# PERILS OF THE CLAIMS PROFESSIONAL

## ("Why I Should Have Gone to Medical School")

by:

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# ATTACHMENTS

**1.**

# WHY THIS MANUAL?

**How many times have you lain awake at night wishing you had that perfect handbook on California insurance law? Probably more times than your daydreams of owning some tropical island in Fiji, palms swaying gently overhead, warm volcanic sand under your feet, sparkling emerald lagoon lapping your private beach, sounds of rhythmic native music coming to your ears. You're rocking gently in the breeze, snug in your hammock strung between two palms, sun tenderly caressing your skin through the morning shadows. Your private valet is nearby cooking the dawn catch. The crackle of the grill is already arousing your appetite. Snuggled atop your belly is your favorite cold beverage in a coconut half-shell. You're struggling to keep your eyes open underneath your sunglasses. And you're telling yourself: "This would be perfect if only I had the perfect insurance manual to read."**

**Does this describe you? This manual is definitely not for you if it does. And you should seriously consider seeking professional help. But this small book might be welcome for those in claims who work for a living and who might need a simple tool to help spot some California issues that tend to bedevil old hands and newcomers alike. This material makes no claim to perfection and it is certainly not intended to be an exhaustive treatise. I simply attempt to shed some light on practical problems that you may encounter in your day-to-day routine.**

**The focus is on California law, but there is a bare touch of Florida law thrown in for good measure. This is because I practice in Florida as well as California and because the occasional contrast between the two states' laws makes for some interesting points. Naturally, you should not use this booklet to attempt to answer specific coverage questions. That would only cause you trouble. You should hire a coverage lawyer to cause trouble for you. That's the traditional way.**

**2.**

# A TOO SHORT PRIMER ON THE RULES OF POLICY INTERPRETATION.

**Ambiguities and uncertainties in a policy of insurance are resolved in favor of the insured. Gray v. Zurich Insurance Co. (1966) 65 Cal.2d 263. The words used in a policy of insurance are to be construed according to the plain meaning a layman would ordinarily attach to them, and the policy is to be construed as a whole, each clause helping to interpret the other. McBride v. Farmers Ins. Group (1982) 130 Cal.App.3d 258; Ray v. Farmers Insurance Exchange (1988) 200 Cal.App.3d 1411. If a policy term is undefined, a court may utilize the plain, ordinary and customary definition of the term using either standard reference materials or the custom and practice of the insured's business. Giddings v. Industrial Indemnity Co. (1980) 112 Cal.App.3d 213; Maryland Casualty Co. v. Reeder (1990) 221 Cal.App.3d 961; California Civil Code Sections 1644 and 1645.**

**Thus, if the language of the policy is ambiguous or uncertain, it must be interpreted in favor of the insured where the insured's proffered meaning is not unreasonable. Doubts should be resolved in favor of the insured's reasonable expectations of coverage, including doubts as to the extent or fact of coverage, the peril insured against, the amount of liability and the persons protected. Producers Dairy Delivery Co., Inc. v. Sentry Ins. Co. (1986) 41 Cal.3d 903.**

**All provisions, conditions or exceptions that tend to limit liability are construed strictly against the insurer. Safeco Ins. Co. v. Gillstrap (1983) 141 Cal.App.3d 524. However, a strict construction does not cause a "strained construction." A court may not, under the guise of strict construction, re-write a policy to bind the insurer to a risk that it did not contemplate and for which it has not been paid. Safeco Ins. Co. v. Gillstrap (1983) 141 Cal.App.3d 524.**

**Exceptions and limitations on coverage -- especially in the case of standardized insurance contracts -- that the insured would**

**not otherwise reasonably expect, must be called to the insured's attention, clearly and plainly, before the exclusion will be interpreted to relieve the insurer of liability or performance. Logan v. John Hancock Mut. Ins. Co. (1974) 41 Cal.App.3d 988; Underwriters Ins. Co. v. Purdie (1983) 145 Cal.App.3d 57. Naturally, endorsements or modifications to the basic insuring forms of the policy may either alter or vary the terms or conditions of the policy. Endorsements may provide new insuring agreements or may provide for limitation on the coverage provided under the basic insuring form. As a general rule, the terms and conditions of an endorsement will prevail over the terms and conditions of the basic insuring form. Mission National Ins. Co. v. Coachella Valley Water Dist. (1989) 210 Cal.App.3d 484; Price v. Zim Israel Nav. Co. (9th Cir. 1980) 616 F. 2d 422; Burak v. General American Life Ins. Co. (10th Cir. 1988) 836 F. 2d 1287.**

**i i i**

**A LITTLE COURTROOM HUMOR**
**(VERY LITTLE)**

*LAWYER: Tell us about the fight.*
*WITNESS: I didn't see no fight.*
*LAWYER: Well, tell us what you did see.*
*WITNESS: I went to a dance at the Turner house, and as the men swung around and changed partners, they would slap each other, and one fellow hit harder than the other one liked, and so the other one hit back and somebody pulled a knife and someone else drew a six-shooter and another guy came up with a rifle that had been hidden under a bed, and the air was filled with yelling and smoke and bullets.*
*LAWYER: You, too, were shot in the fracas?*
*WITNESS: No, sir, I was shot midway between the fracas and the naval.*

**i i i**

**3.**

# WHY AN INSURER MIGHT SAY "NO WAY" TO INDEMNITY BUT YELL "OUCH" ABOUT DEFENSE COSTS

**The duty of an insurer to defend is broader than its duty to indemnify. Val's Painting & Drywall, Inc. v. Allstate Ins. Co. (1975) 53 Cal.App.3d 576, 585, 126 Cal.Rptr. 267. An insurer owes a duty to defend whenever a suit against the insured potentially seeks damages within coverage of the policy. Truck Insurance Exchange v. Superior Court (1997) 51 Cal.App.4th 985, 59 Cal.Rptr.2d 529.**

**The duty to defend and the duty to indemnify are separate contractual obligations. Coverage questions do not necessarily excuse the insurer's duty to furnish a defense against the third party's claim. The court in the third party's suit does not adjudicate the issue of coverage. The only question litigated in a third party suit is the insured's liability. Gray v. Zurich Insurance Co. (1966) 65 Cal.2d 263.**

**If there is potential coverage for any claim, the insurer's duty to defend extends to the entire lawsuit. Hogan v. Midland Natl. Ins. Co (1970) 3 Cal.3d 553, 91 Cal.Rptr. 153. Accordingly, if only one of five causes of action is potentially covered under an insurance policy, the insurer must also defend the insured against the uncovered causes of action.**

**The duty to defend continues until the insurer can conclusively eliminate, through undisputed facts, any potential for**

**coverage under the policy. An insurer may owe a duty to defend its insured in an action in which no damages ultimately are awarded.** **Montrose Chemical Corp. v. Superior Court** **(1993) 6 Cal4th 287, 24 Cal.Rptr.2d 467, 861 P2d 1153.**

## MORE COURTROOM HUMOR?

*LAWYER: How do you feel about defense attorneys?*
*JUROR: I think they should all be drowned at birth.*
*LAWYER: Well, then you are obviously biased for the prosecution.*
*JUROR: That's not true. I think prosecutors should be drowned at birth, too.*

**4.**

# A LESSON IN PHYSICS: FOUR CORNERS OF A COMPLAINT IS TWO-DIMENSION GEOMETRY WHILE DUTY TO DEFEND IS THREE-DIMENSION GEOMETRY

## (DOES ANYBODY KNOW WHAT THE HECK THIS MEANS?)

**Initially, the duty to defend is determined by comparing the allegations of the underlying complaint with the terms of the policy. Montrose Chemical Corp. v. Superior Court, 6 Cal4th 287, 24 Cal.Rptr.2d 467, 861 P2d 1153. But an insurer's duty to defend is not limited by the allegations of the complaint. An insurer is required to perform a reasonable investigation to determine "if facts exist outside of those found in the pleadings" that could potentially implicate insurance coverage. Gray v. Zurich Insurance Co. (1966) 65 Cal.2d 263.**

**Even where no potential for indemnification can be found in the complaint an independent investigation may show other facts which may give rise to a potential duty to indemnify. Mullen v.**

**Glen Falls Ins. Co. (1977) 73 Cal.App.3d 163, 140 Cal.Rptr. 605. If such facts are revealed by the investigation the insurer is required to provide a defense. Mullen v. Glens Falls Insurance Co. (1977) 73 Cal.App.3d 163; Horace Mann Ins. Co. v. Barbara B. (1993) 4 Cal.4th 1076, 17 Cal.Rptr.2d 210, 846 P2nd 792.**

**An insurer is therefore under an affirmative duty to investigate the underlying facts of the claim. If a reasonable investigation should have revealed that the claim could potentially trigger coverage under the policy -- irrespective of the failure of the claimant to plead herself into policy coverage -- there is a duty to defend. [1]**

**On the other hand, if the facts learned during the investigation indicate there is no potential for coverage, despite the contrary allegations of the complaint, the insurer may decline to defend the insured. But such decision is at the sole risk of the**

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[1]**In Florida the duty to defend is determined solely from the allegations of the complaint. In other words, if the allegations of the complaint do not implicate coverage, there is no duty to defend.**

**insurer. State Farm Mutual Auto Insurance Co. V. Flynt (1971) 17 Cal.App.3d 538; Dillon v. Hartford Accident & Indemnity Co. (1974) 38 Cal.App.3d 335; and Saylin V. California Insurance Guaranty Association (1986) 179 Cal.App.3d 256.**

**One case has contradicted the holding of the above three cases and stated that "as long as the complaint contains language creating the potential of liability under an insurance policy, the insurer must defend an action against its insured even though it has independent knowledge of facts not in the pleadings that established that the claim is not covered." CNA Casualty of California v. Seaboard Surety Co. (1986) 176 Cal.App.3d 598. But an insured may not trigger a duty to defend by speculating about extraneous facts regarding potential liability. Zelda, Inc. v. Northland Insurance Company (1997) 56 Cal.App. 4th 1252, 66 Cal.Rptr. 2d 356.**

**All four of the above cases are appellate court decisions. The California Supreme Court has not yet ended the split of authority between the courts of appeal.**

**Another important point: Where more than one insurer has a duty to defend, each insurer has an unlimited and equal duty to defend the insured. Continental Casualty Co. v. Zurich Insurance Co. (1961) 57 Cal.2d 27, 17 Cal.Rptr. 12. But costs of defense should be equally apportioned between the insurers. The non-defending insurer should be subject to suit for contribution by the defending insurance carriers. CNA Casualty of California v. Seaboard Surety Company (1986) 76 Cal.App. 3d 598.**

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**MORE COURTROOM HUMOR . . .**
**(OR WHY A DEFENDANT SHOULD NEVER REPRESENT HIMSELF)**

*DEFENDANT: Did you get a good look at me when I stole your purse?*
*VICTIM: Yes, I saw you clearly. You are the one who stole my purse.*
*DEFENDANT: I should have shot you while I had the chance.*

**i i i**

**5.**

# POWER OF THE DARK SIDE: WHEN THE BROAD DUTY TO DEFEND CLASHES WITH THE NARROW DUTY TO INDEMNIFY

**Because a duty of an insurer to defend is broader than its duty to indemnify, the insurer's dilemma is how to defend the action against the insured without waiving a claim of non-coverage. The insurer could secure a non-waiver agreement from the insured or make an adequate reservation of rights. Val's Painting & Drywall, Inc. v. Allstate Ins. Co. (1975) 53 Cal.App.3d 576. The reservation of rights avoids the insurer being bound by adverse findings in the basic liability actions (e.g., findings that the insured's acts were negligent rather than willful and intentional). Gray v. Zurich Insurance Co. (1966) 65 Cal.2d 263.[2]**

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[2] **By contrast to California there is a "Claims Administration" statute in Florida that appears to statutorily occupy the field of when reservation of rights should be issued. See, Florida Statutes, Section 627.426. This statute provides in material part:**

> **"(2) A liability insurer shall not be permitted to deny coverage based on a particular coverage defense unless:**
>
> **(a) Within 30 days after the liability insurer knew or should have known of the coverage defense, written notice of reservation of rights to assert a coverage**

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> defense is given to the named insured by registered or certified mail sent to the last known address of the insured or by hand delivery; and
>
> (b) Within 60 days of compliance with paragraph (a) or receipt of a summons and complaint naming the insured as a defendant, whichever is later, but in no case later than 30 days before trial, the insurer:
>
> 1. Gives written notice to the named insured by registered or certified mail of its refusal to defend the insured;
>
> 2. Obtains from the insured a nonwaiver agreement following full disclosure of the specific facts and policy provisions upon which the coverage defense is asserted and the duties, obligations, and liabilities of the insurer during and following the pendency of the subject litigation, or
>
> 3. Retains independent counsel which is mutually agreeable to the parties. Reasonable fees for the counsel may be agreed upon between the parties or, if no agreement is reached, shall be set by the court."

Requiring a reservation of rights to be forwarded in the prescribed manner “within 30 days after the liability insurer knew or should have known of the coverage defense” may seem at first like an exacting standard. But such a rule of “reasonableness” may actually be more lenient than the “waiver” rule that appears controlling in California. Although some California courts seem to relax the waiver rule, many courts in the state write that an insurer waives a coverage defense if it is not specifically set forth in a reservation of rights at the time the insurer first assumes the insured’s defense.

The Claims Administration statute was not intended to create

**An insurer clearly has a right to issue a reservation of rights at the time it assumes the defense of an insured, however, if the reservation creates a conflict an insurer may be required, at its own expense, to provide the insured with an independent counsel, who then controls the litigation.[3] California, Civil Code,**

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**coverage under a liability policy that never provided coverage, even where the insurer failed to comply with the statute. Progressive American Ins. Co. v. Papasodero, (1991) 587 So.2d 500; National Union Fire Ins. Co. of Pittsburgh, Pa. v. Goldman, (1989) 548 So.2d 790. The term "coverage defense" has been interpreted not to include a disclaimer of liability based upon a complete lack of coverage for the loss sustained. AIU Ins. Co. v. Block Marina Inv., Inc., (1989) 544 So.2d 998. Where compliance is required, some courts have allowed "substantial" compliance to satisfy the statute although technical compliance did not occur. Pepper's Steel & Alloys, Inc. v. U.S. Fidelity and Guar. Co., (1987) 668 F.Supp. 1541. Other courts demand strict compliance and have found a waiver of coverage defenses even where substantial compliance occurred. Country Manors Ass'n, Inc. v. Master Antenna Systems, Inc., (1988) 534 so.2d 1187.**

[3] **The court in San Diego Navy Federal Credit Union v. Cumis Ins. Society, Inc. (1984) 162 Cal.App.3d 358, 208 Cal.Rptr. 494 held that whenever the insurer provides a defense under a reservation of rights, the carrier relinquishes the right to control the litigation and the insured has the right to retain independent defense counsel at insurer's expense. California Civil Code 2860 and subsequent court decisions have limited the scope of the Cumis holding.**

**Section 2860. But not every conflict of interest triggers an insurer's obligation to provide independent counsel. Golden Eagle Ins. Co. V. Foremost Ins. Co. (1993) 20 Cal.App. 4th 1372, 25 Cal. Rptr. 2d 242; Sun Investment Group v. Ticor Title Ins. Co. (1987) 189 Cal.App.3d 1265, 235 Cal.Rptr. 34. [4]**

**When such a conflict exists the insurer must notify the insured of the conflict and allow the insured to select independent counsel. However, the Cumis rule does not broaden the insurer's duty to defend. Moreover, the insured need not provide independent counsel in matters other than the defense of the civil action. United Pacific Ins. Co. V. Hall (1988) 199 Cal.App.3d 551.**

**A reservation of rights will trigger a conflict of interest whereby Cumis counsel must be appointed where coverage is denied on**

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[4] **Section 2860 limits the areas in which a reservation of rights letter gives rise to a Cumis conflict, sets minimum requirements for counsel the insured can retain to defend the case and provides the "insurer's obligation to pay fees to the independent counsel selected by the insured is limited to the rates which are actually paid by the insurer to attorneys retained by it in the ordinary course of business in the defense of similar actions in the community where the claim arose or is being defended."**

**grounds that will cause "the outcome of the coverage issue to be controlled by counsel first retained by the insurer for the defense of the claim." McGee v. Superior Court (1985) 176 Cal.App.3d 221; California, Civil Code Section 2860(b). On the other hand where the coverage issue is extrinsic and independent of issues raised by the third party action, there is no conflict because the insurer and insured have an identical interest in showing that the insured is not at fault. McGee v. Superior Court (1985) 176 Cal.App.3d 221.**

**The court in McGee v. Superior Court (1985) 176 Cal.App.3d 226, 221 Cal.Rptr. 421, explained that the "crucial fact in Cumis [analysis is whether] the insurer's reservation of rights on the ground of noncoverage [depends upon] the nature of the insured's conduct, which as developed at trial would affect the determination as to coverage."**

**The most common example of where the coverage issue depends upon the nature of the insured's conduct is where the insured's actions could be characterized as either intentional or negligent.**

Of course, in the former circumstance there would be no coverage (assuming the insurer appropriately reserved its rights) while there would be coverage under the latter circumstance. In this situation, an insurer would be under a duty to notify the insured of the conflict and offer the insured an independent counsel at the expense of the insurer.

