Nos. 01-15145, 01-15246, 01-15307 & 01-15330

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

THOMAS ANDERSON,
Plaintiff - Appellee and Cross-Appellant,

v.

ALLSTATE INSURANCE COMPANY,
Defendant - Appellant and Cross-Appellee.

On Appeal From A Judgment Of The United States District Court
Eastern District of California No. CV-00-907-PAN
The Honorable Peter A. Nowinski, U.S. Magistrate Judge

PROPOSED CORRECTED BRIEF OF AMICUS CURIAE UNITED POLICYHOLDERS IN SUPPORT OF THOMAS ANDERSON, PLAINTIFF - APPELLEE AND CROSS-APPELLANT

Eugene R. Anderson, Esq.
Anderson Kill & Olick, P.C.
1251 Avenue of the Americas
New York, NY 10020
Tel: (212) 278-1751
Fax: (212) 278-1733
Attorneys for Amicus Curiae
United Policyholders

Of Counsel:
Amy Bach, Esq.
Law Offices of Amy Bach
42 Miller Avenue
Mill Valley, CA 94941
Tel: (415) 381-7627
Fax: (415) 381-5572

TABLE OF CONTENTS

PRELIMINARY STATEMENT 1

CORPORATE DISCLOSURE STATEMENT 1

STATEMENT OF RELATED CASES AND PROCEEDINGS 1

INTEREST OF AMICUS CURIAE 1

POINT I. UNREASONING ANTI-POLICYHOLDER BIAS 3

POINT II. CASE CITATIONS ARE NOT FACTS 4

POINT III. CORRUPTION OF THE LEGAL TREATISES 5

POINT IV. THE SCALES OF JUSTICE ARE TIPPED IN FAVOR OF THE TRILLION DOLLAR INDUSTRY 7

POINT V. LAW v. LORE 11

POINT VI. WHAT CONSTITUTES A THOROUGH INVESTIGATION 12

POINT VII. EVERYONE, BUT ALLSTATE IS OUT OF STEP 12

CONCLUSION 13

TABLE OF AUTHORITIES

FEDERAL CASES

Humana Inc. v. Forsyth, 525 U.S. 299 (1999) 2

Miller-Wohl Co., Inc. v. Commissioner of Labor and Industry, 694 F.2d 203 (9th Cir. 1982) 1

STATE CASES

Chateau Chamberay Homeowners Association v. Associated International Insurance Company, 108 Cal.Rptr.2d 776 (Cal.App. 2 Dist. 2001) 11

OTHER AUTHORITIES

Michael A. Berch, Analysis of Arizona's Depublication Rule and Practice, 32 ARIZ. ST. L.J., 175 (Spring 2000) 5

Philip Carrizosa, Making the Law Disappear; Appellate Lawyers Are Learning to Exploit the Supreme Court's Willingness to Depublish Opinions, Cal. Law, 65 (Sept. 1989) 4

Jill E. Fisch, Rewriting History: The Propriety of Eradicating Prior Decisional Law Through Settlement and Vacatur, 76 Cornell L.Rev. 589 (1991) 4

Stacy Gordon, Vanishing Precedents: Policyholders Can Get Better Deal – If Rulings Are Erased, Bus. Ins., 1 (June 15, 1992) 5

R. Long, 3 Law of Liability Insurance, App. 58 (1973) 6

F.J. Maloney, What Constitutes A 'Thorough' Investigation?, Mealey's Litig. Rept.: Ins. Bad Faith, 18 (Nov. 2, 1999) 12

James J. Markham ET AL., The Claims Environment (1st ed. 1998) 7

Roger Parloff, Rigging the Common Law, Am. Law. 74 (Mar. 1992) 5

R. Stern, E. Greggman & S. Shapiro, Supreme Court Practice 70-71 (1986) 1

Peter Nash Swisher, Judicial Interpretations of Insurance Contract Disputes: Toward a Realistic Middle Ground Approach, 57 Ohio St.L.J. 545 (1996) 6

Walter Updegrave, Stacking the Deck, Money, 50 (Aug. 1986) 7

Wishful Thinking – A World View of Insurance Insolvency Regulation, House Subcommittee 103d Cong., 2d Session (Comm. Print 103-R, Oct. 1994) 7

PRELIMINARY STATEMENT

United Policyholders as an amicus curiae submits this brief in support of Thomas Anderson, Plaintiff – Appellee and Cross-Appellant.

CORPORATE DISCLOSURE STATEMENT

United Policyholders has no corporate affiliates.

STATEMENT OF RELATED CASES AND PROCEEDINGS

Counsel for United Policyholders is not aware of any cases that fall within the ambit of Ninth Circuit Rule 28-2.6.

