NO. A166049

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FIRST APPELLATE DISTRICT, DIVISION 3

MARK BENNETT, D.D.S.,
Plaintiff and Appellant,

v.

OHIO NATIONAL LIFE ASSURANCE CORPORATION,
Defendant and Respondent.

CASE NO. CIV1903075

HON. ANDREW E. SWEET, TRIAL JUDGE
APPEAL FROM A JUDGMENT OF THE
MARIN COUNTY SUPERIOR COURT

APPLICATION FOR LEAVE TO FILE AMICUS CURIAE BRIEF IN SUPPORT OF PLAINTIFF-APPELLANT MARK BENNETT, D.D.S.; AMICUS CURIAE BRIEF

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Rules

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APPLICATION FOR LEAVE TO FILE AMICUS CURIAE BRIEF IN SUPPORT OF PLAINTIFF-APPELLANT MARK BENNETT, D.D.S.

Pursuant to California Rule of Court 8.200(c), United Policyholders ("UP") respectfully applies for this Court's permission to file the accompanying amicus curiae brief in support of Plaintiff-Appellant Mark Bennett, D.D.S. in his appeal of an adverse judgment in his action against Defendant-Respondent Ohio National Life Assurance Corporation.

STATEMENT OF INTEREST OF AMICUS CURIAE

United Policyholders ("UP") is a non-profit 501(c)(3) organization founded in 1991, and is a respected voice and trusted information resource for insurance consumers in all 50 states. UP

promotes fair claim and sales practices and integrity in the insurance marketplace. UP does not accept funding from insurance companies. Donations, foundation grants, and volunteer labor support the organization's work.

UP assists and advocates for individual and commercial policyholders regarding the full spectrum of insurance products, including home, automobile, health care, long term care, and business owner's insurance. UP hosts a library of tips, sample forms, and articles on commercial and personal insurance products, coverage, and the claims process at its website, www.uphelp.org.

UP's work is divided into three program areas: Roadmap to Recovery (disaster recovery and claim help), Roadmap to Preparedness (insurance and financial literacy and disaster preparedness), and Advocacy and Action (advancing pro-consumer laws and public policy).

Under its Advocacy and Action program, UP analyzes trends, issues, and problems related to claims and the insurance marketplace. Commercial and individual insureds, claim professionals, and lawyers share information with UP about coverage and claim disputes every day. UP informs the public and the courts and assists regulators and legislators in effectively overseeing business and personal insurance matters. UP's Executive Director, Amy Bach, has been an official consumer representative to the National Association of Insurance Commissioners since 2009 and is in her second term as an appointed member of the Federal Advisory Committee on Insurance.

As part of its work, UP strives to assist courts throughout the country in resolving insurance disputes by filing "friend of the court"

briefs in important cases such as this one. UP's amicus briefs have been cited in published decisions by the United States Supreme Court and numerous state and federal appellate courts. *See, e.g., Humana, Inc. v. Forsyth*, 525 U.S. 299, 314, 119 S. Ct. 710, 142 L. Ed. 2d 753 (1999). UP has appeared as amicus curiae before California courts on numerous occasions. *See, e.g., Pitzer Coll. v. Indian Harbor Ins. Co.* (2019) 8 Cal. 5th 93, 104-105 (favorably citing UP's amicus brief); *Ass'n of Cal. Ins. Cos. v. Jones* (2017) 2 Cal.5th 376, 382-383 (favorably citing UP studies).[1]

UP'S AMICUS CURIAE BRIEF WILL ASSIST THE COURT

UP submits that the Court should grant it leave to file an amicus curiae brief in this matter because it can provide information, perspective, and argument that can help the Court beyond the help the parties' lawyers have provided. The central issue in the case is of course a legal one, i.e., when did Dr. Bennett's statute of limitations accrue? However, determining when a statute accrues, especially in the insurance context, can be difficult. Any decision by the Court should take into account competing policy arguments and consider the larger consequences for insureds and insurers going forward. UP submits that its perspective as a non-profit organization focusing on the insurance marketplace, and the claims made within that marketplace, is valuable in providing guidance to the Court as to the implications of its decision in this case.

