

## **CHAPTER 2**

# **THE BUSINESS OF INSURANCE**

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## Issue checklist

- ♦ Outline issues and factual matters to be addressed. Consider the following:
  - ♦ Where the Regulations are relevant, obtain a copy of the Regulations and carefully analyze them.
  - ♦ Determine whether a policy of insurance has been issued (if material to inquiry).
  - ♦ Examine binder and other documentation to see if valid (if relevant to inquiry).
- ♦ Where events in question occurred over a period of time, prepare outline.
- ♦ Identify all pertinent policies of insurance and obtain the policies available.
- ♦ Follow the steps for analyzing a policy of insurance as set forth in *Chapter 5*.

**Cross reference:** For a comprehensive checklist in insurance litigation matters, please see the general checklist at the beginning of *Chapter 1*.

**Cross reference:** See *Chapter 5* for detailed discussion of insurance policy interpretation.

## A. PRIVATE INSURANCE COMPANIES

### **Issue spotter: Plaintiff**

Insurance companies operate under several different forms depending upon the manner in which stock is held. It is beneficial for an attorney to understand the different forms in order to understand the different philosophies under which an insurer might handle claims files. For example, some types of insurance companies, such as mutual insurance companies, would seem more likely to settle first party claims promptly since the policy holders are the owners. Such insurers would seem to be less likely to have the same profit motivation as insurers owned by a small number of individuals, or even a larger number of shareholders, whose sole investment objective is profit motivation.

### **Issue spotter: Attorney for insurer**

Attorneys for the insurer should also have an understanding of the different forms of ownership of insurance companies in order to understand the needs and demands of their clients. An attorney for an insurer may be called upon to answer a wide variety of questions beyond the normal claims handling matters. For example, an insurer may ask an attorney to render an opinion under the regulations specific to that type of insurer with an expectation of an immediate response. It could be awkward and embarrassing for an attorney to have to ask detailed ques-

tions of his client pertaining to its formation and structure, when he has handled a wide variety of matters for the insurer beyond the normal claims matters. On the other hand, an attorney who has not only a working knowledge of the different types of insurance companies, but also the manner in which his client's stock is held, will appear far more impressive than an attorney who has to spend a couple of days studying insurance company structure before he can even ask the appropriate questions.

## §2:10 Introduction

Private insurance companies' objectives are profit maximization and protection of the insured. In some instances, the objective is to earn profits for their stockholders or members. In other cases, the objective is to earn profits which are paid to the policyholders in the form of return premiums.

### §2:10.10 **Forms of private insurance companies**

There are several major forms of private insurance companies as follows:

#### §2:10.11 **Stock insurance companies**

Stock insurance companies are owned by private investors in the form of issued stock, much like any other corporation. These insurance companies are profit oriented with the intention of paying the stockholders in dividends and appreciated stock. The stockholders are issued stock certificates and many of these insurance companies are public corporations whose stock is traded on the various stock exchanges.

#### §2:10.12 **Syndicates**

Syndicates consist of a group of underwriters who combine financial resources for the purpose of providing insurance.

#### §2:10.13 **Mutual insurance companies**

Mutual insurance companies are, in essence, owned by the policyholders who have many of the same rights as stockholders in a stock company. They generally have the right to elect the directors. The objective of mutual insurance companies is to earn profits for the policyholders, who are paid in the form of returned premiums.

#### §2:10.14 **Reciprocal insurers (insurance exchanges)**

Reciprocal insurers are, in some respects, similar to mutual insurance companies in structure. They are unincorporated groups in which the insureds are members and

the insurance exchange is the insurer. The members share in profits and indemnify one another for losses. These types of insurance companies are governed by *Insurance Code §§1280-1530*. In the absence of fraud, corruption, oppression or conflict of interest, courts will not interfere in the business judgment of its managers. [See *Exchange of Automobile Club of Southern California (1996) 50 CA4th 694, 710-711, 57 CR2d 798, 807-808*]

### **Practice tip — Plaintiff**

A stock insurance company is owned by shareholders, most of whom may not have policies of insurance with that insurance company. Such companies are more likely to be driven by a profit motive and for that reason, may be conservative in case evaluation. Mutual insurance companies, on the other hand, are owned by policyholders whose primary concern is making certain they receive the maximum benefit under their policy. For this reason, the mutual insurance company may not have the same pressure for profit maximization and may be much more liberal in evaluating claims. When evaluating settlement possibilities in a given case, try to have an understanding of the type of insurer with which you are dealing.

### **§2:10.20 Structure of insurance companies**

Most insurance companies are divided into various departments. The major departments are the following.

#### **§2:10.21 Sales department/marketing department**

The insurance sales department consists of agents who are usually paid on a commission basis for selling insurance policies. Ordinarily, the agent is paid out of the premiums received from the policyholders to which they sell insurance. When the person selling the insurance is not an employee of the insurance company, and sells insurance for other insurance companies as well, he is a broker or an independent agent. The marketing department usually oversees the sales department and supervises advertising and other forms of promotion.

#### **§2:10.22 Underwriting department**

The underwriting department is responsible for determining what policies should be written and to whom insurance should be provided. This department also sets the rates and determines the risk a given policy will present. The underwriting department issues the policy to the insured.

#### **§2:10.23 Claims department**

The claims department is responsible for processing claims that are submitted to the insurance company. This includes reviewing the claims, communicating with the claimant or his attorney, making decisions concerning the retention of attorneys and experts and determining the amount of the settlement.

### **Practice tip — Defense**

In some states, the exact scope of the authority of the claims examiner in dealing with defense counsel is under review. It is alleged by defense attorneys that their ability to properly represent the insured is impeded by the requirement of receiving authority to perform necessary legal tasks. Attorneys have also alleged that their refusal to follow poor legal advice of claims examiners has cost them business, and insurance companies have been sued over this issue. Most likely this question will be raised in the near future in California, particularly with the increasing number of “in house” law firms and the greater exercise of control by the claims departments.

For a detailed discussion of the claims handling process, see the discussion of this topic in *Chapter 19*.

#### **§2:10.24 Financial operations/financial department**

The financial department handles financial matters including investments, accounting and related matters.

#### **§2:10.25 Legal department**

The legal department handles legal matters that may arise. They provide consultation to the other departments. In some insurance companies, they are called upon to provide coverage opinions and they usually work closely with the claims department. Also in some insurance companies, the legal department is called house counsel and is responsible for litigating cases.

#### **§2:10.26 Medical department**

Medical departments are usually found in health and life insurance companies. They are also common in insurance companies that provide medical malpractice insurance. The function of these departments is to provide consultation to the other departments concerning medical matters. For example, the medical department will render advice concerning the appropriateness of a course of treatment being recommended by a physician.

Or, for example, in a medical malpractice action, the medical department will advise the claims department concerning the propriety of medical care provided in a given case.

### **§2:10.27 Policyholder service department**

The policyholder service department is responsible for serving the policyholders. This includes collecting premiums, handling renewals and dealing with the policyholder's inquiries.

### **§2:10.28 Governmental department**

The governmental department handles matters pertaining to various governmental entities and regulatory authorities with which the insurance company must cooperate.

### **Practice tip — Plaintiff**

When prosecuting a claim against an insurance company for refusing to defend on grounds that a policy lapsed before the date of loss, failure to send notice of cancellation for non-payment of premiums could be a primary issue. In that situation, determine which department was responsible to send notice of cancellation for non-payment of premiums (most likely underwriting or policyholder service department), and depose the persons within that department who would be responsible for carrying out this task. The deposition should focus upon establishing that notice was not sent, the identity of the person responsible for the failure and the reason the failure occurred. In most cases, a "person most knowledgeable" deposition notice will flush out the person who has this information.

## **B. GOVERNMENTAL REGULATION OF INSURANCE COMPANIES**

### **Issue spotter: For all attorneys**

Insurance companies are very closely regulated in the State of California. These regulations often directly impact the insured and third party claimants. This section presents the history of government regulation of insurers and the manner in which the different branches of authority interact. The next section will examine the specific regulations that apply to insurers.

### **§2:20 Introduction**

The business of insurance has become heavily regulated at both the federal and the state level. This

section focuses upon the history of that regulation as well as the nature of regulation in California. *Section C* below addresses the statutory regulations in force in the State of California.

### **§2:20.10 History of regulation**

Regulation of insurance was deemed to be a state function by the United States Supreme Court over one hundred years ago. In *Paul v. Virginia (1869) 75 US 168, 183*, the Court determined that the business of insurance was not "commerce" within the meaning of the Commerce Clause and thus not subject to regulation by the federal government. As the scope of the Commerce Clause expanded over the last century, the business of insurance was determined to be within its scope and thus legitimately the subject of federal regulation. [See *United States v. South-Eastern Underwriters Association (1944) 322 US 533, 64 S.Ct. 1162*] In 1945, Congress adopted a "hands-off" attitude towards the business of insurance by enacting the McCarran-Ferguson Act. That Act exempted the business of insurance from federal regulation. The United States Supreme Court explained the purpose of the Act one year later in *Prudential Insurance Co. v. Benjamin (1946) 328 U.S. 408, 66 S.Ct. 1142, 90 L.Ed 1342*. The Court stated, "obviously Congress' purpose was broadly to give support to the existing and future state systems for regulating and conducting the business of insurance."

