Chapter 1 Insurance Claims

The total impact of an insurance claim can be either a most comforting or a most devastating event. As an agent, you have certainly come to realize that when your clients have problems, you have problems. Therefore, anything you can do to eliminate these problems "pre-loss," is a clear "win" for you and your insurer. In order to best serve your client and your own personal exposure to claim uncertainties requires taking your practice to a higher by gaining a better understanding of the Claims Process.

Agent Risk Management
Risk managing can be defined as any conscious action (or decision not to act) that identifies and reduces the frequency, severity, or unpredictability of loss claims. As you know, sometimes there is simply no coverage available for certain exposures or the clear definition of coverage is uncertain or ambiguous. These are times when your role and obligation is to identify the "gap in coverage" to your client so they understand, in no uncertain terms, that an exposure still exists. In other moments, you become their advisor on ways to mitigate potential claims. In either case, you are managing their claims through loss control.

Risk control strives to reduce the frequency or the severity of this loss of resources. Risk control can focus on actual harm, not on the money paid to restore, compensate for, or otherwise finance this harm, which is the concern of risk financing. For example, when a machine is destroyed or a person dies, an organization, a family, or society as a whole suffers a loss of resources. From a risk control perspective, the extent of such a loss of resources is not changed. Similarly, the severity of the loss is not reduced because the owner of the machine or the family of the deceased receives financial compensation for the loss.

A "risk control technique" is risk control only for one or more specified exposures. For example, fire-suppression sprinklers are risk control for fire damage, but not for loss by embezzlement. Similarly, a sprinkler system can be effective risk control for most fires. However, if the system uses water as an extinguishant, the water is a hazard rather than a safety measure for grease fires, which are spread or intensified by water. In short, specifying a risk control technique also requires specifying the exposure being controlled.

Perspective of a Given Entity
The effect of a given risk control technique can be measured only from perspective of a given entity. For example, pedestrians are exposed to bodily injury from being struck by automobiles, and drivers are exposed to the liability from such accidents. The pedestrians' exposure to injury and the drivers' exposure to liability are two different exposures growing out of the same circumstances. Any risk control technique that safeguards pedestrians from being struck by automobiles has different risk control effects for the pedestrians than for the automobile drivers. For the pedestrians, the effect is to safeguard against bodily injury; for the automobile drivers, the effect is to protect against liability. For one entity, an elevated walkway is risk control for a personnel loss; for the other, it is risk control for a liability loss.

Identifying Loss Exposure
To identify exposures, or possibilities of loss, the risk management professional must be able to do three things:

-Apply a logical classification scheme for identifying all possible exposures to loss.

-Employ proper methods for identifying those specific loss exposures that particular persons or organization faces at a particular time.

-Test the significance of these actual loss exposures by the degree to which they may occur and disclose to clients the possible results and remedies.

Loss exposures are typically categorized in terms of the nature of the value exposed to loss. All financial losses that are the concern of risk management can be categorized as property losses, net income loss, liability losses, or personnel losses. The only exception to this would be losses of purely sentimental value.

Elements of Insurance

Purpose of Insurance

The fundamental purpose of insurance is to provide protection against risks of loss that attend the ownership and use of real and personal property and the health and life of an individual. Conceptually, the ownership of any type of property or engaging in any activity involves some risk of loss, and, presumably, for the right price, insurance could be acquired that would protect against such loss.

In reality, most persons cannot afford to insure against losses on an individual basis. Therefore, insurance is feasible only when there is a sizable group of individuals willing to pay a sufficient amount into an insurance pool so that risks can be spread among the participants at a reasonable price.

Insurance as a Legal Contract

Insurance is a legal contractual arrangement creating corresponding rights and duties among the parties to a policy. An insurer has the privilege of specifying the conditions and rules which apply to those who wish to participate in the insurance pool, and a policyholder has a duty to obey such rules and conditions if he or she anticipates coverage for insured losses.

Notwithstanding the contractual nature of a policy, an insurer cannot compel a policyholder to pay premiums, but in such event it can deny claims or cancel the insurance policy.

Parties to an Insurance Policy

The central parties to an insurance policy involve the "issuer," the "owner," the "insured" and the "beneficiaries." The "issuer" is the company that extends insurance coverage over the subject matter by the sale of a contract known as an insurance policy. The issuer is commonly referred to as the "insurer," and less frequently as a "carrier." The "owner" of an insurance policy is the purchaser of the policy. The "insured" is the person who is protected against loss and may or may not be the owner of the policy. A "named insured" is a person or persons whose name is shown on the cover page or the front of a policy.

Even though he or she may not be included specifically on the front of a policy, a spouse who is a resident in the same household as a named insured would automatically assume the same status. An "additional insured" is a person designated under a policy by way of endorsement, because such person has either a legal liability or an insurable interest in respect of the property.

Significant Definitions

The concept of insurance is facilitated by an understanding of certain other terms that are customarily used in the industry and that have established legal meanings. A "loss" commonly means being without a tangible or intangible that previously had ownership assigned to it. In insurance parlance the term loss is more restricted and has come to mean "an unplanned, undesired reduction of value on an economic basis."

Losses are not to be confused with expenses. In an insurance sense, expenses relate to something that is predictable, such as depreciation.

Insurable losses are either "direct" or "indirect." If "direct," a loss is the immediate or first result of a peril. An "indirect" loss, the secondary result of an insured peril, is sometimes designated as a "consequential loss." There can be no indirect loss without a direct loss. Insurance policies

distinguish between direct and indirect losses when specifying the types and amounts of coverage.

A “chance of loss” refers to a ratio or a fraction where the numerator is the actual or anticipated degree of loss, and the denominator is the total number of loss exposures. By way of illustration, if there are 1,000 vehicles in an insurance pool, and the underwriters expect three of these vehicles to be destroyed during a flood, the expected “chance of loss” is 0.003 or 3/1,000. The “chance of loss” is determined in part by the number of claims filed for a given period, and it is a chance of loss that drives the necessity for insurance.

The causative agent of the loss is referred to as a “peril.” Criminal acts, fires, tornadoes, hurricanes, floods, and slip-and-fall accidents are all examples of insurable perils. Losses caused by perils are at the very heart of an insurance policy.

However, coverage under every insurance policy is not predicated upon a specific peril. Except perhaps for suicide, an insurance policy does not specify the peril causing a death. “Hazards” are conditions that enhance the degree of severity or the frequency of a loss.

Another important concept, particularly in property insurance, is “proximate cause,” the first peril in a chain of events without which a loss would not have been sustained. If the pilot of a small Cessna, lost in a fog, flew into a petroleum storage tank which exploded, causing several houses in the surrounding area to burn to the ground, the proximate cause of the destruction of the houses would be the plane crash.

Not all situations involving multiple perils are that clear, and when that is the case it may take litigation to determine the proximate cause of the underlying event specified in a claim. One of the basic rules of insurance coverage is that an insured cannot collect unless either the proximate cause or one of the other occurrences in the chain of events is an insured peril.

There are two specific definitions of the term “risk.” In the first situation, “risk” is a “variation” in possible outcomes of an event predicated upon chance. The more frequent the number of outcomes, the more enhanced is the risk. The second interpretation of “risk” is “the uncertainty involving a possible loss.” Those involved in the insurance business sometimes refer to a risk as an “exposure to loss.” The “degree of risk” is an index of the specificity with which the outcome of an event founded on chance can be foreseen. The less accurate the forecast of an outcome, the greater the amount of risk. For an insurance company, a better record of predicting the outcome translates into economic benefits. One of the greatest uncertainties in predicting risk is the uncertain aspect of human behavior.

A “third-party loss” occurs when there is damage to the property or health of a person other than the insured. If the insured was sailing on a lake when the boom on her boat hit her friend on the head, a third-party loss would be involved. If the boom knocked the insured unconscious, a first-party loss would have occurred.

“Premiums” are periodic payments made during the term of an insurance policy by an owner to the issuer for insuring against a loss. Funds attributable to premiums are placed into various investment vehicles by an insurance company. The payment of losses is funded by an insurance company from premiums and income earned on the investment of premiums.

An insurer may be a third party, such as a private company or the government, or a self-insurer. Private insurers are usually involved in selling vehicle and life insurance. The government is an insurer to the extent it provides Medicare and Medicaid coverage, flood insurance, veteran’s disability benefits, and FDIC coverage for savings and other types of bank accounts. As the cost of obtaining health insurance continues to increase, many businesses are covering health care plans for employees through self-insurance. In such case, employees contribute to a pool, usually through payroll deductions, and certain medical costs are then paid for by the employer,

functioning in the capacity of an insurer.

Suitability of Loss for Insurance Coverage
Not every exposure to loss is suitable for insurance coverage. A number of factors determine whether an exposure to loss is appropriate, including the existence of a suitable class of similar items exposed to the same peril, accidental losses, specific losses that cause extreme economic hardship, and a significant probability of a low incidence of catastrophic losses.

To be relatively successful, a carrier must accurately predict losses before they occur in order to reduce risks. Accuracy in prediction cannot be attained unless a large pool is involved. In order to establish a fair premium, the units in a pool must be substantially similar; otherwise, the pool cannot equitably transfer the expenses relative to the losses. Perils faced by each unit in an insurance pool should be identical. If half the roofs in a condominium complex were covered with wood shingles and the remaining half with composition shingles, the first half would pose a much greater fire hazard, and the risk of loss would be allocated inappropriately among all of the condominium owners.

Intentional losses are against public policy. If a policyholder could burn down his or her building and collect for the loss, the expenses would not be spread equitably among the insured pool. Thus, for a loss to be insurable in a practical sense, it must be accidental and beyond the control of a policyholder. It is that same principle that excludes normal wear and tear from the umbrella of property insurance coverage.

Notwithstanding this basic principle, it is interesting to note that many carriers consider a suicide by a policyholder that occurs within two years of acquiring a life insurance policy to be an intentional loss. A suicide that occurs two years and one day after the policy was issued, however, is treated as an accidental loss, and is typically considered the result of some type of mental illness.

In ascertaining the nature and extent of a casualty, a competent claims adjuster appreciates that a loss must be measurable, definite, and of a sufficient degree of severity to cause economic hardship. It must be beyond question that a loss has occurred. Insured losses must be quantifiable. The large-loss principle means that the purchase of insurance is only appropriate when a potential loss is large and uncertain.

Many catastrophic losses are not insurable because the occurrence of a few could possibly bankrupt an insurer. A “catastrophic loss” is one that is, relative to the amount of the property in an insurance pool, extraordinarily large. Generally, catastrophic losses have two characteristics: They cannot be predicted with any degree of accuracy and they are limited in geographical scope. In that sense, a catastrophic loss may also be thought of as a loss that is unpredictable and capable of producing damage that is extraordinarily large relative to the quantity of property in the insurance pool.

From the standpoint of a policyholder, an insurable risk is one that does not require the payment of prohibitive premiums. The financial status of the insured as well as his or her attitude toward and tolerance of risk determine what may be prohibitive to him or her. The potential loss must be of sufficient magnitude to create economic difficulties for a policyholder if not covered by insurance. There are situations which generally are uninsurable, such as losses attributable to changes in price or a competitive market environment. Then there are political risks, such as insurrections, war and devaluation of currency, which are usually not insurable hazards either, although some such perils may be insured by a government instrumentality.

Claims Made Coverage
The ability to predict risks has a direct bearing on the establishment of premiums. Reliance on long-term predictions presents an inherent difficulty in setting reasonable rates. There are two

forms of insurance coverage, and each has a distinct impact on the process of pricing insurance.

"Occurrence coverage" policies extend coverage for liability for activities that occur over a policy year, notwithstanding the fact that a suit might be brought at a later date to determine liability on the part of a carrier. The duty of a carrier to provide indemnification for an insured for losses incurred during a policy year could theoretically extend to claims filed a substantial time after the expiration of that term.

Thus, it becomes necessary for a carrier to fashion a premium that covers the eventual or probable results of any present activities. If both the severity and the number of claims is likely to increase over the immediate future, pricing of insurance can become extremely difficult. Because of the burdensome nature of establishing premiums with confidence under occurrence coverage policies, a trend has developed to issue "claims-made" policies.

"Claims-made" policies provide insurance coverage against liability for any claims that are presented to an insurance carrier during a policy year, regardless of when the underlying conduct giving rise to the liability occurred. The premiums for a claims-made policy can be set with more certainty because there is no necessity for a carrier to predict exposure to claims that are more long-term in nature. Because a policyholder under a claims-made insurance agreement is always under the threat of having his or her policy canceled because of unsafe operations, there is an inherent incentive in claims-made insurance to create safe conditions in the insured environment.

Current Events

The Hard Markets

The general downturn in business is forcing companies to look for ways to reduce costs in all areas, especially claims. Risk avoidance, loss control, fraud avoidance, electronic productivity, automating workflow, legacy system improvements are all encouraged to make the handling of claims more efficient.

Challenging the Claim

In response to certain state legislation aimed at reducing premiums, insurers are challenging accident claims far more aggressively than in the past. They have been less willing to settle claims.

Class Action Problems

A disturbing trend is the severity of individual claims and wholesale growth in class-action lawsuits. In essence, people today are not waiting for something to happen to sue, they're out looking for vulnerabilities.

Natural Disasters/Global Warming

In recent years there have been at least fifteen "billion-dollar" climate-related natural disasters that have put some reinsurers out of business and the outlook is not good.

Fraud

Insurers claim to be losing between $85 and $120 billion a year to fraud. The problem will get worse as long as insurers continue to handle claims by phone or mail instead of investigating and negotiating claims in person.

Fraud Detection

The industry knows that insurance fraud is growing at an alarming rate. New software advances using predictive, similarity search, and visual link resources are proving to be effective investigative tools.

Internet Fraud

As carriers expand their online presence and begin integrating claims services electronically, the

forging of documents and falsifying accident reports will most likely be commonplace. Currently, misleading web ads are rampant and the source of many claim problems.

"All Claims" Database
Slowly, but surely, the insurance industry is moving toward a national "all-claims" database system to be used by insurers and law enforcement agencies to help identify questionable claims and other insurance fraud.

September 11
The effects of 9/11 on America and property insurers are profound. Business interruption claims, for example, are being filed whether or not there was any direct physical loss of property. Coverage analysis of the many claims still being submitted will necessarily be dependent on the particular facts of each individual claim.