[1] A list of amicus curiae briefs filed by UP can be found at https://www.uphelp.org/resources/amicus-briefs.

RULE 8.200(c)(3) DISCLOSURE

Consistent with California Rule of Court 8.200(c)(3), UP states that no party or any counsel for any party authored this amicus brief in whole or in part, or made a monetary contribution intended to fund the preparation or submission of this brief. No other person or entity made a monetary contribution to fund the preparation or submission of the brief other than the amicus curiae and its counsel.

CONCLUSION

UP respectfully asks the Court to grant this application and permit UP to file the accompanying amicus curiae brief.

Dated: March 30, 2023

Respectfully submitted,
KANTOR & KANTOR LLP

By 

Glenn R. Kantor
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BRIEF OF AMICUS CURIAE IN SUPPORT OF PLAINTIFF-APPELLANT MARK BENNETT, D.D.S.

INTRODUCTION

UP's focus is on protecting insurance consumers and their reasonable expectations when buying insurance and dealing with insurance companies. As explained below, the trial court's ruling upends the expectations of insurance consumers and will lead to unwanted consequences. The ruling below promotes unnecessary conflict between insureds and insurers, will lead to increased litigation over unripe claims, and will prevent insureds from obtaining the benefits for which they have contracted, in contravention of California insurance law, which is designed to protect insureds. UP therefore urges the Court to reverse.

ARGUMENT

A. The Focus of California Insurance Law Is on Protecting Insureds

As California courts have recognized, insurance is unlike any other commercial activity. Insurers' obligations are "rooted in their status as purveyors of a vital service labeled quasi-public in nature. Suppliers of services affected with a public interest must take the public's interest seriously, where necessary placing it before their interest in maximizing gains and limiting disbursements." *Egan v. Mut. of Omaha Ins. Co.*, 24 Cal. 3d 809, 820, 620 P.2d 141, 146 (1979). *See also German All. Ins. Co. v. Lewis*, 233 U.S. 389, 415, 34

S. Ct. 612, 620, 58 L. Ed. 1011 (1914) (the business of insurance is "'clothed with a public interest,' and therefore subject 'to be controlled by the public for the common good.'").

Furthermore, the relationship between insurers and insureds is "inherently unbalanced; the adhesive nature of insurance contracts places the insurer in a superior bargaining position." *Egan*, 24 Cal. 3d at 811.

For these reasons, the California legislature and the courts have traditionally viewed the relationship between insurers and insureds with a critical eye. *See Calfarm Ins. Co. v. Deukmejian*, 48 Cal. 3d 805, 830, 771 P.2d 1247, 1262 (1989) (insurance is "a highly regulated industry"). Insurance companies, while not fiduciaries *per se*, are held to a higher standard than traditional contracting parties. The courts have imposed "special and heightened" duties on insurers, which "arise because of the unique nature of the insurance contract[.]" *Vu v. Prudential Prop. & Cas. Ins. Co.*, 26 Cal. 4th 1142, 1151, 33 P.3d 487 (2001).

As a result, "the rights and obligations of the insurer cannot be determined solely on the basis of rules pertaining to private contracts negotiated by individual parties of relatively equal bargaining strength." *Barrera v. State Farm Mut. Auto. Ins. Co.*, 71 Cal. 2d 659, 669, 456 P.2d 674, 681-82 (1969). Instead, "statutes pertaining to, and contractual provisions contained within, insurance policies must be construed in light of applicable public policy, promoting the protection of the insured and the public at large." *20th Century Ins. Co. v. Superior Ct.*, 90 Cal. App. 4th 1247, 1266, 109 Cal. Rptr. 2d 611, 626 (2001).