INTEREST OF AMICUS CURIAE

United Policyholders respectfully submits this brief in support of Thomas Anderson. In this brief, United Policyholders seeks to fulfill "the classic role of amicus curiae by assisting in a case of general public interest, supplementing the efforts of counsel, and drawing the court's attention to law that escaped consideration." Miller-Wohl Co., Inc. v. Commissioner of Labor and Indus., 694 F.2d 203, 204 (9th Cir. 1982). This is an appropriate role for amicus curiae. As commentators have stressed, an amicus is often in a superior position "to focus the court's attention on the broader implications of various possible rulings." R. Stern, E. Greggman & S. Shapiro, Supreme Court Practice 570-71

(1986) (quoting B. Ennis, Effective Amicus Briefs, 33 Cath. U. L. Rev. 603, 608 (1984)). In Humana, Inc. v. Forsyth, 525 U.S. 299, 314 (1999), Justice Ginsberg cited the amicus curiae brief prepared by Anderson Kill & Olick, P.C., attorneys for United Policyholders in that case.

United Policyholders is a non-profit corporation dedicated to educating policyholders about their rights and duties under their insurance policies. Specifically, United Policyholders engages in charitable and educational activities by promoting greater public understanding of insurance issues and policyholder rights. United Policyholders' activities include organizing meetings, distributing written materials, and responding to requests for information from individuals, elected officials, and governmental entities. These activities are limited only to the extent that United Policyholders exists exclusively on donated labor and contributions of services and funds.

Amicus curiae has a vital interest in seeing that the standard form insurance policies sold to countless policyholders are interpreted properly and consistently by insurance companies and the courts. As a public interest organization, United Policyholders seeks to assist and to educate the public and the courts regarding policyholders' insurance rights and to have them enforced consistently throughout the country.

This brief was prepared by Eugene R. Anderson, a partner in the New York City law firm of Anderson Kill & Olick, P.C. He is the author of numerous articles on insurance law, as well as a two volume treatise on insurance coverage litigation; Eugene R. Anderson ET AL., Insurance Coverage Litigation (1997). Mr. Anderson has been called the "dean of insurance policyholder attorneys" by Business Week magazine.[1]

No fee has been paid or will be paid for preparing this amicus brief.

POINT I.
UNREASONING ANTI-POLICYHOLDER BIAS

Allstate contends that is has a "right to be wrong". See Allstate brief page 33.

One can scarcely imagine a more perverted, counter-culture concept than a "right to be wrong". This concept is powerful evidence of Allstate's mental attitude towards its policyholders. No company or industry has a right to be wrong. Neither Johns-Manville nor Firestone have a right to be wrong. Governments, judges, citizens and even lawyers do not have a right to be wrong.

---

[1] See Michael Schroder & Tim Smart, "The Toxic Waste Battle is Boiling Over, " Business Week, Aug. 3, 1987, at 73.

It is a small wonder that a jury would impose punitive damages on a company that tries to sell its "Good Hands" and then delivers its "Right To Be Wrong".

The Allstate's wrong headedness is even more dramatic when one realizes that the author of the "right to be wrong" perfidy Douglas Houser of Bullivant Houser Bailey, regularly represents Allstate. Mr. Houser is Allstate's lawyer, though not in this case.

POINT II.
CASE CITATIONS ARE NOT FACTS

Allstate contends that the case law is on its side. Determining the weight of authority with respect to insurance coverage matters is impossible. Consider this: fifty percent of the pro-policyholder judicial decisions in California are wiped off the law books by the insurance industry. See Philip Carrizosa, Making the Law Disappear; Appellate Lawyers Are Learning to Exploit the Supreme Court's Willingness to Depublish Opinions, Cal. Law., Sept. 1989, at 65. Judges have a very hard time believing that their "stock in trade" has suffered from tampering. The writings of Professor Jill E. Fisch of Fordham Law School have had a major impact on awakening the judiciary. Jill E. Fisch, Rewriting History: The Propriety of Eradicating Prior Decisional Law Through Settlement and

Vacatur, 76 Cornell L. Rev. 589 (1991). See, also, Roger Parloff, Rigging the Common Law, Am. Law., 74 (Mar. 1992); Stacy Gordon, Vanishing Precedents: Policyholders Can Get Better Deal – If Rulings Are Erased, Bus. Ins., 1 (June 15, 1992).

One of the latest articles on tampering with the law books is Michael A. Berch, Analysis of Arizona's Depublication Rule and Practice, 32 ARIZ. ST. L.J., 175 (Spring 2000).

POINT III.
CORRUPTION OF THE LEGAL TREATISES

Not only are cases rigged, but insurance treatises suffer from pro-industry bias. The corruption of legal treatises on insurance is suggested by an insurance law professor:

> It may be significant that Mr. Appleman was the former head of the Legal Department of the State Insurance Companies in the 1930s when he found "much of the insurance field in chaotic condition," . . . his treatise's general philosophy of emphasizing the more predictable and more uniform Formalistic contractual approach to the interpretation of insurance policies . . . As a former insurance defense attorney while writing his impressive insurance law treatise from 1939-47, Mr. Appleman arguably may not have been a strong advocate of Legal Functionalism in the academic or legal community. Furthermore, his law school training may, or may not, have predated the rise of Legal Realism as a

