subsequently:
  - Estimate of repairs.
  - Appraisals and surveys.
• Difference in value before and after the accident.
• Exact amount of loss of use.
• Medical Expense
  • Doctors’, specialists’ and dentists’ bills.
  • Travel expenses to and from doctors.
  • Registered nurses’ fees.
  • Practical nurses’ fees.
  • Hospital or clinic bills.
• Cost of ambulance.
• X-rays.
• Laboratory fees.
• Prosthetic appliance or surgical apparatus.
• Medicines, drugs, etc.
• Funeral Expenses

Investigating Fatal Claims
In the investigation of fatal claims, the following points should be checked:

• Duration of the time the decedent lived after the accident, to determine the amount of possible pain and suffering.
• Age of the decedent.
• General health of the decedent. Determined by:
  • Neighborhood canvass.
  • Life insurance examinations.
  • Army or school examinations.
• Medical history investigation, if warranted.
• General habits and morals, if warranted.
• Life expectancy.
• Earnings.
• Potential earning capacity and increases expected.
• Names and addresses of all close relatives.
• Age, sex and number of dependents.
• General economic condition and social status.
• Marital status with certificates or other documentary proof or written corroboration.
• Complete medical bills.
• Complete funeral expenses.
• Causal relationship between death and accident, derived from:
  • Coroner’s report and transcript of hearing.
  • Death certificate.
  • Autopsy report.
  • Medical report.
  • Medical history.

You will often hear it said that the claim department is the eyes and ears of an insurance company. As has already been seen, its activities extend far beyond the old concept of routine claims handling. One of the important functions and duties of the claims person is to report to the underwriting department any information that may affect the desirability of a risk or the adequacy of the premium rate.
Ordinarily, it is not the province of the claim department to recommend the cancellation of a risk. There are many reasons why the underwriter may decide to retain a risk, despite some undesirable features. It is the duty of the claims department to bring to the attention of the underwriting department any information that may aid them in arriving at a proper decision concerning cancellation, or which may necessitate corrective action. In the course of the investigation of an accident, much information will come to the attention of the claims person that might affect the desirability of a risk. Final decision concerning cancellation, however, should rest strictly with the underwriting department.

**Risk Report**

Most companies have some form for this purpose which is variously termed "Questionable Risk Report," "Confidential Risk Report," or some similar designation used for the same purpose. The types and kinds of deficiencies that should be noted and brought to the underwriters' attention can be grouped roughly into five categories. Examples of each, are:

**Physical defects:**

- Poor condition of an automobile or building.
- Defect of equipment, such as brakes, broken headlights, defective horn or steering mechanism on an automobile; defective machinery on compensation risks, and so forth.
- Improper equipment.
- Machinery safeguards not being used, or no safeguards provided.
- Dangerous machinery.
- Unoccupied premises.

**Moral Hazards:**

- Bad reputation of insured or driver with reference to speeding, reckless driving or criminal background.
- Police record.
- Philandering.
- Intoxication.
- Apparent collusion.
-Fraudulent acts or false statements.
- Illegal operation of vehicle, elevators, machinery, or equipment.

**Physical Infirmities:**

- Glasses required and not used, poor eyesight, or blind in one eye.
- Loss or impaired use of fingers, arm or leg.
- Insured or driver afflicted with epilepsy, heart condition or other infirmity or disease which could momentarily disable the driver.
- Insured or driver aged or infirm.

**Matters Affecting Premium:**

- Age of driver.
- Usual traveling distance on truck bearing local truck man's endorsement.
- Principal garaging of automobiles.
- Operations or employment not covered under compensation policy.
• Improper classification of automobile or job.

Other Hazards:

• Accident frequency or excessive traffic violations.
• Poor class of drivers or employees.
• Truck used to transport employees.
• Gross negligence or wanton disregard involved in an accident under investigation.
• Improper registration or no driver’s license.
• Catastrophe hazard, such as transportation of butane gas, asphalt, or dynamite; fire hazard, and so on.
• Non-cooperation.
• Employment of minors.
• Occupational disease exposure.
• Unsafe practices.

Although it is not ordinarily the province of the claim department to recommend cancellation of a risk, as we have previously stated, a claims person should always notify the underwriting department when such cancellation might adversely affect an open claim or suit.

In some instances involving serious accidents, it is essential that the good will and complete cooperation of the insured be maintained, especially where he or she has some influence over others, such as witnesses and perhaps even a claimant. In such instances, the claim department may wish to take a calculated risk and remain on the policy, since cancellation might antagonize the insured and result in the loss of his or her future cooperation. In this type of case, it is the duty of the field claims person to let the underwriter know the circumstances, and request that no cancellation be made until further notice by him, or upon disposition of the claim or suit.
SECTION 5: CLAIM STATEMENTS

Introduction
Because the taking of signed statements takes up so much of the working time of the average casualty claims person, it is important that this phase of the operations be discussed in detail. Only a small percentage of the signed statements taken by an investigator may ever be used. However, all statements have potential importance, and the investigator must learn how to take a correct, proper and complete statement early in his training.

A claims person, therefore, may have some preconceived ideas about the manner in which a signed statement should be taken, and about the average person's reluctance to sign it. Experience will be his best teacher, but he can learn how to avoid a few of the pitfalls from the experience of others. Above all, he should relax and be natural. Anxiety is a sign of uncertainty and will be as obvious as timidity.

One should immediately get a signed statement. The longer it is delayed, the less likely that it will be obtained. If the purpose and reasons for obtaining signed statements are understood, the claims person will be that much more qualified and prepared to answer questions asked by the witnesses. Why is a signed statement so important in claims work?

Importance of Signed Statements
There are several reasons why signed statements are critical:

- It provides an opportunity to obtain details in a permanent record form while they are fresh in the minds of the witnesses. Unless an investigator can take shorthand, no notes will be as comprehensive as a complete statement taken from a witness.
- It can be used as a subsequent refresher, if memory dims the details. This may become important if the case goes into suit and eventually to trial.
- Signed statements can sometimes be used as a substitute for the witness' personal testimony if the witness is not available to give his own version. Unless statements are taken by a court reporter, are depositions, or are notarized, it might be difficult to get them admitted in evidence. Signed statements are subject to the same rules of evidence as other testimony.
- A witness' statement can be used to discredit him either before or during trial if he should attempt to change his story.
- Once the witness has signed a statement, he is less likely to change his story, for he realizes that his statement can be used against him.
A signed statement is a reliable and usually accurate factual record of the information obtained for the file and for transmission to the home office.

A signed statement can be used as a means of convincing opposing counsel of the falsity of certain allegations and make him more amenable to a fair settlement figure.

The first thing to do in preparing and planning for a signed statement is to obtain a signed statement that is logical, concise and in chronological order. The claims person must plan his strategy in advance. The average statement involving an automobile accident should not require the seasoned claims person to spend much preliminary time jotting down points of information he does not wish to forget in questioning the witness.

For the new claims person in the field, it is best to do sufficient preliminary planning on every case until the taking of certain types of signed statements become second nature. The less time that is available to take a statement, the more preliminary planning is necessary, so that the most relevant information can be obtained in the least amount of time. Ordinarily, it is not only common courtesy, but intelligent handling to see a witness when he or she has the time to spare. This is not always possible, and to arrange for another appointment without making any attempt to get a signed statement during the first interview can be disastrous. Any delay provides too many opportunities for the witness to change his mind or to be persuaded to change it.

The approach to interviewing the witness is very important. Anything that is done to antagonize the witness defeats the purpose for which he is being interviewed. The manner in which witness cooperation is gained is something personal to each claims person and cannot be learned by reading a book.

The claims person should attempt to gain the attention and interest of the insured on some common basis of appreciation or endeavor. Confidence should be gained by the sincerity and evident fair-mindedness of the claims person. He should not simply introduce himself, and then sit down and immediately pull out a writing pad. Rather, the claims person should talk to the witness first, and put him at ease. The witness will shortly begin to talk about the accident quite naturally. The claims person can then start taking notes of salient points that he wishes to include in the statement. This will be the outline and preparation before writing the actual statement.

The claims person must watch for reactions from a witness and must be able to change his approach the moment he senses antagonism. The sight of a statement pad will often cause an immediate negative reaction. Accordingly, the claims person must put the witness at ease by explaining his mission, and he must convince the witness of his desire to get the true facts. When the interview is concluded, the witness should be thanked for the time he has graciously given.

For the most part, taking signed statements is a matter of common sense. The new claims person however, may find a few guidelines helpful in establishing a procedure.

**Principles of Handling a Claim**

There are a number of elementary principles with which a person handling a claim should be familiar:

- **Coverage Problems**—Whenever a coverage problem is involved, two separate signed statements should be obtained from the insured; one covering the facts of the accident, and
the other covering the information to be obtained on the coverage problem. The statement concerning coverage problems will usually contain references to the agent or broker as well as to the insured's carrier, which should not be in the statement concerning the facts of the accident. Most states still forbid the injection of insurance coverage status in the trial of an action for negligence.

- **First Person**—The statement should be written in the first person in order to show that the witness is doing the talking.

- **Separate Statements**—No two people will ever see an accident exactly alike. It is, therefore, a good practice to obtain a separate signed statement from each witness. The claims person should refrain from having one witness add either his signature to the statement of another, or even a paragraph to the effect that his version of the accident corresponds with a version as stated by the other witness. There are unusual circumstances that could make such a practice acceptable where the alternative would be no statement at all from the second witness, but this should be the exception rather than the rule.

- **Legible Writing**—The handwriting on the statement must be legible. If the handwriting of the claims person is difficult to decipher, he should get a portable typewriter or computer or have the witness write out the statement himself. Requests to have the witness write out a statement may not always be granted, but the request will usually make the witness much more amenable to signing the one written or typed by the claims person. **Handwritten statements** should be written in ink. Where the witness is willing to write his own signed statement, the claims person will have to help him or her with it and this could be troublesome where the statement may have to be admitted into evidence. When the witness writes his or her own statement without any direction whatsoever, it will usually be inadequate; therefore, the claims person often has a difficult decision to make regarding this issue. In any event, the claims person should never request that a witness who is self-conscious about his education or spelling write his own statement.

- **Narrative Form**—Unless a court reporter's statement is being taken, the straight narrative form is the best form for the ordinary signed statement. The question and answer type of statement looks too legalistic for the average layman. It may breed suspicion, whereas the ordinary narrative statement would not. Narrative however, does not mean to imply that the claims person is to write a novel. He or she should be specific, brief and to the point without overlooking important material. The question and answer form usually requires a great deal of extraneous writing. It may, for instance, require a whole series of questions to obtain personal and comparatively unimportant details about the witness before the claims adjuster can get to the meat of the statement. In addition, if the answers are not written exactly as given, it could lead to misinterpretation that might cause the entire statement to be discredited.

- **Arrangement**—Although every effort should be made to arrange the statement chronologically for easy reading, the writer should not be afraid to add paragraphs at the end, either upon request by the witness or to cover information that he forgot to include previously in the body of the statement. In other words, he should be orderly but need not make a fixation of it.

- **It has been said that the signed statement should be taken without paragraphing, under the belief that in breaking the statements into paragraphs, there is some opportunity for the one who holds the statement to add a few words after it has been signed. It is more important than the suspicion that might be aroused by leaving part of the line unfilled.**

- **Solitary Interview**—If the claims person can possibly avoid it, he should not try to take a signed statement from a witness when the witness is surrounded by family and friends. It is best to suggest tactfully that the noise and disturbance will be too great for concentration. Then, if possible, he should attempt to interview the witness alone where he will have his undivided attention. There are exceptions, such as if the witness is very young, in a hospital or other institution, or is illiterate or unfamiliar with the English language. Again, it is
recognized that there may be times when gatherings are unavoidable and when the claims person must either take a signed statement under adverse conditions or not get one at all.

- **Style**—Whenever it is appropriate, simple language and short sentences should be used. The written statement should record as closely as possible the witness' manner of speech, but bad grammar or objectionable language should not be used purposely. Occasionally, the investigator will take down a direct quotation. When this is done, he must, of course, use the exact language of the witness. However, bad grammar is an obvious condescension that leaves as bad an impression as the use of words that are far beyond the obvious knowledge of the witness. The claims person should refrain from using unfamiliar legal, medical or technical language.

- **Preprinted forms**—The claims person should avoid the use of preprinted forms in taking signed statements. They serve no useful purpose and, again, will only create suspicion and be less effective if needed to be presented as evidence.

- **Factual Material**—Whenever possible, try to give factual information and avoid opinions or conclusions. While this is not always possible or even advisable, some effort should be made to keep opinion and conclusion at a minimum, unless it is pertinent. If any statements overheard by a witness immediately after an accident are included, they should be quoted as close to verbatim as possible. If an opinion based upon obvious circumstantial evidence is included, it should be kept to a minimum and wherever possible such words as "probably" and "perhaps" should be avoided. Also, where possible, recognized designations of speed, distance and direction should be used to indicate speed. Approximate miles per hour should be used instead of such words as "fast," "slow" or "moderate." The points of a compass rather than "right" or "left" should be given, and distance should be measured from such landmarks as large trees, mail boxes, buildings, etc. While it is advisable to be as definite as possible, it is not advisable to be dogmatically so. A statement that a car was traveling at thirty-seven miles per hour could be torn to pieces on cross examination.

- **Insurance**—All mention concerning the name of the company that is involved in the investigation, or the phrase "insurance company" should be avoided. It may be necessary to use this statement in a court trial and the introduction of insurance in any form may cause a mistrial.

- **Conditions Affecting Statement**—A signed statement should not be taken from anyone who is under the influence of alcohol or narcotics, or who is in a state of shock following an accident. If a witness has slurred speech, seems drowsy or is unusually slow in his answers to ordinary questions, the investigator should be doubly cautious and make thorough inquiries concerning the witness' condition before obtaining a statement from him. This is one of the few exceptions to the rule of promptness. To obtain an effective statement and to keep his ethics above reproach, the claims person must observe local laws, ordinances, or codes that regulate the time or place for the taking of statements. If, for instance, he must take a statement in a hospital under circumstances that permit it, he should try to have a nurse, attendant, or possibly doctor present as a witness. The attendant will also be able to attest to the fact that the patient was free from apparent unusual pain and from the influence of narcotics and that the witness appeared to be in a rational frame of mind.

- **Objectionable Phraseology**—The use of objectionable words or phrases should be avoided unless the investigator is quoting what the witness said. Otherwise, any reference to race, religion, foreign background or any evidence of bigotry or obscenity should be scrupulously avoided. A completely innocent remark concerning race, intended merely as a descriptive appellation, could easily be misinterpreted by a juror.

- **Preserving the Statement**—The claims person should refrain from physically mutilating a statement in any way. It is a valuable piece of evidence, and should not be soiled, torn or shopworn. In addition, it should not be date-stamped by an office clerk or by any other marking that might make it unacceptable as evidence.
Constructing a Statement

There will be times when, because of pressure, peculiarities of an individual, the facts of an accident, or for other reasons, the statement will not follow an orderly pattern. Most times the general construction of a signed statement should be obtained from a witness—the insured, claimant or disinterested outside witness—should follow an orderly, chronological form. This not only makes for easier reading, but indelibly impresses its pattern on the claims person so that he will automatically obtain the necessary information because it fits into his regular routine. An outline of a good construction pattern for a statement should include the following subjects generally in the order given:

- **Date, Time and Address**—At the top and upper right-hand corner of the statement, always place the date and time when the statement was taken, and the address of the place where it was taken. By including the time, the claims person pegs down the surrounding circumstances more definitely, and makes it more difficult for a witness to later deny that he gave the statement.

- **Identification of the Subject**—The first paragraph of the signed statement should be concerned with the identification of the subject who is giving the statement. It should include his name, age and address. It is of primary concern that the authenticity of a statement be provable. Therefore, the more personal details, within reason, that can be obtained and placed in a signed statement, the less likely it is that the witness will ever be able to deny that he gave it. It is suggested that such additional information as the witness’ place of employment, Social Security number or other pertinent data be added to the statement where warranted. The degree of identification of the subject should depend on the nature of the accident and the type of witness with whom the investigator is dealing.

- **Location and Reason for Witness’ Presence**—This paragraph should be devoted to a description of the location of the accident and should include the reasons for the witness being there at the time. The direction in which the witness may have been walking or riding should be given, as well as the exact spot from which he viewed the accident. Naturally, in subsequent investigations the claims person should make it a point to check on the story given by a witness to determine whether he actually could have viewed the accident from the position where he says he was. Included here should be the facts indicating what attracted the witness’ attention to the accident.

- **Factual Details**—This paragraph should include the factual information concerning the details of the accident. It should, as far as possible, be confined to facts. Hearsay information should be avoided unless it involves spontaneous remarks made directly before or after the accident, or unless the remarks contain information which will attack the credibility of a witness. If, from the claims person’s knowledge, he or she realizes that the information being given is obviously wrong because of an honest mistake on the part of the witness, he or she should try to clarify the situation before putting it down on paper. On the other hand, if there is any question of dishonesty, or if the witness stubbornly maintains his position on the situation, it should be taken down as is. By doing so, the witness will at least destroy his value as a witness for the opposition.

- **Physical Description**—The physical description of the scene of the accident should be as complete as possible, and should include weather and lighting conditions, road surfaces, road and other measurements, and any other pertinent details. Whenever possible, some effort should be made to get the witness to draw some form of diagram, illustrating the factual situation. Drawing the diagram will help clarify the facts and impress the interested parties with the credibility of the witness. It is important to have the diagram signed as well as the statement, and is best to keep the names of other witnesses out of the signed statement. They may turn out to be unreliable and the statement, if read in court, might create an erroneous impression.
• **Injuries and Damage**—The next section of the signed statement can include details concerning the nature of the property damage and the injuries received. This should include not only as complete a description of the damage as possible, but an estimate of the cost of repairs, if one has been obtained. Description of the injuries should be as complete and detailed as possible, and should be in the language used by the claimant. The names of all attending doctors with their addresses should also be included.

• **Special Damages**—In statements obtained from claimants, complete lists of all special damages should be obtained and itemized. The items that make up special damages have previously been covered.

• **Police Action**—An indication of any possible arrests or other police action should be included toward the end of the statement.

• **Corrections**—Having finished the body of the statement, it is now the duty and responsibility of the claims person to make sure that the statement contains the exact information given by the witness and that it does not deviate in any way from the information which he gave. Now is the time to give the witness the statement to review and to point out any errors, any parts of the statement which are not clear, or any sections which the witness for any reason whatsoever wishes to have changed. Wherever possible, all changes or corrections should be made by the witness in his own handwriting. If the witness shows any reluctance, or objects to making the corrections in his own handwriting, the claims person should make sure that each correction made is initialed by the witness. Under no circumstances should any portion of the statement be erased. Rarely is a statement written first-draft without needing some minor corrections. The claims person should not look upon this as something objectionable. The fact that a witness has made corrections in the body of a statement in his own handwriting, or has initialed such corrections, is an admission that he has not only read, but studied the statement. It would be difficult indeed for him to try to testify subsequently that he had not read the statement or was not aware of what it contained after having corrected it.

• **Acknowledgment**—Having placed the pen in the hands of the witness for the purpose of making corrections, it then becomes a mere matter of routine procedure, after he has completed his corrections, to ask him to acknowledge the fact that he has read the statement and affirms the truth by adding in his own handwriting, the words "I have read the above and preceding number of pages, and state that the information contained therein is true and correct," or words of a similar nature. This sentence should be written on the line following the end of the statement, allowing for no empty space in between.

• **Signature**—If the claims person has obtained the acknowledgment that the witness has read the statement and affirms the information to be true, in his own handwriting, he should not have any difficulty with the signature. Most witnesses will append it automatically. It is preferable that the claims person does not use the word "sign" in asking the witness to put his name down on the next line after the acknowledgment. The individual who continually bemoans the fact that he or she cannot obtain signed statements is one who is making excuses for certain internal deficiencies. A positive attitude (and this does not mean an overly aggressive attitude), a matter-of-fact handling of the situation, and above all, the absence of any hint of defeatism or timidity, will ordinarily accomplish the necessary results. Refusals to sign a statement should be the exception, rather than the rule. No signature will ever be obtained without some effort or attempt to get it. Nor will it be obtained with an attitude or words that signify, "You don’t want to sign this, do you?" Each page of the statement should be initialed by the witness or, preferably, signed with his full name. When a witness hesitates to put his signature on the statement, the claims person may point out to him that he is merely being asked to verify the truth of the statements he has made. It sometimes helps to ask the witness what phrase of a statement he seems uncertain about. If the witness adamantly refuses to sign the statement, in some instances a third party who was present during the time the statement was taken might be induced to add his signature.
to a paragraph attesting to the fact that the statement was read by (or to) the witness, and that he affirmed it to be true and correct. In some instances, witnesses may refuse to add their signatures to a statement but will not object to placing the letters "O.K." at the end. Sometimes, the witness might be willing to answer the following questions as written out by the person who has obtained the statement, "Have you read the above and preceding pages?" "Is the information contained therein true and correct?" An affirmative answer to each of these questions in his own handwriting has the same effect as though the witness had signed the statement. Occasionally, the very sight of a statement pad will affect a witness as a red flag affects a bull. He will vehemently and violently tell you that there is no use in your writing out a statement since he will absolutely refuse to sign it. The claims person must not let this throw him off balance. He should put his pad away, inform the witness that he is merely attempting to arrive at the truth and ask the witness to give the facts. After the claims person has obtained the witness’ version verbally and after the witness has had a chance to calm down, the claims person can then explain to the witness that he does not want to rely on his memory in order to report on the facts as given by the witness. Accordingly, the claims person can indicate that he would like to make a few notes to be certain that he reports the information exactly as given to him. In most instances, if properly explained, the witness will not object. The claims person can then proceed to write up the statement. Surprisingly enough, the witness will often feel ashamed for having given vent to his anger and may sign the statement obligingly.

- **Witness to the Statement**—Whenever practical, signed statements should be witnessed by one or two disinterested parties who should place their full names and addresses on the statement. The claims person taking the statement should not ordinarily witness it. Occasionally, a claims person will encounter a witness who does not have sufficient understanding of the English language to be able to read the statement. In that event, it is necessary to obtain a translator’s affidavit or short statement appended to the bottom of the statement obtained from the witness. The affidavit or appended statement should indicate that the translator read the statement to the witness in his own language, that the witness understood it, and affirmed the facts contained therein to be true and correct. Such a clause can read as follows: "I, John Doe, residing at [address] attest that I can fluently read and write French as well as English. I further state that I have read the above and preceding statement of Mary Smith and that I have accurately translated it into the French language which she understands. Mary Smith affirmed the fact that this is her statement, that she thoroughly understands it, and that the information contained therein is true and correct." This paragraph should be signed by the translator and either witnessed or notarized. Before obtaining the signature of the translator, the signature of the witness should be obtained at the bottom of the statement, even though written in a foreign language.

Despite the fact that the percentage of illiteracy in this country is extremely low, the claims person will nevertheless encounter illiterate witnesses more often than he or she would think likely. Sometimes an illiterate person will attempt to cover up this ignorance by what may appear to be an obstinate refusal to confirm the statement by reading it, or to sign it. With a moderate degree of persistence, the claims person should be able to recognize this. In any event, obtaining a statement from an illiterate person requires the utmost tact and diplomacy. The claims person should read the statement to the witness, make whatever corrections are necessary and, if possible, call in the services of a notary or some other reliable person in whom the witness has confidence and who the claims person believes to be reliable.

The claims person should have the third person reread the corrected statement to the witness and obtain the witness’ assurance that the statement is true and correct. Then, in place of a signature, he or she should have his or her mark placed at the bottom of the statement and append a paragraph on the same page stating that the statement has been read to the witness
and that this witness has affirmed that the information contained therein is true and correct. Such an appended statement, to be signed by the third person who has read it to the witness, can read as follows:

"I, John Doe, residing at [address], read the above and preceding [#] pages to Mary Smith. She stated that she understood the statement, affirmed that it was hers, and that it is true and correct."

This paragraph should be signed by the person who read the statement to the witness and corrections should all be initialed by this individual. If a notary has been called in to assist either as translator or to read the statement to an illiterate person, the notary should add his or her own form of affidavit.

In investigating serious or important claims, the claims person will obtain leads that will direct him or her to people who will deny any knowledge of the accident. In those instances where the denial is persistent, and where he or she believes there is a possibility that they are either covering up or may subsequently appear as witnesses for the opposition, every effort should be made to obtain a short, signed statement from such persons. It should state that they did not see the accident and from their own observation know nothing about it. Such a negative, signed statement will at least prevent that person from later appearing as a surprise witness for the opposition. If the witness does appear, it will enable the defense attorney to discredit this individual.

If a case which the claims person is investigating is of any consequence, it warrants a personal interview with every witness. Occasionally, the obstacles to personal interviews may be extreme, involving distance, weather conditions or the time element. The claims person may, therefore, after due consideration, and at a calculated risk, determine that the most advisable course of action is to attempt to get information from a witness through the mail. Having learned by now that the writing of a statement is an involved matter, proficiency in it requires practice. Therefore, the claims person should not expect that the ordinary witness will always be able to write a satisfactory narrative account of an incident without help.

Again, proper judgment must be used to avoid asking so many questions that the witness is discouraged. At the same time, he should be thorough enough to get the information he needs. He should use great care and spend enough time to prepare the questions so that they will be pertinent and intelligible. As much care should be used in framing the accompanying letter to the witness as in the preparation of the questions themselves. He must remember that he is imposing on the time of the witness and that the witness is doing him a favor in complying with his request.

It has often been said that children make unreliable witnesses. It may, in fact, be quite the contrary. Some children have vivid imaginations and sometimes cross the borderline between truth and fantasy. This, however, is usually not hard to determine. For the most part, a child who has sufficient mental development can be impressed with the importance of his remarks to the extent that he will make a reliably factual statement. The average child who is able to read and write will, for the most part, give a more straightforward and honest account than the average adult.

Whether the statement should be written in the handwriting of the child, or whether the claims person should write it out himself, is a matter of judgment involving elements of time and the child’s personality, general intelligence and education. If the child has acquired reasonable skill
in writing, it is advisable to have him write the statement himself. In this case particularly, it is essential that all useless verbiage be eliminated in order not to tire the child or cause him to lose interest. Such a statement should always be obtained in the presence of a parent, adult relative or friend. It is particularly important that the words used should not be in comprehensible to the child. His vocabulary will vary with his age and development.
Introduction
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
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**

Property upon which the total value has been paid as a result of a claim under an insurance policy rightfully belongs 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.

**Handling Salvage Claims**

The following summarization is an outline of steps to be considered in the handling of a claim involving salvage.

- Whenever you have paid for the total loss of an article, either obtain credit for it from the claimant or take it in salvage, assuming that it is available and has some value.
- Protect the salvage from theft, further deterioration and the elements.
- Arrange for storage at the lowest possible cost.
- Explore the market for all possible buyers.
- Dispose of the salvage as soon as possible. Retention increases depreciation as well as storage charges.
- Ordinarily, avoid selling salvage to coworkers or to yourself. You may both become dissatisfied customers and may in addition leave yourself open to unwarranted suspicion.

**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.

**Obtaining Medical Information**

The first time a trainee copies a hospital report, he or she may come out of the experience quite bewildered. Five years later, the individual may be inclined to criticize the diagnosis and question the treatment.

The truth of the matter is that the average person can, with some diligent study, acquire a good working knowledge of medical terminology and enough of an understanding of the field in which he is interested to discuss injuries, and even treatment, quite intelligently. Of course, the physician who has spent years of his or her life studying and practicing medicine knows more than the claims person about medical problems. Therefore, while he or she should learn as much as possible, the claims person should never try to replace the physician.
Medical and legal textbooks should be available to the claims person, and he or she should be able to discuss medical problems with a resident or examining physician, or with the home office. Even if the office out of which he or she is working maintains a resident physician on its staff, there is still need for the claims person to have a certain familiarity with injuries or diseases which may result from, or may become aggravated by, accidental injury. The individual must, in any event, be able to:

- **Evaluate the injury**—This can be done only if he or she is able to understand the medical reports and appraise their significance. If he cannot evaluate the injury, he obviously cannot evaluate the claim and must therefore, depend entirely upon his supervisor to set a figure on its value.

- **Help detect fraud or malingering**—Unless he or she has at least some fundamental knowledge of symptoms, causes, and effects, he or she will be completely unprepared to determine the appropriateness of a particular claim.

- **Help determine whether proper treatment is being given**—This is especially important in compensation claims. Claim adjusters, quite obviously, are human. They do become emotionally involved in their claims. It is natural, therefore both from the humanitarian and business point of view, for the claims person to be anxious for the claimant to receive the best possible treatment, so that he can make the quickest possible recovery.

- **Learn when to order a medical examination and by whom it should be made**—Ordering an examination shortly after a claimant has received a fracture and is still in a cast is not only useless, but is a complete waste of money if there does not appear to be a question about the genuineness of the injury or the honesty of the claim. On the other hand, if there is or may be an element of fraud or malingering, the claims person may find it advisable to assign a medical examination as soon as possible, or at least after enough time has passed so that any subjective complaints would have materialized.

The best time to obtain medical information and a written authorization from the claimant to procure medical information is when the claims person first interviews the claimant.

Authorization should be phrased in simple language, and should avoid legal terminology. The authorization should state that the bearer is authorized to receive a medical report on the accident from the doctor or hospital involved, and should be signed by the claimant. Enough copies should be given so that medical information can be obtained from each attending physician, hospital, clinic, or any other person or organization that rendered medical services.

**Components of Medical Information**

Medical information obtained from the claimant should preferably be incorporated in a signed statement obtained from him. Whether obtained orally or in writing, the information should include:

- Detailed description of all objectives (noticeable evidence of injury).
- Detailed account of any unconsciousness, giving exact duration.
- Complete list of subjective complaints (not accompanied by noticeable evidence of injury), when they first developed, and their duration.
- Assistance rendered at the scene of the accident.
- First aid rendered and by whom.
- Name of hospital or doctor to whom the claimant was taken immediately after the accident.
- Name and address of family physician who subsequently treated the claimant.
- Name and address of any specialists who were called in for consultation and treatment.
- Dates of all visits to physicians, specialists, hospitals or clinics.
- Dates of visits made by doctors or specialists to the home of claimant.
• Dates of admission to and discharge from a hospital.
• Information concerning X-rays—taken by whom, when and what part of the body they covered.
• Details of operations or casts.
• Details of the nature of the treatment rendered.
• Exact duration of confinement to bed.
• Exact duration of confinement to the home.
• Exact length of disability from work.
• Exact nature of present complaints, if any.
• Description of any scars or disfigurements (include snapshots or photographs, if obtainable).
• Complete details of previous medical history:
  • Family history, including inherited tendencies or weaknesses and the history of family deaths that might have a connection with the present or future disability of the claimant.
  • b. Names and addresses of all doctors and hospitals that were involved in previous serious ailments that might have a connection with the present disability or which might have been aggravated by the accident.
• Complete list of previous operations, with full details, including previous X-rays taken.
• Details concerning any previous protracted treatments.
• General observations regarding obesity, undue nervousness, unusual despair or other indications of a similar nature that may have a direct bearing on the injury, disability or recovery.
• History of previous disease, such as cancer or heart condition, which may have been aggravated as a result of the accident.
• History of previous ailments or diseases which might have left after-effects, such as scarlet fever, measles, and so on.
• History of any previous diseases which might affect healing in any manner, such as tuberculosis, syphilis, gonorrhea, diabetes and so on.
• Special emphasis on previous injury to eyes, ears or any part of the body that may have impaired complete function or contributed to the cause of the accident.
• Previous dental history, if applicable.
• History of all extensive previous physical examinations, such as for life insurance, armed forces, or induction to the armed forces, employment, or school examinations.

In reporting the medical information, some comment should be made concerning the competency, qualifications, and reputation of the claimant’s attending physician or physicians. If these are unknown to the claims person, the qualifications of the attending doctors should be checked in the local medical directory or directory of medical specialists.

**Lien Laws**

Congress (Veteran’s Hospitals) and a number of state legislatures have, by statute, given hospitals and doctors a means of legally protecting their bills for services rendered in connection with casualty claims by allowing them to file a lien. Such a lien requires the party on whom it is served to pay the medical bills out of any money paid in settlement of a third-party claim.

These statutes are known as lien laws. Where applicable, they require notice of lien to be given by hospitals or doctors to third parties alleged to be liable for the injuries received by the claimant. In some instances, notice is required to be given to the third party insurance carrier, if known. Sometimes the liens must be filed in the county clerk’s office in order to become effective.
Failure to comply with the provisions of the lien law after notice obligates the third party or his insurance carrier to reimburse the hospital or doctor for the bills covered in the lien, regardless of any settlement which may have been made with the claimant. Accordingly, it is obviously important to note the existence of any lien and take whatever steps may be necessary to insure payment of the bill before settlement is consummated. This may be done by issuing a separate draft to the claimant and the doctor or hospital for the amount of the bill at the time of settlement, if it is still unpaid.

In many jurisdictions, recognition of the lien will permit the claims person to obtain medical information from a hospital. Usually, there are certain prescribed forms which must be completed before the information will be released. The filing of a lien can sometimes be used to advantage when all other avenues for obtaining medical information have previously failed.

**Getting Medical Information**

One of the most important steps in the investigation of bodily injury claims is the problem of obtaining complete medical information from the claimant’s attending physician as soon as possible. Most companies provide some sort of printed form for obtaining this information. We will shortly discuss some of the items of information that should be contained in a physicians’ report. No definite rules can be established concerning the advisability of using such form, or the manner in which it is to be used. This will depend entirely on the claims person’s knowledge of the attending physician. He should get to know his local physicians and their secretaries as soon as possible. The latter are often the guardians of the physician’s time and records.

In some cases, a mailed request enclosing the form with a stamped, addressed envelope will suffice. In others, it may be necessary to call the physician on the telephone before sending such a form. Sometimes, especially where the injury is severe, the claims person should see the doctor personally. In such instances, there is no substitute for a personal interview.

If it is believed that the reaction to the request will be favorable, the claims person should arrange by telephone for a personal interview at the physician’s convenience. In other instances, it may be advisable to call on a doctor during his office hours and wait until he has finished with his last patient. In no event should an attempt be made to interview a doctor while a patient is waiting to see him, unless the doctor invites the interview. Even if the doctor refuses written information, he may provide some verbal information that could be valuable. When a definite appointment has been made, a claims person should be absolutely sure that the appointment is kept promptly, and should never keep a doctor waiting. If at all possible, a medical report form should be completed during the interview. If the doctor is pressed for time he may request that the form be left with a stamped, addressed envelope to be forwarded at his earliest convenience.

Prompt medical information obtained from the claimant’s attending physician will help to determine the need for a physical examination, and give the claims person an opportunity to prepare the case properly for defense, if necessary. If the attending physician’s qualifications and integrity are unquestionable, settlement can often be effected based on his information without the delay and expense of a physical examination. It is equally important to obtain the attending doctor’s report where a physical examination is needed, so that the examining physician may have the benefit of the medical allegations before making his examination.

Most casualty claim departments have some printed or copied medical report form to be completed by attending doctors. In many instances these are so detailed that they discourage a
busy doctor. He may either ignore them completely or fill them out in a sketchy manner. In other instances, forms have been so whittled down that they lose much of their potential value.

**Components of Effective Medical Forms**
To be most effective, the form should contain at least the following categories:

- **Personal and descriptive data**—This should include notation of the date, time, and place where the initial examination was made. It should also include at least the name, address, marital status, age, weight, height and occupation of the claimant.
- **History of the accident**—Whether or not detailed questions concerning the time, place, location and other factual details of the accident itself should be printed on the form is a matter of judgment. Suffice it to say that some provision must be made for the history or factual details concerning the accident.
- **Previous medical history**—Here the details included in the form may vary. For a checklist of the information that can be obtained under this category, see the list provided under "Medical Information to Be Obtained From the Claimant," discussed previously.
- **Details concerning the initial examination**—This includes any X-rays or laboratory test reports, and consultant’s reports.
- **Treatments rendered**—This includes the type and the dates of all office and home visits.
- **Diagnosis**—This should include a detailed account of the doctor’s findings concerning ailments and disability, with special emphasis on trauma.
- **Prognosis**—This concerns the estimated disability and possibility or probability of partial or ultimate recovery with emphasis on a possible partial or permanent disability.
- **Conclusion and recommendations**—Here the doctor should comment on recommendations concerning future treatments, operations, or further hospitalization, as well as any other details that affect the medical picture.
- **Diagrams**—Diagrams of various parts of the body are usually imprinted on the opposite side of the medical form to enable the doctor to show scars or indicate the location of fractures, burns, or other injuries.
- **Doctor’s bill**—Provision should always be made for the doctor to show the amount of his bill up to the time the report is made, with provision for estimated future medical expense.

**Dental History**
In all cases involving injury to teeth, a claims person should obtain as complete a dental history as possible, including the general condition of the subject’s teeth immediately before the accident, an account of any diseases of the mouth, details concerning bridge work or plates, pivots or caps, and any other information that might have a bearing on the injury allegedly sustained as a result of the accident under investigation. For instance, it is not unusual to find that teeth which may have been knocked out as a result of an accident were in advanced stages of decay.

**Components of Hospital Records**
In investigating serious accidents, a claims person should make a transcript of the complete hospital record. He should not be content with an abstract of the hospital records merely because the abstract will save him the bother of copying the record. This copying is admittedly a time-consuming and tedious chore, but it pays off often enough to make it worthwhile. An abstract is ordinarily only a very brief digest of the information contained in the record. If a case
is important enough to warrant such an examination, every paper in the hospital records should be carefully scrutinized. The records will usually contain:

- **Admission information**—Beside the ordinary information about the date of admission and the history of the accident as given by the patient, there may be welfare board reports concerning the financial background of the claimant, policy reports, an itemized list of the clothes and possessions of the claimant at the time of admission, condition of the clothes, and other extremely valuable information. The history of the accident as given by a claimant to a hospital attendant immediately after an accident can be of extreme importance if the claimant seems inclined to change his story later.

- **Examination reports**—These are reports by attending physicians and interns, X-ray reports, notes and instructions by interns and doctors, details concerning treatment, pathologists’ and laboratory reports.

- **Nurses’ notes**—Such notes, made for the benefit of the attending doctors and interns, contain comments that are often pertinent concerning a patient’s attitude and morale and will also indicate what drugs have been administered.

- **Diagnoses and prognoses**—These must be gathered from the various attending physicians and specialists, along with the date and circumstances under which the patient left the hospital. A nurse, whether in attendance in a hospital, nursing home, or private home, spends much more time with a patient than a doctor, and sees the patient under conditions that tend to be more personal and informal than the standard doctor-patient relationship. Not only does the nurse see the patient in unguarded moments, but also learns much more about the personality and character of the injured. She is the one who hears all of his subjective complaints, can observe his attitude and is the best judge as to whether or not the patient is exaggerating his injuries, consciously or otherwise. Accordingly, an alert investigator should not miss the opportunity to obtain information from this source.

**Objectives of the Medical Examination**

A proper medical examination can be an important source of information. It is also a valuable defense weapon but it should not be ordered indiscriminately. Consideration should be given to the ultimate objectives which are to:

- Help to determine if the allegations of disability are true and to corroborate the injuries sustained.
- Help to determine if the alleged injuries or disability resulted from the accident.
- Help to determine the true extent of any disability.
- Help to determine if the claimant is receiving proper, sufficient or too much treatment.
- Obtain the history of the accident as given to the examining physician or corroborate any conflict with the previous information he gave to the hospital or other doctors.

If the object of the examination is merely to corroborate information, then the hospital records, the reputation of the claimant’s attending physician and the information he gives may be sufficient. However, in order to avoid second-guessing, where there is no allegation of further injury or disability, an attempt should be made to obtain a signed statement or report from the doctor.

Medical examinations should never be assigned routinely as a matter of course. It is a costly measure at best. When deciding on the advisability of a physical examination, the claims person should obtain as much medical information as he can from the attending physician, hospital records or other sources. Otherwise, the examining doctor may be concentrating on the effect of a fracture and completely miss a subsequent allegation of neurosis. The claims person must
never forget that a medical examination can be a double-edged sword. Made by the wrong doctor at the wrong time, or without sufficient preparation, it can do more harm than good. Obviously, the doctor will be able to make a much more thorough examination, and one of greater value, if he is familiar at the outset with all the allegations and complaints.

Local custom and statutes vary with reference to the obtaining of physical examinations. When a case goes into suit, at least one physical examination is ordinarily permitted by law. However, in view of the fact that both the claimant and any attorney which he may have engaged are ordinarily anxious to obtain a settlement, they will in most instances cooperate to the extent of permitting at least one examination even when the case is not in suit. Since this may be the only examination that is permitted, the claims person must be intelligent about its use.

He or she must make the best use of the examination that is permitted. Except in the unusual or long disability case, it would be difficult to justify more than one examination. Reluctance on the part of either the claimant or his attorney to permit a medical examination is usually an indication that some attempt at exaggerating the injuries or the disability may be made. As has been said before, judgment must be used in determining when a physical examination should be made. If there is no question of fraud or malingering, or the propriety or necessity for further treatment, an examination should be delayed until the maximum healing has taken place.

Otherwise, a physical examination should be obtained as soon as enough time has elapsed to develop any subjective complaints that might be alleged in the future.

The physician making the examination should be properly qualified, impartial, honest, and should make a good impression as a witness. If the allegations require the services of a specialist, get a specialist to make an examination. Barring unusual circumstances, a jury will not give as much credence to a general practitioner as it will to a specialist. This can cause disaster if the specialist is testifying for the opposition. The claims person should not use doctors who may be even unconsciously biased in his favor. He should make arrangements with a physician who is thorough and competent, but not too busy to make a proper examination and give a proper report.

It is also important to remember the examining physician may have to testify at trial. Because some specialists rate their services quite highly, you should accordingly have an understanding with the doctor concerning costs before engaging his or her services. When the claims person has decided on a doctor, he or she should be given all the information available before the examination takes place. Under no circumstances should an examining physician advise the claimant about treatment, or suggest a course of treatment to him. Under rare circumstances, the attending physician may wish to consult with the doctor who made an examination for the company, but even here the situation must be handled with the greatest tact and diplomacy to avoid putting the company in a position where it may be accused of practicing medicine.

Finally, the claims person should make sure that the examining doctor’s report is intelligible and that he or she thoroughly understands it. If not, it is important to discuss it with the doctor until all questionable points are cleared up.

The claims person, in making an assignment to a physician for a medical examination, or the claimant’s physician, in evaluation, should know how to interpret information obtained from the American Medical Directory, or from other medical directories published in this country or abroad. Such directories give information concerning the school or university from which a doctor graduated; the year of graduation; any specialties which he practices; any fellowships or special degrees or honors; any medical societies to which he belongs; his staff and hospital
associations and other such valuable information that can help to determine a doctor's experience, education and competence.

However, it is important to remember that such background information, while exceedingly important, is not the complete picture. There are many general practitioners who are extremely competent medical practitioners, despite their lack of a specialty or higher degree, and despite the fact that they may not have graduated from a prestigious university or medical college.

**Specialties**
The development of medicine is marked by an ever-growing list of specialties to which practicing physicians more and more confine themselves. In fact, general practice is itself becoming a specialty. In rural areas, a country doctor must be a good practitioner who has some familiarity with all types of medicine, including surgery. In highly-populated cities, more and more medical professionals continue their studies along very specialized lines. With the growth of large clinics and medical centers, specialization is now commonplace.

In order to be able to determine the particular specialist to whom the claims person may wish to assign a physical examination, he or she should have at least some familiarity with the more common specialties which are being practiced today. These are as follows:

- **Allergy**—Deals with the unusual susceptibility of a person to a substance or substances usually harmless in similar amounts for the average person.
- **Anesthesiology**—The study of anesthesia and anesthetics.
- **Bacteriology**—The science that represents the study of bacteria and other microscopic organisms. Examining physicians usually refer their specimens to bacteriologists for bacteriological tests.
- **Cardiology**—The study of the heart and its functions.
- **Clinical Pathology**—A branch of medicine pertaining to or founded on actual treatment or observation of patients.
- **Dermatology**—The study of the skin and skin diseases.
- **Gastroenterology**—The study of the stomach and intestines and their diseases.
- **Gynecology**—Deals with female ailments, especially those of the genital, urinary and rectal areas.
- **Internal medicine**—Deals with the diagnosis of ailments within the body and covers an area encompassed by many specialized fields. An internal medicine specialist was formerly referred to as a diagnostician.
- **Laryngology**—Specializes in ailments of the throat, larynx and associated organs.
- **Neurology**—Deals with the nervous system and its disorders.
- **Obstetrics**—Deals with childbirth and the management of pregnancy and labor.
- **Ophthalmology**—Concerns the eye and its diseases and disorders.
- **Otology**—Deals with the ear and its diseases and disorders.
- **Pathology**—Studies the essential nature of disease and concerns itself especially with the structural and functional changes which cause or are caused by disease.
- **Pediatrics**—Concerns child development, and children’s diseases and their treatment.
- **Proctology**—Deals with ailments of the rectum.
- **Psychiatry**—Specializes in the mind and its disorders.
- **Rhinology**—Studies the nose and its diseases.

- a) True  
- b) False

Internal medicine deals mainly with the use of X-rays in the treatment of disease.

Radiology—Concerns the use of X-ray in the diagnosis and treatment of disease.

Pathology—Studies the use of X-ray in the diagnosis and treatment of disease.
- Roentgenology—Deals with the use of X-ray, both in diagnosis and treatment.
- Urology—Specializes in disorders of the urinary tract and male reproductive organs.
- Surgery—Specializes in operative procedures. Three fields of surgery with which the claims person will most often come in contact are:
  - Neurological surgery—surgery which is confined to the nervous system, especially the spinal cord and the brain itself.
  - Orthopedic surgery—concerns itself with the preservation and restoration of the skeletal and muscular systems and is the branch with which we most often come in contact in dealing with fractures.
  - Plastic surgery—deals with the restoration and the building up of tissues as they affect the general appearance of an individual. The claims person will most often come in contact with this branch of medicine in dealing with permanent and disfiguring scars as a result of injury.

**Veterans’ Records**

While some selective service records are privileged, the part of the record concerning physical disability and injury can usually be obtained without undue difficulty. This information usually contains a complete medical history and a record of any injuries, ailments, or treatments while in the service, particularly where there may have been any disability resulting in a pension. These records are most important where there is any allegation of neurological or psychiatric complications and can, if necessary, be subpoenaed in an action in federal court. In state courts, the power of subpoena with reference to such records is at the discretion of the judge.

Veteran records concerning disability are ordinarily very comprehensive and include among other items:

- Name, age and other personal data.
- Military record.
- A complete chronological medical history, including examination of admission, treatments and examination on discharge.
- A history of all accidents or injuries.
- Medical history.
- Nurses’ notes, doctors’ progress notes and doctors’ orders.
- Laboratory tests, X-rays, electrocardiograms, etc.
- Clinical notes and outpatient records.
- Consultation records.
- Report of the Board of Medical Service.
SECTION 7:
PERSONAL AUTO CLAIMS

PERSONAL AUTO POLICIES

Almost 50 percent of all liability-property insurance underwritten in the United States involves insurance on vehicles, including private automobiles, station wagons, vans, panel and pickup trucks, and jeeps. A typical policy will cover personal and most business uses. Vehicle insurance covers liability, collision loss of the vehicle, comprehensive losses and medical expenses occasioned by the driver, passengers or other persons. Coverage typically applies to anybody who is driving the car at the time of the loss with the express or tacit permission of the owner of the vehicle. Endorsements can be added to cover a number of options, to afford liability coverage for additional circumstances and to provide insurance for special accessories and equipment. Vehicle liability coverage is mandated by law in most states up to a particular monetary limitation. Coverage may be excluded when a vehicle has been driven in a foreign country. Following are some of the more important aspects of a vehicle insurance policy:

- **Property damage liability**—When a policyholder’s vehicle causes damage to property of another, claims and legal costs arising from such damage are covered under this provision. Lamp posts, buildings, telephone poles and other forms of stationery property are also covered. The policyholder and resident family members are included within coverage when driving a vehicle of the insured or of another with that owner’s permission. In some states, if an insured lends his or her vehicle to a second person who entrusts the vehicle to a third person, the insured may be liable for damages caused by such third person under the "negligent entrustment theory," on the basis that he or she should have reasonably foreseen that the borrower of his or her vehicle might let a third person use it.

- **Bodily injury liability**—If an insured causes bodily injury or death to another while using his or her vehicle, he or she is protected from losses by this type of coverage. Expenses for hospital and medical care, rehabilitation, legal fees, pain and suffering, lost wages and potential future earnings may be covered. Unless required otherwise by state law, an insurer is not required to pay any claims under this type of coverage unless a driver has been negligent. When litigation or claims are filed against a policyholder, bodily injury liability insurance offers protection in the form of legal defense, and the insurer will pay damages or losses stated in the policy up to the limits of coverage if the policyholder or another named insured is legally liable.

- **Underinsured motorist coverage**—In the event a party who is responsible for an accident does not have enough insurance to pay medical expenses, this type of coverage will make
up the deficit, subject to policy limitations. This feature is included automatically in some states when extraordinary amounts of uninsured motorist coverage are obtained.

- **Uninsured motorist coverage**—If a person is hit by an uninsured driver or a hit-and-run motorist, he or she can recover expenses for bodily injury or property damage under this part of a policy. Coverage is also available when the insured is injured by a motorist whose insurance carrier has become insolvent. Coverage extends to family members and nonpaying passengers.

- **Medical payments insurance**—This type of coverage extends to medical expenses of the insured and of any passengers that are incurred as a result of an accident. Payments are made without regard to the fault of any of the parties involved. Generally, this coverage applies to invited guests and family members who are residents of the insured as well as to the policyholder. If the policyholder or his or her immediate family members are injured while in another car or by a vehicle while walking or running, coverage is also available.

- **Personal injury protection**—This kind of coverage is sold mostly in states that have no-fault insurance laws. Generally, personal-injury coverage is mandatory.

- **Collision insurance**—damage to an insured’s vehicle is covered without regard to which party caused an accident. An insurer may pay a claim to the insured, and then seek to recover from the insurer of the other party when the latter is at fault. This type of coverage ordinarily has a deductible ranging from $100 to $1,000 dollars. The insurer will pay for repair costs of the policyholder even if another driver is at fault, and will then seek reimbursement from the other driver’s carrier.

- **Comprehensive coverage**—Losses from damage to a vehicle attributed to a cause other than a collision are protected against under comprehensive coverage. Comprehensive insurance typically covers situations where theft, fire, breaking of glass, vandalism, flood, explosion, earthquakes, hail and malicious mischief are the cause of the damages.

### Exclusions

Following are some of the more common exclusions from a personal vehicle insurance policy:

- Intentionally causing bodily injury or property damage—One who uses a vehicle to intentionally inflict injury to the person or property of another is not included within coverage, because such activities are of a criminal character and it is against public policy to insure such behavior.

- Damage to property owned or being transported by an insured—Liability coverage is provided for damages to property owned by others.

- Damages to property of others in the possession of the insured—While an insured has custody and control of the property of another, he or she is treated as the constructive owner of such property and coverage is not available.

- Injuries to an employee of the insured while working for the insured—It is against public policy to allow an employer to thwart his or her responsibility to carry workers’ compensation by acquiring liability insurance.

### No-Fault Insurance

Under "no-fault" auto insurance, a policyholder recovers from his or her own carrier losses, such as medical and hospital expenses and lost income. Generally, a policyholder is required to waive his or her right to sue the party at fault, except in the case of death, permanent disfigurement or injury. Some states require no-fault policies to include coverage for property damage.
Financial Responsibility Laws
Such laws require drivers of vehicles to produce evidence of financial responsibility as a condition to obtaining and keeping a drivers' license. Financial responsibility provisions are an alternative to acquiring personal liability insurance, and evidence of such responsibility can be demonstrated by a cash deposit or by the acquisition of a surety bond.

Responsibilities of an Insured Following an Accident
A personal vehicle insurance policy imposes responsibilities on an insured, such as:

- **Personal injury**—The first order of business at the scene of an accident involving a vehicle is to see that treatment is provided for personal injuries. The insured should make a mental note of injuries in the event one of the parties to an accident later attempts to stage an injury. Photographs can be useful.
- **Witnesses**—A thorough search for witnesses should be conducted.
- **Notification to the insurer**—Most policies require an insured to report any accident to an insurance company, even though the insured may be at fault. An insured should follow the notification procedure provided by the policy or in other written instructions from his insurer, which usually requires information, such as the location and time of the accident, the names, addresses and telephone numbers of parties involved in and witnesses to an accident, the make, model and license number of any vehicles involved, the nature and amount of damage to all vehicles and the location where the vehicles were taken, the name of the police department that responded to the accident and the name of the insurance company of any other driver involved.
- **Notifying the police**—Not only does a standard insurance policy include provisions concerning notification to the police, but state laws ordinarily require that the police must be informed under certain circumstances. An accurate statement of the accident should be provided. Coverage may be denied if the police are not notified under some policies. If a civil or criminal charge may be filed against someone under the policy as the result of a loss or injury, the police should be made aware of such possibility.
- **Protection from further damage**—An insured must take all reasonable steps to protect a wrecked vehicle from further damage.
- **Inspection**—An insurer must be permitted to inspect a vehicle before repairs are undertaken.
- **Cooperation during an investigation**—A policyholder must cooperate with his or her insurer during an investigation of the conditions surrounding a collision. If anyone has been injured, it will be necessary for such person to undergo a physical examination.
- **Legal proceedings**—If any party involved in a collision institutes legal proceedings, copies of the complaint and any additional papers filed with the court must be provided to the insurer. Every effort must be made by the insured to submit to depositions and answer interrogatories and requests for production of documents.
- **Notification to lien holders**—If there is an outstanding note on the vehicle, the lien holder should be notified.

Following is a typical provision in a personal vehicle insurance policy regarding the duties of the insured:

*We have no duty to provide coverage ... unless there has been full compliance with the following...*

1) **We must be notified promptly of how, when and where the accident or loss happened.** Notice should include the names and addresses of any injured persons and any witnesses.
2) A person seeking coverage must:
   a. Cooperate with us in the investigation, settlement, or defense of any claim or suit.
   b. Promptly send us copies of any notices or legal papers received in connection with the accident or loss.
   c. Submit, as often as we reasonably require:
      i) To physical exams by physicians we select.
      ii) To examination under oath.
   d. Authorize us to obtain:
      i) Medical reports.
      ii) Other pertinent records.
   e. Submit a proof of loss when required by us.
3) A person seeking uninsured motorist coverage must also:
   a. Promptly notify the police if a hit-and-run driver is involved.
   b. Promptly send us copies of the legal papers if a suit is brought.
4) A person seeking coverage for damage to an auto must also:
   a. Take reasonable steps after loss to protect "your covered auto" or any "nonowned auto" and its equipment from future loss. We will pay reasonable expenses incurred to do this.
   b. Promptly notify the police if "your covered auto" or any "nonowned" auto is stolen.
   c. Permit us to inspect and appraise the damaged property before its repair or disposal.

SPECIAL AUTO COVERAGE ISSUES

Rental Cars
Agents disagree on whether clients should purchase the Collision Damage Waiver from car rental companies. Although the cost of this coverage is sometimes outrageous and seems like a duplication in protection, following are reasons why your clients should still buy it:

Loss Valuation
The Personal Auto Policy covers the lesser of the "actual cash value" of the vehicle and the amount necessary to repair it. Some rental agreements obligate your client to reimburse the rental company for "full value".

Loss Settlement
PAP policies typically give the insurer the right to "inspect and appraise the damaged property before it is repair or disposed". The rental care companies, however, are under no such obligation. They may decide to immediately repair the vehicle which could forfeit your own coverage.

Loss of Income and Expense Costs
The rental car contract may make your client responsible to pay for their loss of rental income. Your coverage may have very specific limits here.

Also, the rental contract may obligate your client to pay various administrative expenses or losses related to towing, appraisal, claims adjustment, storage, etc. Your PAP may not cover these.

Excluded Vehicles
Client rented vehicles that are NOT private passenger autos, pickups, vans or trailers may not be covered by your PAP.
Uses and Drivers
Your PAP may not cover certain drivers of a rental car or cover the use for which they were rented. Rental insurance can specify coverage for these drivers and uses.

Excess Coverage
Your PAP covers your client for any "excess" over the coverage provided by the legal owner of any auto they drive. Can you see where someone may try to argue that no primary insurance is in place?

Premium Increases
Your PAP policy premiums will most certainly include deductibles and if a claim is filed, premiums will likely increase. Rental car contracts may have few deductibles and will not effect your client's premiums.

Cars for Kids
There is much discussion in the industry as to the handling of cars for children. Some feel that the car should be titled in the name of the parents and fall under their coverage. Others believe that a separate policy, with minimum coverage and lower premiums, should be issued in the child's name.

While there is no correct answer, consider the following claim problems that can develop when minimum coverage is requested:

Minor / Dependent Status
If a child is under 18 and/or living at home with his parents, he will probably still be classed a minor or dependent falling under his parents liability exposure. Thus, a major claim exceeding his policy limits would likely fall to the parents to satisfy.

Car Swapping
The parent's policy will cover the parents and other family members but not the child with his own policy. So, let's say the family's 17-year old daughter (covered under the parent's policy) decides to drive her brother's car (covered under his own, minimum coverage policy). Since PAP policies exclude coverage for resident family members insured separately, the daughter must rely solely on the brother's low policy limits. Any excess may fall back on the parents to cover personally.

Also, there is the risk that the brother, like many teenage boys, has not made his premium payment last month. He may be already cancelled!

State Requirements
Some states require parents to sign financial responsibility contracts which obligate them to pay for any damages or liability regardless of whether the car is in the child's name or parent's name.

Umbrella Gaps
If an umbrella policy can be tapped in a claim, it responds AFTER the underlying limits have been reached. If the parent's primary policy has a limit of $300,000, but the kid's separate policy is only $100,000, a potential gap of $200,000 exists. This assume, that the umbrella policy would pay anything against a child's separate policy.
In summary, kids are expensive to insure because they are risky drivers. Trying to put a "pretty" face on this issue by recommending cheaper, lower limit policies for child drivers is likely to result in a faulty claim. This, in turn, can come home to roost at the agent's door in the form of a malpractice suit. It is best to always advise your clients (in writing) of the gaps and coverage deficiencies possible when applying for separate policies for their children.

**Trusts & Autos**

Since a lot of clients have personal trusts these days there is more opportunity for titling problems to develop into claims. Traditional PAP policies are designed for individuals. So, if the named insured is a trust, not an individual, there could be potential coverage gaps. For this reason, vehicles owned by a trust are technically supposed to be covered by a Business Auto Policy. Be sure to question the underwriter on how the insurer's criteria and the application of certain language -- especially "you" and "family members" will be interpreted when covering trusts. Another possible solution is to have the trust, as the legal owner, execute a written lease of at least six months to the persons having custody of the vehicle, so they can insure it under their own PAP and additionally insure the Trust as if they were a lien holder.