Examples of this focus on protecting the insured are easily found throughout California insurance law. For example, California requires insuring clauses to be interpreted broadly. *Montrose Chem. Corp. v. Admiral Ins. Co.*, 10 Cal. 4th 645, 667, 913 P.2d 878 (1995), as modified on denial of reh'g (Aug. 31, 1995). If an insurer attempts to enforce an exclusion or limitation in a policy, that exclusion or limitation is "strictly construed against the insurer and liberally interpreted in favor of the insured." *Delgado v. Heritage Life Ins. Co.*, 157 Cal. App. 3d 262, 271, 203 Cal. Rptr. 672 (Ct. App. 1984). The burden is on the insurer to prove that any such exclusion or limitation applies. *Garvey v. State Farm Fire & Cas. Co.*, 48 Cal. 3d 395, 406, 770 P.2d 704, 710 (1989).

Furthermore, while insurance policies are contracts, and many rules of contractual interpretation apply with equal force to policies, if a policy is ambiguous, the reasonable expectations of the insured will be enforced. *Bank of the West v. Superior Ct.*, 2 Cal. 4th 1254, 1265, 833 P.2d 545 (1992). If the "reasonable expectations" doctrine does not resolve the ambiguity, the rule of *contra proferentem*, or contra-insurer, provides that "ambiguities are generally construed against the party who caused the uncertainty to exist (i.e., the insurer)[.]" *Powerine Oil Co. v. Superior Ct.*, 37 Cal. 4th 377, 391, 118 P.3d 589, 598 (2005), as modified (Oct. 26, 2005), as modified (Oct. 27, 2005). *See also* Cal. Civ. Code § 1654 ("In cases of uncertainty not removed by the preceding rules, the language of a contract should be interpreted most strongly against the party who caused the uncertainty to exist.")

In short, the insurance relationship, particularly in first-party coverage situations such as the disability insurance in this case, is one where the courts have traditionally tipped the scales in favor of insureds, and for good reason. "[T]he object of California insurance law generally, and statutory incorporation more specifically, is to protect the insured, not the insurer." *Pollock v. Fed. Ins. Co.*, No. 21-CV-09975-JCS, 2022 WL 2756669, at *8 (N.D. Cal. July 14, 2022).

B. In the Event the Court Has Doubts Regarding How to Apply the Statute of Limitations in This Case, It Should Resolve Such Doubts in Favor of Dr. Bennett

Of course, California's priority on protecting insureds does not mean that disputes between insurers and insureds should always be resolved in favor of the insured. However, the above authorities, and California's long-standing policy in favor of protecting insureds, do suggest that when a question of law arises under California law that can be reasonably interpreted in different ways, that question should be resolved in favor of the insured.

To be clear, UP believes that the issue presented in this case – whether Dr. Bennett's cause of action accrued in 2015 or 2018 – is not ambiguous or uncertain. UP contends that California law straightforwardly supports Dr. Bennett for the reasons set forth in his briefing. As Dr. Bennett correctly argues, his cause of action could not have accrued in 2015 because there was no breach of contract until Ohio National stopped paying his benefits in 2018. UP agrees with Dr. Bennett that this result is the correct legal result because a cause of action does not accrue until all elements have occurred, and in Dr.

Bennett's case, the final element – nonpayment of benefits – did not occur until 2018.

However, to the extent that the Court has doubts as to which result is correct, and considers the policy implications of its decision, UP urges the Court to consider the authorities cited above, among others, favoring California insureds. In other words, the Court should interpret statutes of limitations under California insurance law in a manner that protects insureds when evaluating their reasonable rights and duties under their policies.

Under this approach, the question becomes: what is the reasonable response of an insured when faced with a letter such as that sent by Ohio National to Dr. Bennett on June 8, 2015?

As Dr. Bennett points out in his briefing, Ohio National's obligation under Mr. Bennett's disability insurance policy was to pay benefits on a monthly basis pursuant to the policy's "Time of Payment" provision, which states, "Income is paid at the end of each month of Disability for which it is due." AA Vol. 1, 219, 236, 260. As a result, Ohio National's obligation under the policy was not to pay lifetime disability benefits, or for any set period of time at all. Instead, its obligation was to pay benefits periodically – i.e., every month – so long as Dr. Bennett satisfied the terms and conditions of the policy. *See Erreca v. Western States Life Ins. Co.* (1942) 19 Cal.2d 388, 402 (disability insurance policy is "a continuing contract for periodic installment payments depending upon the insured's continued disability, and he has no cause of action, nor the insurer any liability, except for benefits which have accrued").