> jurisprudential model in American law school classrooms of the 1930s.
>
> Likewise, Couch's Cyclopedia of Insurance Law, in its discussion of the interpretation of insurance contracts, has no mention whatever of the Keeton Functionalist doctrine of reasonable expectations, other than a tangential discussion of dealing with ambiguous contract provisions. See, e.g., 1-2 GEORGE J. COUCH, CYCLOPEDIA OF INSURANCE LAW §§ 1:4, 15:16 (Mark S. Rhodes, rev. 2d ed. 1984).
>
> Little is known of George J. Couch except that he was born in 1881, that he was a member of the New York Bar, and that he wrote his insurance law treatise from 1929-31, a time which predated the Keeton Functionalist reasonable expectations approach . . ..[2]

The views expressed in legal treatises can change. A well-known example of this occurred when a commentator discussed the, then-new "polluters" exclusion in 1973. Professor Long observed in his treatise, the Law of Liability Insurance, that the polluter's exclusion clause was a restatement of the occurrence definition contained in standard CGL insurance policies.[3] Professor Long's comments disappeared from later versions of his treatise. This "white-out" had massive consequences for California policyholders with environmental insurance claims.

---

[2] Peter Nash Swisher, Judicial Interpretations of Insurance Contract Disputes: Toward a Realistic Middle Ground Approach, 57 Ohio St. L.J. 545, 558, n. 48 (1996).

[3] R. Long, 3 Law of Liability Insurance, App-58 (1973).

POINT IV.
THE SCALES OF JUSTICE ARE TIPPED IN FAVOR OF THE TRILLION DOLLAR INDUSTRY[4]

THE DECK IS STACKED![5]

The LORE of insurance works; the LAW of insurance does not work. The standard textbook on claims handling which is used to train tens of thousand of claims handlers and claims handling supervisors[6] states:

"Claim representatives have a great deal of power."

Markham at 191.

> "**The Power of Money**. Everyone who submits a claim to an insurance company wants money. Because the claim representative controls the money, he or she is in a great position of power. Yet, this power must be used wisely and appropriately to prevent problems for the claim representative and the insurance company. Claim representatives are required to disperse money according

---

[4] See Wishful Thinking – A World View of Insurance Insolvency Regulation, A report by the House Subcommittee, 103d Cong., 2d Session (Comm. Print 103-R, Oct. 1994). The insurance industry is described in this report as being:

1. "[A] 2.3 trillion financial Industry . . . "
   Id. At III, and
2. "Premiums generated in the United States reached $482 billion in 1990, which was 35 percent of the $1.3 trillion world total."
   Id. At 51.

[5] See Walter Updegrave, Stacking the Deck, Money, 50 (Aug. 1986).

[6] James J. Markham ET AL., The Claims Environment (1st ed. 1998) (hereinafter referred to as "Markham").

to the insurance policy terms. A claim representative who refuses to perform his or her role properly can suffer discipline or sanctions."

Markham at 192.

"**Waiting Power**. Insureds and claimants are usually much more eager than claim representatives to get claims resolved. Claim representatives can better afford to wait. This circumstance gives great power to claim representatives, but, as with money power, waiting power can be abused. Claim representatives who make insureds or claimants wait unnecessarily are likely to encounter hardened attitudes that make claim settlements more difficult and, ... are probably guilty of bad faith."

Markham at 193.

"**Litigating Power**. Litigating power has two different dimensions: (1) the financial and emotional resources necessary to conduct litigation and (2) the willingness to risk whatever verdict results from the litigation process.

Markham at 194.

"Claim personnel can develop litigation power."

Markham at 195.

"Even among conscientious, professional claim personnel, there is a lower level of concern than there is in the person who has experienced the loss and needs indemnification."

Markham at 196.

"In general, a person who is less personally involved and cares less about a particular matter has power over the person who is personally involved and cares more. The person who cares more is willing to be more flexible and give more on other matters to get his or her way."

Markham at 196.

> "Power comes from money, but also from knowledge and from the abilities to wait and to litigate. Claim representatives have power based on being less personally involved in a claim than the party who suffered the loss."

Markham at 201.

The Insurance companies are in a "no lose" position and the policyholders are in a "no win" position.

The Markham text book is used to train thousands of students of insurance throughout California.

Training courses utilizing the Markham text are available at:

California

Entire State	*	800/655-4432 Lynne Exton-Frampton, Ins. Educ Assn (IEA)
Entire State	J#	800/772-8998 David Garden, IBA West
Entire State	*#	800/517-7500 Sandi Kruise, CPCU, CPIW, Sandi Kruise Ins Training
Bakersfield	G	805/868-3868 John Mellow, ARM, Kern Cnty Risk Mgmt
Bakersfield	GJ 8	805/835-4542 John Prior, CPCU, ARM, AAI, AIS, Ind Ins Agents & Brokers of Bakersfield
Fresno	*	800/655-4432 Lynne Exon-Frampton, Ins Educ Assn (IEA)
Inland Empire	*	800/655-4432 Leslie Hernandez, Ins Educ Assn (IEA)

