Turning Bad Faith Inside Out: How Plaintiff Attorneys Are Creating Third-Party Bad Faith Claims[†]

Michael F. Cunningham
Lewis F. Collins, Jr.

"The number of bad faith cases filed in the courts appears to be exponentially increasing, but the increase does not appear to be directly linked to the actions of the insurers."[1]

I.
INTRODUCTION

Originally, Florida implemented a balanced and healthy "bad faith" legal system. It punished insurers who put their interests ahead of their insureds' by delaying payment or improperly choosing to reject a time limit demand from an opposing party. As that system developed, however, the original intent was lost. What remains is a system favorable to plaintiffs and their attorneys. It creates incentives for duplicitous and questionable behavior. It encourages gamesmanship at the expense of fair play and professionalism.

The purpose of this Article is to demonstrate the myriad ways in which plaintiffs' attorneys are "setting up" insurers in an effort to open their policy limits. Their efforts are ratified by juries who have seen their insurance rates rise and, prior to jury duty, have been helpless to strike back. This Article will reveal how the original purpose of "bad faith" laws has become perverted, leaving a system in which a minor error, miscommunication, or misunderstanding leads to a finding of bad faith. Sometimes that "error" is due to the deliberate conduct of the plaintiff's attorney, who claims he or she is merely doing what is in the best interests of his or her client.

This Article also will demonstrate how the conduct of plaintiffs' attorneys, permitted under current law, actually hurts many and protects only a select few. Rather than protecting the public, the excesses and injustice caused by Florida's current bad faith laws are actually detrimental to the vast majority of consumers and well-intentioned companies and advantageous to only a few plaintiffs and their attorneys.

While Florida trial attorneys are at the forefront of exploiting bad faith laws, such exploitation is not limited to Florida. What happens in Florida (law) does not stay in Florida. Strategies perfected by Florida trial attorneys are imported into other states via plaintiffs' attorneys with a sophisticated and effective network for sharing resources and strategies throughout the country. While the attorneys in other states are not yet as experienced or adept at

---

[†] Submitted by the authors on behalf of the Extra-Contractual Liability section. The authors wish to gratefully acknowledge the assistance of David A. Mercer, a Senior Associate with the law firm of Butler Pappas Weihmuller Katz Craig in Tampa, FL for his invaluable assistance in preparing the underlying research that formed the basis of this article.

[1] Allstate Ins. Co. v. Regar, 942 So. 2d 969, 973 (Fla. Dist. Ct. App. 2006).

carrying out these strategies, and not all states have case law similar to Florida's, it is only a matter of time before attorneys in other states catch up.

This Article will conclude with proposals intended to both remedy the unintended advantage given to plaintiffs' attorneys in the system and offer a fair and balanced approach to bad faith. This approach will neither lead to nor encourage insurer misconduct. Rather, it will provide incentives for all parties to handle claims in a forthright and honest manner, promoting justice for all parties involved.

II.
THE INEVITABLE, AND NECESSARY, RISE OF BAD FAITH LAW

Bad faith law is a necessary and important part of our jurisprudence.[2] Should an insurer fail to give proper consideration to a settlement opportunity or choose to "roll the dice" with an insured's money, it is reasonable to place the burden of these decisions on the insurer.

This principle was recognized in Florida by the supreme court in the frequently cited *Boston Old Colony Insurance Co. v. Guiterrez.*[3] Although this case was decided in favor of the insurer, it set forth four principles that govern the insurer's responsibility to its insured: (1) "to use the same degree of care and diligence as a person of ordinary care and prudence should exercise in the management of his own business"; (2) "to advise the insured of settlement opportunities, to advise as to the probable outcome of the litigation, to warn of the possibility of an excess judgment, and to advise the insured of any steps he might take to avoid the same"; (3) to "investigate the facts, give fair consideration to a settlement offer that is not unreasonable under the facts, and settle, if possible, where a reasonably prudent person, faced with the prospect of paying total recovery would do so"; and (4) to avoid acting in what the insurance company "considers to be its interest alone."[4] Together these principles protect the public by particularizing the duty of insurance companies to act fairly and honestly toward their insureds.

Following *Boston Old Colony*, however, the bad faith rules have been expanded by a series of decisions by the Florida courts and by creative lawyering, which has led to unanticipated consequences. Consider the following scenarios:

1. An insurer believes its insured is not at fault for causing a serious accident. The claimant/plaintiff sues the insured, claiming damages in excess of $500,000. The insurer chooses to defend the lawsuit rather than paying its $50,000 policy limits, believing its decision will be vindicated at trial. Instead, the jury finds the insured liable for the accident and awards $750,000 to the plaintiff.

2. An insurer recognizes that it will likely owe its full policy limits to a seriously injured plaintiff. However, despite repeated requests from the plaintiff's attorney, the insurer fails to send the policy limits to the plaintiff's attorney. Finally, the plaintiff's attorney is forced to file suit. The insurer immediately offers its policy limits to attempt to settle the case.

---

[2] This Article focuses on the insurer's duty to settle third-party claims. The voluminous topics of first-party bad faith and the insurer's duty to defend go beyond the scope of this Article.

[3] 386 So. 2d 783 (Fla. 1980).

[4] *Id.* at 785–86.

3. Upon the initial report of a serious accident, the insurer immediately recognizes that the loss will exceed its policy limits of $50,000. It affirmatively tenders the policy limits to the plaintiff's attorney. The plaintiff's attorney returns the check and demands that the insurer provide numerous affidavits to be returned to it within twenty days. The plaintiff's attorney indicates that if the affidavits are returned within the specified time period, the plaintiff's attorney will accept the policy limits in return for a release of all claims. Despite the fact that the insurer exercises due diligence, the check and the affidavits are not received by the plaintiff's attorney until the twenty-second day after the demand (the insured was on vacation and returned the affidavits to the insurer late). The plaintiff's attorney rejects the offer and advises the insurer that he will file suit and pursue a bad faith claim against it.

4. An insurer immediately recognizes its exposure for its insured's full policy limits. It receives a time limit demand from the plaintiff's attorney. The demand requires that the insurer produce all documents required by Florida Statute section 627.4137. The insurer produces all such documents, but in its initial reply, the disclosure is signed by the handling adjuster, not a manager, corporate officer, or superintendent as required by the disclosure statute. The plaintiff's attorney rejects the offer the same day for this reason. Later the same day, the insurer hand-delivers the same document to the plaintiff's attorney's office, and the document is now signed by the proper party. The plaintiff's attorney rejects the offer and advises the insurer that he will file suit and pursue a bad faith claim against it.