**LAWS AND AUTO CLAIMS**

**Comprehensive Laws**

Comprehensive coverage protects the insured against fire, theft, vandalism and other potential perils. Surprisingly, a collision with a deer typically falls under comprehensive coverage rather than collision coverage. Since comprehensive coverage is usually written with a lower deductible than collision, insurance people joke that insureds are quick to blame deer as the source of their collision rather than revealing how it really happened.

There will be unusual instances where no deductible is applied. Suppose the insured is driving along the road and another vehicle kicks up a stone which damages the windshield. This damage would be covered by his or her comprehensive coverage. The insured would be able to file a claim under the comprehensive coverage in his or her automobile policy. Normally there will be a deductible under that coverage, but on occasion the insurance carrier might waive the deductible if the insured agrees to have the windshield repaired rather than replaced.

If the *damage to the windshield* is in the driver's line of vision, a repair is usually not permitted. The windshield must be replaced. The cost of replacing it runs from $200 to more than $1,000, depending on the make and model of the car. The windshield replacement is covered by the comprehensive coverage and is subject to the deductible. In some states such as Florida, no deductible will be charged even if the windshield has to be replaced.

Automobile liability insurance policies ordinarily contain a provision requiring immediate written notice of the occurrence of an accident or of a claim for damages resulting therefrom. This requirement is not limited to the named insured, but applies to any person insured under the policy who seeks its protection. The purpose of this notice is to enable the insurer to receive prompt information concerning the accident, so that he or she may investigate the circumstances, prepare a defense, or be advised whether it is prudent to settle any claim arising from it. Because of its apparent necessity, such a provision generally has been held to be a reasonable and valid one. Ordinarily if the policy expressly makes the insured's failure to give
timely notice a ground of forfeiture, or compliance a condition precedent to liability, no recovery can be had where timely notice has not been given.

In an automobile liability insurance policy requiring immediate notice of the occurrence of an accident, the word "accident" means an undesigned and unforeseen occurrence of an afflictive or unfortunate character, resulting in injury to the person or property of another. The word "loss," in an automobile indemnity insurance policy, means the injury or damage caused by the accident for which the insurer may, under the provisions of the policy, be liable, though at the time, the extent of the loss may not be known.

The provisions in the policy as to the time within which notice must be given to the insurer are of very great importance. They may take on a variety of forms such as "immediate," "prompt," "forthwith," "as soon as practicable," and "within a reasonable time." The exact phraseology used seems to make very little, if any, difference, and it is well settled that none of these expressions require an instantaneous notice but rather they call for notice to be given with reasonable dispatch and within a reasonable time in view of all the facts and circumstances of each particular case.

By the terms of a clause, the notice of an accident is to be given by "the insured." This does not mean that the insured must personally give the notice; it may be given by another acting as his or her agent and representative in the matter. Thus, it has been held that notice given by a mortgagee of the vehicle, by the injured person, or by an additional insured, is sufficient to satisfy the requirement of the policy as to giving notice of an accident. Where the insured is a corporation, such notice may be given by and through its officers and agents. Upon the death of the insured, the duty to give timely notice devolves upon his or her personal representative.

In some of the earlier automobile liability insurance policies, clauses requiring notice of an accident did not specify in what manner or by what means the notice should be given. Now, the clause ordinarily requires written notice. As a general rule, such a requirement that notice must be in writing is not satisfied by an oral notice, such as notice given by telephone. However, the requirement of written notice is one which the insurer may waive or be estopped to set up. Telephoning the state automobile association through which the policy was obtained, a day or two after an accident, and following that with a detailed written report several days later, satisfies the policy requirement of an immediate written notice.

In the case of liability insurance policies in general, the standard motor vehicle liability insurance policy contains a provision giving the insurer the right to investigate, negotiate, and settle any claim or suit as he or she deems expedient. Motor vehicle liability insurance policies also usually contain a clause which prohibits the insured from voluntarily assuming any liability, settling any claims, incurring any expense, or interfering in any legal proceedings or negotiations for settlement, except with the consent of the insurer. The purpose of this provision is to prevent collusion and to invest the insurer with the complete control and direction of the defense or compromise of suits or claims.

In the Basic Standard Automobile Liability policy, the insuring agreements entitled "Coverage," concerning bodily injury and property damage liability, state:

"To pay on behalf of the insured all sums which the insured shall become legally obligated to pay for damages caused by accident and arising out of the ownership, maintenance or use of the automobile."

The word use is further delineated in the declarations of the automobile policies as follows:
"Use of the automobile for the purposes stated includes the loading and unloading thereof."

In the Family Automobile policy, the word "use" is specifically defined as including the loading and unloading thereof.

In attempting to delineate the scope of loading and unloading, we are not only concerned with coverage that may or may not be extended to an insured under certain circumstances, but also with the controversy between insurance carriers. One carrier may have the automobile coverage and the other the general liability coverage on the premises on which the loading or unloading occurred. The first question which must be determined is whether there was any causal relationship between the act of loading or unloading, and the accident. If there was some definite intervening cause that contributed to the accident, most decisions have held that such intervention takes it outside the scope of coverage.

Some of the decisions on this subject have been based merely on interpretation of what constitutes maintenance or use of the automobile. Most of the decisions however, have based their reasoning on two separate theories:

- The "coming to rest" rule, prevalent in most of the earlier decisions, confines "loading" to that period of time which begins when the object is first picked up and kept in motion, without interruption, pause, or rest of any kind, until it is placed on the truck. "Unloading," according to this theory was held not to extend beyond the point where the object was first set down, so that again, movement from the time unloading began had to be continuous and uninterrupted. This rule is also known as the "Continuous Passage Rule" in some jurisdictions, and is identical in that it requires continuous and uninterrupted movement without any breaks or pauses in order to establish coverage.

- The Complete Operations Rule is the majority view and the more prevalent trend today. This doctrine holds that the scope of loading and unloading covers the movement of the operation from the time the insured receives possession until possession is turned over to the receiving party upon whom delivery is to be made.

- If the trends and decisions were clear-cut and definite on the Complete Operations Rule, we would have some demarcation line. It is impossible to guess how far the courts may go in extending this coverage. A sticky situation arises when a motor vehicle is being unloaded on premises owned by someone else. These cases normally involve pickup and delivery.

**Omnibus Clause**

The Omnibus Clause applies only to the automobile policy and creates as an additional insured "any person while using the automobile and any person or organization legally responsible for the use thereof, provided the actual use of the automobile is by the named insured or said spouse or with the permission of either." This means that if employees of the firm owning the premises where a delivery or pickup is being made are helping the insured's driver to unload, they are using the automobile with the permission of the insured and are hence additional insureds.

In addition, there is the complication that the general liability policies exclude automobile exposure away from the premises but do include such exposure if the accident occurs on the premises. However, it must be noted that since the general liability policies do not contain an Omnibus clause, employees of the insured are not additional insureds under these policies. The claim associations tried to set up some guidelines for the settling of disputes between the automobile and the general liability carriers.
Before considering the general principles, statutory provisions, and particular matters pertaining to "representations," "misrepresentations," "warranties," and "conditions," in the law of automobile insurance, it will help to reflect upon the meaning of these terms.

**Representation**

A "representation," in the law of insurance, is an oral or written statement by the insured or his or her authorized agent made prior to the completion of the contract, giving information as to some fact or statement of facts with respect to the subject of the insurance. A representation is intended or necessary for enabling the insurer to determine whether he or she will accept the risk and at what premium. Representations are either affirmative, as to facts then existing, or promissory, as to what is to happen during the existence of the insurance. A "misrepresentation," in insurance, is a statement of something untrue, which the insured states with the knowledge that it is untrue and with an intent to deceive; or, a misrepresentation is a statement that the insured states positively as true without knowing it to be true, and which has a tendency to mislead.

**Warranty**

A "warranty," in the law of insurance, is a statement, description or undertaking on the part of the insured, appearing in the policy or in another instrument properly incorporated in the policy, relating contractually to the risk insured against. The warranty must appear on the face of the policy; or, if in another part of it, it must appear that the statements were intended to form a part of the policy.

If in another paper, the statements must be incorporated or referred to in the policy to clearly indicate that the parties intended them to form a part of the warranty. Warranties are either affirmative or promissory, and either expressed or implied, and there may be several warranties of different kinds in one policy.

**Types of Conditions**

"Conditions" in insurance policies are of two kinds—precedent and subsequent. The term "condition precedent" is commonly understood and technically used. It means a condition precedent to the consummation of the insurance contract, and is one that is to be performed before the contract becomes effective. "Conditions subsequent" are those which pertain, not to the attachment of the risk and the inception of the policy, but to the contract of insurance after the risk has attached and during the existence thereof. The terms "warranty" and "conditions precedent" are often used interchangeably or synonymously, although there is a distinction between the two. A warranty does not suspend or defeat the operation of the contract, and a breach of warranty affords either the remedy expressly provided in the contract or that furnished by law. A condition precedent is one without the performance of which the contract, although in form executed by the parties and delivered, does not spring into life. Promissory warranties are usually regarded as conditions subsequent to be performed after the policy has become a valid contract, a nonperformance of which will work a defeasance.

As a general rule, an insurer who has issued a motor vehicle insurance policy may, in accordance with the principles applicable to insurers generally, void the policy or liability thereon if, in procuring the insurance, the insured misrepresented a fact material to the risk and the
falsity of the representation, unknown to the insurer, or if the insured is guilty of a breach of an affirmative or promissory warranty or condition contained in the policy.

However, if a combination policy, such as one insuring against fire "and" theft, is in legal effect two separate policies, a breach of a condition which renders only one void does not prevent recovery on the other. As indicated in the definitions, the distinction between a representation and a warranty in an insurance contract is that the former precedes and is not part of the contract and need be only materially true, while the latter is part of the contract and must be strictly fulfilled or the policy is void. However, this distinction between representations and warranties has been abrogated in whole or in part by statutes in many states. Where an applicant for automobile insurance gives correct information to an insurance agent who, without knowledge of the applicant, records the answers incorrectly, the acts of the agent under such circumstances are binding upon the insurer.

Named insureds are those persons or legal entities whose names are actually on the policy. There are many others, however, who qualify as "insureds" under the automobile policy. The Basic Standard policy defines "insured" in part as "any person using the automobile and any person or organization legally responsible for the use thereof, provided that the actual use of the automobile is by the named insured or such spouse or with the permission of either."

**Problems Involving Permissive User**

In addition to individuals who may be driving the automobile with the permission of the named insured, those legally responsible for its use can be as broad a class as an agency relationship can make it. For instance, any organization whose business is being furthered by the activities of the driver of the automobile may be legally responsible for its use under the law of agency. The organization would be covered under this broad provision if we assume that permission to drive had been obtained from the named insured.

No problem is presented when direct permission is given to the driver, as long as his or her acts remain within the scope of the permission granted. However, if some limitation of time, place, or purpose for driving has been placed by the named insured, a definite problem is presented when an accident occurs outside the scope of the driving authority given. Most courts have held that deviation by the driver from the authority granted must have been material in order to take it out of the scope of permissive use. A few minutes over the time specified, or a few blocks outside the normal route of travel, would ordinarily not be sufficient to permit the company to disclaim coverage.

On the other hand, if the driver was sent on a definite business mission. Before returning the car, decided to go on a long distance joyride that had no connection whatsoever with the purpose for which the car was put in his or her charge, he or she would have made a material deviation sufficient to deny himself coverage in most jurisdictions.

Cases involving a second permittee present another problem when a driver receives permission from the named insured, then allows someone else to drive the car and an accident occurs while said second permittee is driving. Again, if the initial driver has been given direct authority to permit someone else to drive, there is no question, because the second driver obviously has the named insured's permission to drive. Also, if the insured is present in the car at the time the second permittee is driving and makes no objection, the permittee obviously has the named insured's tacit permission to drive.

What is the situation, however, when the named insured is not present in the car and there has been no discussion whatsoever concerning anyone else driving the car? Sometimes the
decision can be reached from previous conduct under similar circumstances. For instance, if the named insured has entrusted his or her car on previous occasions to an individual without objection, it can be assumed that implied permission was granted at the time that the accident occurred.

What Is Permission?

There is a good deal of controversy about what actually constitutes permission. Some authorities have stated that permission can only be given if one also has the authority to refuse permission. Others have said that it need only be apparent authority to grant permission. It has been held that the use must be legal to be permissive. It is commonly agreed that a former owner of a car can no longer grant permission to a new owner or to anyone else driving it, since he or she no longer has any legal control over the vehicle.

An Exception to the Omnibus Clause

As has been stated many times, the policy must be read as a whole because there are many sections which are interdependent and many exceptions which affect other parts of the policy other than the one directly referred to. For instance, although there is a specific section of the policy dealing with exclusions, there is an exception in the provision with which we are dealing which has the same effect as an exclusion. "Definition of insured" goes on to state:

The insurance with respect to any person or organization other than the named insured or said spouse does not apply to any person or organization or to any agent or employee thereof, operating an automobile sales agency, repair shop, service station, storage garage or public parking place, with respect to any accident arising out of the operations thereof.

This provision does not apply to a resident of the same household as the named insured, to a partnership in which such resident or the named insured is a partner, or to any partner, agent or employee of such resident or partnership. To any employee with respect to injury to or sickness, disease or death of another employee of the same employer injured in the course of such employment in an accident arising out of the maintenance or use of the automobile in the business of such employer."

Multiple claims occur when several persons are injured as a consequence of negligent conduct by someone who is covered by liability insurance. For example, suppose a negligently driven car covered by a liability insurance policy with a liability limit of $20,000 per accident collides with another driven car and results in serious injuries to the driver and five passengers in the second car. If the damages sustained by those six persons as a consequence of the accident substantially exceed the insurance policy liability limit of $20,000, the individuals injured in such an accident will have sharply conflicting interests because each of the injured persons seeks compensation from the available, but inadequate, liability insurance. The question of how a limited amount of liability insurance would be allocated when the claims exceed the available coverage has long been recognized as a vexing problem when there are multiple claims arising from an insured event.

Whenever the amount of insurance for any insured event is less than the total losses, the persons sustaining losses may have divided interests. In such situations, if the insurance company exhausts the applicable liability insurance by settling with one or more of the claimants, the interest of the person(s) receiving compensation has, in essence, been preferred over the interests of the others. Depending on the circumstances, the specific settlement(s) with the individual claimants may not be in the best interests of one or another of the claimants.
Ordinarily, when tort claims exceed the applicable liability insurance, the insured’s interest is best served by use of the available insurance coverage as to minimize the insured’s risk of liability in excess of policy limits. This is especially true if the insured’s resources may be subject to claims by the other injured persons. Therefore, when there are multiple claimants, the insured have interests that may be adversely affected by the settlements if even more of the claimants receive settlement payments—in exchange for an agreement that releases the insured from any additional liability obligation—while others do not.

**Compulsory Liability**

Compulsory liability insurance law is principally designed to protect travelers and to provide compensation to persons injured as a result of the negligent operation of a motor vehicle. Vehicle registration is conditional upon a showing by the registrant that he or she has liability insurance coverage on that vehicle. The purpose of financial responsibility acts is to protect the public and to provide compensation for innocent persons injured through faulty operation of motor vehicles, to secure solvency of operators upon highways, and to provide funds for payment of claims of those injured in an accident. Without the requirements of such laws, negligent vehicle owners and operators often might be unable to compensate their innocent victims.

Further, a provision in a compulsory insurance act requiring a nonresident whose car is registered in another state to have insurance with an insurer who can be served in the state and who complies with the requirements of the act has been held not to constitute a discrimination against nonresidents denying them equal protection of the law since it merely puts nonresident owners upon an equal footing with resident owners.

Compulsory motor vehicle insurance is a remedial statute and is broadly construed to carry out its benefit purpose of providing compensation to those who have been injured by automobiles. Well-settled principles covering the interpretation of an ordinary policy of insurance will be disregarded in determining the scope and extent of a compulsory motor vehicle policy where necessary to accomplish the legislative aim. A liability policy which expressly states that it was issued to meet a statute requiring motor vehicle liability insurance must be stated in connection with such statute, public policy, and principles.

**No-Fault Laws**

A no-fault insurance plan which provides for compulsory personal injury protection benefits, and which modifies traditional civil liability, does not violate the due process clause of the Fourteenth Amendment to the Constitution of the United States or corresponding provisions of state constitutions.

In a compulsory motor vehicle insurance act which deals with indemnity for personal injury arising out of the ownership, operation, maintenance, control, or use "upon the ways of the commonwealth" of the motor vehicle, the quoted words mean public ways within the commonwealth or a way laid out under the authority of statute. Where an ordinance imposes as a condition of conducting a car-rental business the securing of liability insurance covering vehicles "rented, leased, operated, or used in the city," the policy applies to a vehicle rented in the city and involved in an accident outside the city boundaries. But a statute requiring persons engaged in the car-rental business to take out insurance or to be personally liable on failure to do so does not apply to a business conducted in another state even though a vehicle rented in such other state is operated within the state at the time of the injury.
The primary objective of the No-Fault Act is the prevention of duplicate recovery. Thus, where the insured sustained personal injuries in a one-car automobile accident, medical payments received by the driver from the driver's own no-fault insurer were deductible from a private or civil wrongdoing (tort) recovery against the township which negligently placed traffic control signs at the location of the accident. No-fault laws typically require that an individual buy personal injury protection (PIP). No-fault is a system in which the insured's coverage pays for his or her injuries, regardless of who caused the accident. This is why the required personal injury protection is sometimes called no-fault insurance.

In states that do not have no-fault laws, the insurer of the person who was at fault is the company that pays for injuries. If an individual did not cause the accident, it is the other driver's coverage that pays, which means that to collect, an individual will sometimes have to sue that other driver and establish in court that the accident was his or her fault.

Lawsuits typically take a long time to settle. In Los Angeles County, for example, it takes an average of five years for a civil case to come to court. Often, a victim must be very well-off to afford the luxury of waiting for his or her day in court. A poor family could become bankrupt waiting that long for money to pay the medical bills and for the loss of income resulting from a serious auto accident.

Lawsuits also cost a lot of money—and a large chunk of it goes to pay lawyers rather than to compensate victims. As much as one-third to one-half of compensation paid in the fault system goes to lawyers and other legal expenses.

The basic principles behind no-fault insurance are to get accident victims' bills paid promptly, regardless of who caused the damage; to lower the cost of auto insurance by reducing the number of lawsuits; and to channel more of the premium dollar toward paying for losses rather than litigation expenses.

No-fault insurance is also an attempt to solve a dilemma at the heart of the auto insurance system. As a responsible person, an individual spends money for coverage to make sure that anybody he or she injures will be compensated—without causing bankruptcy. But an individual's life savings are at the mercy of less responsible drivers. The savings could be wiped out paying his or her own medical bills as a result of an accident caused by a person who has no coverage. No-fault lets the premiums work to pay for the insured's injuries.

In exchange for getting speedy reimbursement of their medical expenses and lost wages, drivers in no-fault states typically forfeit the right to sue except in the most serious cases. Several federal studies have found that under no-fault, accident victims get higher compensation, and receive it much more quickly than in fault states. And more victims get paid too. A recent insurance industry study by the All-Industry Research Advisory Council, for example, found that about one-third of the people who received no-fault benefits would not have been eligible for payment on a fault basis.

In some "fault" states, how much a victim collects depends on the degree to which he or she was at fault. If a judge or a jury find the insured 20 percent responsible for the collision, for example, and the other driver 80 percent responsible, the insured will get 80 percent of the damage award. In others, if the insured bears any responsibility for the accident, he or she will collect nothing. But the effectiveness of no-fault also depends on which no-fault law you are talking about. Fourteen states and Puerto Rico currently have some form of no-fault law—but no two have the same law. No-fault laws vary primarily in two areas: the breadth of coverage they
require and how they define an injury serious enough to warrant a lawsuit for additional damages.

Generally speaking, the toughest no-fault laws—the ones that give the most generous no-fault benefits in exchange for the strictest prohibition against lawsuits—have been the most effective, both at compensating victims and at holding down the cost of insurance. The system does not work nearly as well in states that have mandated very generous insurance benefits regardless of fault, while also making it easy to sue for additional damages, even for minor injuries. This is the most expensive combination of no-fault and fault systems.

Michigan has the strongest no-fault law of the states with such laws. It requires very generous insurance benefits—unlimited medical and rehabilitation coverage and three years' worth of wage loss benefits—and includes coverage for property damage as well as bodily injury. But Michigan's law also has very tough restrictions on the right to sue. Lawsuits are limited to situations in which a victim dies or suffers serious disfigurement or the serious impairment of a bodily function. If the insured lost both legs in an auto accident, for example, he or she would feel entitled to compensation above and beyond the no-fault policy limits—and he or she would be able to sue for it. People typically sue for their pain and suffering to provide for future compensation. It is left to the courts to decide if they should receive higher awards for their injuries.

The Michigan law has a verbal threshold that must be passed before a person can go to court; that is, it gives a verbal definition of "serious" injury. Some other states have dollar thresholds; they define as "serious" any injury resulting in a specified amount of medical costs. Clearly, a verbal threshold reduces the number of permissible lawsuits more effectively than a low dollar threshold, or even a relatively high one, given the rapid escalation of medical costs today.

There is a compulsory personal insurance protection coverage with some restrictions on lawsuits in these states: Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Massachusetts, Michigan, Minnesota, New Jersey, New York, North Dakota and Utah.

There is compulsory personal insurance protection coverage and optional liability insurance and also some restrictions on lawsuits in these states: Florida and Puerto Rico.

There is compulsory personal insurance protection and liability insurance and no restrictions on lawsuits in these states: Delaware, Oregon, Pennsylvania and Maryland.

There is compulsory liability with optional personal insurance and no restrictions on lawsuits in these states: Arkansas, South Carolina, Texas and the District of Columbia.

There is insurance protection (but not compulsory and optional personal insurance protection) with no restrictions on lawsuits in these states: New Hampshire, Virginia, Wisconsin, South Dakota and Washington.

Kentucky, New Jersey and Pennsylvania allow consumers to chose between a no-fault option and the liability system.

No-fault insurance statutes have been upheld against a variety of objections. It has been held that the provision of a no-fault statute exempting a negligent person from liability up to the statutory limit as a result of an automobile accident caused by the driver's own negligence does not deprive the injured party of any property rights. However, compulsory provisions included in a no-fault statute have been held to violate the state constitutional guaranty of the right to trial
by jury. A no-fault insurance statute does not violate the due process requirements of the Constitution merely because it compels unlimited medical expense payment without guaranteeing the insurer the right to recover that payment by way of subrogation and reimbursement.

Mandatory arbitration provisions of no-fault laws do not violate the constitutional right to due process. On the other hand, a noncompulsory no-fault system has been held unconstitutional and void in regard to the due process clause of the Fourteenth Amendment to the United States Constitution and of similar provisions of a state constitution because the classifications in the statute were discriminatory and arbitrary.

The fact that all persons are not treated the same under no-fault laws does not mean that such laws invalidate the equal protection clause of the Constitution. Such a law is not invalid on the basis that it creates two groups of motor vehicle accident victims, one with tort remedies and one without. A no-fault law which grants immunity from most tort liability to a person who is involved in a private or civil wrongdoing (tortfeasor) insured as required by the law, while denying such immunity when the tortfeasor is uninsured, does not violate equal protection principles. A no-fault law does not violate equal protection rights. Although it does not permit a nonresident to recover, it permits him to maintain a civil tort action against a resident tortfeasor subject to the limitations of recovery which would apply if benefits were to be paid under the no-fault law. The nonresident injured party’s recovery is subject to the threshold limitations applicable to residents with respect to recovery of nonpecuniary damages. In this case, the injured party’s rights are violated. Since the nonresident’s right to sue for pain and suffering is limited when he is non-negligent, he obtains the counterbalancing effect of being protected from comparable claims where he has been negligent.

No-fault provisions limiting recovery for nonpecuniary damages such as pain, suffering, mental anguish, and inconvenience to persons injured in motor vehicle accidents having medical expenses in excess of a reasonable specified threshold value, do not violate equal protection rights. Medical costs vary geographically, and the poor normally receive medical care at lower costs than do those of financial means, and are therefore less likely to reach the medical threshold.

Nor is the right to equal protection denied by the fact that the statute requires some vehicles to carry no-fault insurance and not others, thereby making an injured person’s remedy depend upon the nature and use of the vehicle causing the injury. A no-fault insurance statute which requires a reduction of benefits to the insured by the amount of benefits received from governmental sources for the same injury is not a violation of equal protection principles.

A provision of the Florida no-fault insurance act allows recovery of intangible damages in cases in which medical benefits do not exceed the threshold amount of $1,000, and in which no death or permanent injury results, but in which injury or disease consists in whole or in part of a fracture to a weight-bearing bone or compound as a displaced or compressed fracture.

The Michigan no-fault insurance act was held to be constitutional insofar as it provided insurance benefits to victims of motor vehicle accidents as a substitute remedy; however, the mechanisms contained therein for controlling the rate-making procedure were found to be constitutionally inadequate in certain respects.

The South Carolina Automobile Reparation Reform Act requires automobile insurance carriers doing business in the state to write or renew policies for all insurable applicants, whether or not they are good or poor insurance risks. This does not violate the insurer’s rights to equal
protection and due process, since the act bore a reasonable relation to the state objective of guaranteeing adequate coverage for all drivers.

The Kansas No-Fault Act provides certain benefits to injured employed persons and their survivors and not to unemployed persons and their survivors. This does not violate equal protection clauses of the Constitution.

The New Jersey No-Fault Act provides that the resident’s relatives seeking recovery for personal injury protection benefits were bound by the cost containment option selected by the insured. This does not violate equal protection rights.

**Financial Responsibility Laws**

Financial responsibility laws are designed not merely to regulate the rights of operators and owners of motor vehicles but also the rights and obligations of insurers issuing policies to comply with those statutes. It has been suggested that although public policy prevents the indemnification of one who intentionally causes damage, the financial responsibility law is itself declaratory of public policy and supersedes any rule of public policy applicable to ordinary insurance law, so that it is not against public policy for the insurer to be held liable for the intentional act of the insured. Such a result is for the protection of the injured party and to insure that he or she is compensated for his injuries; it is not intended to benefit the intentional wrongdoer, so that a policy with such a requirement may have a provision for reimbursement of the insurer for any payments which the insurer might not have been obligated to make except for this statutory requirement. A financial responsibility statute is designed to subject insurers to absolute liability only where they are aware of the status of the applicant as a member of the statutory class.

When an automobile liability insurance policy is issued to satisfy the requirements of a financial responsibility law, the resulting situation closely resembles that which exists when a compulsory liability insurance law is in effect and a policy is issued pursuant to the requirements of that law. As may be expected, the construction and application of financial responsibility laws and liability policies issued in compliance with those laws closely parallel the construction and application of compulsory liability insurance laws and policies that have been issued.

An insurance policy, issued for the purpose of enabling the insured to comply with a financial responsibility act, must comply with the requirements of the act, and if any provisions of the policy are inconsistent with those statutory requirements, the provisions of the act will prevail, and the nonconforming provisions of the policy will be held to be invalid. A specific provision put into an insurance contract by force of a financial responsibility statute, should be interpreted according to the intention of the legislature, irrespective of how the contractors understood it.

Under a financial responsibility law providing that every motor vehicle liability policy shall insure the named person and any other person using or being responsible for the use of a specified motor vehicle with the express permission or implied permission of the insured, an insurer cannot limit coverage in a liability policy to the insured and the insured’s immediate family.

Although provisions of a liability policy are invalid where they are inconsistent with the terms or intent of the financial responsibility law to which the policy was issued, the coverage of the policy will not be expanded beyond its terms where such expansion is not reasonably required to satisfy the statutory provisions or legislative intent. An insurer does not, under the financial responsibility law, become an insurer of all owned automobiles merely by issuing a policy on one automobile that he or she owns.
An insurer will be estopped from denying that liability for injuries sustained is covered by a policy it issued to one who negligently caused such injuries, where, knowing that the insured had been previously involved in an accident which brought into operation the statutory obligation of the insured to submit proof of financial responsibility, the insurer issued a policy so limited as to circumvent the statutory policy of protection for innocent persons injured by the operation of the insured vehicle, or where the insurer has failed to notify the motor vehicle commissioner of the fact that a previous accident was not covered by the insured’s policy, which excluded coverage of motor vehicles owned by the insured.

A financial responsibility law may provide that violation of the terms of an insurance policy shall not defeat or void the policy. However, where such a statutory provision exists, care must be exercised to distinguish between violation of the terms of the policy and circumstances which merely reflect a use outside the scope of the coverage of the policy.

The Arizona Financial Responsibility Act requires that a motor vehicle liability policy provide specified coverage, and exclusions or conditions which dilute that coverage are void and of no effect. An exclusion in a motor vehicle liability policy certified under the Safety Responsibility Act concerning an automobile owned by the insured, or any resident of the same household is in conflict with the act and invalid.

Under the financial responsibility law, the omnibus clause is a part of every policy regardless of whether the policy states it or not. The statute relating to civil liability and financial responsibility of owners and operators of vehicles is incorporated into every vehicle operator's insurance policy.

The requirements of a financial responsibility law cannot be avoided through a separate agreement, not incorporated into the insurance policy, which would limit the coverage of a policy in a way which would contravene the requirements of the law.

A financial security law requires the maintenance of certain minimum levels of insurance, but it does not prevent the insurer and the insured from agreeing to coverage in excess of the statutory requirement. Either the insurer or the insured may limit the coverage provided under some parts of the policy to the statutory minimum required by the financial responsibility law, while having a higher limit of liability apply under other parts of the policy.

Although a financial responsibility law may be in effect, such an act has no effect upon automobile insurance which is not required, and the terms of such other coverage need not comply. Since the mandatory provisions of financial responsibility laws come into play only after an accident has occurred, such laws normally have no effect upon an insurance policy voluntarily obtained at a time when the person obtaining that policy was under no obligation to demonstrate financial responsibility, at least where the policy does not satisfy the requirements of the law. Thus, a policy may contain an enforceable provision, even though such provision would be rendered invalid by the financial responsibility law if it fell within the provision of that law. However, with the widespread adoption of financial responsibility laws, many insurers began including in their policies a provision that such policies should comply with the terms of applicable financial responsibility laws.
**Claim Investigations**

Some states have adopted regulations which impact upon an insurer's handling of claims under a vehicle insurance policy. For example, in 1993 the California Insurance Commission adopted a number of rules designed to facilitate the processing of claims, including requirements that:

- Within 15 days of receipt of notice of a claim from a policyholder, a carrier must provide written notification of receipt of the claim. Within that same time frame, the carrier must commence investigation of the claim.
- Within 40 days after receiving a proof of claim, the carrier must affirm or deny both the claim and liability, or, in the event the carrier finds that forty days is not sufficient, it must notify the claimant, specifying why a longer period is necessary and delineating what further information is needed.
- If there is a partial or complete denial of a policyholder's claim, the claimant must be notified in writing, specifying under what provisions of the policy and the factors upon which coverage is denied. The claimant must be advised of his or her right to have the denial reviewed by the insurance department and of the address and telephone number of the department.
- Carriers must disclose to their policyholders any time limits, benefits, coverage or other material provisions of any policy the carrier has issued and sold that may apply to the facts underlying the claim. If a policyholder sends any other communication which reasonably suggests a reply is expected in regard of a claim not the basis of a lawsuit, the carrier must respond within fifteen days of receipt of the same.

**HISTORY OF AUTO CLAIMS**

In the early days of auto insurance, almost all auto policies were written by agents. The agent could be an employee of a certain company, or he or she could be an "independent agent." The independent agent could represent many companies, and could offer the customer a "laundry list" of carriers from which he or she obtained the most favorable premium price for his or her customer.

Today if you ask a person with whom he carries his or her auto insurance, most of the time the answer will be the name of an insurance agency. Seldom does the policyholder know the name of the company which actually wrote the policy.

Therefore, most of the time when a driver is involved in an auto accident, if in the driver's judgment the accident is deemed to be serious enough to report, he or she will report the occurrence to his or her insurance agent.

Let us assume that the other driver was insured and has reported the accident to the agent. What next? The bureaucratic wheels will begin to turn. In due course—several days or even weeks—an adjuster will be in contact. The insurance adjuster will either be a staff adjuster (an employee of the involved company) or an independent adjuster. The independent adjuster, much like the independent agent, represents a number of casualty companies which—by reason of size, choice or accident locale—do not have staff adjusters available.

In 1960, an on-the-scene adjuster was involved in every claim, be it a fender bender or a multiple fatality accident. If an individual had a collision claim, he or she might simply be instructed to "get three estimates" and send them in; however, an adjuster was involved.
In the case of a more serious accident, the adjuster visited, diagrammed and photographed the scene. He searched for and obtained statements from witnesses. He interviewed the investigating law enforcement officers and all involved parties. He even visited the hospital rooms of the accident victim, if for no other reason than to leave his or her business card. This "hands on" treatment of claimants persisted for years until the paranoia of the elevated loss adjustment expense became paramount in the minds of casualty company senior management. Consequently, a new era was born.

The independent adjusters, because of extreme pressures from companies to hold down expenses, began utilizing the telephone more. They found they could handle more claims less expensively by telephoning to take statements, tracking down leads on additional witnesses, and a multitude of other investigative functions which were previously done "on the street."

Companies have made wide usage of the "drive-in" claims service concept. The modus operandi is that the insured or third party claimant is requested, if the auto is drivable, to make an appointment at a staff or independent drive-in claims facility where they are assured prompt service and quick payment.

In most cases, good service is provided and prompt payment is made. The insured or claimant leaves the drive-in facility with an estimate of damage written on a company form and a draft or check. This sometimes provides a truly happy ending to the always traumatic experience of an auto accident. But this is not always the case. The only problem is that the insured or claimant must find an auto repair facility which is willing to do the work for the sum of money the appraiser has decreed. Many times there are no problems, but in a number of cases there are. The repair facility of choice will not agree to repair the car for the sum of money the appraiser has allowed, additional damage is discovered after repairs are commenced or the work is done improperly. Guess who winds up in the middle?

Despite these minor inconveniences to the insurance consumer, the direct handling of physical damage losses was hailed as a great success. Inspired by this success, it has been decided by many companies to expand this technique to the handling of "minor" bodily injury, PIP and med pay claims. The BI direct handling claims person should be an individual who is reasonably experienced in the determination of liability, has a pleasant telephone personality, is articulate and has a fair command of medical terminology.

Most companies place time constraints on the number of months a file can remain in a BI direct handling unit. These mandated time constraints are largely ignored; however, it would be in the best interest of both the agent and client to assemble the settlement documentation as quickly as the client’s medical recovery permits and relay that documentation.

Procrastination may result in the client’s file being referred to a higher level, to a more experienced claims person who is even more overworked than the lower level person, the end result being that a second opinion by a more experienced person may well change the company’s outlook on the clients’ claim and kill an advantageous opportunity for settlement.

**PERSONAL AUTO CLAIMS**

**First Party Claims**

Simply defined, a "first party" claim is a claim for indemnification made by the policyholder against his or her own coverage. The most elementary examples of such claims should be under the auto policy claims for damage due to collision, theft or fire. Under a property policy, a
simple example would be a claim made for a loss due to fire, hail, windstorm, etc. All of these types of claims usually involve a clearly defined amount of dollar damages. About the only dispute which can arise is a difference of opinion as to whether the compensation offered is adequate.

An often misunderstood auto coverage is "comprehensive" coverage. As the name implies, this coverage is designed to cover risks which produce damage "other than by collision." It is supposed to protect the owner of an insured auto against any "direct and accidental" loss other than those "losses" which are excluded, such as mechanical breakdown and normal wear and tear.

Comprehensive coverage has some peculiar traits, covering certain "collision" occurrences, such as accidental breakage of glass, with breakage usually occurring as a result of a "collision" by some object with the auto’s glass. Another unusual example is the damage to an auto caused by a hood accidentally flying up while driving. Obviously, there was a collision between the hood and passenger compartment of the car; yet such claims are paid under the comprehensive coverage based upon the rationale that an auto or a part thereof cannot collide with itself.

Probably more unique and complicated coverage questions arise under the comprehensive coverage of the policy than any other, yet casualty companies usually start their rookie claims people adjusting losses under this coverage. After all, the companies reason, what is so tough about handling a broken antenna and stolen hubcap losses?

At the other end of the spectrum is the rock-punctured oil pan of a $60,000 Mercedes Benz, which results in oil loss and the replacement of a very expensive engine. The standard procedure is to attempt to pay for the damaged oil pan and deny the claim for the engine, based upon the "insured’s failure to protect the vehicle after loss and subsequent mechanical failure."

This is a very common type of claim and each must be judged by its own particular circumstances. The final test is whether the insured acted prudently after becoming aware of the loss of engine lubricant and, if not, were there additional extenuating circumstances which induced the insured to act other than in a prudent manner. There are no inexpensive engines, so one should not be surprised if he or she is consulted on a claim such as this. In the many states which have adopted the California doctrine of "bad faith" or "outrageous" conduct, the denial of a simple and small first party loss can be tremendously expensive to the company.

Mundane coverages account for $.70 of every loss dollar spent. Next on the list is medical payments or Personal Injury Protection Coverage. In the agent’s representation of clients, he or she should be totally familiar with these coverages.

Under the old Family Auto Policy, there was no Personal Injury Protection (PIP) Coverage, only Medical Payments Coverage. This coverage provided for 100 percent reimbursement for medical expenses, up to the specified dollar limit, due to accident or illness while occupying the insured auto. "Occupying" was defined as "in, upon or alighting from." It also protected the insureds under the policy against medical expense resulting from being struck by a motor vehicle while a pedestrian. The period of coverage was one year. Some litigation occurred as a result of this coverage.

Dental and scarring injuries were particularly troublesome as their treatment usually lasted much longer than the one year time period. Some innovative insureds actually entered into contractual agreements with dentists and physicians, thus claiming that the future expenses
were "incurred" within one year. The success rate in the courts was about 50 percent depending upon the expertise of the author of the contract and the amount of consideration exchanged and when it was exchanged. "In, upon or alighting from" the insured auto also created business for the courts. The condition alighting from caused much controversy. Is a person with one foot on the ground "alighting from"? The answer is clearly "yes," but what about five feet or ten feet away from the car? Exploding batteries and tires can also create some problems. Enlightened companies generally made decisions based upon common sense rather than a pure technical interpretation of the policy. All of these problems still remain despite the birth of the "Easy Read" policy.

**Personal Injury Protection**

Personal Injury Protection coverage (PIP) was the solution adopted by many states when the pressure for enactment of "NoFault" coverage was at its peak. In the final analysis, all PIP did was to add income loss reimbursement to the old med pay coverage. Disability coverage has been on the market for years, but not as a part of the auto policy. PIP also extended the time period of the coverage from one to three years.

There is a wide variation from state to state as to whether a provider of Med Pay or PIP coverage can subrogate against a responsible tort feasor or deducts such payments from Uninsured Motorist or Underinsured Motorist settlements. Many jurisdictions have held that such subrogation and setoffs are void as against public policy. Recent "bad faith" litigation involving attempts to subrogate these coverages has also dampened the subrogation efforts of many carriers.

The U.S. government, under the Medical Care Recovery Act and case law relative thereto, does have the right to claim against either the responsible third party’s liability coverage, UM/UIM Coverage or MP/PIP coverage. However, the government is entitled to be reimbursed only once. It is important to remember that in cases of even minor hardship, the government is usually willing to compromise or even waive their entire claim.

Enforcement of the government’s right of subrogation is the responsibility of the Justice Department. This type of litigation is usually at the bottom of their priority list. When a client’s recovery depends solely upon the amount of the liability limits available, it will be in the best interest of both agent and client to attempt to obtain a compromise or waiver of the government’s claim, especially if damages are great and the limits are low.

MP/PIP coverage in many states will "stack" or pyramid even with a policy pronouncement to the contrary. It will generally stack when a client is injured while he or she is an occupant of an auto owned by some other person or entity.

**Uninsured Motorist Coverage**

A form of coverage which is finally coming into more and more prominence is that of Uninsured Motorist protection. This coverage was first presented to the various state insurance departments as a substitute or alternative to compulsory liability insurance. For many years, the coverage was only offered in limits of $10,000 per person and $20,000 per accident or an amount equal to the financial responsibility coverage law limits of a particular state. From its very inception, the policy provided that disputes between insured and coverage would be resolved by arbitration under the auspices of the American Arbitration Association.
In the early years of uninsured motorist coverage, it proved to be a huge financial boon for the industry even though the premium charge was typically very cheap. In the past, contributory negligence was an absolute bar to recovery, physical contact with the uninsured auto was a universally enforceable requirement, and guest statutes were the order of the day.

The greatest fear of a company—then and now—is that a case would actually be decided by AAA arbitrators. An arbitration award of less than the policy limit was considered an absolute victory. The reason for the horrible results from the industry point of view regarding the AAA is that most of the arbitrators were plaintiffs' attorneys. Insurance defense counsel did not have the time or the inclination to serve as arbitrators and would not volunteer their names to the AAA.

In some states—Texas for example—arbitration of a UM claim is not allowed and suit must be brought against the uninsured and the company providing the uninsured motorist coverage. While the companies may fare somewhat better than AAA arbitration, they are still disadvantaged as the company is named defendant in a suit by a policyholder. In recent years, things have changed insofar as the coverage itself is concerned. The changes have been dramatic and have completely altered these coverages. All changes benefit the injured party, yet this coverage remains much misunderstood by plaintiffs’ counsel as well as the insured.

In most jurisdictions, the coverage is no longer Uninsured Motorist Coverage. Secondly, if requested, it must be written in the same coverage amounts as the Bodily Injury Liability Coverage. For example, an insured who carries $300,000/$500,000 BI liability limits, upon request, can carry the exact same UM/UIM limits. This is a giant step from the days of 10/20 UM. Again, the premium difference between 10/20 UM/UIM and 300/500 UM/UIM is a few dollars a year. It is probably the best insurance buy in the market today. When reviewing their insurance policies clients should do two things: (1) if indicated, raise their BI limits and (2) buy equal UM/UIM limits.

Underinsured Motorist coverage is a relatively new form of coverage. The specific application of this coverage varies by state and it would be in an agent’s best interest to find out how it works in his or her jurisdiction. Some of the variations are as follows:

- The company is entitled to offset or take credit for the amount of coverage carried by the responsible tort feasor. Example: If the claimant has $10,000 in coverage, the insured’s UIM coverage is $100,000. Total exposure to the UIM carrier is $90,000.
- Some states allow no offset of the tort feasor’s coverage. Thus, in the example above, the insured would be entitled to claim the full $100,000. Typically, this is the better rule because the insured paid a premium for $100,000 UIM coverage, not $90,000.
- In some states, if the claimant’s coverage is equal to or exceeds the UIM coverage, there is no UIM claim.
- Some states allow "stacking" of both UM and UIM coverage.

There is generally a right of subrogation under the UM/UIM coverage and a policy condition that any settlement against the responsible party must be with the permission of the company.

The auto policy covers every relative residing in an insured’s household. Consider, for example, the aged lady who resides with her son, daughter, brother or uncle. She has not driven a car for 20 years and does not own an auto, and is struck while taking her morning walk by a hit and run driver. Is she covered? Yes—under the UM/UIM coverage(s) on the relative’s auto(s).
Consider a case where an individual is badly injured in a multiple car accident while a passenger in a friend’s car which is not insured or has low BI liability limits. If the combined limits are not adequate to compensate for the injuries sustained, the individual would make a UIM claim under his or her own auto policy or that of the relative with whom he or she resides.

"Stacking" is another opportunity for a client to apply additional coverage. Some years ago, the industry wrote the "single car" policy regardless of the number of vehicles insured by a single individual. The courts, however, almost universally "stacked" all of the coverages, especially the UM coverage. Consequently, for the sake of efficiency and service and to hold down rates, the multi-car policy was born. It became much more difficult to "stack" the coverages of all autos listed on the multi-car policy.

A UM/UIM claim cannot be made against the combined limits of all autos in the multi-car policy. Only the coverage of the car actually being driven at the time of the accident will apply. With more and more people carrying higher limits, both BI and UM/UIM, probably the UIM coverage will shortly become as important a source of compensation for injured claimants as has been the traditional BI liability coverage carried by negligent claimants.

It is important to remember that numerous states have recognized the bad faith clause of action in claims by insureds against numerous insurance contracts such as auto, health and accident, homeowners, etc. Many other states are on the brink of recognizing punitive damage actions predicated upon "bad faith" handling by a casualty company. The point is that a claim by an insured under his or her UM/UIM coverage, while based upon tort liability and personal injury, is nevertheless a first party claim against a person’s own insurance company. Therefore, the company is placed under a much greater duty to properly handle and negotiate in good faith as compared to the duty placed upon a liability carrier in the handling of a claim by an injured third party against its insured.

It should also be remembered in regard to UM/UIM coverage, that most states now require this coverage to also cover damage to the insured auto. Collectibility under this type of policy is based upon claimant liability of the uninsured motorist and generally provides for a $250 deductible. Therefore, in the absence of collision coverage on a client’s auto, consideration should be given to a claim under the UM/PD coverage. In this day of comparative negligence, unless the client is totally at fault, the chances are good that the insured will be able to recover for all or most of the damage to his or her car.

**Claim Handling Procedures**

There are five general phases to good claim handling procedures:

1) Proper preparation.
2) Prompt and thorough investigation.
3) Decision and action.
4) Adequate reporting.
5) Self-discipline.

Proper preparation enables the claims person to plan an orderly investigation without loss of time or effort. Such preparation avoids the necessity for callbacks to the insured, claimant or witnesses. Callbacks are not only a waste of time, but are bad public relations as well. An additional interview gives the impression that the company is uncertain, and is looking for an "out.” A thoroughly planned initial interview makes it more likely that the adjuster will obtain correct and complete information. Claimants and witnesses become suspicious when a callback is made to get additional information which should have been obtained in the initial contact. Not
only does the adjuster run the risk of losing control of the case, he or she greatly lessens the chances of getting the entire truth in the form of a signed statement.

Proper preparation should begin at the very inception of a case—that is, at the receipt of the first report. It requires prompt and thorough analysis of the problems involved. Such an analysis must be based upon the facts at hand, the coverage information, and the applicable law. It cannot be based upon guess and surmise.

**Incredible Auto Claim Stories**

The following are actual statements found on insurance forms where car drivers attempted to summarize the details of an accident in the fewest words. These instances of faulty writing serve to confirm that even incompetent writing may be highly entertaining. (Copyright 1997, 1998 Rocket Science Digital Productions, Inc, All Rights Reserved.)

- Coming home I drove into the wrong house and collided with a tree I don’t have.
- The other car collided with mine without giving warning of its intentions.
- I thought my windows was done but I found out it was up when I put my head through it.
- I collided with a stationary truck coming the other way.
- A truck backed through my windshield into my wife’s face.
- A pedestrian hit me and went under my car.
- The guy was all over the road. I had to swerve a number of times before I hit him.
- I pulled away from the side of the road, glanced at my mother-in-law and headed over the embankment.
- In my attempt to kill a fly, I drove into a telephone pole.
- I had been shopping for plants all day and was on my way home. As I reached an intersection, a hedge sprang up, obscuring my vision and I did not see the other car.
- I had been driving for 40 years when I feel asleep at the wheel and had an accident.
- I was on my way to the doctor with rear end trouble when my universal joint gave way causing me to have an accident.
- As I approached the intersection, a sign suddenly appeared in a place where no stop sign had ever appeared before. I was unable to stop in time to avoid the accident.
- To avoid hitting the bumper of the car in front, I struck the pedestrian.
- My car was legally parked as it backed into the other vehicle.
- An invisible car came out of nowhere, struck my car and vanished.
- I told the police that I was not injured but on removing my hat, I found that I had a fractured skull.
- I was sure the old fellow would never make it to the other side of the road when I struck him.
- The pedestrian had no idea which direction to run so I ran over him.
- I saw a slow moving, sad faced old gentlemen as he bounced off the hood of my car.
- The indirect cause of the accident was a little guy in a small car with a big mouth.
- I was thrown from my car as it left the road. I was later found in a ditch by some stray cows.
- The telephone pole was approaching. I was attempting to swerve out of its way when it struck my front end.

**AUTO CLAIM INVESTIGATIONS**

The investigation, once started, becomes a constantly shifting picture with new leads and new avenues of inquiry opening up as it develops. The claims person will need some imagination
and inquisitiveness, and a lot of determination and persistence. For instance, sometimes a witness cannot be located unless a neighborhood investigation is made, which can only be effectively done by ringing doorbell after doorbell. The investigator may not get the signed statement from the policeman who investigated the accident but the chances are certainly in his or her favor that the police officer will discuss the accident, and supply some pertinent information. This certainly would not happen if he or she decided it was useless to attempt to see the officer in the first place.

Purposes of Investigation
There are only three purposes involved in every investigation of casualty claim: (1) to determine the facts, (2) to establish liability and (3) to obtain and preserve the evidence. A claims person cannot be content with guesswork. All allegations should be thoroughly checked for accuracy and must either be corroborated or denied by evidence which can be presented in court. An attitude of alert skepticism is healthy. An investigation is made to determine the truth as closely as possible. No useful purpose is served by philosophizing on the nebulous quality of the word "truth." The new claims person will learn, within the period of his first few months, that four people can see an accident and give four different versions of how it happened and each witness will be convinced that he is telling the truth. Do not start an investigation with any preconceived notions or prejudices. Let them speak for themselves. There are specific areas of investigation that will involve the special coverages. These will be discussed later.

Principles of Investigation
Following are general principles involved in handling casualty claims:

- **Review the Report**—Review the initial report carefully and make notes on the information contained therein. These notes should be made in the form of a worksheet which the investigator should have for every claim that he handles. Some companies have preprinted work sheets which outline the investigation to be made and leave space for the insertion of important information such as the file number, names of the insured, claimant and witnesses, coverage information, facts, etc. If such preprinted sheets are not available, it is easy to make them.

  If the original report of an accident is incomplete, a telephone call to the insured will usually provide sufficient details to enable the adjuster to arrange an orderly plan of action. Such a call may also serve the purpose of arranging for an appointment with the insured, since it will be necessary to obtain a detailed signed statement from him on any serious claim. Quite often, drawing a rough diagram from the facts at hand will help to clarify the picture.

  Not all claims will demand the same kind of investigation. The insured's first report may indicate that the matter is of minor importance and may contain sufficient information to avoid the necessity of further contact with him. Again, the matter may be important enough to warrant a phone call for additional information without personal contact. Each company has its own policy concerning the degree of investigation necessary, depending upon the importance of the case involved, and the supervisor will soon inform the adjuster concerning the company's attitude in this respect.

- **Examine the Coverage**—Over the years, a mystique has developed concerning coverage problems. In many companies the new adjuster is not required to do any policy reading as to matters of fact, and is even occasionally discouraged from doing so. However, instruction in coverage problems is of prime importance and will be as long as the adjuster is involved in
claim work. This instruction should begin as soon as possible. If an insured is expected to know what is in his policy, the adjuster should at least be just as familiar with it. It cannot be expected that a new claims person will be able to interpret a policy which is complicated or needs legal interpretation, but he or she should at least become familiar with the major problem areas as soon as possible.

He should examine the coverage carefully in the light of the facts at hand on all important cases involving anything other than the ordinary, uncomplicated accident report. The application and all endorsements should be "pulled" and examined. If the adjuster recognizes a coverage problem, he or she should immediately consult with the supervisor concerning it and make a careful outline of the investigation needed for a proper determination of the problem involved. All of the facts connected with the problem should be obtained. Specific coverage questions will be discussed in detail subsequently.

- **Outline the Projected Investigation**—After the facts and the coverage information have been reviewed, a complete outline of the projected investigation should be made. Here is where a worksheet becomes invaluable. Enough space should be allocated so that the claims person can list everything that has to be done in the order of its importance. One may get the impression that he or she does not have the time to do this, but in the long run the time spent in outlining the projected investigation will be more than made up by the time saved in wandering around aimlessly. Where necessary, use all available technical aids such as textbooks, articles on related subjects, and the policy itself.

- **Outline the Interview**—Some sort of an outline should be made of the points that are to be covered in each interview. While the interview is progressing, it is impossible to remember everything about a complicated claim. The use of proper notes reduces the possibility of overlooking an important point and avoids the necessity for callbacks.

- **Consultations**—If there is any doubt or confusion about the direction of the investigation or the facts to be obtained, a claims person should discuss the matter with his or her manager or supervisor to get additional ideas or clarification of the objectives. To consult with someone else on a complicated problem is not an admission of weakness. The very act of talking over the situation will help to clarify the objectives. The old adage that "two minds are better than one" has been proven time and again in claims work.

- **Make an Itinerary**—If an adjuster were handling only one claim at a time, it would be relatively easy to make an itinerary that would be efficient and productive. Unfortunately, the economics of the situation are such that this is impossible since every adjuster is required to handle a sizable workload. Accordingly, it is essential that the following factors are considered in planning the itinerary for the day.

1) The order of importance of the claim itself—the claims person may have an important case that is going into suit where it is absolutely essential for him to obtain some information as soon as possible.

2) The location of the stops that he or she is to make—it is important for him to try to arrange the itinerary so that he or she does not have to backtrack any more often than is absolutely necessary. If backtracking is required, it might be more efficient to arrange to make several stops in different areas on different days.

3) Where possible, he or she should make advance appointments which will have to be fitted into the itinerary. It is not always necessary to make appointments. There will be instances where it will be advisable to try to surprise a witness or a claimant and not give
him any advance notice that the claims person wants to interview him. However, where the element of surprise is not involved, appointments will save a lot of time.

4) Finally, in making an itinerary, the claims person will have to consider the likelihood that the individual he is seeking will be at home or at his or her place of business at the time when he or she will be there. Give consideration to this factor before making up the itinerary.

It is impossible to make up a perfect itinerary; however, if the above factors are taken into consideration in making up the itinerary, it will certainly be much more advantageous than to start making calls blindly without any advance planning. On an individual important case there can be no set formula. If sufficient facts have been obtained from the insured in the first report, or in a telephone conversation, it may be better to see the claimant personally on the first call. On the other hand, if the claims person is ready to start the investigation, and he or she does not have sufficient facts to form a fairly clear picture of what happened, he or she may consider it advisable to see the insured first. Where "ambulance chasing" is prevalent, it is usually more practical to make an attempt to see the claimant immediately. Seeing the insured is usually wise when coverage questions are involved, since a determination of the coverage problem may make it advisable to contact the claimant at all. If the scene of the accident is on the way to the insured or to the claimant, the claims person might wish to examine the scene before he or she interviews the principals.

It is important that a decision be made as promptly as possible on whether or not a case is one for settlement of declination. To do so is not only good business practice, but good for the reputation and public relations of our industry as well. A claimant has the right to know the attitude of the insurance carrier and its decision, so that future actions may be guided accordingly. If the investigation is complete and the case is one to decline, the claims person should do so courteously and promptly, and give proper explanation for the decision. The claimant then knows where he stands and the company will know all the sooner whether he intends to press the matter further.

Prompt decision is especially important in compensation cases where the claimant is disabled and depends upon indemnity payments for living expenses. Such payments are scrutinized very closely by most states and the time element involved in making them is of the utmost importance. If the claim is compensable and properly covered, be sure that the payments are made on time.

Advance payments are not at all unusual, making it essential to determine as soon as possible what the ultimate decision is going to be in any particular case. However, there is a diversity of opinion. Some companies feel that where the injury warrants control, and where this factor is of utmost importance, they may decide to make advance payments even though the liability picture is not altogether clear. This is a matter for each individual company to decide.

**Evidence**

In motor vehicle accident cases, the general rule is that hearsay evidence is inadmissible. The usual reason given for the exclusion of hearsay evidence is that it is not subject to the tests which can ordinarily be applied for the ascertainment of the truth of testimony; the evidence if admitted would derive its value, not solely from the credit to be given to the witness upon the stand, but in part from the veracity and competency of some other person. It is upon such considerations, and not because of its irrelevancy and immateriality, that hearsay evidence is generally condemned. Accordingly, the rule followed in most jurisdictions is that hearsay testimony admitted without objection may properly be considered and given its natural probative
effect, although the weight of hearsay evidence is minimized by the same inherent weaknesses which are grounds for its exclusion when objection is made.

Normally, a witness in a motor vehicle accident case must testify to the evidentiary facts and not to conclusions, opinions, or inferences—that is, he or she must state what was witnessed or observed and not opine or draw conclusions based on such observations. It is necessary that testimony be composed of facts and opinions, and exceptions to the general rule that witnesses must testify to facts have been found to be necessary to the due administration of justice.

**Admissions**

Despite the general rule of exclusion of hearsay evidence, there are many exceptions to this rule, perhaps the most important of which, in motor vehicle accident cases, are those relating to admissions against interest, and to statements, exclamations, or conduct admissible in evidence. Admissions made by one of the parties involved in the case may be used against him, and such admissions may be shown in evidence without laying a foundation in the nature of impeachment. Pleadings containing allegations inconsistent with subsequent pleadings made by the party in the action may be admissible in evidence.

An admission by one injured in a collision with a motor vehicle that the accident was due to his or her own fault is acceptable as an explanation. A statement by the driver of an automobile that he or she was responsible for an accident in which a guest was killed, that it was caused by his or her recklessness and disregard for the safety of others, and that he or she was engaged in driving at the time with an indifference to consequences, is—in light of undisputed testimony that the accident was due to a mere lapse of attention to the road—a mere conclusion on the part of the driver as to the legal effect of his or her conduct, and therefore not properly taken into consideration as evidence on a motion, in an action for the death of the guest, to set aside a verdict for plaintiff and to enter a judgment for the defendant.

It is often difficult to distinguish, in the testimony of a witness, facts within his or her knowledge from observations or opinions regarding the facts. A question asked of the owner of the motor vehicle which struck the plaintiff concerning whether the vehicle was being used in connection with his or her business is not objectionable as calling for a conclusion from the witness, and a witness may testify as to the method by which defects in the wheel of a motor vehicle could be ascertained. Testimony that a motor vehicle, when struck by one motor vehicle, was headed right into another, is a conclusion of fact which the driver of the first vehicle is permitted. But the witness must be qualified to give an opinion, and the rule, fundamental to the law of opinion evidence in general, that the knowledge of the witness must be shown, and that he or she must testify to the facts upon which conclusions are based, applies to testimony by observers of a motor vehicle accident. Furthermore, the necessity for opinion evidence exists only where the facts in controversy are incapable of being detailed and described so as to give the jury an intelligible understanding concerning them. Opinion evidence is not as a rule admissible when facts can be reproduced before the jury so as to show the conditions upon which the opinion is desired.