Los Angeles Metro Area	*	800/655-4432 Lynne Exton-Frampton, Ins Educ Assn (IEA)
Modesto	*	800/655-4432 Lynne Exton-Frampton, Ins Educ Assn (IEA)
Orange Cnty	*	800/655-4432 Leslie Hernandez, Ins Educ Assn (IEA)
Sacramento	*	800/655-4432 Lynne Exton-Frampton, Ins Educ Assn (IEA)
San Diego	*	619/224-7521 Sharon Rice, INSpir Solution
San Diego	B	619/744-6000 Sue Lisowsky, IAB, ROP, Grossmount CC
San Diego Cnty	*	800/655-4432 Leslie Hernandez, Ins Educ Assn (IEA)
San Francisco Bay Area	*	800/655-4432 Leslie Hernandez, Ins Educ Assn (IEA)
San Francisco	AI #	800/772-8998 Nicolas Seperas, IBA West
San Jose	*	800/655-4432 Leslie Hernandez, Ins Educ Assn (IEA)
Santa Maria Co	*	800/655-4432 Lynne Exton-Frampton, Ins Educ Assn (IEA)
Stockton	*	800/655-4432 Lynne Exton-Frampton, Ins Educ Assn (IEA)
Ventura Co.	*	800/655-4432 Lynne Exton-Frampton, Ins Educ Assn (IEA)
Walnut Creek	*	800/655-4432 Leslie Hernandez, Ins Educ Assn (IEA)

This Court should note the important educational activities in California.

POINT V.
LAW V. LORE

The Markham textbook makes it abundantly clear that contract damages are insufficient:

> "When an insurance company fails to pay claims it owes or engages in other wrongful practices, contractual damages are inadequate. It is hardly a penalty to require an insurer to pay the insured what it owed all along."

Markham at 274.

That is the LORE of the business. United Policyholders submits that the law should catch up with the business.

Judges reading cases are in effect reading tombstones. One cannot learn about how the insurance industry operates and how it is supposed to operate from reading cases. Judges who learn about insurance from reading cases soon become underwriters by hindsight.

No judge would try to learn how to perform an appendectomy by reading malpractice cases involving botched operations.

For a good example of the current exhalation of LAW over LORE see Chateau Chamberay Homeowners Association v. Associated International Insurance Company, 108 Cal.Rptr.2d 776 (Cal.App. 2 Dist. 2001).

POINT VI.
WHAT CONSTITUTES A THOROUGH INVESTIGATION

One of Allstate's outside lawyers (from the same law firm that gave rise to the "right to be wrong" perversion) has written an article on property loss investigation, F.J. Maloney, What Constitutes A 'Thorough' Investigation?, Mealey's Litig. Rept.: Ins. Bad Faith, 18 (Nov. 2, 1999). A copy of this article by the Bullivant Houser Bailey lawyer is attached to this brief for the convenience of the court and counsel. United Policyholders commends the article to this Court.

POINT VII.
EVERYONE, BUT ALLSTATE IS OUT OF STEP

Allstate's brief suggests moderate to rampant dishonesty on the part of neighbors and the Anderson family. A jury could reasonably conclude that "It takes one to know one".

CONCLUSION

United Policyholders respectfully urges this Court to enter judgment in favor of Thomas Anderson.

Dated: August 1, 2001

CORRECTED
Dated: August 9, 2001

Respectfully submitted,

Eugene R. Anderson, Esq.
Anderson Kill & Olick, P.C.
1251 Avenue of the Americas
New York, NY 10020
Tel: (212) 278-1751
Fax: (212) 278-1733

Attorneys for Amicus Curiae
United Policyholders

Of Counsel:

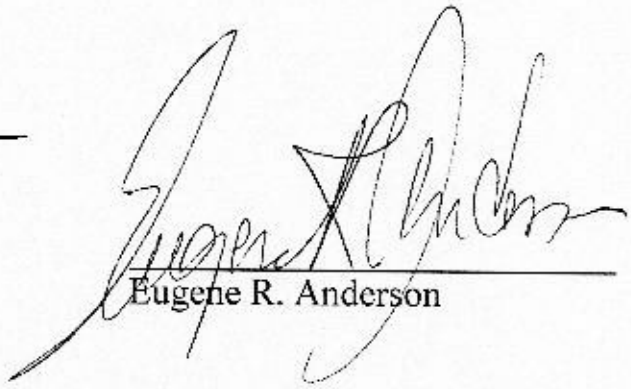
Amy Bach, Esq.
Law Offices of Amy Bach
42 Miller Avenue
Mill Valley, CA 94941
Tel: (415) 381-7627
Fax: (415) 381-5572

CERTIFICATE OF COMPLIANCE PURSUANT TO FED.R.APP. 32(a)(7)(C) AND CIRCUIT RULE 32-1 FOR CASE NUMBERS 01-15145, 01-15246, 01-15307 & 01-15330

I certify that pursuant to Federal Rule of Appellate Procedure 29(d) and Ninth Circuit Rule 32-1, the foregoing amicus brief of amicus curiaeUnited Policyholders is proportionally spaced, has a type face of 14 points or more and contains 7000 words or less.