Network Problems
The recent experience of insurers with network repairs has been frustrating and expensive. Several state legislators have adopted anti-steering reform bills, and insurance executives are looking at shifting their business to independent call centers that operate in fields detached from suppliers, such as technology or software. Carriers and agents are better assured that their customers are professionally served and that work is done correctly, completely and cost-effectively.

E-Business Claims
Most traditional forms including Property, Business, Income, and CGL policies require that physical or tangible damage occur to be eligible. Look for new CGL language with exclusionary language related to computer losses as well as new, innovative policies/endorsements offering first party and third party coverage for technology related offenses, perils, and security.

American Disabilities Act
Insurance companies and their agents will see increased activity in the area of civil rights claims, particularly those dealing with the American Disabilities Act (ADA).

AIDs/HIV
Cases are surfacing that challenge the AIDs/HIV policy exclusions and limitations and emphasize that the limitation must be highlighted or set apart in some way.

Defining Occupation
In essence, insurers are attempting to narrow down the definition of client's occupations as a way to deny benefits with varying degrees of success. Look for more of these "narrow definition" conflicts which may involve agents.

Psychologically Induced Illness
Insurers are attempting to deny claims because they felt that some of their client's injuries were at least partially psychologically induced. The courts, however, seem likely to rule in favor of the client if his disability is "total" as defined by the policy, regardless of whether the illness was psychologically stimulated or entirely physical.

Experimental Treatment
There will undoubtedly be many cases defining what constitutes experimental treatment under health policies in the years ahead. Recent cases have "tested" policy meaning regarding alleged experimental breast cancer treatment, AIDs-related liver transplants, bone marrow transplants, etc. Insurance companies have lost their cases where an exclusion about experimental treatment was NOT highlighted in a conspicuous manner or where policy language was considered ambiguous.

Language Barriers
There are new cases developing in the area of language misunderstandings where clients have pursued claims on the basis they did not fully comprehend the matters at hand. The courts have determined that the insurance company could only deny coverage where an intent to deceive was found.

Defining Accidental
Policy language often limits coverage for "accidentally sustained" injuries, so when cases are built around attempted suicides have left clients permanently or severely injured insurance companies have generally refused to pay. The courts seem to focus on if "accidental" was highlighted in the policy, and if the insurance company is required to treat the self-inflicted injuries or the mental disorders that usually motivate such actions.

Tenants as Implied Beneficiaries
The courts are leaning more and more to the proposition that tenants are implied beneficiaries under a landlord's policy with occasionally bizarre results. Research Bannock vs Sahlberry (1994), American National Fire Insurance vs A. Secondino (1995), Cigna Fire vs Leonard (1994) for details.

EIL vs CGL
Within the last 20 years the insurance industry introduced environmental impairment liability insurance (EIL) in an effort to provide pollution coverage for events the industry deemed not to be covered by the more well-known comprehensive general liability policy (CGL). A very important distinction between these coverages is that EIL policies are claims-made policies, while CGL policies are occurrence-based. What is covered un EIL and CGL policies and where these policies overlap has been the subject of much debate and litigation.

Contamination
Despite the fact that policies have been written as "All Risk," insurers continue to deny contamination claims based on policy exclusions.

"Sick Building" Syndrome
People have an unusual ability to acquire the problems and illnesses of others. Most "sick building" illnesses are found to be psychologically based rather than rooted in fact. Courts have sided with the insurer in many of these cases.

Asbestos
The removal of asbestos continues to be a major source of conflict between clients and insurance companies. Client's all risk policies do not typically cover the removal of asbestos since it is not considered an unexpected event.

Lead
New standards introduced in September 1996 require property owners who are selling or renting real estate built prior to 1977 to disclose any known lead-based paint or lead hazards. Experts believe that the next wave of lawsuits will result from these disclosures and potential client illnesses, real or not.

Business Interruption
On the heels of major hurricanes and earthquake, claims are surfacing concerning business interruption where clients have been forced to close stores and businesses incurring major damages. A major issue that occurs in these cases is the determination of income. Most policies include a clause similar to this: "In calculating your lost income we will consider your situation before the loss and what your situation would probably have been if the loss had not occurred."

Miscellaneous Actions

In addition to the events mentioned above, experts anticipate actions in the areas of Y2K compliance, Fen-Phen and Redux diet drugs, latex gloves, construction product defects, intellectual property, tobacco and carbon monoxide.

Chapter 2 Insurance Company Structure

Types of Insurance Companies
There are two fundamental types of insurance companies – the mutual insurance company and the stock insurance company. A mutual insurance company is owned by its policyholders. Dividends, if any, are paid to the policyholders. The ability to pay dividends is nearly directly proportional to the profitability of a mutual insurance company. Favorable operating results are common in a mutual company. Premiums usually exceed the amount necessary to pay anticipated losses and expenses, resulting in "built-in" premiums to the policyholders.

Policyholders are vested with rights similar to those of shareholders in a for-profit corporation. They can elect directors and vote on extraordinary corporate transactions, such as a change in bylaws or an increase or decrease in the number of directors. Even though mutual insurance companies are designated as not-for-profit corporations, typically they are run efficiently and economically.

Mutual Insurance Companies
Perhaps the most significant type of mutual insurance company is the "advance premium mutual," in which premiums are paid by policyholders upon commencement of insurance coverage, and upon termination, policyholders become eligible for a dividend. Advance premium mutual companies ordinarily do a very high volume of business. In the "assessment mutual," policyholders may or may not pay premiums at the inception of coverage, but they are liable for their pro rata share of expenses and company losses upon termination of their policy. The "factory mutual" is a third type of mutual insurance company which provides significant loss protection such as frequent examination of the insured premises. Factories must satisfy rigid safety requirements, such as including fire alarms and sprinkler systems on the premises, before they can qualify for coverage. A deposit of the entire premium for years in advance may be required.

Stock Insurance Companies
The other type of insurance company is a stock insurance company, which is substantially like any other corporation. It is not a prerequisite that a policyholder must first be a stockholder in the insurance company. Another difference between a mutual insurance company and a stock insurance company is that in the latter, stockholders are not liable for their share of corporate expenses and losses.

The Reciprocal Exchange
A "reciprocal exchange" is similar to a mutual insurance company due to the fact that policyholders provide insurance for each other on a nonprofit basis, although a reciprocal exchange is an unincorporated vehicle. Reciprocal exchanges are popular in the western part of the United States, providing a substantial amount of vehicle insurance. A reciprocal exchange is managed by an attorney-in-fact who is responsible for the performance of all the management functions of the organization.

Divisions
The basic functions of most insurance companies are carried out among four corporate divisions – underwriting, marketing, finance, and claims. The underwriting department is responsible for the evaluation of risks, determining which risks will be underwritten and setting premium rates. Tailoring policies to individual needs, directing sales and advertising are the functions of the marketing department. The finance department is responsible for corporate and financial activities, tax preparation, investments, annual reports and the preparation and filing of necessary reports with state and federal regulatory agencies. The claims department, perhaps the least

favored department because of its perception of contributing to the shrinkage of the bottom line, handles the investigation, evaluation and settlement of claims.

Claims Departments
Within the claims division of a sizable insurance carrier, there may be a corporate office claims department which establishes claims procedures and practices for the entire carrier, a regional claims office which supervises branch claims offices within its jurisdiction, and branch claims offices which supervise claims representatives or adjusters as well as the investigation, evaluation and disposition of all but the largest and most troublesome claims presented to a carrier.

The head of a corporate office claims division is responsible for all of the big picture decisions made by the company including the establishment and supervision of common procedures, ensuring conformity and fairness across policies and payouts, and monitoring significant litigation.

The branch claims facility is the office to which most claims are directed. Most branch offices are located in significant population centers. The personnel within a branch claims office handle and supervise claims and issue the settlements. Line supervisors are typically found at branch claims offices and are directly responsible for supervising adjusters. Line supervisors specialize in claims surrounding a line or specific type of insurance. Typically, a line supervisor has the final word on the disposition or settlement of a claim. A line supervisor usually reports directly to a claims manager who is in charge of a branch office and is rarely involved with a claim.

The Adjuster
An insurance adjuster, sometimes referred to by a number of different titles, is a professional, trained in the examination, evaluation, and dispensation of claims as well as the identification of fraudulent or frivolous claims.

Some insurance carriers use both field adjusters, who spend substantial amounts of time at the site of an accident or a loss, and office adjusters, who for the most part remain in their offices handling claims by telephone under the direct supervision of a claims manager. Originally, office adjusters handled only small claims in which there was little or no liability. Presently, most claims are processed by an office adjuster over the telephone. If a claim is within elementary guidelines, many carriers will allow an office adjuster to settle the claim over the telephone without the intervention of an outside adjuster, thus reducing administrative and overhead expenses considerably for an insurer. Quick resolution of small claims also enables a carrier to establish a reputation for the effective handling of claims. Claims of a larger magnitude or that appear to be complex or potentially fraudulent, may be assigned to a field adjuster who makes personal contacts with both the claimant and witnesses and is responsible for the direct investigation of the subject or site of a loss. Turnover rates among field adjusters is understandably high considering that they are usually the target of hate for claimants, are typically underpaid, and are perceived to be low on the corporate ladder.

Adjusters, whether in the office or the field, must keep written progress reports about their investigation and disposition of claim files under their supervision and control. All telephone calls, instructions from supervisors and activities taken on each claim are recorded. Also, both field and office adjusters are, for legal purposes, agents of an insurance carrier. As a result, an insurance company is responsible for the actions of agents that are carried out in the ordinary course of business. Inadvertent or negligent acts or omissions can result in a carrier having to pay a claim it might not otherwise have intended to pay.

The professional loss claims adjuster must possess a substantial degree of expertise and knowledge to avoid imposing a settlement of unwarranted claims on a carrier. To that end, there are two legal principles that an adjuster must be extremely familiar with—"waiver" and "estoppel." The intentional abandonment of a known right is designated as a "waiver," and "estoppel" is the

result of behavior that is incompatible with asserting a known right. The successful assertion of either one of these legal defenses by a claimant could result in a carrier being saddled with liability it might have otherwise avoided.

Independent Adjusters
A smaller insurance company that does not have branch offices may employ the services of an independent adjuster to provide claims services relative to the investigation, evaluation, and settlement of claims. Independent appraisers are typically hired by carriers for several reasons. During certain times of the year, such as hurricane and tornado season, the needs of many carriers are increased such that a number of extra adjusters are required. In less densely populated areas, the number of claims is not typically large enough to justify staffing a full-time office, so carriers look to independent adjusters to take care of the infrequent number of claims that are filed in such places.

Independent adjusters are typically self-employed but can be associated with a larger group of professional independents. Either way, independent adjusters usually have to pass exhaustive examinations to receive their licenses. The fact that most independent adjusters are paid on a case-by-case or hourly basis, unaffected by any payout or settlement, encourages them investigate quickly and come to a fair decision.

Public Adjusters
Sometimes referred to as a "loss consultant," a public adjuster also works independently of a carrier, but, unlike an independent adjuster, he or she is typically hired by a claimant. Many public adjusters have scanners in the fire and police departments and are labeled ambulance chasers. Unlike an independent adjuster, a public adjuster works on a percentage of the amount recovered. In some states, a public adjuster must be licensed before he or she can offer his or her services to the public, but this is not universal. A competent public adjuster is thoroughly grounded in the subtle provisions of a policy and usually handles all the paperwork and negotiation involved with the claim and settlement on the claimant's behalf. On average, a public adjuster recovers at least 17 percent more than a claimant acting on their own.

Catastrophic Situation Adjusters
One of the most remarkable trends in the development of insurance over the past several decades has been the organization of a team of insurance experts to deal effectively and swiftly with losses in major catastrophes. The result is immediate loss adjustment in an area of a disaster. Insurance professionals, including claims adjusters, sometimes use superhuman efforts investigating, evaluating, and settling claims, and often working long hours under very stressful conditions. The mobile operation may involve the use of sound trucks to advise policyholders of the availability of loss claims adjustment services. Temporary living facilities may be located. Cleanup crews may be made available. Also, the insurance team may assist the victims in securing lumber and other building supplies to begin needed repairs and reconstruction of their homes.

The Claims Department and the Underwriters
One of the responsibilities of the claims department of an insurance company is to advise the underwriters about various obstacles they encounter, such as: unfavorable laws, areas with an excessive incidence of claims, various cost items, and other potentially burdensome items. These claims files assist an underwriter in determining what can go wrong through an evaluation of the costs of different kinds of losses and practices of maintaining reserves. In turn, the underwriters should advise the claims department about stressful situations developing between the company and any policyholders. Expenses involved in the negotiation of claims and the cost of litigation can drive the general and administrative overhead and related expenses of an insurance company through the roof if there is little or no cooperation between the claims department of an insurance carrier and that company's underwriters. Postmortem conferences between the underwriters and the claims departments can help minimize or prevent future problems.

The Marketing and Claims Departments
One commonalty that exists between the marketing and claims departments of an insurance carrier is that both represent the carrier to the public. Nothing tests the performance quality of an insurance product more than a claim. An unsatisfactory resolution of a claim indicates that the insurance product has failed to perform its intended need and function. The claims department can measure the delivery end of a carrier for the marketing department. Many facts developed from experiences with claims can make for a better insurance product.

The Claims and Loss-Control Departments
A significant amount of information from a claims department can enhance a loss-control specialist's knowledge of what to guard against in an attempt to reduce losses. Safety improvements and other changes may be warranted. Pre-claim activity should have as its goal the mitigation of losses. Necessary evidence should not be lost or misplaced after a loss. Claims and loss control should work together to prepare and maintain records that are invaluable following a loss. Such a system enhances quality control of the insurance product. The combined input of both departments can be provided to an underwriter to help in the decision about whether an insured's potential loss is desirable. Accurate information about losses is important to help emphasize to the carrier the trends in – and resulting costs of – accidents and their effects on premiums and rates and the need for a reliable safety programs.

The Insurance Policy
An insurance policy is a legally-binding contract between an insurance carrier and a policyholder that sets forth certain obligations, such as a requirement on the part of a policyholder to pay premiums in a timely manner, in return for a duty on the part of an insurer to cover losses relating to an insurable event included in the policy upon presentation of a valid claim by an insured.