That the insurer disputes coverage does not automatically entitle the insured to a Cumis counsel. Blanchard v. State Farm Fire & Casualty Co. (1991) 2 Cal.App.4th 345, 2 Cal.Rptr.2d 884. Nor does the fact the complaint seeks punitive damages or damages in excess of the policy limits require an insurer to provide Cumis counsel. California, Civil Code Section 2860(b). If the coverage dispute is based solely upon an interpretation of the policy, and the dispute will not be controlled by resolution of the third party claims, a Cumis conflict does not arise. Native Son Investment Group v. Ticor Title Ins. Co. (1987) 187 Cal.App.3d 1265, 235 Cal.Rptr. 34.

**A Cumis conflict may also arise when an insurer undertakes to defend alternative or multiple claims where coverage does not extend to all claims. The interest of the insurer and insured are often in conflict in such situations. For example, where both intentional and negligent conduct are alleged in the complaint the insured's interest is to argue he was negligent but the insurer's interest is to show the insured acted intentionally, thereby excluding coverage altogether. Villicana v. Evanston Ins. Co. (1994) 33 Cal.Rptr.2d 690, 28 Cal.App.4th 631.**

**A similar conflict is created requiring appointment of independent counsel where a punitive damage claim is a substantial portion of the potential liability of the insured. See Nandorf, Inc. v. CNA Insurance Co. (1985) 134 Ill.App. 3d 134, 479 N.E.2d 988; Previews, Inc. v. California Union Insurance Co (9th Cir. 1981) 640 F.2d 1026.**

**Another potentially difficult conflict is created when the third party action seeks damages in excess of the policy limits. If prevailing on the liability claim is a reasonably possibility,**

**the insurer may well be motivated to try the case while the insured would prefer to seek settlement to avoid the risk of judgment substantially exceeding the policy limits. Lysick v. Walcott (1968) 258 Cal.App.2d 136, 65 Cal.Rptr. 406.**

**In Lysick, the defense lawyer rejected the settlement offer of $12,500, when the policy limit was $10,000 and the insured offer to pay the excess of $2,500. A judgment was entered against insured for $225,000. The insured then filed an action against the defense lawyer and prevailed.**

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## ANOTHER ROUND OF COURTROOM HUMOR? (OR DO YOU FEEL SORRY FOR THE PLAINTIFF'S LAWYER?)

*PLAINTIFF LAWYER: What doctor treated you for the injuries you sustained while at work?*
*PLAINTIFF: Dr. J.*
*PLAINTIFF LAWYER: And what kind of physician is Dr. J?*
*PLAINTIFF: Well, I'm not sure, but I remember that you said he was a good plaintiff's doctor.*

## A. THIS JOB WOULDN'T BE TOO BAD IF I DIDN'T HAVE TO MAKE ANY DECISIONS.

**When simultaneously pressured by a demand for defense and the uncertainty of a coverage dispute an insurer might:**

**(1) Refuse the defense altogether (STOP THE PRESSES -- YOU'D BETTER BE DARN SURE THERE IS NO POTENTIAL OF INDEMNIFICATION).**

**(2) Accept the defense and waive any objections to lack of coverage (YOU'RE EITHER A NICE GUY OR YOU JUST DON'T WANT TO CREATE A CUMIS PROBLEM AND THE EXPOSURE TO FEES FROM TWO SETS OF LEGAL COUNSEL).**

**(3) Decline the demand for a defense but promise to reimburse the insured if after a further investigation the insurer determines a defense is owed (WATCH OUT ON THIS ONE, TOO -- PROBABLY A BREACH OF THE DUTY TO DEFEND IF THERE IS ANY POTENTIAL FOR INDEMNIFICATION).**

**(4) Defend but issue a reservation of rights. The insurer must decide if appointment of an independent counsel to defend the insured is required. McGee v. Superior Court (1985) 176 Cal.App.3d 221, 227, 221 Cal.Rptr. 421, 424.**

**(5) File a declaratory relief action seeking a judicial determination of its duty to defend (i.e., whether there is any potential for indemnification under the policy). Naturally, the insurer could (and probably should) simultaneously provide a defense under a reservation of rights.**

**Amato v. Mercury Casualty Co. (1993) 18 Cal.App.4th 1784, 1792, 23 Cal.Rptr.2d 73.**

**i i i**

**ANOTHER SHOT AT HUMOR . . .**
**(DON'T LAUGH, THIS LAWYER COULD BE ON YOUR APPROVED PANEL)**

*LAWYER: Do you know how far pregnant you are now?*
*WITNESS: I'll be three months on Nov. 8.*
*LAWYER: Apparently, then the date of conception was Aug. 8?*
*WITNESS: Yes.*
*LAWYER: What were you doing at that time?*

## B. NOT SO FAST ON THAT ACTION FOR DECLARATORY RELIEF.

**In 1993, the California Supreme Court wrote that "To eliminate the risk of inconsistent factual determinations that could prejudice the insured, a stay of the declaratory relief action pending resolution of the third party suit is appropriate when the coverage question turns on facts to be litigated in the underlying action." Montrose Chemical Corporation of California v. Superior Court (1993) 6 Cal.4th 287, 24 Cal.Rptr. 467. The California Supreme Court discussed the "classic situation" where the insured is sued in negligence (a covered claim) and for intentional conduct (an excluded claim). There is the "potential" that the "insurer's proof will prejudice its insured" if the declaratory relief action is allowed to proceed before a judgment is entered in the third party litigation against the insured.**

**On the other hand, according to the California Supreme Court, if the "coverage question is logically unrelated to the issues of consequence in the underlying case, the declaratory relief action**

**may properly proceed to judgment." There would be small risk of prejudice to the insured in this situation.**

**A California appellate court addressed the issue somewhat more forcefully in California Insurance Guarantee Association v. Superior Court (1991) 231 Cal.App.3d 1617, 283 Cal.Rptr. 104. There, the court said, " ... a separate declaratory action where the coverage question turns on facts to be litigated in the underlying action (e.g., where the insured acted "intentionally") is not permitted. This is so because the insurer may well owe a defense in the underlying action even if the facts ultimately determined in that action show that there was no coverage. If the rule were otherwise, 'any time an insurance company had a questionable claim due to an uncertain exclusion clause, it could defend, under a reservation of rights, and immediately bring an action for declaratory relief seeking to rid itself of the arguable duty to defend. As a result, the duty to defend would eventually be no broader than the duty to indemnify."**

**Importantly, the insurer in California Insurance Guarantee Association argued that if the stay were not lifted it would be irreparably harmed because it would be forced to incur costs to defend the underlying action against the insured (even though it may be ultimately found to have no obligation to indemnify the insured) without any hope of recovering those costs from the insured. The California court quickly discounted this plea. Thus, it appears that in California an insurer is not deemed to be harmed by incurring costs, regardless of how substantial, to defend an insured, although the insurer may ultimately owe no duty to indemnify.[5]**

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[5] **Through the present date, unlike its counterpart in California, the Florida Supreme Court has not delineated the circumstances under which an insurer may proceed with its declaratory relief action when there is an underlying third party claim against the insured. Interestingly, the court has refrained from addressing this issue even though the District Court of Appeal of Florida, Fifth District, certified the following question for resolution by the Supreme Court:**

> **"May the insurer pursue a declaratory action in order to have declared its obligation under an unambiguous policy even if the court must determine the existence or nonexistence of a fact in order to determine the insurer's responsibility?"**

**See, Allstate Insurance Company v. Conde (1992) 595 So.2d 1005. The Conde court wrote:**

> **"Moreover, the argument that [Allstate] should extend**

**i i i**

**WHEN DOES THE HUMOR BEGIN?**
**(WHO SAID CROOKS WERE SMART?)**

*JUDGE: The charge here is theft of frozen chickens. Are you the defendant?*
*DEFENDANT: No, sir, I'm the guy who stole the chickens.*

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**defense under a reservation of rights, instead of resolving the coverage issue in a separate declaratory judgment action in advance, ignores the fact that providing a defense where there is no legal obligation to do so constitutes an irreparable injury in and of itself."**

**This stated rule of law is directly contrary to the law of California, as discussed above. In California, the courts do not recognize irreparable harm to an insurer where the insurer provides a defense where there is no ultimate obligation to do so.**

**In Florida, an insured who prevails in a declaratory relief action against his insurer is entitled to an award of a reasonable attorney's fee, however, an insurer is not entitled to a fee award if it prevails against its insured. See, Florida Statutes, Section 627.428; James Furniture Mfg. Co. v. Maryland Cas. Co, (1959) 114 So.2d 722. The purpose of the statute is to encourage insurers not to contest close coverage issues with its insureds and to protect insureds from insurers' non-compliance with a duty to defend. Florida Rock & Tank Lines, Inc. v. Continental Ins. Co., (1981) 399 So.2d 122; Argonaut Ins. Co. v. Maryland Cas. Co., (1979) 372 So.2d 960. The fee award does not depend upon a finding of bad faith. In other words, an insurer which acts in the upmost good faith but nevertheless looses a declaratory relief action will still be ordered to pay the fees incurred by the insured.**
**There is no analogous statute in California, although an insured may be entitled to recover fees if he prevails in a bad faith action.**

## C. BETTER FAX THAT RESERVATION OF RIGHTS, MA'AM.

**The general rule is that if a liability insurer, with knowledge of a ground of forfeiture or non-coverage under the policy, assumes and conducts the defense of an action brought against the insured, without disclaiming liability and giving notice of its reservations or rights, the insurer is thereafter precluded in an action upon the policy from setting up such ground of forfeiture or non-coverage. Miller v. Elite Ins. Co. (1980) 100 Cal.App.3d 739; Phoenix Ins. Co. v. U.S. Fire Ins. Co. (1987) 189 Cal.App.3d 1511, 235 Cal.Rptr. 185. In other words, the insurer's unconditional defense of an action brought against its insured constitutes a waiver of the terms of the policy and an estoppel of the insurer to assert such grounds. Miller v. Elite Ins. Co. (1980) 100 Cal.App.3d 739.**

**The law in California is divided as to whether a belated reservation of rights waives the insurer's right to dispute coverage where the insured has not suffered detriment resulting**

**from the delay. Insurance Co. of the West v. Haralambos Co. (1987) 195 Cal.App.3d 1308, 241 Cal.Rptr. 427.**

**The court in Haralambos held that the insured must show that it detrimentally relied upon a failure to provide a prompt reservation of rights to demonstrate waiver by the insurer. The court in Intel Corp. v. Hartford Acc. & Indm. Co. (N.D. Cal. 1988) 692 Fed.Supp. 1171 disagreed with Haralambos and held that it is unnecessary for the insured to demonstrate detriment from a party reservation of rights.**

**Some courts have held that an insurer's failure to include a particular ground in a reservation of rights letter precludes the insurer's subsequent assertion of that ground. McLaughlin v. Connecticut General Life Ins. Co. (N.D. Cal 1983) 565 Fed.Supp. 434; Val's Painting & Drywall, Inc. v. Allstate Ins. Co. 53 Cal.App.3d at 586. Later decisions hold that the insured generally must demonstrate some resulting change of position or detrimental reliance to prevent the insurer from later raising the matter. Hartford Fire Ins. Co. v. Spartan Realty (1987) 196 Cal.App.3d**

**1320; Becker v. State Farm Fire and Cas. Co. (N.D. Cal. 1987) 664 Fed.Supp. 460; Stinson v. Homes Ins. Co. (N.D. Cal. 1988) 690 Fed.Supp. 882.**

**The California Supreme Court has held that a failure to properly reserve rights properly may render the carrier responsible for punitive damages awarded against its insured despite the fact that carriers are ordinarily precluded from insuring punitive damages in California. Tomerlin v. Canadian Indemnity Co. (1964) 61 Cal.2d 638, 39 Cal.Rptr. 731. But see PPG Industries, Inc. v. Transamerica Insurance Company (1999) 20 Cal. 4th 310, 84 Cal.Rptr. 2d 455.**

**Estoppel and implied waiver may not usually be used to create coverage under an insurance policy where coverage did not originally exist. Aetna Cas. & Bur. Co. v. Richmond (1977) 76 Cal.App.3d 645, 143 Cal.Rptr. 75. An insurer's unconditional defense of an action brought against its insured constitutes a waiver of the terms of the policy and an estoppel of the insurer to**

assert noncoverage. Miller v. Elite Insurance (1980) 100 Cal.App.3d 739, 161 Cal.Rptr. 322.

In California, the duty to defend exists in prelitigation stages of settlement. Miller v. Elite Insurance (1980) 100 Cal.App.3d 739, 161 Cal.Rptr. 322. The insurer involved in prelitigation settlement discussions without advising insured of possible coverage issues will be estopped from challenging coverage later.

Waiver and estoppel are two distinct doctrines that rest on different legal principles. "Waiver" is used to designate the act, or the consequences of the act, of one side only, while "estoppel" is applicable where the conduct of one side has induced the other to take such a position that it would be injured if the first should be permitted to repudiate its acts. See 30 Cal.Jur.3d (1976), Estoppel and Waiver § 1, pp. 693-694.