As a result, any position Ohio National might take in 2015 regarding Dr. Bennett's eligibility for benefits in the future – in this case, more than three years in the future, in 2018 – would be highly speculative. In that three-year time span, any number of things might happen: Ohio National might change its mind, Dr. Bennett's symptoms might abate, his physicians might find a cure for his condition, or, in a worst-case scenario, he might pass away. In any of these scenarios, Ohio National's position regarding what it might do in the future would be irrelevant.

As a result, Dr. Bennett was faced with two choices in 2015. One was to file a lawsuit against an insurer that was paying his claim on the off chance that several years in the future the stars might align to cause the insurer to terminate his benefits. The other choice was to wait to see if the conditions that were required to satisfy the insurer's position ever came to pass, and whether the insurer would maintain that position even if they did.

The objectively reasonable choice in this scenario should be self-evident. Disability claimants are typically in a highly precarious position. They no longer have income from their jobs, and thus are often reliant on benefits from their insurers in order to stay financially afloat. As a result, the prudent choice is to wait and see if the insurer will actually violate its promises, rather than assume that it will several years down the road. There is no sense in an insured "rocking the boat," or as Dr. Bennett puts it, "poking the bear," Opening Brief at 38, while his or her claim is being paid. Doing so might anger the insurer, or cause it to more aggressively investigate a claim it otherwise would not, which could result in a termination of benefits at

a time when the insured can least afford it. *See Fletcher v. Western Nat'l Life Ins. Co.*, 10 Cal. App. 3d 376, 404, 89 Cal. Rptr. 78, 95 (Ct. App. 1970) ("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."); *Mathews v. Eldridge*, 424 U.S. 319, 342, 96 S. Ct. 893, 906, 47 L. Ed. 2d 18 (1976) ("the hardship imposed upon the erroneously terminated disability recipient may be significant").

A reasonable claimant in Dr. Bennett's position has no incentive, and should not be required, to engage the full force of the legal system when doing so is contrary to his interests, not to mention premature and potentially unnecessary. *See Romano v. Rockwell Int'l, Inc.*, 14 Cal. 4th 479, 502, 926 P.2d 1114 (1996) ("there is little reason to require the employee to bring a claim when the termination decision still may be reversed and compensation may never be interrupted"). Such a requirement upsets the relationship between the insured and the insurer, unnecessarily stokes the fires of a controversy that might be resolved over the passage of time, and burdens the courts with disputes that have not yet fully ripened. *Id.* at 497-98 (warning of "of unripe and anticipatory lawsuits").

In short, there are numerous policy reasons why an insured should not be forced to sue his or her insurer over benefits that might or might not be paid in the future based on speculative and contingent rationales presented by the insurer.

C. Ohio National's Policy Concerns Are Misplaced and Outweighed by Other Concerns

UP recognizes that Ohio National contends otherwise. Although Ohio National does not directly address the above policy arguments in its opposition, it does present a competing policy argument, namely the concern about "stale claims." Respondent's Brief at 41-43. Ohio National warns that insurers might be "thrown off their guard" by a "lack of prosecution" and that evidence relevant to a determination may disappear or attenuate. *Id.*

At the outset, such concerns are misplaced in this context. Here, Ohio National announced in 2015 that Dr. Bennett's disability was due to "sickness" rather than "accident." In order to do so, it necessarily assembled evidence to support its position, including obtaining Dr. Bennett's medical records. As a result, if and when its determination is challenged, as it was in this action, that evidence still exists in Ohio National's file and it is free to rely on it.

