IN THE COURT OF APPEALS
STATE OF ARIZONA
DIVISION ONE

CARLA LIRISTIS, individually and on Behalf of her minor child, NIKO LIRISTIS, RAYMOND SKIBA and CHRISTOPHER LIRISTIS and AMY LIRISTIS, Individually and on behalf of their minor Child, STEVEN LIRISTIS, Plaintiffs-Appellants, Cross-Appellees, vs. AMERICAN FAMILY MUTUAL INSURANCE COMPANY, a Wisconsin Corporation, Defendants-Appellee, Cross-Appellant.	No. 1 CA-CV 00-0539 Maricopa County Superior Court Cause No. CV 99-007046

BRIEF OF *AMICUS CURIAE* UNITED POLICYHOLDERS

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STATEMENT OF THE CASE

This case arises from an August 25, 1996 fire damage claim appellants submitted to American Family under a homeowners insurance policy (R.1).[1] In their complaint, the policyholder appellants alleged breach of contract, insurance bad faith, and punitive damages (*Id.*). On March 1, 2000, American Family filed its motion for summary judgment on the insurance coverage issue (R.19). That same date, the policyholder appellants filed a motion for partial summary judgment regarding coverage for biological pollutants (R.21). The trial court granted American Family's motion for summary judgment and denied the policyholder appellants' motion for partial summary judgment, finding that there was no insurance coverage under the American Family insurance policy for mold damages caused by a covered water loss (R.48).[2]

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1 "R" references are to the Index of Record on Appeal.

2 The trial court's minute entry dated June 1, 2000.

UNITED POLICYHOLDERS URGES THIS COURT TO ADOPT THE INTERPRETATION OF THE INSURANCE CONTRACT ADVANCED BY THE APPELLANTS

Counsel for United Policyholders has reviewed the briefs and adopts the arguments advanced by the appellants in favor of coverage for all damages resulting from this accidental covered loss. Coverage exists for mold damage resulting from a covered accidental event just as certainly as coverage exists for "cracking," "bulging," and "marring" to a building caused by covered fire, water or wind damage. The entire loss suffered by the Liristis family was *caused by* an accidental fire. Mold was not the *cause* of the loss any more than "marring," "cracking" or "bulging" are the *causes* of loss to drywall, ceiling and flooring that is inevitably damaged any time there is a fire and water suppression efforts.

The trial court here erroneously excluded coverage based on a non-fortuitous loss exclusion that exists in a substantially similar form in virtually every homeowners' insurance policy throughout the country. This standard form policy exclusion has been used for many years to limit an insurer's obligation to pay for loss of value in a home associated with natural processes that are an inevitable consequence of time and are normally addressed through routine maintenance and

upkeep. Such an exclusion, however, has never been applied to limit an insurer's obligation to pay for all damages that result from a covered accidental event.

The proper policy construction is extraordinarily simple. If a "crack" occurs naturally in drywall as it ages the homeowner must pay for this routine maintenance and upkeep of the home. If a "crack" occurs in the same piece of drywall because the home is hit by a tornado, that crack is part of the covered resulting damages. The same is true for mold. If a non-toxic mold grows on drywall in a bathroom because of high humidity and poor maintenance, the homeowners must perform this routine maintenance at their own expense. If firefighters saturate that same wall with water while fighting a fire, causing toxic mold growths throughout the interior wall cavities, then the mold and the resulting toxins are both part of the covered damages. The *cause* of loss in these examples are the tornado and the fire respectively – not the mold.

Major insurance carriers throughout the country are routinely paying for the remediation of mold contaminations resulting from covered water losses. The reason for this is thoroughly explained in the Appellants briefs. The risk of mold contaminations resulting from covered events is well known to the nation's

insurance underwriters and the prices of policies certainly reflect this risk. If the trial court's holding were to become the law of this state it would result in a staggering windfall of unearned profit to the insurance industry. The policy construction that the Appellants have presented this Court is a reasonable reflection of the risk assumed by the insurer and the protection purchased by the insured at the time the policy was sold. It is also consistent with the proper interpretation of insurance contracts by Courts and commentators throughout the country over the last 100 years.

This *Amicus* brief adopts, but will not repeat, the substantive arguments of the Appellants regarding the inapplicability of the non-fortuitous loss exclusion and the availability of coverage under the resulting loss provision and the pollutant clean-up coverage. The balance of this brief raises additional points related to the interpretation of contracts of adhesion and the role of the insurance industry in controlling the development of case law that defines an insurer's contract obligations.