It is generally true that an eyewitness to a motor vehicle accident may describe it in terms that import a conclusion as to the cause, if the conclusion is but incidental to the description. For example, a witness may say that a truck was "zigzagging across the street and appeared to be out of the control of the driver," or a passenger in a bus may testify, from the action and feel of the bus, that it "was skidding." However, if the witness includes in the description something that goes beyond the mere objective portrayal of the facts and resorts to what is argumentative opinion, the answer or that part of it will not be accepted as evidence.
An eyewitness of a motor vehicle accident cannot be asked, after having described the whole circumstances of the collision, to say, on that basis, who was at fault or to issue blame for the collision. In testifying regarding the cause of a pedestrian being struck by a motor vehicle, a witness stating that the pedestrian was drunk is inadmissible without preliminary testimony by the witness relating to what he observed about the pedestrian's appearance or manner which led to that conclusion.

Opinions of experts who observe the conditions after a motor vehicle accident are usually based on either an observation of the tire or skid marks at the scene of the accident, or an observation or inspection of the vehicle involved in the accident. Sometimes the opinion of a person who did not observe the accident or the conditions after the accident, but who knows how the type of vehicle in the accident performs and handles, is offered in evidence as the opinion of an expert and admissible as expert testimony.

Proof which is addressed directly to the senses, generally characterized as real or demonstrative evidence, while comprising a comparatively small proportion of the evidence ordinarily produced in the trial of a motor vehicle accident case, is a most convincing and satisfactory class of proof, and its importance in the determination of controversies is relatively great. Evidence of this character includes objects brought into court and exhibited to the court and jury, the exhibition of injured persons, the use of maps, plats, and diagrams concerning some fact in issue, the use of photographs, moving pictures, X-ray pictures and the conducting of experiments and tests.

**Photographs**
Photographs are evidence in motor vehicle accident cases when they appear to have been accurately taken and are proved to be a faithful and clear representation of the subject, which cannot itself be produced, and of such nature as to throw light upon a disputed point. For example, photographs of the locale of an accident, and of skid marks or tire marks, are admissible in evidence. This evidence is based upon tire or skid marks at the scene of an accident relating to the speed of a motor vehicle involved in the accident. Such evidence must be based upon skid marks made prior to the accident rather than after, and the calculations upon which the opinion is based must be made by the witness.

Opinions of experts based upon the observation of skid marks have been held admissible in regard to evidence other than speed, such as opinions as to how certain tire marks of the vehicle were made, where such evidence tended to show the position of the vehicle and the effect of the collision upon it. Furthermore, a witness qualified as an expert with respect to knowledge of motor vehicles and how they operate under certain conditions may express an opinion as to the operation of the car based on his observation of photographs of brake or skid marks at the scene of an accident.

Even a nonexpert witness, from observation of tire or skid marks at the scene of an accident, may properly be allowed to give an opinion concerning the identity of the vehicle making the marks, or in regard to the position of the vehicles on the highway at the time of the accident. Indeed, in some cases, although there is authority to the contrary, statements of witnesses based on their observation of tire marks at the scene of the accident, regarding whether the motor vehicle went in a certain direction, whether it skidded, how far it went after the collision, or whether the wheels of the vehicle were braked at the time of the accident, are admissible as evidence within the personal observation of the witness and not objectionable as far as being considered merely the opinion of the witness.
In order for photographs to be considered as evidence, it must be proved that they were taken at or near the time of the occurrence of the event before there had been any change in the condition or position of things; otherwise they will be inadmissible. A photograph of the scene of an automobile accident which is obscure and indefinite in its details and was taken when the foliage, shrubbery and lighting conditions were different from those existing at the time of the accident, is normally not admissible.

**Classification of Photographs**

Photographs can be divided into two general classifications:

- **Snapshots**—For the most part, these are to be used merely for the transmitting of information from the investigator to the file. They are not ordinarily used in a trial because in many jurisdictions, photographs are not admissible unless taken by a qualified expert. The average investigator does not have the experience to qualify as an expert; furthermore, it is usually advisable to avoid having the investigator for an insurance company testify at a trial. Snapshots should be taken in those cases in which the scene or object is difficult to describe or to draw in detail. Snapshots taken for this purpose require only the use of a simple camera that can be operated with a minimum of technical ability.

- **Commercial Photographs**—Commercial photographs are taken primarily to be used as evidence at a trial. It is therefore important that the photographer not only be well qualified professionally, but that he or she have the necessary characteristics for a good and convincing witness. Accordingly, it is important that all photographs be properly identified on the reverse side or by an attached tab. In view of the large number of cases that require the use of a commercial photographer, cost, in the average case, should be a definite consideration. Not only must the claims person have a definite understanding about the price before engaging the services of a commercial photographer, he or she must specify the number of photos desired. This should not be left to the discretion of the photographer.

The commercial photographer whose services are engaged should definitely understand that any photographs he or she takes belong to the company that ordered them, and that no prints are to be made available to anyone else. Commercial photographs can be important in the defense of a case not only by showing the entire scene of an accident, but by illustrating the point of contact through pictures of both vehicles that show the damage to them.

The claims person must remember that he or she is trying to show the condition as it existed at the time of the accident. He or she should see that the photographs are taken not only at the same time of year, but even at the same time of day or night, so that the shadow formations and lighting conditions will be similar. It is also important that the weather conditions be the same.

Everyone has seen examples of trick photography, and photographic distortions made either intentionally or by accident. The angle of a shot, the type or combination of filters, the direction of the lighting, and the like, can so distort a picture that it bears little resemblance to the actual object represented. Such distortions should be guarded against not only in taking photographs but in examining those taken by others who are trying to present a different point of view.

**Superimposed Photographs**

Some commercial photographers are also qualified to testify concerning surveys and measurements. They usually specialize in superimposed photographs. These photographs
consist of a thin sheet of transparent paper, placed over the photograph, with measurements drawn on the paper sheet.

In some instances, photographers specialize in marking a scene of an accident with rulers, chalk or other objects to indicate measurements shown up on the actual photograph itself. Care must be used so that the effectiveness of the photograph is not lost because of the markings and changes made by the photographer. Superimposed photographs can sometimes serve a very useful purpose. Where the importance of a case warrants their use, the claims person should make sure that the person who does the work is well qualified and has a previous history as an expert witness.

**Aerial Photographs**

An investigator will not often have use for aerial photographs. For the most part, he will be interested in a detailed study of a small area, not an aerial shot of a vast area. In the exceptional case, it may sometimes be advisable to take an aerial photograph to show the general contour of a road or area over a considerable distance. Even though this should be kept in mind as a possibility, its use should be kept at a minimum.

**Panorama Shots and Enlargements**

Use of panorama shots and enlargements should be limited to use in important cases that are definitely pointed for defense, because these photos are expensive. They are very effective in courtroom cases in which a detailed study of the scene is important to the defense of a case. Skilled commercial photographers can make overlapping photographs that will represent a considerable area. Though there is a certain amount of unavoidable distortion in such photographs, it may be unimportant if the extent of the area to be covered is of prime importance.

**Stereoscopic Views**

Stereoscopic photography is valuable when it is important to present a three-dimensional picture. While the photography itself should not present any great problems for the commercial photographer, the finished prints must be viewed in a special viewer or through special glasses. Consideration should be given to the taking of stereoscopic views when dealing with the defense of claims involving steps, curves and inclines that would, in the ordinary photograph, blend into the background. These photographs can also be important when it is desirable to highlight a dent in a car that might be almost invisible in the ordinary flat-plane photograph.

**Color Photographs**

Color photographs are very effective for showing personal injury. It is, however, one thing to show an actual injury honestly, and quite another to highlight blood and gore for the sake of inciting the jury’s sympathy. Many of our courts have become more conservative in the admission of color photographs because of abuses by some attorneys who have, without purpose, taken progressive photographs during the course of an operation, or who have photographed undressed wounds. The tendency today is to permit only the part of the body that is essential to a proof of injury to be shown.

Color photography has an important place when color is a vital factor in an accident. For instance, a full-color photograph of a stop sign is far more effective than the same photograph in black and white. If it is desirable to show that damage to a vehicle was long-standing and that rust was encrusted in the damaged areas long before the accident occurred, color photography can be extremely valuable.
**Slides and Projections**
Occasionally, detail of an object or an area is so important that it is advisable to project a picture of it onto a screen. Both black and white and color projection can create a dramatic and impressive effect.

However, the claims person must realize that it may be difficult to have a slide admitted in evidence and to obtain the judge’s permission to project it onto a screen. When problems of admissibility arise, it may be necessary to use a highly qualified expert who can, among other things, testify that a projected image can show gradations in tone and color that are impossible to reproduce in a print on paper.

**Police Photographs**
Very often the police or detectives who make the investigation of an accident will take their own photographs. These shots are important because they have been taken by an impartial agency, usually very shortly after an accident. Many jurisdictions will release copies of such photographs on payment of a fee. The claims person should always determine whether such photographs have been taken and whether copies are available to him.

**Newspaper Photographs**
Occasionally, a news photograph of a scene of an accident or vehicles involved in it is advantageous to the defense of a case. Ordinarily, copies of such a photograph are made available upon payment of a small fee. In many instances photographs may have been taken by a free-lance photographer from whom not only the prints but sometimes the negatives can be bought.

**Motion Pictures / Videos**
The view generally followed by the authorities is that motion pictures are evidence, under a proper exercise of discretion by the trial court, where their relevancy, authenticity, and accuracy of portrayal are established by the laying of an adequate foundation. But the motion pictures must be authenticated and verified, and their accuracy or correctness shown before such pictures may be admitted in evidence.

The taking of motion pictures/ videos is a specialized art, requiring professional competence if the movies are to be effective. Again, the claims person must remember that the pictures themselves have no value as evidence unless the person who took them can qualify as an expert. Those who have had experience in this field have the equipment such as trailers, telephoto lenses, and the necessary know-how to take pictures of claimants without revealing the fact that the subject is being photographed. The use of motion pictures in claim work is usually confined to checking on the activities of a claimant in order to refute an allegation of disability.

Ordinarily, it is not necessary to incur the expense of motion pictures unless some element of fraud is involved.

**Diagrams**
It is a well-established rule that diagrams and maps illustrating the scene of an accident and the relative location of objects, if proved to be correct, are evidence used to understand and apply the established facts to the particular case, and to illustrate the position of the automobile involved. Accordingly, maps or diagrams indicating tire or skid marks or their location at the scene of a motor vehicle accident are admissible under certain circumstances.
A diagram made by an investigator need not be a work of art, nor need it have the precision of a draftsman’s blueprint. However, since its main purpose is to dispel confusion, not compound it, enough care and effort should go into its composition to make it understandable.

Diagrams drawn by the investigator have many advantages:

- A visual drawing of the scene of an accident is mentally absorbed much more quickly than a word description.
- It is very often much easier to draw a diagram illustrating what occurred than it is to describe the occurrence in words.
- A diagram will help the reviewer of the file, whether he be the local manager or the home office examiner, to understand the factual situation much better and arrive at a determination of liability more quickly.
- The drawing of a diagram will force the investigator to make a closer than ordinary observation and help impress the physical facts that much more firmly in his or her mind.
- Studying a complete diagram will often suggest leads for additional investigation that might uncover as-yet-unknown witnesses.

The method of drawing diagrams varies with the individual. Some investigators can make a complete and finished diagram at the scene of the accident without having to redo it later. Others are so meticulous that they are not satisfied with a diagram drawn under adverse conditions on the spot; they redo it subsequently at home or in the office. Several aids can be purchased that are helpful in making diagrams. They range from cutouts designed into rulers or celluloid squares, to elaborate diagram kits which include rubber stamps to represent all types of transportation equipment, traffic signals, and even human beings in various positions.

Properly used, these aids can be very helpful. However, effective diagrams can be made without any of them. A diagram need not be elaborate to be effective. Although it should be complete, clear and understandable, a diagram drawn by an investigator is not made to be presented in court as evidence.

The quality of a claims person’s work can usually be judged by the diagram he or she draws, and by whether one is drawn at all. The essential information in all diagrams should include:

- All of the details of the physical facts, including the surrounding area, the makeup and general condition and composition of the streets or roads, lighting, defects, obstructions, points of vantage from which witnesses could have viewed the scene, traffic controls, and all other details which will be further itemized in discussions of investigations of automobile and other types of accident claims.
- Position of the vehicles involved in an automobile accident before, during and after the accident.
- All measurements that have a direct bearing on the investigation, including distances from lighting, skid marks and street or object measurements.
- A compass indication at the top of the diagram, showing north to be the top of the page.
- If the diagram is done to scale, key to the scale in the lower right hand corner.
- A legend at the bottom of the diagram giving label to all objects or vehicles involved and including the date and time when the diagram was drawn, as well as the date and time of the accident.
- The signature of the diagram’s maker.
- In motor vehicle accident cases, as in other cases, it is proper in some instances to conduct, or show the results of, tests or experiments concerning the operation of a motor vehicle involved in the accident, or the operation of a motor vehicle at the locale of the accident. For
instance, testimony showing tests and experiments relating to the speed or control of a motor vehicle involved in an accident, or concerning the visibility of persons or objects, or the line of vision of the operator of a motor vehicle involved in an accident, has been admitted.

Such basic factors as testing the adequacy of brakes or steering on an automobile that has been involved in an accident, products and professional liability coverages have proven the need for many kinds of laboratory tests that might be helpful in trying to determine liability. Testing can determine the reason for the failure of structural material including metal, wood and rope; the breaking point of glass objects; the reason for malfunctioning of appliances and other mechanical and electrical equipment; the contamination of foods and drugs; and the allergenic qualities of contact materials such as chemical fabrics, detergents, cosmetics, etc.

The admissibility of such experimental evidence rests largely in the discretion of the trial court. If the essential conditions under which the experiment or observation is made are substantially the same as those surrounding the accident which is being investigated, any departure or minor variation goes to the weight rather than the admissibility of the evidence. Experimental evidence has also been held admissible for the purpose of showing the control of a damaged motor vehicle, or to determine the performance of a motor vehicle when "freewheeling."

Police reports made by various departments of the state and municipal governments can be exceedingly helpful in the investigation of an accident case. Most of these reports are a matter of public record and are available for a small fee. Others may not be available when criminal prosecution is involved, and still others are confidential reports that can only be obtained through confidential sources or by discovery processes.

A police report is usually made when an accident of a serious nature occurs. Depending on the jurisdiction, it may be made by state troopers, local municipal police, or the sheriff’s office. These reports are becoming more and more inclusive and contain much of the following information:

- Date, time and place of the accident.
- Traffic details, usually including a small diagram.
- Names of all parties and witnesses involved in the accident, including the owners and drivers of vehicles, or the owners of the premises involved in an accident.
- A description of the driver, including his age and license number.
- The names and addresses of all injured parties, and a digest of their injuries including the place where they received medical attention.
- Description of the accident, ranging from brief to detailed.
- Names of witnesses to the accident.
- Weather, lighting and road conditions.
- Description of motor vehicles involved in the accident.
- Property damage sustained.

Occasionally, police reports will furnish even more detailed information, in the form of questions requiring check-mark answers. These reports are ordinarily available in photostatic form or can be copied. In some cases, a small fee is charged.

Police officers often have more information in their notes than appears on the actual report. Sometimes this information is hearsay that can lead to profitable avenues of additional investigation. Therefore, it is always advisable for the investigator to see the police officers personally if the magnitude of the case warrants it.
Most states have a motor vehicle department that is separate and distinct from the police department. This department usually requires each involved party to an accident that involves a certain minimum of property damage, ranging from $50 and up, or that involves any bodily injury, to submit a report promptly. The forms are available, usually in photostatic reproduction, for a nominal fee. Although these motor vehicle accident reports cover much the same ground as the police and state troopers’ report, their importance is greater because they are usually made out by the drivers involved in the accident and often include admissions against interest.

Within the motor vehicle department, some states will provide a certified abstract of a driver’s operating record for a nominal fee. This record usually contains the type of license the operator holds (private passenger, junior license or truck), the number and type of accidents in which the driver was previously involved, a record of any traffic convictions, and a record of any suspensions, revocations, or restorations of a driver’s license.

A coroner’s report may be available in cases involving the possibility of criminal prosecution as a result of a death. Most of the larger municipalities automatically conduct a coroner’s inquest in a case where death has resulted from an accident.

Ordinarily, for a small fee, a certified copy of an abstract of the coroner’s report can be obtained and usually contains at least the following information:

- Date, time and place of the examination.
- Name, age, occupation and personal description of the deceased.
- A detailed description of his injuries.
- A history of the incident or the accident taken from police information.
- Probable cause of death.

Occasionally, an important bit of information can be obtained from newspaper accounts of an accident. The investigator, however, should read all newspaper reports with an extremely jaundiced eye. After comparing newspaper accounts with the results of his own investigation, he sometimes begins to wonder if it is the same accident. There are, however, occasions when such articles do reveal names of witnesses or other information not previously obtained.

Some claims persons may find it surprising or unnecessary to discuss the subject of self-discipline in dealing with handling claims. Self-discipline can be the most important attribute of a successful claims person. One of the most desirable features of claim handling is the fact that it is one of the fields that is freest of rigid outside discipline. Most companies, particularly in rural areas, do not require the claim adjuster to report in to the office every day as long as the job is done properly and on time.

**Accident Reports**

The report of a motor vehicle accident, made to a public official by the operator of a motor vehicle involved therein, in pursuance of a statutory duty, is generally not admissible evidence in an action to recover damages of injuries sustained in such accident. When such report is introduced on behalf of the party who made the report, it is not admissible for the reason that it is a self-serving declaration. It is provided by statute in some jurisdictions that an accident report required by the statute may not be used as evidence in any trial arising out of an accident, except that the proper department shall furnish upon demand of any person who has made or claims to have made such a report, or upon demand of any court, a certificate showing that a specified accident report has or has not been made to the department, solely to prove a compliance or failure to comply with the requirements that such a report be made to the
department. However, while accident reports made to public officials are generally not admissible, such a report has been held admissible where it is offered by the plaintiff to show material inconsistencies between the defendant’s statements in the report and the evidence introduced by him at a trial.

Notwithstanding the rule that records and reports made by public officers or employees are admissible in evidence, the courts usually exclude statements contained in automobile accident reports concerning the cause of, or responsibility for, an injury to the person or damage to property. However, while the accident report of a highway patrol officer is not admissible evidence, the patrol officer himself is free to testify regarding the accident and the statements made to him, even though such statements are substantially the same as the contents of the report.

The matter of accident reporting by a field claims person in the handling of a casualty claim is by no means complete when he or she has progressed through the investigation or even the disposition of a claim. The information obtained and the work done must be shown in the file so that his or her decision will stand scrutiny by anyone. Since the claims professional has nothing to conceal, he or she should welcome the most critical investigation of his or her files. Letters and other file material should be well-worded and show exactly what he or she means. Careless wording can inadvertently create a false or distorted picture. Claims files are confidential; however, a claims person should not record any statement that could not be brought before any court, insurance department or other official body, without fear of embarrassment or criticism.

Pertinent material of a confidential nature definitely belongs in the file, but unnecessary or derogatory (as distinguished from descriptive) reference to race, religion, national origin or even appearance has no place in the files. Every file must speak for itself. There should be no unanswered questions, or at least as few as possible. Why settlement was made, what amount was paid or why the claim was denied should be shown and fully explained in the report.

Finally, the field claims person should try to anticipate the needs of the home office. Reports should be accurate and thorough enough to avoid (as much as possible) correspondence from the home office correcting errors or calling for clarification. He or she should use proper English grammar, write legibly, send readable copies, and try to be clear and logical in his or her thinking and reporting.

The Statement
A statement is a report provided to an insurance carrier that describes the underlying event or accident for which insurance coverage is sought. The statement will be analyzed and evaluated for details by an insurance examiner. A statement can be provided in one or more of four ways, including the following:

- **A verbal statement**—This is the least used form of a statement and is generally reserved for a situation in which there is little or no question about liability.
- **The insurance company form**—This is a standard form prepared and used by an insurer. During the initial examination of an incident, it may become obvious to an examiner that a more detailed account of the underlying transaction is necessary. In the case of an accident involving a vehicle, the company form may be substantially similar to the one provided to the state department of motor vehicles.
- **Recorded statement**—This is a verbal statement taken from the claimant which is typically in a question and answer format. It is necessary for an adjuster to provide the claimant with a written copy of the transcript of a recorded statement, and the claimant should be provided with an opportunity to review and sign the statement before it becomes an official part of the
record. Recorded statements are especially useful to a staff adjuster who is employed by a carrier. Recorded statements are also useful if a claimant lives a long distance from the offices of an adjuster. Generally, a recorded statement will not be legal unless the adjuster obtains the permission of the claimant or another party involved.

- **Written statement**—This is the most frequently used type of statement, and is typically taken by an adjuster in a surrounding familiar to the other party, such as a home or an office. One of the advantages of a written statement is that it allows the adjuster and the other party to discuss the underlying events on an informal basis before the written statement is obtained. Like the transcript of a recorded statement, the person providing a written statement should be allowed to review it and make any corrections, if necessary, before signing. A written statement is used by an examiner to evaluate the facts underlying the accident and to determine if any injuries resulted. Written statements are usually not admissible as evidence in a court of law. If a party refuses to give a written statement, an examiner may conclude that coverage is available based only upon scanty evidence.

### Contents of a Statement

In investigating a claim, an insurance adjuster or examiner will first seek to ascertain that the statement contains the required amount of information. Depending upon the type of accident and the nature of the coverage involved, a written statement may include the following information:

- The name of the claimant or witness.
- The marital status and number of children of a claimant.
- The permanent residence and business addresses.
- Social Security number.
- Driver’s license number.
- Date of birth.
- General information about the insured’s property, such as location, the existence of liens, condition of the property before the accident and the location of any personal property if it was moved after the accident.
- The immediate events leading up to an accident.
- Weather conditions at the time of an accident.
- Location of an accident.
- The existence of potential witnesses.
- The occurrence of any personal injury or death.
- A detailed description of the events surrounding the loss or accident.
- Diagrams or sketches of the underlying events.
- Any other facts which the parties involved feel may be pertinent or material.
- The signature of the person providing the written statement.

In the event of a vehicular accident, whether involving personal injury, death or property damage, the following factors must be taken into consideration by an examiner, especially if the question of fault is at hand:

- **Speed limit**—Compliance with applicable speed limits may determine the extent and amount of settlement.
- **Tailgating**—The distance between the claimant’s vehicle and those in front are frequently determinative of whether the claimant or the driver allowed for sufficient space to brake properly. The required distance increases in harsh weather conditions.
• **Traffic lights**—Running a red light or entering the intersection on a yellow light may be indicative of negligence.

• **Seat belts**—In some states, failure to use a seat belt is presumptive negligence. In others, the use or failure to use a seat belt may not be a crucial or material factor in determining fault or the amount of damages.

• **Maintenance of a vehicle**—An adjuster might investigate the maintenance history of a vehicle with an eye to whether improper maintenance or a lack of maintenance may have contributed to an accident. Items such as the windshield wipers, horn, headlights, tires, brakes, transmission and turn signals are frequently considered.

• **Driving under the influence**—Under the terms and conditions of some policies, coverage may be negated if a driver is violating the law while an accident occurred. Even if driving while intoxicated or under the influence of drugs was not the proximate cause of an accident, coverage could nevertheless be avoided in such cases.

• **Turn signals**—An adjuster may seek to determine if an accident was caused by the failure of any of the parties involved to use a turn signal.

• **Last clear chance**—In those states in which liability under the negligence doctrine can be avoided if the claimant had the "last clear chance" to avoid an accident, an examiner will be looking for signs of whether the claimant took proper precautions to minimize or eliminate an accident. For example, a driver sitting at an intersection in which there is a traffic light cannot pull into the intersection when the light turns green if he or she sees an oncoming driver running a red light, and then recover when he or she could have avoided the accident by waiting for the negligent driver to clear the intersection.

• **Use of an insured's vehicle by another**—An adjuster must ascertain if a person other than the insured was using the vehicle with the "permission" of the insured. In a number of policies, the "insured" may be defined to include "any other person while using such car if its use is within the scope of consent of you or your spouse . . ." One court has held that once permission is implied, it will be given a very wide and liberal meaning in determining coverage. If the initial use of a vehicle received the implied or express consent of the insured, subsequent changes in the scope or character of use will not demand the consent of the insured, and coverage will be denied only in the event later usage is tantamount to theft or the display of other conduct showing utter disregard for the return or safekeeping of the vehicle.

**Evaluation of a Claim Involving a Personal Vehicle**

The evaluation of a claim surrounding a vehicle may involve property damage as well as personal injury or death. Carriers usually do not assign adjusters to evaluate a claim for damages to a vehicle. Rather, material damage appraisers are used to assess the amount of loss. Some of the larger carriers that issue personal vehicle insurance have facilities into which a claimant can drive his or her vehicle to get an estimation of the amount of damage. The appraiser or the adjuster will assess the damage on the spot and offer the claimant a check in settlement of the claim. The amount of money that a claimant may recover for property damage depends on an appraisal of the damages done by an insurance adjuster after he or she has made a visible inspection of the damaged vehicle and has reached an agreement with the repair shop. If an appraiser determines that any repairs were undertaken before authorization on the carrier's part, the extent of the damages may be questioned by the adjuster.

**Determination of Value**

There is always the possibility that a vehicle may be determined to be a total loss. In such case, the actual cash value to be paid by a carrier is based to a large extent on the value of the
vehicle set forth in the National Dealer’s Association publication or the “Red Book,” another trade publication. Certain items, such as the existence of air-conditioning, type of transmission, airbags, anti-lock brakes, mileage and a sunroof, are all factors which an examiner may use to determine the actual cash value. An adjuster should get the claimant to sign a written appraisal.

Deciding Which Party Is at Fault
Evaluating what dollar amount to assign to a claim is frequently difficult because of the fact that more than one person may have contributed to the accident. In such case, it becomes necessary to allocate the extent of coverage and the amounts of the settlement among various parties. Three types of liability may apply in such a situation:

- Contributory negligence—There are a few states in which a claimant can collect nothing if he or she in any way contributed to the accident or loss.
- Absolute comparative negligence—Under this doctrine, claimants can collect the amount of their damages minus any costs which are attributable to their own negligence.
- Partial comparative negligence—Under the laws of most states, a claimant can collect from another party’s carrier if such other person has contributed to less than half of the damages. Anyone who has contributed more than 50 percent of the losses can collect nothing under this doctrine.

Disparity Between a Body Shop Estimate and a Carrier's Appraisal
Frequently, there is a significant disparity between the estimates secured by the insured from his or her body repair shop and those provided by a carrier’s appraiser, because of an unwillingness on the part of many repair shops to use reconditioned parts. In evaluating the cost of repairs, a carrier is usually bound to pay no more than the prevailing rates in a given area.

AUTO CLAIM DISPOSITION

Personal Property
A claim for a loss arising from a lost or stolen vehicle is settled by a carrier by payment of funds, repairs or replacement of the vehicle. Stolen property may be returned to the insured, in which case the carrier will pay for any damages resulting from the theft. The property may be retained by the carrier at an agreed-upon or appraised value. If a loss is paid in cash, the carrier may be required to pay an applicable sales tax for the damages to the stolen vehicle. If a vehicle of the insured is stolen from a garage or a repair shop or if the shop burned to the ground, the carrier will not pay for any repairs or body work that may have been done to the vehicle. If there are any other sources of recovery on the loss, such as physical damage coverage provided by a lender, the carrier will pay no more than its share of the loss.

Totaled Vehicle
When a claimant comes to terms with a carrier on a claim involving a totaled vehicle, the carrier will take possession of the vehicle after obtaining the keys and a properly endorsed certificate of title.
In the event a claimant settles with a carrier other than his or her own, the claimant must dispose of the vehicle after the other carrier deducts the salvage value from the actual cash value of the vehicle in question. The claimant is then free to dispose of the vehicle as he or she deems fit, including selling it for parts.

When a claimant settles with a carrier, the adjuster should provide the claimant with a tax credit letter stating the amount and nature of the settlement. The amount of the tax credit may be added to the amount of the settlement.

In the event of a settlement involving a stolen vehicle that is either never recovered or is damaged beyond rehabilitation, a total loss is applicable in determining the amount of the settlement. In many instances involving a stolen vehicle, a carrier is required to wait thirty days before settlement to make certain the vehicle is not recovered. Personal items inside a stolen and never-recovered vehicle may figure into the amount of the settlement.

**Liability**

Personal vehicle liability insurance imposes on the carrier a duty to pay third party claims against an insured as well as an obligation to provide legal representation if the insured is sued by a third party. Known as a "duty to indemnify" and a "duty to defend," an ordinary policy usually provides as follows:

*The company will pay damages and losses which the insured becomes legally responsible for because of bodily injury or property damage...from an accident. The company may investigate or settle any claim or suit for damages against the insured. If the insured is sued for damages, the company will provide a defense...even if the allegations are fraudulent, false or groundless.*

Usually, a third-party claimant will attempt, through his or her attorney, to negotiate a settlement with the insured’s carrier. If the claim is excessive or frivolous, the carrier may allow the claim to go into litigation so it can obtain more detailed facts through discovery. If the case cannot be settled, it is likely the claimant will file suit against the insured. The carrier is entitled to notification of any summons and complaint against the insured. Following that, the insured is not entitled to pay any money to the claimant or agree to settlement or to incur any expenses on behalf of the claimant without the prior written permission of the carrier. If the claimant is awarded a judgment against the insured, the carrier will pay the claim to the extent of the amount of coverage.

There are times when a carrier may settle against the wishes of the insured. Insurers have wide latitude in resolving third-party claims, including settling if it is deemed expedient to do so. Homeowners and vehicle liability policies do not usually require the insured’s consent to settle a third-party claim.
SECTION 8:
HOMEOWNER CLAIMS

HOMEOWNER POLICIES

Intended to cover residential and personal property of a mainstream policyholder, homeowners insurance is a comprehensive mix of liability and property coverage. A homeowners policy is typically issued to extend coverage to premises used principally as a private residence that contain no more than two-family living units. Separate units on the premises, such as garages, sheds or guest houses, are covered separately. For condominium owners and apartment dwellers who do not have a need to cover their dwelling, there are separate policies available that extend coverage for liability and for personal property.

Homeowners policies are designed to cover owner-occupied residences only. A policyholder can lose coverage if he or she rents property to a tenant and does not take out a rider to cover the changed situation. An ordinary homeowners policy is divided into two sections and includes the following coverage:

- **Living Expenses**—If damage to an insured’s primary residence is covered by a homeowners policy and the home is rendered uninhabitable by such damage, a policy may pay for the costs of lodging and food in excess of what the insured would normally pay.
- **Personal Property**—Coverage is extended to general classes of personal property, such as furniture and clothing, which are located within the insured’s dwelling. Personal possessions that are kept in temporary quarters, such as a motel or a college dormitory, may also be insured against loss.
- **Primary Residence**—The actual dwelling and any attached structures, such as a garage or a sun-porch, are protected against loss.
- **Approximate Structures**—Unattached, freestanding structures, such as a detached garage, are included.
- **Medical Expenses**—If a guest is injured, whether on or off the insured premises, a nominal amount of coverage is provided for medical expenses.
- **Personal Liability**—If an insured or a protected member of the insured’s family accidentally inflicts bodily injury upon or damage to the property of another, coverage will extend to damages and legal costs.

All homeowners policies include a loss deductible that applies to almost every type of covered loss. A deductible applies one time to each occasioned loss. The deductible is subtracted from the amount of the loss rather than the amount of the settlement.
Risks of Loss Covered in a Homeowners Policy
A standard homeowners policy includes coverage for losses due to:

- An explosion.
- Damages attributable to vehicles not owned by the insured or any covered person.
- Theft.
- Ice, snow and sleet.
- Hot water heaters and home appliances.
- Lightning and fire.
- Riots.
- Smoke damage.
- Window breakage.
- Collapse of the structure.
- Injury to electrical parts and wiring.
- Hail and windstorm.
- Frozen pipes, from heating and air conditioning.
- Aircraft.
- Falling objects.
- Vandalism.
- All other perils, excluding flood, earthquake, nuclear accident and others specifically excluded in the policy.

Whether an insured is covered against some or all of the above risks depends on what type homeowner policy has been purchased. Basically there are six standard homeowners policies from which a consumer can select. One type of policy is a renter's policy, and another is specifically for insuring a condominium. The most basic, known as "homeowners policy-1," covers only about half of the risks specified above. At the other end of the spectrum is "homeowners policy-5," which extends coverage against all of the listed potential losses. All policies provide the same amount of coverage for medical payments and personal liability, and additional amounts can be purchased for an increased premium. There are, of course, limitations on the amount of coverage for damages resulting from any of the specified hazards and exclusions of certain types of risks.

Certain hazardous situations are excluded from coverage under a normal homeowners policy. Bodily injury or property damage arising from or connected to the following items or activities may be excluded from coverage:

- Business or commercial activities—If one uses a primary residence to conduct a full- or part-time trade, profession or occupation, business-related property may either be excluded from coverage or there may be severe limits on the amount that will be paid for damages. Also, there is no liability coverage for a professional who engages in malpractice.
- Property in transit—Extends to personal property and effects being moved from one location to another.
- Floods and mudslides—Water damage occasioned by either event is excluded.
- Possessions of a boarder—Personal property of a renter, if the primary residence is used in part as a boarding facility.
- Cooling and heating systems—Unless a loss occurs as a result of physical damage to such facilities located on the insured's property.
- Nuclear radiation—Losses incurred in a situation such as the Chernobyl incident.
- Earthquake losses—Damages due to an earthquake, tremor or an aftershock occurring in any location.
• Property—Servicing equipment items, such as a lawnmower or a ladder, that are not used to service and maintain the primary residence.
• Secondary damage—When due care is not taken to protect injured property from subsequent or secondary damage.
• Rental property—Any leased or rented property which is stored in a primary residence, shed or garage.
• Off-premises injury from motorized vehicles—The only exception is a golf-cart.
• Outdoor apparatus—Antennas and outdoor carpeting.
• High-risk areas—Locations where an increase in a specific risk of loss has been designated, such as a high-crime area.
• Loss of personal property from unlocked Cars—Unless it can be shown that the vehicle was locked and entry was forced.
• Construction—Tools used during renovation, remodeling or construction of a primary residence, garage or freestanding structure.
• Other coverage—Property which is insured under another policy, such as damage to a car parked in a garage which is covered by comprehensive automobile insurance.
• Household staff—Workers, babysitters, maids or gardeners who incur an injury or damage to the property while on the job.
• Pets—Only injury caused by a pet to a third person is included. If an insured kept an exotic pet, such as a boa or an alligator, at his or her residence, there would be no coverage since protection does not extend to injuries caused by animals other than normal pets that are kept legally on the premises.
• Other injuries—Those covered by workers’ compensation laws.
• Many of these exclusions can be covered under an extension to a homeowners policy or through the purchase of special insurance referred to as a "floater policy."

Floater Policy

Insurance carriers offer coverage known as a floater policy, which is either a separate policy or an endorsement to a homeowners policy designed to cover specific items of property. A need for a floater policy arose out of a practice of the insurance industry to write homeowners policies to cover "unscheduled" personal property, subject to limitations and exclusions. Specifically, a floater endorsement or policy applies only to scheduled items. Coverage provided is on an all-risk basis, and is therefore quite extensive. Insuring scheduled items is less expensive if handled through an endorsement to a homeowners policy than by the use of a floater policy. Limitations in a standard homeowners policy are not applicable to scheduled items, although ordinarily there are exclusions for damages resulting from vermin, nuclear reactions, acts of war, wear and tear, insects, government regulations and confiscation of property by government officials under the provisions of eminent domain. Additionally, there may be exclusions that relate only to a given type of property. With respect to fine arts, such as antique furniture or paintings, there is no coverage for losses arising from the repair, restoration or retouching, or by breaking of fragile and glass items, unless occasioned by lightning or fire, aircraft and vehicles, windstorm, earthquake, flood, explosion, vandalism or derailment or overturn of a vehicle of conveyance. To cover property on exhibit, the location would have to be named specifically in the floater policy or rider.

The "personal articles floater" is the most common form of policy used to insure personal property, covering such items as jewelry, furs, cameras and related equipment, musical instruments, stamps, coins, fine arts, golfers’ equipment and silverware. A separate premium is charged for each item. Many of the items may be covered for a percentage of the actual listed value or a specific dollar amount, whichever is less.
Flood Insurance
Prior to the 1960s a homeowner could not obtain any flood insurance, since then, as now, it was excluded from a standard homeowners policy. Congress established a federal plan, known as "The National Flood Insurance Program," which offers flood insurance to residents in flood-prone areas at subsidized rates. Not every loss that would at first blush appear to be a flood is covered under flood insurance. Losses covered by the backup of sewers are not covered items. Flood coverage is available only if a local community agrees to participate in the federal program. Insurance can be purchased through any private insurance company that has been designated to make it available. Following are some of the more significant features of flood insurance:

- **Waiting Period**—Once a consumer signs up for flood insurance, there is a thirty-day waiting period before coverage is effective.
- **Structure**—The property to be insured must have walls and a roof and cannot be located either underground or completely over water.
- **Coverage**—The amount is limited.
- **Deductibles**—A standard deductible of $500 is applicable to both structural damage and personal effects.

Guaranteed Replacement-Cost Policy
A number of carriers issue guaranteed replacement-cost policies which offer to pay the entire amount necessary to replace a residential dwelling, such as a house or townhouse, as well as all of the contents, although the replacement costs may be in excess of policy limits. Some insurance companies set limits on coverage, paying 120 or 150 percent of the face value of the policy. There may also be a ceiling for coverage of the contents, which is ordinarily established at 75 percent of the replacement cost of the dwelling.

Condominium Insurance
Under a deed, declaration or bylaws which govern a condominium development, a homeowners association is usually required to insure the buildings. A condominium owner should determine if coverage is only to the bare walls or includes built-in items, such as cabinets and appliances. Individual condominium owner's insurance extends coverage to personal property of a homeowner. A condominium policy usually includes coverage for fixtures, alterations and improvements, up to a nominal limit, which can be raised for an additional premium. A condominium owner may purchase an individual policy from the same company that insures the entire structure. In the event of damage to the structure as well as to the personal property of an insured, there would only be one company to deal with in filing claims, proving losses and collecting insurance proceeds.

Dwelling Policy and Personal Property Insurance
A dwelling policy and personal property insurance policy covers a policyholder’s dwelling, certain other surrounding structures on the same ground, specific types of use of loss such as additional living expenses or rental value, and personal property owned by the insured and his or her family members. Dwelling insurance is sometimes used synonymously with fire insurance. Similar in many ways to a homeowners policy, a dwelling policy does not cover theft
or personal liability unless separate coverage is provided in an endorsement or a supplement to the policy. The most compelling reason to buy a dwelling policy is in a situation where a consumer owns two residences and does not need the more extended coverage of two complete homeowners policies. Also, it is usually easier to qualify for a dwelling policy than it is for a homeowners policy. Dwelling policies can be written to extend coverage to up to a four-family dwelling.

Managing Homeowners Personal Property and Liability Risk

Individuals and families must manage risk in their lives in a fashion similar to a business. Individuals have property risks, such as loss or damage to a home and personal property, as well as liability risks and are subject to liability claims related to home ownership or driving an auto. Insurance agents may assist individuals and families to manage these important risks, as well as others that may arise in an individual’s specific life circumstances, with the result that the individual and family is more financially secure and less likely to suffer a loss from which they cannot recover.

Basic Coverage
Homeowners insurance provides property insurance protection against damage or loss to the home itself (the home is referred to as the dwelling within homeowners insurance forms), to structures attached to the dwelling, such as a garage, to other structures not attached to the dwelling, to personal property and to other items on the residence premise, such as trees and shrubs. The dwelling is generally insured against damage due to fire, windstorm, hail, theft, vandalism, and other perils such as falling objects, weight of ice, snow or sleet, freezing, and even volcanic eruption. Other structures covered under homeowners policies include gazebos, detached garages, sheds, mailboxes, satellite dishes and other such structures on the premises. Usually the amount of coverage for other structures is limited to 10% of the total coverage on the dwelling.

Some of the landscaping around the home is also covered under homeowners policies through trees, plants and shrubs provisions. Generally coverage for these items is limited to 5% of the coverage on the dwelling. Trees, plants and shrubs are covered against many of the same perils as the home, but normally excluded from this coverage is damage due to windstorm. Since windstorm damage occurs with frequency to landscape items, windstorm insurance is too expensive for the average homeowner to purchase as part of trees, plants and shrubs coverage.

Personal property is also covered under homeowners policies. The coverage limit for most personal property is 50 – 70% of the amount of coverage on the house. However, policies include special limits of liability for certain items, such as coins, precious metals, valuable papers, watercraft, business property and other items. If more coverage is needed, liability limits may be increased through riders or endorsements, or by purchasing separate policies.

Personal property is also generally covered under homeowners policies against loss away from home – even when outside of the US. Many policies provide this worldwide coverage against property damage. Additional insurance can be purchased to protect property from theft away from home as well.

Another coverage offered under homeowners insurance is loss of use coverage. Loss of use coverage pays for additional expenses incurred because a covered loss makes all or a portion of the home not fit to live in. Included are such expenses as hotel bills and meals away from
The normal expenses that the insured would have incurred were there no loss or damage to the dwelling are not include in the amounts payable under the coverage. The loss of use coverage is generally limited to about 20% of the amount of coverage on the dwelling.

**Liability Coverage**
An important component of homeowners insurance is liability coverage. For example, if someone stumbles down a homeowner’s steps and injures himself, liability insurance will pay for the injury done and for the medical care the injury necessitated. The liability coverage pays for both the covered damage or injury and the costs of defending an insured against a claim or suit arising from the damage or injury, even if the suit is groundless, false or fraudulent. Medical expenses to others are paid if the injury occurs on the homeowner’s premises and the injured party has permission to be on the premises (or the insured location, as the residence premises may be referred to within the policy).

**Homeowners Forms**
Standardized forms have been created for the use of insurers offering homeowners policies. A service agency for the property-casualty industry called ISO, or Insurance Services Office, has written and filed with the states many standardized homeowners forms and endorsements. Insurers use the standardized forms as the basis for their policies, but, unless state regulations prohibit, an insurer may change some of the provisions in the standardized forms and add special features to them.

There are six ISO forms used for homeowners policies. These are HO-1, the basic form, HO-2, the broad form, HO-3, the special form, HO-4, the tenants form, HO-6, the condominium form, and HO-8, the modified coverage form. Each form has its own special features and uses.

**HO-1**
The HO-1 basic form is not available in all areas because some state regulators have not approved its limited coverage for sale in their respective states. It is also not purchased by consumers as often as other forms in areas where it is approved because of its limited coverage. Protection against damage due to falling objects, the weight of ice, snow or sleet, accidental discharge of water or steam from household appliances, freezing, volcanic eruption and other perils covered in the other HO forms are not insured against through the HO-1 form.

**HO-2**
The HO-2 broad form is a named peril form. A named peril form is one that names each peril it protects against. Seventeen perils are named within the HO-2 form, including those listed above as not covered under the HO-1 form and the perils of fire, lightning, windstorm, hail, riot, vandalism and more.

**HO-3**
The HO-3 special form is an all risk form and provides dwelling and other structure coverage against all perils except those specifically excluded from coverage. The personal property coverage is the same broad coverage provided through the HO-2 form.
**HO-4**
The HO-4 tenants form is a form used by renters. It does not cover the dwelling, since the renter does not own the dwelling. It covers personal property against basically the same perils as the HO-2 and includes essentially the same liability coverage.

**HO-6**
The HO-6 condominium form includes limited dwelling coverage. Its personal property and liability coverage is similar to that found in the HO-2 and HO-3 forms.

**HO-8**
The HO-8 modified coverage form is used to cover older homes. It includes valuation provisions not found in the other HO forms because the older homes it was designed to cover often have replacement values that far exceed the home’s market value. Some state regulators are not comfortable with the limits placed on the coverage due to the form’s valuation provisions and so have not approved the HO-8 form for use in their states.

The homeowners forms that include dwelling coverage have the following sections and coverage types:

- **Section I – Property Coverages**
  - Coverage A – Dwelling
  - Coverage B – Other Structures
  - Coverage C – Personal Property
  - Coverage D – Loss of Use
- **Section II – Liability**
  - Coverage E – Personal Liability
  - Coverage F – Medical Payments to Others

**Coverage A – Dwelling**
The dwelling coverage applies to the dwelling on the residence premises and also to the structures attached to the dwelling, such as a garage or carport. Materials and supplies located on or next to the residence premises that are used to construct, alter or repair the dwelling or the other structures on the residence premises are also covered through the provisions of Coverage A.

Coverage A is not found in form HO-4, the tenants form. HO-6, the condominium form, provides one thousand dollars of dwelling coverage. Generally, the condominium association should have insurance that covers the buildings the association owns.

The Coverage A under HO-6 also covers alterations, appliances, fixtures and improvements in the part of the building that contains the residence premises. It covers real property pertaining to residence premises, property that is the responsibility of the insured under a condominium association agreement and other structures solely owned by the insured at the insured location.
Coverage B -- Other Structures
Homeowners policies cover the other structures on the residence premises that are set apart from the dwelling by clear space. The coverage also applies to structures connected to the dwelling by only a fence, a utility line or similar connection.

The other structures coverage does not apply to structures used in whole or in part for a business or rented to anyone who is not a tenant of the dwelling, unless it is used solely as a private garage.

Generally, the other structures coverage amount is limited to 10% of the limit of liability that applies to Coverage A.

The other structures coverage is not found in the HO-4 form.

Coverage C – Personal Property
Personal property is generally covered while anywhere in the world. Property away from the residence is normally covered for 10% of the personal property coverage limit. If the insured requests, the personal property owned by others while on a residence premises that is occupied by the insured can also be covered. The insured can also request that the personal property owned by a guest or residence employee be covered while in any residence occupied by an insured.

Excluded from personal property coverage are:

- Animals, birds and fish
- Motorized vehicles, other than certain trailers, off-road recreational vehicles, golf-carts, motorized lawn mowers, tractors, electric wheelchairs and other similar vehicles
- Property owned by boarders (who should cover their property through their own HO-4 coverage)
- Property owned by renters of an apartment owned by or rented out by an insured (like boarders, renters should purchase their own insurance to cover their personal property)
- Business data and records, although the cost of blank recording or storage media and packaged software is covered
- Property rented to others off of the residence premises

Certain personal property items are subject to special limits of liability. Additional coverage for many of these items can be obtained through personal article floaters.

Coverage D – Loss of Use
Loss of use coverage pays for additional living expenses related to maintaining the insured's normal standard of living if the residence premises, which must be the insured's principal place of residence, is uninhabitable due to a covered peril.

Additional Coverages
The homeowners forms include some additional coverages. Some of these additional coverages have a specified limit of liability and others are paid as a part of the property's applicable policy limit. Unless specifically stated, these additional coverages are found in all the homeowners forms.
**Debris Removal**
Reasonable expenses are paid for the removal of debris of covered property if a peril insured against caused the loss, and for ash, dust, or particles from a volcanic eruption that has caused direct loss to a building or to property contained in a building.

**Reasonable Repairs**
The reasonable repairs coverage pays the reasonable costs incurred by the insured to take necessary measures to protect covered property against further damage.

**Trees, Shrubs and Other Plants**
Trees, shrubs and other plants on the residence premises are covered if damaged by the perils of fire, lightning, explosion, riot or civil commotion, aircraft, vehicles not owned or operated by a resident of the residence premises, vandalism or malicious mischief or theft.

**Fire Department Service Charge**
The policy pays up to $500 for fire department charges if the insured must pay them due to an agreement or contract with the fire department.

**Property Removal**
If covered property must be removed in order to protect it against a covered peril, it is protected against direct loss from any cause. The maximum time frame this coverage applies to property removed is thirty days.

**Credit Card, Fund Transfer Card, Forgery and Counterfeit Money**
There is an additional $500 limit of liability available to cover the legal obligation of the insured to pay due to:

- The theft or unauthorized use of credit cards or fund transfer cards
- Loss caused by forgery or alteration of any check or negotiable instrument
- Loss through the acceptance in good faith of counterfeit US or Canadian currency

**Loss Assessment**
If a named insured is charged a loss assessment by a corporation or association of property owners, and the loss is a direct loss to the property caused by a covered peril (other than earthquake, land shockwaves or tremors before, during or after a volcanic eruption), standard homeowners policies will pay up to $1000 for the insured’s share.

**Glass of Safety Glazing Material**
Also covered is the breakage of glass or safety glazing material that is part of a covered building, storm door or storm window. Damage to covered property by glass or safety glazing material that is part of a building, storm door or storm window is also covered.

**Collapse**
Under the HO-2, HO-3, HO-4 and HO-6 forms, additional coverage for collapse is included. Collapse coverage pays for direct physical loss to a building or any part of a building caused by:

- Perils insured against under the personal property coverage
- Hidden decay
- Hidden insect or vermin damage
- Weight of contents, equipment, animals or people
- Weight or rain that collects on a roof
• Use of defective materials or methods in construction, remodeling or renovation if the collapse occurs during construction, remodeling or renovation.

Landlord’s Furnishings
The HO-1, HO-2 and HO-3 forms include coverage for appliances, carpeting and other household furnishings in an apartment on the residence premises that is regularly rented or held out for rental to others by an insured. The coverage applies only if loss is caused by any peril insured against except theft.

Building Additions and Alterations
The HO-4 form includes additional coverage for fixtures, installation and improvements made or acquired at the insured’s expense.

Perils Insured Against
The forms vary somewhat regarding the perils insured against. Form HO-4 has no dwelling coverage, so the perils insured against within the form apply only to the personal property coverage. The perils insured against under the HO-6 form, which like the HO-4 form is a named peril form, apply to the limited dwelling coverage that is within the HO-6 form, and to the personal property coverage. Personal property under both the HO-4 and HO-6 is covered with the same perils insured against as the HO-2 form, except that the HO-6 form has expanded coverage under the peril of accidental discharge or overflow of water or steam.

HO-3 provides all risk coverage, also known as open peril coverage, which applies to the dwelling, but the personal property coverage within the HO-3 form is named peril coverage, and provides coverage for the same perils as those found in the HO-2 form. The HO-2 form has the broadest coverage, and so includes perils insured against not found in forms HO-1 and HO-8. The HO-2 form also has expanded coverage provisions related to the perils of vehicles and smoke. The HO-8 form includes many of the same perils as the HO-1 form and uses special loss valuation provisions that serve to limit coverage.

Perils Insured Against by Form - Dwelling Coverage
(Note: Form HO-3 provides all risk coverage on the dwelling, so covers all perils except those specifically excluded. All other homeowners forms discussed provide named peril coverage for the dwelling. Form HO-8 uses special loss valuation clauses that differ from the other forms. The HO-6 form has limited dwelling coverage.)
<table>
<thead>
<tr>
<th>Peril</th>
<th>Form</th>
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<tr>
<td>Fire or Lightning</td>
<td>HO-1, HO-2, HO-6, HO-8</td>
</tr>
<tr>
<td>Windstorm or Hail</td>
<td>HO-1, HO-2, HO-6, HO-8</td>
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<tr>
<td>Explosion</td>
<td>HO-1, HO-2, HO-6, HO-8</td>
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<tr>
<td>Riot or Civil Commotion</td>
<td>HO-1, HO-2, HO-6, HO-8</td>
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<tr>
<td>Aircraft</td>
<td>HO-1, HO-2, HO-6, HO-8</td>
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<tr>
<td>Vehicles</td>
<td>HO-1, HO-2, HO-6, HO-8 (HO-2 contains expanded coverage)</td>
</tr>
<tr>
<td>Smoke</td>
<td>HO-1, HO-2, HO-6, HO-8 (HO-2 contains expanded coverage)</td>
</tr>
<tr>
<td>Vandalism or Malicious Mischief</td>
<td>HO-1, HO-2, HO-6, HO-8</td>
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<tr>
<td>Theft</td>
<td>HO-1, HO-2, HO-6, HO-8</td>
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<td>Falling Objects</td>
<td>HO-2, HO-6</td>
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<td>Weight of Ice, Snow or Sleet</td>
<td>HO-2, HO-6</td>
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<tr>
<td>Accidental Discharge or Overflow of Water or Steam</td>
<td>HO-2, HO-6</td>
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<tr>
<td>Sudden and Accidental Tearing Apart, Cracking, Burning or Bulging</td>
<td>HO-2, HO-6</td>
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<tr>
<td>Freezing</td>
<td>HO-2, HO-6</td>
</tr>
<tr>
<td>Sudden and Accidental Damage From Artificially Generated Electrical Current</td>
<td>HO-2, HO-6</td>
</tr>
<tr>
<td>Volcanic Eruption</td>
<td>HO-1, HO-2, HO-6, HO-8</td>
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</tbody>
</table>
Exclusions
All the forms include the following exclusions. The HO-3 form includes additional exclusions related to the Dwelling and Other Structures coverages.

- Ordinance or Law: Loss caused directly or indirectly by the enforcement of any ordinance or law regulating the construction, repair or demolition of a building or other structure is excluded from coverage.
- Earth Movement: Excluded from coverage is loss caused directly or indirectly by earthquake, including land shock waves or tremors before, during or after a volcanic eruption, by landslide, mine subsidence, mudflow, or earth sinking, rising or shifting, unless as a result of the earth movement, loss from fire, explosion or the breakage of glass or safety glazing material which is part of a building, storm door or storm window, ensues.
- Water Damage: Water damage arising from items such as flood, water which backs up through sewers or drains, and water below the surface of the ground that exerts pressure on or seeps or leaks through a building is excluded.
- Power Failure: Loss due to the failure of power or other utility service is excluded from coverage if the failure takes place off the residence premises.
- Neglect: Neglect of the insured to use all reasonable means to save and preserve property at and after the time of loss, is not covered.
- War: Loss due to war is not covered.
- Nuclear Hazard: Loss due to nuclear hazard is generally excluded.
- Intentional Loss

Coverage E - Personal Liability
If a claim is made or a suit brought against an insured for damages because of bodily injury or property damage caused by an occurrence covered by the insurance, the insurer will pay, up to the limit of liability, for damages for which the insured is legally liable. Damages include prejudgment interest.

The insurer will provide a defense for the insured, even if a suit is groundless, false or fraudulent. The insurer may investigate and settle any claim or suit that the insurer decides is appropriate. The insurer’s duty to settle or defend ends when the amount paid for damages reaches the applicable limit of liability.

Coverage F - Medical Payments to Others
Under the medical payments coverage, the insurer will pay the necessary medical expenses that are incurred or medically ascertained within three years from the date of an accident causing bodily injury. Medical expenses include reasonable charges for medical, surgical, x-ray, dental, ambulance, hospital, professional nursing, prosthetic devices and funeral services. The medical payments coverage does not apply to the named insured, a covered spouse, or regular residents of the insured’s household except residence employees.

Exclusions from Personal Liability and Medical Payments Coverage
Exclusions from the personal liability and medical payments coverage include the following:

- Expected or Intended Injury or Damage
- Business Liability: Business liability should be covered through professional, commercial or business owners liability forms.
- Rented Premises: Generally, bodily injury or property damage that arises out of the rental or holding for rental of any part of any premises by an insured is excluded.
- Professional Liability: Professional Liability should be covered through professional liability and errors & omissions insurance forms
- Uninsured Location: Also excluded is bodily injury or property damage that arises out of premises that are not an insured location.
- Motor Vehicles: Most damage, injury and liability related to motor vehicles is excluded.
- Watercraft: Most bodily injury or property damage that arises out of large watercraft is excluded.
- Aircraft: Most bodily injury or property damage that arises out of aircraft is excluded.
- War
- Communicable Disease: Also excluded is bodily injury or property damage arising out of the transmission of a communicable disease by an insured.
- Abuse: Bodily injury or property damage that arises out of sexual molestation, corporal punishment or physical or mental abuse is also excluded.
- Drug Use

**Summary**

The homeowners forms can be used to cover most of the property and liability insurance needs of the homeowner. A home, its outbuildings, landscaping and contents can all be protected from most perils. Special coverages for certain types of property can be purchased and higher limits can be added to the forms to create a coverage package that fits the needs of individual homeowners.

**Inland Marine Coverage – Personal Property Floaters**

One of the gaps homeowners insurance may leave is insufficient coverage for valuable personal property. This gap may be filled by inland marine insurance personal property floaters

Inland marine personal property floaters apply to many types of property that is mobile. A “floater” is a policy that follows the property. Property that may need floater coverage includes construction equipment, personal property taken on vacation, clothes being cleaned at a dry cleaning establishment, sculptures on loan to a museum and many other types of property.

Inland marine coverage for personal lines may generally be issued only to cover property of an individual or of spouses who reside together, or members of the insured’s family of the same household. Policies may also be issued to unrelated individuals residing together, as long as they are legally co-owners of the property. Policies may also be issued to an executor or administrator of a decedent’s estate to cover estate property eligible for coverage.

The most common personal property floaters include the Personal Jewelry Floater, the Personal Fur Floater, the Camera Floater, the Musical Instrument Floater, the Silverware Floater, the Golfer’s Equipment Floater, the Fine Arts Floater, the Stamps and Coins Collection Floater and the Personal Property Floater.

**Personal Jewelry Floater**

The Personal Jewelry Floater covers jewelry owned by an individual. The coverage may be added to a homeowners policy, or through a separate policy. In order to determine the coverage amount of the policy, the jewelry must be appraised, or other suitable documentation verifying the jewelry’s value must be submitted to the insurer. Exclusions to coverage include (1) wear and tear, gradual deterioration, insects, vermin or inherent vice, (2) loss arising from nuclear radiation or radioactive contamination and (3) loss due to war.
Personal Fur Floater
The personal fur floater covers fur articles owned by an individual. Items that may be included in this coverage include fur coats, items consisting mostly of fur, garments trimmed with fur and imitation fur items. Each fur item must be listed or scheduled along with the applicable amount of insurance for each article. The exclusions to this coverage include wear and tear, nuclear radiation and war. Coverage may be provided through endorsement to a homeowners policy or through an individual floater policy. The coverage applies on a worldwide basis.

Camera Floater
Coverage for cameras and similar equipment is available through camera floaters. In addition to cameras, equipment that may be covered includes projection machines, motion picture recording equipment, films, binoculars and telescopes. Each item is scheduled and assigned a value. The exclusions to this coverage are also wear and tear, nuclear radiation and war. Coverage may be purchased through an endorsement to a homeowners policy or through an individual floater form.

