DISABILITY INSURANCE:
Individual Disability Dollars or Litigation Disaster

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I. INTRODUCTION

So your client wants to bring a claim under his disability policy? Be forewarned: Taking on a disability insurer is not for the timid or faint of heart. Your client will be bombarded with a seemingly endless barrage of anti-coverage grenades that share a single target – preventing your client from collecting disability benefits.

If your client's benefits would pay him more money than he was making at his occupation, the insurer will argue that he is pursuing his claim out of choice or for financial gain – not because he is truly disabled. If your client is self-employed, the insurer will argue that, in addition to his profession, your client is a "business owner" capable of performing administrative duties, and thus is not totally disabled. If your client is undergoing conservative treatment rather than submit to invasive medical procedures, the insurer will argue that the treatment your client is receiving is inappropriate for his condition. If the insurer suspects that your client is feigning his disability (and, with alarming frequency, even if it doesn't), the insurer will trot out one of its well-paid "independent" physicians to conduct a medical examination that, inevitably, will find your client in perfect health. And if all else fails, the insurer will have its paparazzi conduct a week-long surveillance of your client that will produce – after careful editing – a 60-minute videotape which suggests that your client could easily qualify for the Olympics (or, at the very least, perform his occupation).

As if this wasn't enough, you will almost certainly be hit with the insurer's motion for summary judgment attempting to take out your bad faith and punitive damages claim long before the case ever gets to the jury. The insurer's position will be that, because there was supposedly a "genuine" issue about the validity of the claim, its failure to pay benefits was reasonable as a matter of law.

What can you – and your client – do? This syllabus, and the presentation that accompanies it, will help you combat the insurer's arsenal of coverage weapons and, in the process, fortify your bad faith action against the insurer.

II. PICKING THE RIGHT PLAINTIFF

At the risk of stating the obvious, the first step is to get to know your client. Will he make a good plaintiff? What is your first impression? Do you believe his story? Does he appear to be forthright? Is he honest or evasive? For example, were the representations on his policy application true, complete and accurate? If his answers to medical, occupational or financial questions on the application do not fully comport with the facts, the carrier will argue that he lied to obtain the policy and thus that his claimed injury or sickness cannot be believed either. And the jury may, in fact, discredit him if he lied or exaggerated when he first dealt with the insurance company.

You also need to evaluate whether your client is articulate and likable enough to be an outstanding witness at trial. Does he exhibit kindness, good sense, tolerance and patience? Does he have the emotional stamina to pursue protracted litigation and handle a trial? And does he have the financial wherewithal to litigate and the staying power to survive the appeal process, or is he looking for a quick settlement?

In addition, it is essential that you get to know the other people who will need to corroborate your client's story and confirm his damages. What kind of third-party witnesses (spouse, children, friends, employees, supervisors, co-workers, neighbors) does he have? What about their mannerisms, communication skills and emotional stability? Will a jury believe them? Are they intelligent, likable and competent? Will they be coachable? And what about the treating physicians? Are they respected in the medical and legal communities, or are they known for providing unnecessary treatment and telling patients – and lawyers – whatever they want to hear?

You also need to evaluate your client's damages. How has the insurer's failure to pay benefits affected his life? Has he lost his house? Has his car been repossessed? Did his wife have to sell her wedding ring? Have his children been taken out of private school? Did he have to sell anything in a fire sale? Has he had to cash in an IRA or 401k? Has his credit been ruined? Is his family living off cash advances? Has the gas or electricity been turned off? This analysis will give you a better idea of what the case is worth in real damages, before you start thinking about possible punitive damages.

Next, you need to obtain and review all pertinent documents in your client's possession. These would include: (1) advertising and marketing materials – these will help you understand what the "bait" was, what your prospective client's reasonable expectations regarding coverage were, and whether the insurer ultimately delivered what it promised; (2) the policy, including the application and all declarations pages, riders, endorsements, amendments and any "specialty" letters; (3) payment information – canceled premium checks, receipts and premium lapse notices; (4) claim notices and proof of loss forms; (5) prior written or recorded statements by your client; (6) medical records; (7) tax returns; and (8) correspondence between your client and the insurer, insurance agents, and any other key players.

Additionally, have your client provide you with any diaries, logs or journals he has maintained. If he doesn't have any, ask him to prepare a detailed summary of his loss, any medical treatment, and all dealings with the insurance company.

After the client has left your office, you should conduct the classic 3-step analysis for first-party bad faith cases: (1) determine the insurer's *contractual* liability (i.e., whether it was obligated under the terms of the contract to pay the insured's claim for policy benefits), (2) evaluate whether the insurer's failure to pay or delay in paying subjects it to *extracontractual* liability for compensatory damages over and above whatever is owed under the policy, and (3) analyze whether *punitive damages* might be recoverable based upon the insurer's conduct.

III. SHEDDING THE ERISA ALBATROSS

If the insured's policy was provided by his employer, the insurer will argue that his civil suit is preempted by the Employee Retirement Income Security Act (ERISA). Remedies in connection with an ERISA-preempted insurance policy are limited to the benefits owed and, in the court's discretion, reasonable attorney's fees. Thus, most courts hold that no consequential damages, emotional distress damages or punitive damages can be recovered in an ERISA action.[1]

Here are a few ways to circumvent ERISA:

- An **independent contractor** is not an "employee" and is therefore not subject to ERISA preemption,[2] unless he obtains insurance benefits through the same group plan that covers employees of the company.[3]

- A **government employee** or the employee of a public agency is exempt from ERISA.[4]

- **Employees of churches** or church-operated businesses are exempt from ERISA.[5]

- **Sole proprietors, partners, and their spouses** are exempt, so long as the business does not provide benefits under the policy to a common-law employee.[6]

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[1] *Massachusetts Mut. Life Ins. Co. v. Russell* (1985) 473 U.S. 134, 142-144, 105 S.Ct. 3085, 3090; *Mertens v. Hewitt Assoc.* (1983) 508 U.S. 248, 113 S.Ct. 2063, 2069.
[2] *Nationwide Mut. Ins. Co. v. Darden* (1992) 503 U.S. 319, 327, 112 S.Ct. 1344, 1350; *Barnhart v. New York Life* (9th Cir. 1998) 141 F.3d 1310.
[3] *Harper v. American Chambers Life Ins. Co.* (9th Cir. 1990) 89 F.2d 1432, 1434.
[4] 29 U.S.C. §§ 1002(32), 1003(b).
[5] 29 U.S.C. § 1003(b).
[6] 29 C.F.R. § 2510.3-3(b), (c). See also *Robertson v. Alexander Grant & Co.* (5th Cir.