The first two scenarios present viable bad faith claims; however, most would agree that the latter two scenarios do not present a traditional bad faith claim. Nevertheless, under Florida law, each of these scenarios presents a claim for bad faith with sufficient merit to reach a jury on the issue of the insurer's bad faith.

An analysis of the case law following *Boston Old Colony* will demonstrate how the law developed in such a way as to allow technical or trivial issues to support claims of bad faith and more importantly, how the case law created an opportunity for plaintiffs' attorneys to recover more than an insurer's policy limits. The holdings in the cases discussed below lead to a distinctly pro-plaintiff system, a system that leaves insurance companies vulnerable to questionable bad-faith suits. If the plaintiff's attorney fails in the tactics to create a bad faith claim, he or she has lost nothing. If the attorney succeeds, he or she may have drastically increased the client's recovery. As Justice Wells noted in his dissent in *Berges*, "[t]he goal of this strategy is to convert a policy purchased by the insured which has low limits of insurance into unlimited insurance coverage."[5]

A. *Time Limit Demand Deadlines*

First, a plaintiff or a plaintiff's attorney can choose an arbitrary, short deadline by which an insurer must respond to a time limit demand (TLD). The courts have provided no firm rules as to how many days are appropriate. In certain circumstances, a demand of less than a week might

[5] *Id.* at 685 (Wells, J., dissenting).

be acceptable. If the insurer misses the deadline by even one day, there is generally a question of fact for a jury as to whether the insurer has acted in good faith.[6] An insurer who diligently works to respond to a time-compressed TLD but falls short by one day may have opened its policy limits and have unlimited exposure for the plaintiff's injuries. This result holds true even if in reality the failure to meet the demand in a timely fashion was designed and intended by plaintiff's counsel.

Some creative plaintiffs' attorneys knowingly engage in actions that make it even more difficult for insurers to respond to TLDs in a timely manner. These tactics include sending the demand to the wrong department in the insurance company, dropping or transposing digits from addresses and zip codes, sending the letter when the primary adjuster is scheduled to be out of the office, or failing to mail the demand letter for some time after dating it. The attorneys then refuse to take calls from the insurer or respond to any written inquiries. While a TLD is pending, it is common for a claim adjuster's calls to be taken exclusively by a member of the support staff who replies that the attorney is not available, not in the office, or otherwise engaged.

Other plaintiffs' attorneys send cover letters to the insurer with an enclosed compact disc (CD). The letters typically reference some inconsequential aspect of the claim and make no reference to a TLD. However, buried among many other documents on the CD is a TLD that was never referenced in the cover letter. Plaintiffs' attorneys intend that the adjuster will assume the CD contains photos of the vehicle or a copy of the letter and will not review the documents on the CD during the TLD period. If the adjuster does not review the CD during the short time period allowed for in the TLD, the attorney will claim the policy limits are opened and that the insurer has acted in bad faith.

Providing a short time to respond to a TLD, made "shorter" by mailing it to the wrong address or otherwise working to keep the demand from the insurer's attention, is typically just the beginning of the set up.

B. *Complicated TLD Terms*

Second, plaintiffs' attorneys can make the terms of the TLD letter very complicated so that the insurer may inadvertently miss a step or fail to follow every demand exactly. The "mirror image rule" provides that any deviation from the terms of the demand, no matter how small or how quickly remedied, can constitute a complete and total rejection of the settlement opportunity. Failure to produce one document requested by the plaintiff in the settlement demand can create bad faith liability for the insurer.[7] Producing the requested information even one day after the expiration of the TLD is insufficient to cure the failure to accept, and the TLD is deemed rejected[8] even if the delay was manufactured by the plaintiff's attorney.

---

[6] *See, e.g.*, Hartford Accident & Indem. Co. v. Mathis, 511 So. 2d 601, 602 (Fla. Dist. Ct. App. 1987)(upholding the jury's finding of bad faith after the insurance company failed to respond to plaintiff's demand within the ten days set out by the plaintiff).

[7] *See* Nichols v. Hartford Ins. Co. of the Midwest, 834 So. 2d 217, 220 (Fla. Dist. Ct. App. 2002)(holding that the plaintiff's demands were not satisfied where the insurance company sent a settlement check and offer but the terms were not satisfactory to the plaintiffs. The offer contained a release of all future claims, which was objectionable to the plaintiffs, who returned the check and rejected the offer. The insurer therefore, did not comply with the terms of the demand letter.).

[8] *See* Berges v. Infinity Ins. Co., 896 So. 2d 665, 678 (Fla. 2004)(finding that the issue of the insurer's bad faith was properly submitted to the jury where the insurance company was aware that the insured would be liable for damages in excess of the policy limits, the TLD of twenty-five days was reasonable, the insurer failed to ask for an extension, and the insurer submitted an offer one day after the TLD expired).

Many TLDs request a large amount of information that is outside the insurer's immediate control. For example, many TLDs request that the insured provide a financial affidavit. The form of that affidavit and the information required are not stated in the TLD, and often the attorney will not provide any clarification as to what is required. It can be an extraordinary challenge to obtain information from an unavailable or uncooperative insured and to relay that information in an acceptable manner to the plaintiff's attorney within the timeframe.

Florida courts have made it abundantly clear that almost anything short of full compliance with everything requested in a TLD (mirror image acceptance) will be a rejection of the demand.[9] Consequently, if an insured is vacationing out of the country or is otherwise out-of-touch during the TLD period, the insured's unavailability will cause the insurer to "reject" a TLD that requires information from, or a signature of, the insured. To compound this problem, nothing in Florida law requires the plaintiff or the plaintiff's attorney to extend the demand-period when requested.

C. *Focus on the Insurer's Conduct*

Third, following *Boston Old Colony*, no matter how improper the conduct of the plaintiff or plaintiff's attorney, that conduct is not the focus of a bad faith trial; instead, the focus is on the insurer's conduct.[10]

Regardless of how egregious the plaintiff's attorney's conduct might have been, the jury will never hear about it. This doctrine is often referred to as "reverse bad faith." Since the focus of a bad faith claim is on the insurer's conduct, the insurance company does not have much leeway to demonstrate that the plaintiff's attorney's entire course of conduct was designed to get the insurer to "reject" the TLD.[11] Viewing only the insurer's conduct, and having no frame of reference with respect to the plaintiff's attorney's conduct, it is exceedingly difficult for an insurer to demonstrate that it was the plaintiff's conduct (or the plaintiff's attorney's conduct), and not its own, that caused the demand to be "rejected."

