2014 CLM Annual Conference

April 9, 2014 – April 11, 2014

Boca Raton Resort
501 E. Camino Real
Boca Raton, FL 33432

Roundtable 1: Thursday, April 10, 2014 (10:10 am – 11:10 am)

Making your File a Winner: Common Denominators in Successful Bad Faith Outcomes

Commonly, bad faith presentations bring with them feelings of fear of the unknown. The critical facts that drive the exposure are foreign to many claim handlers and therefore the material becomes an exercise in anxiety-control. Extra-contractual exposure (ECL) is particularly sensitive because it comes out of the company's profits and it is nearly impossible to quantify or underwrite because the risk is not capable of calculation. For these reasons, many claim handlers and attorneys dread the ECL case and rather than take an aggressive stance when it is warranted, look for a reason to justify a settlement. Compounding this problem are common misperceptions among both the tort plaintiff and the tort defense bar as to what facts are likely to cause a jury to find liability. The result is that many lawyers, who are eminently capable while participating in the underlying case, find themselves analyzing and predicting jury results for the ECL case without having participated in an ECL case from the pre-suit stage through verdict.

Over the last several years, there have been a number of victories because the industry has been pushing back aggressively and finding that the results are very favorable. This course is designed to identify common threads *from a judge's or a jury's* standpoint that have resulted in wins for the industry. Bad faith is very simple in concept, but very complex in application. Simply stated, Juries view bad faith cases very differently than lawyers and industry personnel. To the surprise of many, the manner in which they view the cases is favorable to the industry if the case is presented properly.

This course discusses and focuses on cases which we all know will not settle, despite there being an 'overture' to settle. We have all faced claims where demands are made that make it nearly impossible to get a resolution – by design of course. Many claim professionals and attorneys throw their hands up in a fatalistic submission because they feel – and they are right – that no amount of diligence will result in a settlement and it is easy to just give up on the claim. Don't give up, though, those demands are your best evidence at the ECL trial.

The first part of the discussion will focus on common tactics of the Plaintiff's bar. The second part of the discussion will focus on how juries and Courts have handled those tactics and what a carrier can do proactively to create processes designed to fully expose the conduct by the Plaintiff that will maximize the chances for a victory at the ECL trial.

I. Laying the Groundwork

A. First Party Claims - A first-party action is one in which the insured is also the injured party who is to receive the benefits under the policy

B. Third Party Claims - a third-party action is one in which an injured third-party, not the insured, is entitled to the benefits under the policy as the result of the insured's tortious conduct.

C. Bad Faith Defined Generally
Failing to settle a claim when, under all the circumstances, you could and should have done so, had you acted fairly and honestly toward the insured and with due regard for his or her interests. Failing to settle, if possible, where a reasonably prudent person, faced with the prospect of paying the total recovery, would do so.

D. Understand the Joror’s Mind - Why do you have these obligations?

The Policy is a contract that binds the insurance company and the insured party. Pursuant to the policy language, an insured party turns his or her claim over to the insurance company for handling. Insurance company controls the outcome of the policy holder’s defense of the claim. The insurance company has control over the handling of the litigation. It chooses and works with defense attorneys it is comfortable with, not attorneys selected by the insured parties.

II. Practical application

E. What a Juror wants to see and why each is important

1. That the insured was informed about settlement opportunities
2. That the insured knew about the risks of the case (probable outcome)
3. That the insured knew there could be an excess judgment
4. That the insured was told how to mitigate the risks
5. That the carrier wanted to settle and protect the insured

F. Discussion on how the claim file reflects these elements

1. Copies of all communications
2. Ability to contribute
3. Initiation of settlement negotiations
4. Fair and timely consideration of a settlement offer noted in the claim notes
5. Advising insured of conditions placed on a demand; or in a response
6. Avoid overreaching with the release
7. Supervisor Comments

8. To-Do Lists

9. Consistent communications (or attempts to communicate)

10. Act on information in the file (first report, contact info, nature of injuries)

11. Highlight and number conditions in a demand

12. Language in cover letter with offer and release

13. Follow up after demand deadline

III. Practical application in real life - victories that utilized these concepts offensively for the Defense.

Novoa v. GEICO Indem. Co., 12-80223-CV, 2013 WL 172913 (S.D. Fla. Jan. 16, 2013)

- Within 17 days GEICO sent the deceased's wife a letter with a check for the BI policy limit for bodily injury and asked her to provide GEICO with information so that GEICO could evaluate the property damage portion of her claim. Also included with the letter was a document entitled a "release of all claims."
- Although the letter stated that the claimant's property-damage and bodily-injury claims were being handled separately and implied that the release would only extinguish her bodily injury claims, the release stated that it applied to all of the claimant's claims arising from the accident.
- Regarding the argument that GEICO acted in bad faith by sending the claimant a release that was overbroad, the court reasoned that the letter, which accompanied the release, expressly indicated that the release was intended only to apply to the bodily injury portion of the claimant 's claim and that the property-damage claim was being handled separately.