- Some courts have suggested that a plan is not "established or maintained" by an employer[7] unless the employer **intended** to create an ERISA plan.[8] Other courts have indicated that an employer has "established or maintained" an ERISA plan only if it actively **participated** in the design and operation of the plan, directly **controlled** the day-to-day operation of the plan, exercised substantial **discretion** over the plan, and/or established a **separate administrative scheme** to manage the plan.[9] Still others have found that the "established or maintained" requirement may not be met even if the employer was significantly involved in the administration of the plan.[10] Certain others have indicated that an ERISA plan has not been "established" where the insurer failed to comply with ERISA's reporting and disclosure requirements and failed to mention ERISA in policy documents, brochures and letters.[11] And a few others have held that the "is maintained" requirement implies that the plan must be in **current operation**,[12] and thus that ERISA does not apply where the former employer has **sold his business** and stopped contributing to the plan[13] or has gone **bankrupt** and ceased any involvement in the plan.[14]

- Plans that fall under the Department of Labor's "**safe harbor**" regulations are exempt from ERISA.[15] The regulations generally state that ERISA is inapplicable

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1986) 798 F.2d 868; *Meredith v. Time Ins. Co.* (5th Cir. 1993) 980 F.2d 352; *Fugarino v. Hartford Life & Acc. Ins. Co.* (6th Cir. 1992) 969 F.2d 178; *Slamen v. Paul Revere Life Ins. Co.* (11th Cir. 1999) 166 F.3d 1102, 1104.

[7] 29 U.S.C. § 1002(1).

[8] See *Kanne v. Connecticut General Life Ins. Co.* (9th Cir. 1988) 867 F.2d 489, 493; *Stanton v. Paul Revere Life Ins. Co.* (S.D. Cal. 1999) 37 F.Supp.2d 1159; *Hansen v. Continental Ins. Co.* (5th Cir. 1991) 940 F.2d 971, 978.

[9] See *Hansen v. Continental Ins. Co.* (5th Cir. 1991) 940 F.2d 971, 978; *Johnson v. Watts Regulator Co.* (1st Cir. 1995) 63 F.3d 1129, 1134; *Elco Mechanical Contractors. Inc. v. Builders Supply Assoc. of West Virginia* (S.D. W. Va. 1993) 832 F.Supp. 1054, 1057-1058; *Taggart Corp. v. Life and Health Benefits Administration, Inc.* (5th Cir. 1980) 617 F.2d 1208, 1210; *Sindelar v. Canada Transport, Inc.* (Neb. 1994) 520 N.W.2d 203, 207.

[10] See *Zavora v. Paul Revere Life Ins. Co.* (9th Cir. 1998) 145 F.3d 1118, 1121; *du Mortier v. Massachusetts General Life Ins. Co.* (C.D. Cal. 1992) 805 F.Supp. 816, 821; *Garrett v. Delta Air Lines, Inc.* (N.D. Ind. 1978) 1978 U.S. Dist. LEXIS 16460.

[11] See *Johnson v. Watts Regulator Co.* (1st Cir. 1995) 63 F.3d 1129; *du Mortier v. Massachusetts General Life Ins. Co.* (C.D. Cal. 1992) 805 F.Supp. 816.

[12] See *Stanton v. Paul Revere Life Ins. Co.* (S.D. Cal. 1999) 37 F.Supp.2d 1159.

[13] *Loudermilch v. The New England Mutual Life Ins. Co.* (S.D. Ala. 1996) 942 F.Supp. 1434.

[14] *Mizrahi v. Provident Life and Accident Ins. Co.* (S.D. Fla. 1998) 994 F.Supp. 1452.

[15] 29 C.F.R. § 2510.3-1(j).

where (1) the employer does not "endorse" the program;[16] (2) employee participation is completely voluntary; (3) premiums are paid entirely by the employee;[17] (4) the employer's sole functions are to permit the insurer to publicize the program, collect the premiums through payroll deductions, and remit the premiums to the insurer; **and** (5) the employer receives no consideration, except reasonable compensation for collecting and remitting the premiums. Significantly, however, some courts have found the "safe harbor" regulations applicable despite employer activities far beyond those permitted by the regulations.[18]

- An insurer sometimes concedes that the insured is a partner or other non-employee and that the disability policy covers only him, but argues that his claims are nevertheless subject to ERISA because his policy is part of an overall company benefit plan that included other policies which *did* cover employees. This argument has been made – and soundly rejected – in several recent opinions.[19]

- ERISA preemption does not extend to state-law claims arising under an individual insurance policy even though the policy was converted from an earlier group policy subject to ERISA.[20]

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[16] "Endorsement of a program requires more than merely recommending it." *Johnson v. Watts Regulator Co.* (1st Cir. 1995) 63 F.3d 1129, 1136.

[17] The mere fact that the employer gave employees the option of using a portion of their pre-tax salary to purchase plan benefits does not mean that it contributed to the payment of plan premiums. See *Hrabe v. Paul Revere Life Ins. Co.* (M.D. Ala. 1996) 951 F.Supp. 997, 1001.

[18] *Garrett v. Delta Air Lines, Inc.* (N.D. Ind. 1978) 1978 U.S. Dist. LEXIS 16460; *Johnson v. Watts Regulator Co.* (1st Cir. 1995) 63 F.3d 1129.

[19] *LaVenture v. Prudential Ins. Co. of America* (9th Cir. 2001) 237 F.3d 1042, 1044-1045 ["A disability policy, not originally covered by ERISA, is (not) converted into an ERISA plan merely because a company offers its employees unrelated health insurance coverage"]; *In re Watson* (9th Cir. 1998) 161 F.3d 593, 596, n. 4 ["Even if the plans were created simultaneously or shared other common characteristics, they are independent plans under ERISA."]; *Slamen v. Paul Revere Life Insurance Co.* (11th Cir. 1999) 166 F.3d 1102 ["Non-ERISA benefits do not fall within ERISA's reach merely because they are included in a multibenefit plan along with ERISA benefits"]; *Rand v. The Equitable Life Assur. Society of the U.S.* (E.D.N.Y. 1999) 49 F.Supp.2d 111 ["The plaintiff's disability insurance policies, which are not covered by ERISA, are not converted into an ERISA plan merely because the plaintiff's employees received unrelated health insurance"].

[20] *Waks v. Empire Blue Cross/Blue Shield* (9th Cir. 2001) 263 F.3d 872, 877.

IV. BAD FAITH FACTORS

Once you have decided to accept the case, your first step will be to file a detailed, fact-intensive complaint. It is essential that you have a firm grasp on all aspects of the implied covenant of good faith and fair dealing, and that you weave the insurer's breaches of that covenant into your complaint.

The implied covenant of good faith and fair dealing includes the duty to:

- **Advise** the insured of all coverages, time limits and other policy provisions that may apply to his claim;[21]

- **Thoroughly investigate** the insured's claim, and to "fully inquire into all possible bases that might *support* the insured's claim";[22]

- **Objectively evaluate** the insured's claim,[23] and to "give at least as much consideration to [the insured's] interests as it does to its own";[24]

- **Promptly investigate** the insured's claim;[25]

- **Timely respond** to the insured's inquiries and otherwise **communicate** with the insured;[26]

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[21] "Every insurer shall disclose to a first party claimant all benefits, coverages, time limits or other provisions that may apply to the claim." Cal. Code Regs., tit. 10, § 2695.4(a). See also *Davis v. Blue Cross of Cal.* (1979) 25 Cal.3d 418, 427-28, 158 Cal.Rptr. 828; *Sarchett v. Blue Shield of Cal.* (1987) 43 Cal.3d 1, 15, 233 Cal.Rptr. 76.