August 9, 2001

Date



Eugene R. Anderson

Vol. 13, #13 November 2, 1999

BULLIVANT HOUSER BAILEY
A PROFESSIONAL CORPORATION

on Bad Faith

What Constitutes A 'Thorough' Investigation?

By
F. J. Maloney

[Editor's Note: F. J. Maloney is an associate with the West Coast law firm of Bullivant Houser Bailey, practicing in its Portland, Oregon office. Mr. Maloney's practice focuses on first-party insurance coverage litigation, including complex and extra-contractual claims. Copyright 1999 by the author. Replies to this commentary are welcome.]

I. Introduction

With the increasing number of "bad faith" lawsuits filed against insurance companies, it has become imperative for insurance companies to conduct a thorough and "good faith" investigation prior to making any claims decision. The claims investigation may set the tone for any subsequent litigation — a sloppy or incomplete investigation can open the door to allegations of bad faith, whereas an organized and thorough investigation, in addition to providing important coverage information, can often prevent allegations of bad faith.

Almost all state and federal courts have now held that there is an implied duty of good faith between an insurance company and its insureds.[1] This implied duty of good faith is separate and distinct from the duties that arise under the terms and conditions of the insurance contract.[2] Courts have held that this duty of good faith extends to the insurer's obligation to thoroughly and promptly investigate claims by its insureds,[3] the failure of which may result in tort liability for "bad faith" and potential exposure to punitive damages.[4] In fact, the Supreme Court of Washington has held that an insured can still maintain a tort action against an insurance company for bad faith investigation of a claim even where the insurance company was ultimately correct in determining coverage did not exist![5]

The ultimate goal of a thorough claims investigation is to obtain enough information to make an informed, objective and accurate coverage opinion. This article will discuss how to achieve this goal and how to protect against allegations of "bad faith" after a claim has been denied.[6] Although this article will for the most part discuss how to thoroughly investigate first party property claims, the investigative steps and suggestions apply equally to liability claims.

II. *Purposes And Goals Of A Thorough Investigation*

The primary goal of a thorough good faith investigation is to obtain enough information to make an informed and objective decision about (1) whether coverage exists for the claim, and (2) if there is coverage, the amount of the covered loss. It is impossible to evaluate any questionable claim without investigation.

All states have now, in one form or another, enacted statutes and/or regulations regulating insurance claims handling practices. These "unfair claims settlement acts" impose generalized obligations by statute and more detailed obligations in regulations promulgated pursuant to the statutes. An investigator should become familiar with and give special attention to the respective states' rules throughout every step of an investigation. Failure to abide by these regulations may subject an insurance company to claims of bad faith. Examples of violations of these laws include refusing to pay claims without conducting a reasonable investigation,[7] failing to acknowledge and respond to a submitted Proof of Loss within 15 working days,[8] and failing to give a prompt and reasonable explanation for denying a claim.[9]

In conducting a thorough investigation, always keep in mind that if allegations of bad faith are later made by the insured, the factfinder (whether a judge or jury) will be looking back in time to evaluate the reasonableness of the insurance company's investigation. Whether fair or not, the factfinder's analysis is often made with the benefit of 20/20 hindsight. A good question to always keep in mind is how the insurance company's investigative steps, or lack of investigative steps, will look to a reasonable third person six months or a year from now.

There are a number of readily available resources that the insurance company can look to in initially investigating the claim. The first place to look is the insurance policy itself. Be careful not to overlook the basics: Is the claim being submitted by an "insured person?" Is the loss location a "covered location?" Did the claimed loss occur during the applicable policy period? What losses are covered and excluded? Are there applicable sublimits of liability? A review of the applicable coverages and exclusions will go a long way in narrowing the scope of any investigation and streamlining investigative efforts.

Other helpful places to investigate include:

- *The Underwriter's File.* The underwriter's file, including the insurance application, is an often overlooked resource that can provide valuable insight regarding the claim. The insurance application may also provide evidence of misrepresentation of material facts in the application. Most insurance contracts, including the standard New York fire insurance policy (the "165 lines policy"),[10] have a specific provision voiding the contract if the insured makes any willful misrepresentation material to the policy or claim. Be aware that many states have passed statutes imposing further requirements, such as physically attaching a copy of the policy application to the policy at the time it is issued to the insured, before an insurance company may rely on a misrepresentation in the policy application to deny a claim.[11]

- *Police Reports.* If the claim is for a theft or other crime, a police report can provide valuable corroboration regarding the date and time of the loss, what items

are claimed and the circumstances of the claim. Most policies require the insured to file a police report as a condition to filing a theft claim. The fact that the insured did not bother to report the matter to the police should be examined. Because police reports are made soon after the loss is reported, a police report may provide the "freshest" recollection of the events.