In *Securities and Exchange Commission v. National Securities, Inc. (1969) 393 U.S. 453, 89 S.Ct. 564*, the United States Supreme Court once again addressed the appropriate role of federal regulation in the insurance industry. This time the question did not concern so much trade practices of insurance companies, but rather, whether a stock insurance company was governed by the Securities Exchange Act of 1934 in dealing with its stockholders. Or, stated in the alternative, whether the McCarran-Ferguson Act exempted a stock insurance company from regulation by the Securities and Exchange Commission. The Court distinguished laws focusing on the relationship between the insurance company and the policyholders and laws focusing on the relationship between the insurance company and its stockholders. The former clearly constituted the business of insurance, which is governed by state law under the McCarran-Ferguson Act. The latter, however, constituted the business of selling securities and not the business of insurance and thus, could appropriately be governed by the federal government through the SEC. While the Securities Exchange Act of 1934 contains some exemptions applicable to insurance companies, state and feder-

al regulation of securities may coexist, and federal regulation in this area is not barred by the McCarran-Ferguson Act.

With more and more insurance companies crossing state borders to sell insurance, there is a high probability that substantial pressure will be placed upon Congress to expand the role of the federal government into the business of insurance. Thus, it is fair to say that this controversy is far from resolved. For the time being, however, the business of insurance remains within the purview of state regulatory agencies which, in most instances, is the State Department of Insurance or a similarly designated institution of state government.

### §2:20.20 Regulation in California

The business of insurance is regulated by the California Insurance Code in the State of California. *Insurance Code* §§12900, 12906 established the Department of Insurance, which is supervised by the elected Commissioner of Insurance. The responsibility of the Insurance Commissioner is to enforce the laws regulating the business of insurance in California [*Insurance Code* §12921] and to regulate the form and content of certain types of insurance policies. [*Insurance Code* §10291.50] The areas of regulation include financial regulation [*Insurance Code* §§900-924], licensing [*Insurance Code* §§1631 et seq.] and rate regulation and trade practices. [*Insurance Code* §§790 et seq. and §§1850.4 et seq.]

### §2:20.30 Public policy considerations

In addition to the statutory regulations governing insurance companies, public policy considerations impose certain obligations upon insurers. These include obligations of good faith and fair dealing [*Egan v. Mutual of Omaha Insurance Co.* (1979) 24 C3d 809, 820 169 CR 691, 696-697], but the obligations do not go so far as to make the insurance company a fiduciary of the insured. [*Henry v. Associated Indemnity Corp.* (1990) 217 CA3d 1405, 1419, 266 CR 578, 586-587]

### §2:20.40 Additional rights and duties of insurance companies

Although insurance companies have the right to determine the parties to whom they will provide insurance [*Quelimane Co., Inc. v. Stewart Title Guar. Co.* (1998) 19 C4th 26, 43, 77 CR2d 709, 718], they may not discriminate against a class of persons protected by feder-

al or state law [*Kotev v. First Colony Life Ins. Co.* (CD CA 1996) 927 F.Supp. 1316, 1320] and may not conspire to restrict trade or commerce. [*Bus. & Prof. Code* §16720]

## C. STATUTORY AND ADMINISTRATIVE REGULATION OF INSURANCE

### Issue spotter: For all attorneys

Government regulation of insurance companies is very important in the operation and function of insurance companies. The Regulations impact directly upon insurance companies and often govern the conduct of insurance companies with respect to the rights of insureds and third party claimants.

### §2:30 Introduction

California has adopted a comprehensive statutory and regulatory system for the operation and business of insurance in this state that ordinarily preempts federal law under the *McCarran Act*. [*See Farmers Ins. Exch. v. Sup. Ct.* (1992) 2 C4th 377, 396, 6 CR2d 487, 499] This section addresses those statutory and administrative regulations.

### §2:30.10 McBride-Grunsky Insurance Regulatory Act

The *McBride-Grunsky Insurance Regulatory Act* (*Insurance Code* §§1850-1860.5) was enacted by the California legislature in 1947, just prior to the expiration of the moratorium on the application of federal antitrust laws to the business of insurance. The purpose of the Act was to prevent excessive, inadequate and discriminatory rates.

### §2:30.11 Enforcement by Commissioner of Insurance

Where a person believes he has been aggrieved by a rate change, he may request the insurer or the rate organization to review the manner in which the rate was applied. If he is unsatisfied with that result, he may request a hearing before the Commissioner of Insurance. [*Insurance Code* §1858] If, after receiving a complaint by the aggrieved party, or after conducting its own investigation, the Commissioner determines that the insurer has failed to comply with the requirements of the *McBride Act*, it may issue a "notice of noncompliance." [*Insurance Code* §1858.1] If the insurer fails to make the changes necessary to correct the noncompliant act, or fails to show that the noncompliance does not exist, the Commissioner will hold a public hearing in not less than 30 days and within 60 days thereafter will issue an order

based upon its findings. [*Insurance Code §1858.2*] The Commissioner has additional remedies available for a noncompliant insurer pursuant to *Insurance Code §§1858-1858.7*. These include the following powers:

- ♦ to take corrective action deemed necessary and proper [*Insurance Code §1858.3*];
- ♦ to impose a monetary penalty not in excess of \$1000 for each failure of the insurer to comply, up to a total penalty in an aggregate of no more than \$30,000 [*Insurance Code §1858.3*];
- ♦ to issue an order identifying the violation and requiring compliance within a reasonable time thereafter [*Insurance Code §§1858.3(b) & (c)*]; and
- ♦ to suspend or revoke the certificate of authority of any insurer who violates the provisions of the Act [*Insurance Code §1858.3*] or who fails to comply with the Commissioner's orders [*Insurance Code §1858.4*].

For a review of the Commissioner's enforcement authority for violations other than rate violations, see §2:30.2 below.

#### **§2:30.11(a) Compliance with Commissioner's investigation**

Any insurer or person who willfully withholds information from the Commissioner or fails to comply with orders of the Commissioner under the *McBride Act*, is subject to a penalty as high as \$5000. [*Insurance Code §§1859, 1859.1*]

#### **§2:30.12 Commissioner's exclusive authority**

Since the authority of the Commissioner of Insurance to set rates is exclusive, no private action may be maintained against an insurer for charging rates approved by the Commissioner. [*See Insurance Code §1860.1; Walker v. Allstate Indem. Co. (2000) 77 CA4th 750, 759-760, 92 CR2d 132, 138*]

#### **§2:30.13 Exemptions under McBride Act**

The *McBride Act* created numerous exemptions not only from federal law pursuant to the *McCarran Act*, but from other state laws of California. One of those exemptions from state law is that actions taken pursuant to the Act do not constitute a violation of, or grounds for, criminal or civil prosecution under any other laws of the State of California that do not specifically reference

insurance. [*Insurance Code §1860.1*] Another exemption occurs in a statute that provides that no other law relating to insurance will be read to supplement or modify the *McBride Act* unless it specifically so provides. [*See Insurance Code §1860.2*]

#### **§2:30.13(a) Antitrust and unfair business practices**

It was not the intent of the *McBride Act* to exempt insurers from the *Cartwright Act* or the *Fair Trade Act*. [*See Quelimane Co. v. Stuart Title Guar. Co. (1999) 19 C4th 26, 44, 77 CR2d 709, 718*]

#### **§2:30.13(b) Insurers subject to state laws generally**

Insurers are subject to the same laws that are applicable to any other business, including antitrust and unfair business practice laws of the *Business & Professions Code*. [*See Insurance Code §1861.03(a) (adopted as Prop. 103)*]

#### **Practice tip – Plaintiff**

Unless specifically exempted, state laws governing other businesses in California also govern insurers. Thus, when ascertaining the appropriate conduct of an insurer, look beyond the *Insurance Code*. For example, an insurer may be liable for violating employment laws or anti-discrimination statutes. Additionally, an insurer may be sued for unfair trade practices under *Business & Professions Code §§17200 et seq.*, which permits a plaintiff to incorporate an underlying statute into its provisions, and thereby seek an injunction, restitution and attorney fees.