[22] *Egan v. Mutual of Omaha Ins. Co*. (1979) 24 Cal.3d 809, 819, 169 Cal.Rptr. 691; *Mariscal v. Old Republic Ins. Co.* (1996) 42 Cal.App.4th 1617, 1623-24, 50 Cal.Rptr.2d 224 ["insurance company may not *ignore evidence which supports coverage*" or "just *focus on those facts which justify denial* of the claim"]. See also *Ward v. Allstate Ins. Co.* (C.D. Cal. 1997) 964 F.Supp. 307, 312-13; *Betts v. Allstate Ins. Co.* (1984)154 Cal.App.3d 688, 707, 201 Cal.Rptr. 528.

[23] *Hughes v. Blue Cross of N. Cal.* (1989) 215 Cal.App.3d 832, 845-46, 263 Cal.Rptr. 850; *Blake v. Aetna Life Ins. Co.* (1979) 99 Cal.App.3d 901, 924, 160 Cal.Rptr. 528.

[24] *Gruenberg v. Aetna Ins. Co.* (1973) 9 Cal.3d 566, 575, 108 Cal.Rptr. 480.

[25] California Insurance Code § 790.03(h)(3) requires *"prompt investigation and processing of claims"* by insurers. In fact, an insurer's delay in investigating a claim constitutes bad faith even if there is no coverage. *Murray v. State Farm Fire and Cas. Co.* (1990) 219 Cal.App.3d 58, 65, fn. 5, 268 Cal.Rptr. 33. See also *Pray v. Foremost Ins. Co.* (9th Cir. 1985) 767 F.2d 1329, 1330 [an insurer has "the duty *actively* to investigate . . . a claim"].

[26] *Delgado v. Heritage Life Ins. Co.* (1984) 157 Cal.App.3d 262, 278, 203 Cal.Rptr. 672.

- **Contact** and speak with the insured's treating physicians;[27]

- Refrain from **misrepresenting** what is covered under the policy[28] or committing other **fraudulent claims practices**"[29] or "**oppressive conduct** . . . seeking to reduce the amounts legitimately payable"[30] under the policy;

- **Pay benefits** due and owing under the policy;[31]

- **Timely pay benefits** due under the policy;[32]

- **Fully pay benefits** owed under the policy,[33] particularly that portion of a claim which is **not disputed** by the insurer;[34]

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[27] *Egan v. Mutual of Omaha Ins. Co.* (1979) 24 Cal.3d 809, 819, 169 Cal.Rptr. 691; *Mariscal v. Old Republic Ins. Co.* (1996) 42 Cal.App.4th 1617, 1624-25, 50 Cal. Rptr. 2d 224.

[28] *Delos v. Farmers Ins. Group* (1979) 93 Cal.App.3d 642, 664, 155 Cal.Rptr. 843.

[29] *Moore v. American United Life Ins. Co.* (1984) 150 Cal.App.3d 610, 626, 197 Cal.Rptr. 878.

[30] *Love v. Fire Ins. Exch.* (1990) 221 Cal.App.3d 1136, 1153, 271 Cal.Rptr. 246.

[31] *Gruenberg v. Aetna Life Ins. Co.* (1973) 9 Cal.3d 566, 574, 108 Cal.Rptr. 480; *Neal v. Farmers Ins. Exch.* (1978) 21 Cal.3d 910, 920, 148 Cal.Rptr. 389; *McLaughlin v. Connecticut Gen. Life Ins. Co.* (N.D. Cal. 1983) 565 F.Supp. 434; *Christian v. American Home Assur. Co.* (Okla. 1977) 577 P.2d 899, 904.

[32] *McCormick v. Sentinel Life Ins. Co.* (1984) 153 Cal.App.3d 1030, 1035, 1050-51, 200 Cal.Rptr. 732; *Richardson v. Employers Liability Assur. Corp.* (1972) 25 Cal.App.3d 232, 239, 102 Cal.Rptr. 547; *Waller v. Truck Ins. Exch.* (1995) 11 Cal.4th 1, 36; 44 Cal.Rptr.2d 370; *Fleming v. Safeco Ins. Co.* (1984) 160 Cal.App.3d 31, 37, 206 Cal.Rptr. 313; *Love v. Fire Ins. Exch.* (1990) 221 Cal.App.3d 1136, 1153, 271 Cal.Rptr. 246; *Dalrymple v. USAA* (1995) 40 Cal.App.4th 497, 514-15, 46 Cal.Rptr.2d 845.

[33] *Egan v. Mutual of Omaha Ins. Co.* (1979) 24 Cal.3d 809, 169 Cal.Rptr. 691; *Neal v. Farmers Ins. Exch.* (1978) 21 Cal.3d 910, 148 Cal.Rptr. 389.

[34] Pursuant to Title 10 of the California Code of Regulations, § 2695.7(h), "[u]pon acceptance of the claim . . . , every insurer . . . shall immediately, but in no event more than thirty (30) calendar days later, *tender payment of the amount of the claim which has been determined and is not disputed by the* insured." Section 2695.7(b) adds that "[u]pon receiving proof of claim, every insurer . . . shall immediately, but in no event more than forty (40) calendar days later, accept or deny the claim, in whole *or in part*." See also *Neal v. Farmers Ins. Exch.* (1978) 21 Cal.3d 910, 920, 921, 148 Cal. Rptr. 389; *Richardson v. Employers Liability Assur. Corp.* (1972) 25 Cal.App.3d 232, 239, 102 Cal.Rptr. 547; *Mission Ins. Group, Inc. v. Merco Constr. Eng'r* (1983) 147 Cal.App.3d 1059, 1066-68, 195 Cal.Rptr. 781.

- **Promptly settle** claims where liability has become reasonably clear;[35]

- Refrain from making **lowball settlement offers**;[36]

- Reserve rights only when it has a **good faith belief** in the existence of the rights asserted;[37]

- Institute declaratory relief or other litigation against its insured only where it has a **reasonable** basis for doing so;[38]

- Refrain from construing a disability policy term in a more **restrictive** manner than the accepted legal definition;[39] and

- Refrain from imposing **additional preconditions to coverage** beyond those set forth in the policy.[40]

In addition to numerous takeovers and mergers, more and more insurers are entering into Administration/Servicing Agreements, Marketing Agreements and Coinsurance Agreements with respect to their disability blocks of business. Thus, it is important to name all possible defendants – not just the insurer who issued the disability policy – as non-issuing insurers can be liable for breach of contract and bad faith. In spite of the

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[35] California Insurance Code § 790.03(h)(5) requires an insurer to "attempt[ ] in good faith to effectuate *prompt*, fair and equitable settlement of [a] claim[ ] in which liability has become reasonably clear," while Title 10 of the California Code of Regulations, § 2695.7(b) imposes an even higher standard, providing that '[u]pon receiving proof of claim, every insurer . . . shall immediately, but in no event more than *forty (40) calendar days* later, accept or deny the claim, in whole or in part." See also *Pray v. Foremost Ins. Co.* (9th Cir. 1985) 767 F.2d 1329, 1330 [an insurer has "the duty *actively* to . . . attempt to settle a claim by making . . . [a] reasonable settlement offer"].