Waiver is a voluntary and intentional relinquishment of a known right. Insurance Company of the West v. Haralambos Beverage

**Company (1987) 195 Cal.App.3d 1321, 241 Cal.Rptr. 427. A waiver may occur (1) by an intentional relinquishment or (2) as the result of an act which, according to its natural import, is so inconsistent with an intent to enforce the right as to induce a reasonable belief that such right has been relinquished. Id.**

**In order to establish an estoppel, four elements must be satisfied: (1) The party to be estopped must know the facts; (2) he must intend that his conduct shall be acted upon, or must so act that the party asserting the estoppel had a right to believe that it was so intended; (3) the party asserting the estoppel must be ignorant of the true state of facts and (4) he must rely upon the conduct to his injury. Insurance Company of the West v. Haralambos Beverage Company (1987) 195 Cal.App.3d 1321, 241 Cal.Rptr. 427.**

**"If the insurer adequately reserves its right to assert the noncoverage defense later it will not be bound by the judgment [against the insured]." Gray v. Zurich Ins. Co. (1966) 65 Cal.2d 263, 279, 54 Cal.Rptr. 104, 419 P.2d 168. "The insurer can avoid being bound by the judgment against the insured if it secures a**

**nonwaiver agreement from the insured [citations] or makes an adequate reservation of rights. [citations.]" Val's Painting & Drywall, Inc. v. Allstate Ins. Co. (1975) 53 Cal.App.3d 576, 586, 126 Cal.Rptr. 267.**

**The insurer is not responsible to pay for defense costs generated before the insured tenders the claim to the insurer. Gribaldo, Jacobs, Jones & Associates v. Agrippina Versicherunges A.G. (1970) 3 Cal.3d 434, 449, 91 Cal.Rptr. 421.**

**i i i**

**COURTROOM HUMOR . . .**
**(THE JUDGE DIDN'T THINK SO)**

*JUDGE: I know you, don't I?*
*DEFENDANT: Uh, yes.*
*JUDGE: All right, tell me, now do I know you?*
*DEFENDANT: Judge, do I have to tell you?*
*JUDGE: Of course, you might be obstructing justice not to tell me.*
*DEFENDANT: Okay. I was your bookie.*

## D. YOU CAN'T STICK YOUR HEAD IN THE SAND . . .

**A failure to advise an insured of a conflict of interest and a failure to provide Cumis counsel is a breach of the insurer's duty to defend. Villicana v. Evanston Ins. Co. (1994) 33 Cal.Rptr.2d 690, 28 Cal.App. 4th 631. This is true even where the insurer has assumed the defense of the insured and hired counsel to represent the insured in the underlying litigation.**

**The insurer is viewed as creating the conflict of interest by asserting a reservation or rights. The insurer therefore has the duty to advise its insured of a conflict of interest. Permitting the insured to hire independent counsel at the insured's own expense while the insurer continues to control the litigation through its own counsel does not satisfy the insurer's duty. Villicana v. Evanston Ins. Co. (1994) 33 Cal.Rptr.2d 690, 28 Cal.App.4th 631.**

**In Villicana the insured funded a settlement without the consent of the insurer and then brought an action against the**

**insurer and claimed that the insurer should reimburse the insured. In defense, the insurer asserted the "No Action Clause" in the policy which generally prohibits the insured from suing the insurer unless a third party has obtained a judgment against the insured, or unless the insurer has given its written consent to a settlement by the insured.**

**The court, however, stated that a conflict existed between insurer and insured that required the insurer to provide an independent counsel, and that the insurer failed to provide such counsel and hence failed to provide a defense. The court concluded that the "No Action Clause" may not be asserted as a defense where the insurer has failed to provide a defense.**

**i i i**

**IF YOU HAVEN'T HAD ENOUGH COURTROOM HUMOR . . .**

*LAWYER: You say that the stairs went down to the basement?*
*WITNESS: Yes.*
*LAWYER: And these stairs, did they go up also?*

## E. HOW CAN I EXPLAIN THIS ONE TO THE CLAIMS MANAGER?

**If an insurer breaches its duty to defend and a default judgment is entered against the insured as a result of that breach the insurer will be held liable to pay the default judgment. Amato v. Mercury Casualty Company (1996) 58 Cal.Rptr. 2d 784. In Amato the insurer ultimately prevailed on the coverage issue. The court ruled that in the final analysis the insurer had no duty to indemnify. But there was a potential for indemnification at the time the insured first tendered the defense. The insurer refused to provide a defense. The insured could not afford counsel. The insured was defaulted.**

**And an insurer will receive no special treatment when it attempts to vacate a default even where it has acknowledged its duty to defend. Stafford v. Allstate Insurance Company (1998) 64 Cal.App. 4th 1174, 75 Cal.Rptr. 2d 809. In Stafford, Allstate had acknowledged its duty to defend. But then the claims examiner inexplicably failed to respond to plaintiff's counsel's letters or telephone calls. Plaintiff's counsel then filed suit. The claims**

**examiner failed to assign the case to defense counsel. A default was entered against the insured. When Allstate finally assigned the case to counsel a motion to vacate the default was filed. But the court denied the motion and stated that Allstate had not acted with due diligence.**

**A "no action" clause in a policy generally prohibits an action against an insurer where the insured has not fully complied with the policy terms or where the obligation of the insured to pay has not been fully and finally determined either by judgment at trial or by a written settlement agreement by the insured. A "no action" clause will not bar an insured's action against the insurer for reimbursement of settlement amount, even in the absence of a judgment after trial, or where the insurer was not advised or consented to the settlement, where the insurer assumed the insured's defense, but did not provide Cumis counsel. Villicana v. Evanston Ins. Co. (1994) 33 Cal.Rptr.2d 690, 28 Cal.App.4th 631.**

**In Mosier v. Southern California Physicians Insurance Exchange (1998) 63 Cal.App. 4th 1022, 74 Cal.Rptr. 2d 550, the insurer**

**provided a courtesy defense to a non-insured. The insurer would have been required to provide an independent counsel if the non-insured had been an insured (i.e., a conflict existed between insurer and "insured" based upon the conduct of the "insured"). But the insurer failed to provide an independent counsel to the non-insured. The court ruled the insurer breached a duty to the non-insured. The insurer is liable for all damages flowing from that breach.**

**Why would any adjuster want to pay a claim that should have been denied under an exclusion? Who knows? But it happens (not to the same adjuster twice). The good news is that a voluntary payment doesn't bar the insurer from seeking subrogation. State Farm Fire And Casualty Company v. East Bay Municipal Utility District (1997) 53 Cal.App. 4th 769, 62 Cal.Rptr. 2d 72. A flip analysis: An insurer can unconditionally acknowledge an indemnity obligation to its own insured but still contend there is no coverage against other insurers seeking subrogation. Mitchell, Silberberg & Knupp v. Yosemite Insurance Company (1997) 58 Cal.App. 4th 389, 67 Cal.Rptr. 2d 906.**

**An adjuster better watch out for multi-insurer coverage disputes. In United Pacific Insurance Company v. First State Insurance Company (1997) 97 Daily Journal D.A.R. 15100, an insurer settled with its insured in an environmental coverage dispute. The insurer moved for a finding of "good faith" under California Code of Civil Procedure, Sections 877 and 877.6. A finding of good faith normally precludes a claim for indemnity against the settling party. But the court in United Pacific held that the good faith procedure does not apply to insurers who share the same coverage risk. In other words, the insurer who settled in United Pacific was not protected from continuing actions for indemnity from the other insurers.**

**i i i**

**STILL TRYING WITH COURTROOM HUMOR**
**(LET'S HOPE HE WAS DEAD)**

*LAWYER: Do you recall approximately the time that you examined the body of Mr. Edington?*
*WITNESS: It was in the evening. The autopsy started about 8:30 p.m.*
*LAWYER: And Mr. Edington was dead at the time; is that correct?*

6.

# SO, YOU'RE DESPERATE TO SETTLE BUT YOU TOLD MAMA YOU OWE NO INDEMNITY

Under the "Comunale rule" an insurer is required by law to pursue a settlement, notwithstanding the presence of a coverage issue. See, Comunale v. Traders & General Ins. Co. (1958) 50 Cal.2d 654, 328 P.2d 198. Comunale holds an insurer denying coverage does so at its own risk and although its position may not have been entirely groundless, if the denial is found to be wrongful it is liable for the full amount which will compensate the insured for all the detriment caused by the insurer's breach of the express and implied obligations of the contract. Maryland Casualty Company v. Imperial Contracting Company (1989) 212 Cal.App.3d 712, 260 Cal.Rptr. 797.[6]

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[6] The insurer not only has a right to participate in and to control the litigation, it has a duty to do so. Pruyn v. Agricultural Ins. Co. (1995) 42 Cal.Rptr.2d 295, 304, 36 Cal.App.4th 500. When a defense is being provided without reservation of rights, and the insured is fully covered by the primary insurance, the insurer is entitled to take control of the settlement negotiations and the insured may not interfere. Consent of the insured to such a settlement is usually superfluous as the insured cannot normally bind the insurer or prevent the settlement by withholding consent. Robertson v. Chen (1996) 1995 WL 853049.

**It appears that it is settled law that an insurer may be held liable for breach of the implied covenant of good faith and fair dealing although the insurer had a good faith belief that no coverage existed. If the insurer is incorrect on the coverage issue, the primary dispute in the following bad faith case will be the amount of damages (i.e., what damages were caused by the insurer's breach) and whether the insured is entitled to recover punitive damages.**

**It is recognized, however, that an insurer's duty to settle requires that an insurer first have an opportunity to settle within the applicable policy limits. McLaughlin v. National Union Fire Ins. Co. of Pittsburgh (1994) 23 Cal.App.4th 1132. As a general principle, there should be no bad faith exposure if the insurer never had the chance to settle within the policy limits.**

**The California Supreme Court in the case of Johansen v. California State Automobile Assoc. Inter-Insurance Bureau, 15**

**Cal.3d 9, 123 Cal.Rptr. 288, confirmed that in certain circumstances an insurer may settle on behalf of the insured while also reserving its rights to then seek reimbursement from the insured. In Johansen, the insurer was found liable for wrongful failure to settle the claim against the insured within the policy limits. The insurer had refused settlement, claiming the policy did not cover the incident, although coverage was later found by the courts to apply. Rejecting the insurer's argument that bad faith liability would require an insurer to settle all cases irrespective of coverage, the Supreme Court wrote:**

> **"Moreover, contrary to defendant's assertion, an insurer in defendant's position retains the ability to enter an agreement with the insured reserving its right to assert a defense of noncoverage even if it accepts a settlement offer. If, having reserved such rights and having accepted a reasonable offer, the insurer subsequently establishes the noncoverage of its policy, it would be free to**

> **seek reimbursement of the settlement payment from its insured."**

**In Val's Painting and Drywall, Inc., v. Allstate Insurance Company (1975) 53 Cal.App.3d 576, 126 Cal.Rptr. 267, the insurer settled on behalf of the insured and then sought recovery of the amount paid in settlement. Val's Painting was a demurrer case where the trial court ruled that the insurer had not sufficiently pled the right to seek reimbursement under the Johansen opinion. Although the appellate court agreed that the insurer's pleading was deficient, it ordered the trial court to allow the insurer to amend in an attempt to plead a valid claim. It is instructive to note, however, the allegations that were found lacking to establish a right of reimbursement.**

**The insurer had sent a reservations of rights letter that simply stated that "in investigating the said accident . . . or negotiating for compromise settlement, or in making any settlement . . . [Allstate] does not waive any of its rights or admit any obligations under the policy." There was no allegation that the**

**insurer had informed the insured of the settlement, that the insured had expressly or impliedly agreed that the claimants should be paid the amount of the settlement, that the settlement was reasonable, that the insured was given an opportunity to assume its own defense if it did not think the settlement reasonable, or that the insured had expressly or impliedly agreed that if such sum was paid the question of policy coverage should be left to future determination. The appellate court wrote:**

> **"Absent an agreement by the insured -- express or implied in fact -- that the insurer may commit the insured's own fund toward any reasonable settlement, the insurer is not permitted to seek reimbursement for a particular settlement unless it has secured specific authority to make that settlement or had notified the insured of a reasonable offer by the claimant and given the insured an opportunity to assume the defense."**

**In Maryland Casualty Company v. Imperial Contracting Company (1989) 212 Cal.App.3d 712, 260 Cal.Rptr. 797, the appellate court was asked to decide whether an insurer (under a policy ultimately determined not to provide coverage) may recover from the insured the amount paid in a "good faith settlement" when: (1) the insurer had issued a reservation of rights letter and defended the underlying action under the reservation of rights letter while also litigating the coverage issue; (2) the insured refused to provide consent to the insurer's participation in the settlement after the insurer gave notice of its intent to settle but retain its right to pursue the insured for the sums paid in settlement; and (3) after the insured refused to provide consent, the insurer obtained trial court permission to participate in the settlement with an order that specifically stated the insurer's participation in the settlement would be without prejudice to the declaratory relief action and which reserved the right of the insurer to later contest coverage and attempt to recoup the payments made on behalf of the insured.**

**The trial court ruled that under the above circumstances, the insurer could not recover the settlement payment even though there was no coverage under the policy. The appellate court reversed the lower court and held that the insurer had fully satisfied the requirements set forth in the Val's Painting case. Interestingly, the court wrote that:**

> **"The record reflects that the parties operated under the reservation for about two years . . when Maryland asked for Imperial's consent to the settlement. Imperial refused to consent. Conceptually this event required Maryland to choose among the following -- it could turn over the defense to Imperial and await the outcome of the declaratory relief action; relinquish its earlier reservation of rights and acknowledge coverage, or proceed with the settlement in the manner which occurred here."**

**The court explained that it was unnecessary to offer Imperial the chance to assume its own defense. The court order authorizing the insurer to enter into the settlement where the insured expressly rejected the insurer's request for authority to settle fully comports with the "Val Painting rule."**

**A liability insurer, which has provided a defense to its insured under a reservation of rights, may under certain circumstances recover from that insured the attorney's fees and costs expended to defend the insured from claims for which there was no coverage under the policy. Buss v. Superior Court (Transamerica Ins. Co.), (1996) 50 Cal.Rptr.2d 447, 449, 42 Cal.App.4th 1663, 1666-67.**

**For those noncovered claims for which a potential for coverage existed but were ultimately determined not to be covered an insurer may not recover its defense costs (incurred prior to the determination of noncoverage) absent an express policy term so providing or an agreement with the insured supported by a new consideration. However, for those claims for which there was never**

**any potential for coverage under the terms of the policy but were nonetheless required to be defended because they were joined with other claims for which a potential for coverage did exist, the insurer may recover such costs as it can prove, by a preponderance of the evidence, are fairly and reasonably allocable solely to the noncovered claims. Id.**

**A final note: generally, because an insurer's duty extends to all of its insureds, an insurer may within the boundaries of good faith reject a settlement offer that does not include a complete release of all of its insureds. Strauss v. Farmers Insurance Exchange (1994) 26 Cal.App.4th 1017, 31 Cal.Rptr.2d 811.**

**i i i**

**COURTROOM HUMOR . . .**
**(WHERE DID THIS LAWYER GET HIS MEDICAL DEGREE?)**

*LAWYER: Mrs. Jones, do you believe you are emotionally stable?*
*WITNESS: I used to be.*
*LAWYER: How many times have you committed suicide?*

7.

# PRAISE THE CHIEF JUSTICE: MY DUTY TO DEFEND IS OVER . . . MAYBE

The duty to defend ends when it is clear that there is no potentiality for indemnification. See Saylin v. California Insurance Guarantee Assn. (1986) 179 Cal.App.3d 256, 224 Cal.Rptr. 493. Likewise, the duty to defend terminates when the policy limits are exhausted. See e.g. Johnson v. Continental Ins. Companies (1988) 202 Cal.App.3d 477, 248 Cal.Rptr. 412.

A carrier is entitled to withdraw its defense if after the conclusion of the liability phase of a bifurcated trial between liability and damages, the carrier has no possible duty to indemnify, such as where all causes of action for which coverage was arguably available are dismissed. See California Union Ins. Co. v. Club Aquarius, Inc. (1980) 113 Cal.App.3d 243, 169 Cal.Rptr. 685.