#### **§2:30.20 Unfair Insurance Practices Act (UIPA)**

The Unfair Insurance Practices Act was enacted in 1959. [*See Insurance Code §§790 et seq.*] The Unfair Claims Settlement Practices Act [*Insurance Code 790.03(h)*] was enacted in 1972 and was an amendment to the *UIPA*. The *UIPA* differs from the *McBride Act* in that the former is concerned primarily with unfair insurance settlement practices, deceptive practices and other anticompetitive activity excluding rate setting for casualty insurance. Rate setting practices, however, are exclusively within the scope of the *McBride Act*. [*See Karlin v. Zalta (1984) 154 CA3d 953, 974, 201 CR 379, 390*]

### §2:30.21 **Unfair or deceptive act or practice**

*Insurance Code §790.02* prohibits any person from engaging in any unfair or deceptive act or practice in the business of insurance. Such unfair or deceptive practices include:

- ♦ fraud and misrepresentation in connection with advertising, false statements concerning financial condition, unfair methods of competition, rate discrimination, dividends benefits and similar matters [*Insurance Code §§790.03(a)-(g)*];
- ♦ entering into any agreement to commit, or by any concerted act committing, any act of boycott, coercion or intimidation resulting or tending to result in unreasonable restraint of, or monopoly in, the business of insurance. [*Insurance Code §790.03(c)*]

### §2:30.22 **Unfair claims or settlement practices**

*Insurance Code §790.03(h)* (of the UIPA) identifies and prohibits certain unfair claims settlement practices by insurers who knowingly commit or perform such practices with sufficient frequency as to indicate a general business practice. The following acts constitute unfair settlement practices identified within *Insurance Code §790.03(h)*:

- ♦ Misrepresenting to claimants pertinent facts or insurance policy provisions relating to coverages at issue;
- ♦ Failing to acknowledge and act reasonably promptly upon communications concerning claims arising under the policies in question;
- ♦ Failing to adopt and implement reasonable standards for prompt investigation and processing of claims arising under insurance policies;
- ♦ 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;
- ♦ Failing to attempt, in good faith, to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;
- ♦ 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 such insureds, when such insureds have made claims for amounts reasonably similar to the amounts ultimately recovered;

- ♦ 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 a part of an application;
- ♦ Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured, his representative, agent or broker;
- ♦ Failing, after payment of a claim, to inform insured or beneficiaries, upon request by them, of the coverage under which payment has been made;
- ♦ 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;
- ♦ 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 contain substantially the same information;
- ♦ Failing to settle claims promptly, where liability has become apparent, under one portion in the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage;
- ♦ 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;
- ♦ Directly advising a claimant not to obtain the services of an attorney;
- ♦ Misleading a claimant as to the statute of limitations. [*Insurance Code §790.03(h)*]

### §2:30.23 **Enforcement of UIPA**

The enforcement of *UIPA* is limited to proceedings brought by the Insurance Commissioner. [*See Insurance Code §§790.035(a), 790.05*] While under prior law, the courts recognized a private right of action for violations

of the Act, [see *Royal Globe Ins. Co. v. Sup. Ct.* (1979) 23 C3d 880, 153 CR 842] under current law no private right of action exists for such violations. [See *Moradi-Shalal v. Fireman's Fund Ins. Co.* (1988) 46 C3d 287, 250 CR 116]

### **Practice tip – Plaintiff**

When unable to make progress through the normal channels of litigation, a report of misconduct to the Commissioner of Insurance will often result in prompt resolution of a claim. Attorneys should not overlook this tool.

#### **§2:30.23(a) Attempt to reinstate private action failed**

In 1999 the California legislature enacted the *Fair Insurance Responsibility Act of 2000* (Civil Code §§2870 et seq.). This Act would have allowed third party claimants to sue liability insurers for violations of *Insurance Code §790.03(h)*, where the third party obtained a judgment against the insured in excess of the claimant's pretrial demand. However, the Act was invalidated by referendum during the election on March 7, 2000 (Props. 30 and 31).

#### **§2:30.23(a)(1) Private actions under other Acts**

Although private actions are not allowed under *UIPA*, they are permitted under the *Cartwright Act* (Business & Professions Code §§16600, 16720) and the *Unfair Competition Act* (Business & Professions Code §17200). Private parties may prosecute civil actions for damages and attorneys fees for violations of *UIPA* under the *Cartwright Act* where the violation is of both the *UIPA* and the *Cartwright Act*. [*Manufacturers Life Ins. Co. v. Sup. Ct.* (1995) 10 C4th 257, 283-284, 41 CR2d 220, 235-236] Moreover, violations of *UIPA* may also be prosecuted under the *Unfair Competition Act*, though recovery is limited to equitable relief such as injunctions and restitution. [See *Quelimane Co., Inc. v. Stewart Title Guar. Co.* (1998) 19 C4th 26, 43, 77 CR2d 709, 718]

**Example:** A broker who alleged that certain life insurance companies boycotted him of structural settlement annuities to punish him for providing information about the cost of annuities to injured claimants and their attorneys could state a cause of action under the *Cartwright Act*. Moreover, an action against the insurer pursuant to *Business and Professions Code §§17200 et seq.* could be predicated upon violation of the *Cartwright*

*Act* and *UIPC*. [*Manufacturers Life Ins. Co. v. Sup. Ct.*, (1995) 10 C4th 257, 41 CR2d 220]

### **Practice tip – Plaintiff**

California courts have held that *Insurance Code §790.03(h)* establishes the standard of conduct required of insurers in the State of California. [See *Spray, Gould & Bowers v. Associated Int'l Ins. Co.* (1999) 71 CA4th 1260, 1274, 84 CR2d 552, 560 (dictum)] Arguably, a violation of the *UIPA* would constitute the necessary elements for breach of the implied covenant of good faith and fair dealing with respect to an insured (although not as to third parties). Thus, violation of *Insurance Code §790.03(h)* may serve as evidence of breach of implied covenant of good faith and fair dealing. [See *Shade Foods, Inc. v. Innovative Products Sales & Marketing, Inc.* (2000) 78 CA4th 847, 915, 93 CR2d 364, 412]

### **Practice tip – Plaintiff**

Violations of statutes aimed at insurer conduct may be used to impeach an insurer's experts, agents and employees who testify within a given area concerning the appropriate conduct of an insurer. Cross examination of a claims examiner on his knowledge of those provisions is effective when he testifies in a manner contrary to statutes or regulations.

#### **§2:30.24 Liability under Insurance Code §§1861 et seq. (Prop. 103)**

Although *Insurance Code §1861.03* (Prop. 103) deals primarily with rate regulation, it also creates two theories of liability against insurers for improper claims handling. First, it provides that the business of insurance is subject to California laws applicable to other businesses within the state, including, among others, the *Unruh Civil Rights Act* (Civil Code §§51-53) and the antitrust and unfair business practices statutes [Business & Professions Code §17200]. Additionally, *Insurance Code §1861.10(a)* provides standing to any person to enforce any article of its provisions. [See *Insurance Code §1861.10(a)*]

#### **§2:30.25 Unfair Claims Settlement Practice Regulations**

Numerous regulations have been promulgated by the California Department of Insurance for the purpose of enforcing the *UIPA*. Frequently, such regulations are called the Insurance Commissioner's Regulations, although the

correct name is the *Unfair Claims Settlement Practice Regulations*. The regulations may be found at *10 California Code of Regulations §§2695.1-2695.14*.

### **§2:30.25(a) Scope of regulations**

The *Unfair Claims Settlement Practice Regulations* apply to claims handling practices of all classes of insurance. [*10 Cal.C.Reg. §2695.1(b)*] Moreover, they apply to all persons or entities holding a license, or Certificate of Authority, from the California Department of Insurance or who require the consent of the Commissioner of Insurance to transact business in California. [*10 Cal.C.Reg. §2695.2(m)*] These regulations apply to practices knowingly committed in an isolated case or on an ongoing basis sufficient to constitute a general business practice. [*See 10 Cal.C.Reg. §2695.1(a)*]

#### **§2:30.25(a)(1) Exceptions to application of UCSPR**

The regulations do not apply to:

- ♦ workers' compensation insurance [*10 Cal.C.Reg. §2695.1(d)*];
- ♦ medical malpractice insurance [*10 Cal.C.Reg. §2695.1(e)*]
- ♦ self-insured or self-funded employee plans which are not multiple employer welfare arrangements [*10 Cal.C.Reg. §2695.1(b)(3),(4)*]
- ♦ Surety insurance is partially exempt from the Regulations [*10 Cal.C.Reg. §2695.1(c)*]

**Comment:** Although these regulations do not apply to the foregoing types of insurance, the Commissioner still has enforcement authority over these types of insurance pursuant to *Insurance Code §790.06*.

#### **§2:30.25(b) Claims handling time limitations**

The *UCSPR* sets out strict time limitations for the performance of various tasks in the claims handling process, including the following:

- ♦ Insurance agents and claims agents must immediately transmit any notice of a claim to the insurer [*10 Cal.C.Reg. §2695.5(d)*];
- ♦ With the exception of life insurance claims and disability claims, the insurer must, within 15 days of receiving notice of a claim:
  - ♦ acknowledge receipt of the notice;
  - ♦ provide the claimant with the necessary claim forms and instructions for filing a claim; and

- ♦ commence investigation of the claim. [*10 Cal.C.Reg. §2695.5(e)*]
- ♦ The insurer must respond to any inquiry from the California Department of Insurance within 21 days and any inquiry from the claimant within 15 days. [*10 Cal.C.Reg. §2695.5(a),(b)*]
- ♦ Subject to certain exceptions, an insurer must accept or deny claims, either in whole or in part, and affirm or deny liability, within 40 days after receiving notice of the claim, unless it advises the claimant in writing of the reasons for the delay, and thereafter updates the reasons for further delay in writing every 30 days. [*10 Cal.C.Reg. §2695.7(b),(c)*]
- ♦ Subject to certain exceptions, the insurer must pay all claims within 30 days after coverage is determined or a settlement agreement is executed. [*10 Cal.C.Reg. §2695.7(h)*]
  - ♦ Where a settlement is negotiated, the insurer must tender payment of the settlement amount immediately upon receipt of the executed settlement agreement, but in no event more than 30 days after receipt of the settlement agreement. [*10 Cal.C.Reg. §2695.7(h)*]
  - ♦ Where multiple coverages exist, and there is no dispute as to the obligation of the insurer under some of those coverages, and the payee is known, payment shall be tendered immediately on those undisputed coverages, and in no event more than 30 calendar days after determination of coverage, if payment would terminate the insurer's known liability under that individual coverage, unless payment would impair the insured's interests. However, this provision has no application where the policy provides for a waiting period after liability and coverage have been affirmed and before payment of benefits is to be made. [*10 Cal.C.Reg. §2695.7(h)*]
  - ♦ Where a reasonable basis exists, which is supported by specific information available for review by the 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 defined in *Insurance Code* §§1871.1(1) and 1871.4(a), the number of days for accepting or denying the claim as set forth in *10 Cal.C.Reg.* §2695.7(b) shall be:

- ♦ increased to 80 days; or
- ♦ suspended until otherwise ordered by the Commissioner of Insurance, provided the insurer has complied with *Insurance Code* §1872.4 and the insurer can demonstrate that it has made a diligent attempt to determine whether the subject claim is false or fraudulent within the 80-day period. [*10 Cal.C.Reg.* §2695.7(k)]

**§2:30.25(c) Claims handling and settlement standards**

The Regulations establish minimum standards for claims handling and settlement of cases. Conduct not addressed by these Regulations may also constitute unfair claims settlement practices pursuant to *Insurance Code* §790.03(h). [*10 Cal.C.Reg.* §§2695.1(a)(1), 2695.1(b)] The following standards are applicable to all insurers:

**§2:30.25(c)(1) No requests for immaterial information**

Insurers are prohibited from seeking information not reasonably required for, or material to, the resolution of a claim. [*10 Cal.C.Reg.* §2695.7(d)]

**§2:30.25(c)(2) May not require other source of payment**

Except as permitted by law or by other policy provisions, an insurer is prohibited from delaying or denying settlement of a first party claim on the basis that other parties should have that responsibility. [*10 Cal.C.Reg.* §2695.7(e)]

**§2:30.25(c)(3) Unreasonably low settlements**

Insurers are prohibited from attempting to settle a claim for an amount the Commissioner later determines to be an unreasonably low offer. In determining whether an offer is unreasonably low, the Commissioner considers the following:

- ♦ the extent the insurer considered evidence offered by the claimant supporting the value of the claim;
- ♦ the extent to which the insurer considered evidence made known to it from sources other than the claimant, which is reasonably available;
- ♦ the extent to which the insurer considered the advice of its claims adjustors as to the amount of damages;
- ♦ 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;
- ♦ the procedures used by the insurer in determining the dollar amount of the property damage;
- ♦ 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; and
- ♦ any other credible evidence presented to the Commissioner which 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. [*10 Cal.C.Reg.* §2965.7(g)]

**Practice tip — Plaintiff**

While the foregoing Regulations do not give rise to a private action against an insurer, they do set the standards with which an insurer must comply. For that reason, it may be possible to show violations of the foregoing as evidence of insurer's obligations and breach, despite the absence of a private action created by such violations.

**§2:30.25(c)(4) Releases prepared by defense counsel**

Where a claimant is not represented by counsel, an insurer may not ask that claimant to sign a release of claims in excess of those the insurer has paid, nor to waive unknown claims, unless the insurer has made a full disclosure of the effect of the release. [*10 Cal.C.Reg.* §2695.4(e)]

### Practice tip – Defense

Exercise caution in preparing a release of claims. Arguably, where the release provides a release of an insurer from liability for acts for which the insurer has not compensated the claimant, the release may be set aside, at least to the extent of the excess release. To avoid this problem, carefully determine what is being released and make certain it corresponds to the intent of the parties.

### Practice tip – Plaintiff

When presented with a release by an insurer that exceeds the damages paid by the insurer, address this discrepancy in detail with the client. Generally, advise the client not to sign an overbroad release. In some instances, however, it may be in the client's best interest to sign the release where the benefit to the client outweighs any benefit to be derived by refusing to sign the release. For example, releases of liability for personal injury invariably include a waiver of unknown injuries. Where the likelihood of unknown injuries is minimal, the waiver is not excessive. However, where there is substantial likelihood of future injuries resulting from past wrongdoing of the defendant, the waiver may be excessive. Insurers often enter into settlements with the plaintiff wherein the insurer pays a premium, or a greater amount, for potential future claims. Typically, the greater amount is less than the amount the insurer might have to pay if the injury materializes, but is excessive if in fact the injury does not materialize. In this situation, the claimant is willing to risk the possibility of a future uncovered injury in order to obtain a larger settlement at the present time. These issues are never presented in black and white. Often the best approach is to inform the client of the benefits and consequences of signing versus not signing the release. In situations where a client has already signed an excessive release without the benefit of an attorney, move to set aside the release, or at least the excessive portion, pursuant to *10 Cal.C.Reg.* §2695.4(e).

#### §2:30.25(c)(5) Additional limitations on insurers

In addition to the foregoing, insurers are not permitted to do the following:

- ♦ discriminate in claims settlement practices based upon the claimant's race, gender,

income, religion, sexual orientation, national origin or physical disability, or the territory of the property or person insured [*10 Cal.C.Reg.* §2694.7(a)];

- ♦ inform a client that unless he signs a particular form or release within a certain period of time, his rights may be impaired (unless that statement refers to a statute of limitations violation) [*10 Cal.C.Reg.* §2695.7(i)];
- ♦ request or require that the insured submit to a polygraph examination (except where authorized by state law or the insurance policy) [*10 Cal.C.Reg.* §2695.7(j)];
- ♦ deny a claim based upon information obtained from a telephone conversation or personal interview, unless that conversation is documented in the claims file [*10 Cal.C.Reg.* §2695.7(l)];
- ♦ seek reimbursement from the insured for excessive or unnecessary payments made under medical payments coverage, unless the claim is false or fraudulent [*10 Cal.C.Reg.* §2695.7(m)];
- ♦ request an independent medical examination before paying benefits without a good faith belief that the examination is necessary to determine whether treatment is reasonable or necessary [*10 Cal.C.Reg.* §2695.7(n)]; or
- ♦ require that the claimant not complain to the CDI concerning the insurer's handling of a claim [*10 Cal.C.Reg.* §2695.7(o)].

### Practice tip – Plaintiff

If an insured is seeking to obtain coverage, or otherwise involved in a dispute with the insurer, carefully consider each of the requirements set forth above. If the insurer has violated one or more of the above provisions, you may be able to show that the violation is evidence of bad faith.

#### §2:30.25(c)(6) Limitations in certain types of insurance

The following types of insurance have standards set by the Regulations:

- ♦ claims arising under automobile insurance policies [*10 Cal.C.Reg.* §2695.8]
- ♦ claims arising under replacement cost coverage provisions in fire and extended coverage property insurance [*10 Cal.C.Reg.* §2695.9]

- ♦ claims arising under surety insurance policies [10 Cal.C.Reg. §2695.10]
- ♦ claims arising under life and disability policies [10 Cal.C.Reg. §2695.11]

#### **§2:30.25(c)(7) Recordkeeping**

Insurers are required to maintain records of all claims files for the current year and the previous four years for review by the California Department of Insurance. [10 Cal.C.Reg. §2695.3]

#### **§2:30.25(c)(8) Notice of need for additional time**

Where an insurer requires more time to determine whether a claim should be accepted or denied than the amount of time allotted in 10 Cal.C.Reg. §2695.7(b), the insurer is required to provide the claimant with written notice of the need for the additional time and must do so within the time allowed in 10 Cal.C.Reg. §2695.7(b). [10 Cal.C.Reg. §2695.7(c)(1)] The notice must comply with the following requirements:

- ♦ The notice must specify the reasons the additional time is required, including specification of any additional information required by the insurer to make its determination. The insurer is also required to provide, to the claimant, written notice of any continuing reasons for the inability to make a determination.
- ♦ Unless extraordinary circumstances exist that materially effect the ability of the insurer to comply, the written notice must be provided within 30 calendar days after the initial notification required by Cal.C.Reg. §2695.7(c), and every 30 days thereafter until a determination is made or notice of legal action is obtained.
- ♦ Where the insurer is unable to make a determination until the occurrence of some event, process or third party determination, the insurer must comply with the requirement by advising the claimant of the situation and providing an estimate as to the time at which a determination can be made.

#### **§2:30.25(c)(9) Notice of denial of claim**

An insurer must follow certain guidelines when denying a claim brought by its own client or by a third party.