[36] Title 10 of the California Code of Regulations, § 2695.7(g) provides that "[n]o insurer shall attempt to settle a claim by *making a settlement offer that is unreasonably low*." California Insurance Code § 790.03(h)(5) adds that an insurer must "attempt[ ] in good faith to effectuate prompt, *fair* and *equitable* settlement of [a] claim[ ] in which liability has become reasonably clear."

[37] *Fletcher v. Western Nat'l Life Ins. Co.* (1970) 10 Cal.App.3d 376, 395, 89 Cal.Rptr. 78; *Sprague v. Equifax, Inc.* (1985) 166 Cal.App.3d 1012, 1032, 213 Cal.Rptr. 69.

[38] *Kelly v. Farmers Ins. Exch.* (1987) 194 Cal.App.3d 1, 239 Cal.Rptr. 259; *Dalrymple v. USAA* (1995) 40 Cal.App.4th 497, 513-15, 46 Cal.Rptr.2d 845.

[39] *Moore v. American United Life Ins. Co.* (1984) 150 Cal.App.3d 610, 626, 197 Cal.Rptr. 878.

[40] *Mission Ins. Group, Inc. v. Merco Constr. Eng'r* (1983) 147 Cal.App.3d 1059, 1066-68, 195 Cal.Rptr. 781.

general rule that claim administrators cannot be held liable for breach of a contract to which they are not a party,[41] non-issuing insurers can be liable as members of a joint venture based on "a community of interest in the business of claims administration," including claim liability and a sharing in the profits and losses.[42] Non-issuing insurers can also be held liable on an alter ego theory where there is a "unity of interest" negating corporate separateness and "inequitable results" will follow if the corporate separateness is respected.[43]

And it is important to consider the possibility of naming defendants other than the insurance companies (especially if you are trying to defeat federal diversity jurisdiction). Potential defendants include the agent who procured the policy for the insured,[44] the insurer's claim investigator,[45] the physician retained by the insurer to perform an "independent" medical examination of the insured,[46] and the insurer's claim adjusting agency.[47] The theories of recovery against those defendants may include conspiracy to defraud,[48] intentional infliction of emotional distress,[49] misrepresentation of coverage,[50] and/or professional negligence.[51]

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[41] *Gruenberg v. Aetna Life Ins. Co.* (1973) 9 Cal.3d 566, 576; *Filippo Indus., Inc. v. Sun Ins. Co.* (1999) 74 Cal.App.4th 1429, 1443.

[42] *Forest v. The Equitable Life Assur. Soc'y,* 2001 WL 1338809, *7-8 (N.D. Cal.). See also *Delos v. Farmers Ins. Group* (1979) 93 Cal.App.3d 642, 652; *Gatecliff v. Great Republic Life Ins. Co.* (Ariz. 1991) 821 P.2d 725; *Wolf v. Prudential Ins. Co.* (10th Cir. 1995) 50 F.3d 793; *Farr v. Transamerica Occidental Life Ins. Co.* (Ariz. App. 1984) 699 P.2d 376; *Albert H. Wohlers and Co. v. Bartgis* (Nev. 1998) 969 P.2d 949; William M. Shernoff, et al., *Insurance Bad Faith Litigation* § 2.03[1], p. 11 (2001 supp.).

[43] *Tomaselli v. Transamerica Ins. Co.* (1994) 25 Cal.App.4th 1269, 1285; *Sonora Diamond Corp. v. Superior Court* (2000) 83 Cal.App.4th 523, 538-39. But see *Wady v. Provident Life and Accident Ins. Co.*, 2002 WL 988557 (C.D. Cal.); *Forest v. The Equitable Life Assur. Soc'y* 2001 WL 1338809 at *9-10 (N.D. Cal.).

[44] *Westrick v. State Farm Ins.* (1982) 137 Cal.App.3d 685, 187 Cal.Rptr. 214; *Free v. Republic Ins. Co.* (1992) 8 Cal.App.4th 1726, 11 Cal.Rptr.2d 296; *Clement v. Smith* (1993) 16 Cal.App.4th 39, 19 Cal.Rptr.2d 676.

[45] *Sprague v. Equifax, Inc.* (1985) 166 Cal.App.3d 1012, 213 Cal.Rptr. 69.

[46] *Younan v. Equifax, Inc.* (1980) 111 Cal.App.3d 498, 169 Cal.Rptr. 478.

[47] *Id.* See also *Sprague v. Equifax, Inc.* (1985) 166 Cal.App.3d 1012, 213 Cal.Rptr. 69; *Hernandez v. General Adjustment Bureau* (1988) 199 Cal.App.3d 999, 245 Cal.Rptr. 288.

[48] See *Sprague v. Equifax, Inc.* (1985) 166 Cal.App.3d 1012, 213 Cal.Rptr. 69; *Younan v. Equifax, Inc.* (1980) 111 Cal.App.3d 498, 169 Cal.Rptr. 478.

[49] *Hernandez v. General Adjustment Bureau* (1988) 199 Cal.App.3d 999, 245 Cal.Rptr. 288. See also *Younan v. Equifax, Inc.* (1980) 111 Cal.App.3d 498, 169 Cal.Rptr. 478; *Sprague v. Equifax, Inc.* (1985) 166 Cal.App.3d 1012, 213 Cal.Rptr. 69.

[50] See *Clement v. Smith* (1993) 16 Cal.App.4th 39, 19 Cal.Rptr.2d 676.

[51] See *Westrick v. State Farm Ins.* (1982) 137 Cal.App.3d 685, 187 Cal.Rptr. 214; *Free v. Republic Ins. Co.* (1992) 8 Cal.App.4th 1726, 11 Cal.Rptr.2d 296.

V. DEPOSING KEY INSURANCE COMPANY PERSONNEL

After filing a detailed, fact-intensive complaint, your next step will be to develop a comprehensive discovery plan. Your discovery should be designed to corroborate your client's story, document the insurer's delay, denial and bad faith, bolster your client's chances of recovering punitive damages, and otherwise prepare the case for trial.

Generally, the documents you should request from the insurance company include (1) the insurer's complete claim file (local, regional and home office), including all documents regarding the processing, payment and/or denial of your client's claim; (2) medical reports; (3) investigative reports; (4) photographs and videos; (5) underwriting manuals; (6) claim manuals, including additions, deletions and other revisions from previous versions; (7) other materials used to train adjusters; (8) advertising and marketing materials concerning the policy purchased by your client; and (9) training materials and other documents sent to independent agents to teach them how to advertise, promote and sell the policy bought by your client.