POINT I

LATIN

MUS IN FAUCIBUS CATTI MELIUS ESSE EST QUAM CLIENS IN MANIBUS ADVOCATI

This famous quotation has been attributed to Sargent Andersoni, a member of the Roman Senate and an ancestor of one of the authors of this brief. For readers unskilled in Latin it translates as follows:

> It would be better to be a mouse in the jaws of a cat than a client in the hands of a lawyer.

American Family Mutual Insurance Company and its lawyers appear to love Latin. The insurance company and its lawyers stated in their brief:

> "*i. Noscitur A Sociis.*
>
> The doctrine of *noscitur a sociis* applies to subsections 6a and 6e, which are cited in appellants' opening brief (pp. 10-21). In short, this doctrine requires that doubtful words be interpreted in the light of the words with which they are associated. *See Olvey v. Calizona Land & Cattle Co.*, 76 Ariz. 368, 372, 265 P.2d 432, 434 (1954); *Porter v. Hall*, 34 Ariz. 308, 271 P. 411 (1928), rev'd in part, *Harrison v. Laueen*, 67 Ariz. 337, 196 P.2d 456 (1948). Under the doctrine, the court can ascertain the meaning of questionable words by reference to words associated

with them. *Warren v. Lemay*, 494 N.E.2d 206, 209-10 (Ill. App. Ct. 1986)."[3]

Later, the insurance company brief states:

> "*ii. Ejusdem Generis*
>
> Appellant's argument also ignores the necessary application of the rule of construction called *ejusdem generis*, which provides:
>
> > Where general words in a contract are followed by enumerated specific terms involving the same subject matter...the meaning of the general terms is presumed...to include only those things of the same nature as those specifically enumerated.
>
> *Keggi v. Northbrook Prop. and Cas. Ins. Co.*, 336 Ariz. Adv. Rep. 14, 13 P.3d 785, 789-90 (App. Div. 2000) (applying *ejusdem generis* to exclusions within an insurance policy); *see also State v. Barnett*, 142 Ariz. 592, 596, 691 P.2d 683, 687 (1984); *United California Bank v. Prudential Ins. Co.*, 140 Ariz. 238, 273, 681 P.2d 390, 425 (App. Div. 1983); *Black's Law Dictionary*, (defining *ejusdem generis* as "[o]f the same kind, class or nature")."[4]

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[3] Appellee's Answering Brief/Cross-Appellant's Opening Brief at 18 (dated Feb. 26, 2001), Liristis v. American Family Mutual Insurance Company, (Ariz. Ct. App.) (No. 1 CA-CV 00-0539).

[4] Appellee's Answering Brief/Cross-Appellant's Opening Brief at 20 (dated Feb. 26, 2001), Liristis v. American Family Mutual Insurance Company, (Ariz. Ct. App.) (No. CA-CV 00-0539).

A thorough investigation of this case, would have disclosed that none of the plaintiffs is fluent in Latin. See F.J. Maloney, What Constitutes A "Thorough' Investigation?, Vol. 13 #13 Mealey's Litig. Rpt. Ins. Bad Faith, Nov. 2, 1999, at 18. A copy of this article is attached as an appendix. Mr. Mahoney's firm, Bullivant, Houser Bailey, is one of the West Coast's leading insurance nullification law firms. The law firm regularly represents insurance companies in legal battles against policyholders.

American Family may love Latin, but plain English should be the law of the land. The courts are and should be wary:

> In the case before us, the facts found by the trial court can be discussed more clearly in plain English, and it will not be necessary to use the Latin phrase to explain the reasons for reversing the judgment.[5]

The resort to Latin is an admission by the insurance company of an ambiguity.

This rule was succinctly put by a California Court:

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[5] Superior Lumber Co. v. Sutro, 92 Cal. App. 3d 954, 957, 154 Cal. Rptr. 333 (1979).

> By invoking this maxim of construction, the majority 'must necessarily thereby recognize the ambiguity of the contract; (but) in that event other legal techniques...including the rule that they should be interpreted against the draftsman, also come into play.' (*Steven v. Fid. & Cas. Co.*, supra, 58 Cal.2d 862, 871, 27 Cal. Rptr. 172, 177, 377 P.2d 284, 289).[6]

POINT II

WHEN DETERMINING WHETHER AN AMBIGUITY EXISTS IN A POLICY, THE COURT EXAMINES THE LANGUAGE FROM THE VIEWPOINT OF ONE NOT TRAINED IN LAW OR IN THE INSURANCE BUSINESS

The insurance company in this case correctly states:

> When determining whether an ambiguity exists in a policy, the court examines the language from the viewpoint of one not trained in law or in the insurance business.[7]

POINT III

FICTIONS AND RULES OF CONSTRUCTIONS

Court's have adopted fictions in an attempt to force insurance policies into "contract" construct. A homeowners' insurance policy is not a "contract" in any real life sense. It is a consumer product purchased under compulsion (the state

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[6] National Ins. Underwriters v. Carter, 17 Cal.3d 380, 551 P.2d 362, 131 Cal. Rptr. 42 (1976).