#### **§2:30.25(c)(9)(a) First party claim**

An insurer that denies or rejects a first party claim must in writing provide a statement of the factual and legal basis for the denial which is, at that time, within the knowledge of the insurer. [10 Cal.C.Reg. §2695.7(b)] Where there is a particular policy provision upon which the insurer is basing the denial, in whole or in part, the written denial must include a reference to that provision along with an explanation and an application of that provision, condition or exclusion to the facts of the claim. [10 Cal.C.Reg. §2695.7(b)] The notification must include a statement that if the claimant believes the claim has been wrongfully rejected or denied, the claimant may have the claim reviewed by the California Department of Insurance. The notification must also include the address and telephone number of the unit of the Department which reviews complaints regarding claims practices. [10 Cal.C.Reg. §2695.7(b)(3)]

#### **§2:30.25(c)(9)(b) Third party claims**

Where an insurer denies a third party claim, in whole or in part, or disputes liability or damages, it must do so in writing. [10 Cal.C.Reg. §2695.7(b)] The notification must include a statement that if the claimant believes the claim has been wrongfully rejected or denied, the claimant may have the claim reviewed by the California Department of Insurance. The notification must also include the address and telephone number of the unit of the Department which reviews complaints regarding claims practices. [10 Cal.C.Reg. §2695.7(b)(3)] However, the insurer has no obligation to notify the insured that the claim is being investigated as a suspected fraudulent claim. [10 Cal.C.Reg. §2695.7(c)(2)]

#### **§2:30.25(c)(10) Warning about statute of limitations**

Where a claimant is not represented by counsel, the insurer must provide written notice to the claimant of any applicable statute of limitations or other limitations (such as contractual limitations) that may be relied upon by the insurer to deny a claim on the grounds that it is untimely. The notice must be given at least 60 days before the expiration of the applicable time limitation, except for claims based upon uninsured motorist coverage, which must be given 30 days before the running of the time limitation. Where the claim is first received within the applicable period for notification (30 days for UM claims and 60 days for other claims), the notice must be provided immediately. [10 Cal.C.Reg. §2695.7(f)]

The failure of the insurer to provide such warning is grounds for precluding the insurer from asserting the statute of limitations or other contractual limitations as a defense. [*Spray, Gould & Bowers v. Associated Int'l Ins. Co.* (1999) 71 CA4th 1260, 1271, 84 CR2d 552, 558]

#### **§2:30.25(c)(11) Violations of regulations**

An insurer may be found to have violated a regulation either by “knowingly committing” a single act of noncompliance or by engaging in a pattern of noncompliant activity. [*10 Cal.C.Reg.* §§2695.1(a), 2695.12(a)] The failure of an insurer to take remedial action against an employee or claims examiner violating the Regulations subjects the insurer to liability for the acts of those individuals. [*See 10 Cal.C.Reg.* §2695.12(a)] An act is “knowingly committed” when it is performed with actual, implied or constructive knowledge, including but not limited to, that implied by operation of law. [*10 Cal.C.Reg.* §2695.2(l)]

#### **§2:30.25(c)(11)(a) Factors considered**

In order to determine whether an insurer is in violation of the Regulations, the Commissioner of Insurance will consider the following evidence, provided it is admissible:

- ♦ whether extraordinary circumstances exist concerning the violation;
- ♦ the complexity of claims involved;
- ♦ whether the insurer has a good faith and reasonable basis to believe that claims are fraudulent or otherwise in violation of applicable law and has complied with the provisions of *Insurance Code* §1872.4;
- ♦ the existence or absence of prior violations;
- ♦ whether the insurer has taken remedial actions to correct noncomplying acts;
- ♦ whether property has been secreted that has been claimed as lost or destroyed;
- ♦ the number of claims wherein noncomplying acts have been found to exist in comparison to the number of claims the insurer handled during the relevant time;
- ♦ the degree of harm caused by the violation;
- ♦ whether the insured made a good faith attempt to comply with applicable regulations under the totality of circumstances; and
- ♦ the frequency of occurrence and/or the severity of the harm caused by the violation of any particular Regulation. [*10 Cal.C.Reg.* §2695.12(b)]

In determining violations or penalties to be imposed, the Commissioner shall not consider reasonable mistakes or opinions as to valuation of property, losses or damages. [*10 Cal.C.Reg.* §2695.12(c)]

#### **§2:30.25(c)(12) Enforcement of code provisions**

The Commissioner is provided the following means to enforce the regulatory provisions:

#### **§2:30.25(c)(12)(a) Mediation of claims**

*Insurance Code* §12921.1 authorizes the Claims Service Bureau of the Consumer Services Division of the California Department of Insurance to receive, evaluate, and attempt settlement practices. [*See Insurance Code* §§12921.1 et seq.] However, the California Department of Insurance is not empowered to adjudicate claims. Its authority is limited to mediation of claims. [*Insurance Code* §§12921.3, 12921.4]

#### **§2:30.25(c)(12)(a)(1) Implementation procedure**

The California Department of Insurance has adopted procedures for processing complaints against insurers. Under these provisions, the California Department of Insurance is required to maintain records of complaints for three years, and to disclose its activities and efforts in the annual report to the governor. Complaints may be made telephonically at 1-800-223-9045. The Department of Insurance may disclose the complaint record of an individual insurer to the extent necessary to assist the public in finding an insurer. However, disclosure of individual complaints made to the Department of Insurance is prohibited to the extent any other laws prevent disclosure. [*Insurance Code* §12921.1(a)(5)] It would seem that a party bringing a bad faith action against an insurer may have a basis for obtaining such records by way of subpoena, with the identity of the person making the complaint redacted. The purpose would be to show a pattern of acts constituting bad faith.

#### **§2:30.25(c)(12)(b) Surveys of market conduct**

The California Department of Insurance is authorized to investigate the conduct of every person engaged in the business of insurance to ascertain whether they have violated the UPA or the UCPA. Such investigations are called “market surveys.” [*Insurance Code* §790.04] Additionally, the California Department of Insurance is authorized to examine all admitted insurers concerning

any act of conduct in the insurer's business. These investigations are called "field examinations." [*Insurance Code* §§730, 736]

**§2:30.25(c)(12)(b)(1) Information re: insurer**

The Commissioner of Insurance is also authorized to disseminate information about individual complaints and to evaluate patterns of complaints to determine if additional enforcement efforts are required. Nonetheless, disclosure of individual complaints is prohibited. [*Insurance Code* §12921.1(a)(5)]

**§2:30.25(c)(12)(c) Order to show cause**

An order to show cause may be issued by the Commissioner of Insurance, and a hearing conducted where the Commissioner has reason to believe an insurer has engaged, or is engaging, in any unfair or deceptive act or practice as defined in *Insurance Code* §790.03, and the Commissioner can show that such a proceeding would be in the interest of the public. A similar proceeding may be instituted pursuant to *Insurance Code* §790.06, where the conduct is believed to be unfair but not covered by *Insurance Code* §790.03.

**§2:30.25(c)(12)(c)(1) Conduct of hearing**

Where the insurer maintains that it has not engaged in any unfair practices, a hearing must be held pursuant to the Administrative Procedure Act (*Government Code* §§11500 *et seq.*) [*Insurance Code* §790.05] Under this Act, the hearing must be conducted by an administrative law judge, rather than the Commissioner of Insurance, and the Commissioner's involvement is limited to adopting, amending or rejecting the administrative law judge's decision. However, the Commissioner's action must be based solely upon the record. [*Insurance Code* §1861.08; *see also Fireman's Fund Ins. Cos. v. Quackenbush* (1997) 52 CA4th 599, 606, 60 CR2d 732, 735]

**§2:30.25(c)(12)(c)(2) Cease and desist order and order to pay penalty**

Where a charge made pursuant to *Insurance Code* §790.05 or §790.06 is shown to be justified, the Commissioner of Insurance will issue and serve an order to pay a penalty pursuant to *Insurance Code* §790.035 and to cease and desist from the act or practice in question. [*Insurance Code* §790.05]

**§2:30.25(c)(12)(c)(3) Violation of cease and desist order**

Where the insurer has been found to be guilty of violating *Insurance Code* §790.03 or engaging in conduct subject to *Insurance Code* §790.06, the Commissioner may order the violator to pay \$5000.00, or up to \$55,000.00 (if willful), in addition to any penalty due under *Insurance Code* §790.05. The failure of the insurer to pay any order issued pursuant to *Insurance Code* §790.035 constitutes a violation of the cease and desist order. [*Insurance Code* §790.07]

**Practice tip – Plaintiff**

Do not overlook the possibility of bringing regulatory violations to the attention of the Commissioner of Insurance. The insurer may choose to remedy the problem, which may benefit the client. However, always avoid threatening the insurer with criminal action in order to extort a civil gain. Such conduct could be grounds for disciplinary action.

**§2:30.25(c)(12)(d) Suspension of license**

In the most egregious cases, the Commissioner of Insurance has the authority to suspend or revoke the license of an insurer engaged in the business of insurance in this state. [*See Insurance Code* §§701, 704, 728]

**§2:30.25(c)(12)(e) Acts not prohibited by Insurance Code §790.03**

Where, after a hearing pursuant to the Administrative Procedure Act, an act or practice of the insurer is found to be unfair or deceptive, even if not a violation of *Insurance Code* §790.03, the Commissioner is required to issue a report so stating. If after 30 days the act or practice is continuing, the Commissioner, through the Attorney General, may file a petition in Superior Court to enjoin and restrain the act or practice, and seek the appropriate orders and writs in connection with such a proceeding. [*Insurance Code* §790.06]

**§2:30.25(c)(13) Unreasonable conduct**

Where an insurer violates one of the Regulations, it would seem to thereby engage in unreasonable conduct. The Regulations establish the appropriate conduct for an insurer in California. [*Spray, Gould & Bowers v. Associated Int'l Ins. Co.* (1999) 71 CA4th 1260, 1274, 84 CR2d 552, 560-561] However, the violation will not subject an insurer to bad faith liability by a third party.