**Punitive damages are viewed as merely ancillary to claims for compensatory damages. Because the average insured would reasonably believe he was covered for punitive damages, therefore creating a potential for coverage, where both general and punitive damages are sought against the insured, termination of the general damages portion of the case during which the insurer acknowledged a duty to defend will not relieve the carrier of its duty to defend as to the punitive damage claims unless the policy expressly excludes claims for punitive damages. Ohio Casualty Ins. Co. v. Hubbard (1984) 162 Cal.App.3d 939, 208 Cal.Rptr. 806.**

**Where circumstances present themselves which permit the insurer to withdraw a defense the carrier must exercise care regarding how the withdrawal occurs or potentially expose itself to a "bad faith" claim. Travelers Ins. Co. v. Lesher (1986) 187 Cal.App.3d 169, 231 Cal.Rptr. 791. Once a carrier undertakes to defend the insured the carrier has a duty to conduct a defense in the same manner that it would if there were no coverage dispute. Even where it is ultimately determined that the carrier has no duty**

**to indemnify, as a matter of law, mishandling of the defense may constitute "bad faith." Id.**

**iii**

**YET ANOTHER ATTEMPT AT COURTROOM HUMOR**
**(DON'T THEY HAVE LAWS ABOUT THIS?)**

*JUDGE: Is there any reason you could not serve as a juror in this case?*
*JUROR: I don't want to be away from my job that long.*
*JUDGE: Can't they do without you at work?*
*JUROR: Yes, but I don't want them to know it.*

**8.**

# WHOSE LAWYER IS IT ANYWAY?

**The California Rules of Professional Conduct, Rule 3-310(F) forbids a lawyer from receiving compensation for representing a client from one other than the client unless: (1) There is no interference with the lawyers independence of professional judgment or with the client-lawyer relationship; (2) information relating to the representation of the client is held in the strictest confidence; and (3) the lawyer obtains the informed written consent**

**of the client. "The Cumis rule requires complete independence of counsel when an insurance company interposes a reservation of rights...." State Farm Fire & Casualty Co. v. Superior Court (1989) 216 Cal.App.3d 1222, 1226, 265 Cal.Rptr. 372, italics added.**

**Obvious potential conflicts are created where an insurer designates a lawyer to represent an insured and in the course of his representation, the insured advises the lawyer of facts supporting a policy defense. As discussed below, the lawyer appointed by the insurer to represent the interests of an insured is obligated to keep all communications with the insured in strictest confidence.**

**A lawyer may not represent a client if the lawyer reasonably believes that the representation of the client will adversely effect another client or if the representation of the client may be materially limited by the lawyer's responsibilities to another client. Under the Model Rules of Professional Conduct of the American Bar Association, Rule 1.7, moreover, a lawyer may not use**

**information relating to his representation of a client to the disadvantage of the client unless the client consents after consultation. Rule 1.8 of the ABA Model Rules of Professional Conduct.**

**The insurance defense lawyer represents both insurer and insured and is ethically obligated to protect the interests of each. See Bogard v. Employers Casualty Co. (1985) 164 Cal.App.3d 602, 609, 210 Cal.Rptr. 578, 582. When in the course of the litigation, the interests of the insurer and the insured differ, the insurance defense lawyer's ethical duty of undivided loyalty to the client is owed to the insured. ABA Informal Opinion 1476 (1981).**

**Where the insurer hires and compensates counsel to defend its insured and does not raise or reserve any coverage dispute, and where there is otherwise no actual or apparent conflict of interest between the insurer and the insured that would preclude an attorney from representing both, the attorney has a dual-attorney-client relationship with both insurer and insured. The insurer therefore**

**may bring a legal malpractice action against the attorney for negligent acts committed in the representation of the insured. Unigard Ins. Group v. O'Flaherty & Belgum (1995) 45 Cal.Rptr.2d 565, 569, 38 Cal.App.4th 1229, 1237.**

**Cumis counsel is obligated to "disclose to the insurer all information concerning the action except privileged materials relevant to coverage disputes" (subd. (d)); must timely "inform and consult with the insurer on all matters relating to the action" (subd.(d)); and must "cooperate fully in the exchange of information that is consistent with ... counsel's ethical and legal obligation to the insured" (subd. (f)). Assurance Co. of America v. Haven, (1995) 38 Cal.Rptr.2d 25, 32, 32 Cal.App.4th 78. These duties for Cumis counsel parallel the long-standing duties of an insured to make a full and prompt disclosure of known, relevant information to the insurer so as not to delay or impede the insurer's claim investigation. Id.**

**The insurer can provide its own counsel to participate in the litigation along with the Cumis counsel. The insurer-provided**

**counsel is "allowed to participate in all aspects of the litigation." Civil Code §2860(f).**

**Cumis counsel is under no duty to the insurer to investigate or make determinations regarding how the case will be handled. It is the insurer's duty to make its own investigation and determinations, if needed, using, among other sources, the section 2860 information provided by Cumis counsel. United States Fidelity & Guaranty Co. v. Superior Court (1988) 204 Cal.App.3d 1513, 1526-1527, 252 Cal.Rptr. 320.**

**A liability insurer can sue its insured's Cumis counsel for negligence based on a breach of his statutory duty under Civil Code § 2860 for failing to inform and consult with the insurer in a timely manner, to disclose to the insurer all known, nonprivileged information, and to cooperate in exchanging information with insurer where those failures preclude the insurer from timely asserting a complete defense to an entire action or to a cause of action that has been brought against its insured. However, Cumis counsel cannot be held negligently or statutorily liable to the**

**insurer for failing to investigate, prepare, assert, establish, or perform similar functions regarding that complete defense. This distinction is drawn in recognition of the duties specified in Section 2860 and in recognition of the independence of Cumis counsel who represents the insured, not the insurer. Assurance Co. of America v. Haven, (1995) 38 Cal.Rptr.2d 25, 29, 32 Cal.App. 4th 78.**

**A lawyer may represent multiple insureds even where the policy limits differ for each insured without creating a conflict of interest. Spindle v. Chubb/Pacific Indemnity Group (1979) 89 Cal.App.3d 706, 152 Cal.Rptr. 776.**

**The insurer may exclude insured's independent counsel from settlement negotiations and need not obtain insured's consent before accepting settlement offer within policy limits, even where settlement allegedly injures insured's reputation where policy confers control over settlement to insurer. Western Polymer Technology, Inc. v. Reliance Ins. Co.(1995) 38 Cal.Rptr.2d 78, 32 Cal.App.4th 14.**

**i i i**

**COURTROOM HUMOR . . .**
**(THIS LAWYER IS BRAIN DEAD)**

*LAWYER: What happened then?*
*WITNESS: He told me, he says, "I have to kill you because you can identify me."*
*LAWYER: Did he kill you?*

**9.**

# IS THERE HOPE?
# LIMITATIONS ON THE DUTY TO DEFEND

**A liability insurer owes a broad duty to defend its insured against claims that create a potential for indemnity. The carrier must defend a suit which potentially seeks damages within the coverage of the policy. The duty to defend is broader than the duty to indemnify; an insurer may owe a duty to defend its insured in an action in which no damages ultimately are awarded. Montrose Chemical Corp. v. Superior Court (1993) 6 Cal.4th 287, 295, 24 Cal.Rptr.2d 467, 861 P.2d 1153.**

**Courts typically will not impose duty to defend where complaint seeks recovery for matters which the policy does not provide coverage. For example:**

**1. Claims for "intangible" property damage.**

**California courts have held that there is no duty to defend under comprehensive general liability policies with limited coverage for bodily injury or damage to intangible property in cases where only damages are sought for loss to intangible property, such as loss of money or profits. E.g. Allstate Ins. Co. v. Interbank Financial Services (1989) 215 Cal.App.3d 825, 264 Cal.Rptr. 25.**

**2. Claims for wrongful discharge, employment discrimination, sexual harassment.**

**The termination of an employee is considered an intentional act and therefore California courts have found no possibility for indemnification in wrongful discharge cases. E.g. Dyer v. Northbank**

**Ins. Co. (1989) 210 Cal.App.3d 1540, 259 Cal.Rptr. 298; the insurer owed no indemnity or defense to an insured employer under an employer liability policy for an employee's action for employment discrimination and retaliatory discharge. B&E Convalescent Center v. State Compensation Insurance Fund (1992) 8 Cal.App. 4th 78, 9 Cal.Rptr. 2nd 894; Save Mart Supermarkets v. Underwriters (N.D. Cal. 1994) 843 Fed.Sup. 597. There was no duty to indemnify an employer against claims of serious and willful violations of an employee's right to a safe workplace. Reagen's Vacuum Truck Service, Inc. v. Beaver Ins. Co. (1994) 31 Cal.App. 4th 375, 37 Cal.Rptr. 2d 89.**

**3. Claims for sexual molestation of minors**

**Because the courts have found that sexual molestation of children is harmful per se, the conduct is inherently outside the scope of liability coverage with no associated duty to**

defend. See Merced v. Mendez (1989) 213 Cal.App.3d 41, 261 Cal.Rptr. 273; J.C. Penny Casualty Ins. Co. v. M.K. (1991) 52 Cal.3d 1009, 278 Cal.Rptr. 64, 804 P.2d 689; State Farm Fire & Cas. Co. v. Ezrin (N.D. Cal. 1991) 764 Fed.Sup. 153.

4. Murder Cases

It remains an open question whether certain kinds of psychological illness may make deliberate criminal conduct, including murder, "unintentional" for insurance purposes. In Clemmer v. Hartford Ins. Co. (1978) 22 Cal.3d 865, 151 Cal.Rptr. 285, 587 P.2d 1098, the California Supreme Court held that there was a duty to indemnify and defend an insured in a wrongful death action brought by the heirs of an individual that the insured had killed and for whose death the insured had been tried and convicted of murder in the second degree. Despite the second degree murder conviction, the carrier had failed to demonstrate that the insured necessarily had the mental capacity to have acted

**"willfully" and therefore brought his conduct outside the scope of the coverage provided by the policy. But Safeco Insurance Company of America v. Robert S. (1999) 82 Cal.Rptr. 2d 880, held that the insurer had no duty to defend the insured in a wrongful death action where the applicable exclusion read "arising out of any illegal act committed by or at the direction of an insured." Safeco concerned a teenager's accidental shooting of a friend. The decedent's family sued the teenager (who had been adjudicated guilty of involuntary manslaughter) and the parents for negligent supervision. Interestingly, in Michaelian v. State Comp. Ins. Fund (1996) 50 Cal.App. 4th 1093, 58 Cal.Rptr. 2d 133, the court ruled there was no duty to indemnify an insured against claims of assault, battery and intentional infliction of emotional distress.**

**5. Toxic Clean Up Expenses**

**In toxic clean up cases the California Supreme Court has ruled that injunctive relief and abatement ordered against insured in environmental clean up action was a "legal obligation" of insured and reimbursement of environmental clean up response costs were "damages" affording coverage under policy. AIU Insurance Company v. Superior Court (FMC Corporation) (1990) 51 Cal.3d 807, 274 Cal.Rptr. 820, 799 P.2d 1253. But the Supreme Court ruled in another case that an administrative cleanup order isn't a suit as that term is used in a comprehensive general liability policy and hence there was no duty to defend. Foster-Gardner, Inc. v. National Union Fire Insurance Company of Pittsburgh (1998) 98 Daily Journal D.A.R. 8398.**

**6. Restitution and Reimbursement**

**The California Supreme Court in Bank of the West v. Superior Court of Contra Costa County (1992) 2 Cal.4th 1254, 10 Cal.Rptr.2d 538, held that**

**restitution and reimbursement are not "damages" and therefore are not compensable under an insurance policy agreeing to pay damages which an insured becomes obligated to pay. Accordingly, there should be no potential coverage for claims of restitution or reimbursement and no corresponding duty to defend.**

**7. Claim for Malicious Prosecution**

**The court in Venture v. LMI Insurance Company (1998) 78 Cal.Rptr. 2d 142, held that California, Insurance Code, Section 533 (prohibiting indemnification for willful acts) prohibited an insurer from indemnifying for malicious prosecution. But under the terms of policy the insured did have a duty to indemnify.**

8. Racially Motivated Hate Crimes

A federal court held that California, Insurance Code, Section 533 prohibits indemnification of an insured who is accused of a racially motivated hate crime. Allstate Ins. Co. v. Tankovich (N.D. Cal. 1991) 776 Fed.Supp. 1394.

9. Business and Commercial Litigation

Where the plaintiff alleges the insured induced a patent infringement, an act which is necessarily both intentional and knowing, there is no duty to indemnify. Aetna Casualty Surety Co. v. Superior Court (1993) 19 Cal.App. 4th 320, 23 Cal.Rptr. 2d 442. There is no duty to indemnify where the plaintiff alleges the insured intentionally violated the Sherman Anti-Trust Act. Trailer Marine Transport v. Chicago Ins. Co. (N.D. Cal. 1992) 791 Fed.Supp. 809. There is no duty to indemnify an insured employer where its president and managerial employee was alleged to have engaged in acts of sexual harassment. Coit Drapery

**Cleaners, Inc. v. Sequoia Ins. Co. (1993) 14 Cal.App. 4th 1595, 18 Cal.Rptr. 2d 692.**

**iii**

**ANOTHER ROUND OF COURTROOM HUMOR**
**(A LOGICAL PLEA)**

*JUDGE: You are charged with habitual drunkenness. Have you anything to say in your defense?*
*DEFENDANT: Habitual thirstiness?*

**10.**

# I TOLD YOU WHEN WE WROTE THE RISK THAT HE COULDN'T EVEN SPELL COOPERATION.

**Under California law, an insured's breach of notice conditions will relieve the insurer of liability if the insurer is actually prejudiced by the late notice. Collin v. American Empire Insurance Co. (1994) 21 Cal.App.4th 787. The insurer bears the burden of proof on the issue of prejudice. Select Insurance Co. v. Superior**

**Court (1990) 226 Cal.App.3d 631. The insurer's burden is not carried by a showing of possibility of prejudice. The insurer must establish, at the very least, that if the cooperation clause had not been breached there was a substantial likelihood the trier of fact would have found in the insured's favor. Northwestern Title Sec. Co. v. Flack (1970) 6 Cal.App.3d 134.**

**The case of Eyvind Earle and Joan Earle v. State Farm Fire & Casualty Company (March 19, 1997) 97 Daily Journal D.A.R. 3623, addressed a situation where the insured first made the tender after the conclusion of trial. Although the case was decided by the United States District Court, Northern District of California, the issue of post-trial tender addressed in the case was a matter of first impression in California. The court in Earle noted that at least one state court has determined that coverage does not exist as a matter of law where the insured was aware of the potential for coverage but did not contact the insurer until after the trial. Felice v. St. Paul Fire & Marine Insurance Co. (1985) 42 Wash. App. 352. Although the court in Earle did not decide that prejudice existed as a matter of law in California where a tender first**

occurs post-trial, it did uphold the entry of a summary judgment in favor of the insurer, finding prejudice to the insurer based upon the particular facts of that case.

The insurer can sue its insured for bad faith. Agricultural Insurance Company v. MKDG/Rhodes SC Partnership (1999) 70 Cal.App. 4th 385, 82 Cal.Rptr. 2d 594. This is the so-called "reverse bad faith. But the insurer's action for breach of the covenant of good faith and fair dealing is limited to a claim for breach of contract. This contrasts with the insured's action for bad faith which, of course, sounds in tort. The difference is crucial. An insurer can recover only contract loss damages. An insured can recover tort damages.

Does an insurer have any remedy where it is the victim of a fraud? California Insurance Code, Section 1871.7 (amended in 1995) provides that anyone who knowingly takes part in certain schemes to defraud an insurance company is liable for civil penalties up to $10,000 per claim and three the amount of damages sustained by the carrier because of the fraud.