- *Public Court Records.* Although sometimes more difficult to track down, public court documents of lawsuits involving an insured may be helpful in evaluating a suspicious claim. Does the insured have any criminal convictions for theft, fraud, perjury or other crimes of dishonesty? Are there any recent judgments against the insured? A recent divorce may also provide sworn affidavits regarding property distributed to the insured as part of the divorce decree.[12]

After initially reviewing the insured's claim, the insurance policy, underwriting file and other available materials, the investigator should note specific goals of the investigation. Although these goals should not be exclusive, they should provide the general direction for the investigation. By following general goals, unnecessary investigative tangents and expenses can be avoided. The investigation must be objective and fair to the insured. Possible goals include:

- *Coverage of the loss.* Is the claimed loss actually covered by the policy? Depending on how the claim is presented by the insured, what may appear at first glance to be a covered loss may in fact not be covered upon closer examination. Many policies only cover damage caused by an "occurrence." Did an "occurrence" cause the loss, or was the loss caused, for example, by a preexisting condition or excluded cause?

- *Fraud/Misrepresentation.* One of the most common concerns is fraud or misrepresentation in the claim. Investigative issues to consider may be whether the property ever existed, whether it was actually owned by the insured and whether the property was actually destroyed or damaged. An intentional fraud or misrepresentation may also be made in the valuation of the claim. Can receipts and invoices be verified? Have any receipts or invoices been altered? Although there is an endless list of ways to submit a fraudulent claim, "the devil is in the details." Many fraudulent claims can be discovered through verification and cross-referencing, with objective sources, of the information provided by the insured. Keep in mind that a requirement in proving fraud/misrepresentation is proving that the misrepresentation was intentional, and not merely a "mistake."

- *Motive.* Although not an actual element required to prove a fraudulent claim, practically speaking, motive is a necessary part of the investigation. Motive is most often financial. Indications of recent changes in lifestyle that may have caused a sudden change in financial circumstances are important considerations.

- *Opportunity.* Proving that the insured did or did not have the opportunity to have caused a loss is necessary in any claim suspected to have been caused by the insured. Where was the insured at the time of the loss? Can the insured's whereabouts be verified through independent witnesses, restaurant receipts, airline tickets, etc.?

- *Specific Exclusions.* Depending on the nature of the claim, specific policy exclusions may become relevant to the coverage investigation. For instance, was the personal property used for an excluded business purpose? Was the insured house vacant for more than 60 days? Much of this type of information is not immediately evident and requires looking beyond the initial report made by the insured.

- *Contractual Suit and Time Limitations.* Most insurance policies have a suit limitation provision limiting the time in which the insured may file suit against the insurance company. In many states, these suit limitation provisions are superseded by statute.[13] It is important to note the actual date the loss occurred, and not simply the date the loss was reported. Although a suit and time limitation provision does not operate as an exclusion, it may prevent a later lawsuit from being filed. Insurance representatives should be careful not to waive any suit/time limitation provision in the policy.

- *Subrogation.* If the loss is a covered loss, and the insured is indemnified, then the investigative goal may be to determine the viability of a possible subrogation. Most often, this involves a product liability action.

III. Steps In The Claims Investigation Process

Although no two claims are exactly alike and stages of the investigation are likely to overlap with each other, there are generally 6 identifiable stages of the claims process, beginning with the time of loss through the final coverage decision. These include:

1. The initial report (recognizing red flags);
2. The preliminary investigation;
3. Invoking the insurance company's contractual right to Notice and Proof of Loss;
4. Conducting Examinations Under Oath;
5. Follow-up investigation;
6. Making the coverage decision.

In addition to briefly describing these investigative steps below, several of these steps are discussed in more detail in the section regarding "Using the Policy's Contractual 'Tools'."

1. The Initial Report

The local claims adjuster is usually the first insurance company representative to receive information and potentially to notice suspicious circumstances (red flags). Red flags may be something as subtle as a suspicious inconsistency, or as blatant as a statement the claims adjuster know is false.

Many times red flags are not obvious without a detailed review. For example, a business interruption loss claim, because it is based upon projected losses, may be especially easy to exaggerate. Fire losses are also susceptible to possible misrepresentation because in many cases the only verification of the loss was destroyed in the fire. It is a good idea to be aware of losses that by their nature are difficult to verify and easy to misrepresent.

In other instances, information initially known to the insurance representative does not raise any red flags until a later date when other facts become known. For instance, an initial comment to the claims representative that the insured was at a restaurant at the time of loss may appear to be of no real significance until the same insured tells the adjuster that he was not at the restaurant at the time of loss. For this reason, all phone calls, communications and conversations with the insured should be clearly documented in the claim's log entry at the time of the conversation. This may also prevent an insured from later changing his or her story to "fit" with evidence that is turned up in the investigation. Detailed log notes of conversations with the insureds (and other witnesses) may be as valuable as a recorded statement.