[*Spray, Gould & Bowers v. Associated Int'l Ins. Co.*, *supra*, 71 CA4th at 1274, 84 CR2d at 559]

### **§2:30.25(c)(14) Collateral estoppel**

Where the findings of the Commissioner in an administrative hearing are that a violation has occurred, such violations should be entitled to a collateral estoppel effect in a subsequent bad faith action by an insured against its insurer. [See *Imen v. Glassford (1988) 201 CA3d 898, 907-908, 247 CR 514, 518-519*]

### **§2:30.25(c)(14)(a) Opinion not collateral estoppel**

Where the Commissioner publishes its opinion in response to inquiries from an insured, this is not res judicata in litigation between the insured and the insurer. [See *20th Century Ins. Co. v. Quackenbush (1998) 64 CA4th 135, 140, 75 CR2d 113, 116*] Such publications would not meet the requirements for res judicata in litigation since the parties would not have actually litigated such claims.

## **D. SETTING RESERVES**

### **Issue spotter: For all attorneys**

All attorneys who handle insurance litigation matters and liability cases involving covered claims should have a thorough understanding of how insurers set reserves. Such an understanding will assist the Plaintiff attorney in determining the settlement range within which the insurer is willing to pay for settlement and the defense. The defense attorney should also be familiar with methods for calculating reserves, since such knowledge will assist in making recommendations to the client. In some cases, an attorney may be requested to set the reserves in a given case. However, it is important for all attorneys to realize that reserve amounts do not necessarily reflect the amount an insurer is willing to pay on a given claim. At best, they might provide some insight into the settlement range.

## **§2:40 Introduction**

This section focuses upon the methods by which reserves are set and provides important information concerning the procedure for setting reserves.

### **§2:40.10 Setting reserves**

*Insurance Code §923.5* requires insurance companies doing business in California to establish and maintain reserves in amounts sufficient, according to estima-

tion, to pay all losses and to cover the expenses associated with adjustment and settlement of claims. It is important to understand that reserves are not synonymous with settlement authority. The purpose of loss reserves is to comply with statutory requirements for the maintenance of amounts necessary to pay claims. The claims examiner is not necessarily authorized to settle a case for that amount and it may have no correlation to the amount the insurance company is actually willing to pay. [See *Lipton v. Superior Court (Lawyers Mutual Insurance Co.) (1981) 39 C3d 220, 240, 178 CR 343, 355*] There are three primary types of reserves:

### **§2:40.11 Voluntary reserves**

“Voluntary reserves” refers to money that is set aside by the insurer on a voluntary basis to pay liabilities, such as dividends and taxes.

### **§2:40.12 Unearned premium reserves**

“Unearned premium reserves” are premiums that are retained for the policyholders for the term of the policy that has not yet expired.

### **§2:40.13 Loss reserves**

Loss and loss anticipated expense reserves are the reserves set aside in amounts estimated to be sufficient to cover the claims, including the legal and other expenses of defending the insured, under all of the policies issued by the insurer.

### **§2:40.20 Method of computation**

The Insurance Commissioner carefully monitors and regulates the reserves set by insurance companies, which helps assure that the amounts set by the insurance company are realistic. Nonetheless, there are substantial variations in the way insurance companies set the reserves.

### **§2:40.21 Setting reserves on individual cases**

This method of computation involves assessing the value of a claim based upon a review of the damage estimates, medical bills, invoices and similar documents available to the insurer. The insurer then sets the reserves, based upon its own internal formula, that are intended to cover the claim if the case is prosecuted to judgment.

#### **§2:40.21(a) Bulk method**

This method, sometimes called the “fast track” method, is utilized when an insurer has numerous smaller claims anticipated to settle quickly, which allows the

insurer to develop a bulk estimate of the average amount necessary to settle all of the existing or anticipated claims. In short, this amount is derived by multiplying the number of claims by the average amount necessary to settle each of the claims.

**§2:40.21(b) Average value method**

The average value method is similar to the bulk method. Utilizing this method, the insurance company groups categories of claims, and based upon its past experiences and often jury verdict reports, values each category of claim based upon the average value of each claim within that category.

**§2:40.21(c) Loss ratio method**

This method of calculation, also known as the “formula method,” utilizes statutory formulas to set reserves in workers’ compensation cases.

**§2:40.21(d) Tabular value method**

This method of calculation, which utilizes mortality tables, is frequently used in workers’ compensation cases involving death or permanent disability. The intent is to calculate present cash value of the payments over the period in which payments are to be made.

**Practice tip — Plaintiff**

While reserves are not an indication of how the insurance company values a given case, understanding the process utilized by insurance companies in setting reserves can provide some insight into the method it used in arriving at case values. This, in turn, will help an attorney understand what an insurance company might consider a reasonable settlement value on a case. It should also be noted that since setting reserves means “tying up” insurance company money, if an insurance company is going to err, it would prefer to err on the conservative side. While reserves are generally discoverable in bad faith actions by the insured to show that the insurer considered the underlying claim to have some settlement value, [See *Security Officers Service, Inc. v. State Comp. Ins. Fund* (1993) 17 CA4th 887, 897, 21 CR2d 653, 658] they are generally not discoverable in first party claims by an insured since they do not accurately reflect the value of a claim. [American Protection Ins. Co. v. Helm Concentrates, Inc. (ED CA 1991) 140 FRD 448- 450 (applying California law)] Simply understanding the process by which an insurer sets

reserves might help you reach a “ballpark” estimate of where a given claim might settle. However, you must be careful in utilizing such an approach because reserves are often only loosely tied to the value of the claim, if at all.

**E. ENTERING INTO A CONTRACT FOR INSURANCE**

**Issue spotter: For all attorneys**

An attorney working in insurance matters should be familiar with law of contracts, including formation, performance and remedies for breach. While the law imposes special rules for insurance policies, very often those rules simply restate or apply general contract rules.

**§2:50 Contracts for insurance**

An insurance policy is a contract just as any other contract between parties. While general rules of contract sometimes apply to the formation and interpretation of insurance contracts, statutes and case law have created special rules for insurance contracts. Those special rules are addressed in various sections of this book. Where such special rules exist, they will be enforced by the courts even where they deviate from the general rules of contract formation and construction.

**§2:50.10 Requirements for contract formation**

In order to form a valid contract of insurance, there must be a meeting of the minds of the parties concerning the essential terms of the agreement. [See *Long v. Keller* (1980) 104 CA3d 312, 163 CR 532] Those essential terms include the subject matter to be insured, the risk insured against, the policy period, the amount of insurance, the premium charged and the date the premium is to be paid. [Long v. Keller, supra, 104 CA3d at 321, 163 CR at 536] “There must be both an intentional offer and an acceptance manifesting assent to the terms of the offer in a manner invited or required thereby.” [Quackenbush v. Omnicor, Inc. (1995) 34 CA4th 1283, 1288, 40 CR2d 816, 819] The components of an insurance contract are the “consideration” (premium for the insurer’s undertaking), the “risk” (the perils against which the assured is protected), and the “indemnity” (the stipulated compensation to be paid to the assured in event of loss through the perils or contingencies specified). [Physicians Defense Co. v. Cooper (1912) 199 F. 576, 118 C.C.A 50]

### **§2:50.11 Mistake in offer invalidates contract**

When the party making an offer of insurance does so without intent, that is, by mistake, then no contract of insurance is formed. [See *Quackenbush v. Omnicor, Inc.* (1995) 34 CA4th 1283, 1288, 40 CR2d 816, 819] (Insurer mistakenly sent a late notice announcing a grace period nearly six months after a policy had lapsed for nonpayment of premiums. Insured could not reasonably have believed the insurer intended an offer and, in fact, had purchased another policy elsewhere in the interim. No insurance contract was formed by the late notice.)

### **§2:50.12 Material misrepresentations in application**

An insurer has a right to rely upon the representations made in an application for insurance and is entitled to rescind the policy, even after a loss has occurred, if the information provided proves to be materially false. This is true even if the misrepresentations were unintentional. [*Imperial Casualty and Indemnity Co. v. Sogomonian* (1988) 198 CA3d 169, 179, 243 CR 639, 643]

**Cross reference:** For further discussion of the implications of material misrepresentations in an application for insurance, please see discussion of this topic in §17:20.51.

### **§2:50.13 Insurer under no duty to evaluate applicant's needs**

An insurer has no duty to evaluate the policy needs of the prospective insured. The only obligations of the insurance company are those that arise out of the policy it has issued. The company has no duty to determine whether the policy in question is appropriate for a given insured or whether the amount of coverage is adequate. [See *Gibson v. Government Employees Ins. Co.* (1984) 162 CA3d 441, 452, 208 CR 511, 519] By the same token, an agent of the insurer generally has no duty to determine whether a policy in question is appropriate for a given insured, since the agent is the agent of the insurer and not the insured. [See *Fitzpatrick v. Hayes* (1997) 57 CA4th 916, 927, 67 CR2d 445, 452] However, a broker hired by the insured might have such an obligation if the insured is relying upon the broker for this purpose. [See *Free v. Republic Ins. Co.* (1992) 8 CA4th 1726, 11 CR2d 296]

For a detailed discussion of rights and obligations of brokers and agents, see *Chapter 3* of this book.