[7] Appellee's Answering Brief/Cross-Appellant's Opening Brief at 7, (dated Feb. 26, 2001), Liristis v. American Family Mutual Insurance Company, (Ariz. Ct. App.) (No. 1 CA-CV 00-0539).

in the case of automobile insurance or a mortgage lending institution in the case of homeowners insurance). The idea that Liristis' homeowners insurance policy in this case is a contract is a king who has no clothes.

To go back to basics, we refer once again to California:

> Because of the nature of the contract and the contracting parties, the most *precise* language imaginable may prove insufficient to eliminate coverage.[8]
>
> * * *
>
> In order to understand why additional requirements apply to this contract, we first begin with the proposition that any contract is construed against the party who prepared the contract. (*Federal Leasing Consultants, Inc. v. Mitchell Lipsett Co.*, (1978) 85 Cal. App. 3d Supp. 44, 48, 150 Cal. Rptr. 82.). No one questions that Blue Cross prepared and printed this contract. Hence every term must be construed in favor of appellant. Secondly, this is not an ordinary contract, but an *insurance* contract which imposes an even more stringent duty on the court to interpret in favor of the insured. (*Schmidt v. Pacific Mut. Life Ins. Co.*, (1969) 268 Cal. App. 2d 735, 738, 74 Cal. Rptr. 367; *Hays v. Pacific Indem. Group* (1970) 8 Cal. App. 3d 158, 162, 86 Cal. Rptr. 815.) Thirdly, the contract term in dispute is an exclusion from coverage. And an exclusion is subjected to the closest possible scrutiny. (*State Farm Mut. Auto Ins. Co. v. Jacober* (1973) 10 Cal.3d 193, 110 Cal. Rptr. 1, 514 P.2d 953;

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[8] Ponder v. Blue Cross of Southern California, 145 Cal. App. 3d 709, 717, 193 Cal. Rptr. 632, 635 (1983).

Gray v. Zurich Ins. Co., (1966) 65 Cal.2d 263, 269, 54 Cal. Rptr. 104, 419 P.2d 168; *Cal. Comp and Fire Co. v. Industrial Acc. Comm'n* (1965) 62 Cal.2d 532, 534, 42 Cal. Rptr. 845, 399 P.2d 381; *Steven v. Fid. & Cas. Co.*, (1962) 58 Cal.2d 862, 882, 27 Cal. Rptr. 172, 377 P.2d 284; *Pepper Indus. v. Home Ins. Co., supra*, 67 Cal. App. 3d 1012, 1018). Finally, we find this is not just an insurance contract but an adhesion contract for insurance.[9]

* * *

An adhesion contract is a standardized contract written entirely by a party with superior bargaining power. The weaker party to an adhesion contract must "take it or leave it," and be without opportunity to bargain. (*Steven v. Fid. & Cas. Co., supra*, 58 Cal.2d 862, 882, 27 Cal. Rptr. 172, 377 P.2d 284; *Gray v. Zurich Ins. Co., supra*, 65 Cal.2d 263, 269, 54 Cal. Rptr. 104, 419 P.2d 168, *Schmidt v. Pacific Mut. Life Ins. Co., supra*, 268 Cal. App. 2d 735, 737, 74 Cal. Rptr. 367; Note, *The Adhesion Contract of Insurance*, (1964) 5 Santa Clara Law. 60; Note, *Contracts of Adhesion under California Law* (1967) 1 U.S.F.L.Rev. 306; Hurd and Bush, *Unconscionability: A Matter of Conscience for California Consumers* (1973) 25 Hastings L.J. 1, 32-73; Slawson, *Mass Contracts: Lawful Fraud in California* (1974) 48 So.Cal.L.Rev. 1; Sybert, *Adhesion Theory in California: A Suggested Redefinition and Its Application to Banking* (1978) 11 Loyola L.A. L.Rev. 297.) This particular standardized contract was prepared entirely by a major insurance company whose bargaining power is clearly superior to individual members of the general public. Appellants were not at liberty to sit down with

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9 Id. at 718.