Bell v. Geico Gen. Ins. Co., 489 Fed. Appx. 428 (11th Cir. Sept. 14, 2012)

- Payment of the benefits owed, paid in part directly to a Hospital, was sufficient to cure (even in the face of alleged violation of damage caused by a delay in payment of a hospital lien) because the insurer was contractually entitled to pay funds directly to the Hospital.
- Additionally, the court founds that the CRN did not contain a sufficient explanation of facts and circumstances linking the alleged bad faith conduct to damages claimed to be the problem, in order to give insurer the insurer opportunity to remedy the specific problem complained about in the suit. The CRN identified "claim denial" as the "reason for notice," and described the "facts and circumstances giving rise to the insurer's violation" as follows:

  > CLAIMANT HAS PROVIDED PROOF OF CLEAR LIABILITY ON THE PART OF AN UNDERINSURED/UNINSURED MOTORIST, AND DAMAGES IN EXCESS OF THE POLICY LIMITS, YET GEICO HAS FAILED TO UNCONDITIONALLY TENDER THE INSURED'S UM POLICY LIMITS.

Knipper v. Allstate Prop. & Cas. Ins. Co., 8:11-CV-742-T-24 TGW, 2012 WL 1004844 (M.D. Fla. March 26, 2012)

- Plaintiffs argued that Allstate, through its assigned defense counsel, did not advise Knipper: (1) that she was required to provide a financial affidavit, (2) that her failure to provide the financial affidavit would constitute a rejection of the claimants' offer, or (3) that her failure to provide the financial affidavit was virtually certain to result in the claimants filing a lawsuit against her and that Allstate had an affirmative obligation to seek a confidentiality agreement or other protection prior to the insured providing financial information in response to a request in a demand since the insured cited confidentiality concerns as her basis for refusing to provide the requested financial affidavit.
- The court found that the undisputed evidence shows that: (1) upon receiving notice of the accident, Allstate warned Knipper that the claimants' damages appeared to exceed her policy limit and that she would be liable for any damages in excess of her policy limit; (2) Allstate communicated claimants' request for a financial affidavit to Knipper and hired attorney Reed to help her complete it; (3) Reed met with Knipper for three hours to go over the claimants' requests; (4) Reed explained to Knipper that if she chose not to provide a financial affidavit, she might be sued, and that there was no guarantee that if she did provide a financial affidavit, she would not be sued-was accurate; and (5) after claimants returned Allstate's check for the $100,000 policy limit, Reed reiterated to Knipper that he expected the claimants to file suit and that a judgment against her in excess of her policy limit was very possible. Thus, the Court found that the undisputed evidence shows that Allstate fulfilled all of its duties to its insured and that it did so in good faith.

McGuire v. Nationwide Assur. Co., 8:11-CV-559-T-24 TBM, 2012 WL 712965 (M.D. Fla. March 5, 2012)

- Plaintiffs contend that Nationwide acted in bad faith when it refused to accept the claimant's May 14, 2008 telephonic offer to settle in return for the $25,000 bodily injury limit, plus the cost of setting up the victim's guardianship.
- Nationwide responds that it could not have acted in bad faith, because it offered to pay the $25,000 policy limit, and that was all that it was required to pay under the policy.
- The court found that there was no realistic possibility of settling within the $25,000 bodily injury limit, because Nationwide offered the $25,000 bodily injury limit, but the claimant was also asking for payment of the cost of setting up Ms. Miller's guardianship.
- Furthermore, Nationwide proved that the insured would not have paid the cost of setting up Ms. Miller's guardianship, by showing that the insured was unable or unwilling to contribute the additional $9,900 needed in order to satisfy the demand. Accordingly, the court held that Nationwide's failure to communicate with its insured about this offer did not result in the excess judgment, and without causation, there can be no bad faith damages