D. *Refrain from Making Demand*

Fourth, after *Boston Old Colony* the insurer can still be held liable for bad faith even if the plaintiff does not submit a demand letter for settlement.[12] Even in the absence of a demand or any indication that the plaintiff would settle for policy limits, the insurer is obligated to affirmatively negotiate the claim.[13] A failure to tender policy limits to a plaintiff only twenty days after the insurer receives notice of the loss has been found sufficient to support a bad faith claim.[14]

Allowing bad faith claims absent a demand letter has led some plaintiff's attorneys to actually refrain from making demands to settle the claims of their seriously injured clients.

---

[9] *Nichols*, 834 So. 2d at 220.

[10] *Berges*, 896 So. 2d at 677 (stating that "the focus in a bad faith case is not on the actions of the claimant but rather on those of the insurer in fulfilling its obligations to the insured").

[11] *See id.*

[12] Powell v. Prudential Prop. & Cas. Ins. Co., 584 So. 2d 12, 13 (Fla. Dist. Ct. App. 1991).

[13] *Id.*

[14] Snowden v. Lumberman's Mut. Cas. Co., 358 F. Supp. 2d 1125, 1126 (N.D. Fla. 2003)(upholding jury finding of bad faith where twenty days passed between the insurance company finding out about the severe injuries of the injured party and the injured party filing suit).

These attorneys attempt to "stay off the radar," in hopes that the insurer will not make an affirmative offer. By failing to demand the policy limits, the plaintiff's attorney can possibly "create" a bad faith claim by simply remaining quiet and allowing time to pass. Then, if the policy limits (or some portion thereof) are ultimately offered, the attorney may be in position to claim it was simply "too late" and refuse the offer. In addition to refusing to send a demand letter, the attorney may avoid providing the insurer with detailed information concerning his client's injuries. The plaintiff's attorney will refrain from taking any action that would alert the insurer to the potentially serious claim.

E. *Questions of Fact*

When there are multiple claimants to a limited insurance fund, the insurer should try to settle as many claims as possible within the policy limits.[15] While the insurer has discretion to decide which claims to settle, the reasonableness of the insurer's strategy is always a fact question.[16] Any claimant who feels he or she was offered an insufficient portion of the policy limits is free to bring suit against the insurer. That suit will not be dismissed on summary judgment, no matter how reasonable the insurer's conduct, because the reasonableness of the insurer's conduct will always be a fact question for a jury.

This rule allows the claimants to refuse a fair split of the available policy limits and, in fact, encourages them to refuse to even come to the table to discuss settlement (a common occurrence). Should the claimants fail to agree among themselves and refuse to attend a global mediation, the insurer must choose to settle with some, but not all, of the claimants. Typically, and as demonstrated in an example below, the claimants will make conflicting demands that place the insurer in a no-win situation. Any course of action it takes, even if reasonable, will leave legitimately damaged claimants without any or enough of the insurance policy proceeds.[17] This situation inevitably leads to bad faith lawsuits by those who receive none of the proceeds, a suit which will likely be heard by a jury since the reasonableness of the insurer's conduct is a question for the jury. As outlined above, the focus in the trial will not be on the attorney's conduct but rather on the conduct of the insurer.[18]

F. *Releasing One of Multiple Insureds*

An insurer with multiple insureds must attempt to get all insureds released when it settles a claim. However, as the court held in *Contreras v. U.S. Security Insurance Co.,*[19] if the plaintiff will release only one of the insureds, the insurer is required to attempt to secure settlement for that insured only.

For example, the plaintiff's attorney represents the owner and driver of a car that was involved in a car accident. The attorney sends a letter to the insurance company requesting a release of the "insured," then refuses to provide clarify which "insured" is seeking the release. If the insurer responds without clarification, the claimant's attorney will indicate that he or she was willing to release only the insured *owner*, not the insured driver. The attorney did, after all, use

---

[15] Shuster v. S. Broward Hosp. Dist. Physicians' Prof'l Liab. Ins. Trust, 591 So. 2d 174, 177 (Fla. 1992).
[16] Farinas v. Fla. Farm Bureau Gen. Ins. Co., 850 So. 2d 555, 561 (Fla. Dist. Ct. App 2003).
[17] *Id.*
[18] Berges v. Infinity Ins. Co., 896 So. 2d 665, 677 (Fla. 2004).
[19] 927 So. 2d 16 (Fla. Dist. Ct. App. 2006).

the word "insured." Plaintiff's attorney will then file suit against the insured driver, claiming that the policy limits are open with respect to the driver under the *Contreras* holding.[20] If the insurer seeks clarification, the plaintiff's attorney will typically fail to respond, leaving the insurer to choose its poison. Should the insurer request a release of both insureds, the plaintiff's attorney can claim that the insurer is overreaching or failed to "mirror" the demand (clearly the TLD used the singular "insured"). Should the insurer request, on the other hand, a release of only one of its insureds, the insurer could be acting in bad faith for refusing to seek clarification under *Contreras*.[21] This example is yet another example of plaintiff's attorney benefiting from ambiguity in the TLD and a failure or refusal to provide any clarification.

G. *Settlement with a Decedent's Representative Before Probate*

An insurer may settle a death claim with a deceased claimant's representative, or likely representative, even when the probate proceedings have not been initiated.[22]

This situation results in the insurer paying insurance proceeds to someone who "might"' be the proper representative of the deceased person's estate. While the likely representative of the estate might seem obvious, it is not always so. Faced with multiple claims from different persons with different relationships to the deceased, the insurer must determine who is the proper recipient of the insurance proceeds prior to any probate proceedings. An attorney attempting to benefit from a bad faith claim understands these rules and may have a person unlikely to be the personal representative make a TLD with a short deadline. The insurer is faced with the unenviable task of deciding whether to pay this person before the probate court hears the matter.

H. *Timely Promise to Pay with Settlement Check Issued Later*

An insurer's binding promise to pay the policy limits is insufficient to meet a demand. An insurer can be found in bad faith even when it makes a binding promise to pay policy limits if it does not actually send the settlement check in time for it to be received by the plaintiff or the plaintiff's attorney by the attorney's deadline.[23]

Consider the following situation: An adjuster receives a TLD with a short deadline. The TLD is confusing and ambiguous, and it requires the insurer to obtain comprehensive affidavits and other information from its insured to properly accept it. The adjuster has asked for clarification, but the plaintiff's attorney has not responded. On the last day the demand is due, the adjuster finally receives the affidavits from its insured. The adjuster reviews the affidavits at 3:00 p.m. on the date the demand is due. Sending the policy limits without the affidavits could, under current law, fairly be construed as a rejection of the TLD, so the adjuster has not sent the policy limits. Upon receipt of the affidavits, the adjuster faxes a letter to the attorney with the affidavit and "accepts" the TLD, placing the check for the policy limits in the mail. The agreement to pay the limits is binding on the insurer, but the plaintiff's attorney rejects the offer. The reason, supported by Florida law, is that the check was not *received* "in hand" by the plaintiff's attorney by the due date. Despite complying with all terms of the demand with the

[20] *Contreras*, 927 So. 2d at 21.
[21] *Id.*
[22] *Berges*, 896 So. 2d at 674–75.
[23] *Id.* at 676–77 (rejecting the insurer's argument that because the insurer agreed to pay the policy limits within the time frame set by the TLD, the issue of bad faith should be rejected as a matter of law).

exception of check in hand (made difficult if not impossible due to the requirements of the demand itself), and making a binding promise to pay the policy limits, the insurer can be found in bad faith because the plaintiff's attorney did not have the check in hand by the deadline.