You will then want to depose key insurance company personnel. Consider deposing not only the handling claims adjuster, but also his supervisor, claims managers, and corporate executives. You also should consider taking the deposition of the insurer's "persons most knowledgeable" (PMK) regarding areas specified in your deposition notice. For example, you may want to notice PMK depositions concerning the company hierarchy, authentication of documents, training of adjusters, investigation of plaintiff's claim, denial of plaintiff's claim, and/or company-wide practices. The major advantage of PMK depositions is that they keep you from floundering around trying to ascertain which executives in the corporate hierarchy should be deposed.

You will want to ask the insurer representative about his education, employment history, and training (initial classroom training, claim manuals, seminar updates, etc.). In addition, you will need to examine him regarding his duties and responsibilities. For example, have him testify concerning his duties as they were prescribed by his superiors, claim manuals, and/or company memoranda. Also, have the deponent testify regarding his understanding of what key policy terms mean.

At the same time, try to weave in the law (statutes, insurance regulations and cases) regarding an insurer's duties. Also, get the deponent to commit to his understanding of an insurer's duties, including the implied covenant of good faith and fair dealing. Get him to admit that the implied duty is part of the insurance contract. Ask the deponent to agree that the implied covenant of good faith and fair dealing includes the duty to thoroughly and objectively investigate claims, timely respond to inquiries, and promptly settle claims where liability is reasonably clear.

Of course, you also will need to examine the insurer representative regarding the handling of your client's claim. For example, did he follow the insurer's claim manual and other company guidelines, policies and procedures concerning investigation, payment, denial and other claim handling? Was help available, as he felt it necessary? Was he free to consult as needed with a claim committee, a medical advisor, in-house counsel and/or outside counsel? And how did he interact with his superiors? Whom did he report to regarding the file? What was his supervisor's role in the handling of the file? Also, has he ever been reprimanded concerning his handling of your client's file? Did it ever come up in any annual or semi-annual performance reviews?

Consider taking the deposition Monday morning, to increase the likelihood that any deposition preparation will be stale (because it was done the previous Friday) or short (because it was done early Monday morning). And try not to let the deponent get too comfortable. Instead of easing into the deposition with background inquiries (education, prior employment, etc.), consider starting off with the tough questions. If you spend the entire morning on easy background material, the deponent's counsel can do further preparation during the lunch break for the meatier inquiries.

Also, try to go to the insurer's home office to take your depositions, especially of senior executives. And be sure to videotape the depositions. Videotaping will help curb overzealous defense attorneys who interject excessive objections, overly coach the deponents, or take too many breaks. It also tends to reduce the number of "I don't know," "I'm not sure," and "I can't recall" answers given by deponents. And a videotaped deposition can be an effective forum for making the insurer aware of any "smoking gun" documents you may have discovered.

VI. AVOIDING THE "GENUINE ISSUE" QUICKSAND

It is inevitable that the insurer will file a motion for summary judgment seeking dismissal of your bad faith and punitive damages claims. And based on the recent decisions in *Chateau Chamberay Homeowners Ass'n v. Associated International Ins. Co.*, 90 Cal. App. 4th 335, 108 Cal. Rptr. 2d 776 (2001), and *Guebara v. Allstate Ins. Co.*, 237 F.3d 987 (9th Cir. 2001), which extended the "genuine issue" doctrine to factual disputes, it is virtually certain that the insurer will assert the "genuine issue" defense. The insurer's position will be that, because there was supposedly a "genuine" issue about the validity of the claim, its failure to pay benefits was reasonable (i.e., no bad faith), as a matter of law. If not read carefully, *Chateau Chamberay* and *Guebara* suggest that an insurer can insulate itself from bad-faith liability simply by relying on the opinions of experts. However, a close reading of these cases makes it clear that an insurer is entitled to summary judgment in a bad-faith case only when: (1) there are ***no*** factual disputes, (2) the insurer relied on the opinions of ***independent experts***, and (3) the insurer did not conduct a ***biased investigation*** (i.e., no bad faith).

In *Guebara*, the Ninth Circuit made it clear that the "genuine issue" doctrine does not alter the historic obligation of an insurer to conduct a fair and unbiased investigation. More importantly, the court made it clear that the "genuine issue" doctrine does not provide a "safe harbor" for an insurer who relies on its paid-for expert in connection with an otherwise "biased investigation":

> Our decision does ***not*** eliminate bad faith claims based on an insurer's allegedly biased investigation. ***Expert testimony does not automatically insulate insurers from bad faith claims based on biased investigations***. Although this list is not exhaustive, we can think of several circumstances where biased investigation claims could go to a jury: (1) the insurer is guilty of misrepresenting the nature of the investigatory proceedings [citation omitted]; (2) the insurer's employees lie during the depositions or to the insured; (3) the insurer dishonestly selected its experts; (4) the insurer's experts were unreasonable; and (5) the insurer failed to conduct a thorough investigation.[52]

Moreover, the court rejected a rigid application of the "genuine issue" doctrine. Refusing to establish a bright-line rule, the court held that "the genuine dispute doctrine should be applied on a case-by-case basis. ***In some cases, the application of the rule to purely factual disputes will be inappropriate***."[53] In affirming the district court's grant of summary judgment based on the "genuine issue" doctrine, the Ninth Circuit pointed to "the insurer's ***three independent experts***" and inconsistencies between the insured's contents list and the experts' investigation.[54]

Chateau Chamberay, authored by Justice Croskey, was the first California decision to give the "genuine issue" doctrine a hard look. In *Chateau Chamberay*, another property-loss case, the insured's claim seemed grossly inflated in light of the appraisal award, which was only 45% of the original claim, and the carrier had paid 80% of that amount before the suit was filed.[55] In affirming summary judgment, the court found "no dispute as to the underlying facts" and the insured did not offer any factual support for its contention that the insurer acted unreasonably in adjusting the claim.[56]

Chateau Chamberay confirmed that the "genuine issue" doctrine must be applied in a discriminating manner on a *case-by-case* basis[57] and emphasized that the true focus in applying the doctrine is whether the dispute is, in fact, "genuine":

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[52] *Guebara v. Allstate Ins. Co.* (9th Cir. 2001) 237 F.3d 987, 996 (emphasis added).
[53] *Id.* at 994 (emphasis added).
[54] *Id.* at 996 (emphasis added).
[55] *Chateau Chamberay Homeowners Ass'n v. Associated Int'l Ins. Co.* (2001) 90 Cal. App.4th 335, 350, 108 Cal.Rptr.2d 776.
[56] *Id.* at 340 fn.1.
[57] *Id.* at 348.