Barnard v. Geico General Ins. Co., 448 Fed. Appx. 940 (11th Cir. (Fla.) Dec. 9, 2011)

- The insurer tendered a check for the policy limits and a proposed release just 11 days after the accident, it then attempted to contact attorney on at least 16 separate occasions to discuss the status of its release and tender of the policy limits, without being prompted it issued another check for the policy limits and a proposed release when the first check expired, and the incorrect date on insurer's letter to attorney did not evince an attempt to characterize the communication as being sent prior to the date it was received.
- The court held that the insurer's efforts were thwarted by repeated failure of representative's attorney to respond to its communication, and thus insurer did not act in bad faith.
- Further, failure of Geico to include the name of Raymond Paulk, the tortfeasor, in the proposed release does not give rise to an inference of bad faith because, if they had been signed, Raymond Paulk would have been subject to personal liability. The court characterized this as a negligent oversight that falls far short of bad faith contemplated by this cause of action. Moreover, because

these releases were never executed, the failure to include Raymond Paulk's name does not in any way constitute causation for the liability in excess of the policy.

Losat v. Geico Cas. Co., 8:10-CV-1564-T-17, 2011 WL 5834689 (M.D. Fla. Nov. 21, 2011)

- GEICO tendered a policy limits check sixteen (16) days after the accident, which was within twenty-four hours of discovering the identity and location of the claimant. GEICO tendered LNU's policy limit to LOSAT and five (5) days later tendered another policy limits check to LOSAT's attorney. It undisputed that LOSAT's attorney declined this first hand-delivered policy limits check, and as a result GEICO then immediately sent the check for the policy limits to LOSAT's attorney via certified mail.
- It is also undisputed that once GEICO learned of LOSAT's new attorney, GEICO then offered the policy limits cheek to LOSAT's new attorney. It is also undisputed that GEICO attempted to deliver another policy limits check to LOSAT's second attorney after a demand was received by GEICO.
- GEICO notified their insured of the ongoing situation: GEICO made at least fourteen (14) phone calls and sent at least six (6) letters to LNU during the relevant time period. LNU was also copied on at least six (6) letters that were forwarded to LOSAT's attorneys. There is no fact to contradict that LNU was made fully aware of the situation with LOSAT and also kept up to date on any ongoing progress in attempting to settle the claim.
- Taking into account LOSAT's attorneys unwillingness to settle combined with GEICO's constant attempts to achieve settlement, the court held that no facts support any wrong doing on the part of GEICO.

Machalette v. Southern-Owners Ins. Co., 2011 WL 3703368 (M.D. Fla., August 23, 2011)

- Southern–Owners concedes that within days of the accident, it knew its insured was entirely at fault for causing the accident. Thus, this case turns on the issue of whether Southern–Owners had knowledge that Mr. Olivio's injuries were so serious that a judgment in excess of the policy limits was likely.
- Five days after the accident, Southern–Owners asked Mrs. Olivio to send medical documentation. The next day, Southern–Owners learned that Mr. Olivio retained Walker to represent, so Southern–Owners requested from Walker's office verification of Mr. Olivio's damages and injuries. Walker did not provide the necessary information for more than five months, despite Southern–Owners' attempts to verify Mr. Olivio's damages with Walker on eight separate occasions.
- The information was finally provided after the attorney representing the insured in the underlying action filed a motion to compel the information and the court set the matter for hearing. Southern–Owners tendered a check for the policy limits within forty-eight hours.

Kim v. GEICO Cas. Co., 2:09-CV-667-FTM-29, 2011 WL 2218894 (M.D. Fla. June 7, 2011)

- On the first business day following the accident, GEICO obtained a copy of the police report from the Florida Highway Patrol and attempted to contact its insured in order to obtain his statement. Once GEICO was able to contact the insured, it advised him that they would provide a defense on his behalf and warned him that he may be exposed to liability in excess of his policy limits. Ten days after the accident occurred, GEICO retained counsel to defend the insured and provided the claimant with a signed and notarized affidavit of coverage, a proposed release, and a check for $10,000, which was the full amount of the insured bodily injury coverage under the policy.