Musical Instrument Floater
Musical instruments may be covered through either an individual policy or scheduled under a homeowners policy endorsement. Use of the covered instruments for remuneration is not allowed unless specifically provided for through an endorsement. Excluded from coverage of immobile instruments is damage or loss caused by repairing, adjusting, servicing or maintenance operations, or any mechanical or electrical failure.

Silverware Floater
Silverware, silver-plated ware, goldware, gold-plated ware and pewterware, including flatware, hollowware, tea sets, trays and trophies made of or including silver, gold or pewter can be covered under a silverware floater or under a homeowners policy floater endorsement. Each item must be scheduled. Coverage is offered on a worldwide basis. Exclusions include wear and tear, nuclear radiation and war.

Golfer's Equipment Floater
Under the golfer's equipment floater, golf equipment, including clubs, golf clothing and other clothing kept in a locker at a building used for golfing, is covered. Loss of watches and jewelry is excluded under this coverage. Most golf equipment can be covered on a blanket basis, but some items may require scheduling. This coverage may also be provided under a homeowners endorsement.

Fine Arts Floater
Collections of paintings, antique furniture, rare books, glasses, ornamental knick knacks and manuscripts may be covered under a fine arts floater or homeowners endorsement. Typically, the insurer requires an appraisal in order to determine value. Excluded from coverage is damage caused by repairs, restoration or retouching. Breakage is generally excluded for fragile items such as art glass objects, statuary, marble, bric-a-brac and porcelain, unless caused by fire, lightning, explosion, aircraft, collision, windstorm, earthquake, flood, malicious damage, theft or derailment or overturn of a conveyance. Unlike the other personal property floaters discussed, the fine arts floater does not provide coverage on a worldwide basis. The coverage territory is limited to the United States and Canada.
Stamps and Coin Collection Floater

Stamps and coins must be part of a collection to be covered under a stamp and coin collection floater or homeowners endorsement. Depending on the property covered, either scheduled or blanket coverage is available. Besides exclusions for wear and tear, nuclear radiation and war, this coverage excludes loss due to fading, creasing, denting, scratching, tearing, thinning, transfer of colors, inherent defect, dampness, extremes of temperatures, depreciation, and theft from an unattended automobile. Damage due to being handled or worked on is also excluded.

Personal Property Floater

A personal property floater is generally used in circumstances when an insured does not own a home, and therefore has no homeowners policy, but needs coverage for his personal property. It provides coverage for all personal property owned, used or worn by the insured. It is typically used by wealthy insureds that need high limits of insurance.

Summary

Personal property floaters provide individuals with insurance for special types of property. It provides higher limits of insurance than found under unendorsed Homeowners forms. Coverage is generally provided on a worldwide basis, so those who travel with valuable property can benefit from personal property floater coverage. Personal property floater coverage also provides protection for an individual's property while being used locally or stored for safekeeping.

Title Insurance

Title insurance protects against the risk of financial harm that arises from claims against the rights of ownership of real property. Examples of items that could cause such claims include forgery, improper transfers of title, mistakes, fraud, and unknown heirs with rights to the property.

Title insurance is issued on the basis of a close examination of all records and property related to the title. The title insurer is responsible for this examination. In addition to insuring against claims against the title, the insurance provider insures the accuracy and sufficiency of the title examination and of the abstract, which is a summary of the results of the examination, and in some cases also insures the accuracy and sufficiency of items found in a survey or site inspection of the property. Title insurance is purchased to protect the interests of owners, lenders and leaseholders in real property.

Types of Title Insurance Policies

There are several different title policy types available because there are many different title transfer situations which necessitate the various policy forms. Some involve mortgages, others reflect owners in fee simple, still others involve leaseholders or construction loans. Many endorsements also are available to meet many situations. There are those that add coverage excluded by basic policy forms and those that provide for special circumstances, such as certain mortgage types.

Owner’s Policies

One type of title insurance policy is the owner’s policy. Owner’s policies insure estates of ownership, occupancy and possession. Since the policy insures the full amount of the property
owned, the liability of the insurer remains constant over the life of the policy. Owner’s policies generally exclude unmarketability of title and mechanic’s liens from coverage.

**Mortgage or Loan Policies**
Loan policies insure lenders’ interests in title. Loan policies provide broader coverage than do owner’s policies because lenders will not purchase policies that do not provide full coverage.

Under a loan policy, liability of the insurer decreases over time, since the loan amount decreases. If an open-ended loan is involved, a revolving credit endorsement can be added to the policy so that newly borrowed amounts are also covered.

Loan policies include provisions that, should foreclosure occur, the policy becomes an owner's policy. This is because, under a mortgage or deed of trust arrangement, the lender takes possession of the property upon foreclosure.

**Leaseholder Policies**
Leaseholders do not have an owner’s interest in property. However, if the lease is for a specified period of time, state laws require that the Leasehold interest be recorded. This is because the states recognize that although not an owner of real property, a leaseholder can be harmed if title is passed improperly, or if the property is misrepresented in the deed. A leaseholder, especially one with a long lease, pays consideration for the use of the real property. In some cases, a lease arrangement will even allow the lease to be continued by heirs should the leaseholder die. The leaseholder has a valuable consideration in the real property leased. Because of this interest, title insurers developed policies to cover such title interests of leaseholders.

**Construction Loan Policies**
Construction loan policies include many of the same provisions as a loan policy, but include conditions and stipulations applicable only to construction loans, such as providing for coverage for mechanic’s liens based on the laws of the state in the policy issued.

**Summary**
Title insurance cannot protect a title holder from the potential harm arising from every potential problem related to a title. However, it can, along with the processes involved in providing title assurance, greatly reduce the exposure to the risk of loss and damage related to these problems.

**SPECIAL HO COVERAGE ISSUES**

**Ordinance and law**
Older homes might be restricted as to repairs and replacement for "up to code" issues pertaining to wiring, plumbing, sewer, etc. Consider the case where three layers of roof (the maximum the city allows) have built-up over the years. If the home is damaged by hail and needs to be replaced the cost to re-proof the home is covered. However, the cost to tear-off all three layers of roofing material is NOT and this is a considerable expense. Of course, ordinance and law endorsements are an option.
**Adequate Limits**
Remember the Oakland, California fires? Many homes destroyed by the fire were greatly uninsured or exceed replacement cost limits. "Guaranteed replacement cost" is an option. Of course, the insured might incur a replacement cost appraisal and inform the insurer of any significant changes after the endorsement is made.

**Other Structure**
The 10% limit usually covers most additional structures. However, remember that fencing, or rentals may not apply. Consider endorsements.

**Riding Mowers**
Old ISO Homeowner policies provide property and liability coverage as follows:

*Vehicles or conveyances not subject to motor vehicle registration which are used to service an “insured’s residence”.*

From this verbage it seems clear that if the mower were stolen it would be covered. Similarly, if a son or daughter were using the mower to cut their yard and injured a neighbor, there would be liability protection. All that is required is that the mower be used to service the residence.

Consider, however, when the mower is driven off the residence property, say to visit a neighbor to cut his lawn while he is on vacation. The policy does not seem to limit coverage here because there is no requirement that at the time of “an occurrence” the mower must be used to service the residence.

The ISO Homeowners 2000, however, changes all this

*We do not cover “motor vehicles not required to be registered for use on public roads or property which are used solely to service an insured’s residence.*

The word “solely” has made a huge difference. Now, the ONLY thing the riding mower can be used for is serving the insured’s residence. If the homeowners uses it to cut the neighbors lawn again and injures someone in the process, he is NOT covered. Even joyriding the mower on his own property seems to exclude protection.

**Renting The Primary Residence**
There are times when a homeowner may be away from his primary residence for an extended period of time. Say, for instance, they move out and rent their home “full-time” while it is up for sale.

The ISO HO3 policy clearly states that liability coverage extends only to occasional rentals (a few days, or only a portion of your home to a boarder). The question becomes; does the homeowner have clear intentions to return to the house? If not, the dwelling is clearly no longer the insured’s true residence. That means there is no “residence premise” and no Coverages A, B or D – dwelling, other structures and living expenses. Coverage C may still be intact since it is extended on a worldwide basis.
Of course, court cases have interpreted this differently. Some, like Hill vs Nationwide Mutual (1994) have found that where someone “resides” is merely a description and not a warranty of occupancy. Here, the homeowner was supported because the courts felt that he should not suffer a catastrophic loss on a mere “technicality”. Others, however, like Bryan vs United States Fire (1970) disagreed even though the homeowner testified that he had only temporarily relocated and planned to move back at some point.

Clearly, renting one’s residence for any length of time is an issue that should not be “pushed”. As long as the insured maintains an insurable interest in a property, coverage may need to switch from homeowners to a dwelling fire program.

**Property in Storage**

What happens when your client places items in a self-storage facility for an extended period of time? Does the homeowners policy cover them?

Consider the following verbage under Coverage C protection:

*We cover personal property owned or used by an insured while it is anywhere in the world.*

For most homeowners, this seems to say that they will be covered. However, there are limitations; such as . . .

*Our limit of liability for personal property usually located at an insured’s residence, other than the residence premises, is 10% of the limit of liability for Coverage C, or $1,000, whichever is greater.*

Of course, coverage can be increased with an HO 04 50 endorsement.

“Special limits of liability” to Coverage C should also be considered. They usually read something like this:

*This peril does not include loss caused by theft that occurs off the residence premises of:*

*Property while at any other residence owned by, rented to, or occupied by an insured, except while an insured is temporarily living there. – Property of a student who is an insured is covered while at a residence away from home if the student has been there at any time during the 45 days immediately before the loss. – Watercraft, and their furnishings, equipment and outboard engines or motors. – Trailers and campers.*

Insureds who use a mini-warehouse to store watercraft and equipment, or trailers and campers have no theft coverage for such property.

Similar limitations exist for business property:

*$2,500 on property, on the residence premises, used at any time in any manner for any business purpose.*

*$250 on property, away from the residence premises, used at any time or in any manner for any business purpose.*
Again, increased coverage is available under a HO 04 12, but limits are placed on business property used for samples or delivery after sale or for business property pertaining to a business actually conducted on the residence premises.

Valuation is yet another issue to analyze. Some policies disallow Replacement Cost coverage for items in storage or articles considered “outdated or obsolete”. Said another way, “junk in storage” is not eligible for replacement cost.

What about liability? What happens, for instance, if an insured stores a propane gas grill or gasoline container negligently and they injury or damage a third party? Insureds and their attorneys would claim that the “premises” where they were stored were controlled by the insured and therefore covered. However, Section II in most policies exclude claims “arising out of a premises that is not an insured location”. Still covered? Probably, because the definition of an “insured location” is any part of a premises occasionally rented to an insured for other than business use. However, what about long-term storage? Check with an underwriter or declare the facility an “insured location”.

College Students Living Away From Home

Most homeowner policies cover any personal property owned or used by an insured if it is lost or damaged in a covered peril. The term “insured” includes resident relatives and courts have consistently found that a dependent child away at school is still a resident of the insured’s household. The usual limitation that is placed on this coverage is 10% of Coverage C or $1,000 if greater. 10% of Coverage C is usually enough to cover losses like a computer, although there is a deductible to contend with. In addition, limitations say that any losses be reported to the police. It is assumed that “campus police” is adequate here, but not 100%

The HO 2000 definition of an “insured” has changed somewhat:

A student is enrolled in school full time, as defined by the school, who was a resident of your household before moving out to attend school, provided the student is under the age of 24 and your relative or 21 and in your care.

The problems presented by this new definition are several. Now the student must be “full-time”. This can vary from school to school, but it usually means 12 credits per semester. So, a child who could not get a full “load” for a given semester may not be fully covered.

The age restriction poses problems for graduate students or those taking a little longer to get their degrees. Technically, they are not covered. The student, under this definition, would have to get his own HO4 and umbrella.

ISO, however, created an “additional insured” endorsement – student away at school – for use by those who are over the age limit or not considered full time. Even here, potential problems lurk because kids move a lot. You sign them up for the endorsement at one address and when they move, they are essentially uncovered.

Few courts have interpreted policies so literally as to be highly concerned because it can usually be proven that the student has not moved away permanently. They usually still have a key to mom and dad’s house or stop by to do laundry. However, the endorsement may still be a good idea.
**Personal Trusts**
Over the last several years, huge numbers of people have created family trusts to help avoid probate and save on estate taxes. Most of the time, the trust will take ownership of homes, autos and other property. A lot of agents have simply been adding the trust as an “additional insured”.

While trusts have increased in popularity, older ISO policies are still designed for individuals. The trust is not a “family member” or natural person, so how can it own and occupy a dwelling?

The HO2000 has addressed this problem with a “residence held in trust” endorsement designed for this exposure. The policy is written in the name of the trustee, grantor or beneficiary. The trust gets the benefit of all Section I and II coverages and the party that resides on the premises – the grantor or beneficiary – gets the benefit of all coverages except Section IA and B (dwelling and other structures).

A residence owned by a corporation would not qualify for the endorsement. As always, it is best to check with each carrier to learn any specific requirements.

**Earth Movement**
Most policies contain some form of exclusion for damage to buildings caused by the shifting movement of the ground beneath it. Typical wording might read as follows:

*We do not insure for any loss to the property which consist of, or is directly and immediately caused by . . . Earth Movement, meaning, the sinking, rising, shifting, expanding or contracting of earth, all whether combined with water or not. Earth movement includes but is not limited to earthquake, landslide, mudflow, sinkhole, subsidence and erosion.*

Of course, there are many claim controversies that develop when interpreting this kind of language.

In Strubble vs United Services (1973), for example, an insured's home was situated on a cliff. Prior to 1967 a slight landslide occurred which destroyed the home's patio. In 1967, an earthquake caused a crack and shifted the earth under the house, precipitating a very slow landslide. Over the next few months, the crack became wider and the insureds took steps to shore up the property. Unfortunately, in a short time, two-thirds of the house collapsed and the house was abandoned. Disputes quickly arose as to whether the earthquake, which was a covered peril under this particular policy, caused the landslide. Experts disagreed, so the appeals court held that the burden was on the insurer to prove that the earth movement exclusion applied, i.e., the earthquake was the culprit. Because the insurer could not prove it, the loss was covered.

Other claims were not so cut and dry. Consider:

*Henning Nelson vs Fireman's Fund (1985).* The courts held that the earth movement exclusion applies only to natural disasters.

*Government Employees Ins vs Dejames (1970).* The earth movement exclusion did not apply to damage caused by crushing of a foundation by the pressure of the outside earth load against it.
Bergeron vs State Farm (1967). The earth movement exclusion applied to the damage caused to a plaintiff's house by the failure of a nearby dam, even though the dam failed due to faulty construction. The damage was the "resulting loss" from the earth movement within the dam, and therefore it came within the exclusion.

Rankin vs Generali (1999). An insured's basement wall was twisted due to heavy machinery parked near the building which placed pressure on the earth abutting the basement wall. The court held that the earth movement exclusion precluded coverage.

Murray vs State Farm (1998). Several large boulders and rocks fell off a quarry's high wall and onto the houses owned by the plaintiff. Engineers determined that what occurred was a "rock fall" and not a "landslide". The courts originally decided in favor of the policyholder, but on appeal, they reversed themselves on the basis that a question still remained as to whether the loss was caused by negligence of a third party or by the excluded natural event. This case is yet to be determined.

**Water Line Access**

Most policies include a "tear out" provision that covers the cost to remove and repair portions of a home to access broken or leaking water pipes. "Risk exclusions", however, might exist concerning normal wear and tear, deterioration, inherent vice, latent defect, mechanical breakdown, settling of pavement, animals, etc. And, a special endorsement might protect the inured as follows:

*If any of these cause water damage not otherwise excluded, from a plumbing, heating, air conditioning or automatic fire protective sprinkler system or household appliance, we cover the loss caused by the water including the tearing out and replacing of any part of a building necessary to repair the system or appliance. We do not cover loss to the system or appliance from which the water escaped.*

The dispute that is sometimes raised concerns the phrase "water damage" or "building".

For instance, what if there is no actual water damage now, but it will occur if the insured flushes his toilet one more time. Is the loss of the toilet considered a physical loss caused by the water? What about a case where there is no physical damage to a building, but the insured is "losing water"? Is that "water damage"? Probably, because once the water passed through the insured's water meter, it became personal property, a covered loss.

The word "building" is a whole other issue. What if it is not necessary to tear out a wall to get to a leaking pipe, but it IS necessary to tear out a detached driveway? Now, it becomes a matter of whether the policy broadly interprets this as "building". An abutting driveway might be easier to consider part of the building. However, the cost of tearing out land is not generally regarded as a covered building tear-out. It's a gray area for sure!

Other special claims may surface where repairs must be made "solely" to protect the covered property. Covered or not? It depends on the interpretation. Again, however, additional coverage is available to cover "reasonable repairs and costs" taken "solely" to protect against further damage (HO 00 03 04 91).
Replacement Cost Holdbacks / Timely Notification

Many homeowner policies contain loss settlement **holdback provisions** stating the insurers right to pay no more than the actual cash value of the damage until actual repair or replacement is complete. Typically, the insured can recover full replacement cost after he has repaired or replaced it, provided he notifies the insurer within 180 days after the loss his intention to rebuild.

Claim disputes have developed, however, when notification was not timely. In **Lucero vs Smith** (2000), for example, the insured waited six years to notify the insured of the intention to replace his home. Keep in mind that the insurer did not require the insured to actually complete, or even start, rebuilding within the 180 day timetable. He only needed to give notice of his intention.

In another case, the insured's decision to rebuild was delayed (beyond 180 days) due to the fact that he learned he could not rebuild the house on the same lot because of local ordinances pertaining to sewerage treatment. The insurer denied the claim, but the court awarded in favor of the insured.

A time limit for actual replacement or completion of repairs is not typically specified in policies. And, when contracts are silent, the courts imposes a "reasonable time" limit. The facts and circumstances will be different for each case. However, it seems reasonable that "years" is unreasonable, while normal delays due to weather, legal issues, etc are ok.

Minor Exclusions

Watch for exclusions found in many homeowner and umbrellas regarding minors. For example, if a minor operates a boat, you may have a potential claim in waiting.

Intentional Acts

Changes are evident between older policy forms and HO 2000. There is little doubt, that this new form intended to create a **true intentional acts exclusions**. Let's look at the modification of the exclusion:

**Expected or intended injury exclusion:**

**Bodily injury or property damage which is expected or intended by an insured even if the resulting bodily injury or property damage:**

a) Is of a different kind, quality or degree than initially expected or intended; or
b) Is sustained by a different person, entity, real or personal, than initially expected or intended

This exclusion does not apply to bodily injury resulting from the use of reasonable force by an insured to protect persons or property.

In the 1991 ISO, the exclusion is for damage simply "expected or intended" by an insured. The insured original action or intent are not the guiding determination. In the 2000 form, however, the word "initially" changes the context radically. For instance, what if an insured fired a gun at a person in his living room and the bullet goes through the window and strikes a neighbor? 1999 will probably pay on the basis that the insured did not originally intended to strike a neighbor. Under ISO 2000, a single word makes a big difference. The insured clearly "expected or intended" the injury or damage -- putting a bullet into someone. But, the fact that
he is a lousy shot isn't going to make the insurer feel any better about paying the claim. It is clearly excluded in the newer policy making it a true intentional acts modification.

**HOMEOWNER CLAIMS & SETTLEMENT**

**Responsibilities of an Insured Following a Homeowner’s Loss**
When a loss is occasioned by the owner of a home or a condominium, there are a number of steps involved surrounding the responsibilities of a homeowner, including the following:

- **Notification to the carrier**—An adjuster will determine whether a claimant complied with the provisions of a policy requiring the policyholder to notify the carrier of a loss.
- **Notification to the police**—In the event a crime was committed during the occasion which gave rise to a loss, it must be determined if the police were notified. A copy of the police report may be useful evidence about the nature and extent of the loss. Under some policies, claims can be denied if law enforcement authorities were not notified.
- **Theft of credit or ATM cards**—If credit or debit cards were stolen, the issuer of such cards must be timely advised.
- **Covered property**—An adjuster will seek to determine if a claimant took steps to protect the underlying property from additional damages.
- **Records**—Records of the costs of repairs, which must be kept by a claimant, will be examined by an insurance adjuster.
- **An inventory of damaged property**—Most policies require the policyholder to prepare an inventory of damaged property, including such items as the cash value, the amount of losses, costs of repairs and a description of the property.
- **Renters**—If there are tenants living in the underlying property, and the owner secured a rider to cover renters, the policyholder must notify the carrier if the negligence of a renter contributed in any way to damages to the property.

**Investigation of a Claim Under a Homeowners Policy**
Having concluded that there were no misrepresentations or omissions on either the application for a policy or within the policy and that the policyholder complied with all of his or her requirements under the policy, a claims adjuster will review the applicable policy during the investigation stage to determine if coverage applies or it can be denied. Following are some of the more significant terms that could affect the nature and extent of insurance coverage for losses under a homeowners policy:

- **“Named Insured”**—Early in the investigative stage, a claims adjuster will review the status of the party or parties which suffered damages to real or personal property, and if such persons do not come within the definition of the “named insured,” coverage may be denied. Many policies contain a provision substantially similar to the following:
  - The provisions of this policy impose joint obligations on the person designated on the declaration page of this policy as the Insured and on the resident spouse of such person. Such persons, for purposes of this policy, are defined as "you" or "your," meaning that the responsibilities, acts and failures to act of such persons specified as "you" or "your" shall be binding on another individual specified as "you" or "your."
  - If a homeowner decided to rent a vacant bedroom to a friend and failed to take out a renter's policy, any damage to the personal property of the tenant located on the homeowner's premise would probably not be covered, since renters would not be included within the definition of "named insured."
• There may be other definitions or use of the word "insured" in a policy which may lead a claims adjuster after investigation not to recommend coverage. Some policies provide that with respect to any animals or water craft of the insured, any person or entity having custody or control of such animals or water craft is also to be considered as one of the insured only so long as that other person or entity does not use the water craft or animals in his or her business without the consent of the insured. Thus, if Ed left his pet German Shepherd, Fletcher, in the care and custody of the Canine Club, a dog kennel, while he went to Easter Island for two weeks, and the dog bit the night watchman, there might possibly be coverage under Ed’s homeowners policy, since the Canine Club would be considered as an additional insured under Ed’s policy. However, if the staff of the Canine Club sponsored a dog show for the public, using the dogs that were boarded at their facility, and Fletcher clawed an elderly man in the audience, there may be no coverage under Ed’s insurance policy.

• "Insured Location"—A typical homeowners policy contains a definition of an "insured location," which includes:
  • The "residence premises."
  • The part of other structures, grounds and premises used by the named insured as a residence and (i) which is shown in the Declarations, or (ii) which is acquired by the named insured during the period of the policy for his or her use as a residence.
  • Any premises used by the named insured in connection with premises specified under "residence premises or any part of a premises (i) which is not owned by an insured and (ii) where an insured is temporarily residing.
  • Any land owned by or rented to an insured on which a one- or two-family dwelling is being built as a residence for an insured.
  • Any part of the premises occasionally rented to an insured for other than a business use.

• "Covered Event"—An "occurrence" is typically defined as an accident or exposure to substantially the same conditions over a length of time which produces (a) "bodily injury" or (b) "property damage." An adjuster must pay particular attention to a policy to see if the accident or injury comes within the definition of "occurrence." Underlying the definition of occurrence are two other terms. "Property damage" may be defined to include a "physical injury to, destruction of or loss of use of tangible property." Tangible property means real or personal property. Some items which relate to the covered premises, such as a floor plan, have no insurable value.

• "Residence Employees"—An adjuster is reviewing a claim for medical expenses under a homeowner's policy involving a situation where the insured's maid tripped over a bottle of cleaning solution and hit her head on the edge of the wet bar. Coverage would only apply if the maid was a "residence employee" within the meaning of the policy — "an employee of an 'insured' whose duties are related to maintenance or use of the 'residence premises', including domestic services," or "one who performs similar duties elsewhere not related to the 'business' of an 'insured.' "

• "Other Structures"—If a claim is filed seeking coverage for damages to a garage, the claims adjuster must determine if the garage is within the policy definition of "other structures." Typically, "other structures" are those set apart from a dwelling by clear space, including "structures" connected to the dwelling by a fence, utility line or similar connection. In addition to a garage, other covered structures might include a pool cabana, guest house or a gazebo. The more questionable structures might involve either a heated greenhouse or an environmentally-controlled doghouse. If an insured rented his or her garage to a neighbor to park his or her car, coverage might apply, but a loft over a garage rented to a college student probably would not fall within the definition of an "other structure."

• "Personal Property"—An ordinary homeowners policy covers "personal property" owned or used by an 'insured' while it is anywhere in the world. "Personal property includes such
items as household goods, furniture, linens, drapes, clothing appliances and paintings. Policy limits on electronic apparatus and software may be limited.

- "Faulty Planning, Construction and Maintenance"—No investigation of a claim brought under a homeowners policy for damages resulting from flooding or a faulty structure would be complete without determining if such losses were due to faulty, inadequate or defective planning, zoning, development, surveying, design, specifications, workmanship, repair or materials used in repair, construction, renovation, remodeling, grading, compaction, or maintenance, since such losses are expressly excluded from coverage in most homeowners policies. If a county flood drainage ditch running behind the house of a policyholder became clogged with debris, causing flooding to the insured’s house, there would be no coverage if the county had failed to remove the debris.

**Examination Under Oath**
The standard homeowners insurance policy allows a carrier to demand an "Examination Under Oath" from a claimant. Such provision is typically as follows:

The insured...shall exhibit to any person designated by the company all that remains of the property herein described, and submit to examinations under oath by any person named by the company...and shall produce for examination all books of account, bills, invoices and other vouchers...at such reasonable time and place as may be designated by this company...

An examination under oath ordinarily is not required except in circumstances in which a carrier suspects fraud or abuse on the part of a claimant, after an investigator has uncovered suspicious circumstances such as financial difficulties on the part of an insured, a dearth of records, similar losses prior to the claimed loss at issue, domestic difficulties or onerous demands for payment or excessive coverage.

Once the procedure has been set in motion for an examination under oath, a carrier will ordinarily engage the services of an attorney to conduct the examination. A court reporter will be present for the questioning. Misrepresentations or lies on the part of the claimant can lead to perjury charges.

**Evaluation of a Claim**
Under the loss settlement provisions of a policy, valuation methods for different types of property are provided. Personal property and structures that do not constitute buildings are valued at actual cash value, and the typical basis of settlement for buildings is the replacement cost.

**Replacement Cost**
This type of coverage, found in virtually every homeowners policy, applies mainly to dwellings and other buildings or building structures with a roof and four walls. Structures attached to a dwelling, such as a patio, are also covered. A replacement cost provision requires an insured to purchase insurance coverage that amounts to at least 80 percent of the replacement cost of the property. The average homeowners policy excludes from the 80 percent calculation excavations, foundations, piers or supports below the undersurface of the lowermost basement floor or below the surface of the ground inside the foundation walls if there is no basement, as well as flues, pipes, wiring and drains that are underground.

The purpose of an 80 percent clause is to deter a policyholder from being underinsured. If an insured acquires less than 80 percent, there will only be partial coverage equaling the amount of
insurance purchased divided by 80 percent, and the result will be multiplied by the measure of
the loss to arrive at the amount of settlement. This requirement is imposed to keep the
calculation of insurance premiums uncomplicated, since premiums are based on a nonwavering
cost of $100 worth of insurance.

The expense of building homes is typically calculated on a cost per square foot and varies
according to the type of construction and the geographical area. Such cost information is
obtained from data that is constantly changing. The replacement cost of a house is a relative
issue. A policyholder is not bound by contract or by law to accept a carrier's determination of the
replacement cost of his or her property. If the insured suffers a loss and the carrier determines
that the policyholder failed to comply with the 80 percent provision, a penalty is attached to a
homeowner's claim in which the amount of the settlement will equal replacement cost less the
penalty specified in the policy or the actual cash value of the repairs, whichever is less.

**Actual Cash Value**
Conceptually, actual cash value is more difficult to determine than replacement cost. With
respect to personal property, the actual cash value is based upon replacement cost less
depreciation. As to real property, actual cash value is based on any number of factors, including
physical condition, obsolescence, age, market value and the worth of any improvements on the
property. Generally, in homeowner's policies, valuation is at actual cash value unless the policy
provides for valuation at replacement cost.

**Costs of Repairs**
Once the parties agree on the scope of the repairs to be done and have a detailed itemization of
the work to be included within the estimate, the next step is to arrive at an agreed cost for
repairs. It is customary for a carrier to use the estimate that it obtains as a basis for establishing
the cost of the repairs. Carriers always retain the right to repair the property, but invoking the
clause seldom happens because a carrier does not want to be placed in a position of having to
warrant the work of the contractor. Claims representatives frequently take an active part in
ascertaining the expense of repairs. An adjuster may obtain an estimate from a company that
does a sufficient amount of work for his or her carrier and invite the policyholder to obtain a
competitive bid. Estimates can vary depending on whether a large or small company is used, if
the contractor subscribes to workers' compensation and if the contractor's workers belong to a
union. Many carriers insist upon a licensed contractor to do the repair work.

Generally, an adjuster will select two or more contractors to make an estimation of the costs of
repairs and will advise a claimant to obtain one of his or her choosing. After repair bids are
made, an adjuster will go over the estimates with the homeowner. Frequently the bids are for
the cost of an entire job without breakdowns for the expenses relating to each item. Some
estimates are offered in the form of a "lump sum" bid, one that does not include individual items
of repair. The itemized bids are compared. Customarily, the settlement amount is the equivalent
of the lowest bid. Once an agreement is reached, an adjuster will ask the claimant to sign a
work authorization sheet. If items of personal property are found to be no longer usable, the
adjuster will total them and pay the claimant the actual cash value of such items. Items that are
damaged but are not a total loss will be adjusted and handled by a cash settlement in the
amount of the loss. Once the cost of the repair is established, a determination of the amount of
the claim is rather easy.
Valuing Personal Property
Ordinarily a policyholder establishes the cost of every item of personal property included in a homeowner’s claim. When that has been done, the claims adjuster will review the insider’s assessment and dispute items, if necessary. The final step is to determine the actual cash value amount of the claim, which in most cases is the replacement cost. Depreciation of the property is factored into the replacement cost.

Valuing Structural Damage
The evaluation of structural damage is complicated in a situation in which the extent of the damage may not become obvious until after work has begun on restoration of the damaged property. An adjuster should encourage a contractor to overbid to include the expenses of hidden damage, provided such increases are based upon his or her experiences. Adjusters involved in appraising the amount of damage to a structure of a building should be experienced in such matters. Once the adjuster authorizes the work, the responsibility for paying is that of the claimant.

If there is a dispute between the claimant and the adjuster, the claimant may demand advance payments that cannot be conditioned on the claimant’s acceptance of the carrier’s valuation of the loss. Deductions for the settlement of structural damage for "betterment" of the property on the theory that a claimant would receive a windfall because the repaired property would be left in a condition that was better than before the loss are not proper in some instances.

Extraordinary Items
If a claim involves the theft, destruction of or damage to special items such as furs, jewelry or antiques, an insurance examiner may evaluate inventories and pictures of such items for proof of existence. Police reports will be reviewed for consistency in the items reported missing or damaged. If the item of property was a gift, an examiner may interview the person who gave the gift for details about the item. Verification of the purchase through a receipt, credit card or canceled check may be considered.

Determining the Meaning of "Reasonable"
The term "reasonable," which usually appears many times in a homeowners policy, gives rise to another aspect of the evaluation of a homeowner’s claim by an insurance adjuster. In one context, a homeowners policy covers "reasonable repairs" to property damaged by an applicable peril. A carrier may pay the "reasonable costs" incurred for necessary measures taken to protect the underlying property against further damage. Reimbursement for "reasonable living expenses" may be allowed. Frequently a carrier may implement a predetermined notion of what is "reasonable" by including limitations for the amount of a covered item within the policy. In instances where "reasonable expenses or costs" are not scheduled, the criteria employed to determine what is "reasonable" may be subjective. For example, an insurance claims adjuster may conclude with "reasonable repairs" that only the lowest bid will suffice.

Evaluation Under a "Floater" Policy
Determining the value to be placed on property insured under a floater policy is usually the responsibility of a policyholder. Pursuant to the provisions of most floater policies, the amount of
insurance coverage is a ceiling on the total amount a carrier will need to pay an insured. Insurance companies frequently have the opportunity to repair the property if that factor is less than the replacement cost. The savings is not passed to the policyholder. Rarely, a floater policy specifies that valuation be based on actual cash value rather than cost of replacement. Valuation may be illusory in cases where an insurance company has a number of avenues available to replace property.

Because of the frequency of repairs and restorations, an insurer may have a number of businesses that specialize in replacing property for insurance companies, and as a result, a carrier may realize substantial discounts beyond the reach of the general public. Replacement or repair items might be purchased by a carrier at an auction. The cost of the item may be considerably less than the amount paid on settlement. This dilemma can be circumvented by the purchase of an "agreed value" policy or a "valued" contract which stipulates a value that is accepted by both the policyholder and the carrier. When a loss is sustained, that amount is paid on settlement.

Consequential Losses
Most homeowners policies provide insurance to cover physical losses. Remote or consequential losses that are not physical in nature and that were not caused by damage to tangible property are not within the limits of coverage, and, as a result, are rarely the subject of a settlement. If a policyholder’s refrigerator was destroyed by fire and the insured had to store his or her food in a neighbor’s freezer, his or her carrier would not be liable to the neighbor for storage charges, because the loss of the refrigerator is a loss of physical property, but the loss of use of it for storing food is not. Additional living expense coverage may be an indirect way of covering the loss of storage space that was provided by the refrigerator.

Settlement of Claims Under a Homeowners Policy

Replacement Cost Claims
Before a construction contract is signed, an adjuster should be certain that all of the required work is set forth in detail. The adjuster should go over the scope of the work in detail with a policyholder, making sure that the estimate describes exactly what repairs are to be completed. If both the adjuster and the policyholder are satisfied with the proposed work, the policyholder will be required to sign a document known either as a "payment assignment," "direction to pay," "payment authorization" or an "authorization to pay," which allows a carrier to designate the contractor as the named payee on the payment draft. Without such an authorization statement, a carrier cannot assign payment to the contractor, since the contract is between the carrier and the policyholder. The payment draft cannot be executed by the contractor without the co-signature of the policyholder.

When claims are settled under a replacement cost provision of a policy, if the losses exceed a minimal amount, typically several thousand dollars, a policyholder must finish the repairs before he or she can collect the entire amount of the replacement cost. An insurance company must pay the actual cash value of the repairs, and after the policyholder furnishes evidence that the repairs have been completed, the insurer must pay the balance of the settlement.

In cases where the estimate of repairs exceeds the amount of the money actually spent on the repairs, a carrier is not liable for payment of the excess amount. Generally, repairs must be made within 180 days of the date the loss was occasioned. Under replacement-cost coverage, a carrier must pay complete replacement costs on every loss under several thousand dollars
when a claim is adjusted without regard to whether repairs were completed. A policyholder in this situation cannot be compelled by his or her carrier to demonstrate the amounts actually spent on repairs.

Generally, replacement cost is the actual cost to replace ravaged property with like type that is substantially similar in function, quality and style. Replacement costs are not to be used interchangeably with "reproduction costs," since, typically, the latter is considerably higher than replacement costs. A carrier is not required to pay for work that enhances the value of the property. In a few states, damaged property does not have to be reconstructed at the same location to satisfy the carrier’s obligations.

**Disposition of a Claim Under a Floater Policy**
The amount of a settlement payable under a floater policy varies according to the classification of property covered by a policy. Settlement under a floater policy may depend on the amount of the insurance that is applicable. In other cases, disposition of a claim will depend on the market value of the property at the time of the loss of the items involved, subject to a maximum limitation. In other instances, the amount of damages recoverable by a policyholder may be limited to the lowest of either (1) the actual cash value at the time of the loss, (2) the cost of repair or restoration of the property, (3) the amount of coverage under the insurance policy or (4) the cost of replacement. If there is a "pair and set" provision in a floater policy, a carrier will have the right to replace or repair the damaged items or to pay the disparity between the remaining part of the set and the value of the complete set before the loss.

**Proof of Loss**
When a contractor has completed all the repairs and the amount of personal property losses has been determined, an adjuster will finalize the claim. Repair and reconditioning costs are added to outside living expenses, and cash allowances are made for items that could not be renovated or restored. After all items are agreed upon, a claimant will be asked to sign a "Sworn Statement in Proof of Loss," which will fulfill a part of the insurance policy. The specific amount that a carrier must pay on a claim will be shown on the proof of loss. Any payments made in advance are deducted from the total amount of settlement.

Homeowners insurance policies uniformly contain a proof of loss provision substantially in conformance with the following:

*Within___ days after the loss, unless such period of time is extended in writing by the company, the insured shall provide the company a proof of loss... stating...the time and origin of the loss, the interest of the insured and all others in the property, the actual cash value of each item thereof and the amount of loss thereto...all encumbrances, all other contracts of insurance...covering any of said property...any changes in the title, use, occupation, location, possession or exposures...since issuance of the policy, by whom and for what purposes any building...was occupied at the time of loss...and...verifiable plans and specifications of any building, fixture or machinery destroyed or damaged...*

Courts have held that if an insured fails to supply a proof of loss but supplies other documents to a carrier such as a sworn statement and other requested documentation, the claimant has met the requirements of filing a proof of loss.

In situations where a carrier and a claimant cannot agree on the amount of the loss, an adjuster may provide a claimant with a blank proof of loss, asking him or her to fill in the amount which the claimant thinks is owed. In that case, the carrier can either pay the amount claimed by the claimant, take exception to such amount or deny the claim if he or she finds the policy does not
cover the loss or damage in question. Exceptions to a proof of loss cannot be frivolous, but must be founded on a substantial basis.

**Settlement Checks**
Settlement checks are usually mailed within a week or two by the carrier. Such checks may be made payable to the claimant, the contractor or the lender that holds a mortgage on the property if the lender is named as a loss payee. A carrier does not normally have a right to include the contractor on the settlement check unless the contractor and the claimant agreed to do so. To avoid a mechanic’s lien being imposed by a contractor, a lending institution will normally insist on some arrangement with the claimant that settlement funds will be used to repair the property.

**Settlement With a Mortgagee**
If a mortgagee is named in a homeowners policy, any loss payable will be made to the named insured and to the mortgagee according to their respective interests in the damaged property. A denial of a claim made by the policyholder does not automatically mean that a claim filed in reference to the transaction by the mortgagee will automatically be denied too, provided the mortgagee has notified the carrier of any change in ownership, substantial risk or occupancy of which it is aware, pays any premium on demand that the policyholder has neglected to pay and submits a sworn statement of loss within 60 days after notification by the carrier that the policyholder failed to do so.

**Denial of a Claim Under a Homeowners Policy**
If a claim for losses under a homeowners policy is denied, an adjuster must take time to explain the reasons for such denial to a claimant. A claimant may engage the services of a public adjuster to whom he or she has given a power of attorney to pursue the claim. Arbitration may be requested through the filing of a proof of loss by the claimant. Each party to the arbitration process generally selects an appraiser. Both in turn choose an umpire. The decision of the umpire may be reviewable in a court of law. Frequently, a carrier may choose to avoid arbitration by taking the matter directly into litigation.

**Litigation**
If the settlement process fails and a policyholder intends to sue his or her carrier, there may be provisions in the insurance policy which govern when and how suit can be brought. Some policies provide that suit cannot be instigated against the carrier unless the policy provisions have been complied with and the suit is commenced within one year from the date of loss.
SECTION 9: PERSONAL UMBRELLA CLAIMS

Introduction
As the number of outlandish civil cases and awards of punitive damages increased dramatically over the past two decades, umbrella policies have gained a tremendous amount of popularity. An umbrella policy is a personal liability policy sold in units of $1 million or more as a supplement to vehicle coverage and homeowners policies and is typically suitable for a person whose assets are substantially in excess of the liability limits of either a homeowners or vehicle policy. Umbrella policies provide coverage for accidents and other situations that can give rise to personal liability when basic coverage under other policy liability provisions is not sufficient to cover losses. Insurance carriers require substantial amounts of underlying coverage for known exposure as a condition to writing an umbrella policy. Typically, such coverage also extends to other types of situations not covered by a homeowners or personal vehicle policy, such as slander, libel, false arrest, invasion of privacy, defamation of character, damage to property in the care or custody of the insured, or claims against the insured resulting from serving as an officer or director of a not-for-profit organization. Liability coverage under an umbrella policy comes after the standard liability policy limits have been exceeded.

All known substantial exposures of an insured must be covered by an umbrella policy, and each exposure must be declared and a premium shown on the declaration page before coverage will apply. Even if a type of property is covered by an underlying policy, an absence of specification in the umbrella policy will result in no excess coverage in the event of a covered loss.

UMBRELLA POLICIES

Individuals may purchase umbrella liability coverage in order to provide higher limits of liability against many personal liability risks. Just as a business is required to have some basic liability coverage, such as General Liability coverage, before being covered by an umbrella policy, individuals must have basic liability coverage, such as that found in automobile and homeowners insurance, before they can be covered by a personal umbrella liability policy.

Umbrella coverage provides excess limits of insurance over the coverage from automobile or homeowners policies. The underlying policies would be the first to be tapped should an applicable liability claim occur. Once the limits of liability are expended from the homeowners or automobile policy, the umbrella policy’s limit of liability is utilized.

Umbrella coverage also provides broader coverage than do personal automobile and homeowners policies. If a claim occurs to which an underlying policy does not apply, the umbrella policy will pay, after the deductible or self-insured retention requirements.
Exclusions to Umbrella Liability Coverage

Umbrella liability coverage generally includes the following exclusions:

- Owned or leased aircraft
- Most large watercraft
- Business use
- Professional services
- Liability to which workers compensation or similar benefits apply
- Intentional acts
- Property damage to property owned by the insured

Summary

Umbrella Liability Coverage can be an important coverage to fully protect against personal liability risks. The umbrella policy can be coordinated with existing coverages to help ensure liability risks are adequately protected against.

UMBRELLA CLAIMS

Under an umbrella policy, the ceiling on a carrier's liability for loss assessments and damages resulting from a "single occurrence" will not exceed the liability limits of the policy. The limit is fixed notwithstanding the number of claims made by an insured, assessments of losses, persons involved, vehicles involved in an accident or the number of exposures or amount of premiums included in the policy.

Umbrella coverage is applicable only on a per-occurrence basis. One occurrence includes loss assessments, bodily injury and property damage resulting from either one accident or repeated exposure to substantially the same general harmful conditions and personal injury resulting from one or a series of related offenses.

If the underlying insurer becomes insolvent or the policyholder cannot pay the deductibles on a primary policy, the policy remains applicable only to the excessive coverage. It does not become a primary carrier in that event. In the case of litigation, if an insured or a carrier providing the underlying insurance chooses not to appeal a judgment exceeding the retained limits of the umbrella policy, the umbrella carrier can do so, provided it pays the expenses of such appeal. If the last party to contribute to a loss is the umbrella policy carrier, it has the first right to recover the full amount of its payment in the event subrogation rights are applicable.
SECTION 10: BUSINESS CLAIMS

BUSINESS POLICIES

Business and commercial risk management may include the purchase of commercial and business insurance. Forms of insurance that may be purchased include property insurance, liability insurance, automobile insurance and surety and bond coverage. This chapter will briefly explain each of these forms of insurance, along with important related legal concepts.

Commercial Property Insurance

Commercial property may be insured through commercial property forms. As with other property casualty forms, Insurance Services Offices, Inc. has developed standardized commercial property insurance forms. These forms are generally issued as part of a Commercial Package Policy. Commercial property forms developed and filed by ISO include:

- Building and Personal Property Coverage Form
- Glass Coverage Form
- Builders' Risk Coverage Form
- Business Income Coverage (and Extra Expense) Form
- Business Income Coverage (Without Extra Expense) Form
- Extra Expense Coverage Form
- Legal Liability Coverage Form
- Leasehold Interest Coverage Form
- Mortgage Holder's Errors and Omissions Coverage Form
- Tobacco Sales Warehouses Coverage Form
- Condominium Association Coverage Form
- Condominium Commercial Unit Owner’s Coverage Form

Building and Personal Property Coverage Form

The most commonly used commercial property form is the Building and Personal Property Coverage Form. It provides direct damage coverage on business buildings and structures and business personal property. It does not cover buildings in the process of construction.

The Building and Personal Property Coverage Form includes three coverage parts: Building, Your Personal Property and Personal Property of Others. Under the Building coverage, the business structure described in the policy, along with permanently installed fixtures, machinery and equipment, outdoor fixtures, personal property used for maintenance of the building and materials and supplies used for additions, alterations, or repairs of the insured structure are all covered. Under the Your Personal Property coverage, furniture, fixtures, machinery and equipment, stock and all personal property owned by the insured and used for the business are
covered. Certain other personal property is also covered, such as the insured’s interest in tenant’s improvements and betterments. Under the Personal Property of Others Coverage, property that is in the care, custody and control of the insured and which is located in or on the business building as described in the policy is covered. Coverage also includes such property on the premises but not in the building or on a vehicle within one hundred feet of the insured premises.

**Builder’s Risk Coverage Form**
Buildings under construction may be covered by the Builder’s Risk Coverage Form. This insured under this form may include the building owner, the general contractor and subcontractors. The coverage applies until the building is completed and occupied.

**Glass Coverage Form**
The Building and Personal Property Coverage form covers glass that is part of the building structure, but excludes coverage for vandalism and malicious mischief. The Building and Personal Property Coverage form also has a limit of coverage for glass of $100 per plate and $500 per occurrence. The Glass Coverage Form can be utilized to provide broader coverage with higher limits. Coverage under this form includes most causes of loss other than fire, war and nuclear damage. All glass covered under this form must be listed, or scheduled, in the declarations.

**Business Income Coverage (and Extra Expense) Form**
The Business Income Coverage (and Extra Expense) Form is one that covers indirect or consequential loss. It is a form of Business Interruption Insurance. It pays for loss of income while business property is being replaced or restored due to covered property damage. The insured can choose coverage based on a fifty percent, sixty percent, seventy percent, eighty percent, ninety percent or one hundred percent coinsurance provision, using the business’ annual earnings over the one-year policy period. There is also available a one hundred twenty-five percent coinsurance option, used when reparations or restoration could take over a one-year period.

“Income” may be defined to include business income including rental value, business income excluding rental value or rental value only, depending on the type of business income to be covered and the insured’s choice. If rental value is used, it is calculated based on the anticipated rent from tenants for the insured business, less expenses that do not continue and less the rental value of any part of the insured business occupied by the insured.

Business income is determined to be the net profit that would have been earned, plus any necessary expenses that continue during the restoration period. The amount that would have been earned is calculated based on the insured’s actual experience before the loss.

**Business Income Coverage (Without Extra Expense) Form**
The Business Income Coverage (Without Extra Expense) Form provides generally the same coverage as the other Business Income Coverage Form, except that it does not cover extra expenses that arise due to the interruption of business.
Extra Expense Insurance
Extra Expense Insurance is used when a business would be able to continue operations in another facility should an insured place of business be damaged or destroyed. Extra Expense Insurance pays for additional expenses incurred by the business when other facilities must be used due to damage or destruction covered by property insurance.

The ISO Extra Expense Form provides a scheduled method of payment. Generally, the business may collect up to forty percent of the form’s coverage limit in the first month following the loss, up to eighty percent through the second month, and up to one hundred percent through the third month and following. The business has the option of choosing different schedules, such as one allowing ten percent the first month, twenty percent through the second month, and so on. The latter arrangement is likely to be used if the business expects that restoration of the destroyed or damaged property will take longer than three months.

Leasehold Interest Insurance
Leasehold Interest Insurance is used when a business has a lease that may be terminated due to fire or other damage to the leased property. Leasehold Interest Insurance would be useful for example if a business has a lease, a fire occurs, the lease is cancelled, and the business could not find similar other space for an amount equal to or less than the terminated lease. Under such circumstances, Leaseholder Interest Insurance will pay an amount, less a specified discount of five to fifteen percent, equal to the difference between the amount the insured would have paid had the original lease continued and the amount the insured must now pay. This difference is known as the leasehold interest. The insurance pays this amount based upon the period remaining in the original lease.

Important Concepts in Property Insurance
Certain concepts are fundamental in property insurance. Insurable interest, subrogation, indemnity and coinsurance are examples of concepts already discussed that are important in property insurance. A few more are detailed below:

Covered Property
Property insurance contracts carefully define which property is covered by the policy, and which property is not. Depending on the policy, property covered by the insurance may include property owned by the insured, property occupied by the insured, property rented by the insured, and property in the care, custody and control of the insured. Not all policies cover all types of property. It is important to understand the terms of the policy carefully in order to make sure the appropriate property coverage is selected to manage the specific property risks identified.

Covered Perils
Property policies also define the perils causing damage to the property that are covered. There are two general types of property policies: named or specified peril policies, and open peril policies. Under a named or specified peril policy, each covered peril is listed and defined within the policy. Under an open peril policy, the policy promises to pay for damage caused by any peril except for perils excluded from coverage.
Another type of property policy is a limited peril or limited coverage policy. Such policies cover only certain risks, such as pollution or rain.

**Excluded Perils**
War, pollution and nuclear hazards are all commonly excluded perils in property damage policies. Other policies may exclude items such as damage due to ground movement, or damage due to weight of snow, sleet and ice.

**Limits of Insurance**
Typically, the property coverage includes a limit of liability based on either actual cash value or the replacement or repair of the property.

**Reporting Form Coverage**
Some property policies require that the insured make regular reports to the insurer in order for the insurer to determine the coverage amount in force on the policy at any given time. Reporting form coverage is generally used for policies that cover inventory or merchandise that fluctuates in value over the year. Retail establishments may have more merchandise for the holidays than in late spring, for example, and therefore need higher amounts of coverage during the holidays, and lower amounts in the spring.

Reporting form coverage generally requires monthly reporting on the part of the insured, and gives the insurer the right to business records having to do with the insurance. If a report is missed, the insurer will use the last report received as the basis for calculating loss. If an insured fails to report the full value of the property insured (thereby resulting in lower premiums), the insurer will not pay any more for a loss than the value reported bears to the amount that should have been reported.

**Conditions**
The common conditions that are included in property policies include items such as:

- changes to the policy,
- fraud on the part of the insured,
- legal action against the insurer,
- subrogation,
- appraisal,
- policy period and territory,
- cancellation and renewal terms,
- assignment, and
- other insurance.

**Commercial Liability Insurance**
Liability insurance is an important tool in risk management. Financial loss due to liability has the potential to devastate a business. And, there may be no other time when the need for protection against liability litigation has been greater. Newspapers and the television news discuss high profile lawsuits almost daily. Employers, businesses, municipalities, the media, professionals, and common citizens are all targets. It appears that one can sue or be sued for
just about anything. The number of liability suits filed has grown tremendously in recent years. Liability insurance may be used to help protect businesses, individuals and professionals against financial ruin due to liability claims.

**Why Lawsuits Have Increased**

Legal observers cite several reasons for the dramatic increase in lawsuits. One of these reasons is a change in the attitude of society toward bringing a legal action against another party. Individuals today, it is said, tend to look for someone to blame, for a party to “pay for” negative circumstances that occur. The vendor must pay when a customer spills coffee and is burned because the vendor kept the coffee too hot. The employer must pay when an employee is not promoted because the employer was discriminatory or failed to notice the excellent work of the employee. The municipality must pay when an auto that veered off into a ditch is damaged because the municipality did not appropriately care for the roadway. Harm which befalls an individual is not seen as happenstance – it could have been avoided if some party had not failed to do the right thing.

Another reason pointed to for the proliferation of lawsuits is the complexity of services and products offered today. The knowledge and technology revolutions have placed some businesses in the position of being able to offer services and products which are new and innovative, but which result in unexpected ramifications. The medical and pharmaceutical industries have created products intended to provide great advances in birth control, weight loss, or as remedies for other health concerns, but have instead resulted in harming the user. Innovative manufactured products have also brought with them some unexpected outcomes, causing skin irritations, fires, toxic fumes, and other harm. Because society’s technological prowess is outpacing its ability to foresee harmful consequences, some say, an increase in litigation is not only to be expected, but is necessary in order to protect society from services and products which are insufficiently tested before being brought to market.

A third reason given for the increase in litigation is the result of increased competition in the marketplace. Professionals and businesses are under pressure to perform. They often have large customer bases, and trying to take care of so many customer needs can lead to mistakes, delays in response times, or carelessness. This lack of care or negligence results in lawsuits.

But the primary reason most experts give for the increase in lawsuits has to do with changes in the legal environment. Several important developments in the legal arena have occurred over the last few decades. These developments, discussed below, include the ability of lawyers to advertise, the amount of money to be made by litigation, the application of joint and several liability in the awarding of damages, and a shift in the application of contract law by the courts.

**Lawyers and Advertising**

Today, statutes and the legal profession allow lawyers to freely advertise their availability. Prior to the late 1970’s, lawyers were generally forbidden by the bar, and in some cases by state law, to solicit business. In 1977, however, a Supreme Court decision stated that a lawyer’s right to advertise was protected by the Constitution (Bates v. State Bar of Arizona, 97 S. Ct. 2691 (1977)). One of the outcomes of this decision is that lawyers now make it their business to inform the public of the many circumstances under which a lawsuit may be made and regularly and openly declare their willingness to assist in such matters.

**The Amount of Money in Litigation**

A criticism that is sometimes made of today’s litigation system is that the lawyers involved are able to earn significant amounts of money from it. In some cases, lawyers earn income even
when a suit is unsuccessful. This situation is believed to encourage the practice of bringing suits that do not have a sound basis, or are frivolous. Another concern is that because there is so much money to be made through litigation, some lawyers may encourage bringing suits rather than finding some other, less expensive, solution.

**Joint and Several Liability**

Joint and several liability is the practice of assigning liability for damages based on an ability to pay. For example, if a corporation or municipality is brought into a lawsuit along with an individual, and both parties are found liable, under joint and several liability rules, the corporation or municipality would likely pay the greatest amount of a damage award. Under joint and several liability rules, even if the individual was the party with the greatest fault, the corporation or municipality may pay the bulk of the damages because they are able to do so. This practice is thought to encourage bringing suits which would normally not have been undertaken because the plaintiff would have little chance of actually collecting damages. It is also thought that joint and several liability rules may encourage bringing parties into lawsuits who previously would have been excluded because their liability was negligible.

**Application of Contract Law**

The change in the legal environment which is thought to have had the biggest impact on the number of liability suits is the view courts take today regarding transactions based on a contract. Up until this century, courts would rarely overrule the terms of a contract if the contract was legal and both parties had agreed to the terms of the contract freely. If both parties had agreed to the terms of a legal contract, liability laws, which apply when a wrong is committed against another party, would not apply. The legal phrase in Latin that was applied to this concept was *volenti non fit injuria* – “to one who is willing, no wrong is done.” If there is no wrong, there is no legal liability. Under traditional contract law, it does not matter whether the consumer or the vendor might suffer harm. If both had agreed to the contract, both parties must stick to the agreement.

As insurance agents know, a contract must follow certain rules in order to be legal: it must have two or more competent parties, a legal subject matter, consideration and assent by the parties. Agents are also taught that the written contract is assumed to include all oral agreements – if something is not written into the contract, unless fraud or misrepresentation is present, courts will uphold the terms of the written contract and exclude or ignore prior oral agreements or negotiations (*the parol evidence rule*).

Recently, liability courts have begun to listen to arguments involving oral negotiations and oral promises and, in some cases, have held parties liable for words spoken, even if a legal contract exists which would in the past have exonerated the parties. (This is one reason agents are often required today by the employer to use a specific telephone script or to follow a specific sales track or use a memorized answer regarding certain policy features. The employer is trying to limit exposure to lawsuits due to the communication of oral information that contradicts a written contract.) Since liability courts will now listen to suits related to oral negotiations prior to a contract which would have traditionally been under the jurisdiction and remedy of contract law, more liability suits occur.

Another change in the legal environment related to contract law has to do with the premise of consent of the parties involved in a contract. As mentioned, it was commonly held that if both parties consented to a legal contract, neither party could be charged with a wrong in a liability court. Contract law would apply. However, some liability courts now hear cases involving
contracts if it can be successfully argued that a party did not consent because they did not know what they were consenting to. In today’s complex climate, contractual transactions can involve complicated clauses concerning items the average consumer knows little about. Courts have sympathy for the consumer, and may award damages against a business due to harm to the consumer resulting from a product sold or service done, even if no violation of contract occurred.

One of the outcomes of this point of view is the creation of the legal concept that some contracts are contracts of adhesion. A contract of adhesion is one where one party creates the terms of the contract, and the other party adheres to them. There is no real negotiation process, it is believed, under a contract of adhesion. Many business transactions are based on contracts of adhesion – one does not normally negotiate the terms of a furnace warranty, or the purchase of an airline ticket, or the price of a mail-order doll. An insurance policy is an example of a contract of adhesion. Since it is so deemed, a court of law is freer to dismiss certain clauses, provisions and terms in a policy if it feels they are damaging to the purchaser than if the contract were considered a negotiated one. Because of the concept of contracts of adhesion, liability courts now hear many cases which previously were under the jurisdiction of contract law.

**Liability and the Law**

Because liability insurance is so important today, the legal concepts applied to liability are important to understand. Liability insurance provisions spring from statutes relating to legal liability and from insurance contract law.

**Common Law**

Common law relies strongly on past court decisions, or precedents. Centuries ago in England, all law was based on the customs and traditions of the local people. When rule in England became united under Norman kings, judges appointed by the king would go from shire to shire to hold court and administer local law. Over time, the rulings of these judges built on and replaced popular customs. As the rulings made by these judges were used and modified by other judges, these judgments were applied throughout the land, resulting in common law.

The United States, as a former colony of Great Britain, generally adopted common law as the basis for civil law in most states. (The State of Louisiana is the only exception, its French roots resulting in the application of the Code Napoleon in the formation of its civil laws.) Common law is developed based on previous court rulings. Once a court makes a decision, other courts can use the decision and the arguments behind it when ruling on cases they hear. Because of this, common law is rooted in tradition and past decisions and yet can change and evolve over time.

**Tort Law**

Common law governs the remedies for tortious acts. A tort is an act that is committed by one party who causes injury or damage to another party or to another’s property. The difference between an act that is a tort and one that is a crime is that a tort is a private wrong against a party or property, and a crime violates a public right. It is possible for an act to be both a tort and a crime, and therefore for the guilty party to be required to pay damages under tort law and also be punished under criminal laws.

A tort is not a breach of contract. Contract law provides the remedy for acts that are considered to be a breach of contract. As has been mentioned, in recent years, some acts that were traditionally the subject of contract law have become the subject of tort law. A tort is remedied by an action for damages. A plaintiff brings suit against the tortfeasor – the party who is alleged
to have committed the tort. The tortfeasor is the defendant in the suit. The plaintiff seeks to be awarded damages, an amount of money, for the injury or damage caused by the defendant.