> Provided there is no dispute as to the *underlying facts* (e.g., what the parties did and said), then the trial court can determine, *as a matter of law*, whether such dispute is "genuine." In making that decision, the court does not decide which party is "right" as to the disputed matter, but only that a ***reasonable*** and ***legitimate*** dispute ***actually*** existed.[58]

Notably, Justice Crosky cited *Guebara's* illustrative examples of "biased investigations" and stated that such cases "*should* go to the jury," cautioning that "an expert's testimony will not *automatically* insulate an insurer from a bad faith claim."[59] As further clarification, the court stated that an insurer may not "insulate itself from liability for bad faith conduct by the simple expedient of hiring an expert for the purpose of manufacturing a 'genuine dispute.'"[60]

A cursory read of *Chateau Chamberay* appears to make summary judgment easier for insurers to obtain, a closer look reveals the "bad facts" and the important qualifying language of this case. First, the insured did not dispute any of the facts set forth in the insurer's motion and the insured did not offer any factual support for its contention that the insurer acted unreasonably in adjusting the claim.[61] Second, the court held that its decision did not mean "that the genuine dispute doctrine may properly be applied in every case involving purely a factual dispute between an insurer and its insured."[62] The court added that a trial court could find a dispute to be "genuine" only when there is no disagreement over the underlying facts.[63] And the court echoed the Ninth Circuit's holding in *Guebara* that whether or not the doctrine may be applied to a factual dispute should be decided on a case-by-case basis.[64] Finally, the courts in both *Chateau Chamberay* and *Guebara* reviewed the entire record to determine whether the insurer in each case acted reasonably and with proper cause.

While *Chateau Chamberay* and *Guebara* are both property-loss cases, the Ninth Circuit recently addressed the "genuine issue" doctrine for the first time in the context of a disability insurance claim. In *Amadeo v. Principal Mutual Life Insurance Co.*,[65] the insurer had issued an "own occupation" disability insurance policy to Amadeo, who had a 20-year career in the securities industry. Amadeo became psychiatrically disabled, stopped working, and then submitted a claim to her insurer. The insurance company denied her benefits on the grounds that she was unemployed at the time she filed her claim, and therefore her occupation at the time of disability was "unemployed person."

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[58] *Id.* at 348 n.7 (emphasis original in part and added in part).
[59] *Id.* at 348 (emphasis in original).
[60] *Id.* at 349 n.8.
[61] *Id.* at 340 n.1.
[62] *Id.* at 348.
[63] *Id.* at 348 n.7.
[64] *Id.* at 348.
[65] *Amadeo v. Principal Mutual Life Ins. Co.* (9th Cir. 2001) 290 F.3d 1152.

The company justified its denial because Amadeo was not permanently disabled from her occupation as an "unemployed person."

The District Court granted summary adjudication on Amadeo's bad faith and punitive damages claim based on the "genuine issue" doctrine. The Ninth Circuit reversed and determined there was sufficient evidence from which a jury could conclude that the carrier acted in bad faith by denying the claim. As the court explained, "[a]n insurer cannot escape bad faith liability by adopting an interpretation of its policy grounded only in the subjective perceptions of its unguided claims adjusters. Arbitrary interpretation of insurance contracts is the antithesis of the reasonable dealing required by the covenant of good faith."[66] The court focused on the insurer's investigation and confirmed that the "genuine issue" doctrine does not apply where the insurer failed to conduct an adequate investigation. The court found there was "sufficient evidence from which a jury could find that [the insurer] lacked any legitimate reason for denying [the] claim."[67] Accordingly, "a jury could conclude that [the insurer's] denial of [disability] benefits to [the insured] was based on a bad faith interpretation of its policy and an inadequate investigation into the basis of [the insured's] claim."[68]

In *Amadeo*, the Ninth Circuit concisely set forth how the "genuine issue" doctrine works in the context of a motion for summary judgment:

> The genuine issue rule . . . allows a district court to grant summary judgment when it is undisputed or indisputable that the basis for the insurer's denial of benefits was reasonable – for example, where even under the plaintiff's version of the facts there is a genuine issue as to the insurer's liability under California law. . . . On the other hand, an insurer is not entitled to judgment as a matter of law where, viewing the facts in the light most favorable to the plaintiff, a jury could conclude that the insurer acted unreasonably."[69]

Thus, under the Ninth Circuit's recent characterization, the "genuine issue" doctrine only applies when (1) the facts are undisputed or indisputable, and (2) the insurer's denial of benefits was reasonable. In sum, if the insurer acts unreasonably or any material facts are in dispute, the doctrine does not apply.

Amadeo also revisited the reasons the California Supreme Court has allowed tort remedies, including punitive damages, against insurers who deny disability claims in bad faith. As the court explained:

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[66] *Id.* at 1163.
[67] *Id.* at 1164.
[68] *Id.* at 1156.
[69] *Id.* at 1161-62 (citations omitted).

> The availability of punitive damages . . . is compatible with recognition of insurers' underlying public obligations and reflects an attempt to restore balance in the contractual relationship. ***These considerations are particularly acute in disability insurance cases where the very risks insured against presuppose that if and when a claim is made, the insured will be disabled and in strait financial circumstances and, therefore, particularly vulnerable to oppressive tactics on the part of an economically powerful entity***. Punitive damages are therefore made available to discourage the perpetuation of objectionable corporate policies that breach the public's trust and sacrifice the interests of the vulnerable for commercial gain. Consistent with this goal, a plaintiff may meet the state of mind requirement for an award of punitive damages by showing that the insurer's bad faith was part of a conscious course of conduct, firmly grounded in established company policy.[70]

The court reversed the grant of summary judgment against the insured on her claim for punitive damages, reasoning that there was sufficient evidence to show that the denial of the insured's claim "was not simply the unfortunate result of poor judgment, but rather resulted from [the insurer's] plainly unreasonable interpretation of its policy and the deliberate restriction of its investigation in a bad faith attempt to deny benefits due to [the insured]. Thus a jury might conclude that [the insurer's] actions were willful and rooted in established company practice."[71]

More recently, in *Hubka v. Paul Revere Life Insurance Co.*,[72] a disability insurer invoked the "genuine issue" doctrine in an attempt to defeat the insured's bad faith and punitive damages claim. *Hubka* involved a hands-on treating chiropractor who filed a total disability claim under his "own occupation" policy. The insured's treating physicians concluded that he was disabled, the independent medical examination ("IME") was, at best, inconclusive for the insurer, and the insurer's in-house doctor concluded that the insured was not totally disabled from his occupation as a chiropractor. The insurer relied on the opinion of its in-house medical consultant to deny the claim.