2. *Preliminary Investigation*

Following the first signs of red flags, either the claims representative or investigator should conduct a preliminary investigation. The purpose of this preliminary investigation is usually to determine whether the claim warrants further investigation. This may include verifying documentation of the loss, conducting recorded statements and interviewing witnesses. Often times there is a legitimate and innocent explanation for what may otherwise appear to be a suspicious claim. It is within the insurance company's good faith duty to investigate these red flags to determine whether there is an innocent explanation for a questionable claim. No claim should ever be denied based solely upon red flags — doing so is an invitation to later claims of a bad faith investigation. An objective investigation is required. It will either support the insured, clarifying what appeared to be suspicious circumstances, or it may lead to objective evidence of a policy violation.

In instances of suspicious larger claims, the investigation may proceed from the first recognition of red flags straight to a full investigation. This is common in cases of suspected arson losses where it is imperative to preserve evidence at the fire scene, rather than having to attempt to reconstruct the fire's circumstances at a later date. It is important that such early intensive investigations be well organized and coordinated. Having a designated "point person" to coordinate all facets of the investigation, and to communicate with the insured, is recommended. This ensures that the insured receives the same information from one person rather than different information or instructions from a number of different insurance company representatives.

3. *Invoking Contractual Duties*

Following the recognition of red flags and initial investigation, and assuming the preliminary investigation indicates further formal investigation is warranted, the insurance company may invoke the "Duties in the event of loss" provision of the insurance policy, and specifically, the right to Examination Under Oath.

4. Examination Under Oath

Often times, depending on the circumstances of the claim, the insurance company's right to Examination Under Oath is asserted. The right to an Examination Under Oath is possibly the single most important tool the insurance company has in its investigation of a claim. It can provide invaluable sworn information directly from the insured about the circumstances of the claim. It is also an opportunity for an insured to dispel suspicions and bring to light important information.

5. Further Investigation

Following the Examination Under Oath, it is important that new information and leads be investigated. Any further documents helpful to the resolution of the claim should be requested from the insured at this time. Keeping in mind that the insurance company's interests should not be held above those of the insured, it is just as important to investigate any innocent explanations provided by the insured during the Examination Under Oath.

6. The Decision

Once the investigation is concluded, the coverage decision should be made. This decision should objectively consider all relevant and material information gathered during the investigation, recorded statements, Proof of Loss, and Examination Under Oath.

IV. Using the Policy's Contractual 'Tools'

The invocation of the contractual "Duties in the event of loss" sets the parameters for the investigation and provides a number of "tools" for a thorough good faith investigation.

A typical "Duties in the event of loss" provision states:

> "DUTIES IN THE EVENT OF 'LOSS'
>
> You must see that the following are done in the event of 'loss' to Covered Property:
>
> a. Given us prompt notice of the 'loss'. Include a description of the property involved.
>
> b. As soon as possible, give us a description of how, when and where the 'loss' occurred.
>
> c. Take all reasonable steps to protect the Covered Property from further damage by a Covered Cause of Loss. If feasible, set the damaged property aside and in the best possible order for examination. Also keep a record of your expenses for emergency and temporary repairs, for consideration in the settlement of the claim. This will not increase the Limit of Insurance.
>
> d. At our request, give us complete inventories of the damaged and undamaged property. Include quantities, costs, values and amount of 'loss' claimed.

e. Permit us to inspect the property and records proving the 'loss.'

f. If requested, permit us to question you under oath at such times as may be reasonably required about any matter relating to this insurance or your claim, including your books and records. In such event, your answers must be signed.

g. Send us a signed, sworn statement of 'loss' containing the information we request to investigate the claim. You must do this within 60 days after our request. We will supply you with the necessary forms.

h. Cooperate with us in the investigation or settlement of the claim."

At this time, and if not asserted earlier, it is paramount that a reservation of any and all rights and defenses be asserted.[14] The reservation of rights should preserve the insurance company's rights and possible defenses, then known and unknown, to prevent any waiver of rights and later arguments of estoppel.[15] An early reservation of any and all rights and defenses should also help prevent a later claim of bad faith where the insurance company does not learn of a possible defense until late in the investigation and then asserts that defense at that time. The reservation of rights should be made in writing and should be reasserted thereafter in every written communication to the insured.

If a blank Proof of Loss form has not already been provided to the insured, the letter invoking the "Duties in the event of loss" (and stating the insurance company's reservation of rights) should usually include a blank Proof of Loss form for the insured to complete.

The "Duties in the event of loss" provision provides a number of valuable tools to use in the investigation. A good faith investigation should use these tools. Failure to use these tools prior to making a claims decision can only provide "ammunition" to the insured in a subsequent bad faith lawsuit. For instance, if fraud/misrepresentation is suspected, and the insurance company denies coverage without taking an examination under oath, the insured can argue that the insurance company had already made up its mind about the claim without ever having used its own investigative tools set out in the policy.

1. *The Proof Of Loss*

The Proof of Loss is intended to objectively tell the insurance company exactly what the claim is in all regards. By requiring the Proof of Loss to be sworn, the insurance company should be able to rely upon its veracity and truthfulness. An insured can be held criminally liable for intentionally submitting a fraudulent Proof of Loss.