### **§2:50.20 When policy takes effect**

A contract of insurance is governed by the same rules as any other contract requiring proof of mutual assent and

lawful consideration. [See *Boyer v. United States Fidelity & Guarantee Co.* (1929) 206 C 273, 274] An insurance policy that sets forth different terms than those requested in the application is a counteroffer to the insured and no contract is formed unless the insured agrees to those different terms. It is when the insurer accepts the application and issues a policy on the same terms as the application that the insurance contract is formed. [See *Linnastruth v. Mutual Benefit Health & Accident Association* (1943) 22 C2d 216, 219, 137 P2d 833, 834]

### **Practice tip — Plaintiff**

As a practical matter, insurance applications are offers by the applicant for a contract of insurance. It is not until the insurer accepts the offer by issuing a policy of insurance that a contract is formed. Time of formation of an insurance contract is often critical in determining the existence or nonexistence of coverage. For that reason, carefully examine the policy to determine when the contract was formed.

### **§2:50.21 Where insurer specifies time of formation**

In some situations the insurer offers a policy of insurance on terms that state that the policy becomes effective immediately upon submission of the application by the prospective insured. In that situation, the contract is formed even if the insurer fails to issue the policy. “There need not be a written policy. Where a valid parol contract of insurance has been entered into, the policy to be issued thereon is simply the memorial of the prior parol contract...” [See *Metts v. Central Standard Life Ins. Co.* (1956) 142 CA2d 445, 450-451, 298 P2d 621, 625]

### **§2:50.22 Effect of omissions in application for insurance**

In order to form a binding contract, the offeree must comply with the terms of the offer, but substantial compliance is all that is required. Omissions of some information in the application will not necessarily void the contract, particularly if the omission would not have made the contract less desirable to the insurer. [See *Melts v. Central Standard Life Insurance Co.* (1956) 142 CA2d 445, 450-451, 298 P2d 621, 625]

### **§2:50.30 Oral contracts**

Although an insurance policy is a written document, an oral contract to provide insurance may also be valid and binding on the parties. [See *Truck Insurance Exchange v. Amoco Corp.* (1995) 35 CA4th 814, 823, 41

CR2d 551, 556] An oral contract of insurance is valid and enforceable, but such contracts are rarely made and are not made in the ordinary course of business, and proof of such oral contract must be clear and convincing. [*Truck Insurance Exchange v. Amoco Corp.* (1995) 35 CA4th 814, 823, 41 CR2d 551, 556; *Gandelman v. Mercantile Ins. Co. of America* (D.C. 1950) 90 F.Supp. 472, affirmed 187 F.2d 654, certiorari denied 72 S.Ct. 228, 342 U.S. 896, 96 L.Ed.2d 671.] “A parol contract... to issue, renew, or make an endorsement upon a policy, or to waive a provision or condition thereof, is valid and enforceable... even though the policy be not delivered until after the loss occurs.” [*Kazanteno v. California Western States Life Ins. Co.* (1955) 137 CA2d 361, 372, 290 P2d 332, 338]

### **§2:50.31 Required proof for oral contracts**

Although oral contracts of insurance are valid and binding upon the parties, such contracts are rare in the insurance industry and proof of such a contract must be by clear and convincing evidence. [See *Gandelman v. Mercantile Ins. Co. of America*, *supra*, 90 F.Supp. 472, affirmed 187 F.2d 654, certiorari denied 72 S.Ct. 228, 342 U.S. 896, 96 L.Ed.2d 671; *K.C. Working Chemical Co. v. Eureka-Security Fire & Marine Ins. Co.* (1947) 82 CA2d 120, 131, 185 P2d 832] (To prove the existence of an insurance contract without a written policy, the insured must prove the essential elements, including the subject matter, the amount, the limits of risk, the duration of the policy, the extent of coverage, the risks covered, the premium amounts, and everything required to distinguish an insurance policy from any other contract.)

### **§2:50.32 Agent’s oral acceptance of risk binds insurer**

The oral contract for insurance is seen most frequently in situations where an agent orally agrees to accept a risk on behalf of an insurance company while promising to the applicant to deliver a policy at a later time. When this occurs, the policy becomes effective at the time the agent accepts the risk. The oral contract continues in force until the policy is delivered, at which time the oral contract is superseded by the written policy. [See *Kazanteno v. California Western States Life Ins. Co.*, *supra*, 137 CA2d at 372, 290 P2d 338]

#### **§2:50.32(a) Proof of agent’s authority**

Proof of the authority of an agent to bind the insurer with an oral agreement must be clear and convincing. [See *Kazanteno v. California Western States Life Ins.*

*Co.*, *supra*, 137 CA2d at 372-373, 290 P2d at 338] (Where agent had represented the insurer in dealing with the insured for years, agent had authority to bind the insurer orally. And where such agent orally agreed to accept a risk on behalf of the insurer and promised to deliver the policy later, insurance begins with the acceptance and continues until the policy is delivered, at which time the policy supersedes the binder.)

### **§2:50.32(b) Effect of contrary language in the insurance policy**

Insurance policies often contain provisions that deny that an agent has the authority to waive any of its terms or to change the policy in any way. Despite such language, courts have held that an insurance company may be bound by waivers made by a general agent, even without a writing or endorsement of the policy. Whether an agent has the authority to make a binding oral contract, or an oral waiver, is a question of fact to be decided on a case by case basis. [See *Raulet v. Northwestern National Insurance Co.* (1910) 157 CR 213, 107 P 292, 300]

#### **§2:50.32(b)(1) Conspicuous language in application**

Conspicuously noted language on an application for insurance, disavowing the authority of any agent to bind, waive or change any terms of the insurance policy, is more difficult to overcome in attempting to show the agent’s authority to bind the insurer. [See *Linnastruth v. Mutual Benefit Health & Acc. Association*, *supra*, 22 C2d at 219, 137 P2d at 834] However, once the policy is issued, prior dealings with the agent which give the insured a sense of confidence may create ostensible authority in the agent to bind the insurer to policy changes. [See *Kazanteno v. California Western State Life Insurance Co.* (1955) 137 CA2d 361, 373, 290 P2d 332, 340]

### **Practice tip**

Discourage clients, whether the insurer or the insured, from entering into an oral contract for insurance, except in situations where a temporary binder is being issued. Even then, the binder should be memorialized in writing by fax, or even e-mail, as soon as the ability to do so arises. In some situations, an oral contract might refer to a specific policy, such as the 2001 standard form policy. Once again, the existence of a contract should be memorialized in writing as soon as practicable and the policy should be provided immediately upon availability.

### §2:50.40 Binders and covering notes

Applicants for insurance will often need coverage immediately upon applying for insurance. Sometimes this is a result of allowing a former policy to lapse, or the result of changing insurance companies just prior to the expiration of a policy. In other situations, the insurance applicant may have just acquired new property or undertaken some obligation that requires immediate insurance. For these reasons, the demands of the insurance industry have forced insurance companies to allow their agents to bind the insurance company immediately upon application, subject to approval by the company. Failure to offer this immediate coverage renders an insurance company less competitive and most companies now do this. In order to evidence the existence of coverage until the policy is issued and delivered, insurers have authorized their agents to issue “binders” and “covering notes.” “Binders” and “covering notes” are similar in function and purpose. The term “covering notes” is seldom used by insurance companies in the present day, though historically it was a popular term. Some older insurance companies still use the term.

### §2:50.41 Statutory definition of “covering notes”

“Covering notes” are issued “to bind insurance temporarily, pending the issuance of the policy.” [*Insurance Code §382*] Thus, binders and covering notes are similar in function and purpose.

### §2:50.42 Statutory definition of “binder”

*Insurance Code §382.5* defines a “binder” as a written instrument which “temporarily obligates the insurer to provide... insurance coverage, pending issuance of the policy.”

#### §2:50.42(a) Binder is contract independent of policy

A binder is a contract, separate and distinct from the insurance policy. The intent of a binder is to provide temporary protection to the applicant while the insurer investigates the risk, and until the insurer either issues the policy or rejects the application for insurance. [*Ahern v. Dillenback, supra, 1 CA4th 36, 48, 1 CR2d 339, 346*] Because the binder temporarily binds the insurer pending the actual issuance of the policy, the insurer is bound to provide coverage after the binder is written until the insurer either writes the policy or refuses to do so. Thus, even where the insurer ultimately gives ten days written notice of withdrawal of coverage pursuant to *Insurance Code §481.1(b)*, it will be bound to cover the loss after

the binder is written but before the notice is effective, if the loss would have been a covered loss under the policy.

#### §2:50.42(b) Compare: Some obligations are not binders

Writings that obligate the insurance company to provide life or disability insurance, or policies of insurance of any kind in excess of \$1 million or more, are not binders. [*Insurance Code §382.5(a)*]

### §2:50.43 Types of binders

A binder may be oral or written. Oral binders are effective between the insurer and the insured. However, binders intending to serve as evidence to third parties of the existence of an insurance policy must be in writing, and require more information than would be required for an oral binder.

#### §2:50.43(a) Oral binders

Oral binders are frequently used by parties attempting to show the existence of an insurance relationship. However, such binders are only recognized by the insurer and the insured.

#### §2:50.43(a)(1) Effect of oral binders

A binder issued by the insurer or its authorized agent is valid and binding between the insurer and the applicant for insurance. [*See Insurance Code §460*]

#### §2:50.43(a)(2) Implied content of oral binders

Unless the binder provides otherwise, it is deemed to contain all of the “usual terms” of the insurance policy upon which it was provided. [*Insurance Code §382.5*]

#### §2:50.43(b) Written binders

Written binders are also used to show the existence of an insurance relationship and are recognized by third parties, as well as by the insurer and the insured.