Blue Cross and bargain individual terms- to trade removal of an exclusion for a slightly higher premium, for example. If they wanted Blue Cross health insurance they had to sign the contract as is. Moreover, as this case itself illustrates, Blue Cross unilaterally changes the terms of the contract from year-to-year without consulting its policyholders.

Since we hold this is an adhesion contract, it is not enough the exclusionary clause could be deemed to be precise. It also must pass muster under two other independent tests. (1) The exclusion must be *conspicuous* and (2) the language of the exclusion must be *plain and clear*. [FN2] We have chosen to divide the traditional statement of the requirement that insurance policy exclusions be "conspicuous, plain and clear" into separate tests. As a matter of logic, this brief clause imposes two very different demands on those who draft insurance policies. First, the exclusion must be positioned in a place and printed in a form which would attract a reader's attention. Secondly, the substance of the exclusion must be stated in words that convey the proper meaning to persons expected to read the contract.

> FN2. "If it (the insurer) deals with the public upon a mass basis, the notice of noncoverage of the policy, in a situation in which the public may reasonably expect coverage, must be conspicuous, plain and clear." (*Steven v. Fid. & Cas. Co., supra,* 65 Cal.2d 263, 273, 54 Cal. Rptr. 104, 419 P.2d 168; *Stewart v. Estate of Bohnert* (1980) 101 Cal. App. 3d 978, 988, 162 Cal. Rptr. 126.).

Nor is an explicit finding of an "adhesion contract" absolutely essential to the imposition of these two tests. Many of the appellate cases interpreting insurance contracts designed for the general public neither make

nor require a specific finding the agreement constituted an "adhesion contract." (*See, e.g., Crane v. State Farm Fire & Cas. Co.* (1971) 5 Cal.3d 112, 95 Cal. Rptr. 513, 485 P.2d 1129; *Stewart v. Estate of Bohnert, supra,* 101 Cal. App. 3d 978, 162 Cal. Rptr. 126; *Miller v. Elite Ins. Co.* (1980) 100 Cal. App. 3d 789, 161 Cal. Rptr. 322). Without bothering to make that finding, the courts apply the special rules of interpretation ordinarily reserved for adhesion contracts. They scrutinize the provisions of these standardized insurance agreements to insure any exclusions or limitations on coverage meet the twin tests of being "conspicuous" and "plain and clear." (*Crane v. State Farm Fire & Cas. Co., supra,* 5 Cal.3d at p. 115, 95 Cal. Rptr. 513, 485 (P.2d 1129 ["An exclusionary clause must be conspicuous, plain and clear."]; *Stewart v. Estate of Bohnert, supra,* 101 Cal. App. 3d 978, 988, 162 Cal. Rptr. 126; *Miller v. Elite Ins. Co., supra,* 100 Cal. App. 3d 739, 751, 161 Cal. Rptr. 322.)

One possible reading of these cases is that all standard insurance policies aimed at the general public are considered adhesion contracts per se since by definition they have the principal attributes of such agreements. Thus it is redundant to continually characterize them as adhesion contracts. [FN3] What is abundantly clear is that this issue is largely irrelevant. Whether characterized as an "adhesion contract" or as merely a "standard insurance contract marketed with the general public" this Blue Cross policy and its exclusions must pass all the tests ordinarily imposed on "adhesion contracts" in other contexts. (footnote omitted).[10]

* * *

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10 Id. at 718, 719.

An exclusion in an adhesion contract of insurance must be expressed in words which are "plain and clear." This means more than the traditional requirement that contract terms be "unambiguous." Precision is not enough. Understandability is also required. To be effective in this context, the exclusion must be couched in words which are part of the working vocabulary of average law persons.