The property & casualty insurance product differs from other insurance company products, such as an annuity, in that tangible payments or benefits are paid only after the occasion of a loss. A contemporary insurance package may contain a broad range of liability and property insurance at rates considerably less than if each type of insurance was purchased separately.

An insurance policy issued by a property and casualty carrier typically has a number of characteristics in common, including:

The Declaration Page – Sets forth the name and address of the policyholder, the maximum dollar limit of coverage, a description of the property or liaFbility to be insured, the amount of the premiums, the date upon which payment is due, and the types of coverage.

The Insurance Agreement – The relative obligations and responsibilities of both the carrier and the policyholder.

Terms and Conditions – Specifies aspects of the coverage as well as what is required of both parties in the event of an insured loss.

Exclusions – Describes any property and liability that are excluded from the coverage

Fraud and Concealment – Allows a carrier to either deny coverage or declare a policy to be void in the event a policyholder is caught committing fraud or concealing facts.

Exclusions of Peril – Any perilous losses that are excluded from coverage, as well as requirements involving the preservation of property following a loss.

Waivers – Declares that the only modifications to the policy that are acceptable to a carrier are those that are in writing and attached to the policy as an endorsement.

Cancellation – The conditions under which a policy may be canceled are included in this section as well as how premiums would be returned.

Interests of a Mortgagee – The provisions that if property covered by a policy is mortgaged, a lender has a vested interest in such property that is recognized by the insurer.

Pro Rata Contributions – The provision that each carrier will pay a fair proportion of a loss when there is more than one policy in effect for the same property.

Requirements of a Policyholder in the Event of a Loss – A policyholder's responsibilities to an insurer in the event of a loss and claim requirements.

Appraisal – The procedures to be followed should a carrier and an insured desire to select and pay for independent appraisers to determine the value of a loss.

A Carrier's Obligations – Permits a carrier to take possession of some or all of damaged property at a mutually acceptable value after settlement, to repair, replace or rebuild the property out of materials of a similar quality and type or to settle a claim in cash.

Subrogation – The rights of a carrier to legally recoup the amount of settlement from a third party who is responsible for a loss after payment of a claim.

Standard and Nonstandard Policies
For many substantial types of coverage, a significant number of carriers utilize a standard form of contract containing identical or substantially similar terms which have developed through legislation, rules and regulations, case law or custom within the industry. Associations or organizations that are responsible for developing rates and establishing policy forms prepare, modify, and distribute standard policy forms.

There are a number of advantages to the use of uniform policies of insurance, including conformity of rates and payouts across clients, a reduction in the need for litigation, a lack of overlap between other standard policies, and a general degree of simplicity when it comes to training agents and selling to clients.

Nonstandard forms are those developed by and for a carrier that do not conform in substance to the terms and conditions of a standard insurance policy.

Terms and Conditions of a Policy
An insurance policy is first and foremost a contract, subject to all of the rules involving the interpretation of the meanings of its terms and conditions. An insurance company may establish such terms as it sees fit, so long as there is no illegality involved and the terms are not against public policy. Certain risks may be insured against and others may be excluded, as long as both the coverage and the exclusions are detailed in clear, concise and unambiguous terminology. Because the words in a policy are those of the carrier, they are generally construed by courts in favor of the policyholder and against the insurer.

The reasonable expectations of a policyholder will govern an interpretation of the terms and conditions of an insurance policy. Most insurance policies are what are referred to legally as "adhesion contracts," a type of legally-binding agreement in which there is little or no bargaining among the parties involved. There is very little give and take or negotiating that goes on between a carrier and a prospective insured when an application for insurance is taken.

Legal Interpretations
The ultimate interpreter of an insurance policy is neither a policyholder, an attorney, a carrier, a mediator, an arbitrator nor a state insurance commission. That decision lies with the courts.

Questions brought before a court about the meaning of the terminology of an insurance policy result in decisions which ultimately evolve into a body of case law. A carrier is required to act in a manner consistent with such case law when the investigation, evaluation and settlement of claims are involved. To do otherwise can result in actionable "bad faith" or "unfair claims settlement" practices.

When evaluating the relative interests of a policyholder in light of those of a carrier, courts have consistently decided quite liberally in favor of the insured. The position of a policyholder must be quite clearly erroneous before a court will rule in favor of the insurance company. Because courts have been favorably disposed toward policyholders, carriers have been compelled to adopt exhaustive measures to preserve and protect their rights and privileges under a policy.

Experts believe that the ultimate effect of a body of court decisions has been to broaden coverage and to include unwritten terms and conditions in a policy that might not have been intended by either a policyholder or a carrier. Another result is a growing body of judicially-crafted standard practices that must be followed by the insurance industry in general.

A company's attitude toward claims and claims administration and adjustment reflects a carrier's policy involving the resolution of controversial claims and the avoidance of litigation. Carriers may go to great lengths to offer superior service to policyholders by reimbursing claimants for questionable claims or those not under coverage. On the other hand, approaches to claims may reflect a policy that is inconsistent with industry practice or not in keeping with specific terms of a policy.

Chapter 3 Claims, Processes, and Techniques

Claims

Notification of a loss to an insurance company by a policyholder or a third person constitutes a claim for payment. Before satisfaction of any claim, a carrier will require an investigation of the facts and circumstances underlying the situation which gave rise to a claim. The adjustment of losses in the industry is probably most significant in property insurance because of the partial nature of such damages and the difficulty of measuring the extent of such losses. This concern does not normally affect life insurance since the loss is complete and the amount of the payment is always a certain sum, the face value of the policy.

One of the first steps in the investigation of a claim is to ascertain if the insurance carrier is responsible for payment of a loss. Infrequently, a claimant will file a claim with the wrong company or describe property that is not the subject of a policy. Other claims may be filed after a policy has expired or when the time for the payment of a premium or premiums has expired. Some losses, such as damage due to floods, may have been specifically excluded from coverage. In a few cases, coverage may not be forthcoming because an applicant filed a fraudulent claim.

Once a carrier has determined it is liable to pay for a loss, the company must then determine the actual amount of damages done. If a carrier and a policyholder can agree on the amount of coverage, the claim will be settled. If not, arbitration proceedings may be warranted. A carrier must take care not to reduce payments for legitimate losses below a level which would constitute an unfair settlement of a claim. If a claimant is willing to settle for less than what the insurer thinks the claim is worth, it would be a show of good faith for the company to pay the reasonable value of a claim.

Once a claim is accepted and agreed upon, it will be paid promptly by a carrier. If a claim is denied or if a claimant thinks the proposed settlement amount is insufficient, the insured can secure the services of a lawyer and sue the carrier.

Claims as an Insurance Company Expense

An insurance carrier is in the business of handling many risks, and the business does not come cheaply. Most insurance companies are large, bureaucratic institutions that operate with very substantial amounts of overhead, including rent, utilities, salaries, company vehicles, legal costs, sales commissions, and expenses resulting from the settlement of claims. All of such costs are included in calculating what amount of premiums to charge. Such expenses also include the costs of frivolous, exaggerated, and fraudulent claims.

People have been known to burn down buildings and fake their own deaths in order to recover under both property and life insurance policies. Some insurance companies are owned by private investors and others by policyholders. In either case, claims are paid from funds attributable to premiums collected and from income from investing such premiums.

Parties Involved in an Insurance Claim
The parties involved in an insurance claim can involve an insured, a carrier, a beneficiary, a third party who may have suffered losses, a staff claims adjuster, an independent adjuster, a specialized investigator, a mediator, an arbitrator, a lawyer, and the state insurance department. An agent who sold an insurance contract to a policyholder may also be useful in reporting the claim directly to the carrier, keeping the policyholder advised of the investigation and the resolution and disposition of the claim.

Elements of a Valid Claim
In order for a casualty or a loss to be covered by insurance, a few basic elements must exist:

Losses must be fortuitous – Losses covered by normal wear and tear or deterioration are the result of a known condition, and therefore are not covered.

Losses must be occasioned by an extraneous factor – If a loss is caused by an inherent physical condition rather than an external agent, coverage will not apply.

Losses cannot be intentionally caused by the policyholder – Damages caused by a suicide attempt more than two years after the purchase of a policy is a typical exception to this rule.

Only legal property can be the subject of a valid claim – Illegal property cannot be the subject of a valid binding contract.

A loss must be sustained – The mere happening of a perilous occasion involving insurable property cannot be the subject of a valid claim unless an actual loss has been sustained.

There must be an "insurable interest" in the property – A policyholder must have some degree of legal interest in the property which is the subject of an insurance claim.

Rights of a Claimant
One of the most significant laws that provides protection to consumers while impacting investigation, evaluation and settlement of claims on the part of an insurance carrier is the "Model Unfair Claim Settlement Practices Act," which has been adopted in one form or another by a substantial number of states. The enumeration of such rights is not by any means exclusive as other legal rights of policyholders that have been established both by legislation and by case law. Also, such rights may serve as a guideline to some courts when confronted with the question of an unfair settlement practice.

The Impact of the Law on Insurance Claims
The claims process is a method of translating the rights provided to a policyholder under an insurance policy into a remedy.

In the past 20 to 30 years, a growing body of statutes, rules and regulations, and judicial

decisions have arisen, creating new responsibilities on the part of carriers where few had previously existed. Growing statutory and case laws have proved in many instances to be quite onerous, and carriers have been encouraged to pay invalid or exaggerated claims just to avoid burdensome litigation.

There are three sets of developments that have resulted in the imposition of extraordinary burdens on insurance companies: the judicially-imposed liability for failure to pay a first-party claim, the creation of a duty to settle claims, and the elaboration of a carrier's duty to defend an insured liability. Underlying all of these developments has been a failure on the part of those who prepare insurance policies to specify clearly the corresponding rights and obligations of both the carrier and the policyholder. As a result, carriers have had an abundance of discretion in determining whether and how to settle claims and how to satisfy other contractual obligations. Some courts have managed to limit this discretion through an equitable, economic application of insurance laws.

When the terms and conditions of an insurance policy are not crafted with a great amount of specificity, sufficient detail must be provided by legislation or by case law. One method of achieving this is to tailor the terms and conditions in such a fashion as the parties would have done if they would have agreed upon the inclusion of such details in the policy. Adjusters should be aware that failure to show a claim a fair amount of diligence may constitute "bad faith" from a legal perspective. The elements of evil intent or deliberate wrongdoing are not necessarily inherent in the legal concept of bad faith. Exceeding the discretion allowed by a contract is frequently enough to constitute bad faith on the part of a carrier. It must be recognized that the term "bad faith" varies from one setting to another as well as from one jurisdiction to another.

One significant development in the legal regulation of claims that has occurred over the past several decades is the evolution of a new cause of action for the bad faith refusal of a carrier to pay claims of first parties. Prior to that, a policyholder could only recover an amount of damages equal to the policyholder's losses under conventional contract law. The measure of damages, being only what the carrier would have otherwise been obligated to pay, did virtually nothing to deter a carrier from breaching a policy. And since the policy was the product of a carrier, the inequitable situation could not be alleviated by including a fuller measure of damages in the insurance contract. More and more, courts are now awarding damages that are not contemplated by the insurance contract, such as legal fees, consequential damages, pain and suffering and exemplary or punitive damages. The great majority of bad-faith cases involve defective investigation of insurance claims which results in an inappropriate denial of claims. Unlimited recovery of damages not provided by the terms and conditions of a policy can lead to over caution on the part of the insurance industry, similar to the degree of safeguards adopted by the medical profession in over diagnosing and over treating to avoid liability. Several states have attempted to stem this development by passing laws that allow recovery of reasonable legal fees and a modest amount of punitive damages in bad-faith cases.

Generally, punitive damages can only be recovered in bad-faith litigation upon proof by the claimant of an intention on the part of an insured to inflict injury or damages. Liability often turns on the intent of the denial. A simple but erroneous conclusion that one is not entitled to coverage would probably be less than a sufficient basis for punitive damages. If denial was made with flagrant disregard of the necessity to investigate, punitive damages may be appropriate. A claim that an adjuster may initially refuse to investigate may be only one of negligence, but a stubborn and willful continuance to refuse to investigate can turn quickly into a case involving bad faith. The appropriate test for determining the existence of bad faith should be whether a carrier took improper advantage of its strategic position with respect to a claimant. Because of the new measure of liability for denial of claims, it is possible that more fraudulent, exaggerated, and frivolous claims will be filed in the future.

At the same time, another body of case law has arisen with respect to an insurer's duty to settle

third-party claims against the insured that has impacted the entire procedure of claims investigation, evaluation and settlement. A first review of an ordinary insurance policy would have the reader conclude that a carrier has near complete discretion about whether to settle or litigate third-party claims. A standard provision appearing in an insurance policy typically provides that, "the insurer shall defend any suit against the insured in which the claimant alleges property damage or bodily injury and seeks damages payable under the terms and conditions of this policy, notwithstanding that the allegations may be false, fraudulent or groundless. The company may at its own discretion conduct such investigation and settlement of any suit or claim as it shall deem appropriate."

Such discretion has frequently led to disagreements and serious conflicts between a carrier and a policyholder. The problem becomes most obvious in a situation where policy coverage is set at one amount and a claimant asserts liability in excess of that amount. If a claimant offers to settle for the limits of coverage and the carrier refuses, the insured is left with the possibility of threatened litigation and, ultimately, a judgment in excess of the policy coverage amounts. Some courts have held that a carrier owes a policyholder equal consideration when weighing the relative interests of its own with those of a policyholder, hoping to establish a deterrence against carriers making institutional decisions to create a reputation for being tough on settlements. The problem with this approach is it places a burden on a carrier to entertain a settlement offer as though there were no policy limitations on coverage, when the penalty for failing to settle a reasonable offer is liability for the entire claim on the part of the carrier. The imposition of a duty to settle reasonable claims has resulted in part in protection for the carrier against liability for coverage exceeding the limitations set forth in a policy.

The extent of a carrier's duty to defend litigation brought against the insured by a third party is also in flux. Under traditional circumstances, carriers had less motive to breach their duty to defend a policyholder against third-party liability claims than they did to refuse to settle reasonable offers, since in the first instance the insurer was typically liable only for the amount of the reasonable settlement. Bad faith was not ordinarily involved in a decision not to defend, but rather the driving force was an unbridled contractual provision in a policy which limited the duty to defend to circumstances in which the carrier could reasonably expect to have to pay the costs of the defense.