**¡ ¡ ¡**

**COURTROOM HUMOR AGAIN . . .**

*LAWYER: I show you Exhibit 3 and ask you if you recognize that picture.*
*WITNESS: That's me.*
*LAWYER: Were you present when that picture was taken?*

**11.**

# NOW THE FUN BEGINS: TO QUOTE SHAKESPEARE ON BAD FAITH: "OH, BOY"

**"It is clear that if there is no potential for coverage and, hence, no duty to defend under the terms of the policy, there can be no action for breach of the implied covenant of good faith and fair dealing because the covenant is based on the contractual relationship between the insured and the insurer." Waller v. Truck Ins. Exchange, Inc. (1995) 11 Cal.4th 1, 35-37, 44 Cal.Rptr.2d 370, 900 P.2d 619.**

## A. FIRST PARTY FUN (INTIMACY BREEDS CONTEMPT)

**"First party bad faith lawsuits" involve an insured's claims against the insurer under coverages written for the insured's direct benefit under a first party policy. Waters v. United Services Auto. Ass'n, (1996) 48 Cal.Rptr.2d 910, 913 41 Cal.App.4th 1063.**

**The gravamen of a first party lawsuit is a breach of the implied covenant of good faith and fair dealing by refusing, without proper cause, to compensate the insured for a loss covered by the policy (Gruenberg v. Aetna Ins. Co. (1973) 9 Cal.3d 566, 574, 108 Cal.Rptr. 480, 510 P.2d 1032) or by unreasonably delaying payments due under the policy (Austero v. National Cas. Co. (1978) 84 Cal.App.3d 1, 29-30, 148 Cal.Rptr. 653.**

## B. THIRD PARTY FUN (NOT MUCH BETTER).

**“Third party bad faith lawsuits” since the California Supreme Court’s holding in Moradi-Shalal v. Fireman's Fund Ins. Companies**

**(1988) 46 Cal.3d 287, 250 Cal.Rptr. 116, 758 P.2d 58) generally involve an insured's suit (or more likely the suit of the third party claimant by assignment from the insurer) against his liability insurer arising out of the insurer's mishandling of a third party claim against its insured, such as by unreasonably refusing to settle within policy limits. (Samson v. Transamerica Ins. Co. (1981) 30 Cal.3d 220, 238, 178 Cal.Rptr. 343, 636 P.2d 32) or unreasonably refusing to provide a defense in a third party action (Tibbs v. Great American Ins. Co. (9th Cir.1985) 755 F.2d 1370, 1375). The older cases (based on Royal Globe Ins. Co. v. Superior Court (1979) 23 Cal.3d 880, 153 Cal.Rptr. 842, 592 P.2d 329, (overruled by Moradi-Shalal) involving a third party claimant's direct action against the carrier for a violation of Insurance Code Section 790.03, subdivision (h), are also sometimes referred to as "third party bad faith cases." Waters v. United Services Auto. Ass'n, (1996) 48 Cal.Rptr.2d 910, 914, 41 Cal.App.4th 1063.**

**In the past, a third party claimant could sue a liability insurer directly for violations of California Insurance Code**

**Section 790.03(h), relating to unfair claims settlement practices. Royal Globe Ins. Co. v. Superior Court (Koeppel) (1979) 23 Cal.3d 880, 153 Cal.Rptr. 842. Under this theory, a third party could recover his own damages based on the statutory violation, including emotional distress and punitive damages. Since 1988, under the Supreme Court's ruling in Moradi-Shalal (1988) 46 Cal.3d 287, 250 Cal.Rptr. 116, there exists no private right of action against an insurer for violations of Insurance Code Section 790.03. Henry v. Associated Indemnity Corp. (1990) 217 Cal.App.3d 1405, 266 Cal.Rptr. 578.[7]**

## C. GOOD NEWS FOR THE CLAIMS EXAMINER?

**An action for breach of the implied covenant of good faith and fair dealing may only be brought by persons entitled to policy**

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[7]**To quote the robot from Lost In Space: "Warning Will Robinson, Warning Will Robinson." As this booklet is revised in June of 1999, SB1237 is pending before the California Legislature. This bill is sponsored by the plaintiffs' bar group Consumer Attorneys of California. If this bill becomes law it would restore the right of third parties to sue insurers for bad faith for certain unfair claims settlement practices.**

**benefits, including a named insured, persons within the class of insured persons under the policy and any express beneficiary, not third party claimants (except those who have been assigned insured's claims.) Hatchwell v. Blue Shield of Cal. (1988) 198 Cal.App.3d 1027, 1034, 244 Cal.Rptr. 249, 253.**

**Claims examiners, claims supervisors or other insurance company personnel involved in the investigation or adjusting of the claim, outside investigators and claims adjustors, and in-house or outside counsel who may have advised the insurer to deny the claim are "immune" from being named as a party to a lawsuit for breach of the implied covenant. Doctor's Company v. Superior Court (Valencia) (1989) 49 Cal.3d 39, 48, 260 Cal.Rptr. 183, 186; Sanchez v. Lindsey Morden Claims Services, Inc. (1999) 84 Cal.Rptr. 2d 799.**

**i i i**

**IS THIS COURTROOM HUMOR?**
**(WHO TAUGHT THIS GUY ABOUT THE BIRDS AND BEES?)**

*LAWYER: She had three children, right?*
*WITNESS: Yes.*
*LAWYER: How many were boys?*
*WITNESS: None.*
*LAWYER: Were there girls?*

## D. THE GOOD, BAD AND UGLY.

**Examples of conduct which might support a finding of bad faith include:**

**(1) Failure to Investigate a Claim Thoroughly. Egan v. Mutual of Omaha Ins. Co. (1979) 24 Cal.3d at 819, 169 Cal.Rptr. 691, 696;**

**(2) Failure to Evaluate a Claim Objectively. Delgado v. Heritage Life Ins. Co. (1984) 157 Cal.App.3d 262, 272-278, 203 Cal.Rptr. 672, 681-682.**

**(3) Unduly Restrictive Interpretation of Policy Language or Claim Forms. Miller v. National Am. Life Ins. Co. of California (1976) 54 Cal.App.3d at 339, 126 Cal.Rptr. 731, 735.**

**(4) Using Improper Standards to Deny a Claim. Moore v. American United Life Ins. Co. (1984) 150 Cal.App.3d 610, 630-631, 197 Cal.Rptr. 878, 890-891.**

**(5) Unjustified Delay in Payment of Claim. Mock v. Michigan Millers Mut. Ins. Co.(1992) 5 Cal.Rptr.2d 594, 4 Cal.App.4th 306.**

**(6) Dilatory Claims Handling. Mock v. Michigan Millers Mut. Ins. Co.(1992) 5 Cal.Rptr.2d 594, 4 Cal.App.4th 306.**

**(7) Deceptive Practices to Avoid Payment of Claim. Moore v. American United Life Ins. Co. (1984) 150 Cal.App.3d 610, 630-631, 197 Cal.Rptr. 878, 890-891.**

**(8) Abusive or Coercive Practices to Compel Compromise of a Claim. Mock v. Michigan Millers Mut. Ins. Co.(1992) 5 Cal.Rptr.2d 594, 4 Cal.App.4th 306.**

**(9) Unreasonable Conduct During Litigation. White v. Western Title Ins. Co. (1985) 40 Cal.3d 870, 885, 221 Cal.Rptr. 509, 517.**

**(10) Arbitrary and Unreasonable Demands for Proof of Loss. McCormick v. Sentinel Life Ins. Co. (1984) 153 Cal.App.3d 1030, 1046, 200 Cal.Rptr. 732, 741.**

**(11) Failure to Have a Reasonable Basis for the Denial of a Claim or Delay in Payment. Arnold v. National County Mutl Fire Ins. Co. (Tex. 1987) 725 S.W.2d 165.**

**(12) Improper Refusal to Defend an Insured. Tibbs v. Great Am. Ins. Co. (9th Cir. 1985) 755 F.2d at 1375.**

**(13) Improper Handling of Defense of Insured Resulting in Loss of Goodwill. Bodenhamer v. Superior Court (St. Paul Fire & Marine)(1987) 192 Cal.App.3d 1472, 180, 238 Cal.Rptr. 177, 1822.**

**i i i**

**MORE COURTROOM HUMOR**
**(IT'S AS OBVIOUS AS THE NOSE ON YOUR FACE)**

*LAWYER: Was that the same nose you broke as a child?*

## E. BAD NEWS BEARS: BETTER INVESTIGATE THAT COVERAGE.

**The duty to investigate facts of coverage applies to both first and third-party claims. Betts v. Allstate (1984) 154 Cal.App. 3d at 707, 201 Cal.Rptr. at 539. The insurer has the duty to conduct an investigation that is prompt, thorough, reasonable, and consider facts both favorable to the insured as well as the insurer, and otherwise conducted in good faith. Egan v. Mutual of Omaha Ins. Co. (1979) 24 Cal.3d at 819, 169 Cal.Rptr. 691, 696. "[A]n insurer cannot reasonably and in good faith deny payments to its insured without thoroughly investigating the foundation for its denial" and must fully inquire into possible bases which might support the insured's claim. Id. Therefore, failing to pay policy benefits due under the policy because of a failure to investigate**

**the claim thoroughly may constitute a breach of the implied covenant of good faith and fair dealing.**

**California Insurance Code Section 790.03(h)(3) requires the insurer to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies. However, no separate cause of action for bad faith can be alleged based upon a violation of this statute, alone.**

**To support an insured's claim of breach of the implied covenant the insurer must have actual notice of the claim. California Shoppers, Inc. v. Royal Globe (1985) 173 Cal.App.3d at 57, 221 Cal.Rptr. at 202. Constructive notice of the claim is not sufficient, though it will support a breach of contract claim. Id.**

**Even where an insured has failed to supply requested information to the insurer, the carrier has a duty to make an independent investigation of the claim. McCormick v. Sentinel Life Ins. Co. (1984) 153 Cal.App.3d 1030, 1046, 200 Cal.Rptr. 732, 741.**

**i i i**

**A LITTLE BLACK COURTROOM HUMOR**

*LAWYER: Now, Mrs. Johnson, how was your first marriage terminated?*
*WITNESS: By death.*
*LAWYER: And by whose death was it terminated?*

## F. BAD NEWS BEARS: BETTER ACCEPT THAT REASONABLE SETTLEMENT OFFER

**The insurer owes a duty to the insured to settle within the policy limits where there exists a substantial likelihood of recovery against the insured in excess of the policy limits. Dalrymple v. United Services Auto. Ass'n(1995) 46 Cal.Rptr.2d 845, 40 Cal.App.4th 497; Samson v. Transamerica Ins. Co. (1981) 30 Cal.3d 220, 237, 178 Cal.Rptr. 343, 353. Under these circumstances, the insurer's failure to settle within the policy limits subjects the insurer to liability for the entire judgment against the insured plus other compensatory damages resulting from its refusal to settle which may include damages for emotional distress and mental suffering and punitive. Betts v. Allstate Ins.**

**Co. (1984) 154 Cal.App.3d at 707, 201 Cal.Rptr. at 539. Where the cause of action is assigned to a third party claimant, the assignee may only recover the amount of the excess judgment. Murphy v. Allstate Ins. Co. 17 Cal.3d at 942, 132 Cal.Rptr. at 427.**

**An insurer does not act in bad faith by refusing to meet a settlement demand where there is no policy limits exposure for claimed covered damages to establish that the settlement demand is reasonable. Camelot by the Bay Condominium Owners' Assn. v. Scottsdale Ins. Co. (1994) 27 Cal.App.4th 33, 53, 32 Cal.Rptr.2d 354.**

**In determining the liability, if any, of insurers alleged to have breached their duty to settle, courts determine whether a prudent insurer would have accepted the settlement offer if it alone were liable for the entire judgment. Betts v. Allstate Ins. Co. (1984) 154 Cal.App.3d at 707, 201 Cal.Rptr. at 539. Where the insurer's refusal to settle is based on a coverage dispute with the insured, as opposed to an evaluation of the settlement demand, if coverage is ultimately found to exist, the insurer will be liable**

**for bad faith. Comunale v. Traders & Gen Ins. Co. (1958) 50 Cal.2d 654, 328 P.2d 198.**

**The elements of a cause of action for bad faith refusal to settle are: (1) the carrier received timely notice of the insured's claim and had a reasonable to settle within the policy limits; (2) the carrier unreasonably rejected or refused a settlement offer within the policy limits; (3) an excess judgment was returned against the insured and the judgment is final (or the case has been otherwise concluded); and (4) the excess judgment against the insured was assigned to the third party (in cases where action assigned to a third party).**

**Whether the insured acted reasonably in rejecting a settlement offer depends upon the court's evaluation of the following factors identified in Brown v. Guarantee Ins. Co. (1957) 155 Cal.App.2d 679, 689, 319 P.2d 69:**

**(1) The strength of the insured's claimant's case;**

**(2) The financial risk to which the insured is exposed in the event of a refusal to settle;**

**(3) The insurer's failure to properly investigate the circumstances to ascertain evidence against the insured;**

**(4) The insurer's failure to inform the insured of the compromise offer to enable the insured to consider "adding to the pot" to effectuate settlement;**

**(5) The insurer's rejection of advice from its own lawyers or claims investigators;**

**(6) Any attempt by the insurer to induce or coerce the insured to contribute to the settlement;**

**(7) The fault of the insured in inducing the insurer's rejection of the proposed compromise settlement by misleading it as to material facts; and**

**(8) Any other factors tending to establish or negate bad faith on the part of the insured.**

**An insured's breach of the covenant of good faith and fair dealing in failing to accept a settlement offer within policy limits does not expose the insurer to liability for a punitive damage award against the insured. PPG Industries, Inc. v. Transamerica Insurance Company (1999) 20 Cal. 4th 310, 84 Cal.Rptr. 2d 455. To allow the insured to shift liability for its own intentional wrongdoing to the insurer would violate California's public policy.**

**Several comments about your potential strategy in responding to settlement demands: (1) Because ignoring what may be perceived to be an incomplete or defective settlement demand may create breach of the insurer's duty (Allen v. Allstate Ins. Co (9th Cir. 1981) 656 F.2d 487, 489), insurers should respond to each settlement demand; (2) Where the insurer receives a defective or incomplete demand, it is good practice for the insurer to state specific reasons why the demand does not merit a substantive reply,**

**and express a willingness to negotiate further. Coe v. State Farm Mut. Auto Ins. Co. (1977) 66 Cal.App.3d 981, 992-993, 136 Cal.Rptr. 331, 337; (3) Failure of the insurer to accept a reasonable settlement demand within the stated time limits (if limits are reasonable) creates a breach of duty and the injured party is relieved of any further duty to continue negotiations. Critz v. Farmers Ins. Group (1964) 230 Cal.App.2d 788, 798, 41 Cal.Rptr. 401, 406. As a matter of practice, an insurer should provide some reply, or request further time to respond. Cal. Prac. Guide: Bad Faith n. 17, at 7:88; (4) A delayed acceptance of a reasonable settlement demand will not "cure" the insurer's breach of duty, but belated settlement for the amount demand may cut off liability for further emotional distress and economic losses. Schlauch v. Hartford Acc & Indem. Co. (1983) 146 Cal.App.3d at 935, 194 Cal.Rptr. at 664.**

**¡¡¡**

**COURTROOM HUMOR . . .**

*LAWYER: Were you present in court this morning when you were sworn in?*

**¡¡¡**

## G. BAD NEWS BEARS: SINGING “I WISH I HAD DEFENDED” BLUES.

**Without more, an insurer's erroneous failure to furnish a defense is simply a breach of contract, entitling the insured only to foreseeable, "consequential" contract damages, which include defense costs and the amount of any judgment against the insured up to the policy limits, but do not include punitive damages. California Shoppers, Inc. v. Royal Globe Ins. Co. (1985) 175 Cal.App.3d 1, 54-55, 221 Cal.Rptr. 171; State Farm v. Allstate (1970) 9 Cal.App.3d 508, 528, 88 Cal.Rptr. 246.**

**An erroneous denial of coverage resulting in a failure to defend may subject the carrier to a claim for breach of the implied covenant of good faith and fair dealing which carries with it tort damages, including punitive damages. See Bogard v. Employers Cas. Co. (1985) 164 Cal.App.3d 602, 210 Cal.Rptr. 578. California law recognizes a cause of action by an insured against its insurer for breach of the implied covenant of good faith and fair dealing based solely on the insurer's unjustified failure to defend. Raymond E.**

**Campbell v. Superior Court of Los Angeles County, Farmers Insurance Company, Inc., ( 1996) 44 Cal.App. 4th 1308, 52 Cal.Rptr. 2d 385.**

**To prevail on a bad faith cause of action against the insurer for wrongful refusal to defend, the insured must plead and prove:**

**(1)The existence of a duty to defend;**

**(2)Notice and opportunity to defend;**

**(3)The unreasonable refusal to defend; and**

**(4)Damages resulting from the bad faith refusal to defend.**

**Gray v. Zurich Ins. Co. (1966) 65 Cal.2d 263, 276-277, 54 Cal.Rptr. 104, 112-113.**

**A carrier that is liable in tort is responsible for all proximately caused harm to the insured. This exposure includes any**