Furthermore, as Dr. Bennett points out in his reply brief, even if Ohio National has a valid policy concern, that concern must be weighed against competing policy concerns. *See* Reply Brief at 21 ("A countervailing policy consideration, of course, is that claims should be decided on the merits."). An analogous issue to the one presented by this case is the issue of "late notice." Insurance policies typically provide for a time limit within which the insured must make a claim. However, California courts have held that insurers cannot deny a claim solely because it is late. Instead, an insurer must "prove that the insured's late notice of a claim has substantially prejudiced its ability to investigate and negotiate payment for the insured's claim."

Pitzer Coll., 8 Cal. 5th at 101. In doing so, the courts have held that prejudice "is not presumed from delayed notice alone." *Id.* at 102.

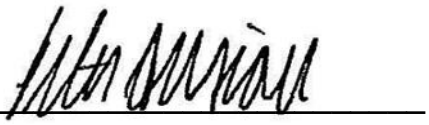
In other words, while the courts may be concerned about the possibility of stale evidence, the courts are also concerned about protecting insureds' rights under their policies. In the notice-prejudice context, the courts have determined that the insured's interests should prevail, and that a bright-line rule will not be imposed against the insured solely due to the passage of time. The Court should reach the same result here in the context of the statute of limitations. Any concern over stale claims is more than outweighed by the desire to decide claims on their merits, avoid unnecessary litigation, and protect insureds.

CONCLUSION

For the reasons set forth above, UP respectfully submits that the trial court erred in this case by ruling that the statute of limitations on Dr. Bennett's claims accrued in 2015 rather than 2018. The trial court's ruling places insureds in an untenable position, promotes potentially unnecessary conflict between insureds and insurers, will burden the courts with unripe disputes, and prevents insureds from obtaining the benefits to which they are entitled under their policies. The Court should therefore reverse.

Dated: March 30, 2023

Respectfully submitted,
KANTOR & KANTOR LLP

By 

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CERTIFICATE OF COMPLIANCE

Pursuant to California Rule of Court 8.204(c), I certify that this brief is reproduced using Times New Roman 14-point type, a proportionately spaced typeface. The lines of text are one-and-a-half-spaced and the word count is approximately 2,336 words, including headings and footnotes, but excluding the items listed in rule 8.204(c)(3).

Dated: March 30, 2023

Respectfully submitted,
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PROOF OF SERVICE
Mark Bennett, D.D.S v. Ohio National Life Assurance Corporation

California Court of Appeal, First Appellate District,
Division Three
Case No. A166049

(STATE OF CALIFORNIA, COUNTY OF Los Angeles)

I am employed in the County of Los Angeles, State of California. I am over the age of 18 and not a party to the within actions; my business address is 19839 Nordhoff Street, Northridge, CA 91324

On March 30, 2023, I served the document(s) entitled **APPLICATION FOR LEAVE TO FILE AMICUS CURIAE BRIEF IN SUPPORT OF PLAINTIFF-APPELLANT MARK BENNETT, D.D.S.; AMICUS CURIAE BRIEF** addressed as stated below**:**

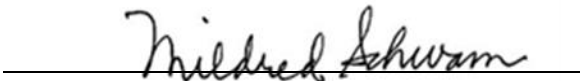
SEE ATTACHED SERVICE LIST

_x__ **(BY MAIL)**: I caused the envelope to be placed for collection and mailing at Northridge, California. The envelope was mailed with postage fully prepaid. I am readily familiar with this firm's practice of collection and processing correspondence for mailing. Under that practice it would be deposited with the U.S. postal service on that same day with postage thereon fully prepaid at Northridge, California, in the ordinary course of business. I am aware that on motion of party served, service is presumed invalid if postal cancellation date or postage meter date is more than 1 day after date of deposit for mailing in affidavit.

_x_ (**BY E-MAIL OR ELECTRONIC TRANSMISSION**): Per Order Mandating Electronic Filing and Electronic Service pursuant to CRC 2.251(c)(1), I caused the foregoing document(s) to be filed electronically with the Clerk of the Court and serve electronically on counsel listed below by using the True Filing System.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on March 30, 2023, at Woodland Hills, California.



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