The more contemporary cases involving bad faith have effected a realignment of the balance between a policyholder and a carrier with respect to relative advantages enjoyed by both. Regulation is justified on the theory that both parties become adversaries, potential courtroom foes, immediately upon the filing of a claim. The insurer's interest is set aside if it has no ultimate duty to cover the loss of the policyholder. On the other hand, the policyholder is assured a defense in almost every case when it can be reasonably expected that one will be necessary. The readjustments do not necessarily create a mandatory obligation on the part of the insured; rather, they impose liabilities for acting unreasonably.

Investigation of a Claim

Generally, the burden of proving the existence of a loss is upon a policyholder. An insurer does not have a legal duty to prove that a loss that is the subject of a claim has not been sustained by a policyholder unless and until the claimant has met his or her initial burden of proof. Although these relative obligations on the part of a policyholder and an insurance carrier are not stated in a policy, they are accepted throughout the insurance industry and are recognized by the judicial system. Notwithstanding the general rule about the burden of proving the existence of a loss, in situations where it is extremely difficult for an insured to demonstrate a loss, a carrier must accept the policyholder's word concerning facts surrounding a loss unless it is able to obtain conflicting evidence. A carrier has a legal right to require a policyholder to prove that the value of a claimed loss is as stated in the notice to the carrier or the proof of loss. The financial burden of demonstrating a loss, including the cost of an appraisal or an estimation of repairs or replacement, is upon the claimant.

Procedural Reasons for Denying a Claim or Terminating a Policy
When an insurance company receives a claim from a policyholder, it assumes a duty to carry out a thorough and competent investigation of the claim to determine what coverage for the underlying loss is applicable and which benefits are payable under the policy. Once a policyholder has filed a claim for insurance, the company will assign the claim to an adjuster, who is the person in charge of investigation, negotiation, evaluation and settlement of a claim. The initial task of an adjuster is to see if the policy in question is in full force and effect. If there are exclusions that apply or if premiums have not been paid timely as required under the terms and conditions of the policy, coverage may not be forthcoming. Another set of circumstances which may enable a carrier to avoid coverage is the existence of fraudulent conduct on the part of a policyholder, either at the time an application for insurance coverage was taken or when the claimant prepared the notice or proof of loss. An adjuster must also satisfy him/herself that the claimant complied with any duties imposed upon him or her by the policy that apply after a loss.

Fraud, Concealment, and Misrepresentation
The entire policy will be void if, whether before or after a loss, an "insured" has intentionally concealed or misrepresented any material fact or circumstance, engaged in fraudulent conduct, or made false statements relating to this insurance. Concealment involves a failure to divulge facts to a carrier which, if otherwise known, would have affected the decision of the carrier to grant coverage or honor a claim. Policyholders frequently try to conceal preexisting conditions in the hopes that their insurance will cover any additional costs associated with those conditions. Misrepresentation, as opposed to concealment, is a misstatement of a fact that is material to the underwriting decision, which can also lead to denial of a claim or termination of a policy.

Duties of an Insured in the Event of a Loss
Virtually every insurance policy involving the loss of property contains a provision providing what steps must be taken by a policyholder in the event of a loss. If an insurance claims adjuster determines that the policyholder failed to comply with such conditions, he or she may recommend denial of the claim to the carrier.

Claim Evaluation
The evaluation of an insurance claim involves assessing the damages or the extent of losses surrounding real and personal property, personal injury, or loss of life. In complicated cases, the process can often be quite lengthy. The first step in an evaluation of a loss set forth in an insurance claim actually occurs when a carrier sends an adjuster for an on-site inspection, investigation, and estimation of damages. The adjuster should attempt to verify that losses are covered by the policy in question.

In the case of damage or losses to property, an adjuster's task is much easier if a claimant has not made any repairs other than those essential to preservation of the property, and if claimant remains cooperative and honest throughout the evaluation process. The adjuster will probably want to verify that the policyholder did nothing to worsen the damage sustained by the property. Independent verification of the facts stated in the claim may be accomplished by reviewing any reports that were filed with the police or by conducting interviews with witnesses. Dollar losses are then calculated by taking inventory of the damages claimed. Each specific item of damage or loss is assigned a value, using either an assessment made by a claimant or a determination by an adjuster who employs external sources, such as established indexes of value or the estimates of a repair shop or a professional appraiser.

Repair estimates, receipts, service charges, and repair bills are evaluated to arrive at an estimation of the amounts which will eventually constitute a settlement. All information bearing on the evaluation of a claim presented by a claimant to an adjuster will be considered. Inadequate or irrelevant information may lead to an undervalued claim.

Disputes about Evaluation of a Claim
Disputes between an insurer and a claimant about the value of a claimed loss constitute one of the most frequent disagreements between a policyholder and an insured. During the processing of a claim, one of the most difficult tasks confronting an insurance adjuster is determining what a claim is worth. Inherent in such determination is placing an accurate value upon the subject of an insurance claim so that every claim can be reduced to a specific dollar amount. Placing the value on a life in the event of death is arbitrary at best. The benefits of future earnings that certain of the survivors would have been entitled to, funeral expenses, and medical costs are amenable to quantification, but such other aspects as loss of consortium and companionship are not capable of being reduced to a dollar amount. Another problematic area involves the evaluation of personal property losses. Items such as family heirlooms and antiques have an intrinsic value to a claimant that can never be replaced. In situations where a claimant has lost everything, such as in a fire or a tornado, it may be impossible to provide evidence of ownership and complete or adequate inventory of every piece of personal property that was owned before the disaster.

Use of an Independent Expert
In the event of a property loss, an insurance adjuster frequently uses the services of an independent expert to evaluate a loss. Experts are typically hired by the claimant, not the adjuster, as a way of ensuring that their settlement is as high as possible. Because it is difficult for one adjuster to be intimately familiar with the costs of repairs and replacements involving every conceivable type of property, it is frequently necessary for a carrier to use the services of an expert to assist an appraiser in establishing a value for a recommended settlement.

Actual Cash Value
One of the most arduous tasks of an adjuster is a balancing act involving the assignment of a value to items that are the subject of a claim while performing his or her responsibility of reducing a claim to a dollar amount. An ordinary insurance policy covering personal or real property provides that benefits payable for damaged or lost property are the "actual cash value" of such property at the time of loss.

The actual cash value is the price that one might anticipate an article or piece of property to bring if offered for sale in a fair market where there is a willing seller and a willing buyer. A forced sale or a price obtained at a public auction would be excluded as determinative of market value. The term "actual cash value" is defined under the laws of some states, and, in other jurisdictions, customary definitions have come into use because of court definitions.

When a market exists for used goods like the kind in question which may have been stolen or destroyed, the value can be measured against the price it would have brought in the open used market. An adjuster cannot reduce a claim to a dollar amount unless he or she knows what items have been lost or damaged. An adjuster will ask a claimant to prove ownership of an item which is the basis of a claim, and may be suspicious if a policyholder asserts that he or she purchased a large amount of items for cash. When there is no public market for a used item, the actual cash value may be determined by taking the acquisition cost of a new item and subtracting an amount reflecting the used component of the item, which is called depreciation. Many carriers employ depreciation tables in evaluating what dollar amount to place on damaged property using the rule of thumb that an item loses value every year over its expected life. Even so, placing a dollar value on used personal property is quite subjective.

Replacement Cost
When old property is involved, the deduction for depreciation might reduce the settled amount to a level below the actual replacement cost. In such a case, a carrier may allow an insured to pay additional premiums for an endorsement that substitutes a replacement cost for an actual cash value. Under replacement cost coverage, settlement is conditioned upon a claimant actually replacing the damaged or lost property. If the claimant elects not to replace the property, the settled amount is limited to actual cash value.

Another exception to an actual cash value policy is a "stated value" policy, in which the insurer and the carrier agree at the time of issuing a policy that the property in question has a specific value. The carrier must then pay the stated value rather than the actual cash value.

Evaluation of Extraordinary Items
Certain items of personal property are not susceptible to replacement value coverage and should be insured separately if coverage is available. There is no rate book that an adjuster can turn to for determining the value of a loss of an extraordinary object, such as an expensive lithograph, a quilt from the Revolutionary War era, or a two-carat diamond inlaid in a customized setting. A reputable certified appraiser should have been consulted before the item in question was insured, but if that was not the case, one will have to be used by an adjuster. Other items which may be included as extraordinary for purposes of coverage include vintage vehicles, antiques, guns, and certain articles of clothing. An appraiser may seek information about whether the item has depreciated in determining the amount of the settlement.

Evaluating Minor Personal Injury Claims
In the event of a minor personal injury, a claim may be filed by the insured or a third party who was on the insured's premises during the time of an injury or may have been injured while a passenger in a vehicle belonging to the insured. Frequently, in determining how much to allow in a claim for minor personal injury, an adjuster may be bound by the consensus of what other carriers allow as well as applicable case law. In an evaluation of a minor personal injury claim, an examiner or adjuster will take the following factors into consideration:

Determination of which carrier will cover a claim – In an event where multiple carriers may be involved, an examiner will determine from police reports and statements whether another carrier should have been notified of the underlying event.

Medical expenses – Medical expenses are reviewed carefully to determine reasonableness and the possibility of double coverage, such as medical and automobile coverage both covering injuries from automobile accidents.

Loss of earnings – Wage-loss information is analyzed for lost income or earnings capacity. An insurance examiner will compare wage statements provided on a W-2, a 1099, or a recent federal or state income tax return or consult with the insured's employer.

Disability – An examiner will evaluate the underlying facts upon which a claim for disability is based. Medical reports and the nature of the underlying treatment will be examined. An adjuster will look to see if there is other evidence to prove or disprove a claim of disability.

Death Due to an Accident
In a claim involving death due to an accident, "wrongful death" statutes may apply in many states. Under such statutes, a surviving spouse, parents or children of the deceased may recover damages from the party responsible for the death. In such a case, one who could so recover becomes the claimant.

One of the first factors which must be determined is whether the deceased contributed by his or her own negligence to his or her death. Whether or not his or her actions were the sole causative factor or just one of a number of factors determines the amount of the damages which an insurance company may have to pay. Another factor to be considered in calculating damages is whether the deceased survived for any period of time after the accident occurred and if the deceased incurred pain and suffering. An examiner must determine if the deceased was conscious before his or her death for any amount of time.

An adjuster must obtain a copy of the death certificate to verify the cause of death. Traces of

alcohol or drugs in the blood of the deceased may confirm contributory negligence. Police investigations and witness statements are useful in this determination and other matters affecting the cause of death.

Settlement of a Claim
The vast majority of insurance claims are paid promptly and without the involvement of a great deal of complexity. Many cases are settled or disposed of through negotiation between a claimant and an adjuster. Insurance adjusters should know that compromise is the basis of a successfully negotiated claim and that non-reciprocal compromises may constitute an invitation to litigation. Negotiations must be made in good faith for an offer to be fair and reasonable. Successful dispositions of an insurance claim, based upon a compromised settlement, must also be based upon a consideration of all of the underlying facts. Reasonable demands or concessions made at inappropriate times have an adverse impact on a settlement. Unreasonable offers should be refused. Settlement agreements should not be signed unless an adjuster and a claimant are reasonably satisfied with the terms and conditions of the proposed settlement.

Release
No matter what the type of claim, a release is the ultimate objective of an insurance company. A release is a legally-binding document which provides that the person who executed it settled the claim for a valuable consideration, and did so knowingly. After a release is signed, and notarized, if required, the insurance company dispenses a check to the party affected by the release. Once signed, the company is entitled to rely on representations by an insured that the claim is settled, and that no additional claims will be made which arose out of the same accident or set of facts.

Following are some of the more important aspects of a release:

Reading the release – A release must be in readable form and should have been reviewed and understood by the insured. A lawyer should be involved if the release cannot be understood by the parties involved.

Good faith – A release should be obtained in good faith. Material misinformation on the part of an adjuster or an insurance company may lead to a release being set aside by a court. In the event of a personal injury, a medical statement should be obtained from a qualified physician before a release is signed.

Waiting period – In a number of states, there is a legally-prescribed waiting period that must by observed before a release can be executed. The waiting period protects an insured or an injured party from receiving inadequate medical treatment or sums insufficient to remedy property damage. It also deters a carrier from avoiding its obligations under a policy. Some states require a waiting period to be 30 days in duration. If signed in less than the requisite time, a release may be invalid.

Expenses – A release typically covers all expenses, whether past, present or future, paid or unpaid. If any third parties paid expenses on behalf of the insured, those payments should be included in a release.

Assets of a Carrier – These must be sufficient to cover a release.
Other Carriers – If additional carriers are involved, they should be apprised of the release.

Negotiating a Settlement
The negotiation of a settlement is a business transaction between a policyholder and an insurance adjuster who is acting on behalf of a carrier. Personal feelings and emotions should be kept out of the negotiating environment. Objectivity should prevail. There should be no insistence on the part of either party to bend or mold contractual provisions or legal precedents. Both parties should be able to detach themselves from personal prejudices which either may hold about the other party.

Threats to cancel a policy on the part of either party are out of place. Negotiation does not have to be a win-or-lose proposition. A fair and equitable disposition or settlement leaves both the policyholder and the carrier feeling like winners. A claim settled within reasonable limits is one in which an adjuster can feel that he or she has done a satisfactory job both for the insured and his or her employer. Adjusters should expect a policyholder to approach the negotiating process with a proposed settlement that is on the high side. By being creative and doing a little extra work in approaching a claim, it is possible for an adjuster to arrive at an amount which is fair and equitable to both the insured and the carrier.

Appraisal

A method which is frequently used to settle a claim between a carrier and a claimant is an appraisal. The standard appraisal provision that is contained in an insurance policy is required under the laws of some states and is a normal provision in a policy covering personal or real property. Either party to an insurance policy has the right to demand an appraisal.