**actual expenses of the insured while defending the case and the entirety of the judgment against the insured notwithstanding the policy limits. Samson v. Transamerica Ins. Co. (1981) 30 Cal.3d 220, 178 Cal.Rptr. 343, 636 P.2d 32. This is true for judgments that are entered where insured offers no defense, judgments that are entered upon a default, and judgments that are entered between insured and third party by stipulation, as long as it is neither fraudulent or collusive. Sunseri v. Camperos Del Valle Stables, Inc. (1986) 185 Cal.App.3d 559, 230 Cal.Rptr. 23.**

**A wrongful refusal to defend, when combined with a wrongful refusal to settle, will subject the insurer to punitive damages if there is sufficient evidence of "oppression, fraud or malice." See e.g. Tibbs v. Great American Ins. Co. (9th Cir. 1985) 755 F.2d 1370, 1375.**

## H. BAD NEWS BEARS: HOW MUCH DID YOU SAY THAT JUDGMENT WAS?

**Under Insurance Code Section 11580, a judgment creditor claimant is entitled to sue an insurer for the balance of any judgment not collected against the insured. Section 11580 makes a judgment creditor of an insured a third party beneficiary of the insurance contract between the insurer and the insured. Hand v. Farmers Insurance Exchange (1994) 23 Cal.App.4th 1847, 29 Cal.Rptr.2d 258.**

**In a recent decision by the Court of Appeals, the court ruled that an insurer's bad faith refusal to pay a judgment creditor the entire amount of judgment against its insured after judgment became final violated the implied covenant of good faith and fair dealing. Hand v. Farmers Insurance Exchange (1994) 23 Cal.App.4th 1847, 29 Cal.Rptr.2d 258. This holding has been questioned by at least one other Court. Hughes v. Mid-Century Ins. Co. (1995) 38 Cal.App.4th 1176, 45 Cal.Rptr.2d 302.**

## I. WHAT GOOD WAS THAT LAWYER ANYWAY?

**Good faith reliance on advice of counsel is a factor to be considered in the evaluation of whether the insurer acted reasonably under the circumstances in rejecting a settlement demand. Merritt v. Reserve Ins. Co. (1973) 34 Cal.App.3d 858, 872-873, 110 Cal.Rptr. 511, 520-521. Advice of counsel may also be used as a complete defense to defeat the extreme and outrageous conduct element of the tort of intentional infliction of emotional distress claim, other intentional torts, and punitive damage claims. Melorich Builders, Inc. v. Superior Court (1984) 160 Cal.App.3d 931, 936-9337, 207 Cal.Rptr. 47, 50. The insurer must show that (1) the defendant acted upon the advice of counsel; and (2) counsel's advice was based upon full disclosure of facts by the defendant; and (3) the defendant relied upon the advice of counsel in good faith. Id.**

## J. A LITTLE ON DAMAGES.

**Emotional distress damages are recoverable in first and third party bad faith cases only when the insureds have suffered a financial loss. Waters v. United Services Auto. Ass'n, (1996) 48 Cal.Rptr.2d 910, 913, 41 Cal.App.4th 1063. Actual (not merely potential) financial loss must be established before an insured can recover emotional distress damages in a bad faith case. Id. Insured's claims for emotional distress and punitive damages against insurer are not assignable, and may not be recovered in bad faith actions brought by third parties. Murphy v. Allstate Insurance Company (1976) 17 Cal.3d 937, 132 Cal.Rptr. 424, 553 P.2d 584.**

**¡ ¡ ¡**

**A FINAL SHOT AT COURTROOM HUMOR**
**(THE BOTTOM OF THE BARREL)**

*LAWYER: Now, doctor, isn't it true that when a person dies in his sleep, in most cases he just passes quietly away and doesn't know anything about it until the next morning?*

**¡ ¡ ¡**

## Article 10. Fees

### § 2691.20. Change of Classification.

The fee for making a change in a license from one classification to another is the same as for an original license to do business under the new classification.

NOTE: Authority cited: Sections 14013(c) and 14097 (e), Insurance Code. Reference: Sections 14013 (a) (c) and 14097 (e), Insurance Code.

### § 2691.21. Renewal Fees.

(a) The renewal fee for a license as an insurance adjuster shall be one hundred dollars.

(b) The renewal fee for a branch office certificate shall be twenty dollars.

(c) There shall be no additional fee charged solely by reason of the classification of a license.

NOTE: Authority cited: Sections 14097 (d) (1), (2) and (c) and 14013(c), Insurance Code. Reference: Sections 14097 (d) (1), (2) and (e) and 14013 (c), Insurance Code.

### § 2691.22. Partnership, Corporation or Unincorporated Association

Before a partnership, corporation or unincorporated association license may be granted, each partner of a partnership, each officer of a corporation, and each member of an unincorporated association, shall file a separate application for such license on the form prescribed by the Commissioner. However, only one officer or partner or manager is required to meet the qualification requirements of Insurance Code Section 14025 in order to qualify for a partnership or corporation license. A separate application fee is required for every partner, officer, or member who is a person named to operate or manage the business of the licensee under the requirements of Insurance Code Sections 14025 and 14029.

NOTE: Authority cited: Sections 14013 (b) and 14025 (d), Insurance Code. Reference: Sections 14029, 14035 and 14097, Insurance Code.

### § 2691.23. Duplicate Copies of License or Identification Card.

The fee for a duplicate copy of an insurance adjuster's license, branch office certificate, or identification card is ten dollars ($10.00).

NOTE: Authority cited: Section 14013 (b), Insurance Code. Reference: Section 12973.7, Insurance Code.

HISTORY

1. Editorial correction of printing error (Register 93, No. 13).

### § 2691.24. No Refunds of Fees.

Application fees, renewal fees, branch office fees or any other fees provided for by statute or regulation shall not be refunded whether or not a license is granted or the examination taken, except under the provisions of Insurance Code Section 12977.

NOTE: Authority cited: Sections 14013 and 14097, Insurance Code; and Section 158, Business and Professions Code. Reference: Sections 14097 and 14099, Insurance Code.

## Subchapter 7.4. Consumer Complaints

### § 2694. Criteria for Determining Whether a Consumer Complaint is Justified.

(a) A consumer complaint shall be deemed justified within the meaning of California Insurance Code section 12921.1(b) where it meets any one or more of the following criteria:

(1) the Department determines that the licensee's act, acts, omission or omissions were in noncompliance with a specific provision or provisions of the California Insurance Code, California Code of Regulations, or other applicable laws and/or regulations;

(2) the Department determines that the licensee's act, acts, omission or omissions were in contravention of an approved rate filing or filings;

(3) the Department determines that the licensee's act, acts, omission or omissions were in contravention of the licensee's rules, policies, procedures or guidelines as relates to sales, marketing, advertising, underwriting, rating, claims and/or customer service, including rate manual filings, underwriting guidelines and/or other filings, statements or guidelines either submitted to the Department or to which the Department would have access during a market conduct examination and the Department determines that there was no substantial justification for deviation from such rules, policies, procedures or guidelines on the facts presented. For purposes of this subsection, all time restrictions or requirements for reply, response, or other legally required insurer action, shall be measured as against applicable time restrictions or parameters established in the California Insurance Code, California Code of Regulations, or other applicable laws and/or regulations.

(4) the Department determines that the licensee's act, acts, omission or omissions were in contravention of, or were otherwise inconsistent with, a provision or provisions of the insurance policy, contract, bond, or other agreement entered into by the relevant parties;

(5) the Department determines that after receiving a written or documented oral communication related to a claim, benefit underwriting or rating transaction, from a policyholder, insured, applicant, third party claimant, beneficiary, principal, or other party with a legitimate interest in the transaction, where that communication reasonably suggests that a response is expected, the licensee has failed to respond or did not provide a complete response; based on the facts then known by the licensee, within the applicable time restrictions established in the California Insurance Code, California Code of Regulations, other applicable laws and/or regulations or, in the absence of such restrictions, the licensee fails to respond within 15 days. A complete response is defined as one that addresses all issues raised and includes copies of any documentation needed to support the licensee's position.

(6) the Department determines that the specific facts surrounding the complaint as against an insurer merit remedial action within the authority of the Commissioner.

NOTE: Authority cited: Section 12921.1(b), California Insurance Code. Reference: Sections 12921, 12921.1, 12921.3 and 12921.4, California Insurance Code.

HISTORY

1. New subchapter 7.4 (section 2694) and section filed 3–11–98; operative 3–11–98 pursuant to Government Code section 11343.4(d) (Register 98, No. 11).

## Subchapter 7.5. Fair Claims Settlement Practices Regulations

### § 2695.1. Preamble.

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

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

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

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

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

(b) These regulations are not meant to provide the exclusive definition of all unfair claims settlement practices; other methods, act(s), or practices not specifically delineated in this set of regulations may also be a viola-

tion of California Insurance Code Section 790.03(h) pursuant to the provisions of California Insurance Code Section 790.06. These regulations are applicable to the handling or settlement of claims brought under all classes of insurance except as specifically provided below:

(1) Workers' compensation insurance;

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

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

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

(c) These regulations recognize the unique relationship which exists under a surety bond between the insurer, the obligee or beneficiary, and the principal. In contrast to other classes of insurance, surety insurance involves a promise to answer for the debt, default or miscarriage of a principal who has the primary duty to pay the debt or discharge the obligation and who is bound to indemnify the insurer. Therefore, only sections 2695.1 through 2695.6, inclusive, section 2695.10, and sections 2695.12, 2695.13 and 2695.14, inclusive, shall apply to the handling or settlement of claims brought under surety bonds.

(d) These regulations shall not apply to the handling or settlement of claims brought under Workers' Compensation insurance policies.

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

NOTE: Authority cited: Sections 790.10, 1871.1, 12340–12417, inclusive, [2921 and 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Section 790.03(h), Insurance Code.

HISTORY

1. New subchapter 7.5 (sections 2695.1–2695.17) filed 12–15–92; operative 1–14–93 (Register 92, No. 52).
2. Editorial correction of printing error in HISTORY 1. (Register 93, No. 4).
3. Amendment of subchapter heading and subsection (b), new subsections (b)(1)–(b)(4), repealer and new subsection (c), amendment of subsection (d), repealer of subsection (e) and subsection relettering filed 1–10–97; operative 5–10–97 (Register 97, No. 2).

## § 2695.2. Definitions.

As used in these regulations:

(a) "Beneficiary" means:

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

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

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

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

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

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

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

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

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

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

(h) "Insurance agent" means:

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

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

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

(4) an underwritten title company.

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

(j) "Insurance policy" or "policy" means the written instrument in which any certificate of group insurance, contract of insurance, or non–profit hospital service plan is set forth. For the purposes of these regulations the terms insurance policy or policy do not include "surety bond" or "bond". For the purposes of these regulations the term insurance policy or policy includes any written instrument in which any certificate of insurance or contract of insurance is set forth that is issued pursuant to the California Automobile Assigned Risk or the California FAIR plan;

(k) "Investigation" means all activities of an insurer or its claims agent related to the determination of coverage, liabilities, or nature and extent of damages afforded by an insurance policy, obligations or duties under a bond, and other obligations or duties arising from an insurance policy or bond.

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

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

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

by an insured or principal solely for informational or incident reporting purposes.

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

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

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

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

(s) "Proof of claim" means any documentation in the claimant's possession submitted to the insurer which provides any evidence of the claim and that supports the magnitude or the amount of the claimed loss.

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

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

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

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

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

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

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

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

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

NOTE: Authority cited: Sections 132(d), 790.10, 12340–12417, inclusive, 12921 and 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Sections 31, 32, 101, 106, 675.5(b), (c) and (d), 676.6, 790.03(h) and 10082, Insurance Code.

HISTORY

1. New section filed 12–15–92; operative 1–14–93 (Register 92, No. 52).

2. Amendment filed 1–10–97; operative 5–10–97 (Register 97, No. 2).

### § 2695.3. File and Record Documentation.

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

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

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

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

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

(c) The requirements of this section shall be satisfied where the licensee provides documentation evidencing inability to obtain data, nonexistence of data, or difficulty in obtaining clear documentary support for actions due to catastrophic losses, or other unusual circumstances providing the licensee establishes to the satisfaction of the Commissioner that the circumstances alleged by the licensee do exist and have materially affected the licensee's ability to comply with this regulation. Any licensee that alleges an inability to comply with this section shall establish and submit to the Commissioner a plan for file and record documentation to be used by such licensee while the circumstances alleged to preclude compliance with this subsection continue to exist.

NOTE: Authority cited: Sections 710.10, 12340–12417, inclusive, 12921 and 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Section 790.03(h), Insurance Code.

HISTORY

1. New section filed 12–15–92; operative 1–14–93 (Register 92, No. 52).

2. Amendment of subsections (b)(1) and (b)(2) filed 1–10–97; operative 5–10–97 (Register 97, No. 2).

### § 2695.4. Representation of Policy Provisions and Benefits.

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

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

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

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

(e) No insurer shall:

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

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

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

NOTE: Authority cited: Sections 790.10, 12340–12417, inclusive, 12921 and 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Sections 790.03(h)(1),(3) and (4), Insurance Code.

HISTORY

1. New section filed 12–15–92; operative 1–14–93 (Register 92, No. 52).
2. Amendment of section heading and subsection (a), repealer and new subsection (h), repealer of subsection (f) and subsection relettering filed 1–10–97; operative 5–10–97 (Register 97, No. 2).

### § 2695.5. Duties upon Receipt of Communications.

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

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

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

(d) Upon receiving notice of claim, every licensee or claims agent shall immediately transmit notice of claim to the insurer. Failure of the licensee or claims agent to immediately transmit notice of claim to the insurer shall constitute a separate and distinct violation of California Insurance Code Section 790.03(h)(3) and this subsection, where the insurer has provided the appointed licensee or claims agent with written instructions as to the proper handling of a notice of claim. Transmission of the notice of claim by the licensee or claims agent to the insurer in conformity with the written instructions received from the insurer shall satisfy the licensee's or claims agent's duty under this section to promptly transmit the notice to the insurer.

(e) Upon receiving notice of claim, every insurer, except as specified in subsection 2695.5(e)(4) below, shall immediately, but in no event more than fifteen (15) calendar days later, do the following unless the notice of claim received is a notice of legal action:

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

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

(3) begin any necessary investigation of the claim.

(4) Subsection 2695.5(e) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the Insurance Code or life insurance subject to Section 10172.5 of the Insurance Code.

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

NOTE: Authority cited: Sections 790.10, 12340–12417, inclusive, 12921, 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Sections 790.03(h)(2) and (3), Insurance Code.

HISTORY

1. New section filed 12–15–92; operative 1–14–93 (Register 92, No. 52).
2. Amendment of section heading and section filed 1–10–97, operative 5–10–97 (Register 97, No. 2).

### § 2695.6. Training and Certification.

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

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

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

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

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

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

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

(3) where the licensee retains independent adjusters, the licensee must provide training to the independent adjusters regarding these regulations and annually certify, in a declaration executed under penalty of perjury, that such training is provided. Alternately, the independent adjuster may annually certify in writing, under penalty of perjury, on an annual basis, that he or she has read and understands these regulations and all amendments thereto or has successfully completed a training seminar which explains these regulations;

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

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

NOTE: Authority cited: Sections 790.10, 12340–12417, inclusive, 12921 and 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Section 790.03(h)(3), Insurance Code.

HISTORY

1. New section filed 12–15–92; operative 1–14–93 (Register 92, No. 52).
2. Amendment of section heading and section filed 1–10–97; operative 5–10–97 (Register 97, No. 2)

### § 2695.7. 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, 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)(1) If more time is required than is allotted in subsection 2695.7(b) to determine whether a claim should be accepted and/or denied in whole or in part, 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.

(2) 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.