- The claimant's attorney responded with seven specific demands and GEICO diligently attempted to meet those demands in less than twenty days. Plaintiff asserts that GEICO acted in bad faith because it failed to provide plaintiff with the specific "Affidavit of No Other Insurance" form prepared by Plaintiff's attorney and attached to his initial letter to the insurer. However, the claimant's attorney waited until two days after the settlement offer expired to inform GEICO that its form affidavit was insufficient and that he had filed a lawsuit against its insured.
- GEICO's immediate response was to contact the insured and request that he sign the specific "Affidavit of No Other Insurance" form provided by the claimant's attorney and sent the signed form just seven days after learning which specific form he required.

Cardenas v. Geico Cas. Co., 760 F. Supp. 2d 1305 (M.D. Fla. Jan. 13, 2011)

- The insured claimed GEICO did not properly accept an offer to settle from the claimant because it provided a proposed release with a hold harmless provision in conflict with the terms of the offer with expressly required the funds to be disbursed without conditioning them on a hold harmless agreement and did not properly and promptly communicate with him about the case and exposure he faced.
- The court determined GEICO's letter the day after the accident generally advising the insured the claimant's damages may be in excess of the policy limits reflected "that Geico responded without delay … to inform [the insured] of the risk of liability beyond the policy limit."
- The Court also considered GEICO's documented effort to respond to the claimant's request and comply with the demand terms, and was critical of the claimant "refusing to communicate with Geico" after sending the demand, and of the insured "failing to promptly respond to communication from Geico."
- The court also noted that "Geico repeatedly, but to no avail, sought assistance from [the claimant] in drafting an acceptable release," and that [the claimant] declined to communicate with Geico and left Geico to draft a release."
- Finally, the court noted "Geico disbursed the policy limit to the claimants … and imposed no condition on disbursement. Furthermore, Geico stated a willingness to consider both a change to the propose release and a release drafted entirely by [the claimant's attorney]."

Boateng v. Geico Gen. Ins. Co., 10-CIV-60147, 2010 WL 4822601 (S.D. Fla. Nov. 22, 2010)

- GEICO offered to tender the full $20,000 per occurrence bodily injury liability policy limits to the Plaintiff on December 13, 2006, only one week after the tragic accident and reiterated the offer on December 19, 2006 by hand-delivering a check for $10,000.
- Plaintiff argued that although GEICO offered to pay Plaintiff the policy limits only six days after the accident, GEICO's representative "only tendered a check for $10,000 along with two releases, one for Kaleb Boateng and one for the Estate of Liessette Boateng and GEICO argued that the reason they failed to tender the second $10,000 was because they wanted to open an estate on behalf of Lissette Boateng before giving him the full $20,000 policy limits.
- The court held that there was ample evidence that GEICO promptly contacted both its insured and the tort victim, undertook an investigation to determine liability, provided Plaintiff with the insured's policy limits, informed Plaintiff that GEICO was going to tender the full policy limits, visited Plaintiff at his home to provide him with a $10,000 check for his son Kaleb's injuries, and retained an attorney on Plaintiff's behalf to open an estate for Lissette Boateng so that GEICO could tender the policy limits for her death. Thus, based on the factual record before the Court, the undersigned finds that no reasonable fact finder could determine that GEICO acted in bad faith.

- The Court stated that it was “not unsympathetic to the incomprehensible grief that Plaintiff must have experienced, and continues to experience, in the aftermath of the tragic accident that took his wife's life and injured his son. Nonetheless, GEICO initiated settlement negotiations with Plaintiff and Plaintiff did not respond. Instead, Plaintiff retained an attorney whose first move was to file a bad faith claim against GEICO.”

<u>Noonan v. Vermont Mut. Ins. Co.</u>, 761 F. Supp. 2d 1330 (M.D. Fla. Nov. 15, 2010)

- Excess automobile insurer did not act in bad faith in adjusting claim of motorcyclist injured in accident with insured driver; insurer had no obligation to insured until primary insurer tendered its policy limit, one week later excess insurer requested medical documentation from motorcyclist's attorney, despite several follow-up requests, the records were not received until nine months later, only two weeks after that excess insurer tendered its policy limit, and excess insurer did not know until it received the records whether the damages implicated its policy limit.