The appraisal method, used infrequently because most claimants are not aware of the process, can be employed to determine the value of real and personal property. Most of the time it is used to settle disagreements that develop over the expenses of restoring commercial, industrial, or residential property destroyed by fire. Appraisals are only appropriate when there is a significant amount of money in controversy. In order to satisfy the requirements of a competent appraiser, the one selected should have impressive credentials in a given area. Licensed contractors specializing in reconstruction of burned properties or an established art dealer when the property involved is a rare painting would probably satisfy the "competent" requirement. In actual practice, an umpire is rarely used to resolve a dispute between two appraisers. The appraisal award is binding on both parties.

Reduction and Denial of Claims

Most reductions or denials of claims result from clauses or phrases in a policy which exclude certain property or transactions from insurance coverage. In order for an exclusion to be valid it must be set forth in a policy in plain, concise and clear language, and the burden is generally on the carrier to prove that the exclusion is both clear and understandable and is applicable to the situation underlying a claim.

If an exclusion is vague, unclear or not capable of being understood, a court will ordinarily construe the language in favor of the claimant. This trend follows a 200-year-old judicial practice that if language in a policy is capable of being interpreted in two different ways, that which favors a policyholder will be upheld. When a claim is filed, an adjuster will conduct his or her examination with a view to whether or not it is payable. If a policy is not in force, if it has expired and premium payments have not been satisfied, the company may deny coverage. Many policies contain a grace period during which a policy can be reinstated if an insured brings all of the delinquent payments up to date. Another issue that must be resolved, especially where a health care claim is involved, is whether the claimant is covered under the policy. Certain medical checkups are excluded from coverage, so it becomes necessary to determine if a visit to a physician was routine or the result of an existing medical condition, disability or disease.

If an insurance application has not been filled out completely and accurately, anything which was not included may be used by a carrier to limit or deny coverage. In the worst possible case, a policy may be canceled. Inflated, overly-exaggerated, frivolous, fraudulent and deceptive claims may also result in the denial of coverage or cancellation of a policy. Claimants are entitled to a written explanation containing the reasons for the denial of a claim. Most state laws require that such an explanation be provided in writing, and failure on the part of the carrier to do so may constitute an unfair claims practice. A claimant's rights are governed to a large extent by the phrases and words included in the governing insurance policy. Claims may be denied for something as trivial as failing to follow the company's specific requirements for filing out claim forms or for failing to file such a claim in a timely manner.

Litigation
A lawsuit in which a carrier is charged with having handled a claim in bad faith or making an unreasonable refusal to pay a valid claim is costly and onerous to a carrier. Bad faith can encompass a carrier's failure to investigate, evaluate, and settle a claim adequately or within a reasonable amount of time. Recovery will entitle a claimant at the very least to the amount of benefits explicitly provided for within the policy and, depending upon the nature of the circumstances, may lead to the recovery of incidental damages, economic loss, future damages, amounts for mental distress or punitive damages. Punitive damages are provided for by law to deter a carrier from engaging in bad faith practices. The California Supreme Court has held that insurance carriers have a relationship of trust with their clients which underlie the interest of the public. Taking advantage of that relationship, public policy dictates imposing punitive damages on a carrier and an attempt to restore the contractual relationship between the carrier and a policyholder. Some states that do not allow punitive damages provide for other kinds of damages or penalties. There are some recent judicial guidelines which must be satisfied before an award of punitive damages would be appropriate. They include:

-An ongoing practice of nonpayment of claims by a carrier.
-A constant and unremedied pattern of egregious practices by an insurer.
-Malicious disregard of the rights of a policyholder.
-The absence of any reasonable basis for the alleged misconduct.
-Actions which constitute more than just a mistake of law or fact, an honest error of judgment, over-zealousness, simple negligence, witlessness, bureaucratic inertia or human failing.

Although no dissertation on the rights of a consumer is intended, it is prudent for an adjuster to have a general awareness of what guidelines a court might use in assessing some of the factors set forth above as the basis for an award of punitive damages. In particular, with regard to the rights of a policyholder, the ones included as specific terms and conditions under a policy will be evaluated, but there are additional ones to be considered. Although it does not have the force of a law, the National Association of Professional Insurance Agents and Consumer Insurance Interest Group has adopted an Insurance Consumer's Bill of Rights and Responsibilities, which can serve as a judicial guide as to what constitutes equitable insurance practices and reliable representation by an insurance agent. Some of the items included are:

The right to a voice – A consumer should have a vote in any significant decisions which affect him or her, including the right to a response to any suggestions or inquiries made by a consumer.

The right to safeguards – A consumer is entitled to be advised of his or her rights as well as his or her obligations which arise under an insurance policy.

The right to a remedy – Claims must be handled and settled in a timely and equitable fashion. Mediation, appraisal and arbitration procedures, and an appeal to the state insurance department or commission must be available.

Although a consumer's rights are emphasized, an adjuster should also be aware that the Insurance Consumer Bill of Rights and Responsibilities imposes concurrent obligations on a consumer, including a duty to timely and accurately file claims, to read the policy before purchase and to seek professional help to aid in understanding terms and conditions, to minimize risks and losses, to report any fraudulent conduct to law enforcement authorities and regulatory agencies, to maintain accurate records and inform the insurance company of any changes, and to comply with policy provisions concerning claims and payment of premiums.

One of the most significant consumer protection laws (which was discussed briefly before), serving as another set of judicial guidelines when the appropriateness of punitive damages is at issue, is

the Model Unfair Claim Settlement Practices Act, which has been adopted in one form or another by many states. Following are some unfair claims practices under this act:

-Failing to adopt and maintain sound criteria for the investigation and processing of claims.

-Misstating policy terms or relevant facts that affect coverage.

-Failing to provide for prompt and equitable settlement of claims when liability is relatively certain.

-Using advertising material that would lead a reasonable person to believe that a claim could be settled for one amount and then refusing to settle for such amount.

-Failing to inform the insured, upon request, under which part of a policy a claim has been paid.

-Failing or refusing to provide an explanation of the reasons relied on in a policy or under the laws for either compromising or denying a claim.

-Misrepresenting the statute of limitations.

-Delaying the investigation or payment of a claim by using multiple forms to obtain the same information relative to a claim.

-Failing to act promptly upon notification of a claim arising under a policy.

-Forcing an insured to sue to recover for a loss by offering to settle a claim for significantly less than what is ordinarily recovered in a suit for similar claims.

-Failing to deny or confirm coverage within a reasonable period of time after proof-of-loss requirements have been satisfied by an insured.

-Settling on the basis of a claim form that was altered by the insurer without permission of or notice to the insured or his or her representative.

-Using the threat of appealing awards or claims to force an insured to accept a lesser amount in settlement of a claim.

-Advising the insured not to obtain legal advice.

Since insurance policies are contracts, a wrongful denial of a claim can give rise to a breach of a contract cause of action as well. Under a breach of contract case, all a claimant has to prove is that he or she was entitled to recover. The motives or conduct on behalf of the carrier or the claimant is not at issue. If a claimant can prove a carrier issued a policy with no intention to pay claims, there may be cause for fraud. Other legal causes of action might include intentional infliction of emotional distress, malicious prosecution, negligence or conspiracy, depending on the underlying circumstances. Courts have held that under certain circumstances, an insurance company owes a special duty to an insured because the company stands in a special relationship with such party. Insurance companies must respond to settlement offers from third parties in a reasonable manner, and failing to respond to such an offer or rejecting a reasonable offer may result in liability on the part of a carrier for bad faith. Under a bad faith claim, an insured can recover damages, which could include the amount of an excessive judgment against a claimant. Some courts have held that the insurer is under a legal obligation to settle claims a claimant has against its own carrier as well or be liable for first-party bad faith claims.

Small Claims Court

If a disagreement between a carrier and a claimant cannot be resolved and involves a small

amount of damages, typically no more than $5,000, a claimant may elect to pursue the matter in small claims court. Since some courts will not allow a defendant to employ a lawyer to appear on his or her behalf, an adjuster may have to represent the carrier. If nobody from the insurance company makes an appearance, a claimant will be entitled to a default judgment. Adverse judgments usually can be appealed to the next highest trial court, which will result in a new trial.

Subrogation
Under the laws of most states, an insurance company which pays an insured for a loss occasioned by a third party is entitled to be subrogated or substituted in place of the insured with respect to the insured's rights to sue such third party. By way of illustration, if a pilot swerved off a taxiway and ran into a restaurant near the end of the field, the pilot would probably be liable for any damages to the restaurant. If the owner of the restaurant filed a claim with his or her insurance carrier and the carrier paid for losses to the owner's property, the restaurant owner's carrier would be entitled to be subrogated to the restaurant owner's rights against the pilot. An insurance company cannot avoid payment by insisting that an insured must first attempt to collect directly from a third party or its insurance carrier. On the other hand, the restaurant owner could not legally collect from both his or her carrier and the pilot or the pilot's insurance carrier. If the restaurant owner waived his or her right to collect for damages from the pilot or the pilot's carrier, he or she would also be waiving the right of his or her insurer to sue the pilot. In that case, the restaurant owner would be estopped from collecting damages from his or her own carrier. Subrogation does not exist with respect to life insurance policies, since such coverage is not a contract of indemnity.

Investigation Principles
The constant goal of a good investigator should be to strive to uncover evidence and valid facts. If he finds that the best information, evidence, photographs, and testimonies rest with the insured, he will be able to work out settlement negotiations for the position of the case.

Due to excessive demands, lack of liability or settlements of a claim may not be consummated and may have to be tried in court. It then becomes most important to show the facts in some tangible form that can be presented as evidence in court. This is accomplished by means of signed statements, affidavits, reporters' statements, photography, diagrams, specialists' testimonies and, where possible, by actually producing the object which was involved in the accident or allegation. It may be true that a defective faucet broke in the claimant's hands, causing his or her hand to be severely lacerated. An examination of the porcelain handle might reveal that it was struck by an object, such as a hammer, and for this reason the claims person can introduce the handle itself, as well as expert testimony concerning it in the trial. The object is naturally the best possible piece of evidence.

It is obvious that such a handle, or some similar evidence should be put in a place of safe keeping and properly identified so that someone will be able to testify at the trial that it was reserved intact and in exactly the same condition from the time immediately after the accident until the moment it is presented in court.

An effective investigation must be planned in advance and properly timed. There must be order and execution. There can be no set pattern in the investigation of a casualty claim because of the varied circumstances in each case which calls for individual handling.

A claims person need not be a politician or a press agent to be a successful investigator, but it helps to have some elements of both. By establishing friendly contacts with the various police agencies, hospital, and motor vehicle clerks, and various officials on both high and low levels, he or she will not only obtain a great deal more information, but will get information more quickly.

Once the claims person has established a good contact, a telephone call may save hours of travel and waiting time. The claims person should never antagonize those upon whom he or she may

subsequently have to call for information, no matter how great the provocation. He should take the time to establish friendly relations with police sergeants, hospital officials or clerks, record clerks and others in similar positions upon whom he is calling for the first time. It will be time well spent. If certain rules or regulations require the investigator to obtain forms or go through red tape routines which he or she feels are cumbersome, he should follow the procedure in good grace and not request shortcuts that will embarrass the clerks who have to abide by those rules.

Friendly contacts are invaluable for picking up gossip or hearsay which may often lead to pertinent information.

The scope of an investigation is determined as it develops. If the case is one to settle and if the demands are within reason, all efforts should be bent upon disposing of the case and eliminating or avoiding any investigation which will serve no ultimate purpose. Over- investigation can be just as costly in the long run as under-investigation. This is particularly applicable in property damage claims of the average kind where the liability has been determined and the damages established.

If the claims person has decided that to see the claimant first is most advantageous in a certain case, he or she will usually find it advisable to get in touch with the insured by telephone and obtain an oral version of the accident before taking the signed statement. If the claims person cannot talk to the insured right away, he or she should see that the insured is notified to give no signed statement to anyone but his own company representative and to be cautious about any verbal information he may be forced to give in making a claim of his own against the other party. Unless a claims person is handling property damage, medical payments, or other run-of-the-mill claims, the investigation will be made by personal interviews. He or she will have to meet, question and take statements from insureds, claimants and witnesses. These people come from all economic groups and have various religious, cultural, economic and national backgrounds. The claim representative must be tolerant, in the accepted usage of this term. It is a broad term and has often been misused, but tolerance includes respecting differences in point of view, politics, dress, mode of life, and other such matters as well as race, religion and foreign background. A claims person must not show prejudices of any sort.

The claims person is usually the insured's first contact with an employee of the company with which he or she is insured. Because of this the claims person's job is to make every effort to see that the interview is pleasant, affable and as smoothly-running as possible. He or she should take all the time needed to get the information necessary to protect the insured's interests, but should not drag out the interview to the point of a social visit, especially if he or she has interrupted the insured or is using time which the insured could spend profitably in some other manner.

In this interview it is best to give the insured a briefing on what may be expected of him in the event that settlement negotiations fail and the case has to be tried. If the matter is brought up by the insured, it is also well to acquaint him with those things the insurer cannot do for him. Some insureds, for example, expect the company claims person to press their claim against the third party. It must be tactfully explained that it would be both unlawful and improper to do so, unless there are subrogation rights involved.

The problem of representation before a criminal court or traffic hearing will also often come up. The same explanation must be given in this respect. If the adjuster is a company representative, he or she should remember that although he may be the local attorney of record for his company, he or she is not in the general practice of law, and it would be both improper and unwise to represent an insured in either a criminal matter, a traffic hearing, or an action against third parties not involving subrogation rights. The claims person may always attend such hearings as an observer, but to take responsibility for the outcome is inadvisable.

Unless a claims person has reached a point where it can be determined that a first-call settlement is possible, it is not advisable to make a definite commitment the first time he or she sees the

claimant. Nor should the claims person decline the claim until he or she has completed the investigation. A claims person should not miss the opportunity to obtain from the claimant written permission to get the doctor and hospital records, whether he or she intends to use these immediately, or sometime in the future. The claims person will have no better opportunity to get this permission than on the initial visit. Any attempt to get a signed statement or further information after the claimant has disclosed the fact that he is being represented by counsel is unethical and deceitful.

An investigator must remember that the control he maintains will depend upon the impression he makes upon the claimant. If he indicates by attitude and gesture, as well as by words, that he intends to act fairly and ethically within the limits set by the policy, his batting average on settlements will be pretty high. Each company has its own policy with reference to such payments. They are becoming more prevalent and have generally helped to keep some serious cases under reasonable control. The claims person will learn the attitude of his or her company concerning such payments and act accordingly.