#### §2:50.43(b)(1) Effect of written binders

A binder that is in writing and contains all of the elements set forth below will be deemed sufficient to show to a third party that the insured has the insurance coverage set forth in the binder. [*Insurance Code §382.5*] The information that must be set forth in the binder includes:

- ♦ the name and address of the insured and any additional named insureds, mortgagees or lien holders;
- ♦ a description of the property insured, if applicable;

- ♦ a description of the nature and amount of coverage and any “special exclusions not contained in a standard policy”;
- ♦ the identity of the insurer and the agent executing the binder;
- ♦ the effective date of coverage; and
- ♦ the binder number (or policy number where an extension or renewal is involved).

**§2:50.43(b)(2) Third parties must accept written binder**

Third parties are required to accept binders that comply with *Insurance Code* §382.5 as proof of insurance unless there is a reasonable cause for the failure to do so. Refusal to accept the binder as proof of insurance subjects the third party to liability for attorneys fees incurred in proving the existence of insurance, and the insured may obtain injunctive relief and other damages as well. [See *Insurance Code* §382.5(d)]

**§2:50.43(b)(2)(a) Exception to requirement**

Third parties are not required to accept written binders as proof of insurance in situations where the insurer is providing life or disability insurance or insurance of \$1 million or more. [See *Insurance Code* §382.5(a)]

**§2:50.44 90-day limitation**

*Insurance Code* §382 imposes a maximum period of 90 days during which the binder will remain effective. However, the Insurance Commissioner may permit an extension of the period of coverage of the binder or coverage note. [See *Insurance Code* §382.5(c)]

**§2:50.44(a) Insurer’s right to cancel with 10 days notice**

*Insurance Code* §481.1(b) authorizes the insurer to cancel or to withdraw coverage under a binder provided the insurer gives 10 days written notice of the cancellation to the insured. 10 days after the insurer mails the notice, the coverage terminates. [See *Insurance Code* §481.1]

**§2:50.44(a)(1) Limitation on cancellation**

In situations where the insured has a temporary life, disability or title insurance policy which the insurer has no right to cancel, the notice of cancellation and the 10-day notice requirement is inapplicable. [See *Insurance Code* §481.1(a)]

**§2:50.44(a)(2) Notice must occur before loss**

Unless there exist grounds for rescission of the policy of insurance, the insurer cannot escape liability for losses arising before the notice of cancellation was sent. In other words, once the loss has occurred, the insurer cannot unilaterally cancel the binder in order to escape liability. [See *Golden Eagle Ins. Co. v. Foremost Insurance Co. (1993) 20 CA4th 1372, 1389, 25 CR2d 242, 253*]

**§2:50.44(a)(3) Notice must be to the insured**

In order for a cancellation of coverage under a binder to be valid and binding on the insured, the notice must be communicated directly to the insured, and not to the agent who bound the risk. [See *Parlier Fruit Co. v. Fireman’s Fund Ins. Co. (1957) 151 CA2d 6, 27, 311 P2d 62, 75*]

**§2:50.44(b) Cancellation by insured**

Often when a broker is obtaining insurance for his client, he will procure binders from several different insurance companies while deciding which is the best. When a decision is made, the broker may “cancel flat” the other insurance policies. This means that the broker will cancel the other policies without incurring any liability on the part of the insured for premiums or on the part of the insurer for losses sustained after the binder was issued. [See *Golden Eagle Ins. Co. v. Foremost Insurance Co. (1993) 20 CA4th 1372, 1389, 25 CR2d 242, 253*]

**§2:50.44(b)(1) Insurer cannot prevent canceling flat**

When an insured cancels flat several insurance policies and seeks to recover for a loss from an insurer with whom it chooses to keep coverage, that insurer cannot compel the insured to keep the other policies and pay for the other coverage to thereby spread the losses. [See *Spott Electrical Co. v. Industrial Indemnity, Co., supra, 30 CA3d at 808, 106 CR at 717*]

**§2:50.50 Implied contract of insurance**

In some situations, a contract of insurance may be implied from the circumstances. For example, when an insured completes and submits an application of insurance, and pays the first premium thereon, and where the language of the policy would lead an ordinary lay person to conclude that coverage was immediate upon performing these acts, a contract of insurance is implied to exist. [See *Ahern v. Dellenback (1991) 1 CA4th 36, 47, 1 CR2d 339, 345*]

**Practice tip — Plaintiff**

When representing an insured seeking coverage under a theory of implied contract of insurance, first examine the facts of the transaction to see if a reasonable person would believe a contract of insurance was formed. The courts have identified elements that will support a claim for implied contract. Those elements are set forth in *Ahern* above. To apply the test of *Ahern*, first look to see if the insured completed and submitted an application for insurance and paid the first premium. Second, examine the language of the policy to see if an ordinary lay person would have believed, from that language, that a contract of insurance was formed. If these actions were taken, then a reasonable person would conclude that a contract of insurance exists, and therefore, an implied contract will be found.

**§2:50.60 Insurance contracts may be effective immediately**

In situations where the insurance application states in clear terms that the policy of insurance will be effective on the date the premium is paid only if the insurer accepts the policy, the courts have found that a contract is formed immediately upon receipt of the premium. Otherwise, the insurer would have an opportunity to wait and determine whether it liked the risk before issuing the policy, even though the insurer retained the premium. [See *Ransom v. Penn. Mutual Life Ins. Co.*, (1954) 43 C2d 420, 424, 274 P2d 633, 635]

**Practice tip — Plaintiff**

While this case deals specifically with life insurance policies, the rationale would apply equally well to any situation where the insurer sought to retroactively decide whether it will accept a particular risk. If you represent an insured where an insurer attempts to retroactively deny a risk, on the grounds that it did not accept coverage despite the payment and acceptance of a premium, you may be able to assert a bad faith claim under the rationale of *Ransom*.

**§2:50.61 Compare: Insurer's right to rescind**

Insurer has the right to rescind policy for life insurance where the insured has made material misrepresentation in the application for insurance. [See *Wilson v. Western National Life Insurance Co.* (1991) 235 CA3d 981, 992, 1 CR2d 157, 264]

**§2:50.70 Issuance and delivery of the policy**

Actual delivery of the policy of insurance is not necessary for the policy to be effective. If the insurer intends that the policy take effect immediately and unconditionally upon issuance, then the insurer is liable for losses even though the policy has not yet been delivered to the insured. [See *Golden Eagle Ins. Co. v. Foremost Ins. Co.* (1993) 20 CA4th 1372, 1388, 25 CR2d 242, 253]

**§2:50.71 Nonpayment of premiums on policy issued on credit**

The failure to pay a premium at time of delivery of a policy of insurance will not void the policy of insurance if it was the intent of the insurer to issue the policy on terms of credit. [See *Golden Eagle Ins. Co. v. Foremost Ins. Co.*, *supra*, 20 CA4th at 1387-1388, 25 CR2d at 252] While the insurer may have a right to cancel the policy for nonpayment of premiums, until the policy is canceled, coverage exists. [See *Golden Eagle Ins. Co. v. Foremost Ins. Co.*, *supra*, 20 CA4th at 1388, 25 CR2d at 252]

**F. FORM****Form 2:1 Sample Written Insurance Binder**

**Form 2:1 Sample Written Insurance Binder**

**INSURANCE BINDER**

THIS BINDER IS A TEMPORARY INSURANCE CONTRACT SUBJECT TO THE CONDITIONS SHOWN ON THE REVERSE SIDE OF THIS FORM

[name of insurer]	[binder number]
[name and address of insurance agency]	[name of insurer]
	[effective date]
	[termination date]

[name and address of insured] [description of operation/property]

**PROPERTY**

TYPE AND LOCATION OF PROPERTY COVERAGE/PERILS/FORMS [amount] [deductible]

**LIABILITY**

TYPE OF INSURANCE

SCHEDULED FORM                       COMPREHENSIVE FORM  
      Premises Operations  
      Products/completed operations  
      Contractual  
 Other  
 Medical Pay        [amount] per person        [amount] per accident  
 Personal Injury

COVERAGE FORMS

LIMITS OF LIABILITY

	Each Occurrence	Aggregate
Bodily Injury	[amount]	[amount]
Property Damage	[amount]	[amount]
Bodily Injury & Property Damage	[amount]	[amount]
Personal Injury	[amount]	[amount]

A\_\_\_ B\_\_\_ C\_\_\_

**AUTOMOBILE**

Liability                       Nonowned     Hired  
 Comprehensive-Deductible    [amount]  
 Collision-Deductible            [amount]  
 Medical Payments                [amount]  
 Uninsured Motorist               [amount]  
 No Fault  
 Other

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 LIMITS OF LIABILITY

Bodily Injury (each person)	[amount]
Bodily Injury (each accident)	[amount]
Property Damage	[amount]
Bodily Injury & Property Damage (combined)	[amount]

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__Workers' Compensation	__Employers' Liability	[limit]	[amount]
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## SPECIAL CONDITIONS/OTHER COVERAGES

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Name and address of	__Mortgagee	__Loss payee	__Additional insured
		Loan Number	_____

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 Signature of Authorized Representative

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 Date

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