III.
TACTICS USED TO "SET-UP" BAD FAITH CLAIMS

One might argue to insurers, "If you know you are going to get 'set-up' for insurance bad faith, simply do what you need to do to avoid that result." Unfortunately, it is not that simple. The plaintiff's attorney's greatest weapon is ambiguity. The attorney leaves important facts unstated or unclear, forcing the insurer to make choices without full information or based on assumptions. This purposeful confusion combined with a short deadline by which to respond to a TLD compounds the problem.

The key to setting up a bad faith claim is to create a situation that makes any response or action problematic, forcing the insurer to choose between several bad options. The "best" set-ups leave the insured with no safe course of action. A few of the most successful scenarios are illustrated below.

A. *The Art of Ambiguity*

On January 1, 2008, an insured plaintiff was involved in a low-to-moderate impact rear-end auto accident that was caused by his negligence. Each vehicle sustained about $1,000 in damage. The plaintiff did not report any injury at the scene of the accident. Shortly thereafter, the forty-five year old plaintiff began treatment with a chiropractor. The plaintiff also had an MRI four weeks after the accident, and the MRI revealed what was interpreted to be a herniated disc.

On March 1, 2008, the plaintiff's attorney sent a TLD to the insurer that, by its terms, would "expire in thirty days." The demand requested payment of the insured's $25,000 policy limits in exchange for a release by the insured. It also requested the insurer to comply with a statute involving the disclosure of policy information.[24] The only document provided with the demand was a copy of the MRI report, which stated that the plaintiff suffered a herniated disc. The demand stated that the insured had not worked since the accident and that any calls or contact from the insurer would be deemed a counter-offer. Although the insurer had sent the plaintiff a copy of an authorization for medical records, that authorization was neither included nor referenced in the TLD.

On its face, the demand might have seemed reasonable. A plaintiff who suffers a herniated disc in an accident and who is unable to work for two months might be entitled to $25,000. However, looking deeper, the trips and traps of the demand become evident.

First consider the more obvious issues raised by the demand:

- When exactly is the demand due? It says it will expire in thirty days. Does this language mean thirty days from the day the plaintiff's attorney sent it, or from receipt by the insurer? The demand was dated March 1, 2008, but not postmarked until March 10, 2008. Did the attorney hold onto it for several days or a week

[24] FLA. STAT. ANN. § 627.4137 (2011).

before sending it? It was received by the insurer's imaging department on Thursday, March 13. Also, it was addressed to the personal injury protection adjuster rather than the liability adjuster and contained an incorrect claim number. The TLD was received by the liability adjuster after being shuffled through several departments on Monday, March 17. Is the demand due on March 31, April 13, or April 18? In order to ensure that it is not deemed to have responded in an untimely fashion, the insurer will have to respond by March 31. Responding at a later date could cause the plaintiff's attorney to refuse to accept a tender of policy limits, claiming that the policy limits are open because the tender is late. However, answering by March 31 gives the insurer only fourteen days to evaluate the demand, to obtain all documents it is required to produce, and to deliver the documents and settlement check, in hand, to plaintiff's attorney.

- How do we know this accident caused the injuries? What is the plaintiff's prior medical history? Did the herniation pre-exist the auto accident, or is it new? Has the plaintiff been treated by this chiropractor in the past for a similar problem? Does he really have a herniated disc, or was the MRI interpreted by a plaintiff-friendly radiologist, who interpreted a herniation whereas others might not? Should the insurer be forced to make a decision within thirty days based on this limited information? Should the insurer be forced to make a decision without the opportunity to review the medical records or have an independent doctor review the MRI films?

- In our adversarial system, in which the plaintiff's attorney is required to produce only evidence that supports his client's position, should an insurer be required to take the plaintiff or plaintiff's attorney's word for the nature and extent of the injuries suffered, without any verification? If the insurer decides not to pay the TLD because it has nothing to verify the information provided by the plaintiff's attorney, should this decision subject it to unlimited liability by a jury in a bad faith trial? The situation is especially troublesome when the plaintiff is truly injured, raising the stakes for the potential bad faith claim.

- Is the plaintiff off work due to the accident? Is the plaintiff a neurosurgeon, or is he a part-time employee at a low paying job? Was the plaintiff even working at the time of the accident? What amount of lost wages is being claimed? Should the insurer be required to accept the claim that the plaintiff is out of work as a result of the accident without any verification other than the attorney's assertion that this information is true?

In addition to the obvious concerns, the example TLD presents additional complications:

- Who will be released by the settlement? The TLD references "the insured." As it turns out, the vehicle was being driven by a permissive user who was also an insured under the policy. The owner of the vehicle, obviously, was the named insured under the policy. The insurer needs to know if the TLD contemplates providing releases for the driver, the

owner, or both. Recall that under the *Contrares* case,[25] the insurer has a duty to attempt to obtain the release of only one insured if that is all the plaintiff is offering. In this instance, it is unclear——is the plaintiff's attorney offering to release the owner or driver or both? If the insurer seeks to clarify the offer, is it making a counter offer? Remember, the letter says that that any effort to seek clarification will be deemed a rejection of the TLD. Without the ability to seek clarification, the insurer might justifiably attempt to get both insureds released. Will this attempt be deemed overreaching when the term used in the TLD is singular and not plural? Is this a "mirror" acceptance? What if the insurer reasonably believes that plaintiff's attorney does not know that there are two insureds? Does this make a difference as to what is reasonably intended by the demand? Is it fair or reasonable to make the insurer guess as to the "true" intention of the plaintiff and his attorney?