One question the investigator will probably ask more often than any other in the investigation of casualty claims is, "Do you know or have you heard of anyone who saw the accident?" He or she will also try to learn this from the insured, the claimant, police offices, and many others as well as outside witnesses, and will scan the police and motor vehicle bureau reports to determine the names of any possible witnesses. The investigator will attend traffic hearings and criminal proceedings, and read the transcripts. He or she will interview coroners and read transcripts of the coroner's inquests to determine the names of possible witnesses to an accident.

In serious cases where the effort is warranted, he will make neighborhood investigations, and if he wants the best results, will make them at the same hour of the day when the accident occurred, and as soon after the accident as possible. Making a neighborhood investigation requires common sense and a great deal of persistence and determination. First of all, it means calling on every store in the immediate vicinity that was open at the time of the accident and finding out not only whether the proprietor or the sales people saw the accident, but also whether there were any customers in the store at the time. It also means checking with these people to determine whether they know of anyone else who saw the accident.

In addition to covering the houses in the immediate vicinity, it also normally means knocking on the door of every apartment that has a window facing onto the scene of the accident. Time after time, investigators have located witnesses who were looking out of an upper story window down onto the scene of an accident. The investigator must ask all of these people whether they know of anyone else who might have seen the accident. Sometimes this involves interviewing four or five people before he tracks down the witness. This individual may be merely described generally since no one may know his name or address.

Most people's lives are set in a fairly well-defined pattern. If buses or trolley cars were present at the time of an accident, it is not unusual to find certain people in them at the same time and place on a subsequent day. Bus or trolley drivers can usually be interviewed through the company for whom they work. Very often the claim departments in these companies will do the preliminary interviewing for the investigator. A claims person may possibly learn that telephone linemen or outside workers of other kinds were present at the scene of the accident, and he will have to track them down. If it is warranted, he should check with delivery people who may have been working in the area at the time of the accident, including mailmen, parcel deliveries, newspaper delivery men and others. After a case has gone into suit, information may be obtained that may lead to the discovery of other witnesses, by means of interrogatories and depositions. If such information is obtained, it should be followed up immediately. Occasionally, in important cases, a catchy advertisement in a local paper will bring forth a witness. All of this presupposes the fact that the nature of the accident deserves this kind of attention.

If the investigator contacts the witnesses promptly, he should be sure to obtain from them the identifying information and the names and addresses of relatives and friends who have a permanent address, and follow this up with regular periodic checkups concerning their availability so that he will have no problems locating the witnesses when he needs them. There will be occasions, however, since no one is infallible, when he will find it necessary to locate a witness that he has lost track of because the witness no longer lives at the last address which the investigator has for him.

There are various "skip-trace" organizations that specialize in locating missing persons for a reasonable fee. All claims persons occasionally have use for such organizations. There will, however, be many instances when, because of the time element, or because other methods have been unsuccessful, a claims person may have to make every effort to locate a witness who has apparently disappeared. If so, he should know that there is no magic formula for locating a missing witness. Should the claims person use some ingenuity, imagination, and a good deal of tenacity, he will probably accomplish his object. It is very difficult for an individual in this country to disappear without leaving any trace whatsoever.

Locating the Witness Checklist
As a stimulant to the investigator's imagination, the following checklist is offered as leads for locating the missing witness:

-A registered letter, return receipt with address requested, sent to the last known address of the witness.

-Telephone directories.

-City directories.

-Interview with janitor or landlord at last known address for any possible leads, including:

    -Names and addresses of relatives or friends.
    -Names of company or collector on an industrial life insurance policy.
    -Names of credit or collection agencies or individuals.

-Name of any federal, veterans' or other organizations that the witness may have belonged to.

-Canvass of the neighborhood or building for any possible leads from friends, relatives or acquaintances. It is essential that such investigations be repeated several times since the investigator will almost never find everyone home the first time the canvass is made. There is also always the possibility that someone he saw before has since seen or heard from a missing witness.

-Business establishments, stores and banks in the immediate vicinity.

-Churches and church organizations.

-Local doctors and dentists who may have treated the witness at one time.

-Local parochial or public schools.

-Name of a moving firm whose vehicles may have been observed by the janitor or any of the neighbors.

-Any former employer of the witness or any member of his family. From this source, the investigator may obtain:

-Union affiliations.
-Names of references on employment records.
-Type of work and employment.

-Information from fellow workmen.

-Automobile or Motor Vehicle Bureaus may have information concerning the witness' address if an automobile has been registered in his name, or if a driver's or chauffeur's license has been issued to him.

-Local election records.

-Utility and telephone companies.

-Military service or veteran's administration records.

-Credit accounts at department stores.

-Welfare agencies.

-Police records.

-Tax records.

-Marriage, birth, or death records of the witness or his immediate family.

-Judgment records.

-Golf, tennis or other athletic clubs that the witness may have belonged to, including leads to any hobbies that the witness may have had.

-Credit card organizations.

Potential witnesses comprise a variety of individuals. An insured or a claimant is an interested witness because he is interested in the outcome. One who knows neither party and is not interested in the outcome, except as a matter of justice, is a disinterested witness. Witnesses are often designated as friendly or hostile, adverse or favorable. These terms are self- explanatory. In interviewing witnesses, a claims person's approach must be one of genuine sincerity. He may have to explain to the witness why it is important to the insurance company to pay just and proper claims and to avoid time-consuming additional investigation and litigation expenses. However, if he can convince the average person that he is sincerely interested in seeing that justice is done, whether or not it affects the company adversely, he will usually get the witness' cooperation and in most cases, a signed statement, without too much difficulty.

Occasionally, a witness will give an initial impression of hostility that is merely a defense mechanism on his part. He may believe that a version unfavorable to the claims adjuster will be received with antagonism. It is up to the claims person to avoid jumping to conclusions and break this false barrier down. He should not misrepresent himself, but should gain witness confidence by his honesty and fairness. Unless the circumstances are extraordinary, it is advisable to have seen both the insured and the claimant and to have visited the scene of the accident before interviewing the witnesses. This presumes that the claimant is not represented by counsel. It does not imply that there should be undue delay in interviewing the witnesses. They should be seen as soon as possible. Time can only dim their memory.

The claims person may wish to take a key witness on an important claim back to the scene of the accident so that he can refresh his memory and familiarize himself with distances and landmarks. While it is perfectly proper and often necessary to refresh the memory of the witness, the claims person should not try to lead him in any definite direction. If the witness is important to the case, the claims person should obtain not only his name and present address, but the name and address of someone such as a parent or other close relative who has a permanent residence and through whom the witness can always be located.

It is important that witnesses be interviewed under circumstances which are comfortable to them. The claims adjuster should not try to interview a witness at his place of business if such an interview might make him ill at ease. He should be seen at home if possible. He should take the time necessary to obtain a proper interview but he should not impose upon the witness. If there is no choice but to interview a witness at his place of employment, an attempt should be made to enlist the aid of his employer, but care must be used—it could boomerang. A good claim representative will try to find some common bond with a witness on which to establish a basis of friendship. If the witness is busy or has only a very short time to give the claims person, he should take whatever information he can, but prepare the way for an additional interview later when the witness is not so rushed. On a follow-up, the average witness will usually go overboard to give whatever information he can, since he feels responsible for the extra call.

Whenever a witness is interviewed, the claims person should obtain complete details and record them along with his impressions of that witness. Did he appear to be honest and sincere? Was he reluctant? Did he seem to be holding back any information? Did he give the impression that he was favoring either side? Was his manner of presentation such as to make him a good witness on the stand? Was his appearance favorable? Did he speak with an accent? Was he hesitant, or straightforward and direct in presentation? Did he appear intelligent and well- educated, or slow, stupid or ignorant?

Was he opinionated, timid or hesitant? Was he uncertain or positive in his statements? Was he friendly or belligerent? Did he have any speech impediment? What was the overall impression of his credibility? What is his reputation? Does he have any physical deformities? Does he appear vindictive?

Whatever his reason, if a witness persists in refusing to give information about an accident which the claims person has reason to believe he has seen or knows something about, it is important to obtain his negative signed statement so that he may be impeached if he tries subsequently to testify for the claimant at a trial.

Special Damages

Special damages is a term used in the investigation of casualty claims to denote losses that can be measured in definite sums of money. Allegations of special damages should not be taken at face value. If the nature of the case or the amount involved warrants it, the items should be checked for authenticity. If special damages have been exaggerated, it is a good indication that other features of the claim may need careful scrutiny. It is also a lot easier to dispose of a claim for a fair value after the claimant has been confronted with proven exaggerations in his special damage allegations.

Special damages which are ordinarily encountered in casualty claim work may be listed as follows:

-Lost time and earnings – It must be borne in mind that the claimant is entitled to his take- home pay only, and that he suffers no loss as a result of tax or other deductions, unless he is called upon to make up some items, such as insurance or hospitalization.

Where the employee is salaried:

-Check the employer's payroll records. Do not be satisfied with a verbal corroboration made by some clerk. In some instances, even a written letter cannot be taken on face value.
-Check the exact lost time
-Check the exact lost earnings. The employer may have paid all or part of the employee's salary.
-Determine the amount of the regular salary.
-Determine the amount of commissions and overtime, and obtain average salary for that particular time of the year.
-Estimate tips and other gratuities, such as board and lodging.
-Determine whether the injury has necessitated a change of job or employment.
-Determine whether the injury has made it necessary for the claimant to obtain part-time work.

Where the claimant is self-employed:

-Check income tax records, including federal, state and city, if any.
-Social Security tax, if possible.
-Unemployment tax.
-Examine private books and accounts.

Property Damage – The following items will be discussed in great detail when we consider automobile property damage losses subsequently:

-Estimate of repairs.
-Appraisals and surveys.
-Difference in value before and after the accident.
-Exact amount of loss of use.

Medical Expenses

-Doctors', specialists' and dentists' bills.
-Travel expenses to and from doctors.
-Registered nurses' fees.
-Practical nurses' fees.
-Hospital or clinic bills.
-Cost of ambulance.
-X-rays.
-Laboratory fees.
-Prosthetic appliance or surgical apparatus.
-Medicines, drugs, etc.
-Funeral Expenses

Investigating Fatal Claims
In the investigation of fatal claims, the following points should be checked:

-Duration of the time the decedent lived after the accident, to determine the amount of possible pain and suffering.
-Age of the decedent.
-General health of the decedent. Determined by:
-Neighborhood canvass.
-Life insurance examinations.
-Army or school examinations.
-Medical history investigation, if warranted.
-General habits and morals, if warranted.

-Life expectancy.
-Earnings.
-Potential earning capacity and increases expected.
-Names and addresses of all close relatives.
-Age, sex and number of dependents.
-General economic condition and social status.
-Marital status with certificates or other documentary proof or written corroboration.
-Complete medical bills.
-Complete funeral expenses.
-Causal relationship between death and accident, derived from:
    -Coroner's report and transcript of hearing.
    -Death certificate.
    -Autopsy report.
    -Medical report.
    -Medical history.

You will often hear it said that the claim department is the eyes and ears of an insurance company. As has already been seen, its activities extend far beyond the old concept of routine claims handling. One of the important functions and duties of the claims person is to report to the underwriting department any information that may affect the desirability of a risk or the adequacy of the premium rate.

Ordinarily, it is not the province of the claim department to recommend the cancellation of a risk. There are many reasons why the underwriter may decide to retain a risk, despite some undesirable features. It is the duty of the claims department to bring to the attention of the underwriting department any information that may aid them in arriving at a proper decision concerning cancellation, or which may necessitate corrective action. In the course of the investigation of an accident, much information will come to the attention of the claims person that might affect the desirability of a risk. Final decision concerning cancellation, however, should rest strictly with the underwriting department.

Risk Report
Most companies have some form for this purpose which is variously termed "Questionable Risk Report," "Confidential Risk Report," or some similar designation used for the same purpose. The types and kinds of deficiencies that should be noted and brought to the underwriters' attention can be grouped roughly into five categories: Physical Defects, Moral Hazards, Physical Infirmities, Matters Affecting Premiums, and Other Hazards. Examples of each, are:

Physical Defects:
-Poor condition of an automobile or building.
-Defect of equipment, such as brakes, broken headlights, defective horn or steering mechanism on an automobile; defective machinery on compensation risks, and so forth.
-Improper equipment.
-Machinery safeguards not being used, or no safeguards provided.
-Dangerous machinery.
-Unoccupied premises.

Moral Hazards:
-Bad reputation of insured or driver with reference to speeding, reckless driving or criminal background.
-Police record.
-Philandering.
-Intoxication.
-Apparent collusion.
-Fraudulent acts or false statements.

-Illegal operation of vehicle, elevators, machinery, or equipment.

Physical Infirmities:

-Glasses required and not used, poor eyesight, or blind in one eye.
-Loss or impaired use of fingers, arm or leg.
-Insured or driver afflicted with epilepsy, heart condition or other infirmity or disease which could momentarily disable the driver.
-Insured or driver aged or infirm.

Matters Affecting Premium:

-Age of driver.
-Usual traveling distance on truck bearing local truck man's endorsement.
-Principal garaging of automobiles.
-Operations or employment not covered under compensation policy.
-Improper classification of automobile or job.

Other Hazards:

-Accident frequency or excessive traffic violations.
-Poor class of drivers or employees.
-Truck used to transport employees.
-Gross negligence or wanton disregard involved in an accident under investigation.
-Improper registration or no driver's license.
-Catastrophe hazard, such as transportation of butane gas, asphalt, or dynamite; fire hazard, and so on.
-Non-cooperation.
-Employment of minors.
-Occupational disease exposure.
-Unsafe practices.

Although it is not ordinarily the province of the claim department to recommend cancellation of a risk, as we have previously stated, a claims person should always notify the underwriting department when such cancellation might adversely affect an open claim or suit.

In some instances, involving serious accidents, it is essential that the good will and complete cooperation of the insured be maintained, especially where he or she has some influence over others, such as witnesses and perhaps even a claimant. In such instances, the claim department may wish to take a calculated risk and remain on the policy, since cancellation might antagonize the insured and result in the loss of his or her future cooperation. In this type of case, it is the duty of the field claims person to let the underwriter know the circumstances, and request that no cancellation be made until further notice by him, or upon disposition of the claim or suit.