(f) Except where a claim has been settled by payment, every insurer shall provide written notice of any statute of limitation or other time period requirement upon which the insurer may rely to deny a 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

[The next page is 752.2(c).]

claim is first received by the insurer within that thirty days, then notice of the expiration date must be given to the claimant immediately. This subsection shall not apply to a claimant represented by counsel on the claim matter.

(g) No insurer shall attempt to settle a claim by making a settlement offer that is unreasonably low. The Commissioner shall consider any admissible evidence offered regarding the following factors in determining whether or not a settlement offer is unreasonably low:

(1) the extent to which the insurer considered evidence submitted by the claimant to support the value of the claim;

(2) the extent to which the insurer considered 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.

(h) 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.

(1) 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.

NOTE: Authority cited: Sections 553, 554, 790.10, 11580.2(k), 12340–12417, inclusive, 12921 and 12926, Insurance Code; and Sections 11342.2, 11152 and 1861.03(a), Government Code; *McLaughlin v. Connecticut General Life Ins. Co.*, 565 F.Supp. 434 (N.D.Cal. 1983). Reference: Section 790.03(h)(2), (3), (4), (5), (13) and (15), 1871.1, and 1872.4, Insurance Code.

History

1. New section filed 12–15–92; operative 1–14–93 (Register 92, No. 52).
2. Amendment of section heading, section and NOTE filed 1–10–97; operative 5–10–97 (Register 97, No. 2).

## § 2695.8. Additional Standards Applicable to Automobile Insurance.

(a) This section enumerates standards which apply to adjustment and settlement of automobile insurance claims. For purposes of this section:

(1) the words "automobile" and "vehicle" are used synonymously; and

(2) a comparable automobile is one of like kind and quality, made by the same manufacturer, of the same or newer model year, of a similar body type, with similar options and mileage as the insured vehicle. Any differences between the comparable automobile and the insured vehicle shall be permitted only if the insurer fairly adjusts for such differences. A comparable automobile must be available for retail purchase by the general public in the local market area within ninety (90) calendar days of the final settlement offer.

(b) When the insurance policy provides for the adjustment and settlement of first party automobile total losses on the basis of actual cash value or replacement with a comparable automobile, one of the following methods must apply:

(1) The insurer may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile including all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of a comparable automobile. Such cost shall be determined as follows and, once determined, shall be fully itemized and explained in writing for the claimant:

(A) when comparable automobiles are available or were available in the local market area in the last 90 days, the average cost of two or more such comparable automobiles; or,

(B) when comparable automobiles are not available in the local market area, the average of two or more quotations from two or more licensed dealers in the local market area; or,

(C) when an automobile total loss is adjusted or settled on a basis which varies from the methods described in subsections (b)(1)(A) and (b)(1)(B) of this section, the determination of value must be supported by documentation. Any deductions from value, including deduction for salvage, must be discernible, measurable, itemized, and specified as well as appropriate in dollar amount and so documented in the claims file. The insurer must take reasonable steps to verify that the value so determined is accurate and representative of the market value of a comparable automobile in the local market area.

(2) The insurer may elect to offer a replacement automobile which is a specified comparable automobile available to the insured, with all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile paid by the insurer at no cost other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the insurer's claim file. A replacement automobile must be in as good or better over all condition than the insured vehicle and available for inspection within a reasonable distance of the insured's residence.

(c) Every insurer shall, if notified within thirty–five (35) calendar days after receiving the claim draft or final settlement offer that the insured cannot purchase a comparable automobile for the gross settlement amount, reopen its claim file and utilize the following procedures:

(1) The insurer shall locate a comparable automobile for the gross settlement amount determined by the company at the time of settlement and shall provide the insured with the information required in (c)(4), below, or offer a replacement vehicle in accordance with section 2695.8(b)(2). Any such vehicle must be available in the local market area; or,

(2) The insurer shall either pay the insured the difference between the amount of the gross settlement and the cost of the comparable automobile which the insured has located, or negotiate and purchase this vehicle for the insured; or,

(3) The insurer shall invoke the appraisal provision of the insurance policy.

(4) No insurer is required to take action under this subsection if its documentation to the insured at the time of final settlement offer included written notification of the identity of a specified comparable automobile which was available for purchase at the time of final settlement offer for the gross settlement amount determined by the insurer. The documentation shall include the telephone number (including area code) or street address of the seller of the comparable automobile and:

(A) the vehicle identification number (VIN) or,

(B) the stock or order number of the vehicle from a licensed dealer, or

(C) the license plate number of such comparable vehicle.

(d) No insurer shall, where liability and damages are reasonably clear, recommend that the third party claimant make a claim under his or her own policy to avoid paying the claim under the policy issued by that insurer.

(e) No insurer shall:

(1) require that an automobile be repaired at a specific repair shop; or,

(2) direct, suggest or recommend that an automobile be repaired at a specific repair shop, unless,

(A) such referral is expressly requested by the claimant; or,

(B) the claimant has been informed in writing of the right to select the repair facility; and,

(C) the insurer that elects to repair a vehicle directs, suggests or recommends that a specific repair shop be used, shall cause the damaged vehicle to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy or as otherwise allowed by these regulations.

(3) require a claimant to travel an unreasonable distance either to inspect a replacement automobile, to conduct an inspection of the vehicle, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.

(f) if partial losses are settled on the basis of a written estimate prepared by or for the insurer, the insurer shall supply the claimant with a copy of the estimate upon which the settlement is based. The estimate prepared by or for the insurer shall be in accordance with applicable policy provisions, and of an amount which will allow for repairs to be made in a workmanlike manner. If the claimant subsequently claims, based upon a written estimate which he or she obtains, that necessary repairs will exceed the written estimate prepared by or for the insurer, the insurer shall:

(1) pay the difference between the written estimate and a higher estimate obtained by the claimant; or,

(2) promptly provide the claimant with the name of at least one repair shop, if requested by the claimant pursuant to subsection 2695.8(e)(2), that will make the repairs for the amount of the written estimate. If the insurer designates fewer than three repair shops, the insurer shall assure that the repairs are performed in a workmanlike manner. The insurer shall maintain documentation of all such communications; or,

(3) reasonably adjust any written estimates prepared by the repair shop of the insured's choice.

(g) No insurer shall require the use of non–original equipment manufacture replacement crash parts in the repair of an automobile unless:

(1) the parts are at least equal to the original equipment manufacturer parts in terms of kind, quality, safety, fit, and performance;

(2) insurers specifying the use of non–original equipment manufacturer replacement crash parts shall pay the cost of any modifications to the parts which may become necessary to effect the repair; and,

(3) insurers specifying the use of non–original equipment manufacture replacement crash parts warrant that such parts are of like kind, quality, safety, fit, and performance as original equipment manufacturer replacement crash parts; and,

(4) all original and non–original manufacture replacement crash parts, manufactured after the effective date of this subchapter, when supplied by repair shops shall carry sufficient permanent, non–removable identification so as to identify the manufacturer. Such identification shall be accessible to the greatest extent possible after installation.

(h) No insurer shall require an insured or claimant to supply parts for replacement.

(i) Every insurer shall provide written notification to a first party claimant as to whether the insurer intends to pursue subrogation of the claim. Where an insurer elects not to pursue subrogation or discontinues pursuit of subrogation it shall include in its notification a statement that any recovery to be pursued is the responsibility of the first party claimant. This subsection does not require notification if the deductible is waived, the coverage under which the claim is paid requires no deductible to be paid, the total loss sustained does not exceed the applicable deductible, or there is no legal basis for subrogation.

(j) Every insurer that makes a subrogation demand shall include in every demand the first party claimant's deductible. Every insurer shall share subrogation recoveries on a proportionate basis with the first party claimant, unless the first party claimant has otherwise recovered the whole deductible amount. No insurer shall deduct legal or other expenses from the recovery of the deductible unless the insurer has retained an outside attorney or collection agency to collect that recovery. The deduction may only be for a pro rata share of the allocated loss adjustment expense.

(k) When the amount claimed is adjusted because of betterment, depreciation, or salvage, all justification shall be contained in the claim file. Any adjustments shall be discernable, measurable, itemized, and specified as to dollar amount, and shall accurately reflect the value of the betterment, depreciation, or salvage. The basis for any adjustment shall be fully explained to the claimant in writing and shall:

(1) reflect a measurable difference in market value attributable to the condition and age of the vehicle, or

(2) apply only to parts normally subject to repair and replacement during the useful life of the vehicle such as, but not limited to, tires, batteries, et cetera.

(l) Every insurer shall provide reasonable notice to a claimant before terminating payment for storage charges, so that the claimant has time to remove the vehicle from storage.

(m) Unless the insurer has provided an insured with the name of a specific towing company prior to the insured's use of another towing company, the insurer shall pay the reasonable towing charges of the towing company used by the insured.

NOTE: Authority cited: Sections 790.10, 12921 and 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Sections 790.03(e) and 790.03(h)(3), Insurance Code.

HISTORY

1. New section filed 12-15-92; operative 1-14-93 (Register 92, No. 52).
2. Editorial correction of subsection (o) (Register 93, No. 42).
3. Amendment of section heading and section filed 1-10-97; operative 5-10-97 (Register 97, No. 2).

### § 2695.9. Additional Standards Applicable to Fire and Extended Coverage Type Policies with Replacement Cost Coverage.

(a) When a fire and extended coverage insurance policy provides for the adjustment and settlement of first party losses based on replacement cost, the following standards apply:

(1) When a loss requires repair or replacement of an item or part, any consequential physical damage incurred in making the repair or replacement not otherwise excluded by the policy shall be included in the loss. The insured shall not have to pay for depreciation nor any other cost except for the applicable deductible.

(2) When a loss requires replacement of items and the replaced items do not match in quality, color or size, the insurer shall replace all items in the damaged area so as to conform to a reasonably uniform appearance.

NOTE: Authority cited: Sections 790.10, 12921 and 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Sections 790.03(h)(3), (5) and (7), Insurance Code.

HISTORY

1. New section filed 12-15-92; operative 1-14-93 (Register 92, No. 52).
2. Amendment of section heading and section filed 1-10-97; operative 5-10-97 (Register 97, No. 2).

### § 2695.10. Standards Applicable to Surety Insurance.

(a) No insurer shall base or vary its claims settlement practices, or its standard of scrutiny and review, upon the claimant's race, gender, income, religion, language, sexual orientation, ancestry, national origin, or physical disability, or upon the territory of the property or person insured.

(b) Within sixty calendar days after receipt by the insurer of proof of claim, and provided the claim is not in litigation or arbitration, the insurer shall accept or deny the claim, in whole or in part, and affirm or deny liability. Every insurer that denies or rejects a claim in whole or in part, or disputes liability or damages, shall do so in writing. Written notification pursuant to this subsection shall also include a notification that the claimant may have the matter reviewed by the California Department of Insurance and shall provide the address and telephone number of the unit of the Department which reviews complaints regarding claims practices.

(c) In the event an insurer requires more time than is allotted in subsection 2695.10(b) to determine whether a claim should be accepted and/or denied, in whole or in part, the insurer shall provide the claimant with written notice of the need for such additional time within the time specified in subsection 2695.10(b). Such written notice shall specify the reasons for the need for such additional time, including specification of any additional information the insurer requires in order to make such determination. The insurer shall provide the claimant with written notice as to the continuing reasons for the insurer's inability to make such a determination. Except in cases where extraordinary circumstances are present which materially affect the insurer's ability to comply, such written notice shall be provided within 30 calendar days of the date of the initial notification, and every 30 calendar days thereafter until such determination is made or notice of legal action is received. If the determination cannot be made until some event, process, or third party determination is made, then the insurer shall comply with this requirement by advising the claimant of the situation and provide an estimate as to when the determination can be made.

(d) No insurer shall fail to pursue diligently an investigation of a claim, or persist in seeking information not reasonably required for or material to resolution of a claim dispute.

(e) No insurer shall deny a claim upon information obtained in a telephone conversation or personal interview with any source unless the telephone conversation or personal interview is documented in the claim file pursuant to the provisions of section 2695.3.

(f) Where the claim is to be settled by payment, and where neither the claim nor the amount is in dispute, such payment shall be tendered (1) within 15 calendar days following affirmation of liability where the insurer does not require the claimant to execute a release, or (2) within 15 calendar days following the insurer's receipt of a release properly executed by the claimant, where such release is required by the insurer. Such release shall be provided to the claimant within ten (10) calendar days following affirmation of liability. Where multiple claimants are involved, payment shall be made pursuant to this subsection, provided such payment shall not increase the insurer's liability, or impair the rights of other claimants under the bond.

(g) In determining whether the insurer has violated this subchapter, the Commissioner shall take into consideration the amount of the bond, the principal's position as to its liability under the bond, the complexity and size of the claim and the nature and extent of any extraordinary circumstances.

NOTE: Authority cited: Sections 790.10, 12921, 12921.1 and 12926, Insurance Code. Reference: Sections 790.03(h)(3), (4), (15) and 12921.3, Insurance Code; and Section 2807, Civil Code.

HISTORY

1. New section filed 12-15-92; operative 1-14-93 (Register 92, No. 52).
2. Amendment of section heading, repealer and new section, and amendment of NOTE filed 1-10-97; operative 5-10-97 (Register 97, No. 2).

### § 2695.11. Additional Standards Applicable to Life and Disability Insurance Claims.

(a) No insurer shall withhold any portion of any benefit payable as a result of a claim on the basis that the sum withheld is an adjustment or correction for an overpayment made on a prior claim arising under the same policy unless:

(1) the insurer's files contain clear, documented evidence of an overpayment and written authorization from the insured or assignee, if applicable, permitting such withholding procedure, or

(2) the insurer's files contain clear, documented evidence pursuant to section 2695.3 of all of the following:

(A) The overpayment was erroneous under the provisions of the policy.

(B) The error which resulted in the payment is not a mistake of the law.

(C) The insurer notifies the insured within six (6) months of the date of the error, except that in instances of error prompted by representations or nondisclosure of claimants or third parties, the insurer notifies the insured within fifteen (15) calendar days after the date of discovery of such error. For the purpose of this subsection, the date of the error shall be the day on which the draft for benefits is issued.

(D) Such notice states clearly the cause of the error and states the amount of the overpayment.

(E) The procedure set forth above in (a)(2)(A) through (D) above may not be used if the overpayment is the subject of a reasonable dispute as to facts.

(b) With each claim payment, the insurer shall provide to the claimant and assignee, if any, an explanation of benefits which shall include, if applicable, the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits.

(c) An insurer may not impose a penalty upon any insured for noncompliance with insurer requirements for precertification of benefits unless

such penalties are specifically and clearly set forth in writing in the policy or certificate of insurance.

NOTE: Authority cited: Sections 790.10, 12921 and 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Sections 790.03(h)(1), (2), (3), (5), and (13), Insurance Code.

HISTORY

1. New section filed 12–15–92; operative 1–14–93 (Register 92, No. 52).
2. Repealer of former section 2695.11 and renumbering and amendment of former section 2695.12 to new section 2695.11 filed 1–10–97; operative 5–10–97 (Register 97, No. 2).

### § 2695.12. Noncompliance and Penalties.

(a) A licensee has knowingly committed an act or acts in noncompliance with this subchapter under the following circumstances including, but not limited to:

(1) where the licensee has promulgated express policies or procedures that are in noncompliance with this subchapter; or

(2) where the act(s) in noncompliance with this subchapter are committed by an employee or claims agent of a licensee and the licensee through its management, either:

(A) gives prior approval of the act(s); or,

(B) subsequently ratifies the propriety of the act(s); or,

(3) where the act(s) are committed by an employee or claims agent of a licensee, and it is established that:

(A) the licensee has failed to adopt, communicate and implement standards for the prompt, fair and reasonable investigation and settlement of claims in accordance with this subchapter or assure that such standards are consistently being met; or,

(B) the licensee's management was aware of facts which did apprise or should have apprised the licensee of the act(s) and the licensee failed to take any remedial measures.