- What does plaintiff's attorney mean by "a release for the insured?" The TLD neither contains a sample release nor mentions the terms of any such release. It does not state who will be responsible for liens or other obligations. While it might seem fair to assume the TLD contemplates a full and final release of the insured, including liens and any other obligations, it certainly does not state this. Relying on this ambiguous language is problematic, especially when it comes to the insurer's duty to get a full and final release for its insured as a condition of the settlement.

- What is the plaintiff's prognosis? Did the plaintiff complete the treatment? Will the plaintiff require additional treatment? Has surgery been recommended? Has the plaintiff decided to undergo surgery? If the insurer rejects the TLD because it has incomplete information, and the plaintiff in fact does have surgery, is it reasonable to hold the insurer responsible when it was never informed of the surgery? What if surgery is recommended to the plaintiff *after* the TLD was sent, and plaintiff's counsel failed to notify the insurer? The plaintiff's attorney may argue that the insurer should have accepted the TLD because it knew of the herniated disc and that the insurer should have expected that the plaintiff would require surgery or future treatment.

- Why has the plaintiff's attorney created these ambiguities? Has he or she simply not considered the above concerns? Is he or she well-intentioned and seeking to quickly recover minimal policy limits for the seriously injured client? Is he or she trying to get more than the claim is worth by failing to disclose that the client has a pre-existing herniation, that the client was being treated by a chiropractor immediately prior to the accident, that the client did not have new symptoms or problems after the accident, or that the client was not working at the time of the accident? Is the attorney trying to get the insurance company to reject the demand because the attorney knows that the client has no pre-existing injuries and intends to undergo expensive and painful spinal surgery? If the insurer rejects the demand due to lack of information, the attorney may claim the insurer is in bad faith and has "opened up" its limits.

Given the ambiguities implicit in this hypothetical TLD, with features common to many actually received by insurers on a daily basis, how should the insurer respond? The insurer can

[25] Contreras v. U.S. Sec. Ins. Co., 927 So. 2d 16 (Fla. Dist. Ct. App. 2006).

choose to pay and settle the claim or refuse the TLD and request additional information. The insurer, in the absence of any other information, must choose whether to take the risk of overpaying a claim where the plaintiff was not really hurt or refusing to pay and later learning that the plaintiff suffered serious injuries. Here are the outcomes that could arise from this situation:

1. The insurer pays the policy limits, but the plaintiff's injuries are worth less than $25,000.

2. The insurer pays the policy limits, and the plaintiff's injuries are worth $25,000 or more.

3. The insured refuses to pay the policy limits, but the plaintiff's injuries are worth less than $25,000.

4. The insured refuses to pay the policy limits, and the plaintiff's injuries are worth $25,000 or more.

Unfortunately, due to the lack of information provided, the insurer has no way of determining which of the above situations it is facing. It has to guess at the best course of conduct, with serious consequences should it choose "incorrectly." The "incorrectness" of its decision will later be determined by a jury in a bad faith claim *after* a jury in a liability case decides (with all the information) the value of the claim.

While this situation is difficult for the insurer, there is no downside for the plaintiff. Under scenario one, the plaintiff reaps a windfall, receiving more money than he or she would rightly be entitled to. Under scenarios two and three, the plaintiff gets precisely what he or she is entitled to from the insurer. Finally, under scenario four, the plaintiff has the opportunity to "open up" the policy limits, to have the insurance carrier pay the entire amount of the plaintiff's damages despite the policy limits, and possibly to recover a bad-faith award as well.[26]

From a public policy and fairness standpoint, the above scenarios are unacceptable. Sometimes the plaintiff will get what he is entitled, but in half of the scenarios, the plaintiff receives a windfall. This windfall is not a product of an insurer's misconduct. Rather, it is the result of the plaintiff's attorney's ability to create a no-win situation for the insurance company: an insurer can risk overpaying a claim that may have little to no value, or risk rejecting the TLD and be found responsible for the full extent of the plaintiff's injuries.

If this incident was an isolated one, it might not be cause for serious concern. However, the common and recurrent nature of the scenario presented above demonstrates the severity of the problem. The insurer faces numerous bad faith claims, even though its actions were not bad, improper, or even negligent.

B. *The Multiple Plaintiff Conundrum*

The following scenario presents another opportunity for a fabricated bad-faith claim. Five teenage co-workers are in a car that is broadsided by a drunk driver. Two of the teenagers are killed; one suffers severe and life-altering injuries; one suffers serious injuries, however, the exact extent of the injuries is unknown; and one has unknown injuries. The party at fault has policy limits of $50,000 per person and $100,000 per accident. There are no other available

[26] This will also include attorney's fees and the possibility of punitive damages.

sources of insurance recovery, and the drunk driver is destitute and facing life in prison. The police report is not available and will not be available for some time due to the severity of the accident and the pending criminal investigation.

The insurance company determines its insured, the drunk driver, was solely at fault for causing the accident. It immediately recognizes its affirmative obligation to tender its policy limits and to make every effort to resolve *all* of the claims. It conducts an extensive investigation into the cause of the accident and into the nature and severity of the injuries resulting from this tragic event.

The insurer consults with its insured driver and retains an attorney to represent the driver's interests. It learns that the driver was not the insured owner, and it also retains an attorney for the insured owner of the vehicle. Both attorneys hired to represent the insureds indicate they want the insurance company to do everything it can to resolve all claims against their clients within the policy limits. Quite properly, they will not provide any more specific advice or guidance as to how the insurer should deal with the multiple claims. In response, the insurer immediately begins efforts to arrange a global mediation or settlement conference to pay its policy limits to the multiple plaintiffs.

However, while this is occurring, the first deceased plaintiff's family hires an attorney who states that he is unwilling to attend a mediation/settlement conference. That attorney also makes a thirty-day TLD to release all insureds. The second deceased plaintiff's family tells the adjuster that they want to be left alone while they grieve, and they are not interested in discussing settlement *at this time*. The third plaintiff is in a coma. Her mother sends a handwritten letter to the insurer, advising that she needs "immediate" payment of the policy limits to pay her daughter's medical bills. The letter states that she is willing to release only the insured owner, not the intoxicated insured driver. The fourth plaintiff was taken from the scene by ambulance, but the insurer has been unable to obtain any further information about her injuries, despite diligent efforts. The fifth plaintiff was also taken from the scene by ambulance. A TLD has been received from the fifth plaintiff's attorney asking for payment of the policy limits in twenty days. It does not indicate who will be released, and the attorney for the fifth plaintiff has not returned the adjuster's phone calls or responded to faxes or letters.