Relying on *Amadeo*, the district court denied the insurer's motion for summary judgment as to the bad faith claim, determining that "a reasonable juror could . . . conclude that [the insurer] was unreasonable in terminating benefits, because: (i) the company never followed the recommendation of the IME to have an independent chiropractic exam; (ii) the only treating chiropractor determined that Plaintiff was totally disabled; and (iii) [the insurer's in-house doctor] made his contrary findings with no examination of Plaintiff and no knowledge of the physical demands of the job on a chiropractor."[73] The court also denied the insurer's motion for summary judgment as to punitive damages because

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[70] *Id.* at 1164-65 (citations omitted) (emphasis added).
[71] *Id.* at 1165 (citations omitted).
[72] *Hubka v. Paul Revere Life Ins. Co.* (S.D. Cal. 2002) 215 F.Supp.2d 1089.
[73] *Id.* at 1094.

there was "evidence that a reasonable juror could conclude that [the insurer] used [its in-house doctor's] opinion as a pretext to end disability payments, contrary to the weight of the medical evidence . . . . Such conduct could reasonably be construed as a 'conscious disregard of the plaintiff's rights.'"[74]

Accordingly, close scrutiny of recent "genuine issue" case law renders the doctrine not so much a defense to a bad-faith claim as a reaffirmation of the implied covenant of good faith and fair dealing and what an insurer must do to comply with it. That is, if an insurer's asserted facts regarding the claim are *indisputable,* if the insurer relied on the opinion of an *independent expert,* if the insurer conducted a *thorough investigation* into the insured's claim, if the insurer and its employees remain *honest* to their insureds regarding the investigation and during litigation, then and only then, can the insurer rely on the "genuine issue" defense. But if any of these elements are missing, then the "genuine issue" defense does not apply.

VII. OVERCOMING THE NOT SO "INDEPENDENT" MEDICAL EXAM

Disability insurers frequently require their claimants to undergo independent medical examinations. In reality, though, they should be called "*defense*" medical examinations, as the doctor is retained and paid by the insurer with one goal in mind: finding the insured *not* disabled. Indeed, it is virtually a foregone conclusion that the carrier's "independent" medical examiner will conclude that your client is not disabled. When the inevitable happens, there are numerous arguments you can make to attack the doctor and his findings. Here are a few examples:

- The doctor has a bias in favor of *insurers generally.* If you're lucky, the vast majority of his practice is devoted to performing "independent" medical examinations for which he is paid by insurers. And those insurers typically get what they paid for, as the doctor finds that the claimant is not disabled virtually every time.

- The doctor is biased in favor of *this particular insurer*. Your client's insurer paid the doctor thousands of dollars to perform the "independent" medical examination, with the obvious expectation that he would come back with a finding of non-disability. And the doctor has performed many "independent" medical examinations for this insurer in the past (to his considerable profit), and certainly hopes that the insurer will continue to retain him in the future. The easiest way to ensure referrals in the future is to give the insurer an opinion that will save it money now.

- The doctor performs "independent" medical examinations, including your client's, for *his* financial gain. Due to the restrictions of managed care, the doctor

[74] *Id.*

is earning far less money in his practice than he once did. It is much more lucrative for him to perform IMEs, at about $5,000 per exam, than to actually practice medicine, especially if he has a volume IME practice. (This can be a particularly effective counterattack if the insurer has taken the position that your client is pursuing his claim for *his* financial gain.)

- It isn't the *insured* who has made a choice to stop working and collect disability benefits. Rather, it's the *doctor* who has made a choice – the choice to sell out to high-paying insurance companies (by discrediting claimants with genuine disabilities) instead of helping patients. (This can be a particularly effect counterattack if the insurer is asserting that the *insured* made the choice to abandon his career.)

- The doctor isn't *qualified* to render an opinion regarding the insured's condition. He is hardly seeing patients anymore, and does not keep current on the *practice* of medicine. Instead, the bulk of his time is devoted to performing "independent" medical examinations for insurance companies. And on those occasions when he does practice medicine, it is outside the medical area relevant to the insured's condition.

- The doctor *ignored objective evidence* of the insured's disability, including X-rays, MRIs, CT scans, discograms, and attending physicians' statements.

- The doctor's opinion was based on *incomplete/stale medical records*, which makes his opinion suspect at best.

You should also depose the examining doctor. During his deposition, get him to acknowledge and confirm the existence of your client's injury/sickness that is causing the disability. You can use the examining doctor to bolster your client's credibility, believability and veracity. You can also use the examining doctor to establish that your client's treating physicians are trusted and respected, and that they treated the insured appropriately and within the standard of care.

In addition, you may want to hire your *own* investigator to help you neutralize the insurer's "independent" doctor and his findings. Your investigator can look for prior malpractice actions against the doctor, Medical Board or license problems, or even disability claims filed by the doctor. The investigator can also search for other cases in which the doctor has testified, during depositions and/or trial, and thereby help you establish that the doctor is biased in favor of insurance companies or has taken a position in other cases that is inconsistent with the one he is advocating in your client's suit.

And while you're attacking the doctor, don't forget the insurer that retained him. If the insurer breached its duty to provide the policy definition of "disability" to the independent medical examiner it utilized to review the insured's claim, that failure should

be highlighted.[75] And if the insurer denied your client's claim without even having him undergo an independent medical examination, you should argue that an insurer has a duty to conduct such an examination before deciding whether its insured is entitled to disability benefits.[76]

VIII. EFFECTIVE TRIAL STRATEGIES

Of course, all of the above – the careful screening of potential clients, the skillful pleading, the tenacious discovery, the aggressive motion practice – will have been for naught if the jury isn't excited about your case. You must come across as credible, competent and caring – you must be sincere, fully prepared and devoted to your client, with an absolute belief in his case. You must also be courteous, following court rules and etiquette, and confident, showing your knowledge of the law in your opening, examination of witnesses and closing.

In order to get (and keep) the jury's attention, you should open with a moral grabber, explain the terms and concepts of bad faith, and undermine the other side. Your goal is to show the jury why you are right and the insurance company is wrong. You must empower the jury to do the right thing and find that not only did the insurer act in bad faith, but it did so with malice, oppression or fraud such that punitive damages are warranted.

A. SETTING THE BAD FAITH TABLE

You must convey to the jury that a mere finding of breach of contract will not fix the problem. There is no penalty in a breach of contract case for the insurer's bad, unfounded, mean, vile, loathsome or despicable denial of benefits. Explain to the jury that, just like in a robbery case, returning the money years after the holdup is of no consequence. Bad faith, on the other hand, levels the playing field by motivating the insurer to act fairly, honestly and pay all legitimate claim on time, every time, or face damages above and beyond the contract benefits. Accordingly, you must lay out the insurer's bad faith conduct so that the jury feels compelled to award extracontractual and punitive damages.

You may be able to set the jury's bad faith compass by tallying up the insurer's broken promises (including statutory and "bad faith" violations), by highlighting the wrongful withholding and unreasonable denial of benefits, by underscoring what the insured had to sell and/or give up to make due, by focusing on the mental agony, shame, worry,

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[75] *Moore American United Life Ins. Co.* (1984) 150 Cal.App.3d 610, 618, 637-38, 197 Cal.Rptr. 878.