"The policy should be read as a layman would read it ...." (*Crane v. State Farm Fire & Cas. Co., supra,* 5 Cal.3d 112, 115, 95 Cal. Rptr. 513, 485 P.2d 1129.) "The insurer bears a heavy burden to draft exclusionary clauses in clear language comprehensible to lay persons." (*Stewart v. Estate of Bohnert, supra,* 101 Cal. App. 3d 978, 988, 162 Cal. Rptr. 126.) The words must be such that "an ordinary layman can understand." (*Thompson v. Occidental Life Ins. Co.* (1973) 9 Cal.3d 904, 912, 109 Cal. Rptr. 473, 513 P.3d 353.) And an "insurer... is bound to use language clear to the ordinary mind." (*Migliore v. Sheet Metal Workers Welfare Plan* (1971) 18 Cal. App. 3d 201, 204, 95 Cal. Rptr. 669.) (*See also*, e.g., *Gefrich v. State Farm Mut. Auto. Ins. Co.* (1980) 109 Cal. App. 3d 500, 503, 166 Cal. Rptr. 516 [reduction in coverage must be "in plain and understandable language"]; *S & H Ins. Co. v. California State Auto. Ass'n. Inter-Ins. Bureau* (1983) 139 Cal. App. 3d. 509, 515, 188 Cal. Rptr. 722 [policy limitation approved expressly because it was "phrased in clear and understandable language."].)[11]

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11 Id. at 723, 724.

The California Supreme Court denied review of the Ponder case on September 29, 1983.[12]

POINT IV

REASONABLE EXPECTATIONS

According to the insurance company Arizona takes a very cramped view of the reasonable expectations rule. In Millar cited by the insurance company the Court of Appeals said:

> As the *Darner* court itself noted, "since most insureds develop a 'reasonable expectation' that every loss will be covered by their policy[,]..." the reasonable expectation concept must be limited by something more than the fervent hope usually engendered by loss. *Darner Motor Sales, Inc. v. Universal Underwriters Ins. Co., supra,* at 390, 682 P.2d at 395. Thus, a plaintiff's expectation of coverage must be objectively reasonable. *Cf. Continental Ins. Co. v. McDaniel*, 160 Ariz. 183, 772 P.2d 6 (App. 1988); *Green v. Mid-Am. Preferred Ins. Co.*, 156 Ariz. 265, 751 P.2d 581 (App. 1987). Under the standard homeowner's policy, such as the one issued to Millar, coverage is provided for accidental loss unless expressly excepted. Millar has no basis for believing that any

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12 Ponder v. Blue Cross of Southern California, 145 Cal. App. 3d 709, 193 Cal. Rptr. 632, reh'g denied, Sept. 29, 1983.

particular loss would be covered without first reading the relevant policy provisions.[13]

This view buys into two pernicious anti-policyholder doctrines.

1. Post-Loss Underwriting

Insurance companies sometimes engage in post-claim or post-loss underwriting. That is, after a claim is filed, the insurance company will scrutinize the insurance policy to find reasons, justified or not, to deny the claim.

A superb description of post-claim underwriting is as follows:

> THINGS PICK UP A BIT on Tuesday, partly because I'm getting tired of wasting time, partly because the witnesses either know little or can't remember much. I start with Everett Lufkin, Vice President of Claims, a man who'll not utter a single syllable unless it's a response to a direct question. I make him look at some documents, and halfway through the morning he finally admits it's company policy to do what is known as "post-claim underwriting," an odious but not illegal practice. When a claim is filed by an insured, the initial handler orders all medical records for the preceding five years. In our case, Great Benefit obtained records from the Black family physician who had treated Donny Ray for a nasty flu five year earlier. Dot did not list the flu on the application. The flu had nothing to do with the leukemia,

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[13] Millar v. State Farm Fire & Cas. Co., 167 Ariz. 93, 97, 804 P.2d 822, 826 (1990), review denied, 168 Ariz. 144, 811 P.2d 1081 (1991).

> but Great Benefit based one of its early denials on the fact that the flu was a preexisting condition.

John Grisham, *The Rainmaker* at 295 (1st ed. Doubleday) (1995). Most lawyers would disagree with Mr. Grisham's statement that post-loss underwriting is "not illegal".

Again, with respect to "post-loss underwriting":

> ....."Here's their scheme," he says, touching a box as if great mysteries are contained therein. "The claim comes in and is assigned to a handler, just a low-level paper pusher. The people in claims are the poorest trained, least paid of all. It's that way in every insurance company. The glamour is over in investments, not claims or underwriting. The handler reviews it, and immediately begins the process of post-claim underwriting. He or she sends a letter to the insured denying the claim. I'm sure you have such a letter. The handler then orders the medical records for the past five years. The medicals are then reviewed. The insured gets another letter from claims saying, 'Claim denied, pending further review.' Here's where it gets fun. The claims handler then sends the file over to underwriting, and underwriting sends a memo back to claims which says something like 'Don't pay this claim until you hear from us.' There's more correspondence between claims and underwriting, letters and memos back and forth, paperwork builds up, disagreements ensue, clauses and sub-clauses in the policy become hotly in dispute as these two departments go to war. Keep in mind, these people work for the same company in the same building, but rarely know each other. Nor do they know anything

> about what the other department is doing. This is very intentional. Meanwhile, your client is sitting in his trailer getting these letters, some from claims, some from underwriting. Most people give up, and this, of course, is what they're counting on. About one in twenty-five will actually consult a lawyer. "

John Grisham, *The Rainmaker* at 314 (1st ed. Doubleday) (1995). Truth is even stranger than this faction.