Statements for Insurance Claims

Because the taking of signed statements takes up so much of the working time of the average casualty claims person, it is important that this phase of the operations be discussed in detail. Only a small percentage of the signed statements taken by an investigator may ever be used. However, all statements have potential importance, and the investigator must learn how to take a correct, proper and complete statement early in his training.

A claims person, therefore, may have some preconceived ideas about the manner in which a signed statement should be taken, and about the average person's reluctance to sign it. Experience will be his best teacher, but he can learn how to avoid a few of the pitfalls from the experience of others. Above all, he should relax and be natural. Anxiety is a sign of uncertainty and will be as obvious as timidity.

One should immediately get a signed statement. The longer it is delayed, the less likely that it will

be obtained. If the purpose and reasons for obtaining signed statements are understood, the claims person will be that much more qualified and prepared to answer questions asked by the witnesses. Why is a signed statement so important in claims work?

Importance of Signed Statements
There are several reasons why signed statements are critical:

-It provides an opportunity to obtain details in a permanent record form while they are fresh in the minds of the witnesses. Unless an investigator can take shorthand, no notes will be as comprehensive as a complete statement taken from a witness.

-It can be used as a subsequent refresher, if memory dims the details. This may become important if the case goes into suit and eventually to trial.

-Signed statements can sometimes be used as a substitute for the witness' personal testimony if the witness is not available to give his own version. Unless statements are taken by a court reporter, are depositions, or are notarized, it might be difficult to get them admitted in evidence.

-Signed statements are subject to the same rules of evidence as other testimony.

-A witness' statement can be used to discredit him either before or during trial if he should attempt to change his story.

-Once the witness has signed a statement, he is less likely to change his story, for he realizes that his statement can be used against him.

-A signed statement is a reliable and usually accurate factual record of the information obtained for the file and for transmission to the home office.

-A signed statement can be used as a means of convincing opposing counsel of the falsity of certain allegations and make him more amenable to a fair settlement figure.

The first thing to do in preparing and planning for a signed statement is to obtain a signed statement that is logical, concise and in chronological order. The claims person must plan his strategy in advance. The average statement involving an automobile accident should not require the seasoned claims person to spend much preliminary time jotting down points of information he does not wish to forget in questioning the witness.

For the new claims person in the field, it is best to do sufficient preliminary planning on every case until the taking of certain types of signed statements become second nature. The less time that is available to take a statement, the more preliminary planning is necessary, so that the most relevant information can be obtained in the least amount of time. Ordinarily, it is not only common courtesy, but intelligent handling to see a witness when he or she has the time to spare. This is not always possible, and to arrange for another appointment without making any attempt to get a signed statement during the first interview can be disastrous. Any delay provides too many opportunities for the witness to change his mind or to be persuaded to change it.

The approach to interviewing the witness is very important. Anything that is done to antagonize the witness defeats the purpose for which he is being interviewed. The manner in which witness cooperation is gained is something personal to each claims person and cannot be learned by reading a book.

The claims person should attempt to gain the attention and interest of the insured on some common basis of appreciation or endeavor. Confidence should be gained by the sincerity and evident fair-mindedness of the claims person. He should not simply introduce himself, and then sit

down and immediately pull out a writing pad. Rather, the claims person should talk to the witness first, and put him at ease. The witness will shortly begin to talk about the accident quite naturally. The claims person should let him talk, if both have the time. The claims person can then start taking notes of salient points that he wishes to include in the statement. This will be the outline and preparation before writing the actual statement.

The claims person must watch for reactions from a witness and must be able to change his approach the moment he senses antagonism. The sight of a statement pad will often cause an immediate negative reaction. Accordingly, the claims person must put the witness at ease by explaining his mission, and he must convince the witness of his desire to get the true facts.

When the interview is concluded, the witness should be thanked for the time he has graciously given.

For the most part, taking signed statements is a matter of common sense. The new claims person however, may find a few guidelines helpful in establishing a procedure.

Principles of Handling a Claim
There are a number of elementary principles with which a person handling a claim should be familiar:

Coverage Problems – Whenever a coverage problem is involved, two separate signed statements should be obtained from the insured; one covering the facts of the accident, and the other covering the information to be obtained on the coverage problem. The statement concerning coverage problems will usually contain references to the agent or broker as well as to the insured's carrier, which should not be in the statement concerning the facts of the accident. Most states still forbid the injection of insurance coverage status in the trial of an action for negligence.

First Person – The statement should be written in the first person in order to show that the witness is doing the talking.

Separate Statements – No two people will ever see an accident exactly alike. It is, therefore, a good practice to obtain a separate signed statement from each witness. The claims person should refrain from having one witness add either his signature to the statement of another, or even a paragraph to the effect that his version of the accident corresponds with a version as stated by the other witness. There are unusual circumstances that could make such a practice acceptable where the alternative would be no statement at all from the second witness, but this should be the exception rather than the rule.

Legible Writing – The handwriting on the statement must be legible. If the handwriting of the claims person is difficult to decipher, he should get a portable typewriter or computer or have the witness write out the statement himself. Requests to have the witness write out a statement may not always be granted, but the request will usually make the witness much more amenable to signing the one written or typed by the claims person. Handwritten statements should be written in ink. Where the witness is willing to write his own signed statement, the claims person will have to help him or her with it and this could be troublesome where the statement may have to be admitted into evidence. When the witness writes his or her own statement without any direction whatsoever, it will usually be inadequate; therefore, the claims person often has a difficult decision to make regarding this issue. In any event, the claims person should never request that a witness who is self- conscious about his education or spelling write his own statement.

Narrative Form – Unless a court reporter's statement is being taken, the straight narrative form is the best form for the ordinary signed statement. The question and answer type of statement looks too legalistic for the average layman. It may breed suspicion, whereas the ordinary narrative statement would not. Narrative however, does not mean to imply that the claims person is to write

a novel. He or she should be specific, brief and to the point without overlooking important material. The question and answer form usually requires a great deal of extraneous writing. It may, for instance, require a whole series of questions to obtain personal and comparatively unimportant details about the witness before the claims adjuster can get to the meat of the statement. In addition, if the answers are not written exactly as given, it could lead to misinterpretation that might cause the entire statement to be discredited.

Arrangement – Although every effort should be made to arrange the statement chronologically for easy reading, the writer should not be afraid to add paragraphs at the end, either upon request by the witness or to cover information that he forgot to include previously in the body of the statement. In other words, he should be orderly but need not make a fixation of it. It has been said that the signed statement should be taken without paragraphing, under the belief that in breaking the statements into paragraphs, there is some opportunity for the one who holds the statement to add a few words after it has been signed. It is more important than the suspicion that might be aroused by leaving part of the line unfilled.

Solitary Interview – If the claims person can possibly avoid it, he should not try to take a signed statement from a witness when the witness is surrounded by family and friends. It is best to suggest tactfully that the noise and disturbance will be too great for concentration. Then, if possible, he should attempt to interview the witness alone where he will have his undivided attention. There are exceptions, such as if the witness is very young, in a hospital or other institution, or is illiterate or unfamiliar with the English language. Again, it is recognized that there may be times when gatherings are unavoidable and when the claims person must either take a signed statement under adverse conditions or not get one at all.

Style – Whenever it is appropriate, simple language and short sentences should be used. The written statement should record as closely as possible the witness' manner of speech, but bad grammar or objectionable language should not be used purposely. Occasionally, the investigator will take down a direct quotation. When this is done, he must, of course, use the exact language of the witness. However, bad grammar is an obvious condescension that leaves as bad an impression as the use of words that are far beyond the obvious knowledge of the witness. The claims person should refrain from using unfamiliar legal, medical or technical language.

Preprinted forms – The claims person should avoid the use of preprinted forms in taking signed statements. They serve no useful purpose and, again, will only create suspicion and be less effective if needed to be presented as evidence.

Factual Material – Whenever possible, try to give factual information and avoid opinions or conclusions. While this is not always possible or even advisable, some effort should be made to keep opinion and conclusion at a minimum, unless it is pertinent. If any statements overheard by a witness immediately after an accident are included, they should be quoted as close to verbatim as possible. If an opinion based upon obvious circumstantial evidence is included, it should be kept to a minimum and wherever possible such words as "probably" and "perhaps" should be avoided. Also, where possible, recognized designations of speed, distance and direction should be used to indicate speed. Approximate miles per hour should be used instead of such words as "fast," "slow," or "moderate." The points of a compass rather than "right" or "left" should be given, and distance should be measured from such landmarks as large trees, mail boxes, buildings, etc. While it is advisable to be as definite as possible, it is not advisable to be dogmatically so. A statement that a car was traveling at thirty-seven miles per hour could be torn to pieces on cross examination.

Insurance – All mention concerning the name of the company that is involved in the investigation, or the phrase "insurance company" should be avoided. It may be necessary to use this statement in a court trial and the introduction of insurance in any form may cause a mistrial.

Conditions Affecting Statement – A signed statement should not be taken from anyone who is under the influence of alcohol or narcotics, or who is in a state of shock following an accident. If a witness has slurred speech, seems drowsy or is unusually slow in his answers to ordinary questions, the investigator should be doubly cautious and make thorough inquiries concerning the witness' condition before obtaining a statement from him. This is one of the few exceptions to the rule of promptness. To obtain an effective statement and to keep his ethics above reproach, the claims person must observe local laws, ordinances, or codes that regulate the time or place for the taking of statements. If, for instance, he must take a statement in a hospital under circumstances that permit it, he should try to have a nurse, attendant, or possibly doctor present as a witness. The attendant will also be able to attest to the fact that the patient was free from apparent unusual pain and from the influence of narcotics and that the witness appeared to be in a rational frame of mind.

Objectionable Phraseology – The use of objectionable words or phrases should be avoided unless the investigator is quoting what the witness said. Otherwise, any reference to race, religion, foreign background or any evidence of bigotry or obscenity should be scrupulously avoided. A completely innocent remark concerning race, intended merely as a descriptive appellation, could easily be misinterpreted by a juror.

Preserving the Statement – The claims person should refrain from physically mutilating a statement in any way. It is a valuable piece of evidence, and should not be soiled, torn or shopworn. In addition, it should not be date-stamped by an office clerk or by any other marking that might make it unacceptable as evidence.

Constructing a Statement

There will be times when, because of pressure, peculiarities of an individual, the facts of an accident, or for other reasons, the statement will not follow an orderly pattern. Most times the general construction of a signed statement should be obtained from a witness – the insured, claimant or disinterested outside witness – should follow an orderly, chronological form. This not only makes for easier reading, but indelibly impresses its pattern on the claims person so that he will automatically obtain the necessary information because it fits into his regular routine. An outline of a good construction pattern for a statement should include the following subjects generally in the order given:

Date, Time and Address – At the top and upper right-hand corner of the statement, always place the date and time when the statement was taken, and the address of the place where it was taken. By including the time, the claims person pegs down the surrounding circumstances more definitely, and makes it more difficult for a witness to later deny that he gave the statement.
Identification of the Subject – The first paragraph of the signed statement should be concerned with the identification of the subject who is giving the statement. It should include his name, age and address. It is of primary concern that the authenticity of a statement be provable. Therefore, the more personal details, within reason, that can be obtained and placed in a signed statement, the less likely it is that the witness will ever be able to deny that he gave it. It is suggested that such additional information as the witness' place of employment, Social Security number or other pertinent data be added to the statement where warranted. The degree of identification of the subject should depend on the nature of the accident and the type of witness with whom the investigator is dealing.

Location and Reason for Witness' Presence – This paragraph should be devoted to a description of the location of the accident and should include the reasons for the witness being there at the time. The direction in which the witness may have been walking or riding should be given, as well as the exact spot from which he viewed the accident. Naturally, in subsequent investigations the claims person should make it a point to check on the story given by a witness to determine whether he actually could have viewed the accident from the position where he says he was. Included here should be the facts indicating what attracted the witness' attention to the accident.

Factual Details – This paragraph should include the factual information concerning the details of the accident. It should, as far as possible, be confined to facts. Hearsay information should be avoided unless it involves spontaneous remarks made directly before or after the accident, or unless the remarks contain information which will attack the credibility of a witness. If, from the claims person's knowledge, he or she realizes that the information being given is obviously wrong because of an honest mistake on the part of the witness, he or she should try to clarify the situation before putting it down on paper. On the other hand, if there is any question of dishonesty, or if the witness stubbornly maintains his position on the situation, it should be taken down as is. By doing so, the witness will at least destroy his value as a witness for the opposition.

Physical Description – The physical description of the scene of the accident should be as complete as possible, and should include weather and lighting conditions, road surfaces, road and other measurements, and any other pertinent details. Whenever possible, some effort should be made to get the witness to draw some form of diagram, illustrating the factual situation. Drawing the diagram will help clarify the facts and impress the interested parties with the credibility of the witness. It is important to have the diagram signed as well as the statement, and is best to keep the names of other witnesses out of the signed statement. They may turn out to be unreliable and the statement, if read in court, might create an erroneous impression.

Injuries and Damage – The next section of the signed statement can include details concerning the nature of the property damage and the injuries received. This should include not only as complete a description of the damage as possible, but an estimate of the cost of repairs, if one has been obtained. Description of the injuries should be as complete and detailed as possible, and should be in the language used by the claimant. The names of all attending doctors with their addresses should also be included.
Special Damages – In statements obtained from claimants, complete lists of all special damages should be obtained and itemized. The items that make up special damages have previously been covered.

Police Action – An indication of any possible arrests or other police action should be included toward the end of the statement.

Corrections – Having finished the body of the statement, it is now the duty and responsibility of the claims person to make sure that the statement contains the exact information given by the witness and that it does not deviate in any way from the information which he gave. Now is the time to give the witness the statement to review and to point out any errors, any parts of the statement which are not clear, or any sections which the witness for any reason whatsoever wishes to have changed. Wherever possible, all changes or corrections should be made by the witness in his own handwriting. If the witness shows any reluctance, or objects to making the corrections in his own handwriting, the claims person should make sure that each correction made is initialed by the witness. Under no circumstances should any portion of the statement be erased. Rarely is a statement written first-draft without needing some minor corrections. The claims person should not look upon this as something objectionable. The fact that a witness has made corrections in the body of a statement in his own handwriting, or has initialed such corrections, is an admission that he has not only read, but studied the statement. It would be difficult indeed for him to try to testify subsequently that he had not read the statement or was not aware of what it contained after having corrected it.