Torts may be either against a person or against property. Personal torts are actions such as false arrest, false imprisonment, malicious prosecution, assault, battery, libel, slander, or other forms of defamation. Property torts include the unauthorized use and assumption of control of another’s property, unlawful entry on another’s land (trespass), unreasonable and improper use by an individual of his or her own property that causes damage to the adjoining property (nuisance), and any act of negligence that causes damage to the property of others.

In order for a defendant to be required to pay damages, he or she must be found legally liable for the damages. Liability is generally based on establishing negligence on the part of the alleged tortfeasor. However, courts also award damages on the basis of absolute liability, strict liability, and imputed or vicarious liability. Before these other forms of liability are examined, negligence will be discussed.

**Negligence**

Negligence is the failure to use due and reasonable care. The standards for determining what reasonable and due care are can vary based on the tort and the parties involved. For example, professionals are generally held to a high standard of care by the courts. Many professionals are in a position of trust – they may be responsible for a customer’s financial, health, housing, or family welfare. If those within a profession are generally expected to be expert, capable, thorough and competent, a court hearing a case against such a professional will judge that conduct that is less than expert, capable, thorough, or competent, as less than reasonable and due care. A non-professional involved in a negligence case may have less stringent standards applied when a court is determining whether negligence exists. In order to establish the presence of negligence, four elements must exist:

- A legal duty to act or to not act;
- A breach of duty;
- Proximate cause between the breach of duty and the damage or injury; and
- Actual loss or damage.

**Legal Duty**

The law recognizes various duties owed. There is a legal duty to protect one another’s rights and property. Reasonable and due care is another legal duty owed.

**Breach of Legal Duty**

Besides establishing that a legal duty is owed, a breach of that duty must be found in order for negligence to be present.

**Proximate Cause**

To establish negligence, there must be proximate cause between the breach of duty and damage and injury. Proximate cause is the legal doctrine that states that the breach of duty must launch an unbroken chain of events that results in the damage or injury in order for liability to be found.

**Damage or Injury**

A court must find that actual damage or injury occurred. A breach of legal duty may occur that does not cause harm. A fiduciary may make an unreasonable financial decision, but that decision may result in greater net worth for a customer. In such a situation, a court might
determine that the fiduciary should be removed, but because no loss occurred, the maximum damages awarded may be expenses related to replacing the fiduciary.

**Defenses Against Negligence**
The courts recognize several different defenses against a claim of negligence. These include intervening cause, last clear chance, contributory negligence, comparative negligence, and assumption of risk.

**Intervening Cause**
Intervening cause is used to defend a case of negligence by eliminating the necessary element of proximate cause. An intervening cause breaks the chain of events leading to the injury or damage. If an intervening cause creates a new chain of events that led to the injury or damage, proximate cause between the breach of duty and the damage may not exist, and therefore, negligence may not exist.

**Last Clear Chance**
Another defense against negligence argues that the plaintiff had the last clear chance, or the final opportunity, to avoid the loss or damage. The plaintiff’s failure to act, it is argued, caused the loss or damage, not the breach of duty on the part of the defendant.

**Contributory Negligence**
Contributory negligence was once a defense used in most states. It has been replaced in most of them by the concept of comparative negligence, but a few jurisdictions still recognize this defense. Under contributory negligence, if the plaintiff is found to have in any way contributed to the damage or loss, no damage award will be made.

**Comparative Negligence**
Comparative negligence rules weigh the proportionate amounts of negligence contributed by all parties in the damage suit. If the plaintiff is found to have contributed to the damage or injury, damages are not dismissed. Instead, the award to the plaintiff is reduced by the amount of his or her own responsibility for the loss.

**Assumption of Risk**
Under the assumption of risk defense, the defendant must prove that the plaintiff understood the risks involved, including the possibility of the damage and injury in question, and yet allowed the act to occur. Under such a scenario, the plaintiff is said to have assumed the risk of the activity, and so cannot hold another liable for resulting harm.

**Liability Without Negligence**
As mentioned, there are forms of liability recognized by the courts without the necessity of establishing negligence in the manner discussed above. A court may award damages based on absolute, strict or imputed liability.

**Absolute Liability**
Negligence does not have to be proven when an activity is considered indisputably hazardous. A party conducting an indisputably hazardous activity is considered to have absolute liability for any damage or injury that arises from the activity. Examples of indisputably hazardous activities are keeping wild animals or handling dangerous materials.
**Strict Liability**

Strict liability is a term first used by the courts in 1962. In that year, the California Supreme Court found a power tool manufacturer strictly liable for an injury caused by a piece of wood that flew out of the tool and hit the operator in the head (Greenman v. Yuba Power Products, Inc., 59 Cal. 2d 57, 27 Cal Rptr. 697, 377 P 2d 897 (1963)). Strict liability was applied because a defect in the product was found to have allowed the piece of wood to fly out of the machine. This inaugurated the precedent that a product defect that causes damage or injury can establish liability without requiring negligence on the part of the manufacturer.

**Imputed or Vicarious Liability**

Imputed or vicarious liability occurs when another party is held responsible for a negligent party’s actions. Employers are generally held to be liable for the actions of their employees under the concept of imputed liability.

**Types of Damages Awarded in Liability Suits**

If the defendant is found to be legally liable, the court will require the defendant to pay damages to the plaintiff. These damages can include compensatory or actual damages, general damages, nominal damages, and punitive damages.

**Compensatory Damages**

Compensatory or actual damages are moneys paid to compensate for the financial loss for which the defendant is liable. These are also sometimes referred to as special damages.

**General Damages**

General damages are charged to the defendant to pay for a loss or injury that is a direct consequence of the tort committed, but not for financial loss. An example of general damages is an award for pain and suffering.

**Nominal Damages**

Nominal damages may be charged in a situation where loss or injury was negligible. They are small awards made in order to show that the liable party was responsible.

**Punitive Damages**

As the name suggests, punitive damages are awarded in order to punish the liable party. They are generally awarded if the court determines the responsible party acted in a malicious, vicious, or willful manner. Besides punishing the liable party, punitive damages also may have the purpose of acting as a deterrent to others, making an example of the defendant, or to teach the defendant a lesson.

**Protection Provided**

Liability insurance is available to provide protection against various types of liability. Besides payment to parties to which the insured is deemed legally liable, the insurer will also defend the insured and pay defense costs. The insurer may also settle claims outside of court on behalf of the insured.
Coverages and Exclusions in Liability Insurance

Negligence
All liability policies cover some forms of negligence in the course of rendering services. They do not cover criminal negligence, however, because criminal acts cannot be covered by insurance contracts.

Strict Liability
Strict liability may be covered by liability policies. Strict liability is a form of liability arising from product defect. It is not considered criminal liability.

Imputed Liability
Imputed liability is covered in employer liability insurance forms and in some professional liability forms where the insured has risks as an employer. A business owners policy form, the Employment-Related Practices form, is also available for this type of coverage. General Liability forms provide some employer liability coverage, although liability for bodily injury and liability that is covered by Workers Compensation laws are excluded.

Legal Obligation for Damages
Liability policies pay only amounts to which the insurance applies and that the insured is legally obligated to pay. This obligation is determined through a court, or, under most policies, the insurer may settle a claim and establish outside a court of law the amount that the insured must pay.

Claims Expenses
Liability insurance also covers expenses related to liability claims such as defense expenses, payment of bail bonds and bonds to release attachments, loss of earnings, and interest on any judgment amount. These expenses all arise from the liability claim and are considered within the scope of the coverage. In some cases, these expense are paid in addition to damages paid under the policy and are included as supplementary payments.

Damages
Liability insurance may cover compensatory or actual damages, nominal damages, general damages and possibly even punitive damages up to the limits of liability in the policy. If the policy does not cover certain types of damages, these damages will be listed as an exclusion within the policy terms.

In some cases, punitive damages may not be covered even if they are not specifically excluded in the contract. The reason for this is that the basis for punitive damages may be fraud, malice (which is by definition a willful act) or the commission of certain criminal acts. Insurance policies will not pay benefits for any act which is fraudulent, willful or criminal.

In certain states, punitive damages can be awarded without the plaintiff establishing fraudulent, willful or criminal conduct on the part of the defendant. If punitive damages are awarded in such a state and the damages are not based on fraud, nor on a willful or criminal act, the insurer may pay them (up to the limits of the insurance and as long as the policy does not specifically exclude coverage of punitive damages). However, in states that require that fraud, malice or the commission of a criminal act be present in order for punitive damages to be applied, punitive damages would not be paid by the insurer, even if the policy terms do not specifically exclude punitive damages.
In some cases, courts have excluded punitive damages from insurance coverage because punitive damages are not for the benefit of the third party. They are awarded to punish the defendant. Since liability insurance is purchased for the benefit of the third party victim, and premiums are paid in order to compensate that victim, having insurers pay for them is against the purpose of the insurance. And, some courts have determined, if insurers are required to pay for punitive damages, premiums will rise for all, in effect causing innocent insureds to take the punishment for the guilty defendant.

Punitive damages, then, may or may not be covered by a policy. If a client has questions regarding whether punitive damages are covered, the insurance company’s legal department may be the best place to find an answer. However, there may not be a definitive answer until a claim is decided by a court of law.

**Intentional Wrongs**

Under the law, insurance is considered an instrument intended to pay for loss which is *fortuitous*, or beyond the control of the insured. Therefore, generally, intentional wrongs are not covered by any insurance policy. However, in some cases, intentional acts are covered by liability insurance. For example, an insured dentist may intentionally remove a tooth from the mouth of a patient because she thought it was the correct tooth, when in fact she was mistaken. Or, an insured doctor may prescribe medicine intentionally, but make an error in doing so because the patient has an allergy to the medication. Wrongs such as these which are intentional but are also mistakes are generally covered by Professional Liability and Errors and Omissions insurance. In order to be excluded from coverage under these policies, courts generally have to find an *intent to cause harm*. Intent to act is not alone sufficient reason to exclude a wrong from coverage.

**Types of Liability Forms**

There are three broad types of liability forms for businesses and professionals, other than automobile liability forms: General Liability, Businessowners Liability and Professional Liability or Errors and Omissions forms.

**Commercial General Liability Forms**

Commercial General Liability forms cover bodily injury and property damage liability, personal and advertising injury liability and medical expenses incurred for bodily injury caused by an accident on or by the premises owned or rented by the insured, or that arise from the insured’s operations. The form does not cover injury to employees of the firm. Such coverage is generally provided through Workers’ Compensation.

The definitions of bodily injury, property damage, personal injury and advertising injury provide an explanation of the coverage provided:

**Bodily Injury**


**Property Damage**

Under this same form, property damage means physical injury to tangible property, including all resulting loss of use of that property. Property damage also means loss of use of tangible property that is not physically injured.
**Personal Injury**

Personal injury is defined in this form as injury, other than bodily injury, that arises out of one or more of the following:

- False arrest, detention or imprisonment;
- Malicious prosecution;
- Wrongful eviction from, wrongful entry into, or invasion of the right of private occupancy of a room, dwelling or premises that a person occupies by or on behalf of its owner, landlord or lessor;
- Oral or written publication of material that slanders or libels a person or organization or that disparages a person’s or organization’s goods, products or services; or
- Oral or written publication of material that violates a person’s right of privacy.

**Advertising Injury**

Advertising injury is defined in the Commercial General Liability form as injury arising out of one or more of the following offenses:

- Oral or written publication of material that slanders or libels a person or organization or disparages a person’s or organization’s goods, products or services;
- Oral or written publication of material that violates a person’s right of privacy;
- Misappropriation of advertising ideas or style of doing business; or
- infringement of copyright, title or slogan.

Notice that none of these injury definitions deal with economic damage.

**Claims Made and Occurrence Based Forms**

Liability policies, including the Commercial General Liability form, are offered as either “claims made” or “occurrence-based” policies. These two terms refer to the conditions under which a policy will pay a claim, or what “triggers” the payment of benefits under the policy.

**Occurrence-Based Policies**

Under an occurrence-based policy, in order for the coverage to apply, the injury or damage must occur during the policy period. As long as the policy applies to the injury or damage, if the injury or damage occurs during the policy period, the policy will pay, even if the claim is made after the policy period ends.

Liability policies at one time were commonly occurrence-based policies. However, not only have lawsuits become more prevalent since that time, resulting in more claims, but the subject of lawsuits has become more often about damage or injury that occurred years ago. Courts ruled that even though damage and injury occurred years ago, if damage was only just discovered, the occurrence-based insurance policies that were in force when the injury was discovered provided coverage. The increase in lawsuits and the fact that current occurrence based policies had to cover risks from years ago made occurrence-based policies very expensive to purchase.

**Claims-Made Policies**

Because of this, most liability policies issued today are claims made policies. Under a claims-made policy, both the damage or injury and the claim must be made during the policy period. Claims-made policies help limit the insurer’s exposure to injury and damage that occurred in the
distant past because the claim must also be made during the policy period. An insurer has a fair degree of certainty that claims to which the coverage applies will be known while the policy is in force. The insurer can then review the risk annually and make premium adjustments based on the experience of the risk over the coverage year.

Claims-made policies can have provisions for expanding the coverage period. They can be written with a **retroactive date** and/or an **extended reporting period**, or ERP.

A retroactive date, typically a date no more than six months before the policy inception date, moves the policy coverage to that earlier date. Injury or damage that occurs before the retroactive date is not covered. Any injury or damage that occurs from the retroactive date until the policy coverage ends is covered, assuming the claim is made during the policy period. The retroactive date is sometimes referred to as a **nose**.

An ERP extends the amount of time under which a claim may be made. ERPs may include two coverages: a relatively short **mini tail** and a longer **midi tail**. The mini tail provides an extended period of time, for example sixty days, to report claims that arise out of covered injury or damage that had not been reported during the policy period. The mini tail, which may be for a period of up to five years, gives an additional period to make claims that arise out of an occurrence that was reported during the policy period or during the mini tail period. ERPs may also provide just one tail coverage – one period of time to report claims for injury or damage that occurred during the policy period.

A Supplemental ERP can be purchased for some insurance that provides an unlimited period of time to report claims for an occurrence reported during the policy period. This is known as **full tail coverage**. There are two ways to purchase full tail coverage. One way is known as a pre-paid tail. The charge for the tail is part of the annual premiums paid. The other way is to purchase the coverage purchases at the end of the policy period. Such coverage must normally be purchased while the policy is in force or within a limited time frame after the policy period ends. The price of full tail coverage varies. Generally, however, the cost of a tail is from 175% to 250% of the last premium. The cost is higher for a tail because the likelihood of a claim is greater as time goes on. A benefit of many claims made policies is free full tail coverage upon death, permanent disability or permanent retirement.

Retroactive dates and extended reporting periods are generally purchased in order to remove any gaps in coverage when one policy replaces another. An ERP provides coverage on a policy which will be replaced if the new claims made coverage has an inception date or retroactive date later than the prior coverage’s policy period ends. A retroactive date provides coverage from the new policy to cover the gap if the old policy ends prior to the new policy’s inception date.

**Exclusions from Commercial General Liability Coverage**

Commercial General Liability Coverage forms include several exclusions. As with all liability insurance, expected or intended injury is not covered. As discussed earlier, intentional loss is never covered by insurance. Also excluded is liability assumed under a contract, unless the contract is an insured contract. An insured contract includes leases, sidetrack agreements, easement agreements, and agreements and contracts of the insured’s business whereunder the insured assumes tort liability of another.

Also excluded from the Commercial General Liability Coverage form is Liquor Liability. Liquor liability is liability arising from an insured who is in the business of manufacturing, distributing, selling, serving or furnishing alcoholic beverages which arises from causing or contributing to
the intoxication of any person, the furnishing of alcoholic beverages to a person under the legal drinking age or under the influence of alcohol, or based on any statute, ordinance or regulation relating to the sale, gift, distribution or use of alcoholic beverages.

**Liquor Liability Coverage Forms**

However, Liquor Liability Coverage forms are available. These forms are for businesses that manufacture, distribute, sell, serve or furnish alcoholic beverages. Liquor liability coverage is available under both an occurrence and claims-made basis. The Liquor Liability Coverage forms available through ISO can be included in a Commercial Package Policy that includes commercial general liability.

Under the Liquor Liability Coverage forms, insurance is provided for damages for injury if the liability results from the insured selling, serving or furnishing any alcoholic beverage. “Injury” as defined under the coverage includes bodily injury, property damage, and damages for care, loss of services or loss of support. If the coverage is occurrence-based, the injury must occur during the policy period. If the policy is claims-made based, the claim must be first made against the insured during the policy period, as long as the injury does not occur before the retroactive date or after the policy period ends.

The exclusions to the Liquor Liability Coverage Forms include:

- Expected or intended injury
- Obligations arising out of acting as an employer
- Injury arising out of selling, servicing or furnishing alcoholic beverage when a required license is suspended
- Injury arising out of the insured’s product causing the poisoning of an individual (product liability)

**Workers Compensation, Employers Liability and Pollution**

Also excluded from the Commercial General Liability Form is any loss payable under any workers compensation, disability benefits, or unemployment compensation law. Employers Liability is also excluded from the Commercial General Liability Form, as is pollution. Both Employers Liability and Pollution Coverage forms are available.

**Employers Liability**

Employers liability insurance protects an employer against claims arising out of acts of an employee while acting within the employee’s scope of duties. Employer’s liability is sometimes also called *vicarious liability* when used to describe coverage under a liability form. Vicarious liability actually encompasses the insured’s liability for acts of any other party, not just for employees. Under some forms, employer’s liability for bodily injury to an employee while in the employ of the insured and carrying out duties related to the conduct of the insured’s business is excluded. Other forms include such coverage. Employers liability or vicarious liability is based on the legal principle of *Respondeat Superior*. This principle is based on the idea that the employer, or under the original principle, the “Master,” is responsible for damages arising out of the actions of the employee, or under older laws, the “Servant.” Under this principle, if injury or damage arises out of the employee’s scope of duties, the employer is generally liable. This is the case even if an employee seeks to conceal damage or injury or the actions leading up to such damage or injury from the employer, because the employer should have oversight processes in place.
Pollution Liability

One way that pollution coverage may be provided is through the Pollution Liability Extension Endorsement. This endorsement modifies the Commercial General Liability form by deleting the portion of the policy that states that “bodily injury” or “property damage” is excluded which arises out of the actual, alleged, or threatened discharge, dispersal, seepage, migration, release or escape of pollutants:

- at or from any location which at any time was owned or occupied or rented or loaned to any insured, unless the “bodily injury” or “property damage” arises out of heat, smoke or fumes from a hostile fire;
- at or from any location which at any time was used by or for any insured for the handling, storage, disposal, processing or treatment of waste;
- which at any time were handled, transported, stored, treated, disposed of, or processed as waste by or for any insured or those for whom the insured is legally responsible unless “bodily injury” or “property damage” arises out of the escape of fuels, lubricants or other operating fluids which are needed to perform the normal electrical, hydraulic or mechanical functions necessary for the operation of “mobile equipment.” However, if the fuels, lubricants, or other operating fluids are intentionally discharged, dispersed or released, or if such fuels, lubricants, or other operating fluids are brought to the location with the intent to be discharged, dispersed or released as part of the operations being performed by the insured, a contractor or subcontracts, any resultant damages are not covered unless the “bodily injury” or “property damage” arises out of heat, smoke or fumes from a hostile fire;
- at or from any location on which any insured or contractors or subcontractors working for the insured if the pollutants are brought on or to the premises, site or location by the insured or contractors or subcontractors working for the insured, or if the operations are to test for, monitor, clean up, remove, contain, treat, detoxify or neutralize, or to respond to, or assess the effects of pollution in any way.

By deleting these provisions from the Commercial General Liability form, the insured is provided coverage in these areas.

Besides the endorsement, forms such as the Pollution Liability Coverage Form, the Limited Pollution Liability Coverage Form and the Pollution Liability Coverage Form for Designated Sites may be used.

Other Exclusions

Besides these exclusions, the Commercial General Liability Form excludes:

- liability arising out of ownership, maintenance, use or entrustment to others of aircraft, motor vehicles and watercraft owned, operated by, or rented or loaned to any insured
- liability arising from mobile equipment, such as bulldozers, farm machinery, forklifts and other vehicles not used on public roads, while transported by an auto, or when being used in any racing, speed or demolition contest, or while practicing for such a contest
- liability arising from war if liability for war is assumed under a contract
- damage to property owned by, rented to, or, if personal property, in the care, custody or control of the insured
- damage to premises sold, given away or abandoned, unless the premises are the insured’s “work”
- property damage to the particular part of real property on which the insured or subcontractor is working, and to property that must be restored, repaired or replaced because of work incorrectly performed on it

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• property damage to the insured’s product that arises from the product
• property damage to the insured’s work arising out of it or any part of it and included in the “products-completed operations hazard” unless the damaged work or the work out of which the damage arises was performed on the insured’s behalf by a subcontractor.
• property damage to “impaired property” or property that has not been physically injured, due to a defect, deficiency, inadequacy or dangerous condition in the insured’s product or work, or due to a delay or failure by the insured or anyone acting on the insured’s behalf to perform a contract or agreement in accordance with the contract’s terms.
• damages claimed for any loss, cost or expense incurred by the insured or others for the loss of use, withdrawal, recall, inspection, repair, replacement, adjustment, removal or disposal of the insured’s product, work or of impaired property if the product, work, or property is recalled because of a known or suspected defect, deficiency, inadequacy or dangerous condition.

**Businessowners Liability Form**

The Businessowners Liability form includes the same coverages as the Commercial General Liability form, and defines them very similarly. This form also does not recognize coverage for economic damages. Businessowners forms are issued only to certain types of businesses. Eligibility may vary by state, but generally includes:

• Office buildings that are no more than six stories high and no more than 100,000 square feet. These office buildings may include apartments and certain wholesale, service or processing occupancies that do not exceed 15,000 total square feet.
• Apartment buildings and residential condominium associations. These buildings may include offices and certain wholesale, mercantile, service or processing “incidental” occupancies.
• Other buildings that are no more than 15,000 square feet that are occupied primarily for certain wholesale, mercantile, service or processing uses.

Certain wholesale and retail services businesses also are eligible for coverage under the Businessowners policy. Eligible wholesale businesses include:

• auto parts and supplies distributors;
• baked goods wholesalers;
• barber or beauty shop supplies distributors;
• coin, stamp or rare book distributors;
• drug distributors;
• fabric distributors;
• fruit and vegetable distributors;
• grocery distributors;
• hardware and tool distributors;
• hearing aid distributors;
• janitorial supplies distributors;
• optical goods distributors;
• toy distributors; and
• other wholesalers and distributors.

Service businesses able to purchase businessowners policies include:

• bakeries;
• barber shops;
• beauty parlors;
• dental laboratories;
• funeral homes or chapels;
• laundries and dry-cleaners;
• photocopy shops;
• printers;
• tailors and dressmakers;
• television or radio repair shops;
• watch, clock and jewelry repair shops; and
• similar small service businesses.

Both the Commercial General Liability and Businessowners Liability forms can be endorsed to add other liability coverages. Businessowners Liability forms can be endorsed to extend pollution liability coverage, covered tenants liability and many other types of liability coverage, similarly to the endorsements that may be added to the Commercial General Liability Form.

**Professional Liability and Errors and Omissions Forms**

The third type of liability insurance is Errors and Omissions and Professional Liability. This is the only type of liability form that meets the special liability needs of professionals.

Each professional liability form includes definitions and terms that are related specifically to the occupation of the professional insured. For example, the form may define *professional services* to mean "the services for which the insured is licensed, trained and qualified to perform in the insured's capacity as a [name of occupation]." The definition of the *named insured* will also typically refer to the specific occupation being covered, e.g. a lawyer's professional liability form might declare that "named insured means the lawyer named in the declarations."

**Consent of the Insured**

The terms Professional Liability and Errors and Omissions (E&O) are often used interchangeably to discuss liability insurance for professionals. There is a slight difference between the technical definitions of Professional Liability and E&O insurance, however. Under the strict definition of E&O insurance, an E&O's contract’s provisions must state that the insurer is not required to have the insured’s consent in order to settle a claim. Under a strictly defined professional liability insurance contract the insurer would have to have the insured’s consent in order to settle any claim. In every other way, the two types of insurance are virtually indistinguishable from one another. The distinction regarding the insured’s consent is not generally recognized by insurers today; many, if not most, “professional liability” policies allow the insurer to settle a claim without the insured’s consent. (Because the two terms are commonly used interchangeably within the industry today, and because many policies, whether called Professional Liability or Errors & Omissions, allow the insurer to settle without the insured's consent, this course also uses either term to describe insurance that covers the liability risks of professionals.)

Some policy forms give the insurer the right to remove itself from a claim if the insured will not accept a settlement to which the insurer and the plaintiff both agree. In such a situation, the insured will likely continue to defend himself or herself against the claim, but the insurer will pay no more to the insured once a damage award is set or a new settlement is agreed to than the settlement amount which the insurer had originally offered. This provision basically allows the insurer to change the limit of liability from the limits in the policy to the amount offered to settle the claim in question. Such a provision does give the insured a way to block the insurer from
settling a claim without his or her consent and includes protection for the insurer because the insurer can limit its liability payments related to the claim.

**Damages**

Professional liability forms generally pay “damages” which the insured is legally obligated to pay because of a claim. Damages under a General Liability form includes damages arising from bodily injury, personal injury, advertising injury and property damage. The definition of damages under an E&O policy is broader and generally means monetary amounts for which the insured is legally liable, and includes amounts paid as judgments, awards or settlements.

**Other Injury**

If a professional liability form does not include a broad definition of damages, it will generally include a broad definition of injury in order to cover professional liability risks. General liability forms specifically cover liability for certain harms that are defined in the policy. These are bodily injury, property damage, personal injury and advertising injury. E&O forms that are based on general liability policies, or which are used as endorsements to general liability policies cover these four harms and cover liability for other injury that arises out of the rendering or failure to render professional services.

**Occurrence**

The definition of “occurrence” in a General Liability form is normally similar to the following: an accident, including continuous or repeated exposure to substantially the same general harmful conditions. Under a professional liability form, any act or omission arising out of the rendering or failure to render professional services is included in the definition of occurrence.

**Premises Liability**

Regarding property damage, the General Liability forms exclude liability for property damage arising out of property owned, rented or occupied by the insured, out of premises sold, given away or abandoned by the insured, out of property loaned to the insured, out of personal property in the care, custody or control of the insured, out of the part of real property on which the insured or any contractor or subcontractor working on the insured’s behalf or out of part of any property that must be restored, repaired or replaced because the insured’s “work” was incorrectly performed on it. Many professional liability forms do not exclude any of these forms of property damage, or offer it at an additional charge since a possible area of liability for a professional can occur when a customer is harmed on the insured’s property, or on property the insured is occupying. This type of property damage liability coverage is known as premise liability.

**Employee Liability**

Bodily injury or personal injury that arises out of an employee’s failure to provide professional services is excluded under General Liability forms. Under an E&O form, bodily injury, personal injury, property damage, advertising injury or other injury is covered that arises out of an employee’s rendering or failing to render professional services in connection with the insured’s business.

**Employment Practices Liability**

Most professional liability forms exclude employment practices liability such as liability that arises out of actual or alleged termination or discrimination. In order to be covered for such liability the professional must purchase additional employment practices liability coverage.
**Contractual Liability**
Most contractual liability is excluded from liability forms for professionals. However, contractual liability protection can generally be added to coverage for additional premium.

**License Protection Coverage**
Some coverages of E&O insurance are applicable only to certain occupations. For example, some professionals are responsible to a board or commission that oversees the professional’s actions. For example, a securities representative may be responsible to the SEC or the NASD. A doctor may be responsible to a medical board. A lawyer may be responsible to a state bar association. These professionals may be subject to discipline from these entities. Within professional liability forms for professions such as these, definitions related to disciplinary proceedings or hearings will be included. Some policies provide *license protection* or *licensing board coverage* that includes reimbursement for expenses related to such disciplinary hearings, including defense expenses. In order for licensing board coverages to apply, the insured is generally required to notify the insurer in writing about the proceeding and to provide documentation of all expenses. The licensing board coverage may be indemnity coverage, meaning that the insured must pay the defense costs and be reimbursed by the insurer.

**Why Professionals Need Special Liability Insurance**
Professionals have unique concerns and issues related to liability exposure. The services performed by professionals are considered very significant to their customers. The customer’s finances, health, housing, or other items of critical importance can be seriously impacted by a professional’s work. If a money manager fails to purchase a new investment on a timely basis, if an accountant overlooks an important tax due, if a real estate agent does not submit a timely bid, the customer can suffer financial loss. If a doctor does not prescribe the right medication, if an engineer miscalculates the amount of stress a structure can bear, or if an architect is ignorant of an important municipal code, the customer can suffer both monetary harm and general loss. A mistake made by a professional that causes damage or injury to a customer can, of course, lead to a lawsuit. Because of the vital nature of services provided by professionals and the potentially serious consequences of an error or omission, they need liability insurance protection.

**State Regulation**
Another reason professionals may need liability insurance is that they may be required by state regulations to carry such coverage. Those who practice medicine are normally required to carry liability insurance in order to carry a state medical license. In many states, directors and officers of charitable organizations must carry liability coverage. Government entities may require that professionals doing business with them carry liability insurance. For example, in Florida, anyone providing legal, architectural, engineering or any other professional services must carry an amount of liability insurance determined by the state department for whom services are performed. Specific business owners may be required to carry liability insurance as well. Oregon recently established a rule that new Tavern Owners and those who offer liquor at public events must carry $300,000 of liquor liability insurance.

**Customer Requirements**
Professionals may also be required to carry liability insurance by non-government customers or contractors who use their services. Businesses may require professionals who are working on an independent contractor basis to carry liability insurance. Contractors may require subcontractors to carry liability insurance. Consumer groups often advise individuals who plan...
to hire professionals, whether architects, lawyers or plumbers, to engage only those who have liability insurance.

**Professional Association Requirements**
Some professional associations encourage or require their members to purchase liability insurance. If the association is a legal entity, e.g. a group of dentists, lawyers or accountants who establish a partnership, the firm may require each member to carry liability insurance.

**High Standard of Care**
Generally, occupations which require a specific degree or accreditation and a license in order to practice are viewed as professional occupations. As mentioned, professionals are expected by the courts and the general public to exercise the greatest care, diligence, judgment and skill in their work because the services they provide are often critical to the welfare of those for whom they are provided. Because of this high standard of care and the critical nature of work done, liability suits are a significant risk for professionals, making liability insurance coverage a prudent purchase. Because a mistake can cause significant harm to a customer, damage awards against a professional can be very high. Without insurance, a professional’s business could be financially ruined.

**Fiduciary Responsibilities**
If the professional is a fiduciary, such as a lawyer, accountant, trustee, real estate broker, retirement plan administrator, or money manager, special liability concerns apply. Fiduciaries are in positions of trust. They must act in the best interests of the client at all times. The law expects the fiduciary to fulfill six specific duties, regardless of the type of occupation the fiduciary is in. These are loyalty, obedience, disclosure, confidentiality, reasonable care and diligence, and accounting.

**Liability Insurance for a Group**
Professional insurance may be issued to a legally formed group, such as a corporation or a partnership of doctors, lawyers or other professionals. There are provisions in such policies that are not necessarily applicable to individual policies.

**Severability**
Severability means that each insured under the policy has his or her own liability limits. If several lawyers are covered under a policy with severability of limits, for example, and the policy has a five million per occurrence and twenty million total liability limits, each lawyer would be covered for $5 million / $20 million in liability.

**Conditions for Coverage**
In some cases, legal group coverage applies only if all members of the group carry their own individual liability policies as well. For example, a policy covering a partnership of doctors may require that each doctor carry malpractice insurance. If so, the policy issued to the group will normally apply as excess insurance over each doctor’s own policy.
Premiums
Premiums for a legal group are generally calculated based on the number of professionals, independent contractors and staff to be covered by the policy. A policy may require that additional premium be paid immediately if an additional insured is added during the policy period. Other policies calculate the extra premium required at the end of the policy period.

Umbrella Liability Insurance and Excess Policies
Umbrella liability insurance is purchased to provide additional, high limit insurance that applies to liability for damages that arise from a suit or claim. These liability policies are called “umbrella liability policies” because they provide broad coverage that encompasses many forms of liability and provide additional insurance over other insurance policies the insured owns.

In order to purchase an umbrella liability policy, the insured must already have General Liability insurance. The insurer may also require other forms of liability insurance as well, such as automobile liability insurance. The requirements for underlying coverages depend upon the coverages the umbrella liability policy provides. This requirement is known as required underlying limits. The reason for this requirement is that umbrella insurance is structured to pay for damages as excess over underlying policies. Premiums are calculated and provisions written based on this assumption.

Umbrella policies generally include some coverage that is not found in underlying policies. For such coverage, the insured is required to pay for damages up to a certain amount, for example $100,000, before the umbrella insurance will pay. This practice of requiring the insured to pay for damages related to coverages not provided by underlying policies is called self-insured retention. Self-insured retention acts as a sort of deductible on the policy.

Excess policies are similar to umbrella liability policies, but do not generally provide broader coverage than the underlying liability policies. Excess policies that offer additional coverage for the same kind of coverage as the underlying policy or policies are called following form policies. Since a following form policy does not provide any coverage not found in the underlying policy, no self-insured retention requirement is involved. Excess policies are also available which do not require underlying insurance, but include other insurance provisions that apply the coverage as excess over any other applicable coverage the insured owns.

Two types of payment clauses are found in umbrella liability policies. One is an indemnity clause which states that the insurer will reimburse or indemnify the insured for amounts which the insured becomes legally liable to pay or which are assumed under contract. The other is a pay on behalf clause which states that the insurer will make direct payment on behalf of the insured for amounts which the insured becomes legally liable to pay or which are assumed under contract.

An umbrella policy or excess insurance policy can be an excellent complement to a professional liability policy if the professional is subject to high damage awards, or to a general liability policy if a business is subject to risks beyond that which will be covered by a general liability form. Purchasing an umbrella or excess policy can be less expensive than purchasing a general liability or professional liability policy with a high liability limit.

Insurability Under Liability Forms
Liability insurance is different from other forms of insurance because the ability to forecast frequency and severity of claims is difficult. Life insurance issuers can use mortality tables along with health risk factors to establish insurability and premium charges. Property insurers
have statistics regarding fires and other perils they can base their rates upon. Automobile property damage insurance relies on accident statistics by make and model of automobile to help establish rates. Liability risks are much more difficult to plot on a graph or include in a calculation. They do not establish a frequency distribution pattern like the other types of risks mentioned.

In order to determine insurability, liability underwriters look at three basic issues: (1) whether the applicant has a prior history of claims, (2) whether the applicant has a prior history of applicable licensing board, state regulatory body or industry association complaints or other disciplinary actions and (3) whether the applicant has ever been cancelled or been denied coverage. Coverage will not necessarily be denied if any of these factors are found to exist, but premium rates may be increased or exclusions added to the policy. Whether or not coverage is denied or premiums are increased depends upon the circumstances surrounding the complaint, claim or coverage denial. A complaint regarding the late filing of taxes will be less significant to an insurer than would a complaint to a state regulatory body regarding fraud.

**Responses To the Risks of Liability Claims**

Liability suits and claims seem an ever-present risk for the business or professional. However, some liability risks can be reduced, and perhaps even prevented. The best ways to reduce these risks include raising the awareness of business staff of the key liability risks of the business, providing education and training in these areas, establishing and following procedures aimed at reducing liability claims, incorporating an unincorporated business to protect the business owners from losing personally owned assets, using contracts to limit liability, and purchasing liability insurance to reduce the financial consequences of liability claims.

**Raising The Awareness of Key Liability Issues**

Each business has different key liability issues related to that business. If the people within the business are not aware of these issues, he or she may be able to get information about them from professional associations, from lawyers who specialize in liability issues, or from liability insurers. By being aware of the items the courts are focusing on, activities in the business can be identified that could put the business at risk for claims or suits in these areas.

**Education and Training**

Many businesses have employees who need education and training on what activities or actions can put the professional's business at risk. Each member of a firm or business should have sufficient training to be able to competently perform assigned duties. Time put into training can seem to a small businessperson to be a drag on productivity and an unnecessary expense. However, a well-trained staff can be well worth the investment not only because of the satisfied clientele it helps to develop, but also because of the liability exposures that are eliminated or reduced solely due to competence.

In some professions, certain positions should be filled by licensed personnel. Again, if a license is not a legal requirement, a business owner may feel equipping staff in this manner is expensive and unnecessary. However, the pre-licensing training and continuing education that come with many licenses can provide liability protection for the professional employer.
Establishing and Following Procedures
Some procedures are critical to a business. Certain disclosures may have to be signed prior to taking on a customer. In some businesses, it is illegal to describe certain services or products in certain ways. For example, in the insurance profession, only certain policies can be referred to as "Medgap" policies, one cannot discuss a state guaranty association except under very limited conditions, and anyone selling annuities has to disclose that the annuity is not FDIC insured. In the securities industry, risks associated with any product must be disclosed and a prospectus must be provided to each purchaser. Every professional outside of a lawyer or tax professional is forbidden to give tax advice. To reduce liability claims it is important that the businessperson and those working with him follow the required procedures of his or her job. One of the best ways to make this happen is to establish procedures, train all staff on them, document them in a procedural manual, and verify that they are followed. By doing so, liability related to omitting such procedures may be avoided or reduced.

Billing disputes are a common subject of claims or suits. Billing disputes can be significantly reduced if procedures are established and followed. Business owners sometimes like to leave the accounting side of an operation to someone else, preferring to concentrate on the services the business provides. But the business owner or key executive is the one responsible for the liability risk, not the secretary who mails the bills, so the owner or executive should take the time to ensure proper billing procedures are in place. All types of billing situations should be contemplated: Will the business allow payments over time? What amount of penalties should be charged for late payments? How often should reminder notices be sent? When will a payment be considered so delinquent that it must be turned over to a collections agency? What amounts will be written off as uncollectible? All these questions should be considered, procedures developed and consistently applied. Additionally, customers should be required to sign a statement indicating their understanding of their responsibility to pay for services and goods, and the signed statement should be kept on file. Should a dispute occurs, the court will want to see that all customers are subject to the same billing rules, and that consistent documentation is kept.

Keeping Good Records
Keeping complete records of all services rendered to customers is important in virtually all businesses. Manufacturers, wholesalers, insurance agents, securities brokers, lawyers, accountants, doctors, dentists, psychologists, bankers and hair stylists all need to keep some form of client records to ensure they are providing appropriate services.

There are many important considerations regarding record keeping. First of all, consistency in record keeping is important. Using standardized forms and following the same steps in dealing with customers in similar matters helps if a liability case must be defended. Following consistent, thorough procedures and documenting them in files can demonstrate to a court that a reasonable standard of care has been met.

Records must also be kept in a safe place. Confidentiality of customer information is also a requirement in most professions and a consideration in the location of customer files. Another issue to consider is access. If too many staff members have access to the records unnecessarily, important documents may be lost or misplaced. Records should also be stored in fire proof cabinets. If the records are kept on electronic media, a back-up procedure should be established and followed.

Whenever a change is made to a document, the date of the change should be noted. If the change is of any significance, the reason for the change should also be noted.
Some professions, such as insurance agents and securities brokers, are subject to regulations regarding the types of records which must be kept, the number of years they must be kept, and where the records must be located (e.g. at a branch location or at the home office). Any professional subject to such rules should ensure that he or she has a complete understanding of these rules and that they are consistently followed.

**Incorporating the Business**

Another method of reducing the financial effects of a liability claim or lawsuit is to consider incorporating a business that is not yet incorporated. A corporation is liable for its activities, and only the assets of the corporation can be the subject of a lawsuit based on those activities. The personal assets of the corporation founder or an employee of the corporation cannot generally be targeted in a lawsuit based on the activities of the corporation. On the other hand, if a business is not incorporated, the owner’s assets and possibly those of his or her spouse, can be at risk should a lawsuit be filed. Incorporating can protect a business owner from the financial devastation a lawsuit can bring.

**Using A Well-Worded Contract**

Another method for reducing liability is through the use of a well-worded contract. As mentioned, the tort courts have expanded their activity regarding contracts in recent decades, but a well worded contract is still the best protection against costly disputes. The majority of court decisions still honor the provisions of a legal contract. By clearly stating the services to be provided, including the scope, duration and all fees involved, the business can protect itself from most disputes regarding these matters.

Contract provisions which should be included in order to avoid disputes include provisions which provide:

- clear payment terms,
- a dispute-resolution method,
- indemnification terms, and
- a detailed scope of services.

**Using Contractual Liability Limits**

Certain businesses can include clauses in their contracts to limit certain types of liability. For example, a financial planner can use a contract with her customers that states that liability will be determined only on the basis of gross negligence or bad faith. Such language makes it more difficult for claims to be made which are not based on serious errors or omissions on the part of the business.

**Performing Due Diligence**

Due diligence is particularly important when a business is operated by a professional, such as a doctor, lawyer or financial advisor. A professional should practice due diligence whenever a professional relationship is contemplated. For example, an insurance agent should investigate the financial condition of an insurer prior to placing business with the insurer. A financial planner or stockbroker should investigate investments thoroughly before recommending them to clients. An accountant, lawyer or doctor should investigate the backgrounds of other professionals who seek to join a practice. The status of licenses should be checked if the
profession is one in which a license is required. Licensing boards can generally provide information regarding any disciplinary orders or complaints. References should be thoroughly checked on any employee who will join a professional’s business.

**Purchasing Liability Insurance**

Even if a business takes the aforementioned steps to reduce exposure to liability claims, lawsuits can still occur. Negligence, errors or omissions happen because the people making up a business are human. They can make mistakes.

Even if a mistake is not made, an unhappy customer can decide to file a suit. Being found error free does not mean that a lawsuit will not bring financial loss. A business can be found to be not liable and yet still undergo great expenses in defending a suit.

Purchasing insurance protection as a response to the risk of liability claims means that the insurer will pay for the damage award for suits to which the insurance applies. The insurer will also pay the expenses involved in defending the insured against the claim, up to the limits of the insurance. The business owner or risk manager that buys liability coverage has the security that should a lawsuit occur, the business will be able to afford the costs the lawsuit inevitably brings.

Liability insurance is used to reduce loss exposures related to the risk that a claim for damages will be brought by a third party against the insured. These loss exposures include the possibility of loss due to investigating, negotiating, settling, defending and paying damages to the party bringing the suit. Anytime a claim or suit is brought, expenses related to these activities are likely to occur. Liability insurance pays for these expenses, up to the limits of the coverage.

Liability insurance provides coverage against the risk that a lawsuit will be brought against the insured. Generally, the coverage protects against liability for acts resulting from the insured’s negligence, but types of liability that do not require the presence of negligence, such as strict and imputed liability, may be covered. The basic types of liability forms available for businesses and business owners are commercial general liability forms, business owners liability forms and professional liability forms.

**Commercial Auto Insurance**

Commercial auto insurance protects a business against property damage risks and liability risks associated with automobiles. Commercial automobile insurance is generally provided on the Business Auto Coverage Form. This form includes Liability Coverage and Physical Damage Coverage for autos defined as covered under the policy. The policy includes several different categories of covered auto, and the policy declarations must state which category is used. These categories are numbered and are as follows:

- **Symbol 1**: Any “Auto.”
- **Symbol 2**: Owned “Autos” Only.
- **Symbol 3**: Owned Private Passenger “Autos” Only.
- **Symbol 4**: Owned “Autos” Other Than Private Passenger “Autos” Only.
- **Symbol 5**: Owned “Autos” Subject to No-Fault.
- **Symbol 6**: Owned “Autos” Subject to a Compulsory Uninsured Motorists Law.
- **Symbol 7**: Specifically Described “Autos.”
- **Symbol 8**: Hired “Autos” Only.
Symbol 9: Non-owned “Autos” Only.

Liability Coverage
Under the Liability Coverage, the insurer will cover amounts an insured must pay as damages because of covered bodily injury or property damage caused by an accident and resulting from the ownership, maintenance or use of a covered auto. The insurer also pays all sums an insured legally must pay as a covered pollution cost or expense that is caused by an accident and resulting from the ownership, maintenance or use of covered autos. The insured will only pay for the covered pollution cost or expense if there is covered bodily injury or property that is caused by the same accident.

Insureds
Under the Liability Coverage insureds are defined as: The person named in the declarations for any covered auto. Anyone else while using with the insured's permission, a covered auto owned, hired or borrowed by the insured, except:

- The owner or anyone else from whom the insured hires or borrows a covered auto, unless the covered auto is a trailer connected to a covered auto the insured owns.
- The employee if the covered auto is owned by that employee or a member of his or her household.
- Someone using a covered auto while he or she is working in a business selling, servicing, repairing, parking or storing autos, unless the business is the insured’s business.
- Anyone other than the insured’s employees, partners, members, or a lessee or borrower or any of their employees, while moving property to or from a covered auto.
- A partner or member for a covered auto owned that person or a member of his or her household.
- Anyone liable for the conduct of an insured as described above, but only to the extent of that liability.

Supplementary Payments
The Liability Coverage also includes payment in addition to the stated limit of insurance of the policy for the following items:

- All expenses incurred by the insurer.
- Up to $2000 for cost of bail bonds, including bonds for relating traffic law violations, that are required because of an accident.
- The cost of bonds, within the limits of insurance, to release attachments in any suit against the insured that the insurer defended.
- All reasonable expenses incurred by the insured at the insurer’s request, including actual loss of earnings of up to $250 a day because of time off from work.
- All costs taxed in any suit against the insured that the insurer defends.
- All interest on the full amount of any judgment that accrues after entry of the judgment in any suit against the insured the insurer defends.

Out-of-State Coverage Extensions
When a covered auto is away from the state where it is licensed, the insurer will increase Liability Coverage limits in order to meet limits specified by any applicable compulsory or financial responsibility law in the jurisdiction where the auto is being used, other than laws regulating motor carriers of passenger or property.
The insurer will also provide the minimum amounts of no-fault coverage, required coverage or out-of-state vehicles coverage applicable in the jurisdiction where the covered auto is being used.

**Liability Coverage Exclusions**
The Liability Coverage has thirteen exclusions:

- Expected or intended Injury
- Contractual liability
- Workers’ Compensation
- Employee Indemnification and Employer's Liability
- Bodily injury to a Fellow Employee
- Property damage to property owned or transported by the insured or in the insured’s care, custody or control, unless liability is assumed under a sidetrack agreement
- Covered pollution cost or expense involving property owned or transported by the insured or in the insured’s care, custody or control, unless liability is assumed under a sidetrack agreement
- Bodily injury or property damage arising from the handling of property
- Bodily injury or property damage arising from the movement of property by a mechanical device
- Bodily injury or property damage arising out of the operation of mobile equipment
- Bodily injury or property damage arising out of the insured’s work after the work has been completed or abandoned
- Bodily injury or property damage arising out of pollutants
- Bodily injury or property damage due to war
- Autos used in any professional or organized racing or demolition contest or stunting activity, or while practicing for such a contest or activity
- Physical Damage Coverage
- The Physical Damage Coverage may provide Comprehensive Coverage, Specified Causes of Loss Coverage and Collision Coverage.

**Comprehensive Coverage**
Under Comprehensive Coverage, the insurer pays for loss to a covered auto or its equipment under the Comprehensive Coverage from any cause except the covered auto's collision with another object or the covered auto’s overturn.

**Specified Causes of Loss Coverage**
Under the Specified Causes of Loss Coverage, the insurer pays for loss to a covered auto or its equipment caused by:

- Fire, lightning or explosion;
- Theft;
- Windstorm, hail or earthquake;
- Flood;
- Mischief or vandalism; or
- The sinking, burning, collision or derailment of any conveyance transporting the covered auto.

**Collision Coverage**
Under the Collision Coverage, the insurer pays for loss to a covered auto or its equipment under the covered auto’s collision with another object, or the covered auto’s overturn.
**Other Coverage**
The Physical Damage coverage also includes towing and labor costs when a covered private passenger auto is disabled. If Comprehensive Coverage is purchased, the policy will also pay for glass breakage, loss caused by hitting a bird or animal, and loss caused by falling objects.

Under a coverage extension, the physical damage coverage pays for certain transportation expenses, such as temporary transportation expenses due to theft of a covered private passenger type, up to $15 per day to a $450 maximum.

**Exclusions**
The Physical Damage Coverage excludes physical damage due to:

- Nuclear Hazard
- War or Military Action
- Racing or Demolition Use
- Wear and Tear

**Conditions**
Conditions under the Business Auto Policy include:

**Appraisal**--If the insured and insurer disagree on a loss amount, either party may demand an appraisal. Each party selects an appraiser and the appraisers select an umpire. Each appraiser will appraise the loss, and if the appraisers disagree, their differences are submitted to the umpire. Once any of the three, the appraisers or umpire, agree, the loss, if the insurer accepts the claim itself, will be valued based upon their agreement.

**Duties in the Event of Accident, Claim, Suit or Loss**-- The insured has several duties in the event of an accident, claim, suit or loss. For example, the insured must provide the insurer with prompt notice of the accident or loss along with required details about the incident.

**Legal Action Against Us**-- The insurer may not have an action brought against it until there has been full compliance with the contract.

**Loss Payment -- Physical Damage Coverages**-- The insurer has the option to pay for, repair or replace damaged or stolen property, return the property and pay for covered damages, or take all or any part of the damaged or stolen property and pay an agreed to or appraised value.

**Transfer of Rights of Recovery Against Others to Us**-- This is the subrogation condition and allows the insurer to recover damages from a responsible party for payments made on behalf of the insured.

**Bankruptcy**-- Bankruptcy or insolvency on the part of the insured does not relieve the insurer of its responsibilities under the policy. Bankruptcy generally relieves an insured of debts. Under bankruptcy rules, an insured would therefore not be responsible for damages awarded under a lawsuit. However, several years ago many state legislatures decided that a liability insurer should pay harmed third parties even if an insured declared bankruptcy. State legislatures felt the third party should be able to collect damages and believed that since the insurance was paid for, the insurer should pay regardless of the bankruptcy. As more and more states adopted such legislation, insurers began making this bankruptcy condition a part of their liability policies, and today this clause is standard.
**Concealment, Misrepresentation or Fraud**-- Any insurance policy is void if the insured commits fraud in relation to the coverage, or intentionally conceals or misrepresents material facts in relation to the coverage.

**Liberalization**-- If the policy form is revised to provide more coverage without requiring additional premium, the additional coverages will apply to the policy.

No Benefit for Bailee – Physical Damage Coverages: The Physical Damage coverage does not apply to any assignment, or grant any coverage for, the benefit of any person or organization holding, storing or transporting property for a fee regardless of any other provision of the Coverage Form.

**Premium Audit**-- the initial premium for the policy is assessed on an estimated basis. At the end of the policy period, the final premium is calculated based on the actual exposures of the insured's business as it relates to the coverage. If the insured owes more premium, the insured will be billed for it, and if the insured is due a refund based on the final premium calculation, the insured will be paid the refund.

**Policy Period, Coverage Territory**-- This condition states that the insurance applies to accidents and losses occurring during the policy period and within the coverage territory.

**Other Automobile Coverage Forms**

Besides the Business Auto Policy, other forms are available to protect against risks associated with automobiles and other motor vehicles. We will provide a brief overview of the Garage Coverage Form, the Garagekeepers Coverage Form, and the Truckers Coverage Form.

**Garage Coverage Form**

The Garage Coverage form is used for businesses such as car dealerships, gas stations and parking garages, that garage cars, and are excluded under the Business Auto Policy. Risks included in this form that are excluded by the Business Auto Policy are those excluding liability for and property damage to property in the insured’s care, custody or control. The Garage Coverage Form provides liability and physical damage coverage.

The Garage Coverage Form includes four sections:

- Section I - Covered Autos
- Section II - Garage Liability
- Section III - Garagekeepers Coverage
- Section IV - Physical Damage Coverage

**Covered Autos**

Like the Business Auto Policy, covered autos are defined according to a number listed in the declarations page. Covered auto categories are as follows:

- **Symbol 21**: Any Auto.
- **Symbol 22**: Owned Autos Only.
- **Symbol 23**: Owned Private Passenger Autos Only.
- **Symbol 24**: Owned Autos Other Than Private Passenger Autos Only.
- **Symbol 25**: Owned Autos Subject to No-Fault.
- **Symbol 26**: Owned Autos Subject To A Compulsory Uninsured Motorists Law.
Symbol 27: Specifically Described Autos.
Symbol 28: Hired Autos Only.
Symbol 29: Non-owned Autos Only.
Symbol 30: Autos Left With The Insured.
Symbol 31: Dealers Autos and Autos Held For Sale.

Garage Liability
The Garage Liability coverage pays for liability arising out of garage operations. Garage operations are defined as the ownership, maintenance and use of covered autos and locations of the garage business, and include all operations necessary or incidental to a garage business and the use of that portion of roads or other accesses that adjoin the business locations.

Who Is An Insured
Under the Garage Liability insurance, an “insured” for the purposes of any of the covered auto coverage is the named insured and anyone who uses a covered auto with the permission of the insured. Excluded from the definition of insured is generally:

- an owner of the borrowed or hired auto;
- anyone who uses a covered auto while working in an automobile or garage business which is not the insured’s business; and
- an employee who uses an auto owned by the employee or a family member of the employee.

Garage Liability Exclusions
Exclusions under the Garage Liability form include:

- damage to property in the insured’s care, custody or control;
- bodily injury to any fellow employee
- workers’ compensation, disability benefits or unemployment compensation law or any similar law
- bodily injury or property damage due to pollution; and
- covered autos used in any professional or organized racing or demolition contest or stunting activity, or while practicing for such a contest or activity
- loss of use to property not physically damaged if the loss of use is the result of a delay or failure of the insured or anyone acting on the insured’s behalf to fulfill the terms of a contract or agreement, or as a result of a defect or deficiency in the insured’s product or work performed.
- damages that are due to products or work withdrawn or recalled from the market.

Garagekeepers Coverage
The Garagekeepers Coverage provides liability coverage for property in the care, custody or control of the insured. Another form of Garagekeepers Coverage called Direct Damage Garagekeepers Coverage is available. Direct Damage Garagekeepers Coverage pays for physical damage to property of others in the insured’s custody.

There are three forms of Garagekeepers Coverage available: Comprehensive, Specified Causes of Loss, and Collision. Under Comprehensive coverage, liability for loss other than
collision is covered. Under Collision coverage liability for loss due to collision or another object or the covered vehicle’s overturn is covered. Under the Specified Causes of Loss coverage liability for loss due to specified losses including fire, lightning, explosion, theft, mischief or vandalism is covered.

**Garagekeepers Coverage Exclusions**

Exclusions under the Garagekeepers Coverage include:

- Theft
- Faulty work or defective parts
- Tape decks and sound equipment

**Physical Damage Coverage**

The Physical Damage Coverage provides three types of coverages: Comprehensive Coverage, Specified Causes of Loss Coverage and Collision Coverage.

Optional coverage under the Physical Damage Coverage for towing pays for towing and labor expenses performed at the place of disablement, if a covered vehicle is disabled. Glass breakage may also be covered under the Physical Damage or under the Comprehensive Coverage. Loss that is caused by hitting a bird, by falling objects or missiles may be covered under Comprehensive Coverage.

**Truckers Coverage Form**

Truckers who hire themselves out to transport goods may be covered by the Truckers Coverage form. This form provides liability and physical damage coverage and may be used in conjunction with the Business Auto Policy Form, or as a stand alone policy. The policy includes the following Sections:

- Section I - Covered Autos
- Section II - Truckers Liability Coverage
- Section III - Trailer Interchange Coverage
- Section IV - Physical Damage Coverage

The covered autos under a Truckers Coverage Form are also defined and designated by numerical symbols, as other commercial automobile forms do. The categories for covered autos under this form are as follows:

Symbol 41: Any Auto  
Symbol 42: Owned Autos Only.  
Symbol 43: Owned Commercial Autos Only  
Symbol 44: Owned Autos Subject to No-Fault.  
Symbol 45: Owned Autos Subject To A Compulsory Uninsured Motorists Law.  
Symbol 46: Specifically Described Autos  
Symbol 47: Hired Autos Only.  
Symbol 48: Trailers In The Insured’s Possession.  
Symbol 49: Trailers in the Possession of Anyone Else.  
Symbol 50: Non-Owned Autos Only.
**Truckers Liability Coverage**

The Truckers Liability Coverage pays for damages due to bodily injury or property damage caused by an accident and arising from the ownership, maintenance or use of a covered auto for which the insured is legally responsible. It also pays for defense of any suit asking for such damages as long as they are covered by the policy.

**Insured**

Under the Truckers Liability Coverage, an insured is the named insured for any auto. Also included as an insured is anyone else who uses a covered auto owned by the insured with the insured’s permission, except for owners of private passenger type autos. Excluded from the definition of an insured is:

- anyone liable for the conduct of an insured;
- anyone who uses a covered auto while he or she is working in a business of selling, servicing, repairing or parking autos except if such business is the business of the insured;
- anyone, other than the insured's employees, partners or lessee or borrower an employee of a partner, lessee or borrower, while moving property to or from a covered auto; and
- a partner of the insured for a private passenger auto that is owned by the partner or by a member of the partner’s household.

**Truckers Liability Coverage Exclusions**

Exclusions from the liability coverage include the following:

- Expected or intended injury
- Contractual Liability
- Loss payable under Workers’ Compensation or similar law
- Employer liability
- Bodily injury to a fellow employee
- Bodily injury or property damage arising from the handling of property
- Bodily injury or property damage arising out of the insured’s completed work
- Bodily injury or property damage due to most pollutants
- Bodily injury or property damage due to war

**Trailer Interchange Coverage**

The Trailer Interchange Coverage provides insurance for the truck while in the possession of the trucker who borrowed or hired it. The three types of coverage available under this form are Comprehensive, Specified Causes of Loss and Collision. Under the Comprehensive Coverage, the policy pays for loss to a covered auto from any cause except collision with another object or the auto’s overturn. Under the Specified Causes of Loss Coverage, the policy pays for loss to a covered auto or its equipment caused by:

- Fire, lightning or explosion;
- Theft;
- Windstorm, hail or earthquake;
- Flood;
- Mischief or vandalism; or
- The sinking, burning, collision or derailment of any conveyance transporting the covered auto.
Finally under the Collision Coverage, the insurer will pay for loss to an auto or its equipment due to the auto’s collision with another object, or the auto’s overturn.

**Physical Damage Coverage**
Under the Physical Damage Coverage of the Truckers Coverage Form, the insurer pays for loss due to physical damage. Optional coverage for towing and related labor expenses is available under this form. Temporary transportation expenses incurred by the insured because of the theft of an auto are covered under either Comprehensive or Specified Causes of Loss Coverage.