(b) In determining noncompliance with this subchapter and appropriate penalties, if any, the Commissioner shall consider admissible evidence on the following:

(1) the existence of extraordinary circumstances;

(2) whether the licensee has a good faith and reasonable basis to believe that the claim or claims are fraudulent or otherwise in violation of applicable law and the licensee has complied with the provisions of Section 1872.4 of the Insurance Code;

(3) the complexity of the claims involved;

(4) gross exaggeration of the value of the property or severity of the injury, or amount of damages incurred;

(5) substantial mischaracterization of the circumstances surrounding the loss or the alleged default of the principal;

(6) secreting of property which has been claimed as lost or destroyed.

(7) the relative number of claims where the noncomplying act(s) are found to exist, as contrasted to the total number of claims handled by the licensee during the relevant time period;

(8) whether the licensee has taken remedial measures with respect to the noncomplying act(s);

(9) the existence or nonexistence of previous violations by the licensee;

(10) the degree of harm occasioned by the noncompliance; and

(11) whether, under the totality of circumstances, the licensee made a good faith attempt to comply with the provisions of this subchapter.

(12) Frequency of occurrence and/or severity of the detriment to the public caused by the violation of a particular subsection of this subchapter.

(c) The Commissioner shall not consider reasonable mistakes or opinions as to valuation of property, losses or damages when determining the licensee's non–compliance with this subchapter or penalties to be assessed.

NOTE: Authority cited: Sections 790.035, 790.07, 790.08, 790.09, 790.10, 1872.4, 12340–12417, inclusive, 12921, 1065, 704, 780–784, 1011, 11690, 12926 and 12928.6, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Sections 790.03(h), 790.035(a), 790.04, 790.05, 790.06, 790.08 and 790.10, Insurance Code.

HISTORY

1. New section filed 12–15–92; operative 1–14–93 (Register 92, No. 52).
2. Renumbering and amendment of former section 2695.12 to new section 2695.11, and renumbering and amendment of former section 2695.14 to new section 2695.12, including amendment of section heading and NOTE, filed 1–10–97; operative 5–10–97 (Register 97, No. 2).

### § 2695.13. Severability.

If any provision or clause of this rule or the application thereof to any person or situation is held invalid, such invalidity shall not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

NOTE: Authority cited: Sections 790.10, 12340–12417, inclusive, 12921 and 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Section 790.03(h), Insurance Code.

HISTORY

1. New section filed 12–15–92; operative 1–14–93 (Register 92, No. 52).
2. Editorial correction of Authority cite (Register 95, No. 42).
3. Repealer of former section 2695.13 and renumbering of former section 2695.16 to new section 2695.13 filed 1–10–97; operative 5–10–97 (Register 97, No. 2).

### § 2695.14. Effective Dates.

(a) These regulations shall take effect one hundred and twenty (120) calendar days after they are filed with the Secretary of State. Any further amendments to the regulations shall take effect seventy–five (75) days after they are filed with the Secretary of State.

(b) Prior to the effective dates of the regulations and any amendments thereto, as set forth above in subsection 2695.14(a), licensees shall, pursuant to Section 2695.6, adopt and communicate to their insurance agents and claims agents standards for the prompt investigation and processing of claims, and provide training and instruction on the regulations and any amendments thereto.

(c) The regulations and any amendments thereto contained in this subchapter shall apply to all new claims submitted to an insurer or insurance agent and to any claims handling that takes place on or after the effective dates set forth under subsection 2695.14(a).

NOTE: Authority cited: Sections 790.10, 12921 and 12926, Insurance Code; and Section 11343.4, Government Code. Reference: Section 790.03(h), Insurance Code.

HISTORY

1. New section filed 12–15–92; operative 1–14–93 (Register 92, No. 52).
2. Renumbering and amendment of former section 2695.14 to new section 2695.12, and renumbering and amendment of former section 2695.17 to new section 2695.14 filed 1–10–97; operative 5–10–97 (Register 97, No. 2).

### § 2695.15. Penalties.

NOTE: Authority cited: Sections 790.035, 790.07, 790.08, 790.09, 790.10, 1872.4, 12340–12417, inclusive, 12921, 1065, 704, 780–784, 1011, 11690, 12926 and 12928.6, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Sections 790.03(h), 790.035(a), 790.04, 790.05, 790.06, 790.08 and 790.10, Insurance Code.

HISTORY

1. New section filed 12–15–92; operative 1–14–93 (Register 92, No. 52).
2. Repealer filed 1–10–97; operative 5–10–97 (Register 97, No. 2).

### § 2695.16. Severability.

NOTE: Authority cited: Sections 790.10, 12340–12417, inclusive, 12921 and 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Section 790.03(h), Insurance Code.

HISTORY

1. New section filed 12–15–92; operative 1–14–93 (Register 92, No. 52).
2. Renumbering of former section 2695.16 to new section 2695.13 filed 1–10–97; operative 5–10–97 (Register 97, No. 2).

### § 2695.17. Effective Date.

(a) These regulations shall take effect thirty calendar days after these regulations are filed with the Secretary of State in accordance with California Government Code Section 11346.2. Licensees shall have ninety calendar days from the effective date of these regulations to provide training and instruction regarding these regulations pursuant to Section 2695.6(c).

NOTE: Authority cited: Sections 790.10, 11346.2, 12340–12417, inclusive, 12921 and 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Section 790.03(h), Insurance Code.

# WEST'S ANNOTATED CALIFORNIA CODES
# CIVIL CODE
# DIVISION 3. OBLIGATIONS
# PART 4. OBLIGATIONS ARISING FROM PARTICULAR TRANSACTIONS
# TITLE 13.5. OBLIGATION TO DEFEND ACTION



Current through End of 1997-98 Reg. Sess. and 1st Ex. Sess.

## § 2860. Conflict of interest; duty to provide independent counsel; waiver; qualifications of independent counsel; fees; disclosure of information

(a) If the provisions of a policy of insurance impose a duty to defend upon an insurer and a conflict of interest arises which creates a duty on the part of the insurer to provide independent counsel to the insured, the insurer shall provide independent counsel to represent the insured unless, at the time the insured is informed that a possible conflict may arise or does exist, the insured expressly waives, in writing, the right to independent counsel. An insurance contract may contain a provision which sets forth the method of selecting that counsel consistent with this section.

(b) For purposes of this section, a conflict of interest does not exist as to allegations or facts in the litigation for which the insurer denies coverage; however, when an insurer reserves its rights on a given issue and the outcome of that coverage issue can be controlled by counsel first retained by the insurer for the defense of the claim, a conflict of interest may exist. No conflict of interest shall be deemed to exist as to allegations of punitive damages or be deemed to exist solely because an insured is sued for an amount in excess of the insurance policy limits.

(c) When the insured has selected independent counsel to represent him or her, the insurer may exercise its right to require that the counsel selected by the insured possess certain minimum qualifications which may include that the selected counsel have (1) at least five years of civil litigation practice which includes substantial defense experience in the subject at issue in the litigation, and (2) errors and omissions coverage. The insurer's obligation to pay fees to the independent counsel selected by the insured is limited to the rates which are actually paid by the insurer to attorneys retained by it in the ordinary course of business in the defense of similar actions in the community where the claim arose or is being defended. This subdivision does not invalidate other different or additional policy provisions pertaining to attorney's fees or providing for methods of settlement of disputes concerning those fees. Any dispute concerning attorney's fees not resolved by these methods shall be resolved by final and binding arbitration by a single neutral arbitrator selected by the parties to the dispute.

(d) When independent counsel has been selected by the insured, it shall be the duty of that counsel and the insured to disclose to the insurer all information concerning the action except privileged materials relevant to coverage disputes, and timely to inform and consult with the insurer on all matters relating to the action. Any claim of privilege asserted is subject to in camera review in the appropriate law and motion department of the superior court. Any information disclosed by the insured or by independent counsel is not a waiver of the privilege as to any other party.

(e) The insured may waive its right to select independent counsel by signing the following statement: "I have been advised and informed of my right to select independent counsel to represent me in this lawsuit. I have considered this matter fully and freely waive my right to select independent counsel at this time. I authorize my insurer to select a defense attorney to represent me in this lawsuit."

(f) Where the insured selects independent counsel pursuant to the provisions of this section, both the counsel provided by the insurer and independent counsel selected by the insured shall be allowed to participate in all aspects of the litigation. Counsel shall cooperate fully in the exchange of information that is consistent with each counsel's ethical and legal obligation to the insured. Nothing in this section shall relieve the insured of his or her duty to cooperate with the insurer under the terms of the insurance contract.

CREDIT(S)

1993 Main Volume

(Added by Stats.1987, c. 1498, § 4. Amended by Stats.1988, c. 1114, § 1.)

< General Materials (GM) - References, Annotations, or Tables >

## HISTORICAL AND STATUTORY NOTES

1993 Main Volume

The 1988 amendment, in subd. (a), inserted "independent" before "counsel" in two places; in subd. (c) substituted "civil" for "tort" in the first sentence; and made nonsubstantive changes.

Former § 2860, enacted by Stats.1872, relating to the liability of the writer of a letter of credit, was repealed by Stats.1963, c. 819, § 2, eff. Jan. 1, 1965. See, now, Com.C. §§ 3408, 5115.

## FORMS

1993 Main Volume

See West's California Code Forms, Civil.

## LAW REVIEW AND JOURNAL COMMENTARIES

Arguments advanced by insureds for coverage of environmental claims. Mark C. Raskoff, 22 Pac.L.J. 771 (1991).

The changing legal climate for insurers in California. Robert A. Wooten, Jr. and Monica L. Irel, 16 L.A.Law. 19 (July/Aug. 1993).

Insurer's duty to provide independent counsel under California's new "Cumis Statute." Philip C. Hunsucker and Hans W. Herb, 16 W.St.U.L.Rev. 603 (1989).

## NOTES OF DECISIONS



### 1. Construction and application

When insurer provides unconditional defense for its insured, insured and carrier share same goal, that of minimizing or eliminating liability in third- party action, and no conflict of interest inhibits ability of one lawyer to represent both insurer and insured. Rockwell Internat. Corp. v. Superior Court (App. 2 Dist. 1994) 32 Cal.Rptr.2d 153, 26 Cal.App.4th 1255, rehearing denied, review denied.

Provision of Civil Code providing for arbitration in fee disputes between Cumis counsel and insured had no application to dispute between insurers and insured over responsibility for payment of independent counsel fees and whether one of the insurers had any responsibility for paying defense costs except as excess insurer; arbitrator would have had to interpret

# WEST'S ANNOTATED CALIFORNIA CODES
# INSURANCE CODE
# DIVISION 1. GENERAL RULES GOVERNING INSURANCE
# PART 2. THE BUSINESS OF INSURANCE
# CHAPTER 1. GENERAL REGULATIONS
# ARTICLE 6.5. UNFAIR PRACTICES



Current through End of 1997-98 Reg. Sess. and 1st Ex. Sess.

## § 790.03. Prohibited acts

The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance.

(a) [Misrepresentations; false or misleading statements] Making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies, or making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or using any name or title of any policy or class of policies misrepresenting the true nature thereof, or making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender his or her insurance.

(b) [Untruthful, deceptive, or misleading statements] Making or disseminating or causing to be made or disseminated before the public in this state, in any newspaper or other publication, or any advertising device, or by public outcry or proclamation, or in any other manner or means whatsoever, any statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his or her insurance business, which is untrue, deceptive, or misleading, and which is known, or which by the exercise of reasonable care should be known, to be untrue, deceptive, or misleading.

(c) [Unreasonable restraint of, or monopoly in, business of insurance] Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

(d) [False statements of insurer's financial condition] Filing with any supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public any false statement of financial condition of an insurer with intent to deceive.

(e) [False entries; willful omissions] Making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom the insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of the insurer in any book, report, or statement of the insurer.

(f) [Unfair rate discrimination] Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the contract.

This subdivision shall be interpreted, for any contract of ordinary life insurance or individual life annuity applied for

and issued on or after January 1, 1981, to require differentials based upon the sex of the individual insured or annuitant in the rates or dividends or benefits, or any combination thereof. This requirement is satisfied if those differentials are substantially supported by valid pertinent data segregated by sex, including, but not necessarily limited to, mortality data segregated by sex.

However, for any contract of ordinary life insurance or individual life annuity applied for and issued on or after January 1, 1981, but before the compliance date, in lieu of those differentials based on data segregated by sex, rates, or dividends or benefits, or any combination thereof, for ordinary life insurance or individual life annuity on a female life may be calculated as follows: (a) according to an age not less than three years nor more than six years younger than the actual age of the female insured or female annuitant, in the case of a contract of ordinary life insurance with a face value greater than five thousand dollars ($5,000) or a contract of individual life annuity; and (b) according to an age not more than six years younger than the actual age of the female insured, in the case of a contract of ordinary life insurance with a face value of five thousand dollars ($5,000) or less. "Compliance date" as used in this paragraph shall mean the date or dates established as the operative date or dates by future amendments to this code directing and authorizing life insurers to use a mortality table containing mortality data segregated by sex for the calculation of adjusted premiums and present values for nonforfeiture benefits and valuation reserves as specified in Sections 10163.5 [FN1] and 10489.2 or successor sections.

Notwithstanding the provisions of this subdivision, sex based differentials in rates or dividends or benefits, or any combination thereof, shall not be required for (1) any contract of life insurance or life annuity issued pursuant to arrangements which may be considered terms, conditions, or privileges of employment as these terms are used in Title VII of the Civil Rights Act of 1964 (Public Law 88-352), [FN2] as amended, and (2) tax sheltered annuities for employees of public schools or of tax exempt organizations described in Section 501(c)(3) of the Internal Revenue Code. [FN3]

(g) [Statement of membership in California Insurance Guarantee Association] Making or disseminating, or causing to be made or disseminated, before the public in this state, in any newspaper or other publication, or any other advertising device, or by public outcry or proclamation, or in any other manner or means whatever, whether directly or by implication, any statement that a named insurer, or named insurers, are members of the California Insurance Guarantee Association, or insured against insolvency as defined in Section 119.5. This subdivision shall not be interpreted to prohibit any activity of the California Insurance Guarantee Association or the commissioner authorized, directly or by implication, by Article 14.2 (commencing with Section 1063).

(h) [Unfair claims settlement practices] Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices:

(1) Misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(3) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.

(4) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured.

(5) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

(6) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds, when the insureds have made claims for amounts reasonably similar to the amounts ultimately recovered.

(7) Attempting to settle a claim by an insured for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.

(8) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured, his or her representative, agent, or broker.

(9) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made.

(10) Making known to insureds or claimants a practice of the insurer of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(11) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(12) Failing to settle claims promptly, where liability has become apparent, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(13) Failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.

(14) Directly advising a claimant not to obtain the services of an attorney.

(15) Misleading a claimant as to the applicable statute of limitations.

(16) Delaying the payment or provision of hospital, medical, or surgical benefits for services provided with respect to acquired immune deficiency syndrome or AIDS-related complex for more than 60 days after the insurer has received a claim for those benefits, where the delay in claim payment is for the purpose of investigating whether the condition preexisted the coverage. However, this 60-day period shall not include any time during which the insurer is awaiting a response for relevant medical information from a health care provider.

CREDIT(S)

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(Added by Stats.1959, c. 1737, p. 4188, § 1. Amended by Stats.1961, c. 1385, p. 3158, § 1; Stats.1970, c. 1205, p. 2114, § 1; Stats.1972, c. 725, p. 1314, § 1; Stats.1975, c. 790, p. 1812, § 1; Stats.1978, c. 186, p. 416, § 1; Stats.1983, c. 1261, § 1, eff. Sept. 30, 1983; Stats.1989, c. 800, § 1.)

[FN1] Renumbered § 10163.1.

[FN2] 42 U.S.C.A. § 2000e et seq.

[FN3] Internal Revenue Code sections are in Title 26 of U.S.C.A.

< General Materials (GM) - References, Annotations, or Tables >

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