2. Judges As Underwriters BY HINDSIGHT

The second anti-insurance foundation for the Millar case relates as well to post-lost underwriting.

Every reasonably intelligent person knows – after a loss – that "no damn fool" would sell insurance to cover the claimed loss. See, Eugene R. Anderson, et al., Insurance Nullification By Litigation, Risk Management, April 1994, at 56.[14] Most insurance companies develop a reasonable expectation that no serious or out-of-the-ordinary loss is covered by their insurance policies. Despite the best of intentions, insurance companies and their claims adjusters have a financial interest in denying claims. Insurance nullification may amount to nothing more than the fervent hope of usually a hardnosed claims adjuster.

The economics of insurance nullification are staggering. If only 1% of the insurance coverage cases are wrongfully decided by the courts, the resulting profit to the insurance industry would run into the billions of dollars.

A complete issue of the Connecticut Insurance Law Journal was devoted to the doctrine of reasonable expectations. See 5 CONN. INS. L.J. 1-504 (1998-1999). This comprehensive law review treatment explores all sides of the issue and provides a unique resource for this Court.

POINT V

CORRUPTION; WHAT YOU SEE IS NOT WHAT YOU GET

Here is a bitter pill for this Court to swallow!

Over 50% of the pro-policyholder decisions are wiped off the law books by insurance companies. See, Michael A. Berch, Analysis of Arizona's Depublication Rule and Practice, 32 Ariz. St. L.J. 175 (Spring 2000).[15] With some judicial courage this Court should conclude that the cases cited by the insurance company are only 50% right.

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[14] This article was written by one of the authors of this *amicus* curiae brief. A copy is attached as an appendix.

[15] A copy of Professor Berch's article is attached as an appendix.

POINT VI

INSURANCE IS A POTENT DEFECTIVE PRODUCT

There are a number of powerful, well financed and well organized insurance industry trade associations fighting policyholders. They include:

Alliance of American Insurers;
American Council of Life Insurance
American Insurance Association;
Association of California Insurance Companies;
Brokers & Reinsurance Markets Association;
Defense Research Institute;
Georgia Association of Property & Casualty Insurance Companies;
Health Insurance Association of America;
Independent Insurance Agents of America, Inc.;
Insurance Environment Litigation Association;
International Association of Defense Counsel;
National Association of Casualty & Surety Agents;
Council of Insurance Agents & Brokers;
National Association of Independent Insurers;
National Association of Mutual Insurance Companies;
National Association of Professional Insurance Agents;
National Council of Compensation Insurance;
The Surety Association of America; and
Wisconsin Insurance Alliance.

In fact, the American Insurance Association has stated that:

> Insurers spend (conservatively) a billion dollars a year in so-called "coverage litigation...."

Brief of *Amicus Curiae* American Insurance Association at 3 (dated Feb. 25, 1993), Affiliated FM Ins. Co. v. Constitution Reinsurance Corp., (Mass. Sup. Jud.

Ct.) (No. SJC 06165), a copy of which is attached as an appendix. See also Leslie Scism, Tight-Fisted Insurers Fight Their Customers To Limit Big Awards, WALL ST. J., Oct. 15, 1996, at 1. A copy this article is attached as an appendix.

CONCLUSION

WHEREFORE, *Amicus Curiae*, United Policyholders, respectfully submits this brief in support of Policyholder's/Appellant's.

Dated this 25th day of May, 2001.

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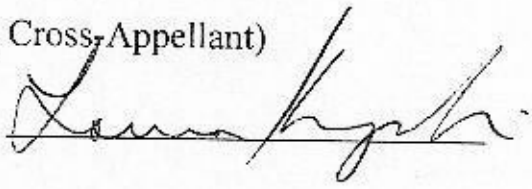

CERTIFICATE OF COMPLIANCE

I, Richard T. Treon, hereby certify that the Brief of *Amicus Curiae* United Policyholders uses a proportionately spaced typeface, Times New Roman, 14 point, and contains 5,342 words.

Richard T. Treon