Plaintiff	**Injury**	**Demand**
Plaintiff #1	Deceased	Thirty-day TLD, release all
Plaintiff #2	Deceased	No demand while grieving
Plaintiff #3	Severe injuries; in coma	Demand for immediate payment, release owner only
Plaintiff #4	Serious injuries, extent undetermined	No contact
Plaintiff #5	Serious injuries, extent undetermined	Twenty-day TLD, unsure who will be released

Under Florida law, the insurer has competing and conflicting obligations. Under *Powell*,[27] the insurer has an affirmative duty to negotiate serious injury claims even absent a demand: Where liability is clear, and injuries are so serious that a judgment in excess of the

[27] Powell v. Prudential Prop. & Cas. Ins. Co., 584 So. 2d 12, 13 (Fla. Dist. Ct. App. 1991).

policy limits is likely, an insurer has an affirmative duty to initiate settlement negotiations.[28] Under *Shuster*,[29] the insurer has an obligation to attempt to settle all the claims.

It is fair to say that even King Solomon would shudder at the possibility of successfully resolving all of the claims with the limited policy in the situation presented. Yet, the insurer must take action and must do so in an extremely truncated manner. It has one demand for policy limits to be paid "immediately," one that expires in twenty days, one that expires in thirty days, and a duty under Florida law to timely pay *all* serious claims. To add another layer of complexity, one plaintiff is willing to release both insureds, another has indicated that it will release only one insured, and a third has not indicated who she will release. Finally, the insurer has to consider whether the third plaintiff's mother is the proper person to be making demands on the plaintiff's behalf. To determine whether the mother is the proper representative, the insurer must consider whether the third plaintiff is a minor, whether the mother has a valid Power of Attorney, and whether the POA was executed properly. The insurer must also consider whether it should treat this claim on par with the other claims.

How should an insured, working in the utmost good faith and in accordance with Florida law, handle this situation? Applying the *Farinas*[30] standard, the insurer has multiple options.

- Call for a global mediation and refuse to settle any of the claims until that occurs
- Pay $50,000 apiece to the first two plaintiffs to make a claim
- Offer to split up the limits among the five plaintiffs equally, or according to some other formula
- Pay $50,000 each to the deceased plaintiffs
- Pay $50,000 each to two plaintiffs who appear at this time and with the information known to have the most serious injury claims
- Refuse to take any action until the insurer has complete medical information on all of the plaintiffs so it can determine the relative merits of each claim and the severity of each injury
- Interplead the policy limits of $100,000 for the court to split in some equitable manner

Unfortunately, under each one of these scenarios, the insurer is likely to face a bad faith claim from one or more of the plaintiffs, a bad faith claim that can only be evaluated later by a jury. If the insurer allows the policy limits to expire while waiting for more information or waiting to set up a settlement conference, the plaintiffs who made those time limited offers may refuse to cooperate, withdraw their demands, and claim that the policy limits are opened for failure to timely respond. If the insurer meets two of the time limit demands, it may face lawsuits from the three remaining plaintiffs who were seriously injured but received nothing.

The only scenario under which the insurer walks away without any bad faith exposure

---

[28] *Id.* at 14.
[29] Shuster v. S. Broward Hosp. Dist. Physicians' Prof'l Liab. Ins. Trust, 591 So. 2d 174, 177 (Fla. 1992).
[30] Farinas v. Fla. Farm Bureau Gen. Ins. Co., 850 So. 2d 555, 561 (Fla. Dist. Ct. App 2003).

would be one in which the plaintiffs all agree how to split the $100,000 before the first time limit demand expires. Absent an agreement from all parties, the insurer is faced with TLDs that force its hand and require it to take action without complete information. This action may result in it being sued for bad faith by plaintiffs who believe they did not get their "fair share" of the proceeds.

The case law referenced above has left insurers in Florida with a no-win scenario. Insurance companies are often left to make decisions in a short time frame, decisions which, no matter how decided, can expose the insurer to bad faith liability. Regardless of how the insurer proceeds, it can be sued for bad faith by the plaintiffs who do not receive all that they are demanding. Simply stated, there is little that the insurer can do, no matter the "good faith" it exhibits, that will insulate it from a bad faith suit.

In practice, the requirements of *Farinas*[31] are unworkable, unrealistic and simply unfair. With any more than two seriously injured plaintiffs and traditional split limits, the insurer can handle the claim perfectly, in lockstep with its insured's best interests, and still face uncertain and expensive bad faith suits.

C. *No Bodily Injury Coverage and the $10,000 Pair of Jeans*

The final technique for setting up a potential bad faith claim arises in the context of policies that do not contain bodily injury coverage. An insured purchases a policy authorized by Florida law, providing $10,000 in property damage (PD) coverage and $10,000 in personal injury protection (PIP) benefits. By its express terms, the policy excludes coverage for bodily injury (BI).

Assume that the insured negligently caused a serious accident. There was one plaintiff who suffered serious and permanent injury. The plaintiff had to be taken to the hospital by flight-for-life. The value of the injury claim is clearly in excess of $500,000.

One month after the accident and before disclosure of any policy information, the insurer received a letter from the plaintiff's counsel, stating the following:

> Please be advised that I represent the plaintiff, who was injured in a horrendous accident. My client has been seriously injured and is in desperate need of funds. Therefore, please pay all of your insured's policy limits to resolve this matter, provide me with an affidavit of no other insurance, and provide an affidavit of no other assets executed by your insured. Be advised that in addition to the life-threatening injuries my client suffered, he also suffered the loss of his eye glasses, his watch, and his pants. These items were one-of-a-kind and made specifically by a world-class designer especially for my client. My client also lost other valuable items. In exchange for payment of the policy limits, my client will release the insured. This demand will expire in seven days. My client's family is desperately in need of the available funds in order to pay medical bills and to purchase food. Failure to respond timely will be a rejection of this demand.

The letter was dated October 8, 2008. It was postmarked October 10, 2008. It was received in the insurer's imaging department on October 13. It was put in the handling adjuster's mailbox the afternoon of October 13. The adjuster opened and read the demand on October 14.

---

[31] *Id.*

As with the other examples provided above, on first glance, the demand appears reasonable and fair. However, on closer examination, it is clear that the demand is cleverly written and uses ambiguity as a weapon to force the insurer's hand. The adjuster reviewing this letter has numerous concerns:

- When exactly is the demand due?

- What "policy limits" are being demanded? Is the demand for PD limits only, is it for PD and PIP, or does the plaintiff's attorney believe there are BI limits available?

- Does the insurer need to pay $10,000 for the property damage claim, even though it has not been provided with any documentation of the amount of property damage actually suffered by the insured? If it requests documentation of the damages, and the time within which to respond to the demand passes, will it be able to pay the PD policy limits and resolve the case once the damages are proven? Should the plaintiff's attorney be required to provide some proof for the damages before the insurer's obligation to pay the claim is triggered?