[76] *Monroe v. Pacific Telesis Group Comprehensive Disability Benefits Plan* (C.D. Cal. 1997) 971 F.Supp. 1310, 1316; *Russell v. UNUM Life Ins. Co.* (D.C. S.C. 1999) 40 F.Supp.2d 747, 751.

frustration, anxiety and personal despair the insured and his family suffered due to the insurer's unreasonable and despicable conduct, and by showing a pattern and practice of such conduct – this is NOT the first time the insurer has acted this way and it won't be the last UNLESS the jury sends a message that such conduct cannot be condoned.

Remind the jury that we are not here for a windfall or jackpot justice. Rather, we are here to teach the insurer accountability and to fix a debt owed to the insured and his family. Explain to the jury that in your state, we punish corporate welchers by giving them a good dose of punitive damage therapy – it cleanses the corporate soul and is good for the economy.

B. EXPERT CONSIDERATIONS

Remember, when it comes to experts credentials can be ignored when jurors are not presented with guidelines on how to evaluate your experts. Be sure you lay a proper foundation by asking your experts the following:

- What exactly is your area of expertise in offering an opinion in this case?
- Look through your CV and tell us what specifically qualifies you to offer your opinion in this case.
- Does that experience generally qualify you or specifically qualify you?
- How is your experience different from "Dr. Flunky?"
- What materials did you review in coming to your opinion?
- Explain your analysis.
- What were your conclusions?
- How do you know you are right?
- How did you know the other expert is wrong?

C. TRIAL THEMES THAT "SING"

From voir dire to opening statement to witness examination to closing argument, you *must* have a consistent, inspiring theme that will continue to resonate in the jurors' minds while they are deliberating – and hopefully, calculating damages – in the jury room. Only if you have raised and reinforced a powerful theme will the jury be compelled to award a substantial verdict to your client.

Here are some possible themes for you to consider:

- **A deal is a deal**. An insurer, like any person, should keep the promises it made. Here, instead of accepting responsibility and owning up to its commitments, the insurer welched on its word.

- **This is a story of *betrayal***. The insured paid hard-earned money for what he trusted would be protection, peace of mind and security. The insurance company betrayed that trust by delaying, then denying, the insured's claim.

- **The insurance company went trolling, and the plaintiff took the bait**. Through newspapers, radio, television, mailings, and agents' presentations, the insurer touted its age-old experience ("been around since the midnight ride of Paul Revere") and dependability, extolled the features, advantages and benefits of its policy, and promised that it would be there if the plaintiff ever needed help – and the plaintiff was hooked. But when the plaintiff became injured or sick, the insurer tossed him back into the ocean and let him fall to the very bottom of his life – and, in the process, wholly disregarded its sales promises. It was advertising and marketing *fraud*, plain and simple.

- **This is a classic example of the two faces of Eve**. On the *sales* side, the insurer is all warm, fuzzy and reassuring, promising peace of mind and security. But when an insured, after faithfully paying premiums for years, has the audacity to actually make a *claim*, the dark side of Eve rears her ugly head. In the claim zone, it's cold, the insured is swimming upstream, and the water is plenty deep. The insured has moved from the asset side of the insurer's ledger to the liability side, and that's where the promise made becomes the promise broken.

- **This insurance company added insult to the insured's injury or sickness**. It spat on the insured while he was down and out. Just when the insured needed a helping hand out of his hole, the carrier kicked dirt down that hole.

- **This lawsuit was *unnecessary***. It could have been prevented if the insurance company had just kept its word, honored what it sold and followed the rules of the road: Don't lie, don't cheat, don't chisel, don't lowball, and don't delay. Just *do the right thing*: Be honest, pay what you owe, pay it on time, and do it every time.

- **Buying an insurance policy is not like buying a car**. You don't get a chance to try it out before you buy it and take it home. So you have to know that it's going to work when you need it. And if it doesn't perform like the seller assured you it would, that seller should be held fully accountable.

- **You can't change an agreement after it's been mad**e (unless both sides want to change it). So, for example, if a policy doesn't specifically say that the insured is entitled to benefits only if he can "objectify" his disability, the carrier can't rewrite the contract to say that he has to do so. And if the policy doesn't expressly state that the insurance company can require the insured to undergo surgery to alleviate his disability, the insurer cannot condition the continued payment of benefits on such surgery. The insurance company has to live with the policy *as it was written*, because it's the insurer and its lawyers who created the product, designed it, selected the language, chose the definitions, decided what to charge, and happily banked the premiums.

- **Instead of paying benefits when due, the insurance company made the insured jump through a series of unnecessary and duplicative hoops – and then, after the insured did so, the insurer *still* refused to pay**.

- **The insurance company didn't even bother to investigate before it denied coverage**. It knew that if it actually looked at the evidence, it would have to pay money to its insured. So, the insurer kept its head buried in the sand, figuring that what it didn't know couldn't hurt it. *It was wrong*.

- **Instead of looking at the insured's claim with a keen, vigilant eye toward objectively evaluating and paying the claim, the insurance company viewed the claim with a closed – or, at best, patched – eye**.

- **Good faith is good business. Bad faith is bad business – and bad business comes with a price: accountability**.

- **You have the chance to restore to this fine family what their insurance company stole from them: *Their dignity***.

- **Plaintiff is not here looking for a windfall**. He isn't looking for jackpot justice. He is simply here to fix a debt, and to make the insurer *accountable*.

- The insurance company put its corporate economic interests before the interests of its insured and his family. **It chose profit over people**.

- **The benefit payments by this insurance company were not some kind of loan or advance**. They were monies that the insurer owed the insured with no strings attached, and the insured is entitled to *keep* those monies. But here, after the carrier paid the insured benefits it obviously owed under the policy, it turned around and sued the insured to get the money back. In so doing, the insurance company acted like a loan shark with an itchy trigger finger, not an insurer that

promised peace of mind and security. And it treated the insured like some down-and-out borrower, not a policyholder who had faithfully and timely paid premiums to the insurer for years.

- **An insured shouldn't need a map – or a lawyer – to navigate his way around his insurance policy**. But the policy cobbled together by this insurer was, for all practical purposes, unreadable – coverage here, exclusions there, limitations here, preconditions there. And although the exclusion is cited by the insurer in bold capital letters in its moving papers in *court*, in the actual *policy* it was buried in fine print in the middle of the policy under a misleading section heading. It is virtually impossible to find that exclusion, much less decipher its legalese.

- **This is nothing more than "denial for dollars"**. The more the insurance company denies, the more money it gets to keep. It has turned the claim department – its purported "service center" – into a profit center.

- **Punitive damages are good "therapy" for insurers who have deceived** and need reminding that they are in the business of helping people who paid – in advance – for that help if they needed it. Punitive damages are good for the corporate soul. They are a cleansing that will surely bring change.

IX. CONCLUSION

One very important aspect of disability insurance – which must be brought to the attention of both the insurer and the court – is its underlying purpose. Insureds do not seek to obtain a commercial advantage by purchasing coverage. Rather, they seek protection against calamity. Insurers that deny legitimate claims have typically forgotten (or, more likely, chosen to ignore) these basic principles. It is our job to remind them – and to make them pay.