Because the Proof of Loss is the basis of the insurance claim, the insurance company should be sure that all documentation, information, and examinations under oath are requested "as a part of the Proof of Loss." Many policies require the insurance company to make a final decision on the claim within 30 or 60 days of acceptance of the Proof of Loss. By clearly stating that all requests for records, examinations under oath

and other information are requested "as a part of the Proof of Loss," the insurance company should not be in the position of having to make a decision on the claim before all follow-up information is obtained and the investigation completed.

Where the insured does not substantially comply with the requirements of the Proof of Loss, it should be rejected as defectively incomplete and a new blank Proof of Loss should be provided for the insured to fully and accurately complete. Be aware that many state regulations prohibit an insurance company from requiring an insured to unnecessarily fill out repetitive forms.[16] It is important that these requirements not be waived — the Proof of Loss is the tool the insurance company uses to know just how much the claim is and how much reserves should be set at.

2. The Inventory

Usually incorporated into the Proof of Loss, the inventory is intended to be a definitive list of the items claimed as damaged. It should list each item separately with the value of each item claimed and the date of purchase. The inventory can provide the basis for the investigation of the property values and whether the items claimed are covered by the policy.

The inventory should be carefully reviewed and cross referenced with documents, bills and receipts submitted in support of the items listed. Unexplained inconsistencies should be further investigated to determine whether they are innocent inconsistencies or evidence that the claim is not covered by the policy.

3. Inspection Of The Property And Records

The duty requiring the insured to allow the insurance company to inspect the property and records evidencing the claimed loss allows the insurance company to have reasonable access to any and all documents pertinent to the claim. Some policy provisions may also include language allowing the insurance company to make copies of all such documents.

In general, the insured's duty to produce documents relevant to the claim is broader than discovery rules.[17] The only limitation on the scope of documents to be produced pursuant to an insurance claim is that the information be "reasonably related" to the circumstances of the claim.[18] Courts have held, for instance, that the insured's refusal to provide financial information to verify the insured's ability to purchase the claimed property violates the insured's duties after loss and voids coverage.[19]

Although most insurance companies have form letters requesting a number of documents from an insured, the insurance company should briefly review the circumstances of the claim prior to requesting documents so that the request can be specifically tailored to the individual claim.

A personal inspection of the physical location of the loss should be conducted whenever possible. Personally viewing the scene can clarify logistical questions and greatly aid the understanding of how the loss occurred.

Diagrams of the scene are also helpful for later recollection of the scene and to aid others in understanding the circumstances of the loss. Whenever possible, take photo-

graphs of the loss location. These photographs should be clearly dated and described so that other persons can understand what the photos depict. Avoid using Polaroid photographs — because there is no negative the photographs cannot be clearly reproduced or enlarged.

4. The Examination Under Oath

The Examination Under Oath of the insured is possibly the single most important investigative tool available to the insurance company. An Examination Under Oath should be utilized when appropriate. It allows the insurance company to personally ask the insured questions relating to the claim, review documents submitted in support of the claim, and to evaluate the credibility and demeanor of the insured. Recorded statements and written answers to questions are no substitute for an Examination Under Oath.[20]

The timing of the Examination Under Oath is usually coordinated to occur after the Proof of Loss and supporting documentation is received. This allows the attorney conducting the questioning to have a more thorough understanding of the claim, the relevant coverage issues, and potential inconsistencies.

The Examination Under Oath also allows the insurance company to hear the insured's explanation of the claim and to put his or her best foot forward. Allowing an insured to present his or her explanation of the events is important to a good faith investigation. Should the insured later try to change or add to the circumstances surrounding the claim, the Examination Under Oath transcript can also be used to show that the insured's story was different at the time of the Examination Under Oath. For this reason, the requirement that "your answers must be signed" should not be waived. By having the insured review, correct and sign off on the Examination Under Oath transcript, the accuracy of the transcript for both the insured and the insurance company is guaranteed.

V. Follow-Up Investigation

An Examination Under Oath will often raise a number of issues not known about the claim prior to the Examination. These new issues may include a new version of events or circumstances surrounding the claim, new witnesses or a possible alibi. To the extent the investigation to date has not objectively proven or disproved the new information, it is important that the new information be investigated promptly. Failure to conduct an adequate follow-up investigation of new issues may subject the insurance company to claims of bad faith investigation. This is not to suggest that an adequate follow-up investigation will prevent claims of bad faith. But in the event a claim is denied after a thorough investigation, having objective information in support of the reasons for denial of a claim will go a long way in quickly disposing of frivolous bad faith claims.

It is important that this follow-up investigation be conducted quickly. There is a dangerous tendency to assume that once the Examination Under Oath is complete, then the investigation is complete. As a result, important follow-up investigations are sometimes overlooked or given a low priority, and the final decision on the claim is unnecessarily delayed. A good Examination Under Oath should be intended to discover information not previously known to the insurance company. The insurance company's implied good faith duty to investigate a claim requires the investigation to promptly pursue this new information and determine whether it is material to the claim.