<u>Davidson v. Gov't Employees Ins. Co.</u>, 8:09-CV-727-T-33MAP, 2010 WL 4342084 (M.D. Fla. Oct. 26, 2010) <u>aff'd,</u> 422 Fed. Appx. 790 (11th Cir. 2011)

- GEICO first tendered the full $10,000 policy limits to the Forbes family (through their counsel) on December 26, 2002. That first tender was rejected by the Forbes family through their counsel, who essentially stated that it was too early to settle the case.
- Next, on January 22, 2003, GEICO sent a letter to the Forbes family's counsel reiterating GEICO's willingness to settle for the full policy limits. In addition, on April 3, 2003, GEICO hand-delivered a check to the Forbes family's counsel in the amount of $10,200 (representing the policy limits plus an additional $200 for Brittany Forbes' personal items).
- An insurer cannot force an injured claimant to settle a claim, and in this case, the court held that the record showed that the Forbes family was not willing to settle with GEICO for the policy limits.
- The Davidsons argue that GEICO committed bad faith by failing to comply with the terms of the Forbes family's March 14, 2003 offer to settle because it failed to also tender a certified copy of another policy with Hanover that also provided coverage.
- The court held that Florida Statute Section 627.4137 did not require GEICO to provide a sworn statement of coverage from another insurance company, namely Hanover, especially when GEICO did not know whether the Hanover policy would provide coverage under the circumstances of the accident: GEICO was only responsible for providing information about and providing tender of its own policy.
- If the Forbes family's offer to settle was conditioned upon Hanover's tender of the policy limits, then GEICO had no opportunity to settle its claim as tender of Hanover's policy was out of its realm of control

<u>Aboy v. State Farm Mut. Auto. Ins. Co.</u>, 394 Fed. Appx. 655 (11th Cir. (Fla.) Aug. 30, 2010))

- Automobile insurer did not breach its duty to its insured by unnecessarily delaying settlement negotiations and a settlement offer to motor vehicle accident victim, even though the insured was clearly liable for victim's injuries, and insurer did not immediately attempt settlement negotiations, where victim admittedly failed for months to authorize insurer to obtain his medical records, and insurer initiated settlement negotiations promptly as soon as it had some form of verification regarding victim's injuries.

<u>Valle v. State Farm Mut. Auto. Ins. Co</u>, 394 Fed. Appx. 555 (11th Cir. (Fla.) Aug. 24, 2010)

- Insurer attempted to obtain global settlement with respect to fatal car accident involving eight potential claimants, which took four and one-half months, and claimant who sued insured did not make formal settlement demand to insurer or otherwise indicate a unique urgency in resolution of her claim, but instead agreed to and did participate in collective settlement negotiations up until moment she rejected insurer's policy-limits offer.

Maldonado v. First Liberty Ins. Corp., 342 Fed. Appx. 485 (11th Cir. (Fla.) 2009)

- Insurer communicated the risks of an excess judgment, but tortfeasor's husband, the owner of the automobile, refused to execute the asset affidavit demanded by estate, not because he did not understand the consequences of a default judgment, but because he believed that doing so would be pointless, given that he had no assets that could be used to satisfy an excess judgment.

Johnson v. Geico Gen. Ins. Co., 318 Fed. Appx. 847 (11th Cir. (Fla.) March 11, 2009)

- Insurer's delay in offering policy limits on an underinsured/uninsured motorist (UM) claim was not bad faith, despite claim that it should have done so earlier in light of an early determination of liability by the insurer, confirmed by an accident report, together with the fact that the accident victim was taken to a hospital from the accident scene and remained hospitalized until his death; liability was initially contested, an adjuster moved quickly to determine liability, and the insurer offered the policy limits just 33 days after the accident.

Fed. Ins. Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh, P.A., 298 Fed. Appx. 845 (11th Cir. (Fla.) Oct. 30, 2008)

- Excess insurer's right to bring an action against a lower-level insurer for failure to timely settle tort claims arising out of an automobile collision was extinguished by a settlement which satisfied the underlying judgment in the tort litigation and eliminated any possible exposure of the insured to an excess judgment in the future.
- In the “Release and Settlement Agreement,” the claimants agreed to “acquit, release and forever discharge” the tortfeasor, the tortfeasor’s employer and the employer’s umbrella and excess insurers “and other related parties from any and all past, present, or future claims of action ... arising from the accident” underlying the litigation and the claimant also agreed to file a voluntary dismissal with prejudice in the underlying case

Mitchell v. Allstate Ins. Co., 8:06-cv-00041-EAK-TBM (Doc. 50)(M.D. Fla. July 30, 2008)

- In Civil Remedy Notices filed by Plaintiff, neither of Plaintiff’s Notices properly complained of Defendant's failure to pay; therefore, Allstate’s responsibility in curing was to investigate and record demonstrated that it did so.