**Physical Damage Coverage Exclusions**
The physical damage coverage includes many of the exclusions found in other forms of automobile coverage, including:

- Nuclear Hazard
- War or Military Action
- Racing or Demolition Use
- Wear and Tear
- Electronic Devices

Another exclusion under this form is the loss of an auto placed in the possession of another person under a written trailer interchange agreement.

**Summary**
There are several types of insurance that may be used for risks found in the commercial, business and professional arena. Property forms may be used to cover most risks of damage, destruction or theft of property. Liability forms may be used to protect against risk of financial loss due to many kinds of legal liability. Automobile policies protect against both property and liability risks associated with autos and other motor vehicles. A clear understanding of commercial insurance forms is essential for the agent working in the risk management arena to support and assist business customers in determining the best insurance plans for their risk management needs.

**SPECIAL BUSINESS COVERAGE ISSUES**

**Outbuildings**
A lot of commercial / industrial owners have dotted their properties with small sheds and storage buildings. Some have even advised their agents to remove these buildings from their schedule in order to reduce premiums since the perceived value is less than the deductible.

Clients should be made aware the cumulative loss of many of these buildings, however, can be substantial. Also, even though these buildings may have little or modest insurable value, the business property stored in them can be significant. Remember, under ISO forms, business personal property is only covered while in a described building or in the open within 100 feet of the premises. Also, don't forget the uncovered cost of "debris removal" if the buildings are leveled or burned.
Independent Contractors
Many businesses use independent contractors. While the business owner is not liable for the actions of the independent contractor, third parties can sue the owner or make claim on the basis that the work created a dangerous situation, defective tools or equipment were supplied or that the contractor was negligently hired or supervised. In essence, anyone can sue!

To protect themselves, owners can require a hold harmless from the contractor, depend on the limits to their policy, be named as additional insured under the contractors CGL or require the contractor to provide an Owners and Contractors Protective policy.

Autos and Business income
Many businesses depend on their auto fleets to such an extent that when one is damaged it can be a threat to business income. In general, most commercial property forms exclude damage to business autos but do they cover the loss of income?

Most business income coverage is triggered by direct damage to property:

*We will pay for actual loss of business income you sustain due to the necessary suspension of your "operations" . . . The suspension must be caused by direct physical loss of or damage to property.*

Therefore, it appears that any resulting business income loss resulting in a suspension of operations would be covered. Of course, damage would have to be a result of a covered peril.

Triple Net Leases
Your clients sign leases to ret space for their business everyday. Many are "triple net" (NNN) agreements that make them responsible for heating, air conditioning, plumbing, carpeting, glass, water heaters, sinks, toilets, etc., included with the space. In the event of a major loss, the typical NNN lease includes a Damage and Destruction clause that makes the Landlord only responsible to rebuild the facility to an unfinished floor. This leaves your Tenant client responsible for damage to the occupied space. The average Business Owners Policy, however, covers personal property and "real property acquired or made at your expense". This leaves a considerable "claim gap". In addition, consideration should be given for business income and extra expense exposures such as boiler and machinery coverages.

Uncovered claims for these exposures can be significant when you consider total losses in a major high-rise or factory. Heating and air conditioning systems alone can amount to six figures.

It is important that agents identify the extent of these risks and suggest adding a building component for the leased space and its fixturing. Here, all risks are clearly identified and assessed.

Leased Property Claims
Clients who lease a large amount of equipment for their business, like a restaurant, are typically responsible to the lessor to bear the entire risk of equipment destruction and/or replacement.
Further, lease agreements typically require that the leasee provide insurance in the amount not less than the full replacement value of the equipment.

The problem is that a lot of ISO Business Policy forms get down to covering leased equipment ("property of others") at actual cash value, versus personal property owned by the business at replacement cost. So, in loss situations, the adjuster is offering ACV for damaged lease equipment, but the insured argues that his equipment lease is actually a "conditional sale" because at the end of the lease he is entitled to purchase it for $1 and the IRS views it as a "capital lease" for tax purposes. He wants replacement cost applied.

The solution? Unfortunately, there is no endorsement in older ISO BOP forms. The newer CP2000, however, has added a "Replacement Cost on Personal Property of Others" option. Even here, there is some tricky language that can result in something less than full replacement cost. In essence, your client tenants need to be aware of this situation.

**Boiler and Machinery**

There are certain ambiguities in many policies that create claim disputes. A typical Boiler and Machinery policy, for example, excludes:

Sewer piping, underground vessels or piping, any piping forming a part of a sprinkler system or water piping other than: Boiler feed water piping; Boiler condensate return piping; or Water piping forming a part of refrigerating or air conditioning system; . . .

A recent claim involved the underground air conditioning water pipes that cracked. The adjuster declined the claim even though the wording above seems to want to cover "piping forming a part of air conditioning systems". Had the class of coverage words . . ."Sewer piping, underground vessels, any piping forming . . . " been properly punctuated, say with semi-colons, they would be clear to be distinct classes resulting in less policy ambiguity.

This is yet another special issue to uncover and disclaim to your clients. Your assurance that it would be "covered" could place "you" in the role as insurer.

**Third Party Claims Exposure**

CGL policies generally exclude claims arising out of employment-related injuries. These are best left to workers' comp and employers liability forms.

However, there are certain cases where a third-party, like an employee, can file a claim that is excluded or partially excluded by all forms, leaving your client exposed. Take for example a case where a machine in your client's warehouse injures an employee. If he is severely injured, he will likely receive workers' compensation which also precludes him from suing his employer (your client). However, the WC policy does not cover liability claims and the state he resides in allows third-party claims. So, the employee sues the equipment manufacturer for $1 million. The manufacturer now sues the employer (your client) citing an indemnity agreement and negligent supervision. Your client's EL coverage cites an exclusion for indemnity agreements and the CGL cites a contractual liability exclusion.

**New "Long-Tail" Exposures**

The CGL form is under revision to clarify previous policy period damage. In essence, injury or damage known about prior to the policy period will not be covered in the current policy period. The change is in direct response to recent court decisions that have expanded the definition of
"occurrence". These decisions have created so-called "long-tail" liability exposures for incidents that happened months or years prior to the policy period. Of course, your clients need to be aware of these changes.
SECTION 11: WORKERS' COMP CLAIMS

Workers’ compensation has been established under state law to provide compensation to workers who suffer occupational injuries or death and to their families for medical costs, loss of support and rehabilitation expenses. Workers’ compensation programs are for the most part administered by the states, although the Longshore and Harborworkers’ Compensation Act and the Federal Employees’ Compensation Act provide coverage for federal employees. Although workers’ compensation laws vary by state and under the two federal statutes, there are some common features, including:

- **Claims**—When an employee is injured or killed due to an occupational-related injury or disease, a claim must be filed with the administrative agency or commission that administers workers' compensation laws. The most frequent type of claim filed is an "accident" or "injury" claim for damages resulting from accidents, such as vehicle collisions, slip and falls, machinery malfunctions, or mishandling and lifting and dropping large or heavy objects. Another common type of claim is one for an occupational disease or illness, such as silicosis- or asbestos-related diseases. Most states differentiate between the two types of claims. In some states, there is a third type of claim for safety-code violations, which allows for additional awards if the injury or death was directly attributable to violation of a safety law or ordinance. Claims which are allowed in the event of a death of a worker result in payment of support, funeral expenses and medical costs to a spouse, dependent children or others who depended on the deceased for their support during his lifetime.

- **Compensation**—The type of compensation awarded depends to a large extent on the manner in which a disabled worker is categorized. Classification includes temporary complete disability, partial temporary disability, scheduled losses, permanent partial disability and total permanent disability.

- **Occupations included**—Coverage generally extends only to employees and not to consultants, leased employees or independent contractors. Federal employees are not covered by state workers’ compensation laws and regulations. One state requires coverage for conditions of hazardous employment.

- **Funding of coverage**—In a few states, employers are not permitted to fund coverage with private insurance, but rather must pay into a state-maintained fund. A number of other states allow employers to provide coverage through private insurance, and in some instances, only larger employers may do so. In some states, self-insurance is allowed.

- **Rights of an employer**—An employer is granted immunity from a lawsuit by a worker or his or her family in the event of occupational injury, disease or death. In some states, immunity does not extend to those situations in which the conduct of the employer was intentional.

- **Construction of laws, regulations and policies**—Because workers’ compensation is designed to protect employees and their families from becoming subjects of public welfare,
regulations governing implementation and administration of the system are construed liberally in favor of an employee and his family.

Workers' Comp & Disability Insurance
A "disability" is defined as a condition or a diminished mental or physical function that adversely impacts the ability of an individual to earn his or her livelihood. The determination of whether one is disabled must be made by medical examinations, testing and evaluation. Usually, an agency that administers workers’ compensation claims is bound by a medical finding that one is disabled. However, the extent of benefits which a disabled person will receive depends on a determination by such agency as to what degree the condition affects the disabled person’s ability to engage in employment.

Many businesses offer a type of insurance to their employees which covers long- and short-term disabilities. Some plans may also cover intermediate disability. The features of such a plan differ somewhat from employer to employer, but every plan has as its goal protection to an employee and his or her family in the event of a prolonged disability caused by a physical or mental condition. Following are some of the more substantial provisions of an employee-sponsored disability plan:

- **Eligibility**—Disability plans are usually available to regular, salaried or hourly nonbargaining employees located in the United States, who work a minimum of 20 hours a week and who contribute a nominal amount to the plan through payroll deductions. Excluded from coverage are temporary employees, members of labor unions whose bargaining agreements do not provide for participation in such a plan, and those who do not work more than six months in a given year. Also excluded from coverage are disabilities arising from self-inflicted injuries, losses that happen during the commission of a felony and injuries sustained during a war.

- **Disability**—Many plans do not contain an exhaustive list of what conditions may cause a person to be considered disabled. Disability plans typically cover conditions that arise both on and off the job. The determination as to whether a qualifying disability exists is left in most cases to the results of a thorough medical examination. A company may accept the medical evaluation of a physician chosen by an employee, while reserving the right to require the employee to submit to a medical examination by a doctor chosen by the company. Some plans require an employee to be totally disabled and others may extend coverage in the event of a partial disability.

An employee who is considered disabled for purposes of short-term coverage may not be sufficiently disabled to qualify for benefits under intermediate- or long-term provisions of a plan. For example, under a short-term disability plan, pregnancy may qualify as a disability. Further, for the first two years of coverage, disability may be defined as a condition that renders the employee unable to perform his or her normal occupation. After the expiration of a two-year period, an employee may be considered disabled only if unable to perform any job for which he or she is reasonably qualified by training, education or experience.

Preexisting conditions may disqualify an employee if a physician was consulted or medical care was obtained within three months before coverage under the plan began. Sometimes, coverage will be allowed if the disability began after an employee worked full time for a year and was not absent due to the disabling illness or injury.

Additionally, employees may be excluded from coverage if a disability was caused by intentional self-infliction of an illness or injury, act of war, insurrection, terrorism or riot, or
during the commission of a felony. Thus, one who attempted suicide would not be eligible to receive any kind of benefits under an employees’ disability plan.

- **Types of coverage**—Eligible participants are usually covered automatically under short-term disability provisions and further enrollment is required for coverage under long-term disability provisions of the plan.

- **Short-term disability**—This coverage usually applies to a disability that endures for a six-month period. A salaried employee who has completed a brief period of employment, usually two or three months, will receive all or part of his or her base salary in the event of a short-term disability. The amount of benefits received depends on the length of service an employee has provided the company and the duration of the disability. For example, a disabled employee who has worked for a company for at least one year may receive 100 percent of his or her salary for one month, and thereafter, 60 percent of such salary for another five months.

- **Long-term disability**—After an employee has been totally disabled for an extended period of time, typically six months, he or she becomes eligible for benefits under the long-term provisions of a plan if he or she qualifies as long-term disabled under the definition of the governing plan. Definitions may be liberal, such as “unable to perform the tasks of the occupation for which the person is trained” or a more conservative one, such as “unable to perform the tasks of any occupation for which the person might be trained.” An employee and the employer share the costs of the premium for long-term coverage. Such cost is normally a small percentage of the employee’s base earnings. Benefits under the long-term disability provisions of a plan are set at a modest amount to deter fraud and malingering, and customarily consist of payment of 60 percent of the employee’s base salary for so long as the disabling condition exists. If a disabled person is receiving Social Security benefits at the same time, such payments are added into the maximum amount of disability benefits.

- **Reduction of payments**—Under a typical disability plan, an eligible employee may be subject to a reduction in his or her benefits if he or she is also receiving other benefits, such as workers’ compensation, primary, family or spousal old age Social Security disability and retirement benefits, disability benefits under state law or no-fault motor vehicle insurance, retirement benefits or periodic benefits in the nature of retirement benefits paid by any employer, maritime benefits under the Jones Act and payments received from a lawsuit involving subrogation of a third-party insurance carrier.

- **Application for Social Security benefits**—Some plans require an employee who seeks benefits under a long-term disability plan to apply for SSDI at the same time. If an employee receives SSDI, the benefits under an employee plan will be reduced by the amount of SSDI payments.

- **Continuation of other employee benefits**—A number of plans allow an employee to participate in other employee benefits. Normally, one collecting short- or long-term disability payments will also be permitted to take part in company-sponsored life, medical and dental plans, provided the employee makes all required contribution for the costs of those plans. Personal accident insurance coverage may be available for several years after the date of disability, if an employee pays the premiums.

**Investigation of a Disability Claim**

Once it is determined that a claim for workers’ compensation coverage will be investigated, the examiner will obtain a statement about the circumstances, secure a medical authorization, verify the accident or injury with the employer and interrogate witnesses.
The most significant requirement is that a claim for workers' compensation must be based upon a "work-related" injury. An investigator must determine if an injury or death is related to, arose out of or is in connection with the claimant’s work. To that end, if an employee was engaged in off-site errands or other activities not directly connected to employment, he or she must determine if the employer received an indirect benefit from such activities. If the claimant contends that he or she was entertaining customers or clients, the crucial issue to be determined by an examiner is whether the employee was engaged in work-related or personal activities. Likewise, if an employee was engaged in personal activities while on the job-site, the primary consideration in an examination of a claim is whether the activities were more personal in nature, rather than in furtherance of employment.

**Preexisting Medical Conditions**

As a general rule, an employee who suffers a work-related injury that results in exacerbation or aggravation of a preexisting condition may be entitled to workers' compensation benefits. Where this is the foundation of a workers’ compensation claim, an investigator will have to determine the nature and extent of preexisting conditions by reviewing medical records for previous injuries or conditions. An examiner may also investigate to see if reimbursement from another carrier for expenses paid may be appropriate.

**Occupational Diseases**

Under the workers’ compensation laws of some states, occupation-related diseases are covered. Some of the more common occupational diseases include hernias, histoplasmosis, allergies, hearing loss, dermatitis, infertility, black-lung disease, lead poisoning, asbestosis, carpal tunnel syndrome and a variety of mental disorders. One of the more difficult tasks of an investigator involved in a claim for an occupational disease can be to determine if the disease arose from the work environment or from other aspects of the claimant’s environment that had nothing to do with work.

**Activity Checks**

Insurance carriers commonly employ independent investigators to monitor the activities of a claimant to make certain there is no inconsistency with the injuries or disabilities reported. Neighbors may be interrogated about a claimant's activities. Public records will also be searched for evidence of prior claims or litigation. It is not uncommon for the investigator to conduct surveillance. All such information is admissible at a hearing.

**Medical Authorization**

During the investigative stage, an adjuster will ask a claimant to sign a medical authorization which will allow for the release from the attending physician of medical records. Medical records allow the adjuster to document the facts underlying the accident or the occupational disease and should show if drugs or alcohol were involved.

**Stress-Related Illnesses**

In the last two decades, more and more courts have been allowing benefits under workers' compensation laws for stress claims in the workplace, if a connection can be made between a work-related incident and a specific disability. Massachusetts, California and Michigan have been the leaders in such a trend. Establishing causation becomes to a significant degree the job of the examiner who must take a daily history of the claimant, asking such questions as the nature of work the claimant was involved in, witnesses to the underlying situation, whether any voices were raised, the presence of any intimidating factors, undue influence carried out by the claimant’s superiors and whether the type and amount of work or deadlines imposed were unreasonable. Additionally, an adjuster will have to probe into the non-work related environment of an employee to see if anything contributed significantly to his or her stress.
Evaluation of a Disability Claim
A person who is injured on a job due to the negligence of his or her employer or another employer may be entitled to pursue a liability claim in court. By pursuing third-party claims, it may be possible to recover for pain and suffering that cannot be realized under workers' compensation laws. When a set of facts such as these exist, an examiner or adjuster for a carrier must evaluate whether the carrier may be subrogated to the rights of the claimant with respect to the third party, or if a carrier can seek reimbursement from the third party.

Independent Medical Examinations
An independent medical examination may be required by a carrier for the purposes of confirming the claimant’s injury, to determine the length and extent of treatment and establish a time for the claimant to return to work. If the independent medical examiner’s report differs from that of the claimant's personal physician, a hearing may be required. If both doctors determine that a claimant is able to return to work on a limited basis, the carrier may only be required to pay the difference between prior gross weekly earnings and what is now earned on a part-time basis.

A Claimant Who Resides in One State and Works in Another
In some cases involving a worker who resides in one state and works in another, the carrier may be saddled with higher benefits if the prescribed amounts vary from one state to another.

Evaluation of a Claim Under a Private Disability Plan
The evaluation of private disability claims may be confusing because of the variety of definitions of disability that arise under state laws. In one state, a person is considered to be totally disabled if he or she is unable to work with reasonable continuity in his or her ordinary and customary occupation or profession or in any alternate job which he or she may reasonably be expected to engage, considering such factors as past employment, job opportunities, education, physical status and mental capacity. Adding to the complexity is a practice by a number of carriers to use definitions of disability that are not the same as or are inconsistent with the definitions used under governing state law.

In assessing or evaluating a disability, the adjuster must satisfy him/herself that a claimant’s physician fully understood certain facts about the claimant, including the job description, the nature and history of the claimant's employment, his or her educational level and whether, considering his or her physical condition, the claimant can be expected within reason to work. A carrier that uses its own doctor to evaluate a claimant may receive information that conflicts with that of the claimant’s physician.

Disposition of a Disability Claim

Medical Bills
Upon approval of a workers' compensation claim, the insurance carrier will begin making payment of medical bills. Medical providers must be notified that an injury is work-related. Up-front payment may be required. All bills are paid by the carrier until the claimant is discharged officially by the treating physician.

Lost Wages
The number of weeks for which lost wages are to be paid is determined by state laws and may last as long as one year. When a carrier receives the average gross earnings for the required statutory period, he or she takes a percentage, and this figure becomes the compensation rate, which is also determined by state law. Under state laws, there is a maximum amount a carrier is
required to pay. Thus, if an injured worker was making $500 a week in gross wages before the
injury, the applicable percentage under state law would be 80 percent, with the carrier not being
required to pay more than $375 per week and the claimant not to receive more than $375 per
week in lost wages. Under the laws of some states, a carrier may be required to add payment
for dependents of the claimant.

Claims That Are Denied
When a claim is denied, a carrier must notify the applicable state regulatory agency. In some
states the department is known as the Department of Workers' Compensation, and in others as
the Industrial Accident Board. The state agency must then notify the claimant of the denial, the
reasons for the same and advise the claimant of his or her right to a hearing or an appeal. If a
claim is denied, the claimant can either accept the denial or request a hearing. Legal fees are
typically assessed to the party who loses.

Settlement
When a workers' compensation case is settled, there is no signing of a release as there is in a
liability case. Claims may remain on record for several years. However, if a claimant settles for
permanent loss of function, the carrier will be released from further action in respect of that
portion of the claim. Some states require the department that administers workers' compensation benefits to approve such a settlement before it is effective.
SECTION 12:
LIFE & HEALTH CLAIMS

HEALTH CARE INSURANCE

Health care insurance plans are the most common type of benefits provided by businesses to their employees. The primary types of health care insurance are individual and group coverage. Benefits are provided in group insurance to a specific mix of individuals whose eligibility is established because of their relationship to a particular group, such as an employee or trade association. Typically, group coverage ends when an individual ceases to be part of the group, unless continuation or conversion options are exercised.

Individual health care policies are usually sold to individuals or families. Sometimes referred to as personal insurance, the cost, coverage and availability vary from one carrier to another. Premiums are frequently quite higher because of the reduced opportunity to spread the risk among a larger pool.

During the 1980s and 1990s, health care costs continue to be among the most rapidly rising of all classes of expenses measured by the Consumer Price Index. The most pressing reasons for the inflationary spiral are escalating costs of physicians, nurses, medical equipment, buildings and other health care costs which rose at rates twice the increases in the Consumer Price Index. Other reasons include the exorbitant costs of research, development and production of technological improvements, staggering premiums for medical malpractice, the expenses attending the practice of defensive medicine, the rise in hospital labor costs, shifting of costs from the government to the private sector, the increase in the use of outpatient care, expenses arising from catastrophic cases such as AIDS, and an individual indifference based upon a perception that such high costs are solely the problem of the health care insurance industry.

Following are some of the more common health care plans:

- **Comprehensive health care plan**—This type of health care plan is one that includes both major medical and basic protection coverage. Benefits which cover expenses for physician services and hospitalization make up basic coverage. Reimbursement of up to 80 percent of hospitalization expenses typically extends to such items as the room, medications, intravenous fluids and laboratory work. Some policies may also offer surgical benefits. Physician-cost benefits cover visitations by a doctor during hospitalization. Routine physicals are not covered. The purpose of major medical insurance is to cover those services not included in basic protection coverage and to insure against the catastrophic expenses of an extended illness. The deductible is rather significant, since such coverage is not intended to pay for ordinary and customary medical expenses.

- **Cafeteria benefit plans**—In such a plan an employer offers an employee a variety of options or benefits in place of a comprehensive health care plan. For example, an employee might elect to take only catastrophic health care in exchange for more vacation or
subsidized child care. Employees are allowed to mix a variety of benefits according to their own individualized wants and needs. In some cases, an employer may establish a spending account on behalf of an employee, against which expenses for health or dental care may be drawn.

- **Catastrophic plans**—This is a plan which is intended to cover a situation in which there is a serious illness or injury necessitating extended hospitalization. Such a plan involves a substantially high annual deductible (typically $5,000 per person and $10,000 for a family). Catastrophic plans pay 80 percent of covered expenses until a large amount of individual or family expenses are paid (usually $25,000 for an individual and $50,000 per family, annually), and then coverage increases to 100 percent. The primary advantage of a catastrophic plan is that premiums are considerably lower than for a comprehensive health care plan.

- **Health maintenance organization**—An HMO is an alternative to a traditional health care plan. Participants in an HMO pay a monthly fee in exchange for comprehensive medical services. The fee is the same regardless of the degree of use by a participant, although some HMOs charge a nominal amount for office visits. HMOs may be for-profit or nonprofit and some are owned by large insurance companies. Some HMOs allow their staff doctors to have an independent private practice. HMOs typically provide complete coverage for such items as physician’s services, home health services, inpatient and outpatient hospital services, diagnostic and laboratory procedures, treatment for drug and alcohol abuse, emergency health services, preventive health care and limited mental-health care.

- **Preferred provider organization**—A PPO is a plan in which a provider, such as a hospital, pharmaceutical company or a physician, enters into a contract with an insurer or an employer to provide health care at lower rates to groups of employees. Discount rates are offered to an insurer or an employer in exchange for a higher volume of patients. Employees who participate in a PPO are offered a greater variety of physicians and medical facilities to choose from than those who take part in an HMO. Employers penalize employees who go to a physician or facility of their choice by only paying half of their medical costs.

- **Managed medical system**—This is a health care plan which blends the features of both an HMO and a PPO. Under an MMS, providers must offer good care at a reasonable cost. If a participant elects to seek treatment from a provider of his or her own choice, the penalty is a large deductible. Like a PPO, an MMS is a prepaid system.

### Exclusions From Group Health Care Plans

There are a number of conditions that are excluded from group health care policies, including the following:

- **Custodial care**—There is no coverage when an insured is in a facility such as a nursing home where the primary purpose of confinement is not improvement of the general health of a policyholder.

- **Physical examinations**—Except for HMOs, group health care plans do not cover routine physical examinations.

- **Cosmetic surgery**—Elective cosmetic surgery is not covered.

- **Preexisting Conditions**—These medical conditions are ordinarily excluded or allowed only under restrictive conditions.
Investigation of a Claim Under a Health Care Policy

Review of Contract
One of the first steps usually taken by an insurance adjuster who is investigating a health care claim is to review the contract to see if a claimant has complied with all of the necessary terms and conditions that are a condition precedent to resolution of a claim. If a claimant intentionally or unintentionally failed to include material facts on the application for coverage, such as his or her medical condition and history, age or any other facts upon which the carrier would have relied in deciding to extend coverage, the carrier may cancel the contract. A carrier may also be able to obtain medical information about a claimant from the Medical Information Bureau ("MIB"), which was established for the specific purpose of preventing consumers from perpetrating fraud upon insurance companies.

When an application is taken for health care, disability or life insurance, a provision may be included on the form requesting permission for a carrier to go to the MIB for a report on any medical information on file about an insured. Medical records that are used in connection with applying for insurance or pursuing a claim are kept by the MIB for a period of seven years. There is no guarantee that information traded among MIB subscribers is correct.

Preexisting Conditions
A preexisting condition is one that affected the policyholder before the effective date of the present health care plan. In order to be classified as such, a medical condition may have had to be obvious for a specified number of months before the present policy, and the policyholder either sought or should have sought medical treatment for the condition. Many policies contain provisions which limit or deny coverage for preexisting conditions. When a claim for health care coverage is filed, an examiner will routinely check to see if the condition for which coverage is sought is a preexisting condition.

Evaluation of a Health Care Claim

Usual and Customary Fees
During the evaluation of a health care claim, an insurance examiner must determine if the charges of a health care provider are "usual and customary fees," since most health care plans limit payment for covered items accordingly. The issue of what is usual and customary is determined on a theoretical basis according to the prevailing rates for the same or substantially similar services in a given geographical area. Usual and customary fees are ordinarily detailed in a health care policy for specific medical and surgical treatments, and in reality may only be a high percentage of what health care providers in the area in which the insured lives typically charge.

Reasonable and Necessary Treatment
Health care claims may be denied when a policy excludes coverage for medical procedures and treatment that are not "reasonable and necessary." One of the most perplexing questions facing consumers and the insurance industry is: Who is the proper party to determine if a medical treatment is reasonable and necessary? Naturally, a carrier claims that its physicians and other medical personnel have the right to make the decision, and the policyholder insists upon his or her own personal physician making the determination. Several state courts have ruled that coverage should be afforded to a claimant who relied upon treatment of his or her own physician, unless the carrier can prove that the attending doctor’s judgment was contrary to established medical practice or unless he or she was guilty of using bad judgment.
If a policy is ambiguous with respect to what medical treatments are reasonable and necessary, courts have been inclined to resolve the matter in favor of a claimant. Pretreatment screening should eliminate the question of whether a procedure is reasonable and necessary.

**Disposition of a Health Care Claim**

The settlement or disposition of a medical claim can be both a time-consuming and complicated process because of the usual involvement of more than one party. Once a policyholder obtains a claim form from his or her employer or group policyholder, it is necessary to provide a form to the doctor and to other health care providers who performed services or treatment. Attending physician’s statements must be filled out by the doctor’s office and returned to the carrier. Frequently, further clarification and supporting documents are required from the physician’s office. If a second opinion was necessary, further delay will be occasioned. Calculations of deductibles may also be involved in determining the amount of coverage and the disposition of a claim.

**Multiple Claims**

When health care plans were not so expensive, it was uncommon for a consumer to be covered by more than one policy. When an injury, illness or disability occurred, both companies paid. One contract would reimburse the provider while the other would pay the insured. In an effort to reduce mounting health care insurance costs, carriers began inserting "coordination-of-benefits" clauses, which allowed a carrier to coordinate payments with other carriers that could be covering one individual through a homeowners policy, a personal vehicle insurance policy or some other group or nongroup policy.

As a result, the primary carrier now pays the full covered benefits and a supplemental carrier pays the unpaid balance. Industry guidelines determine which is the primary and which is the secondary carrier.

**Experimental Procedures**

Frequently, a question arises as to whether an experimental procedure qualifies as a regular and customary procedure. If it does not, there may be no coverage. In most cases, coverage does not apply to experimental procedures, giving rise to an inordinate amount of disputes between a policyholder and a carrier over the issue. When the nature of the treatment is in question, coverage will not apply unless the five criteria, measures of the medical necessity of a procedure, are satisfied. They include:

- The procedure must be appropriate and required for treatment and care of the injury or the illness.
- The treatment must be provided in accordance with accepted principles of medical practice in the United States at the time of the procedure.
- The expenses must be approved for reimbursement by the Health Care Financing Administration.
- Any appropriate technological assessment body established by any state or federal government shall not have deemed the procedure to be experimental, investigational or educational in nature.
- The procedure shall not have been provided in connection with medical or any other type of research.

**Extension of Benefits After Termination of a Policy**

If a claim is for medical expenses incurred after termination of a policy, coverage may not be available in some instances. In Edvadine Forbau v. Aetna Life Insurance Co., the Texas
Supreme Court ruled on the limits of coverage a carrier is faced with when an accident or illness occurs during coverage and expenses relating to the same continue after termination of coverage. A child of the insured, a 14-year-old girl, sustained permanent disabling injuries during a car accident. Two years after the accident, the insured’s employer terminated the group contract with the carrier. Benefit payments continued for approximately another year.

Stating the issues, the appeals court said: "in this case we are called upon to determine whether the...policy...created a vested right in unlimited benefits, or restricted benefits to the recovery of medical expenses incurred while the policy was in effect..." The Supreme Court held that Aetna was only obligated to cover the daughter’s medical expenses as long as she was a covered family member. When the policy was terminated, coverage was discontinued.

LIFE INSURANCE

A policy of life insurance provides protection against the financial strains caused by the premature demise of a provider. There are some life insurance policies which also provide a source of funds for retirement income.

At first glance, the subject of life insurance might seem rather simple, but a more in-depth look reveals a number of complex issues surrounding the topic. Questions such as vested interest, issues surrounding the calculation of premiums and the cost of life insurance, the consideration of gender on the amounts of annuity payments and the part life insurance has as a savings vehicle make for some very challenging issues. Life insurance can be sold in one of three ways—by group insurance, by individual life insurance or by industrial or debit life insurance.

Group life insurance is provided to a specific array of people who are brought together or associated for some objective other than just purchasing life insurance. Examples of groups that might be covered are participants in the National Football League, members of a teacher’s association or federal government workers.

Group life insurance provides a benefit for a specified period of time, ordinarily a year. When the term expires, the policy can be reissued.

When an insured dies, the designated beneficiary is paid the stated death benefit, typically a flat amount. Premiums are predicated upon the average age of the participants in the group. The average age, as is the underlying premium, is based upon the age and number of individuals entering and leaving the group.

Most policies allow an employee to convert to individual coverage in the event of termination of employment. However, conversion is limited to permanent life insurance. Credit life insurance is a specific kind of group life insurance which is bought by a lender for its debtors, typically made available by retail stores, credit unions, banks or other lending institutions who sell merchandise to their customers on an installment basis. Credit life insurance tends to be rather expensive.

Group life insurance benefits are determined by a preset method such as the amount of compensation the insured receives in one year. The maximum amount of individual benefit may be set by state law.

Industrial life insurance, tailored to meet the needs of low-income workers, is basically burial insurance. Usually it is purchased in small amounts, rarely exceeding several thousand dollars. Premiums are collected on a weekly or monthly basis. The cost of industrial life insurance is so excessive due to administrative expenses that some critics of the industry have lobbied for its
abolishment. Industrial life insurance in general has little consumer appeal, but does serve a purpose to those families whose option without it would be no life insurance.

Individual life insurance, sometimes referred to as ordinary life insurance, is written in large amounts. Premiums are ordinarily collected on a periodic basis—quarterly, semiannually or annually. There are two types of life insurance—cash value and term. In "term life" insurance, a policy is written for a period of one to five years, and can be renewed with an increase in the premium as the insured becomes elderly. If an insured dies within that term, the beneficiaries are paid a cash settlement. A term policy has no cash value. Term insurance can be purchased with an option to convert to a cash-value policy. Many people buy term insurance and receive no payments from the carrier because they do not die before the end of the term.

There are several kinds of term life insurance. A "single-year term" will pay the insured if he or she dies within a year of having purchased the policy. Longer-term policies are available for 10, 15 and 20-year periods. "Terms to a specified age" policies pay if the insured dies before the age designated in the policy. "Multi-year-term" policies have benefits that increase, decrease or remain level each year the policy is in force. A "level-term" policy pays the same amount of benefits if the death happens while the policy is effective. "Renewable-term" policies permit an insured to continue coverage up to a specific age regardless of his or her health. Premiums increase each time a term is renewed since the insured will be older. "Convertible-term" policies provide an insured with an option to convert his or her policy to a whole-life policy. If an insured desires to continue the policy on a permanent basis, the option is advantageous.

Term-life insurance is most useful for taking care of a number of financial needs. A level-term policy can be used to meet educational needs in the event of the premature death of an insured. Debt retirement funds can be established by the use of a term policy where installment payments are used to satisfy the obligations of a mortgage payment. Income can be used to support dependent children. If a consumer’s life insurance dollars are limited, term-life insurance is optimal because premiums are considerably less than for a comparable amount of whole life insurance. Term-life insurance cannot provide a regular savings plan nor is it desirable when the necessity for life insurance is permanent.

Under a whole-life insurance policy, payments will be made to designated beneficiaries whenever the death of the insured occurs. Also, if the insured reaches 100 years old, the carrier will pay the benefits to the insured. Because claims are a definite event under whole-life policies, carriers must charge premiums that are sufficient in size to guarantee settlement. The consistent premiums that are paid for whole-life insurance are good for a savings value known as the "cash value." Insurers initially levy premiums that are in excess of what is needed to satisfy early mortality claims. After a period of time, additional premiums and the interest which is compounded on such premiums combines for a significant savings value.

The excess premiums are used to keep the policy effective in later years as the likelihood of death increases. Such savings give rise to a few contractual rights. Money can be taken from the policy at any time when protection is no longer needed. The savings can be used to purchase annuities for a predictable retirement income. Savings can also be used as the foundation for a loan to a policyholder.

Whole-life policies are categorized upon the basis of three methods of premium—single premium, continuous premium and limited premium.

During the late seventies, traditional protection plus savings insurance policies became less popular with consumers because of rapid inflation. Alternative investment vehicles with higher
yields were made available. It was in this economic environment that universal life insurance became popular. Universal life insurance allows a policyholder to acquire term insurance and invest an additional amount with a carrier. A monthly mortality charge is subtracted from the accumulative premium fund and the balance, less a few charges, creates a cash value which earns a guaranteed interest rate and an excess interest rate. Death benefits under universal life insurance can be taken in one of two ways. In the first, the death benefit equals the initial quantity of insurance and accumulated cash value at the time of the death of the policyholder. The initial death benefit is guaranteed. Under the second method, the death benefit remains at a given level until cash value is in excess of a definite amount. When cash value exceeds a prearranged amount, the increased amount is added to the death benefit.

Another type of life insurance which was introduced in the late seventies is variable life insurance. Compared to universal life insurance, variable life is more difficult to comprehend, involves more risk and is subject to federal regulation under the Investment Community Act of 1940 as well as under state law. Those who sell variable life insurance must be registered under federal securities laws as well as under state insurance laws. The premiums are flexible. The policyholder can select one or more underlying investment funds in which cash values can be invested. The investment funds can include money market accounts or stock and bond funds. Although there is no minimum guaranteed cash value, there is a minimum death benefit that is guaranteed.

Investigation of a Life Insurance Claim
Rather simple to process, investigation of a life insurance claim generally involves verification of compliance with the requirements of a beneficiary under a policy, such as notification of the death of the insured, filing of a "statement of claimant," which instructs the company how to dispose of the benefits, providing a death certificate to the carrier and, in some instances, surrender of the policy.

Employment Status
If a company takes out life insurance policies on its officers and employees, a requirement of coverage is that the insured is in fact a bona fide officer or employee. Such policies frequently require the insured to maintain a certain number of hours per week in furtherance of work duties. An insurance adjuster may look into the activities of an insured for a period of time preceding his or her death to make certain he or she was in fact putting in the required number of hours.

Medical History
An examiner will scrutinize the medical records to make certain that the deceased did not misrepresent his or her medical condition or history.

Birth Certificate
An examiner may ask for the deceased’s birth certificate to verify the age of birth, since the amount of premiums are usually based upon the age of the insured. An adjustment may be made in the premium if the insured turns out to be older than he or she represented when completing the application for life insurance coverage.

Competing Beneficiaries
An adjuster may have to determine the whereabouts of competing beneficiaries, and his or her job is frequently made more difficult by a lack of cooperation from known beneficiaries. If the information is incomplete, the carrier may be forced to send the policy through a judicial process to resolve the status of the beneficiaries.
Incontestability Clause
Since all life insurance contracts are presumably made in good faith, there is a duty imposed upon an applicant to answer all questions truthfully and not to conceal any information. If a policyholder does otherwise, he or she (or his or her beneficiaries) may end up in court with the carrier who seeks to void the policy. An incontestable clause states that an insurer may not contest a policy for the purposes of voiding it after a policy has been effective for a specific period, usually one or two years. Thus, a carrier cannot investigate to uncover fraud after the period of contestability has lapsed. However, fraudulent claims for accidental death benefits or income relating to a disability are generally not affected by a noncontestability clause.

Disposition of a Claim for Life Insurance Benefits
A number of state courts and legislatures have promulgated rules, regulations and statutes which address the inequity that can occur when a carrier attempts to withhold or deny benefits under a life insurance policy on the basis that the insured made misrepresentations to a carrier when he or she applied for such insurance. In some states, a carrier must show that an insured intentionally misrepresented information called for by an application. Others require that a misstatement of fact must have been material and that had the carrier known the fact, it would not have issued the policy. Some require the inclusion of an incontestability clause in the policy, which imposes a specific period of time during which a carrier can contest a policy coverage based upon misrepresentations. A few states require that the misrepresentation must relate to a serious ailment, disease or disability. If the questions on the application were vague or ambiguous, the carrier may not avoid payment of the benefits.

Disputes over the cause of death are frequent because of the number of states that allow a carrier to deny benefits for death by suicide if the suicide occurred within a one- or two-year period after the effective date of the policy. There is an arbitrary presumption that if death by suicide occurred after the prescribed period, the suicide was caused by mental illness. Since a policy covers death from other illnesses, a carrier must pay benefits in the event of death attributable to mental illness. Disagreements over suicide arise because of the difficulty of ascertaining the mental status of the insured at the time of his or her death. If an insured realized that death was a certain consequence of his or her actions, the suicide exclusion clause will apply. If he or she was so disturbed mentally that he or she could not have known death would follow his or her actions, the cause of death may be ruled as an accident.

An insured makes payment of the first premium when his or her application is taken. The application may contain a provision that the policy is not effective until acceptance by the home office. If the applicant dies before the application is accepted, the insurer may take advantage of an opportunity to deny coverage, notwithstanding that a policy may have been issued had the insured survived. Another timing situation occurs when the insured becomes sick or disabled, misses a payment and then dies before curing the default.

Many states have adopted laws to remedy these situations. In some states, the policy becomes effective upon payment of the first premium by the insured. In other states, if an insured ceases making payment of premiums, the cash value of the policy automatically converts to term insurance. Under most state laws, if a policyholder neglects to make payment of a premium, the policy is not automatically canceled, but rather a grace period kicks in under which the insured is given a certain period of time, usually 30 days, to make payment if the policy is to remain in effect. Under the laws of a number of states, if a policy has been permitted to terminate, a policyholder is provided with an opportunity to renew the lapsed policy under a reinstatement provision. For example, under the laws of New York there is a three-year period of
reinstatement after the date of default if the policyholder has not taken out the amount of savings or withdrawn the cash surrender value. A number of states that have reinstatement laws may require the policyholder to demonstrate evidence of insurability through good health, including a demonstration that the insured does not engage in hazardous hobbies or pursuits, and the repayment of all premiums in default and any loans made to the policyholder which were secured by the policy.

Several settlement options, which are used to determine how the proceeds of a policy will be paid to a beneficiary after the death of the insured, are available under a life insurance policy, including the following:

- **Single payment for face value**—A single payment affords a beneficiary the greatest flexibility since the entire amount can be spent at one time. Sometimes referred to as a "lump-sum" option, more than 95 percent of all settlements are taken in this manner. A beneficiary pays no federal income tax on the settled amount.
- **Fixed-amount option**—This option affords an opportunity to the beneficiary to receive regular, fixed-income payments that continue until death proceeds and the interest on such proceeds has been exhausted. This option is beneficial in situations where income is necessary for a limited amount of time, such as to finance an education or to carry over a beneficiary until Social Security or private pension benefits are available.
- **Fixed payments for a specific amount of time**—Payments are made over a restricted period of time, such as five or ten years, and the payments are greater than in the prior option.
- **Specified payments lasting until investment income on cash value and death benefits run out**—Under this method, a larger payment results in fewer installments.
- **Investment income on death benefits**—The entire amount of the benefits are left in the custody of the insurer. Generally, a carrier makes payments to one beneficiary in a series of regular payments. After the first beneficiary dies, the second and surviving beneficiary receives payment of the principal in a lump sum. The return earned in a given year determines the size of the payment. The principal amount of the death benefit remains unchanged.
- **Life-income option**—This option guarantees a series of regular payments to the beneficiary for so long as he or she shall live. The life-income option is best for a beneficiary who has no dependents to support after the death of the insured. The size of each payment is determined both by the gender and age of the beneficiary. Females may receive smaller installments than males because their life expectancy is longer.
SECTION 13:
CLAIM TRENDS

The Hard Markets
The general downturn in business is forcing companies to look for ways to reduce costs in all areas -- especially claims. Risk avoidance, loss control, fraud avoidance, electronic productivity, automating workflow, legacy system improvements, etc . . . all are encouraged to make the handling of claims more efficient.

Challenging the Claim
In response to certain state legislation aimed at reducing premiums (Proposition 103 California, for example), insurers are challenging accident claims far more aggressively than in the past. They have been less willing to settle claims. The industry says they need to be more efficient. Critics describe the tactics as "low-balling" and unfair to require accident victims to pay their own costs or sue "at-fault parties" to recover medical and other accident-related expenses.

Class Action Problems
A disturbing trend is the severity of individual claims and wholesale growth in class-action lawsuits. The cost of the American civil liability system runs close to $200 billion. That represents almost 3% of the nation's gross domestic product, compared with 1.4% in 1970 and 0.6% in 1950. These rising costs have spurred efforts for tort reform, which have passed in almost every state. However, not enough to ebb the growth of suits.

Lawyers say the industry should expect new cases to attract massive numbers of complainants and have a wider scope, reaching beyond manufacturers and sellers, to building owners, landlords, contractors and public housing authorities. The base is getting broader, touching every aspects of our lives.

Technology is also playing a role here. A case in point: Two Illinois residents recently filed a class action lawsuit against State Farm concerning the use of non-factory authorized parts to repair their vehicles. Their lawyers established a website to recruit additional litigants. Other lawyers say they use the Internet to look for opportunities in class action insurance claims.

In essence, people today are not waiting for something to happen to sue, they’re out looking for vulnerabilities.
In some cases, the insurers themselves are taking pro-active roles in mounting multi-million-dollar lawsuits against their own policyholders as in the case of manufacturers of polybutylene pipes for residential and commercial construction projects.

**Natural Disasters / Global Warming**

The insurance business is the first in line to be affected by climate change. In recent years there have been at least fifteen "billion-dollar" climate-related natural disasters that have put some reinsurers out of business and the outlook is not good. The "greenhouse effect" may actually be a real threat creating the need for insurers / reinsurers to raise premiums or exit from the market completely.

**Fraud**

There is much discussion in the industry as to the level of fraud occurring and the ways to reduce it. Insurers claim to be losing between $85 and $120 billion a year to fraud. Unfortunately, the way most states investigate, it is a real question whether they consider insurance fraud to be a crime. For instance, a study by the Coalition Against Insurance Fraud (CAIF) determined that there were 2,123 convictions of fraud in the year 2000. That's roughly 52 per state -- not a serious attempt to tackle this area of crime by any means.

Clearly, these convictions are just the tip of the iceberg; but why? Some argue that the difficulty in prosecuting insurance fraud is that insurance companies must use federal racketeering laws to pursue the perpetrators in court. Well, it just doesn't happen. This means that insurers pass along the costs of fraud to the good citizens. In fact, the CAIF estimates that insurance fraud is the equivalent of an annual hidden tax of more than $1,000 per family on the costs of goods and services in the United States.

The problem will get worse, say experts, as long as insurers continue to use the centralized or regionalized claims approach and handle claims by phone or mail; as opposed to the old fashioned method, where adjusters got out on the street to eyeball the claimants, visit the doctors signing the claim documents, and personally negotiate and settle the claim. Some say that the huge outlay for "man-hours" isn't feasible. Others argue that repositioning some of the millions lost to insurance fraud into better claims handling will save more in the long run.

**Fraud Detection**

The industry knows that insurance fraud is growing at an alarming rate. However, insurance personnel are overwhelmed with information to manually sift through and analyze claim files for the proper detection of fraud activities. The criminals know this and have found that the low conviction rate makes it easier and safer to commit insurance fraud than drug dealing, robbery and other illegal crimes.

Technology advances may help. New software advances using predictive, similarity search and visual link resources are proving to be effective investigative tools.

**Predictive Technology:** Monitoring the life of a claim to uncover suspicious activity patterns. In essence, characteristics of claims are compared to fit historical patterns of fraud producing fraud-risk scores to alert adjusters.
**Similarity Search Technology:** A similarity search engine pours through databases to help identify those who might commit insurance fraud through the use of similar but different names, addresses, telephone numbers or other identification.

**Visual Link Technology:** Computers analyze large amounts of data to find significant relationships among what appear to be unrelated statistics. Patterns emerge that can help interpret relationships among people, places, entities, etc to assist in the identification and investigation of fraudulent activities.

**Internet Fraud**
Currently, the web is not being used for claims in any meaningful way. However, as carriers expand their presence and begin integrating claims services electronically, the forging of documents and falsifying accident reports will most likely be commonplace.

When business slows down, the motivation for fraud increases and the Internet is no exception to the rule. Misleading web ads are rampant and the source of many claim problems. Consider an insurance agent in Florida who advertised on his web site the following:

*If you are HIV-positive, you probably think you can't buy life insurance. Now you can!*

Clients responding were encouraged to lie about their HIV status on life applications. The DOI intervened and the agent was convicted of claims fraud, application fraud, second-degree theft, criminal solicitation and communications fraud.

**"All Claims" Database**
Slowly, but surely, the insurance industry is moving toward a national "all-claims" database system to be used by insurers and law enforcement agencies to help identify questionable claims and other insurance fraud. The National Insurance Crime Bureau and the Insurance Services Office (ISO) are the motivating entities behind the database effort which will focus on bodily injury, workers’ compensation, property and vehicle claims.

The value of such a system can go well beyond detection of fraud. It can aid claims managers in the often fluid area of *insurance benchmarking*. For instance, what is a six-year-old’s ability to use his legs "worth" in this country? By researching a central database of legal verdicts throughout the country, a more accurate and fair figure can be derived. Knowing this kind of data can help reduce legal expenses because both sides could have a clearer picture of a case’s value early on. In addition, cases could settle quicker.

The downside of using a central database is seen by some as a privacy issue. And there is legislation being proposed that could greatly limit the use of data. There is even concern among industry critics that information in the database can be used against insurers, such as a market conduct investigation.

The bottom line is that while these concerns may be legitimate, proper use of the data, such as not including specific names unless criminal intent is involved, may yield far more benefits than negatives.
September 11
The effects of 9/11 on America and property insurers are profound. Businesses and claim managers are only now beginning to see results on the downline. Business interruption claims, for example, are being filed whether or not there was any direct physical loss of property. Consider the travel agency that simply lost business due to the first FAA shut-down in air traffic and later to the decreased number of people desiring to travel. It is still not clear how far "civil authority coverage" may extend for these and other types of businesses who were far from any crash sites. After all, the common intent of this coverage was to insure property against damage to a nearby property or where police / fire cordoned off an area for public safety reasons such as happens after a major windstorm to prevent looting or possible danger to onlookers.

The urban riots of the 1960s saw large numbers of claims from businesses well outside the areas of violence. This prompted major ISO form changes requiring that damage occur to property "adjacent" to an insured premises along with many other restrictions of coverage.

Homeowners near the 9/11 crash sites are also effected. Most policies in effect at the time of the attack may have had language similar to the ISO HO-3, which covers loss of use of the residence premises if a covered loss makes them "not fit to live in" or if a "civil authority prohibits use of the residence premises as a direct result of damage to a neighboring premise.

Coverage analysis of the many claims still being submitted will necessarily be dependent on the particular facts of each individual claim.

Network Problems
The recent experience of insurers with network repairs has been frustrating and expensive. One insurer must pay $456 million in damages to recompensate insureds whose cars had been repaired with aftermarket crash parts. The recent windshield network problem is another example. In an effort to lower costs, glass networks were directing business to their own glass shops. Lawsuits based on improper replacement glass, urethanes and techniques have "raised the bar" on liability and the risk of not choosing qualified vendors. Overall, the costs to insurance carriers rose dramatically.

As a result of these activities, several state legislators have adopted anti-steering reform bills and insurance executives are looking at shifting their business to independent call centers that operate in fields detached from suppliers, such as technology or software. These new generation call centers offer full-service claims handling, including extensive auditing of work and billing, monthly statistical analysis of claims, and greater program compliance. The problem of paying different amounts for the identical part or windshield is eliminated. In addition, increased competition from repair shops can result in improved bottom lines. Carriers and agents are better assured that their customers are professionally served and that work is done correctly, completely and cost-effectively.

E-Business Claims
As the computer and internet become an important element, perhaps even dominate our professional and personal lives, the question of data and access coverage comes into play. Most traditional forms including Property, Business Income and CGL policies require that physical or tangible damage occur to be eligible. In State Auto vs Midwest (2001), the courts determined that lost computer data did not constitute tangible property. However, loss of use of computers WAS a loss of tangible property.
In Seagate Tech vs St Paul Fire (2001), the manufacturer of disk drives found to be defective was found liable for rendering a company's computer unusable. Seagate sought coverage under the property damage clause of their CGL but was denied by the court because the computers in question were not rendered unusable. The ruling did not bode well for companies looking to rely on their CGL to protect against liabilities that may arise as a result of hacking activity or malicious code that erased, copied or corrupted computer data, but still left the computer system operational.

Look for new CGL language with exclusionary language related to computer losses as well as new, innovative policies / endorsements offering first party and third party coverage for multimedia offenses, intellectual property perils, trade and copyright infringement, breach of computer security, business interruption, extortion and theft of digital assets.

American Disabilities Act

Insurance companies and their agents will see increased activity in the area of civil rights claims, particularly those dealing with the American Disabilities Act (ADA). In Parker vs. Metropolitan Life (1995) a client alleged unlawful ADA discrimination because the disability plan, administered by Metropolitan Life, distinguished between benefits for mental and physical disabilities. The client had already received the maximum two years of benefit for a mental disorder although the plan provided for payments to age sixty-five for individuals with physical disorders. Although the client did not prevail, the courts would have allowed these benefits for someone else who was ADA “eligible”.

AIDs / HIV

Cases are surfacing that challenge the AIDs/HIV policy exclusions and limitations. In one case, the limitation was outlined in the policy and listed in the data page entitled “Schedule of Benefits”. The courts held that although the line pertaining to the limitation was clearly eligible, it was not highlighted, set apart, or emphasized in any way. Therefore, the limitation was not enforceable. (Gonzales vs American Life - 1994).

Defining Occupation

In Oglesby vs Penn Mutual Life (1995) the insurer denied a disability claim to a client radiologist (vascular interventional radiologist) since a spine and neck problem still allowed him to practice within the same specialty but still permitted him to work as a radiologist. The courts disagreed because the insurance company initially listed his occupation as “radiologist” then later narrowed it to “vascular interventional radiologist”. In essence, they could not deny benefits. Look for more of these “narrow definition” conflicts which may involve agents.

Psychologically Induced Illness

In Rizk vs Dun & Bradstreet / Met Life (1994) the client claimed he was unable to perform certain work tasks due to back injuries. The insurer denied claims because they felt that client’s injuries were at least partially psychologically induced. The courts, ruled in favor of the client because his disability was “total” as defined by the policy regardless of whether the illness was psychologically stimulated.
Experimental Treatment
There will undoubtedly be many cases defining what is experimental treatment under health policies in the years ahead. Recent cases have “tested” policy meaning regarding alleged experimental breast cancer treatment, AIDs-related liver transplants, bone marrow transplants, etc. Clients have lost their claim for coverage on the basis of a legitimate denial based on policy terms (Wolf vs. Prudential Insurance - 1995) and Hendricks vs Central Reserve Life Insurance - 1994 and (Barnett vs Kaiser Foundation Health Plan - 1994). Insurance companies have lost their cases where an exclusion about experimental treatment was NOT highlighted in a conspicuous manner (Gonzales vs Associates Life Insurance - 1994) or where policy language was considered ambiguous (Fredericks vs Blue Cross of Michigan - 1994) and (Bailey vs Blue Cross of Virginia - 1994).

Language Barriers
There are new cases developing in the area of language misunderstandings where clients have pursued claims on the basis they did not fully comprehend the matters at hand. In Parsaie vs United Olympic Life Insurance (1994) a client prevailed in her action against a health insurer because she understood little English and could not read the application. She relied on the advice of the agent but failed to disclose a preexisting condition. The courts determined that the insurance company could only deny coverage where an intent to deceive was found. In this case, they said there was no intent to deceive.

Defining Accidental
Policy language often limits coverage for “accidentally sustained” injuries. Thus, cases have and are developing where attempted suicides have left clients permanently or severely injured. Since the injuries were self-inflicted, insurance companies have refused to pay. In one case, the insurer lost to a client who attempted suicide because “accidental” was NOT defined in the plan documents (Casey vs Uddeholm Corp - 1994). In another example, the client also prevailed because the courts decided her treatment for an attempted drug overdose suicide was really treatment for her underlying depression. Further, the insurer was found to have misled her by not informing that mental and nervous disorders would not be covered if followed by an attempted suicide (Lutheran Medical Center vs Contractors Health Plan - 1994). Finally an insurer was prohibited from withholding a claim because the client had a “subjective expectation of survival”, thus even though his injuries were self-inflicted it was still deemed an accident (Todd vs AIF Life Insurance - 1995).

Tenants As Implied Beneficiaries
The courts are leaning more and more to the proposition that tenant’s are implied beneficiaries under a landlord’s policy. In Bannock vs Sahlberry - 1994 the tenant and landlord had only an oral lease agreement. Even though the tenant was responsible for the fire, the landlord’s insurer could not recover from the tenant since he was an implied “additional insured”. However, in the reverse situation, a landlord could not be construed to be an implied beneficiary of the tenant’s policy (American National Fire Insurance vs A. Secondino - 1995). More bizarre is the case of Cigna Fire vs Leonard (1994). Here, the tenant was required to obtain fire insurance naming the landlord and mortgagee as additional insureds. However, he only purchased insurance on himself and then proceeded to intentionally burn his business to the ground along with the landlord’s building. The courts denied the landlord and mortgagee’s claim against the tenant’s insurer because there was “no clear intention to cover the lessor or
the mortgagee”. Only the tenant was named in the policy but his claim was denied under the policy’s arson provision.

**EIL vs CGL**

Within the last 20 years the insurance industry introduced environmental impairment liability insurance (EIL) in an effort to provide pollution coverage for events the industry deemed not to be covered by the more well-known comprehensive general liability policy (CGL). A very important distinction between these coverages is that EIL policies are *claims-made* policies, while CGL policies are *occurrence-based*. The introduction of EIL insurance provided clients an alternative that was broader than CGL coverage in some respects, while narrower in others. For example, the insurance industry’s position is that EIL insurance affords coverage for the gradual release of contaminants that, according to the carriers, would no be covered under typical CGL policies. On the other hand, as discussed above, claims under an EIL policy must be made during the policy period.

One issue that continues to surface is the relationship of EIL coverage to other insurance purchased. For example, assume a company purchases both primary CGL insurance and EIL insurance. The question then arises whether the EIL insurance is primary coinsurance or excess to the CGL. In *Rhone-Poulenc vs International Insurance (1994)*, the client owned both EIL and CGL policies. However, the EIL policy contained a provision that loss or damage could not be recoverable as long as other insurance was in force. The courts ruled that the EIL was indeed excess coverage, however, there could be cases where EIL, if purchased alone, could be the primary insurer for environmental liabilities.

Recent court decisions have and will greatly effect CGL policies. In the past two decades, a precedent case (International Surplus Lines vs Devonshire) held that CGLs cover only those liabilities arising from torts. New cases (Vanderberg vs Superior Court of California) now say that CGLs cover BOTH tort and contractual liability. The underlying reason that courts ruled against insurers is the CGL phrase “*legally obligated to pay as damages*’ describes liability based on breach of duty imposed by law, i.e.tort rather than contract”.

The courts rejected the distinction between tort and contract liability saying “*A reasonable layperson would certainly understand ‘legally obligated to pay’ to refer to any obligation which is binding and enforceable under the law*”. Experts feel that this decision could have far-reaching negative effects on insurers across the country, just as the International case had positive effects when it was decided in 1979.

**Contamination**

Despite the fact that policies have been written as “All Risk” insurers continue to deny contamination claims based on policy exclusions. In *W.H. Breshears vs Federated Mutual Insurance (1994)*, the court rejected a client’s claim for coverage on the basis that an oil spill on his property was not “covered property” because it was “land” and “pavement” only, not considered “property”. In *Conde vs State Farm Fire & Casualty (1994)*, a client was denied coverage, which was upheld by the court, for contamination caused to his home by an exterminator’s negligence because “contamination” was not defined in the policy. The court also rejected the client’s argument that the exterminator’s negligence (a covered peril) was the actual cause of loss.
“Sick Building” Syndrome
People have an unusual ability to acquire the problems and illnesses of others. Most “sick building” illnesses are found to be psychologically based rather than rooted in fact. In Sternmann vs May Department Stores (1994), an employee claimed a long-term disability from toxic exposure at her place of work. The company refused full disability coverage since tests showed that toxic levels did not exist in the building. The courts ruled against the client even though her physician’s diagnosis was total disability due to toxic exposure and chemical sensitivity.