- Does the insurer need to pay the PIP benefits of $10,000 to the plaintiff? What if the plaintiff has already assigned his or her rights to payment to the medical providers?

- What claims will be released if the policy limits are paid? The letter says it will release "all claims." Does this truly mean that "all claims," including BI claims, will be released with the payment of the PD or PIP limits? Or, upon payment of the PD limits, will the plaintiff's attorney claim that he was willing to release only PD claims for payment of PD limits?

- Is the insurer required to obtain an affidavit of no other insurance and of no assets from the insured? If so, why is it required to do so, since the PD claim cannot be worth more than the $10,000 limits? What if the insurer cannot locate the insured in time? What should those affidavits say? Is the insurer assuming a duty to handle the BI claim if it provides these documents to the plaintiff, even though the plaintiff has no BI coverage?

- If the demand includes a release for bodily injury, is the insurer allowed or required to negotiate this claim on behalf of the plaintiff who has no BI coverage? What are the consequences if it does so?

- Why did the plaintiff's attorney provide only seven days to respond? Did he do so to take advantage of the ambiguity and uncertainty created by his demand?

In addition to the ambiguities created by the TLD, the attorney's actions following the letter can create more dilemmas. Assume that the handling adjuster called the plaintiff's attorney's office to seek clarification. The adjuster was told by the attorney's secretary that the attorney is out of town and cannot be reached. The attorney will be unavailable until October 18. The secretary is not authorized to give an extension to the demand or to answer any questions with respect to the demand. The handling adjuster leaves a message and asks the attorney to call

him if the attorney calls in for messages. The adjuster does not receive a call from the handling attorney, and out of an abundance of caution, he considers the demand to be due seven days from the date noted on the letter. Thus, the due date happens to be the following day, October 15.

With no ability to obtain clarification, the adjuster now faces a quandary:

1. The insurer might obtain the affidavits, pay the PD and PIP limits, and ask for a release of all claims as promised. This solution presumably settles the BI claim, for which there is no coverage, but it likely causes the insurer to overpay the unsupported PD claim. Also, it is quite possible that the attorney, having had all of his or her conditions satisfied, will now claim that he or she was unaware that there was no BI coverage, and indicate that there is no settlement because there cannot be a meeting of the minds.

2. The insurer might fail or refuse to obtain the affidavits but notify the insured of the demand. The insurer might meet the demand with respect to the PD and PIP limits and ask for a release of all claims as promised. This offer will likely be rejected by the plaintiff's attorney for failure to provide the affidavits, resulting in a tort suit against the insured and a later bad faith suit.

3. The insurer might refuse to pay the PD claim and demand proof of damages. This option may cause the plaintiff's attorney to consider the demand rejected and to file suit against the insured seeking the full extent of the BI and PD damages. The insurer will be required to defend the insured for the PD claim and will also be required to defend against any subsequent bad faith suit if a large judgment is entered.

Once again, the case law in the bad faith arena puts the insurer in a no-win situation. If the insurer cannot locate the insured in the short time period allowed, it will have to let the TLD lapse without a response that satisfies the "mirror image" rule. This result may cause the plaintiff's attorney to allege that the policy limits are open and to bring a bad faith suit.

Two cases dramatically reveal the risk the insurer is faced with on claims for which there is no bodily injury coverage. In *Allstate Indemnity Co. v. Oser*,[32] the court held that since the carrier undertook a duty to obtain affidavits from its insured, it could be held responsible for the full extent of the plaintiff's bodily injury damages if a settlement was not properly achieved. Even though the insurer provided no coverage for bodily injury, it is potentially obligated to compensate the plaintiff for his or her bodily injuries.

Likewise, in *Sorocka v. Severe*,[33] the court held that the insurer that rejected what it believed to be an inflated property damage claim could be held responsible for the full extent of the plaintiff's injuries. In *Sorocka*, the plaintiff made a demand for the payment of the BI limits. However, included in the demand was an inflated claim for property damage (PD) with no supporting documentation. Plaintiff's counsel demanded policy limits on the BI claim and $750 for the PD claim for lost property. The insurer believed the BI claim was justified but believed

[32] 893 So. 2d 675 (Fla. Dist. Ct. App. 2005). *But see* Rodriguez v. Am. Ambassador Cas. Co., 4 F. Supp. 2d 1153 (M.D. Fla. 1998) (refusing to find that insurer had acted in bad faith in failing to inform insured of the insured's offer to settle bodily injury claim where insured did not have coverage for bodily injury).

[33] 858 So. 2d 388 (Fla. Dis. Ct. App. 2003).

that the PD claim was inflated. The insurer delivered a release and check for the BI policy limits but never accepted or paid the PD claim.[34]

As a result, plaintiff rejected the tender and filed suit against the insured. The insured claimed that the parties had settled the BI claim. The insurer argued that it was free to settle the BI claim and leave open the PD aspect of the claim because the demand did not specify both claims had to be accepted. The appellate court disagreed, stating that the insurer could not pick the types of damage it wished to accept.[35] Since there was not a proper settlement, the insured was exposed to an excess judgment and the carrier to bad faith liability for failing to settle the claims against its insured.

These cases further illustrate how the law of bad faith in Florida has taken a wrong turn. Originally, bad faith law was intended to prevent the insurance carrier from putting its interests ahead its insureds'. Now, minor errors, value disputes, and simple misunderstandings are sufficient to form the basis of a bad faith lawsuit. These limits have been stretched to include coverage that was not purchased or contemplated by the parties to the insurance contract.

IV.
WHY "TRIAL BY JURY" IS NOT A SUITABLE SOLUTION TO THE PROBLEMS OF BAD FAITH CLAIMS

Florida courts have declared that most bad faith issues should not be decided as a matter of law, but by juries. What could be fairer than having six impartial jurors deciding the outcome of a dispute? Who can quarrel with allowing our jury system to sort out right and wrong in these situations? There are a number of compelling reasons why the right to a trial by jury is not always the appropriate solution to the problems created by bad faith claims that arise in the scenarios described in this Article. First and foremost is the fact that the focus of the trial is on the insurer's conduct, not the plaintiff's actions. For instance, a jury was not allowed to hear a jury instruction on legal causation and the plaintiff's comparative negligence.[36] This rule is the equivalent of putting blindfolds on the jurors. Surely hearing only one side of an argument would tend to bias the jury in favor of the plaintiff. As a result, one could argue that it is impossible for the insurer to receive a fair trial.