Asbestos
The removal of asbestos continues to be a major source of conflict between clients and insurance companies. In University of Cincinnati vs Arkwright Insurance - 1995 asbestos was found in a dormitory that suffered a partial loss due to fire. The client’s all risk policy did not cover the removal of asbestos since it was not considered an unexpected event.

Lead
New standards introduced in September 1996 require property owners who are selling or renting real estate built prior to 1977 to disclose any known lead-based paint or lead hazards. Experts believe that the next wave of lawsuits will result from these disclosures and potential client illnesses, real or not.

Business Interruption
On the heels of major hurricanes and earthquake, claims are surfacing concerning business interruption where clients have been forced to close stores and businesses incurring major damages. A major issue that occurs in these cases is the determination of income. Most policies include a clause similar to this: “In calculating your lost income we will consider your situation before the loss and what your situation would probably have been if the loss had not occurred”. In American Auto Insurance vs Fisherman’s Paradise (1994), the client lost his argument that his store would have made huge profits in the aftermath of Hurricane Andrew if it were left undamaged. The courts disagreed indicating that hypothetical profits would have created a “windfall” not contemplated by the policy.

Miscellaneous Actions
In addition to the events mentioned above, experts anticipate actions in the areas of Y2K compliance, Fen-Phen and Redux diet drugs, latex gloves, construction product defects, intellectual property, tobacco and carbon monoxide.
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Faulty Workmanship

CGL policies do not ordinarily cover a contractor for property damage due to the contractor’s own faulty workmanship. *Owners Insurance Company v. Jim Carr Homebuilder (2013)* seems to defy this premise.

Thomas and Pat Johnson hired JCH, a licensed homebuilder, to construct a new home in January 2006. Within a year of completion the Johnsons noticed several issues with water leakage which resulted in damage to other parts of the home. After JCH’s attempts at remedying the water infiltration issues were unsuccessful, the Johnsons sued for breach of contract, fraud, and negligence. JCH promptly tendered its defense to Owners Insurance Company, its general liability insurer. Owners provided counsel under a reservation of rights. After the dispute between the Johnsons and JCH was settled through arbitration, the trial court granted JCH’s motion for summary judgment holding that Owners policy covered the entirety of the arbitrator award.

On appeal, Owner’s argued that the property damage was not an “occurrence” as defined in the policy and as such no coverage would apply. In accordance with previously established principles, the court noted that whether faulty workmanship constitutes an “occurrence” depends on the nature of the damage caused by the faulty workmanship. On its own, however, faulty workmanship is not an “occurrence.” The court further clarified that “faulty workmanship performed as part of a construction or repair project may lead to an occurrence if that faulty workmanship subjects personal property or other parts of the structure outside the scope of that construction or repair” to harmful or damaging conditions.

In another case, *Capstone Building Corp. v. American Motorists Insurance Co., (2013)*, the court held that commercial general liability insurance policies may cover allegations that a subcontractor’s unintended defective construction work damaged non-defective property.

Capstone Building Corporation and Capstone Development Corporation (collectively, “Capstone”) served as the general contractor and project developer for construction at the University of Connecticut (“U. Conn.”), which purchased a commercial general liability insurance policy from a predecessor of American Motorists Insurance Company. Capstone sought coverage from AMICO as an additional insured when U. Conn. alleged construction defects, but AMICO denied coverage on the ground that the policy did not cover alleged defects arising from Capstone’s own work.
Based on its language, the Supreme Court stated the exclusion “eliminate[s] coverage for property damage caused by an insured contractor’s work, but restore[s] coverage for property damage caused by a subcontractor’s work.”

Finally, the Supreme Court rejected AMICO’s argument that requiring commercial general liability policies to cover defective construction of the policyholder’s property would convert such policies into performance bonds.

The decision in Capstone is part of a growing trend in recent years of courts holding negligent construction defects can be covered under general liability policies. That trend has created a strong majority finding in favor of coverage.

**Assault and Battery**

The “Assault or Battery” exclusion is a common method of excluding or limiting claims based on the intentional acts of third persons at a commercial enterprise. The Mt. Vernon Fire Ins. Corp. v. Oxnard Hospitality Enterprise, Inc., et al (2013) case makes it clear that this exclusion continues to be attacked.

Roberta Busby was a nightclub dancer who suffered bodily injury when a patron of Oxnard Hospitality’s (“Oxnard”) nightclub threw flammable liquid on her and then set her on fire. Her assailant was later convicted of aggravated mayhem and torture. Busby then sued Oxnard and others for negligent failure to provide adequate security.

The insurer used the battery exclusion, the dancer objected on the basis that “union or junction of things that have a material existence, or the touching of material things,” and that actual body-to-body contact was not required.

The court disagreed, citing that insurance policy terms are to be given the “objectively reasonable meaning” a lay person would ascribe to them, and that the context in which a term appears is critical. Here, had Busby’s assailant struck her with a closed fist, there could be no argument that such a striking was not a “battery” under Oxnard’s policy.

Likewise, if that fist was holding a glass container that it used to strike Busby, this too would be a “battery” under the policy. The Court found that the result could not be any different if the glass container was filled, as in this case, with a flammable substance used to set Busby afire. According to the Court, neither Oxnard, nor its assignee Busby, could have had any reasonable expectations to the contrary.

**Chinese Drywall**

in Prestige Properties, Inc. v. National Builders and Contractors Ins. Co,( 2013) the courts had occasion to consider the application of a total pollution exclusion in a general liability policy to underlying claims involving Chinese-manufactured drywall.

The insured, Prestige Properties, was a Mississippi contractor hired to perform repairs on a client’s home that had been damaged as a result of Hurricane Katrina. Part of these repairs involved replacing damaged drywall. Prestige later was named as a defendant in the Chinese drywall multidistrict litigation pending in the Eastern District of Louisiana. Prestige’s client alleged that Prestige had used defective Chinese manufactured drywall in their home and that
the drywall resulted in bodily injury (eye irritation, nausea, respiratory ailments, etc.) and property damage (corrosion and damage to appliances, wiring and object with metal surfaces). The Prestige was insured for the relevant time period under a commercial general liability policy issued by National Builders. National Builders disclaimed coverage to Prestige on the basis of its policy’s total pollution exclusion.

The courts upheld the pollution exclusion theory on the basis that other courts were leaning toward similar defective Chinese drywall cases being covered by homeowner’s insurance rather than the builder’s CGL.

**Use of Vehicle Contested**

Recent court decisions have determined that “use of a motor vehicle” is not adequately defined within some policies.

In *Hays v. Ga. Farm Bureau Mut. Ins. Co.*, (2012), for example, despite their lengthy analyses in search of a more precise standard, courts have generally resorted to common sense applications to determine if the use of the vehicle was connected to the loss.

In *Hays*, two men devised a pulley system by which they would use their truck to hoist a portable toilet onto the top of a deer stand. As one man drove the truck to lift the toilet, the deer stand fell, injuring the other man. The court held that the injury was caused by the use of the truck. This determination was based on the proximity of the truck to the accident, the driver’s control of the truck, and the “plain and ordinary sense” of the term “use.”

*Sunshine State Insurance Co. v. Jones* (2012) presented a more challenging scenario. In *Jones*, four teenagers were driving when the teen in the passenger seat grabbed the steering wheel to “get a rise out of” the driver. When the driver attempted to swat the passenger’s hands away, she lost control of the car, which veered off the road and crashed. Both the passenger’s homeowner’s insurer and auto insurer disclaimed coverage.

The homeowner insurer argued the passenger’s conduct constituted the “use of an automobile.” The auto insurer disagreed and argued that the passenger’s horseplay was not the use of a vehicle. The court determined that the passenger’s grabbing of the steering wheel did not constitute a “use of the vehicle” because he did not attempt to “employ the car in a manner intended … or to exert control over the operation of the car.”

Auto use exclusions are not necessarily limited to vehicles in operation. Two other cases recently analyzed the “use” of parked vehicles under auto use exclusions in homeowner’s policies.

In *State Farm Mut. Auto. Ins. Co. v. Va. Farm Bureau Mut. Ins. Co.*, (2012), a van had been parked at a construction site for a month when it caught fire. The Fourth Circuit Court of Appeals held that the term “use of a vehicle” required employment of the van as a vehicle. Because the van was not functioning as a vehicle when the fire occurred, the loss was not caused by the “use of a vehicle.”
However, in *New London County Mut. Ins. Co. v. Nantes* (2012), the Connecticut Supreme Court found a vehicle to be in use despite the fact that it was parked and had no occupants. In Nantes, a woman parked her running car in the garage overnight with the garage door closed. The carbon monoxide filled the house and poisoned her sleeping guests. The court determined the injuries were caused by the "use of a motor vehicle," noting that "use of a vehicle," according to natural and ordinary usage, is not limited to operation of the vehicle but includes the vehicle being parked.

**Staged Accident Claims**

These crimes continue and are far from victimless. A couple and their 2-year-old daughter died in Los Angeles several years ago after their station wagon was smashed between two big rigs in a fiery crash. Two men were sentenced to 11 years in prison each after pleading guilty to deliberately staging the accident, which started when the Mercury Cougar one defendant was driving slammed on its brakes in front of one of the trucks.

The bad guys typically target vehicles that appear well-insured, such as big rigs or new-model and luxury cars. Some investigators say the crime rings look for vehicles driven by women and the elderly, who are seen as less likely to stage angry confrontations.

Following are the techniques used:

- **The “Swoop and Squat”** scheme involves two cars: one drives beside the victim, while the other 'swoops' in front of the victim car and stops suddenly, causing a rear-end crash. The first car is usually full of accomplices who will claim that they were injured even if it was only a low-speed crash, submitting fraudulent claims to the insurance company. The swoop car is usually driven by an experienced ring member, while the "squat" car is generally full of either accomplices, or victims. In the 1990s poor Hispanic immigrants were recruited to drive the swoop cars: a high-risk job that nobody wanted, but for which the immigrants could be paid only $100. One such driver, Jose Luis Lopez Perez, died after a swoop and squat crash, leading to an investigation which revealed massive amounts of this fraud.

- **The “Panic Stop”** requires two merging traffic lanes. As one driver tries to merge into the next lane, he is waved forward by a car who proceeds to crash into the unsuspecting driver, later claiming they never realized the person was going to merge lanes.

- **The "Sideswipe"** involves a victim car who drifts into the adjacent lane while making a turn. The perpetrator of this fraud rushes to crash into the car that just drifted into his/her lane. Claiming innocence, the perpetrator then submits a claim to their insurer.

- **“Shady Helpers”** this type of fraud usually happens after a genuine crash has occurred. A fraud runner will solicit a crash victim and advertise the services of specific repair shops, chiropractors, or lawyers. These, in turn, will submit fraudulent claims on the victim’s behalf or deceive the victim into undergoing unnecessary treatments or lawsuits.
Latest Liability Trends

Liability insurers face increasing frequency of severity, lower investment yields, a shifting tort climate and the possibility of emerging risk.

“The pendulum is starting to shift from a very business friendly environment to a little bit more muscle from the plaintiff’s side,” says Jeff Theodorou of Conning Research. “You’ve got some things working against the industry,” His best guess of where the industry’s next claims might arise?

Food Safety

One of the most heavily litigated insurance issues relates to outbreaks of widespread foodborne illnesses and the determination of occurrence where multiple people in multiple states are affected by a contaminant that seems to stem from a single source.

The Centers for Disease Control (CDC) estimates that around one in six (or 48 million people) gets sick, 128,000 are hospitalized and 3,000 die of foodborne diseases annually in the United States.

Litigating foodborne illness cases can be challenging because the product in question often “is disseminated over a number of states to multiple claimants who are not going to be amenable to one court's jurisdiction,” said Jean Golden, a partner in the law firm of Cassiday Schade LLP in Chicago, who specializes in these cases.

“The problem that you’re confronted with as an insurer in that situation is that you get a ruling or potentially have access to a ruling in one jurisdiction that won't necessarily preclude a claimant in another jurisdiction from seeking relief against you in another state or federal court.”

Intellectual Property

A 2011 American Intellectual Property Law Association survey found that for cases valued at less than $1 million, litigation costs through trial could total almost $916,000.

“When you get to a case where the amount in controversy is between $1 million and $25 million, the price tag goes up,” said Robert Fletcher, president of Intellectual Property Insurance Services Corp. “It’s going to cost about $2.8 million to litigate those cases because people fight harder.”

The rise in costs and cases is reflective of the fact that every business has some form of intellectual property. “[I]f you define intellectual property as ideas, innovations or reputation, a message or know-how, you’ll find that almost all companies have those assets,” said Fletcher.

One interesting aspect of intellectual property is that no intent is necessary for a claim to be alleged against a business. “If you make it, sell it, import it, you’re on the hook,” said Garrett Koehn, president Northwest U.S., Crump Insurance Services, Inc.
Professional Liability – Healthcare

According to a 2012 report from the Physician Insurers Association of America that analyzed claims between 1985 and 2011, the specialty linked with the highest amount of indemnity paid to date is OB/GYN surgery, accounting for more than $3.6 billion. Paid claims for physicians in this specialty were linked with an average indemnity of $293,087. By comparison, neurosurgery and neurology had the highest average indemnities at $327,557 and $331,886 respectively, while dentists had the lowest, $44,701. Dentists continue to have the highest payment ratio of 47 percent.

Paul A. Greve, Jr., senior vice president and senior consultant with Willis Healthcare Practice, confirmed in his physician liability trends report the most troubled specialties are radiology, obstetrics/gynecology, neurosurgery and emergency medicine.

One factor influencing professional liability costs is state legislation, according to the annual industry study, “Aon/ASHRM Hospital and Physician Professional Liability Benchmark.” Massachusetts and New Hampshire enacted medical malpractice laws in 2012 designed to speed up and fairly compensate injured patients. “These states are at the forefront in changing the environment for healthcare providers,” said Erik Johnson, Aon’s Actuarial and Analytics Health Care Practice leader and author of the analysis.

According to the Nurses Service Organization’s “Nurse Practitioner 2012 Liability Update,” the average malpractice indemnity payment has increased 19 percent over a five-year period, rising from $186,282 to $221,852. The average cost to defend a lawsuit rose to $63,792.

“When you compare our past claim reports, it becomes evident that the cost of nurse practitioner professional liability claims has been steadily rising,” said NSO President Michael Loughran.

Not everyone sees medical malpractice claims rising in the future; some see mitigating trends. “Decreases in frequency of claims among healthcare practitioners, the stabilization of claim severity trends, shifts in the medical profession, the impact of risk management training and advancements in patient safety are all contributors to a positive outlook for the medical liability insurance sector, according to panelists at the Casualty Actuarial Society (CAS) 2012 Seminar on Reinsurance last summer.

Professional Liability – Law Firms

The legal professions also continue to see a rising number of professional liability claims. The insurer survey, “Lawyers’ Professional Liability Claims Trends: 2011” by McLean, Va.-based broker Ames & Gough, found three practice areas had the largest number of claims: real estate, corporate and securities and trusts and estates. Conflict of interest was the largest cause of malpractice claims.

A recent study by CNA’s Lawyers Professional Liability Program, “Investigating the Hidden Risks of Business Transactions Practice,” found that business transactions presented the greatest professional liability risk for attorneys.

More than one-third of business transactions claims involved the improper preparation, filing and/or transmittal of documents. Failure to provide appropriate legal advice was found to be the
second leading cause of claims. The study also found the cost to defend a business transaction claim is more than twice as much as claims arising from other practice areas.

**Cyber Attacks**

According to the 2012 “Cost of Cyber Crime” study by the Ponemon Institute in conjunction with Munich Re, cyber attacks get costly fast. A typical case can take almost two months to resolve and cost an estimated $591,780 to the affected organization, according to the study. The cost is 42 percent higher than it was a year earlier.

Information theft represents the highest cost, followed by business interruption. The problem, Munich Re explains, stems from the fact that “most traditional property and liability policies provide no cover for cyber risks” although there still may be a duty to defend until such time as coverage is determined.

Myriad cyber risk possibilities exist, according to Munich Re, including: virus infections, Internet fraud, industrial espionage, misuse of personal data (identity theft), copyright infringements or denial-of-service attacks that block targeted sites by overloading them with communication requests.

**Environmental**

Michele Schroeder, Zurich Environmental assistant vice president and author of the white paper, “Environmental Claims Experience: What’s Old, What’s New, What’s Coming,” says first party cleanup and third party liability claims are on the decline as office of attorney general lawsuits become the new trend in claims.

Allegations, such as contamination to natural resources and water supplies, don't allege a particular injury to any one person but to the public at large, according to the report. The report identifies toxic tort suits like those involving nanotechnology and genetically modified organisms as additional areas where future claims are expected.

**Environmental – Hydraulic Fracturing**

Much is still unknown about the environmental impact of hydraulic fracturing, also known as fracking. Last year, Ohio-based Nationwide Mutual Insurance Co. became the first major insurance company to announce that it would no longer offer coverage for damage related to fracking.

The Environmental Protection Agency (EPA) is currently collecting information on fracking chemicals from nine companies and 24,925 wells to determine the potential impact on drinking water. The agency doesn’t expect to issue a final report until sometime next year. According to Brian S. Martin, a partner in the Insurance Litigation and Coverage Practice of the law firm of Thompson Coe Cousins & Irons, though there is little evidence suggesting groundwater contamination due to fracking, there have been a number of lawsuits filed alleging pollution. In a recent article published in Insurance Journal, Martin points out some unique issues that will arise with fracking lawsuits.
First, while there may be no coverage for the damage alleged, there still may be a duty to defend. This is of obvious concern for insurers that pay the cost of defending such claims. Second, there will likely be complex coverage issues that will arise from such claims. Third, though most property policies don’t cover contamination of land and water, according to Martin, claims alleging damage due to groundwater contamination may still arise.

**Directors & Officers**

A recent Chubb Public Co. Risk Survey found that more than 80 percent of executives don’t believe they and their directors will be sued within the next 12 months, despite statistics that say otherwise.

“This general lack of concern is disconcerting especially in light of the fact that the directors and officers of nearly one-in-four (23 percent) of the public companies we surveyed already have been sued,” said Evan Rosenberg, senior vice president and global specialty lines manager for Chubb.

Rosenberg said activities such as mergers and acquisitions and enforcement of anti-bribery laws are further increasing directors’ and officers’ exposure to future suits by shareholders, regulators, customers, vendors and competitors.

Merger and acquisition related claims activity was reported to have increased more than 14 percent last year alone, noted Rosenberg. “While M&A-related lawsuits may be covered by the company’s directors and officers liability policy, documented protocols may help improve the company’s defense in court or result in a lower settlement amount,” said Rosenberg.

**Employment Practices Liability**

Employment practices liability insurance claims continue their upward trend. According to a market survey by Betterley Risk Consultants, there are two problem areas: mass claims and wage and hour claims. The report indicated that insureds are experiencing more unexpected covered claims with increasing defense costs.

In addition, more cases are being pursued by the Equal Employment Opportunity Commission. A 2012 PLUS panel noted that the EEOC is currently pursuing the following case types: disability discrimination and leave policies; hiring practices; arrest and conviction records; pay and promotions; gender discrimination; migrant workers; and lesbian, gay and transgender rights under Title VII.

**Social Media**

As the popularity of social media sites grows, so does the liability risk. In a survey of PLUS conference attendees conducted by global specialty insurer Torus last year, 58 percent expected requests for media liability policies to increase in 2013.

“An increasing number of respondents to this survey recognize the need for broader coverage – specifically media liability coverage – due to the potential risks small businesses face when introducing this medium into their business model,” said Christopher Cooper, assistant vice president for media products.
Nearly one-third indicate data leakage is their primary concern. An additional 27 percent of respondents believe the biggest risk is lack of control over potentially damaging content disseminated by employees, while 19 percent believe it to be increased personal injury exposure (e.g., defamation, libel, slander).

**PEX Plumbing Leaks**

As the price of copper continues to rise, more economical plumbing solutions are needed. To accomplish this, synthetic materials are being used and the most prevalent in recent years seems to be PEX plumbing systems. Cross-linked Polyethylene, PEX, has gained in popularity in the heating and potable water plumbing because of its ease of use and less fittings.

Compared with copper or polyvinyl chloride (PVC) piping, PEX can bend around corners where a copper or PVC pipe would need an elbow fitting. On the practical side, this means that PEX can be easier and quicker to install than copper or PVC plumbing systems.

With the sudden increase in the use of PEX in recent years, failures in PEX plumbing systems have been observed. Failures can be linked to two areas; the pipe and the fitting. The pipe can fail when exposed to chlorine within the water, or over exposure to sunlight before installation. In addition, PEX pipe has also been found to be permeable when exposed to some solutions, including oxygen and some petroleum products, and can leach toxic chemicals from the pipe material. As far as the fitting, the leading cause of failure in a brass fitting used with PEX is caused by dezincification. This causes the fitting to corrode and eventually create leaks.

Additionally, failures occur on the hot water supply piping and the failed clamp is often connected to a copper adapter fitting. More specifically, this adapter fitting is the point where copper pipes transition to PEX. Therefore, one side of the fitting has a soldered joint, using flux (an aid to soldering), and the other side uses the stainless steel clamp. The increased temperature of the water accelerates the rate of corrosion. As well, flux itself is said to corrode the nearby stainless steel clamps. Plumbers are not known for their neatness and flux can get on materials even before they are installed. If they are not cleaned after exposure to the metal, as specified by the manufacturer,, corrosion will occur.

There are further issues with exposure to chlorine in the water supply. To battle the effects of chlorine, manufacturers have added antioxidants to the PEX piping. The antioxidants are provided for sacrificial purposes where the chlorine will degrade the antioxidants first. Once these antioxidants are all degraded, the PEX piping is no longer protected and the piping starts to oxidize quickly before failing.

Another problem is exposure to sunlight. When exposed to sunlight for an extended amount of time, PEX piping can break down. Like any plastic pipe, exposure to ultraviolet (UV) light or sunlight causes the molecular structure to break down. This causes the pipe to become brittle and eventually rupture. Most PEX piping manufacturers only allow 30-60 days of exposure for normal piping, and up to 6 months of exposure for PEX plumbing that has had ultraviolet stabilizers added during production. In a similar manner, PEX piping by itself cannot be used outdoors exposed to sunlight. For this kind of use, PEX piping must be used in a protective sleeve.
Permeability issues are also at stake. According to manufacturers of PEX piping, it is a known fact that PEX is permeable to certain chemicals and oxygen. Although oxygen may not be considered an issue by most individuals, it is a problem in closed loop systems. In closed loop systems, often radiant flooring systems, oxygen can cause corrosion of the heating elements.

Similarly, when PEX piping is used underground, a process allowable by manufacturers, the piping can come in contact with ground water. In most cases, this is not a problem. However, in areas where the ground water has been contaminated by petroleum products, the gasoline additive Methyl Tertiary Butyl Ether (MTBE), or pesticides, PEX piping can permeate these chemicals through the pipe and into the potable water thus contaminating the water supply. (Reid 2005)

In addition, during the Engle process of producing PEX piping, chemical byproducts are often left behind in the pipe. The most prominent are Methyl Tertiary Butyl Ether (MTBE) and Tert-Butyl Alcohol (TBA). The amount these chemicals can leach into potable water is uncertain, but one test of AQUAPEX pipe, manufactured by Uponor Wirsbo, showed MTBE levels of 17 parts per billion (ppb) and TBA levels at 6900 ppb. (Reid 2005)

According to the United States Environmental Protection Agency (EPA), MTBE can be a carcinogen when high levels are inhaled. As far as ingesting MTBE, the EPA has no definitive data on the health effects and according to the EPA's website, "there is little likelihood that MTBE in drinking water will cause adverse health effects at concentrations between 20 and 40 ppb or below." However, at these levels, MTBE can still make the water undrinkable due to the it's offensive taste and odor. (Office of Transportation and Air Quality 2009) In addition, TBA has been shown to cause cancer and hyperplasia in mice and rats during lab studies. (United States 1995)

Need more? When brass pipe fittings are manufactured, zinc is added to the copper alloy to increase the strength of the brass. Because the corrosion of brass is dependent on increasing amounts of zinc, it is recommended to keep the zinc content low (15%-19% of the total alloy). To reduce cost, manufacturers have been turning to high zinc levels (35%+) in the alloy.

When water flows through the fitting, the zinc, due to its weak bond strength at the molecular level, leaches from the brass and creates a powdery buildup. This process is known as dezincification. This buildup can cause a blockage within the fitting. The powdery buildup and blockage can be seen in the video to the right, used with permission from SageWater. Also, when the zinc leaches from the copper, it leaves the copper very porous and thus mechanically weak. This weakness can cause the fitting to leak and possibly rupture.

Due to the failures listed above, a civil lawsuit had been filed against AQUAPEX for the piping leaking chemicals into the potable water and class action lawsuits against Zurn and Kitec in regards to their respective PEX products for the dezincification of brass fittings. Discussed below are two resolved lawsuits that involve the piping and the fittings of PEX plumbing systems.
Most lawsuits dealing with PEX piping deal with the dezincification of the fittings. Zurn and Kitec, manufacturers of brass fittings for PEX piping, have been involved with lawsuits dealing with dezincification of brass fittings. (PHR Consultants 2008) Kitec fittings have been the target of a 2006 Nevada class action lawsuit where Ipex, the parent company of Kitec, has agreed to pay a $90 million settlement. Kitec settled the lawsuit to avoid any further litigation and has not admitted liability. The Kitec fittings are still sold and used elsewhere without incident. (Eckhouse 2008)

Now, the thing to be looking for is how the industry will react to the failures of the PEX clamps. Often, the first reaction is to simply create a warning to increase the awareness of the problem. If the problem continues, then alternative designs will be developed, assuming it makes financial sense.

In the meantime, it’s important to document the losses and secure evidence in order to build strong subrogation cases.

Keys to building a strong case are to document, photographically or otherwise, the details specific to the failure mode and analyze the failure of the clamps in a laboratory. Failure mode details include:

- Was it on a hot water supply?
- Was it used in close proximity to a copper fitting?
- Who installed it?
- How long has it been installed?

Ridiculous Lawsuits

The U.S. Chamber Institute for Legal Reform announced the Top Ten Most Ridiculous Lawsuits of 2012 from votes cast throughout the year by visitors to FacesOfLawsuitAbuse.org. The lawsuits were selected from those featured in the website’s monthly polls for 2012. The Faces of Lawsuit Abuse campaign is ILR’s public awareness effort created to highlight the impact of abusive lawsuits on small businesses, communities, and individuals.

The Top Ten Most Ridiculous Lawsuits of 2012 are:

1. Intoxicated Florida driver pleads guilty to manslaughter, then sues victim he killed
2. Michigan woman files $5 million suit for the leftover gas still in her repossessed car
3. 13-year-old Little Leaguer sued by spectator who got hit with baseball
4. Maximum security inmate who went to jail with five teeth sues prison for dental problems
5. Anheuser Busch sued when longneck bottle used as weapon in bar fight
6. National Football League fan sues Dallas Cowboys over hot bench
7. California restaurateur sued for disabilities act violations in parking lot he doesn’t own
8. Colorado man wins $7 million blaming illness on inhaling microwave popcorn fumes
9. $1.7 billion suit claims City of Santa Monica wireless parking meters causing health problems
10. Bay Area parents sue school after their son was kicked out of honors class for cheating
All Risk Policy and Physical Loss

The modern “all risk” policy does not mean every risk is covered since numerous exclusions exist. In the case of certain claims, for instance, a particular item must reach a significant level to warrant coverage, i.e., such quantity to make it comparable to a direct loss like fire, water or smoke on the structure’s use and function.

An example might be an building with asbestos where some form of damage disturbed the asbestos making the building uninhabitable. Here, the policyholder not only suffered physical damage, he also incurred physical loss. This compares to another building where damage did not disturb asbestos, or where there was no asbestos present. The policyowner here did not suffer physical loss.

In recent litigation, courts more and more continue to look for physical loss issues interpreted to be where:

- The actual presence of offending contaminants or odors results in contamination to a level that the property’s function is nearly eliminated or destroyed;
- The structure is made useless or uninhabitable, or;
- There exists an imminent threat of the release of any contaminant that would cause such loss of utility.

ISO Cosmetic Endorsements

The recent occurrence of severe weather-related events increases claims for structural and cosmetic-related damage. Insurers have reported seeing more of these types of claims, and the logical response would be to raise premiums on all homeowners. However, some new ISO cosmetic endorsement exclusions offer some hope for premium relief.

The ISO endorsement actually contains two options: the first allows insurance carriers to cover a building on a full replacement cost basis, but limit the valuation on "roof surfacing" to actual cash value (ACV).

Option two applies to the cosmetic limitation, which is defined as any kind of marring or pitting or other superficial damage specifically from wind and hail that alters the appearance of the roof but does not prohibit it from functioning as intended as a barrier. The election to choose the endorsement could result in lower premiums for the policyowner.

It is to be determined how many insurance companies will actually start applying this endorsement, however given the fact this was created by ISO at the insurance company clients requests it is expected many insurance companies will begin using this endorsement in the near future.

The problem with these endorsements? What actually constitutes cosmetic damage. Here are some examples to demonstrate the confusion:

- Vandals toss a can of paint onto a house’s exterior wall. This is cosmetic damage, and if the insured with the vandalized wall has a cosmetic damage exclusion in his policy, there would be little debate over whether it should be covered. However, the likelihood that there will be far more nuanced debates over what does and doesn’t constitute cosmetic damage seems very high.
• Think of roofing shingles being discolored, which some engineers determine constitutes structural damage because the shingles are no longer fully functioning, as the discoloration portends a weakening of the actual shingles.

• Or, what about a chip in a home’s stucco that does not immediately impact the wall’s ability to keep out rain, but over time, is arguably (from an insured’s perspective) likely to result in more serious, and permanent damage that could cause structural damage?

• Even a crack in foundation can be considered simply cosmetic, causing no unsafe or unsanitary conditions. But if the crack ultimately creates a sloping floor, which has happened in the past, it’s a different issue. In that case, the insured and insurer would probably disagree over whether the crack is cosmetic or not.

The precedent to the cosmetic discussion began when Florida introduced sinkhole legislation requiring insurers to pay for resulting structural damage. The statute was revised several times over the years, then in 2011, the legislature included a restrictive and specific definition of “structural damage.” Before the statute was amended to add the full definition of structural damage, Florida courts determined “structural damage” to constitute “damage to the structure.”

This often resulted in the opposite impact of the exclusion, because harm to any property is thus damage to the property’s structure. This subverted the process of the cosmetic damage exclusion; even using our can of paint splashed on a wall example would be included under this broad definition, because the colored paint causes “damage to the structure,” although the property is not “structurally damaged.”

Look to see more confusion and litigation in this arena.

Copper Theft

In Essex Ins. Co. v. Eldridge Land, L.L.C. (2010) courts addressed the theft exclusion to vandalism coverage in commercial property insurance policies, holding that the "breaking in" exception to the theft exclusion does not encompass building damage done to extract copper pipe or wiring and that the removal of copper pipe and wiring is a theft even if it is not taken away from the building prior to the intruder’s arrest as long as there was proper intent for a theft.

Facts

The commercial property insurance policy at issue covered "vandalism", which was defined as "willful and malicious damage to, or destruction of, the described property", but excluded "theft" with an exception to the theft exclusion for "building damage caused by the breaking in or exiting of burglars." The word "theft" was not defined in either policy. Insurers denied claims based primarily on the exclusion for loss or damage caused by or resulting from theft.

In Eldridge, intruders forced their way into the insured building and removed copper wiring and copper pipe from the building. The intruders caused damage to the building below the deductible amount to gain entry to the interior space. In addition, in the course of removing the wiring and pipe, the intruders damaged sheetrock, ceiling tiles, electrical conduit boxes, and wall coverings.
In a similar case (Nautilus Ins. Co. v. Steinberg (2010)), an intruder climbed onto the roof of the insured building, removed 14 or 15 copper pipes and electrical wiring from air conditioning units on the roof, and left the pipes laying next to the units. The intruder's removal of the copper pipes and electrical wiring from the units caused all of the property damage in Steinberg. The police arrested the intruder while he and the pipes were still on the roof, and the police report listed the offense as theft. The intruder was indicted, pleaded guilty, and was convicted for felony criminal mischief.

Analysis

After analyzing conflicting decisions from other jurisdictions, the Eldridge court stated that the "breaking in" exception to the theft exclusion does not encompass building damage done while breaking into fixtures, walls, ceilings, and floors for the purpose of extracting pipe or wiring. Instead, the "breaking in" exception is limited to building damage caused by the bodily entry or exit of thieves from a building. Thus, the Eldridge court, addressing a novel issue under the law, held that the theft exclusion governed and that the "breaking in" exception to the theft exclusion did not apply.

In Steinberg, the appellate court reversed the trial court to the extent that the trial court had believed that the property allegedly being stolen had to be removed from the premises for a theft to occur. According to state law, the undefined word "theft" is to be given the same meaning in an insurance policy that it has under criminal law. The Steinberg court then found that the intruder had showed control over the insured's personal property by removing the pipes from the units. Because the trial court failed to make a finding on the intruder's intent to deprive the insured of the property's possession, enjoyment, or use, it could not conclude as a matter of law that a theft had occurred. The Steinberg court remanded the matter to the trial court for further proceedings on the intruder's intent.

Conclusion

Under the law, the removal of copper pipe and wiring is an excluded "theft" even if the pipe and wiring is not removed from the building prior to arrest so long as the intruder had the intent to deprive the insured of its possession, enjoyment, or use of the pipe and wire. In addition, the "breaking in" exception to the "theft" exclusion is confined to building damage caused by the bodily entry or exit of thieves from a building and does not include building damage done to remove copper pipe and wiring from the building which is excluded from coverage.

Innocent Insureds

In a recent (2011) decision, the California Supreme Court specifically adopted the "innocent insured" rule as applicable to the California standard form fire insurance policy. The court determined that the standard policy includes an implied exclusion for loss caused by the willful act of "the insured" and the exclusion bars coverage only for the insured who commits the intentional act.

The exclusion does not prejudice the coverage for other insureds under the policy who are innocent of the willful act. As a consequence, policies that exclude coverage for all insureds for loss caused by the intentional act of "an insured" or "any insured" provide less favorable coverage than the standard form and must be reformed.
**Factual Background**

Century-National Insurance Company issued a homeowner’s insurance policy to Jesus Garcia that insured against the risk of loss by fire. The policy excluded coverage for “loss caused directly or indirectly by any of the following excluded perils whether occurring alone or in any sequence or concurrently with a covered peril ... intentional loss, meaning any loss arising out of any act committed by or at the direction of any insured having the intent to cause a loss.” Jesus Garcia was the named insured and his wife and adult son were additional insureds under the policy.

The Garcia’s adult son set fire to his bedroom and the fire caused substantial damage to the home. Garcia submitted a claim under the Century-National policy and the insurer denied the claim relying on the intentional acts exclusion of the policy. Century-National contended that under the policy, the intentional act of any insured barred coverage for all insureds.

Century-National brought a declaratory judgment action. Garcia filed a cross-complaint and the trial court sustained Century-National’s demurrer finding that the policy excluded coverage for innocent coinsureds. The Court of Appeals agreed and Garcia appealed.

**The “Innocent Insured Doctrine”**

The “innocent insured doctrine” protects an insured who has no involvement in the willful or wrongful act of a coinsured which excludes coverage. A policy which excludes loss caused by the intentional act of “any insured” or “an insured” is consistently held to preclude coverage for all insureds, including insureds who had no involvement in the intentional act.

A policy which excludes loss caused by the intentional act of “the insured,” however, is generally held that to only bar coverage to the insured who committed the act and allows innocent insureds to recover. The doctrine is based on the interpretation of insurance polices as creating several and not joint obligations to insureds.

**The California Standard Fire Policy**

The California Supreme Court noted that the California standard fire policy form, Insurance Code §2071, follows the New York standard 165 line form. California law allows insurers to issue policies that do not comply with the standard form so long as the coverage with respect to fire is “substantially equivalent to or more favorable to the insured.” Policy exclusions which conflict with the standard form or result in less favorable coverage are unenforceable.

In reviewing the standard form, the court recognized it does not contain an express exclusion for loss caused by intentional acts or criminal conduct. The court noted, however, that California Insurance Code §533 specifies “an insurer is not liable for loss caused by the willful act of the insured.”

The court determined that because §533 is an implied exclusion in all policies, the standard form policy is “properly read as excluding coverage for losses caused by a willful act of the insured.”
Comparison of the Century-National Policy and California Standard Form Policy

Having determined that the standard policy form included the implied exclusion for the willful act of the insured and that the wording of the exclusion did not preclude coverage for an innocent insured, the court compared the standard form to the Century-National policy.

As written, the Century-National policy excludes coverage for the intentional act of “any insured.” The court agreed that the provision does exclude coverage for innocent insureds. However, the court held the effect of the exclusion is to provide coverage which is “markedly less favorable to insureds than the coverage provided in the standard form.”

The court surveyed cases from other jurisdictions including Arizona, Idaho, Iowa, Louisiana, Massachusetts, Michigan, Minnesota, New York, Nebraska and West Virginia, where courts have held that a clause that excludes coverage for an innocent insured based upon the intentional act exclusion impermissibly reduces statutorily mandated coverage and is invalid. The court noted that although California is not bound to follow out-of-state authorities, “they reflect a broad consensus as to the proper interpretation of the common standard form fire policy.”

The court also noted the use of “the insured” in other provisions of the standard form. The reference to “the” insured “evinces the Legislature’s intent to ensure coverage on a several basis and protect the ability of innocent insureds to recover for their fire losses despite neglectful or intentional acts of a coinsured.”

The issue was of one of first impression in the California Supreme Court. The court adopted the view endorsed by other states that have addressed the issue and held the exclusion in the Century-National policy was unenforceable. Excluding coverage for an innocent insured provides coverage that is less favorable to insureds and is not enforceable.

As a result, fire insurance polices insuring California property now include an exclusion for the willful acts of the insured but insureds who have no involvement in the willful act are not barred from coverage.

Flood Investigation Strategies

If an initial evaluation indicates that a flood claim might have human causes, an engineer can be retained for the limited purpose of surveying background information, the history of the community, and source of the flooding. The goal is to determine if the flood was caused by too much rain falling too quickly, suggesting an Act of God rather than a viable subrogation case. Most of this information can be gathered online from websites tracking rainfall data, stream gage data (USGS has deployed a nationwide system of rain and stream gages), and FEMA flood-insurance studies. FEMA prepares flood studies and flood-insurance rate maps for thousands of communities including the smallest waterways.

Using Engineering Experts

Where warranted in larger claims, engineering analysis is recommended. Typically, this stage can require less than $5,000—a modest investment for a substantial flood case. The engineer will go to the site and photograph and measure all relevant areas and objects, including water marks on buildings, bridges, and fences. Water marks can establish water-surface elevations at
various points on either side (upstream and downstream) of the loss location, which can tell us what caused the flood. You can then determine if a professional site survey is necessary.

A survey will help the expert understand the water-surface elevation as well as landmarks so that accurate measurements and comparisons can be made and data points identified. This analysis allows the expert to determine where the floodwaters came from and what factors contributed to the flooding.

The last and most expensive step is to instruct the engineer to complete a waterway profile. This involves taking actual field measurements of the waterway and adjacent areas and is done in conjunction with the survey. This will enable the expert to prepare a mathematical model (known as a HEC-RAS model) of the waterway. The engineer can calculate and evaluate if changes in dimensions of the waterway (width, depth, roughness of the channel) will impact water-surface elevations at the loss site. This is the essence of a flood recovery case and allows the expert to understand if waterway conditions such as lack of waterway maintenance or obstructions caused or contributed to the flood.

With this information in hand, one can make an informed decision regarding a site inspection. Sometimes the insurer can recover by proving that the defendant’s negligence caused an increase in water levels at the loss location. In the case of a high ticket claim like that from a hospital, data center, or financial institution, three additional inches of water in the wrong place can mean the difference between valuable equipment being damaged or not—the difference between a small claim and a multimillion-dollar claim.

**Wood Decay Analysis**

A recent case study resulting from Hurricane Sandy illustrates the value of a wood decay analysis in determining the extent of water intrusion. A New Jersey building claimed that wind driven rain had impacted the entire two story building. Thermal imaging and moisture mapping of the walls indicated that the wall cavities along the base of the building had late stage wood decay from what appeared to be surface runoff impacting a slab on grade floor. However, the presence of the fungi Stachybotrys with all water damage that was tested, along with the presence of mites and their fecal matter, confirmed that the water damage had been ongoing prior to the storm.

The roof was in poor condition with ponding present throughout, and maintenance on building envelope had rarely been performed. These observations along with the wood decay and fungi present confirmed that that water intrusion in this building had been present prior to the hurricane, and worsened as a result of the chronic water intrusion occurring during and after the storm.

**Social Media & Claims**

A new area of claims investigation is the ability to analyze the huge amount of data available within the social media world through text mining. Investigators are now searching Facebook, YouTube and other social media websites for discriminating evidence of a claimant. While this social media angle is rather advanced, some insurance companies are using software to effectively mine and analyze this unstructured text data in meaningful ways.
Text mining software accesses the unstructured text, parses it to distill meaningful data and analyzes the newly created data to gain a deeper understanding of the claim. For example, one might use text mining to look for scripted comments in auto-accident claims. It would be a little suspicious if multiple claimants, allegedly unrelated, all say exactly the same thing. It would also be suspicious if you get a flood damage claim from someone in an area hit by a hurricane, but none of the neighbors has made a claim. Text mining can be very helpful in revealing these types of discrepancies or conditions.

The claims process collects and generates large volumes of text-based information, such as adjuster notes, emails, customer service calls and claimant interviews. It is interesting to note, that unstructured data, such as social media content, can represent up to 80 percent of claims data.

**Key ISO Form Changes In 2012**

Insurance Services Office has a new commercial property filing. The 2012 filing changes both policy forms and endorsements. The forms have an edition date of October 2012. Since the changes include both broadening and reduction of coverage, agents and adjusters need to be aware of any reductions to reduce the E&O exposure.

**Earth Movement Exclusion**

The policy change adds tremors and aftershocks to the earth movement exclusion. Volcanic eruptions within 168-hours constitute a single occurrence. The exclusion applies whether earth movement is caused by an act of nature or is otherwise caused. There is no change in coverage.

**Debris Removal Additional Coverage**

The change adds removal of other debris (other than covered property debris) that is on the described premises when caused by a covered Cause of Loss. The coverage does not apply to the cost to: remove debris of insured’s property not insured on the policy or property in the insured’s possession that is not covered property; remove debris of property owned by or leased to the landlord unless there is a contractual obligation to insure and the property is insured on the policy; remove any property not covered including property addressed in the Outdoor Property Coverage Extension; remove property of others of a type not covered on the form; and remove deposits of mud or earth. When no covered property sustains direct damage, coverage for removal of debris of others’ property is limited to $5,000. The additional limit is increased from $10,000 to $25,000. The Outdoor Property Extension is revised to include debris removal of trees, shrubs and plants not owned by the insured, except when the insured is a tenant and the trees, shrubs and plants are owned by the owner of the described premises.

This is broadened coverage for removal of certain property of others, increased additional limit of insurance and trees, shrubs and plants that are property of others.

**Fire Department Service Charge Coverage**

A $1,000 limit (or selected higher limit) applies to each premises described. The revision clarifies that the limit applies regardless of the number of responders or the number or type of service performed. This change does not impact coverage.
**Business Property in Described Structures**

Your Business Personal Property and Personal Property of Others covers property when located in a described building. The revision clarifies that it applies to personal property in a structure as well. This represents no change in coverage.

**Extended Business Income, Extended Period of Indemnity**

The business income forms are revised to increase the number of days for extended business income at the end of the “period of restoration” from 30 to 60 days. Any additional days provided by the Extended Period of Indemnity Option will begin after the automatic 60 day extension. This is a broadening of coverage.

**Coverage radius**

When a described premise for tenant’s property are identified in terms of a room or suite instead of a building number or location address, coverage currently extends 100 feet from the described premises. The change states that the radius will be 100 feet from the building or 100 feet from the described premises, whichever distance is greater. This change applies to Your Business Personal Property, Personal Property of Others and Business Income. This is a broadening of coverage.

**Water Damage Exclusion**

In response to claims from Hurricane Katrina, the Water Damage exclusion was revised in 2007 by adding a mandatory CP 10 31 Water Damage Exclusion endorsement. Now the wording is incorporated into the policy. Because of the change, the CP 10 32 is withdrawn. This represents no change in coverage.

**Property in Storage Units**

The previous form covers personal property “in the open” or “in a vehicle” within 100 feet of the premises, but does not address property outside the building in a storage unit. The revision introduces a Coverage Extension titled “Business Personal Property Temporarily in Portable Storage Units”. The extension is for a 90 day coverage period. There is a $10,000 sublimit (higher limit available). This is a broadening of coverage.

**Entrusted Property**

Exclusion 2. h. in the Special Cause of Loss form excludes loss or damage caused by or resulting from dishonest or criminal acts by “anyone to whom you entrust property for any purpose”, which could apply to tenants or bailees. The revision distinguishes between those who have a role in the insured’s business (partners, managers, employees, etc.) and others to whom property may be entrusted (e.g. tenants and bailees). The exclusion is narrowed to apply only to theft to any person “to whom you entrust property”. The change represents a broadening of coverage.
Vegetated Roofs

Vegetated roofs represent a “green” trend in building construction. The revision introduces an exception under “Property Not Covered” for lawns, trees, shrubs and plants that are part of a vegetated roof – such property is an insured part of a building. Under the “Outdoor Property” coverage extension, trees, shrubs and plants that are part of a vegetated roof are not subject to the limited perils applying to trees, shrubs and plants. The vegetation is not covered for loss by dampness or dryness of atmosphere or soil, changes in or extremes in temperature, disease, frost, hail, rain, snow, ice or sleet. The “Additional Coverage” for mold does not apply to vegetated roofs. This is a broadening of coverage for lawns, trees, shrubs and plants which are part of a vegetated roof.

Electronic Data in Building Equipment

The current form limits coverage for electronic data to a $2,500 annual aggregate. This limitation is being removed with respect to loss or damage to electronic data which is integrated in and operates the building’s elevator, lighting, heating, ventilation, air conditioning or security system. There is also a revision in the time element forms so the limitation does not apply to these items. The Additional Coverage does not apply to stock of prepackaged software. This is a broadening of coverage.

Newly Acquired Property

The current forms, under “Coverage Extensions”, provides up to $100,000 for newly acquired business personal property for the earlier of policy expiration, 30 days or when values are reported. ISO felt this is more appropriately handled by a change form or a value reporting form. Therefore, the extension is being removed. This is a reduction in coverage.

Ordinance or Law Exclusion

The current ordinance or law exclusion applies to requirements to comply with building codes, whether the ordinance or law is enforced in absence of a physical loss or following a physical loss. Building code enforcement, which incorporates code compliance as a necessary element is typically handled through the permit process in course of construction, repair or renovation. The wording is being revised so that the exclusion applies to enforcement of or compliance with any ordinance or law. Also revised are the “Additional Coverage” of Increased Cost of Construction, the Loss Payment and Valuation Conditions and the Replacement Cost optional coverage and “Period of Restoration” in the time element forms. There is no change in coverage.

Wear & Tear Exclusion – Special Form

The current form excludes wear and tear unless the wear and tear results in a “specified cause of loss”. Coverage is being expanded for water damage in the “specified causes of loss” to include accidental discharge or leakage or water or waterborne material as the result of the breaking apart or cracking of certain off-premise systems due to wear and tear. The provision in the form is being revised to make it explicit that there is no coverage for losses that are otherwise excluded under the terms of the policy’s Water Damage exclusion. This is a broadening of coverage.
Covered Causes of Loss

The Special Cause of Loss form provides “open perils” coverage subject to exclusions and limitations. In the current form, covered causes of loss are described as “Risks of Direct Physical Loss”. Since the term “risks of” can broaden coverage beyond just a direct physical loss, the phrase is being deleted. There is no change in coverage.

Options for Increasing Specified Limits

The property forms include various specified dollar amounts, some of which may be increased via entry of a higher limit on the declarations page. A revision of coverage grants is being made to refer to the option of a higher limit on the declarations page. The revision is being made in Electronic Data, Newly Acquired Locations, Interruption of Computer Operations and Limitations for theft. These changes are new coverage options.

Disaster Fraud Continues

Disaster fraud, which we'll define as a deliberate act to defraud individuals or the government after a catastrophe, can be divided into five primary categories: charitable solicitations, contractor and vendor fraud, price gouging, property insurance fraud, and forgery.

Charitable solicitations fraud involves people or Internet sites posing as legitimate organizations that claim to be raising funds for disaster victims (such as in the opening case).

Web sites reach a global audience and have the ability to trick the unwary into revealing key identity data. Generous people, who often search the Internet for well-known charities in order to donate funds after disasters, often are deceived by fake Web sites. These phony sites collect donors' credit card numbers and other personal information.

Price gouging, as the name implies, occurs when businesses or individuals increase the price of goods that are in demand or in limited supply in the disaster zone. One enterprising man made a huge profit selling 35 generators on a street corner after Hurricane Wilma struck Florida in October of 2005. A lawsuit alleges that David Medina bought two sizes of generators at a Costco store in North Carolina for $529.99 and $279.99. Medina then resold them in Miami for $900 and $600, respectively, before investigators intervened.2

Contractor and vendor fraud occurs when individuals pose as contractors or repairmen but have no intention of actually repairing damage or completing the job. A typical example involves an ex-pastor from Port Charlotte, Fla., Jackie Ruff, who was accused of collecting deposits but failed to complete repairs on 43 homes damaged by Hurricane Charley in 2004. He was arrested in Montana.3

Disaster-related property insurance fraud against insurance companies include inflating losses, faking repairs, claiming lost services, and in some cases, deliberately causing damage to property to collect on insurance policies in the wake of a disaster. "Hard insurance fraud" occurs when someone deliberately fabricates a claim. "Soft insurance fraud" (also known as opportunistic fraud) occurs when a normally honest person pads a legitimate claim.
Forgery examples include reimbursement checks stolen from mailboxes, submission of false building permits and receipts for claims, forged insurance and federal emergency assistance checks, and fraudulent damage reports.

**Bad Faith Claims On The Rise**

The number of first-party bad faith cases continues to soar in North America creating the need to evaluate both claimant and insurer interests when it comes to insurance policies, particularly where property damage and replacement is involved.

The expectation of law makers and consumers is simple. When the insured is entitled to compensation as per the terms of their contract with the insurer that the amenities and reimbursements are made available promptly. In most cases the claimant has experienced a loss that is creating a significant impairment to their ability to live or operate their businesses. The role of insurance coverage is to compensate for that loss and return the client to pre-loss status as quickly (and painlessly) as possible.

Like other industries, insurance has its share of scrupulous behavior when processing claims. This becomes particularly troublesome when the claimant must wait months and even years for reimbursement.

What kinds of activities qualify for a claim of Insurance Bad Faith?

- Deceptive practices including misrepresentation of policy or facts to avoid paying the claim.
- Fraudulent or altered documents for the purpose of discharging the claim.
- Litigation conduct that is unreasonable, including placing the claimant under duress.
- Unreasonable investigation delay or failure to investigate claim.
- Use of abusive or coercive tactics to settle the claim out of court.
- Failure to disclose details of policy, limitations and exclusions.
- Unreasonable requests for evidence of proof of loss.

The National Association of Insurance Commissioners (NAIC) provides information on the Unfair Claims Settlement Practice Act and a list of States that have complied with the guidelines for insurers.

One of the things that have increasingly created change and discussion on the topic of insurance bad faith claims is the rise of instances of storm and hurricane damages. Believe it or not, you can blame the weather man for this one in most cases.

The changing environment and the increased frequency of super storms with prevailing property loss claims seem to have caught the insurance industry off guard. The business model for insurance organizations was not developed to respond to frequent natural disasters, and the recent events from Hurricane Katrina (2005) to Sandy (2012) created insurable loss in the tens of billions. There is a great graphic by The Economist magazine that demonstrates the rising cost of disaster related loss.
Bad Faith Claim Examples

Two recent opinions from federal courts further refine what is and is not bad faith on the part of insurers. Policyholders rely heavily on such claims in coverage litigation to not only get the insurer’s attention, but press for favorable settlements due to the risk of high jury awards if the bad faith claim gets that far in litigation. These two new opinions provide guidance for pursuing such claims.

The first case arises from a first party property loss under a homeowners policy issued by State Farm. Palmisano v. State Farm Fire and Casualty Co. (W.D.Pa. Aug. 20, 2012). The crux of the bad faith dispute was State Farm's retention of an engineering expert in Texas to inspect the policyholders' home in Pennsylvania. It will not come as a surprise to anyone that the expert found that the home's damage was the result of long-term wear and movement due to hydrostatic and soil pressures. State Farm denied the claim, and the homeowners sued for coverage and bad faith.

Interestingly, the U.S. District Court for the Western District of Pennsylvania denied the coverage claim based on the fact that the homeowners did not sue until more than a year after the damage. State Farm relied on the policy's condition stating, "No [suits against us] shall be brought unless there has been compliance with the policy provisions. The action must be started within one year after the date of loss or damage."

The court had no trouble relying on this provision by noting that the damage occurred on Oct. 9, 2010 and the lawsuit was initiated on Jan. 23, 2012. This policy condition reduced the standard statute of limitations for contract claims by three years.

Denial of coverage does not automatically rule out a claim for bad faith in Pennsylvania. The court next addressed whether the plaintiffs pleaded a bad faith claim. The homeowners attached the structural engineer's report to their complaint, which allowed the court to consider it as part of the motion to dismiss analysis. The plaintiffs' main argument, however, was that the expert was biased towards them from the outset. In addition, the expert performed a fair amount of work for State Farm. The court analyzed the survival of the bad faith claim under the Iqbal and Twombly standard for a Rule 12(b)(6) motion, noting that many federal courts have been called upon to evaluate bad faith claims in light of the "Twiqbal" standard.[1]

Relying heavily on Liberty Ins. Corp. v. PGT Trucking Inc., the court found that the homeowners failed to state a claim for bad faith against State Farm. In PGT Trucking, the court held that a plaintiff must plead facts setting forth the "who, what, where, when and how" the bad faith occurred. Generally alleging conclusory allegations reciting portions of claims handling statutes with minimal facts clearly will not carry the day under this analysis.

In PGT Trucking, the plaintiffs asserted general statements such as: the insurer failed to adequately investigate, settle the claim at an appropriate value and act in the best interests of its insured.[2] In comparing such allegations, the court noted, "[a] cause of action for bad faith under Pennsylvania law requires clear and convincing evidence that: the insurer did not have a reasonable basis for its action, and the insurer knew or recklessly disregarded its lack of a reasonable basis for its conduct."[3] When one compares this level of proof to the Rule 12(b)(6)
standard, a mere recitation of unfair settlement practice statutory language will not hold up under Iqbal or Twombly scrutiny.

In the Palmisano matter, once the court ignored the generic allegations and focused on the one factual assertion that State Farm's engineer provided litigation support services as part of his overall scope of work for clients, that was not enough to set forth the requisite level of supporting facts.

The plaintiffs in Palmisano ran into the same problem as the plaintiffs in PGT Trucking. The lawsuit generally averred that because State Farm's engineer provided litigation support that he acted in the insurer's best interest to provide a basis to deny the claim. The plaintiffs then went on to cite a laundry list of generic bad faith allegations:

- Failing to fairly and properly investigate the claim
- Denying State Farm's clearly established coverage obligations
- Denying coverage based on reasons that have no basis in law or fact
- Engaging in improper, unfair and unlawful claims handling and insurance practice

The list goes on but without true factual detail to backup any of these statements. The lawsuit did not state allegations of who, what, when, and how State Farm acted in bad faith towards its policyholders. The pleading requirement certainly was going to require facts when Pennsylvania courts "have recognized that an insurer's reasonable reliance on an engineering expert's report for a coverage decision does not constitute bad faith."[4] Simply implying that the engineer may have had an improper motive or been hired by State Farm in order to deny the claim is too vague to explain who, what, when and how the acts constitute bad faith.

The second case involves the United States Court of Appeals for the Sixth Circuit's recent opinion tackling a bad faith claim over data-security breaches. Retail Ventures Inc. v. National Union Fire Insurance Company of Pittsburgh, Pa. (6th Cir. Aug. 23, 2012). For those not very familiar with these two parties to the litigation, Retail Ventures is DSW Shoe Warehouse and National Union is owned by Chartis (formerly AIG).

In 2005, hackers breached DSW's main computer system and downloaded more than 1.4 million customers' credit cards and checking information profiles. DSW filed a notice of claim with National Union for the losses of approximately $5.3 million related in various forms to the theft. In response to the insurance claim under DSW's Blanket Crime Policy, which contained an endorsement for Computer & Funds Transfer Fraud Coverage, National Union denied it. This forced DSW to sue its insurer for coverage of the data theft and related costs.

In this particular case, the federal courts were called upon to apply Ohio state law. The courts found the issue, which basically revolved around the interpretation of the simple phrase "resulting directly from," new to Ohio for this type of claim. For DSW, its recovery of over $5.3 million boiled down to a court interpreting for the first time small phrases in the crime policy's computer fraud coverage. One can only imagine the risk posed to a smaller business in having a large claim outright denied; it becomes a life or death struggle for the business against its larger insurer.

DSW, as part of its lawsuit for insurance coverage, sought a finding that the carrier acted in bad faith in denying the claim. Unfortunately, bad faith can also be a hard claim to prove in a lot of
cases, and that was true here. National Union had two outside attorneys provide coverage opinions prior to denying the claim. When the first attorney said coverage existed, the insurer sought a second opinion. That latter attorney issued an opinion that there was not coverage. Then, the first attorney changed his mind in light of the new opinion.

DSW argued that the insurer's seeking of a second opinion when it did not like the first from an attorney that the insurer used regularly was bad faith. The appellate court ruled that requesting a second opinion under the circumstances did not make the insurance investigation so "one-sided" as to constitute bad faith. DSW's other arguments for a finding of bad faith were also rejected.

It is not rare for insurers to seek the opinion of coverage counsel before determining whether a claim will be honored under the applicable policy. As demonstrated here, such acts can be used by the insurance company to set up a defense to a bad faith claim. Clearly seeking a "second opinion" in and of itself does not rise to the level of bad faith when the claim is denied. Similarly to Palmisano, more factual detail of "improper acts" were required to rise to the level of bad faith in order to state a claim.

There are a couple of implications for lawyers arising from these two newly minted opinions. First, the fact that the insurer retains an attorney or expert that receives a substantial amount of business from the carrier does not support bad faith by itself. While it may seem odd that State Farm, for instance, flew an engineer halfway across the country to inspect a residence - that is not bad faith.

Second, complaints must allege sufficient details to support a level of proof for bad faith. While who, what, where, when and how may not be the standard of pleading in bad faith across the country, it does provide an excellent list of what an attorney should be looking to plead factually to support a bad faith claim. It is not rare to see pleadings simply list the sections of state "unfair claim settlement practices" statutes. That will likely not cut it when faced with a motion to dismiss.

Finally, in Palmisano, the plaintiffs attached the engineer's report to the complaint. While the opinion does not go into great detail about the substance of the report, it is clear that the judge was able to consider it in reaching his conclusion concerning the sufficiency of the pleading under Rule 12(b)(6). It may not have mattered in this particular case due to the one-year time limitation preventing the amendment of the complaint, but the opinion does raise the question of when it is or is not a good idea to attach exhibits to the complaint.

The court noted that it usually addresses bad faith issues on summary judgment. How much more could the plaintiffs' counsel have gotten in discovery to bolster the claim before relying so heavily on the report? In conclusion, the old adage that "pleading is an art" is proven by these two outcomes.

As many risk managers, insurance adjusters and coverage attorneys know, a bad faith claim can be the hammer in insurance litigation. It allows a winning insured to seek extra damages over and above the policy limits. Bad faith can prove to be the best arrow in a policyholder's litigation quiver.
Unfortunately, bad faith can also be a hard claim to prove in a lot of cases, and that was true here. Careful planning at the outset concerning how to plead a bad faith claim requires utmost care in order to have the best chance of surviving dismissal.

**Claim Technologies Are Changing**

Over the last few years, a number of new claims systems have emerged, with features such as integrated workflow management, task and process management, correspondence and document management, and easily configurable business rules that enable greater degrees of flexibility. To take advantage of these features, many carriers are investigating and implementing upgrades to their core claims administration systems and other technologies that affect claims.

It is estimated that at least 25 percent of insurers are either in the middle of a core claims administration system replacement or are planning one. Replacing a claims system is a project that all carriers will eventually need to do in order to maintain competitive parity. But it is a long-term, expensive project that not all carriers are ready to take on, and there are other strategies that carriers are leveraging to improve their claims management process.

Top trends in claims include:

- Predictive analytics is being used for predicting claims durations, personnel skills-based routing, forecasting of medical costs and fraud detection. Network link analysis is another sophisticated technique used to identify less-obvious connections between parties resulting in more frequent identification of organized crime rings.

- Location-based services and geographic data mapping enables carriers to provide claimant services, such as tow truck dispatch, at first notice of loss (FNOL). It also enables carriers to find patterns in locations, often leading to the identification of fraud rings, or early identification of new claim types.

- Social media analysis increasingly is used in fraud investigation to identify and resolve suspicious claims by obtaining publicly available information from a wide variety of social media channels.

- Collaboration tools increase the transparency of the process with the claimant. These tools include Facebook applications, collaborative content-evaluation tools, repair shop videos and contractor forums, to name a few.

- Mobile apps are untethering claims adjusters from their desks and allowing them to provide more immediate customer service at the point of need. Other enabling technologies include mapping tools to plan and schedule trips or find customers, mobile check-writing capabilities and e-signature solutions. The adjuster can come to the customer's location, estimate the claim, use a mobile solution to issue a check, printed on a plain-paper portable printer, and have the consumer sign the release electronically and automatically record the signature in the file. Mobile applications aren't limited to claims adjusters. Carriers are looking for ways to provide customers with mobile applications to direct, and thereby speed up the claimant through the claims process.

- SMS is growing in popularity as carriers are updating policyholders on the status of their claims or providing them with information during peak contact center hours via text.
messages. Twitter is another mobile communications channel carriers are taking advantage of, particularly in catastrophe situations.

Claims have a strategic impact on carriers, particularly as policyholders' technology expectations are changing. The variety of sophisticated technologies available for claims support is exploding. While not every technical advance is appropriate for every carrier, many of these advances are delivering rapid and sizeable paybacks for those carriers utilizing them today. Now more than ever, opportunities abound to not only improve operations but to deliver a service experience that stands out in the customer's mind and helps to secure a competitive advantage.

**Employer Injury Claims By Unborn Children**

In *Snyder v. Micheals Stores, Inc* (1997), the parents of a minor sued the mother's employer on behalf of the child, seeking injuries resulting from the employer's “negligence” while the mother was working and pregnant.

Plaintiffs allege that on October 2, 1993, Michael's negligently allowed a janitorial contractor to operate a propane-powered floor-buffing machine in the store without adequate ventilation, resulting in hazardous levels of carbon monoxide. Several customers and employees fainted from the fumes. Some, including Naomi Snyder, were taken to the hospital with symptoms of nausea, headaches and respiratory distress. Plaintiffs allege that both Naomi and her daughter Mikayla, who was then in utero, were exposed to toxic levels of carbon monoxide, which impairs the ability of red blood cells to transport oxygen. As a result, Mikayla suffered permanent damage to her brain and nervous system, causing her to be born with cerebral palsy and other disabling conditions.

The trial court sustained Michael's demurrer without leave to amend, citing Bell, supra, 212 Cal.App.3d 1442, as binding, and dismissed the action as to Michael's. The Court of Appeal, however, reversed as to Mikayla's cause of action and her parents' cause of action for Mikayla's expenses of treatment and care. Because Mikayla's injuries were not derivative of Naomi's, but the result of her own exposure to toxic levels of carbon monoxide, the Court of Appeal reasoned, the exclusive remedy provisions of the workers' compensation law (§§ 3600-3602) were not applicable to Mikayla's injuries. Hence, neither Mikayla's cause of action for her own injuries nor her parents' cause of action for the expenses of her treatment was barred by those provisions.

This case demonstrates how derivative injury claims work. The theory holds that if a fetus suffered and injury apart from the mother, i.e., did not derive it from the mother's injury, the right to sue stands on its own, especially since workers compensation does not apply to the fetus.

The next questions becomes, is there insurance coverage for such a third party claim? Workers compensation obviously covered the mother, but the child is a separate and distinct party. Most CGL commercial general policies provide protection against claims of newborns. But, what of a fetus? While settlement is unknown in this case, it is thought that unless some form of exclusion about an unborn is present, the CGL policy should be applicable in such a third-party claim. This is certainly a new exposure for employers to consider.
California Workers Compensation Legislation Promises Rising Premiums

Senate Bill 863, which was signed into law September 2012 by Gov. Jerry Brown, attempts to curb escalating costs on premiums with a number of treatments, among them changing how benefits are calculated for injured employees, among other measures.

Unfortunately for employers, who for the past two years have contended with double-digit rate hikes, relief probably won’t come until the second half of the year, if not later, because of a hardening insurance market that has kept pressure on carriers.

By law, carriers have to send notice to policy holders if they intend to increase rates by more than 25 percent, and we’ve seen a lot of those notices go out lately.

The latest data from the Workers Compensation Insurance Rating Bureau, which advises the state on rates, estimated a 2011 combined ratio of 139 percent — meaning insurers will pay out $1.39 in claims and expenses for every $1.00 collected in premiums.

“Regardless of what SB 863 does to fix the system, the insurance companies are feeling significant pressure to increase rates in order to lower their combined ratios.

The bill aims to increase benefits for injured workers by approximately $700 million, while promising to lower system wide costs to the tune of $1 billion. It attempts to do so by changing how benefits are calculated for injured employees. It creates a binding-arbitration process to resolve disputes over coverage and eliminates coverage for certain conditions prone to more litigation, such as mental health issues and insomnia. The bill also seeks to prevent disputes with providers over payment, known as liens.

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2016 UPDATE REPORT

We are pleased to provide some of the latest industry trends effecting claims adjusting. Browse below to find specific areas of interest. Some court cases involve out-of-state court decisions that will likely influence California claims law.

Adjusters Can Be Personally Liable

In Linron Properties v. Wausau Underwriters Insurance Co., (2015), a federal court held that an adjuster could be personally liable for her wrongful conduct in handling a claim involving repairs from a storm. The adjuster was responsible for retaining an engineer and contractor known to favor the insurance company in their proposals and findings. The adjuster was also accused of failing to respond to the insured's inquiries regarding the status of the claim and payment. The hearing was preliminary to determine if these actions were sufficient to support a claim against her, in her individual capacity, for violating the Insurance Code. The court agreed the adjuster could be liable.

Specific claims against the adjuster were as follows:

- The adjuster conducted an "outcome-oriented investigation" and hired experts she knew would under-scope the plaintiff's damages in order for the insurer to avoid paying the claim, i.e., the plaintiff was denied full coverage for the damages sustained to the property.

- The adjuster was also accused of failing to attempt in good faith a prompt, fair and equitable settlement of a claim, i.e., a violation of fair claims settlement practices.

This case is actually a departure from other recent cases where the courts concluded that adjusters are typically not held personally liable for unfair settlement practices because they do not have settlement authority. Rather, the adjuster's role is that of assessing the damage. The court went on to say that as the persons primarily responsible for investigating and evaluating insurance claims, insurance adjusters have the ability to affect or bring about a fair, prompt and equitable settlement of claims because it is their investigation that the insurance company's settlement is based. Any delay in an adjuster's evaluation, as accused in this case, will cause a delay in payment of the claim and an insufficient investigation may well lead to a less than fair settlement of a claim.
In another case, Kennedy v. Allstate, (2015), the court held that insurer’s adjusters affirmatively misrepresented and concealed material facts from them to delay the resolution of their claims. This was considered a violation under the State’s Uniform Trade Practices and Consumer Protection Law. Here are some points in the case:

- Plaintiffs allege that defendants improperly evaluated their underinsured motorist claims and engaged in intentional delay, misrepresentation and fraud in the course of processing, investigating and arbitrating their claims.

- Plaintiffs also allege that individual adjuster defendants affirmatively misrepresented and concealed material facts from them in order to delay the resolution of their claims. Plaintiffs allege the purpose of these misrepresentations was to induce a lower settlement by causing plaintiffs to suffer increasing financial hardship from the lack of payment under their insurance policy.

- Adjuster defendants sent plaintiffs 29 letters regarding the status of the investigation of plaintiffs’ claims. Plaintiffs allege these letters falsely stated that the investigation into their claims was ongoing and would be resolved in 30 days or sooner despite the entry of an arbitration award against defendants the day before.

While the Court reasoned that the “majority of courts have determined an insured cannot bring a negligence claim against an independent insurance adjuster” it noted that some courts have found that insurance adjusters owe a duty of ordinary care to conduct adequate investigations of an insured’s claims.

In Pohto v. Allstate Insurance Company, (2011), the insured, injured in a motorcycle accident, claimed that the adjuster acted in bad faith and negligently handled his claim. The insured was injured in a motorcycle accident and made an uninsured motorist’s claim with his insurer, Allstate, who assigned it to Boggs to adjust. Allstate denied the claim, presumably based on Boggs’s findings. The insured sued Allstate and Boggs, alleging they acted in bad faith and/or negligently in the handling of his claim. The specific facts of this case are not as important as the court’s decisions that an insurance adjuster, as a non-party to the insurance contract, may be held personally liable for the bad faith or similar torts committed within the scope of the adjuster’s employment because, under state law, a company’s employees may be held individually liable for torts committed within the scope of their employment.

In McCarter v. Progressive Gulf Insurance Company, (2011), the plaintiff was seriously injured in a car accident, resulting in cognitive impairments so severe that his neuropsychologist recommended that he “should not be put in any position of decision-making or judgment … due to the reduced executive function he is experiencing.” To handle the plaintiff’s claims, the insurer assigned an adjuster, who had the plaintiff sign a settlement. The plaintiff claimed that the adjuster fraudulently procured the release with
the knowledge that the plaintiff had impaired reasoning skills. The court held that an adjuster may be held individually liable to the insured, depending on the “relative education of the parties, the diligence of the claimant in seeking the facts, the actual or apparent authority of the adjuster, the content of his promises to the claimants, misrepresentation or fraud.” Again, here is a case where the adjuster is getting deeper involved in the settlement process than merely evaluating damages.

**Hurricane Sandy Engineering Reports Class Actions**

Allegations that insurers used altered engineering reports while handling Sandy claims sparked an ongoing criminal investigation in New York, prompted mass-settlement negotiations between FEMA and attorneys for homeowners, and fueled a demand for congressional oversight hearings. FEMA administers the program that provides flood insurance to 5.3 million policyholders. It functions in partnership with private insurance companies that issue payments to homeowners with federal dollars, and, in turn, earn fees for selling policies and handling claims.

Cleanup efforts within the agency are under way. FEMA’s recent settlement negotiations have centered on about 2,000 cases in New York and New Jersey courts. Yet the U.S. senators from those states have continued to voice concerns that not all evidence of potential fraud has been revealed and that more homeowners are entitled to payouts.

Still, attorneys are moving quickly to obtain and review a new set of documents: adjusters’ reports. The Merlin Law Group, representing clients in more than 300 pending Sandy flood-insurance lawsuits, is in the process of serving subpoenas to the independent adjusters and the adjusting firms that are contracted by insurance carriers. “We want the draft copies of the estimates, and email exchanges between them and the carriers,” said lawyer Charles R. Mathis IV.

“We have strong evidence that indicates there’s 10,000 reports” that were altered, or followed a template of pre-determined outcomes, attorney Steve Mostyn tells International Business Times. Mostyn’s firm has reviewed about 1 million pages of documents that insurance companies were forced to disclose. The Texas-based lawyer has filed three class-action lawsuits against insurers that handle claims for the Federal Emergency Management Agency, alleging that they and other contractors schemed to alter damage reports and minimize payouts.

**Public Adjuster Solicitations**

In California, the law is a bit general on how public adjusters can and cannot solicit business. In a nutshell:

- No public adjuster shall solicit a client during the progress of a loss-producing occurrence, i.e., the middle of a major wildfire or at the hospital emergency room.

- No public adjuster shall solicit a policyholder between the hours of 6PM and 8AM.
During times of major catastrophes, these rules get a little bent. In Texas, for example, widespread hailstorm damage brought a flood of questionable solicitations prompting state officials to create new, stringent solicitation laws. Here is a sample of the new restrictions:

- A public adjuster may not derive any direct or indirect financial benefit from a construction, repair, salvage or other firm involved in the claim. This clarification ensures that a public adjuster cannot play a dual role in a claim, i.e., an individual can be a licensed public adjuster and can also be a contractor, but the individual simply cannot do both for the same claim.

- Apprentice solicitors are prohibited. Formerly, licensed public adjusters could hire employees to act as “trainees” for up to 360 days without their obtaining an actual public adjuster license. Individuals with little to no experience in the insurance industry or any knowledge of the adjustment of insurance claims — and with no intent to become a legitimate license holder — would abuse this loophole for quick financial gain. The new law requires all public adjusters to obtain the necessary experience and education prior to obtaining a license and performing services as a public adjuster.

- Referral payments to a public adjuster from any third-party “individual or firm, including an attorney, appraiser, umpire, construction company, contractor or salvage company are prohibited. This new section addresses the all-too-common issue of a public adjuster referring work to others — such as construction companies, appraisers and lawyers — in exchange for payments to the public adjuster. The Texas licensing statute is clear that public adjusters can receive compensation only from their policyholder clients. This ensures that the interests of the public adjuster are aligned solely with its policyholder client.

- A public adjuster must actually do the work he is hired to do. This prohibits a public adjuster from entering into a contract with an insured and collecting a commission as provided by without the intent to actually perform the services customarily provided by a licensed public insurance adjuster for the insured.” The obvious intent of this provision is that public adjusters enter into contracts with policyholders with the intent to actually assist the property owner with its insurance claim — the very clear role of the public adjuster. This seems simple enough. Unfortunately, however, certain public adjusters were not signing up clients with this intent, but instead appeared to sign up clients for the sole purpose of immediately referring the policyholder to an attorney. In turn, the attorney would handle the claim on a “reduced” 30 percent contingency fee and the public adjuster would receive a 10 percent contingency fee. Obviously, this far-too-common process subverted the role to be played by the legitimate public adjuster.

- Having lucrative referral agreements with policyholder attorneys is now expressly prohibited. Some public adjusters were in the practice of affixing attorney representation agreements to their contracts to be executed simultaneously with the public adjuster contract. Policyholders in many instances simply signed what was placed in front of them, not realizing they were not only hiring a public adjuster but also an attorney to file a lawsuit against their insurance company.
Now, a license holder may not act on behalf of an attorney in having an insured sign an attorney representation agreement

- Under previous law, a public adjuster was permitted to pay up to a $100 fee to nonpublic adjusters for the referral of an insured to the public adjuster. The new law strikes this exception to the prohibition of referral payments by a public adjuster. The significance of this change is far reaching and eliminates (or at least removes the financial incentive) for unlicensed individuals to go door-to-door following a storm and receive $100 for each contract they are able to sign on behalf of a public adjuster (who likely had no intent to actually adjust the claim and instead would then simply refer the client to an attorney).

While not law in California, you can bet that recent fire claims could bring on some aggressive solicitations. Could this be the trigger to start legislation similar to what we see in Texas?

**Policy Reinstatement**

In the case of *Zeller v. AAA Insurance Company* (2015) Zeller purchased a homeowner's policy from AAA Insurance Company. It contained a very interesting reinstatement provision:

*Conditional Reinstatement - if you make adequate payment after the due date and we reinstate the policy, there will be no coverage during the period of time between the date the policy cancelled and the date and time we received the payment. However, reinstatement of the policy is conditioned upon the following any any Notice of Reinstatement is void if:

  (1) any form of premium payment is not honored for any reason; or
  (2) there is a claim under the policy arising from an event that occurred between the policy cancellation date and the date and time we received your payment to reinstate the policy.*

Zeller failed to pay a premium installment by the cancellation date but mailed a payment that AAA later accepted. Two days after AAA accepted payment, Zeller’s garage was damaged by fire. He submitted a claim to AAA, which denied coverage on the basis that the policy was “not in force” on the day of the fire.

Zeller filed a complaint against AAA alleging breach of contract and bad faith and requesting compensatory and punitive damages. After a bench trial, the trial court ruled against Zeller on the basis that there was no evidence that AAA reinstated the policy.

However, on appeal, Zeller argues that the trial court’s ruling is erroneous because the policy was reinstated when AAA accepted his payment. In essence, Zeller made an offer to reinstate, the insurer accepted. A contract was made. The appeals court reversed the original decision in favor of the homeowner.

The issue that made the case for Zeller is the fact that the cancellation letter stated that payment must be received by November 30. But, no such language appears in or is incorporated into the insurance contract. Plus, there is no deadline in the contract for payments for reinstatement.

2016 Update – California Claims Adjusting
**Insurable Interest**

Lots of homebuyers and business people alike, title their property in the name of their trust, LLC, etc. Their insurance coverage, however, can often be left, by mistake, in their personal name, presenting an issue of insurable interest.

Under California Insurance Code 286, *an interest in property insured must exist when the insurance takes effect, and when the loss occurs*. Thus, where the title is in the name of a trust or LLC and the policy is in the name of the individual homeowner, the homeowner may find that if a direct physical loss to their property occurs, they may not technically have a proper insurance policy to cover the loss. A typical policy, for example, will state that *insurer only promises to indemnify the insured for their loss up to, but no more than, the insurance interest of the person insured*.

Another issue to consider is: Did the agent have knowledge the property title was changed to a trust or LLC and continued to accept premiums and bill the individual? That might be different. Having knowledge that the insured and homeowner are one and the same, would most likely obligate the insurer. Without this pre-existing knowledge, coverage is uncertain.

Other pertinent codes seem to reinforce the need for a real insurable interest:

Insurance Code Section 282, dictates that an insurable interest is defined as *an existing interest, an inchoate interest founded on an existing interest, or “an expectancy, coupled with an existing interest in that out of which the expectancy arises*.

Insurance Code Section 287 states *an insurance policy is void unless the insured has an insurable interest in the property at the time of the loss*. Specifically, if a loss occurs and the named insured is not the titled owner of the property then there is no active policy for the property. To constitute an insurable interest, the insured must have a direct pecuniary interest in the preservation of the property and be exposed to pecuniary loss as an immediate and proximate result of its destruction. ¹

As a side note, the author of this article decided to call his own agent to investigate insurable interest as his home is in the name of a revocable trust, yet the policy is in his personal name. Most would agree that the trustors of a revocable trust are normally considered one an the same as the individuals. And, the author's agent was quick to say that the insurer would always stand by and pay such a claim, despite the title difference. However, it was interesting that despite these verbal claims, the agent spent time to note the file with the trust as an *additional insured*. Further, the author was advised that a new declaration page would be sent. Was all this necessary if it is standard practice to consider individual insureds the same as the trust / title holders of the property? Maybe not. Perhaps this insurable interest issue is a real issue for all to consider.

**Appraisals and Scope of Loss**

The California Insurance Code provides a mandatory method of resolving property insurance claim dispute amounts by the using two different appraisers and an umpire. The job of the appraisers is to determine the amount of damage resulting, but NOT to
resolve questions of coverage or interpret policy provisions. Sounds pretty cut and dry, right?

Well, we have a little issue called scope of loss that gets in the way. A **scope of loss** is a document or a set of documents and measurements that **describe the amount and type of damage that has been done to a structure, plus the quantity and quality of materials and the current cost of those materials and labor that will be needed to repair or rebuild that structure.** And, it often is NOT cut and dry. For example, a water loss floods the kitchen. Can the flooring be repaired or does it need to be replaced? Can the kitchen cabinets be saved or is the homeowner entitled to new cabinets? These types of issues arise and are often a point of contention.

Typically, if an insurance claim for property damage is adjusted properly, both the insurer and insured will agree to a scope of loss. In other words, the two sides are on the same page as far as identifying the damage, recognizing the full extent of the damage and determining the appropriate method or means of repair.

As often happens, however, disputes occur during the adjustment of a claim and often over the scope of loss.

So, the question is can an appraisal to be rejected if there is no agreement on the scope of loss? The recent case of *Lee v. California Capital Insurance Company (2015)* tells us that **disputed items in a scope of loss is NOT a reason to reject appraisal.** In other words, an appraisal resolution may assign a value to items as to which coverage is disputed with the disclaimer that the award does not establish coverage or the insurer's liability to pay. The issue of whether the loss is covered under the policy is a separate, legal issue that must be resolved outside the appraisal process.

Therefore, if an insurer declines to enter the appraisal process contending that the scope of loss is disputed, the policyholder can seek court intervention and obtain an order compelling appraisal. A court may also defer appraisal proceedings pending a resolution on scope of loss.

**Policy Exclusions**

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 . . . as well as "new generation policies" that are very carrier friendly with policy exclusions never seen before.

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.**
So what does the "new generation" policy look like? Consider some of the exclusions/refinements seen below in actual new policy offering:

One such change is the below clause that deals with the payment of overhead and profit:

Claim payments for overhead and profit. General contractor fees and charges will only be included in the estimated reasonable replacement costs if it is reasonably likely that the services of a general contractor will be required to manage, supervise and coordinate the repairs. However, actual cash value settlements will not include estimated general contractor fees or charges for general contractor’s services unless and until you actually incur and pay such fees and charges, unless the law of your state requires that such fees and charges be paid with the actual cash value settlement.

In other words, the payment of overhead and profit is subjective where it is reasonably likely that the services of a general contractor will be required to manage, supervise and coordinate the repairs” (emphasis added).

The insurance carrier will be the one to determine if a general contractor is necessary regardless of the number of trades or complexity of the work to be performed. This can result in a much smaller check to the insured than anticipated.

Water Damage. Most homeowners purchase policies thinking that fire, theft and sudden and accidental water damage from plumbing leaks are covered. Except, that is, in the case of this new generation policy exclusion:

We do not cover loss resulting directly or indirectly from:

Floods
Sewer overflow
Ground water
Water damage
Water in places it is not supposed to be

So, water damage is NOT covered where a water line under a sink bursts or the line to a washing machine rips loose and floods the house. This may be a first!

Collapse Defined

In Queen Anne Park Homeowners Ass’n v. State Farm Fire & Cas. Co.(2015), the Supreme Court held that the term "collapse," when left undefined in a property insurance policy, includes substantial impairment of structural integrity. The policy stated that collapse does not include settling, cracking, shrinking, bulging or expansion, but did go further to actually define the term "collapse."

The case involved the Queen Anne Park Homeowners Association (the "Association"), which insured its two-building condominium complex with State Farm from 1992 to 1998. State Farm’s policies provided insurance for "collapse of a building or any part of a building," caused by "hidden decay. The Association filed an insurance claim with State Farm in 2010, alleging the complex had several areas of hidden decay that had reached a state of SISI. State Farm inspected the two buildings but denied the claim, in part,
because a collapse had not commenced during the period State Farm insured the condominiums.

The Association then sued State Farm. And, after a federal district court granted summary judgment in State Farm’s favor, the Association appealed. On appeal, the Ninth Circuit submitted a certified question to the Washington Supreme Court, asking it to define the term "collapse" in the State Farm policies at issue.

Acknowledging the three collapse standards adopted by other courts—actual collapse, imminent collapse, and SISI—the court held that the term "collapse" was ambiguous and must be construed in favor of coverage. For this reason, the court interpreted the term to encompass SISI. According to the court, SISI means "impairment so severe as to materially impair a building’s ability to remain upright." The SISI must, therefore, render a "building or part of a building unfit for its function or unsafe in a manner that is more than mere settling, cracking, shrinkage, bulging, or expansion." In a footnote, the court warned that SISI should not be interpreted to convert an insurance policy into a maintenance agreement for substantial damage that does not threaten collapse.

Premises Residence Claims

In 2015, a major change in the definition of residence premises has been adopted by ISO. The new endorsements introduce revised language to more explicitly describe that the residency requirement, when determining coverage applicability, will be satisfied as long as the insured resides at the residence premises on the inception date of the policy period. Coverage will be provided through the end of the policy period despite mid-term changes in residency while allowing an insurer the opportunity to confirm residency as part of the renewal underwriting process.

In other words, if the insured resides in the dwelling at the inception of the (new or renewal) policy period, coverage remains in force even if the insured should discontinue residency later in the policy period. This “grace” period lasts throughout the policy term but should be reaffirmed by the carrier on each renewal.

This compares with current or recent language where, depending on insurer claims practices, a policyholder may or may not have coverage when they cease to reside at the residence premises mid-term or at renewal.

Some background: Most homeowners policies provide coverage for the dwelling on the "residence premises." The term “residence premises” is typically defined to include the dwelling “where you reside.” Here is what that policy language might look like . . .

SECTION I – PROPERTY COVERAGE A.

Coverage A – Dwelling 1. We cover:

a. The dwelling on the “residence premises” shown in the Declarations.... This is the definition of “residence premises”: “Residence premises” means: a. The one family dwelling where ‘you’ reside;
b. The two, three or four family dwelling where ‘you’ reside in at least one of the family units; or

c. That part of any other building where ‘you’ reside; and which is shown as the “residence premises” in the Declarations. This is the definition of “you”: In this policy, “you” and “your” refer to the “named insured” shown in the Declarations and the spouse if a resident of the same household.

The “where ‘you’ reside” stipulation means that, if “you” no longer resides in the dwelling, it isn’t a “residence premises,” and thus there is no Coverage A, B or D since each hinge on the existence of a “residence premises.” Another argument says that since the Coverage C limit is a percentage of the Coverage A limit and Coverage A no longer exists, then the Coverage C limit vanishes.

The question is, what happens if you no longer (or never) reside(d) there? Some courts have concluded that, if ‘you’ no longer reside in the dwelling, coverage on that structure immediately terminates.

There are many special circumstances like:

An elderly widow was admitted to a nursing home to recuperate from some health problems in order to be able to return home and to self-sufficiency. Her home remained her legal address and her nonresident children cared for the home, though no one lived there during her presumably temporary stay at the health care facility. After a few months, her home was totally destroyed by fire. The insurance company **denied the claim** on the house on the basis that she did not reside there at the time of loss. But, was she in the nursing home temporarily or did she have no chance of returning to her premises residence? Was the agent apprised of the situation?

As another example, a home was damaged by Hurricane Gustav. The homeowners had temporarily vacated the premises during remodeling though they visited the premises daily. The insurer denied the claim because the insureds were not residing there at the time of loss.

There are dozens of other situations where an insurer could declare that the policyowner was not residing in the home at the time of loss and deny a claim, such as:

- Relocation...the homeowner has been transferred to a new job in a different city. He is living in a hotel while a realtor tries to sell his home.

- Foreclosure...the bank is foreclosing and the homeowner moves out prior to the eviction in order to get her kids settled in a new neighborhood and school.

- Renting all or part of a home

- Child occupies a parent’s home...the parents move to Florida and the daughter stays in the home to stay in college. But if she is not listed as an additional insured, a claim will be denied.

- Parent occupies a child’s home...same as above.
• Divorce . . . one of the spouses moves out the other remains in the home. Unfortunately, the insurance was in the name of the one that moved out.

• Illness or death of the insured . . . relatives who continue on in the home, even paying the premiums for the policy, are not considered as residents, especially if the agent is unaware of the situation.

• Trusts...a couple re-title their home with their son and daughter as sole trustees but the couple continues to reside in the home . . . the son and daughter do not.

• Home seller moves out before closing...

The new ISO language will help, but coverage under older policies will still need to be reviewed to confirm residence premises.

Social Media

With millions of tweets, Instagrams, You Tubes and Facebook uploads each day, social media has become an integral facet of our lives. This media is also fodder for attorneys, employers and others looking for ethical discovery. To defend against this, claimants’ counsel typically instruct clients to limit their social media posts or simply delete their existence. This is why claim professionals are learning to gather beneficial evidence as early as possible after a claim has been filed.

Early investigations of a claimant's social media accounts can reveal a host of facts like:

• Evidence of a preexisting condition
• Property damage
• Risky activities or lifestyle
• Post claim activities that affect future claims

If there is nothing uncovered from an investigation or as a matter of course, it is suggested to check the social media accounts of relatives or friends that may have pertinent information about the claimant and his injury or allegations.

Preserving Evidence

The obvious procedure to preserve a fact found on social media is to print the page or save and print a screen shot using alt+print screen. While this could work, it does not net any metadata.

Metadata is used to describe digital data using metadata standards specific to a particular discipline. Describing the contents and context of data or data files increases their usefulness. For example, a web page may include metadata specifying what language the page is written in, what tools were used to create it, and where to find more information about the subject; this metadata can automatically improve the reader's experience.

The main purpose of metadata is to facilitate in the discovery of relevant information, more often classified as resource discovery. Metadata also helps organize electronic
resources, provide digital identification, and helps support archiving and preservation of the resource. Metadata assists in resource discovery by "allowing resources to be found by relevant criteria, identifying resources, bringing similar resources together, distinguishing dissimilar resources, and giving location information".

There are companies that specialize in retrieving metadata media for use at trial. They can reveal when photos were taken to help solidify the claimant's timeline.

Legal Issues

In one of the early court decisions, Tompkins v. Detroit Metro Airport (2012), it was learned that material posted on a social media account is generally not privacy protected . . . even when the account is set to private or limited viewing. The underlying premise is that anything posted on a social media account is meant for viewing and to be shared.

The hardest part of submitting social media evidence is authentication or proving that the media facts are real and pertinent. For example, in Griffin v. State (2013), the courts determined that merely harvesting facts from a social media account may not be enough to prove a particular person was actually the author of those facts. After all, anyone can create a social media account and post whatever they like about someone else without that someone even knowing about it.

What helps in court is any kind of written discovery (getting the claimant to admit in writing he posted certain facts to his media account), deposition testimony (verbal confirmation he posted certain facts), forensic evidence (a hard drive, metadata, etc.) or stipulation (getting the claimant's attorney to accept the authenticity of the claimant's social media information).

The recent Nucci v. Target (2015) case went even further on the issue of social media evidence. Here, a plaintiff asked for a large slip and fall settlement. But, as the defendant's team discovered, the plaintiff's Facebook page was loaded with pictures showing her participating in physical activities beyond her stated health condition. Over several years, there were many back and forth issues surrounding privacy and the use of these pictures. However, the defendant prevailed in getting the court to order evidence from the plaintiff's social media accounts and smart phone records. Here are the items the court required:

- Identify all social/professional networking websites that Plaintiff is registered with currently (such as Facebook, MySpace, LinkedIn, Meetup.com, MyLife, etc.)
- List the number and service carrier associated with each cellular telephone used by the Plaintiff and/or registered in the Plaintiff's name (this includes all numbers registered to and/or used by the Plaintiff under a "family plan" or similar service) at the time of loss and currently.
- For each social networking account listed in response to the interrogatories, please provide copies or screenshots of all photographs associated with that account during the two (2) years prior to the date of loss.
- For each social networking account listed in the interrogatories, provide copies or screenshots of all photographs associated with that account from the date of loss to present.
• For each cell phone listed in the interrogatories, please provide copies or screenshots of all photographs associated with that account during the two years prior to the date of loss.
• For each cellular phone listed in response to the interrogatories, please provide copies or screenshots of all photographs associated with that account from the date of loss to present.
• For each cellular phone listed in the interrogatories, please provide copies of any documentation outlining what calls were made or received on the date of loss.

In the end, this decision was appealed. And, the appeals court determined that social media posts by a plaintiff are indeed discoverable and that photographs posted on a social networking site are neither privileged nor protected by any right of privacy, regardless of any privacy setting. In essence, before the right of privacy attaches, there must be an expectation of privacy. This does not exist on most social media sites.

Ethical Issues

If someone's social media account is considered public information, courts and bar associations alike agree that it is ethical to visit such sites and harvest any information needed. Getting deeper into "private areas" of a claimant's Facebook page or friending them to get information is still considered an ethical breach, especially since "friending" a claimant is the same as directly contacting them . . . an activity frowned upon between attorneys and their clients. Hiring a third party to "friend" a claimant is likened to the same unethical practice . . . at least among bar associations.

Breach of Warranty

In the ongoing litany of reasons why insurers can and do deny coverage, you can add the breach of warranty. In Guam Industries v. Zurich (2105), a dry dock loaded with barrels of oil was destroyed by a typhoon. The policy had a warranty that required Guam to obtain Navy certification of the dock. It was never done and on that basis the insurer voided the policy and denied the claim for the lost oil.

The lawsuit that ensued raised issues like:

• Plaintiff: The typhoon would have destroyed the dock regardless of Navy certification or not.
• Plaintiff: The "commercial certification" of the dock, obtained by Guam, should have been as good as Navy certification.

• Defendant: We would not have issued the policy but for the warranty.
• Defendant: The Navy certification requirement was not buried in the back of the policy, rather it was in decent size type in a separate paragraph on a policy endorsement.
• Defendant: California law allows the voidance of a policy for any breach of warranty, regardless of how small or immaterial.

The court sided with the defendant insurance company. The claim was denied with the message that policy warranties are a big deal.
Warranties come in many flavors:

Here are just a few:

- The insured must limit occupants to a building or the number of employees working in a room or on a vessel.

- The insured must update the worthiness of a machine, vehicle, aircraft, boat etc. on an annual or regular basis. Failure to do so could void the policy.

- The insured must be truthful in statements made when he purchased an insured vehicle or vessel . . . was it new or used . . . was it involved in a previous accident or fire . . . was it for sale, etc.

- The insured must obtain a certificate of occupancy, license or permit of some kind.

Negligence can trump a warranty

Every claim is different and not all warranty violations result in policy voidance. Take the case of Picket v. Wood (1981). The insured in this case purchased an insurance policy that required annual airworthiness certification. The insured failed to update this certification. Soon after, his plane crashed and it was determined that human error caused the crash.

The law seems pretty clear:

_A breach or violation by the insured of any warranty, condition, or provision of any wet marine or transportation insurance policy, contract of insurance, endorsement, or application therefore shall not render void the policy or contract, or constitute a defense to a loss thereon, unless such breach or violation increased the hazard by any means within the control of the insured._

But, the plaintiff, the pilot’s widow, argued that because the crash was due to pilot error (the plane flew into the ground while attempting to land in bad weather) and not the result of any malfunction, the failure to have a valid airworthiness certificate did not contribute to the accident and that therefore, the statute should apply and prevent the insurance company from relying on the exclusion to deny coverage. In this case, the court agreed and coverage was required to be paid.

Other cases seem to say that any breach of warranty, no matter how small, or whether it contributes to the claim, voids the policy. Perhaps the idea that a widow and not a corporation was the beneficiary has bearing. Always read the warranties.
We are pleased to provide some of the latest industry trends effecting claims adjusting. Browse below to find specific areas of interest. Some court cases involve out-of-state court decisions that will likely influence California claims law.

Adjuster Employees Can Be Personally Sued

In Bock vs Hansen, an adjuster opened himself up for personal liability on a claim involving a large tree limb that crashed into a home's window and chimney.

The adjuster:

- Spent less than 10 to 15 minutes to review the damage
- Pushed branches out of the living room window before taking pictures, ignoring the homeowners inquiry as to why he did that. When the adjuster was asked why he had not taken the pictures first, he ignored the homeowner as told her to “clean up the mess” and demanded that she clean up the living room.
- Removed tree limbs leaning against the chimney before taking any pictures.
- Informed the homeowners that cleanup was not covered under the policy and that they should contact “friends and family members with chainsaws” to clean up the limbs and the mess in the house and backyard. As a result of doing so, the homeowner incurred some injuries.

Based on the adjusters report the Bock claim was denied. The Bocks sued Travelers and the adjuster. The insurer for breach of contract, breach of implied covenant of good faith and fair dealing, misrepresentation (false promise with no intention to perform) and violations of various Business and Professions code. Their claims against the adjuster alleged negligent misrepresentation and intentional infliction of emotional distress.

Emotional distress? The Bocks argued the adjuster ignored overwhelming evidence that the tree limb hit and cracked the chimney; insulted and disparaged them; altered the scene of the accident before taking photographs; misrepresented the terms of the policy; prepared false claim reports; conspired with the claims preparer to intentionally file a false report; knowingly relied on the false report in order to deny a legitimate claim and
that he (the adjuster) knew the chimney was the Bocks’ primary source of heat and that winter was approaching.

The adjuster argued that he cannot be liable as an agent because he was acting in the course and scope of his employment. However, the court found that: “An agent or employee is always liable for his or her own torts, whether the principal is liable or not, and in spite of the fact that the agent acts in accordance with the principal’s directions.

The court also found that the adjuster, as the employee of the party in the special relationship, had a duty to the Bocks. His false claim that it was the responsibility of the owner to clean up a 3-ton tree themselves ended up with the owners incurring some minor injuries and the determination of negligent misrepresentation by the court. It is generally said that “California courts have recognized a cause of action for negligent misrepresentation, i.e., a duty to communicate accurate information . . . ”

The court in this case was also said to be deeply offended by the adjuster's alleged conduct and his "defense" that any possible reliance on his alleged misrepresentations was unreasonable because the insureds should have read their policy.

The parties appear to have settled before further court action.

The importance of this case is that it now appears that even adjuster employees can be individually sued for negligence and misrepresentation.

**Reminder: Adjuster Notes Can Create Bad Faith Litigation**

Emails, letters, reports and even water cooler conversation are fodder for attorneys trying to make a case. In the context of notes to your file or report, they are looking for any unreasonable behavior to support a bad faith claim.

Adjusters should NOT make things any easier by making prejudicial or sexist comments; careless, and politically incorrect comments; or being less than objective in their correspondence.

Gary Blake is a communications expert and he has found some doozies!

**Taking Sides.** Don't say things like this in any correspondence or conversations:

"We have a favorable interview from a neighbor that our insured's driver was not supposed to use the car;"

"Fortunately, there's a neighbor who says that John was not permitted to drive the car."

"We can only hope that the plaintiff's condition continues to deteriorate."

"We think this person will die of cancer, and we will be off the hook."

**Subjectivity.** Don't interject your own ideas by saying something like this:
"This is ridiculous!" (an adjuster venting his belief in the claimant committing fraud);
"These people ...." (Used as a slur against an ethnic group the adjuster felt had ties to organized crime);
"Mr. X dabbles in adult entertainment"
"This place is a dump. Pigs wouldn't live here!"

Stupid Talk:
"I am darn near speechless on how this appeal has been handled by the other area."
"If the claimant calls, don't take the call"
"the claimant walked two steps from the wheelchair to the television set."
"the dishonest claimant is perfectly healthy and quickly jumped from the wheelchair then walked confidently to the television set."

Prejudice.
"This black lady was behind the desk";
"She was an older woman and didn't remember me";
"The boy was too fat to have exited the car in that manner."
"They are deadbeats"
"They are procrastinating";
"They don't have a snowball's chance in hell of getting what they are asking for"
"I just know this claimant doesn't want to go back to work."

Sexism.
"To the 'chick magnet' ... this claim has been assigned to you because you have 'hot hands.'"

It didn't look helpful when a jury heard it.
Any one of these could get you fired and they certainly would not be good for a jury to hear in a case against you or the insurer.

Homeowners Are Rated Poor In Water Leak Mitigation

A recent Chubb insurance survey claims that a majority of homeowners do not view internal water leak damage as a major concern, despite the fact that water leaks are a more frequent risk than fire and theft. And, despite the fact that the Insurance Institute says that the frequency of sudden pipe bursts has doubled in the past few years.

What’s more? "Nearly half of all homeowners (45%) have had personal or second-hand exposure to an internal water leak in the past two years, either in their own home or through someone they know", says Chubb. "That’s the highest level of familiarity as compared to all of the home exposures ranked in the survey, including fire and smoke damage (21%), theft and vandalism
(34%), infestation and pest damage (30%), flood water damage (28%),
weather-related damage (40%), and property-related liability (14%)"

According to the survey, 91% of the respondents rate themselves as vigilant,
yet less than 25% turn their main water off when they leave for an
extended period of time and the majority admit they don't even know where
the shutoff is! And, only 18% have invested in leak detection technologies.

Further, homeowners don’t protect against the full range of property exposures. "The majority of homeowners", says Chubb, believe that water heaters (49%) are the most likely source. While water heater-related leaks are among the top five causes, data from the Insurance Institute for Business & Home Safety shows that plumbing supply system failures are the leading source of residential water loss, with a 48% greater loss (in terms of total payouts) than the second-leading source, toilet failure (identified by only 40% of respondents as the most likely source of internal water damage), and an average cost of $5,092 per incident after the deductible was paid."

What can explain the higher frequency of water-based homeowner claims? The need for better monitoring by homeowners is certainly one factor. The other could be the shorter life cycle of appliances (they don’t build them like they used to) and aging of the housing stock. Says Chubb, "Appliances tend to perform at their best during the first five years. As they age, however, appliances, hoses and related components become less reliable. The sweet spot for these components to fail begins at year eight. Today, America’s housing stock is a decade beyond the multiyear home-building boom that preceeded the financial crisis. That means that the number of U.S. homes in the sweet spot for failing appliances, hoses and the like is cresting".

Who is more likely to file a water leak claim. Well, these leaks don’t
discriminate, but if being proactive is the measure, higher income
homeowners are less likely to maintain and inspect their appliances and
water supply lines than middle-incomers.

**Gradual Damage vs. Sudden & Accidental**

The outcome of a water leak claim may hinge on whether the damage is
gradual or sudden and accidental. Gradual damage water damage is less
likely to be covered, like where lack of maintenance or inspection by a
homeowner where:

- Plumbing, faucets or pipes leaking causing damage to the walls,
  ceilings or floors .
- Water damage caused seepage in cracks in the foundation, or at the
  exterior of the dwelling allowing water to enter your home.
• Flashing, tiles, shingles or deteriorating parts on the roof that indicate signs of needed repair.

Insurance is meant to cover sudden and accidental damage. By definition, sudden and accidental damage means that whatever has happened, should not have been the result of damage over time.

Ways homeowners might justify their claims for gradual water leak damage include:

• Maintain records of repairs and the professionals hired over the years to do maintenance.
• Do regular maintenance to avoid surprises. Small repairs regularly will avoid large expenses.
• Purchasing extra coverages where needed.
• Understand all policy coverages, exclusions, as well as the responsibility to mitigate losses, including:
  ✓ Plugging a leak or turning off a water valve to stop water flow from a burst pipe
  ✓ Covering a leaky roof or shattered window with tarp to prevent rain from entering the home
  ✓ Drying out damp areas of the home to prevent mold formation
  ✓ Removing wet items, such as carpets, upholstery and clothing, from a home after a flood, rainstorm or pipe burst
  ✓ Wiping metal objects dry to keep rust from forming
  ✓ Securing the premises against burglaries and vandalism
  ✓ Pruning a compromised tree to prevent branches from falling on the home or a person
  ✓ Clearing fallen trees and branches from a roof and surrounding land
  ✓ Unblocking gutters and drains clogged by leaves, pine needles, sand and other debris
  ✓ Cleaning up debris from the yard after heavy winds
  ✓ Putting out a fire or calling the fire department immediately

**Outrageous Behavior Leads To Claim Denial**

A commercial umbrella liability insurer has no duty to indemnify its insured against $2.6 million in punitive damages that it paid to settle an underlying wrongful death and survival action based on the insured's "outrageous

On May 30, 2010, while exercising a race horse at Parx Racetrack, Mario Ramiro Calderon sustained fatal injuries in an accident that allegedly occurred when a chicken on the racetrack spooked the horse on which Calderon was riding. The accident caused Calderon to fall, suffer injury and die.

Two years later, Calderon's estate filed a wrongful death and survival action against Parx and its related entities, alleging that they were negligent in allowing chickens to roam freely on the racetrack premises and the racetrack itself.

**Punitive Damages**

The estate filed a second amended complaint, adding a claim for punitive damages. Ace reserved its right to disclaim coverage for any punitive damages that might be awarded in the underlying trial.

On April 9, 2014, a jury returned a $7,764,429 verdict against Parx. Out of the total amount, $2,264,429 was attributable to the wrongful death claim, $500,000 was attributable to the survival suit and $5 million was attributable to punitive damages.

Ace refused to indemnify Parx for the punitive damage award.

Parx appealed but eventually finalized a settlement with the estate for $5.5 million: $2,746,429 was attributable to compensatory damages, $88,196.64 to delay damages and $2,647,374.36 to punitive damages.

Ace tendered payment of $1,820,874.85.

In February 2016, Parx sued Ace in the Philadelphia County Court of Common Pleas for breach of contract and bad faith, seeking to recover the punitive damages portion of the underlying settlement agreement.

The parties cross-moved for summary judgment.

**Outrageous Behavior**

In general, a claim for punitive damages against a tortfeasor who is personally guilty of outrageous and wanton misconduct is excluded from insurance coverage as a matter of law where the insured's liability arises
solely from vicarious liability. That appears to be the case here where the liability of the employer is imputed by the acts of his employees. However, the employer in this case is ALSO the landowner. And, as a landowner, he should have known that chickens regularly walked on the racetrack and premises and knew that this posed a serious risk of injury or death to the decedent and others. So, the vicarious liability exclusion did not work for him.

The judge noted that “the record is filled with evidence of the owner’s own direct negligence based on its knowledge of the chickens' presence and the company’s failure to address the problem.”

“This evidence, along with the court's jury instruction on the duties of a landowner and the court's explanation of the verdict sheet, is persuasive that the jury's punitive damages award was against Parx for its own direct negligence.

The company had failed to maintain a safe racetrack, even as it was aware of the risks. Parx could have taken action, but did not. Landowners like Parx have a duty to protect an invitee not only against known dangers, but also against dangers that might be discovered with reasonable care. The fact that Parx's corporate responsibility stems from actions of its employees does not preclude its own direct liability. If a jury finds that a corporation has committed an outrageous dereliction of duty, punitive damages are appropriate.”

The umbrella policy insurer was not liable to reimburse the insured for the punitive damages he paid.

**Self-Interest and Ill Will No Longer Need Proven In Bad Faith Claims**

In *Rancosky v. Washington National Insurance Company*, the court confirmed that, to prevail on a claim under the bad faith statute, a policyholder no longer needs to prove that the insurer acted with a motive of self-interest or ill will. Insurers now must only satisfy a two-part test, and only a two-part test: A policyholder must prove by clear and convincing evidence that:

1) the insurer did not have a reasonable basis for denying benefits under the policy, and
2) the insurer knew of or recklessly disregarded its lack of a reasonable basis.

This ruling basically eliminates the “Terletsky test, the standard used since 1994 that required proof of self-interest or ill will. The court explained:

*Given our conclusion that there is no basis to distinguish between punitive damages and other categories of damages under Section*
8371, an ill-will level of culpability would limit recovery in any bad faith claim to the most egregious instances only where the plaintiff uncovers some sort of “smoking gun” evidence indicating personal animus towards the insured. We do not believe that the General Assembly intended to create a standard so stringent that it would be highly unlikely that any plaintiff could prevail thereunder when it created the remedy for bad faith. Such a construction could functionally write bad faith under Section 8371 out of the law altogether.

Indeed, [the insurer's] suggested standard – which would require a policyholder to prove (by clear and convincing evidence, no less) the insurer’s bad motive (i.e., what was in the insurer’s head) – would make it exceedingly difficult to prove statutory bad faith, a task which is sufficiently difficult as is. This is especially true since insurers routinely seek to shield their true motives under the attorney-client privilege or attorney work product doctrine.

When Conseco Health Insurance Company originally refused to provide coverage to LeAnn Rancosky under a cancer insurance policy it had sold to her, the trial court concluded that Ms. Rancosky failed to demonstrate that the Insurer lacked a reasonable basis for denying benefits, because she did not prove that the Insurer acted out of “some motive of self-interest or ill will.”

On this appeal, the superior court held that the trial court erred as a matter of law in ruling against Ms. Rancosky based on its finding that she failed to demonstrate self-interest or ill will on the part of the Insurer. According to the Superior Court, Ms. Rancosky needed only to show that (1) the Insurer did not have a reasonable basis for denying benefits under the policy, and (2) the Insurer knew of or recklessly disregarded its lack of a reasonable basis. Motive of self-interest or ill will was not required to satisfy it.

[W]e hold that, to prevail in a bad faith insurance claim pursuant to Section 8371, a plaintiff must demonstrate, by clear and convincing evidence, (1) that the insurer did not have a reasonable basis for denying benefits under the policy and (2) that the insurer knew or recklessly disregarded its lack of a reasonable basis in denying the claim. We further hold that proof of the insurer’s subjective motive of self-interest or ill-will, while perhaps probative of the second prong of the above test, is not a necessary prerequisite to succeeding in a bad faith claim. Rather, proof of the insurer’s knowledge or reckless disregard for its lack of reasonable basis in denying the claim is sufficient for demonstrating bad faith
Lower Level Policy Limits Must Be Exhausted Before Excess Coverage

In Montrose Chemical Corporation v. Superior Court (2017) the insured was denied the right to electively select excess carrier coverage where lower level coverage had not been exhausted.

Montrose has been named as a defendant in several private and governmental environmental contamination actions, some of which are still winding their way through the courts. Since about 1960, Montrose has been covered by comprehensive general liability insurance policies as well as excess liability policies purchased from several insurance companies, all of which provide defense and indemnity coverage for third party claims.

However, when Montrose submitted a claim regarding a Torrance facility DDT manufacturing suit, the excess policy carrier balked. Montrose contends that all of the policies underlying the subject excess insurance policies have been exhausted. The excess insurers argued that all underlying insurance must be exhausted on a horizontal basis before potential coverage is triggered under the excess policies for the subject pollution claims, i.e., there were still underlying policies that had not paid. The court said this:

"Montrose rejected the insurers' horizontal exhaustion approach, asserting that it instead was entitled under the language of the excess policies and the Supreme Court's holding in Continental to "electively stack" its coverage — i.e., to "select any policy to indemnify its liabilities, provided the policies immediately underlying that policy are exhausted" in the same policy period."

"Montrose urges the court to adopt what it terms an "elective stacking" approach. Under this approach, where a policyholder is liable for a continuing injury that potentially is covered by primary and excess policies in multiple policy years, the policyholder "may elect to proceed 'vertically' to exhaust policies for a single coverage year, once the underlying policy exhaustion provisions are satisfied." Montrose urges that "elective stacking" is consistent with Supreme Court precedent "recognizing that policyholders are entitled to look to any independent contract to cover the full extent of their liability (up to policy limits) in accordance with the terms of each individual policy," as well as with the language of the relevant excess policies.

"The Continental insurers urge a "horizontal exhaustion" approach. They contend that the excess policies at issue contain provisions "that make them excess to vertically underlying policies in the same policy period plus 'other valid and collectible' insurance, that is, other insurance that is not vertically underlying and also triggered by the same occurrence." The Travelers insurers separately urge declaratory
relief is premature because Montrose has not demonstrated that it has exhausted its underlying primary policies, and there is no basis for issuing a writ of mandate because Montrose has failed to demonstrate that it lacks an adequate remedy at law or is at risk of irreparable harm.

The court concluded:

Moreover, as we have said, the court's analysis in Continental was based on the language of the particular policies before it in that case, and specifically the insurers' promises "'[t]o pay on behalf of the Insured all sums which the Insured shall become obligated to pay by reason of liability imposed by law ... for damages ... because of injury to or destruction of property,'" up to specified policy limits. (Continental, supra, 55 Cal.4th at p. 193, italics added.) In contrast, many of the excess policies relevant to our analysis do not include "all sums" language, and thus the high court's analysis of the "all sums" language has limited application here.

Further, Continental did not, as Montrose asserts, announce a general principle that insureds covered by multiple policies are entitled to "select which policy(ies) to access for indemnification in the manner they deem most efficient and advantageous." Indeed, Continental did not announce any general principles applicable to all insureds and all policies. Instead, it reaffirmed the principle that insurance policies must be interpreted according to their terms, even if alternative allocation schemes might be more desirable. (See Continental, supra, 55 Cal.4th at p. 199 ["Although some states have concluded, as the insurers urge in this case, that pro rata coverage would be more fair and equitable when compared to all sums allocation, we are constrained by the language of the applicable policies here."].)

Finally, while Continental held that each "triggered" policy may be called upon to respond to a claim (Continental, supra, 55 Cal.4th at p. 200), it did not consider when a higher-layer excess policy is "triggered" in the context of a long-tail environmental injury. That is, Continental discussed the "'trigger of coverage'" issue temporarily, explaining that "'[t]he issue is largely one of timing — what must take place within the policy's effective dates for the potential of coverage to be "triggered"? '" (Id. at p. 196.) Because it was not called upon to do so, the court in Continental did not consider the aspect of "trigger of coverage" before us in this case—what lower-layer excess policies must be exhausted before a higher-layer excess policy is triggered.

In short, while Continental provides a general framework for our analysis, it provides limited guidance on the specific question before us: Whether Montrose may access higher-level excess insurance before exhausting lower-level excess insurance written for different policy
periods. As Continental directs, we turn to the language of the relevant policies to decide that question.

So, form here on, whether excess carriers can require ALL underlying policies in existence to be exhausted before paying will be based on policy language on a case-by-case basis.

Of course, while this case was about paying the claim, there is still the duty to defend. As the Supreme Court has explained, (1) since the duty to defend is broader than the duty to indemnify and (2) since an insurer may owe a duty to defend in an action in which coverage is in doubt and ultimately does not develop, it follows that (3) the duty to defend is a continuing one which arises on the tender of defense and (4) lasts until (a) the underlying lawsuit is resolved or (b) the coverage issue can be determined without prejudice to the insured. Although a further delay necessarily imposes a burden on any carrier which ultimately prevails on the indemnity issues, that is not a sufficient reason to try the indemnity issues before the third party claims are resolved. There are no easy answers here.

**Additional Insured Does Not Cover When the Named Insured Is Not The Cause**

In Advent v. National Union Fire (2107), Advent, Inc. (Advent) was hired as the general contractor for the Aspen Family Village project in Milpitas, California. Advent subcontracted with Pacific Structures, Inc. (Pacific). In turn, Pacific subcontracted with Johnson Western Gunite (Johnson). Advent was covered by an insurance policy issued by Landmark American Insurance Company (Landmark) and an excess insurance policy issued by Topa Insurance Company (Topa). Johnson was covered by primary and excess insurance policies issued by respondent National Union Fire Insurance Company of Pittsburgh, PA (National Union).

While construction on the project was underway, a Johnson employee, Jerry Kiely, fell down an unguarded stairway shaft at the project site and sustained serious injuries. Kiely sued Advent, and Advent tendered its defense to its various insurance companies and to National Union. National Union initially refused the tender but later accepted it under a reservation of its rights. Kiely settled his action for a sum of $10 million. Various insurers, including Topa and National Union (under its primary policy), contributed to the settlement. National Union continued to reserve its rights during the settlement process, and it did not provide coverage under its excess policy.

Advent initiated this underlying action when it sued National Union, seeking a declaration that it was an “additional insured” under National Union's excess policy. National refused the additional insured claim in that their named insured was not the root cause of the injury. The courts agreed with National.
**An Exclusion For Mold Does Not Allow An Insurer To Deny Defense**

Saarman performed remedial construction work at a property owned by John and Stella Lee. Tiffany Jane Molock, who was leasing a unit, discovered mold after the remedial work was completed. In 2011, Molock sued the Lees and the HOA in the San Mateo County, Calif., Superior Court, alleging defects in the unit, including mold, plumbing leaks and water intrusion.

The Lees subsequently cross-claimed against Saarman and the HOA, alleging that Saarman and its subcontractors negligently performed repair work to the building, resulting in water intrusion and water damage to the interior of their unit that contributed to mold growth. The HOA filed a similar cross-complaint against Saarman, seeking indemnification and contribution from Saarman. Eventually, Saarman contributed $65,000 to settle the Lees’ claims. Saarman notified its insurer, Ironshore Specialty Insurance Co., which denied coverage for the underlying claims under the “mold, fungi or bacteria” exclusion.

Saarman then sued Ironshore in the U.S. District Court for the Northern District of California, alleging that the insurer improperly refused to provide Saarman with a defense regarding the two cross-complaints in the Molock action.

Saarman asserted that Ironshore’s *refusal to defend* was a breach of contract and a breach of the implied covenant of good faith and fair dealing.

The courts agreed saying:

"...To the extent that Ironshore relies on the mold exclusion to "evade its duty to defend mixed actions that include covered claims, that language contradicts California law." The judge explained that Ironshore cannot contract around California law that requires insurers to defend the entire action if there is any potentially covered claim.

In essence, Ironshore had a duty to defend Saarman in the underlying suit based on the potentially covered water intrusion and water damage claim. The judge explained that the Lees’ negligence claim against Saarman for water intrusion and damage would have existed even if there were no mold allegations.

This decision was later overturned when it was discovered that Saarman finished his repair work on the property by 2007 at the latest, several years before the policy inception date of June 30, 2011, the exclusion deems any damage resulting from that work to have first existed prior to the policy period and excludes coverage for that damage unless it was ‘sudden and accidental.’ Saarman did not argue damage was sudden and accidental, and therefore does not meet its burden of showing that it satisfies this exception to the CP exclusion. Because the CP exclusion negates any potential coverage, Ironshore does not have a duty to defend,” the judge said.