Second, the jury has the benefit of hindsight, even though it is instructed to evaluate the insurer's conduct with the information available to the insurer at the time of its actions. Although the insurer is forced to make decisions in the absence of much information, the jury in the liability case gets to see how the injuries played out when making its decision. A plaintiff's attorney who does not provide information to the insurer about his client's need for surgery has the benefit of his client actually having undergone surgery by the time of the bad faith trial. What the insurer never knew (but allegedly should have foreseen), the jury now knows. While the jury is told to view the facts as the insurer had them at the time the demand was made, in actuality the jury knows what happened after the demand was made. The jury must determine whether bad faith exists and award damages. Unless there is a system that allows the bifurcation

---

[34] *Id.* at 389.
[35] *Id.*
[36] Nationwide v. King, 568 So. 2d 990, 990 (Fla. Dist. Ct. App. 1990).

of liability and damages, the jury will inevitably apply hindsight when judging the insurance company's conduct.[37]

A third reason why bad faith trials are less than ideal is that jurors in these types of serious injury cases must decide whether to compensate a profoundly injured person at the expense of a well-funded insurance company or send that person home with no money. Despite the court's admonishments concerning sympathy, it is difficult to imagine how a jury could not be swayed by this factor, even in the absence of clear wrongdoing by the insurer.

Finally, refusing to grant summary judgment in bad faith cases (thereby guaranteeing jury trials in bad faith suits) has helped to create the incentive using the tactics described in this Article to set up a bad faith claim.

V.
A PROBLEM THAT AFFECTS EVERYONE

In these difficult economic times, there is an understandable lack of sympathy for insurers facing bad faith claims. However, as Justice Wells of the Florida Supreme Court pointed out, this issue does not impact only insurers. In fact, it harms everyone but the plaintiffs' attorneys and plaintiffs who are successful in their efforts to set up insurers:

> Just as it is an obvious truth that "there is no free lunch," likewise, there is no free liability insurance. It is an undeniable fact which follows logic and common sense that bad faith judgments against insurers drive up the premium costs for all insureds, particularly for insureds who purchase low-limits liability insurance policies. Liability insurance is a pool of money. The pool is filled by premiums and drained by claims. When an insured purchases and pays premiums on $20,000 of insurance but the insurer pays $2.5 million in claims, someone has to fill up the pool. Initially, this amount may come out of an insurer's profits, but eventually the someones are the other insureds, whose premiums are increased.[38]

The real cost of Florida's bad faith laws is borne by all.

VI.
PROPOSED SOLUTIONS

Some Florida judges are beginning to notice and understand that bad faith law has expanded beyond its original framework and that plaintiff's attorneys are perverting it for personal gain beyond its original intent. Courts have also begun to recognize the prevalence of tactics utilized to set up insurance companies for bad faith claims. Courts have little authority to rewrite bad faith law. There are, however, steps that courts and the legislature can take to bring bad faith back into line with its original intent.

To reverse the deviation from the original intent of the bad faith laws, courts can use an objective standard and permit evidence of the plaintiff's conduct. As Justice Wells artfully noted

---

[37] The authors are unable to find one instance where a Florida trial court bifurcated liability and damages in a bad faith case.

[38] Berges v. Infinity Ins. Co., 896 So. 2d 665, 686 (Fla. 2004) (Wells, J., dissenting). .

in his *Berges* dissent, courts can utilize logical, objective standards for bad faith.[39] Once these objective standards have been explained, the court can decide bad faith issues as a matter of law. This system would prevent a jury from escalating a *de minimus* deviation from a demand letter into a multi-million dollar verdict. The second step the courts can take is to recognize and permit evidence of a set-up and comparative (reverse) bad faith. Plaintiffs' attorneys will be forced to ensure that their demands are reasonable and can be justified if the courts permit the insurer to challenge the reasonableness of demands and to provide evidence of whether a plaintiff truly intended to settle the claim under the demand's terms. In such a circumstance, the failure to adhere to the *truly* essential elements of the offer is significant from a damage standpoint. Comparative bad faith—long since rejected—may be a useful tool for the courts to "level the playing field" a bit.

Another solution to avoid unreasonable outcomes is to bifurcate the "liability" and damages portions of the bad-faith trial. As noted above, bifurcation would prevent the jury from learning things about the facts and injuries that the claims representative did not know at the time of the demand. This method may eliminate some of the second-guessing or hindsight from the jury deliberations. A judge would be encouraged to consider bifurcation in such a circumstance.

These proposals could start to bring the laws of bad faith back into line, but the difficulty with the judicial approach is time. Case law has developed, issue by issue, over a period of almost thirty years. Resolving the land mines caused by these decisions may take equally long. The better approach may be for the legislature to step in and define objective standards and goals for the courts. At the same time, the legislature could implement a requirement for a civil remedy notice in third-party cases.

Florida law already requires a civil remedy notice as a prerequisite for the filing of first-party bad faith claims.[40] The civil remedy notice, if properly defined and specific, notifies the insurer of the potential bad faith claim and provides the insurer the precise steps needed to correct the alleged violation. A properly drafted civil remedy notice also provides the insurer a safe harbor period to correct the alleged bad faith. A civil remedy notice would be a good solution if the true reason for bad faith law is to prevent dishonest and unfair tactics by insurance carriers in the settlement of disputed claims. The civil remedy notice would also operate to provide a means to "correct" the concerns raised by plaintiffs, without resorting to arbitrary time demands and confusing settlement terms.

These are just some of the steps that can be utilized to bring bad faith law back to its original intent: to protect the public by enforcing the duty of insurance companies to act fairly and honestly toward their insureds.[41] If bad faith law is meant to prevent an insurance carrier from acting unfairly and dishonestly toward its insured, is it not time for fairness and honesty in evaluating both the claims of the injured and the insurer's conduct in third-party bad faith claims? If a carrier is supposed to evaluate a settlement demand "with due regard" to the interests of its insured, shouldn't its conduct be viewed without the application of hindsight?

Implementing the above suggestions would begin to right the wrong that has been occurring on a daily basis in Florida. It would also serve to promote justice and efficiency by punishing only truly improper conduct by insurers. Finally, it would ensure that consumers are

---

[39] *Id.*

[40] FLA. STAT. ANN. § 624.155 (2004 & Supp. 2011).

[41] An insurance company acts in bad faith in failing to settle a claim when, under all of the circumstances, it could and should have done so, had it acted fairly and honestly towards its insured and with due regard for their interests. Fla. Standard Form Jury Instructions in Civil Cases, § MI 3.1 (2011).

not paying more for their insurance due to bad faith claims that are brought despite the fact that an insurer has made every attempt to act in good faith toward its insured.