Acknowledgment – Having placed the pen in the hands of the witness for the purpose of making corrections, it then becomes a mere matter of routine procedure, after he has completed his corrections, to ask him to acknowledge the fact that he has read the statement and affirms the truth by adding in his own handwriting, the words "I have read the above and preceding number of pages, and state that the information contained therein is true and correct," or words of a similar nature. This sentence should be written on the line following the end of the statement,

allowing for no empty space in between.

Signature – If the claims person has obtained the acknowledgment that the witness has read the statement and affirms the information to be true, in his own handwriting, he should not have any difficulty with the signature. Most witnesses will append it automatically. It is preferable that the claims person does not use the word "sign" in asking the witness to put his name down on the next line after the acknowledgment. The individual who continually bemoans the fact that he or she cannot obtain signed statements is one who is making excuses for certain internal deficiencies. A positive attitude (and this does not mean an overly aggressive attitude), a matter-of-fact handling of the situation, and above all, the absence of any hint of defeatism or timidity, will ordinarily accomplish the necessary results. Refusals to sign a statement should be the exception, rather than the rule. No signature will ever be obtained without some effort or attempt to get it. Nor will it be obtained with an attitude or words that signify, "You don't want to sign this, do you?" Each page of the statement should be initialed by the witness or, preferably, signed with his full name. When a witness hesitates to put his signature on the statement, the claims person may point out to him that he is merely being asked to verify the truth of the statements he has made. It sometimes helps to ask the witness what phrase of a statement he seems uncertain about. If the witness adamantly refuses to sign the statement, in some instances a third party who was present during the time the statement was taken might be induced to add his signature to a paragraph attesting to the fact that the statement was read by (or to) the witness, and that he affirmed it to be true and correct. In some instances, witnesses may refuse to add their signatures to a statement but will not object to placing the letters "O.K." at the end. Sometimes, the witness might be willing to answer the following questions as written out by the person who has obtained the statement, "Have you read the above and preceding pages?" "Is the information contained therein true and correct?" An affirmative answer to each of these questions in his own handwriting has the same effect as though the witness had signed the statement. Occasionally, the very sight of a statement pad will affect a witness as a red flag affects a bull. He will vehemently and violently tell you that there is no use in your writing out a statement since he will absolutely refuse to sign it. The claims person must not let this throw him off balance. He should put his pad away, inform the witness that he is merely attempting to arrive at the truth and ask the witness to give the facts. After the claims person has obtained the witness' version verbally and after the witness has had a chance to calm down, the claims person can then explain to the witness that he does not want to rely on his memory in order to report on the facts as given by the witness. Accordingly, the claims person can indicate that he would like to make a few notes to be certain that he reports the information exactly as given to him. In most instances, if properly explained, the witness will not object. The claims person can then proceed to write up the statement. Surprisingly enough, the witness will often feel ashamed for having given vent to his anger and may sign the statement obligingly.

Witness to the Statement – Whenever practical, signed statements should be witnessed by one or two disinterested parties who should place their full names and addresses on the statement. The claims person taking the statement should not ordinarily witness it. Occasionally, a claims person will encounter a witness who does not have sufficient understanding of the English language to be able to read the statement. In that event, it is necessary to obtain a translator's affidavit or short statement appended to the bottom of the statement obtained from the witness. The affidavit or appended statement should indicate that the translator read the statement to the witness in his own language, that the witness understood it, and affirmed the facts contained therein to be true and correct. Such a clause can read as follows: "I, John Doe, residing at [address] attest that I can fluently read and write French as well as English. I further state that I have read the above and preceding statement of Mary Smith and that I have accurately translated it into the French language which she understands. Mary Smith affirmed the fact that this is her statement, that she thoroughly understands it, and that the information contained therein is true and correct." This paragraph should be signed by the translator and either witnessed or notarized. Before obtaining the signature of the translator, the signature of the witness should be obtained at the bottom of the statement, even though written in a foreign language.

Despite the fact that the percentage of illiteracy in this country is extremely low, the claims person will nevertheless encounter illiterate witnesses more often than he or she would think likely. Sometimes an illiterate person will attempt to cover up this ignorance by what may appear to be an obstinate refusal to confirm the statement by reading it, or to sign it. With a moderate degree of persistence, the claims person should be able to recognize this. In any event, obtaining a statement from an illiterate person requires the utmost tact and diplomacy. The claims person should read the statement to the witness, make whatever corrections are necessary and, if possible, call in the services of a notary or some other reliable person in whom the witness has confidence and who the claims person believes to be reliable.

The claims person should have the third person reread the corrected statement to the witness and obtain the witness' assurance that the statement is true and correct. Then, in place of a signature, he or she should have his or her mark placed at the bottom of the statement and append a paragraph on the same page stating that the statement has been read to the witness and that this witness has affirmed that the information contained therein is true and correct. Such an appended statement, to be signed by the third person who has read it to the witness, can read as follows:

"I, John Doe, residing at [address], read the above and preceding [#] pages to Mary Smith. She stated that she understood the statement, affirmed that it was hers, and that it is true and correct."

This paragraph should be signed by the person who read the statement to the witness and corrections should all be initialed by this individual. If a notary has been called in to assist either as translator or to read the statement to an illiterate person, the notary should add his or her own form of affidavit.

In investigating serious or important claims, the claims person will obtain leads that will direct him or her to people who will deny any knowledge of the accident. In those instances, where the denial is persistent, and where he or she believes there is a possibility that they are either covering up or may subsequently appear as witnesses for the opposition, every effort should be made to obtain a short, signed statement from such persons. It should state that they did not see the accident and from their own observation know nothing about it. Such a negative, signed statement will at least prevent that person from later appearing as a surprise witness for the opposition. If the witness does appear, it will enable the defense attorney to discredit this individual.

If a case which the claims person is investigating is of any consequence, it warrants a personal interview with every witness. Occasionally, the obstacles to personal interviews may be extreme, involving distance, weather conditions, or the element of time. The claims person may, therefore, after due consideration, and at a calculated risk, determine that the most advisable course of action is to attempt to get information from a witness through the mail. Having learned by now that the writing of a statement is an involved matter, proficiency in it requires practice.

Therefore, the claims person should not expect that the ordinary witness will always be able to write a satisfactory narrative account of an incident without help.

Again, proper judgment must be used to avoid asking so many questions that the witness is discouraged. At the same time, he should be thorough enough to get the information he needs. He should use great care and spend enough time to prepare the questions so that they will be pertinent and intelligible. As much care should be used in framing the accompanying letter to the witness as in the preparation of the questions themselves. He must remember that he is imposing on the time of the witness and that the witness is doing him a favor in complying with his request.

It has often been said that children make unreliable witnesses. It may, in fact, be quite the

contrary. Some children have vivid imaginations and sometimes cross the borderline between truth and fantasy. This, however, is usually not hard to determine. For the most part, a child who has sufficient mental development can be impressed with the importance of his remarks to the extent that he will make a reliably factual statement. The average child who is able to read and write will, for the most part, give a more straightforward and honest account than the average adult.

Whether the statement should be written in the handwriting of the child, or whether the claims person should write it out himself, is a matter of judgment involving elements of time and the child's personality, general intelligence and education. If the child has acquired reasonable skill in writing, it is advisable to have him write the statement himself. In this case particularly, it is essential that all useless verbiage be eliminated in order not to tire the child or cause him to lose interest. Such a statement should always be obtained in the presence of a parent, adult relative or friend. It is particularly important that the words used should not be incomprehensible to the child. His vocabulary will vary with his age and development.

Subrogation
Subrogation, in the insurance industry, is the term used to describe the right of an insurance carrier who has paid a claim as a result of an accident of loss covered under a policy, to recover from a wrongdoer for the damage caused, up to the amount paid by the insurer. In other words, the insurer is substituted for the insured for the purpose of making a claim against the third party wrongdoer to recover the money paid under the policy.

Subrogation plays a very important part in claims work. Proper handling of this phase of insurance can make the difference between a profitable and an unprofitable operation. Every dollar recovered after expenses is pure profit. Unlike the premium dollar, there are normally no commissions or other fees that must be deducted.

While the right of subrogation does not arise until after payment has been made to or for the insured by his insurance carrier, the claims person must be alert to the possibilities of subrogation from the very inception of the claim and must prepare his or her investigation accordingly. The right of subrogation may arise in law as a matter of equity or by contractual agreement. We are, of course, particularly concerned with the rights arising out of insurance policies.

Most casualty policies, where subrogation is a factor, contain a subrogation condition which reads as follows:

"In the event of any payment under this policy, the company shall be subrogated to all the insured's rights of recovery therefore against any person or organization and the insured shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The insured shall do nothing after loss to prejudice such rights."

Exactly the same condition appears in the workers' compensation policies. Many of the state insurance statutes incorporate this or similar wording in their workers' compensation laws. Where subrogation rights are asserted under the conditions of the policy, such conditions become the sole measure of the insurer's rights. The insurer is limited to the rights of the insured and only to the extent of the amount paid by the insurer.

Subrogation may apply to the following kinds of insurance policies or bonds:

-Motor Vehicle
-Workers' Compensation
-Marine and Inland Marine
-Fire
-Fidelity-Surety

The basic principle of subrogation is the same in each instance; the insurer is substituted for the insured in any right of recovery against a wrongdoer. In workers' compensation claims, subrogation rights are subject to the laws of the various states. While these may differ in their requirements for bringing actions against the wrongdoer, their purpose is uniform in attempting to deny double recovery to the injured and in protecting whatever subrogation rights an insurer may have. The right of subrogation does not apply to life insurance or to accident and health policies unless the latter contain a specific subrogation clause, which is rare.

In all first party claims involving a third party wrongdoer, the insured has a choice of recovery, either under his or her first party policy, or against the third party wrongdoer, or his or her carrier. Recovery, however, can only be made once. Therefore, if the insured chooses to press the claim against the third party, and makes recovery without the consent of the insurer, he or she relinquishes his right to make a claim under the first party policy.

In the event that the insured recovers under the first party policy, he or she loses the right to recover against the wrongdoer to the extent of the amount paid him by the first party insurer. Accordingly, if settlement is made under a first party policy, the claims person should be certain that the insured is advised that he or she must not try to recover against the third party for the same damage. If recovery is made from the third party (or the third party carrier) after the claim has been paid under the first party policy, the first party carrier is entitled to repayment from the insured, assuming that such recovery is made without the knowledge or consent of the insurer.

On the other hand, the wrongdoing third party could remain liable to the first party insurer if he or she knew of the first party insurer's rights of subrogation at the time the latter settled the claim. It is therefore obvious that the company must notify the third party and his or her carrier of its interest in the matter as soon as possible after receiving a report of an accident. A release given by an insured ordinarily voids the right of subrogation unless a lien or some notice has been filed with the wrongdoer.

It has been held that the mere sending of a lien letter in advance of payment of a claim is not sufficient to hold the third party wrongdoer or his or her insurance carrier in double jeopardy unless the carrier with the subrogation rights notifies the wrongdoer or his carrier that payment has actually been made on the claim. The court held in that case that the plaintiff's right to subrogation did not actually arise until the claim had been paid and since the lien letter preceded any payment made, and did not give the amount of any expected payment, it was ineffective.

Accordingly, the letter notifying the wrongdoer or the carrier of subrogation rights should be followed by a notification that payment has been made including the amount of such payment. It is just as essential that the claims person keep possible subrogation involvement in mind when making a sizable property damage settlement. As we have indicated, payment of such a claim to a third party claimant where notice of subrogation rights has been received could put the company in a position of double jeopardy.

No single form can be devised to fit all situations. The following letter therefore is given as an example only.

"John J. Jones, insured under [Insurance Co.] Policy No. [X] has made claim or damage to the [automobile] caused by the negligent operation of your car resulting from the accident which occurred on [date of accident] at [place of accident]. The [Insurance Co.], because of its subrogation rights, hereby makes claim against you for the amount [state amount if known] which it has been or will be required to pay and requests prompt settlement of this claim. If, at the time of this accident, you were insured against loss arising out of claims of this kind, we suggest that you forward this letter to your insurance company without delay. Please let us know when this has been done and send us the name and address of your insurance company. We shall appreciate it if

you will let us hear from you by return mail."

Subrogation rights are not necessarily limited to first party (collision, fire, theft, etc.) or workers' compensation policies only. They may arise because of vicarious liability imposed upon a third party insured under a financial responsibility statute or in some instances because of agency. For example, if payment is made under a non-ownership policy because of the negligence of the driver-owner of the automobile, the carrier may bring an action to recover the amount paid against the driver-owner.

In subrogation actions, suits may be brought in the name of the insured or may be required to be brought in the name of the carrier, depending upon the law of the jurisdiction involved, and the nature of the action being brought. In either event, investigation should be completed as soon as possible and action to recover should be taken without too much delay after payment has been made.

Any defense which a wrongdoer could ordinarily get away with can also be asserted against the insurer in a subrogation action. The insurer does not lose its right of subrogation by waiving any of its rights of subrogation or by waiving any of its policy defenses for breach of policy conditions such as late notice or failure to cooperate. However, the wrongdoer can defend a subrogation action against the insurer on the grounds that there was no coverage in the first place or that coverage was specifically excluded.

Subrogation rights do not extend to voluntary payments made by the insurer. Payment of a claim properly covered by an insurance policy is not construed as a voluntary payment. It is merely the fulfillment of a legal or contractual obligation. If the insurer chooses to pay a claim that is not covered, with full knowledge of this fact, he thereby becomes a mere volunteer and is not entitled to subrogation rights.

An insurer may waive his right of subrogation either by express agreement or by failure to act. If an insurer pays a claim with full knowledge of a settlement that has already been made between the insured and the wrongdoer, he waives his right of subrogation. In addition, if he induces the insured to make settlement with the third party, he loses his right of subrogation. Furthermore, if an insurer unreasonably delays a settlement, knowing that the insured has financial need, he may waive his right to subrogation in the event that settlement does not take care of the complete obligation under the policy.

Loan Receipt
An action against the wrongdoer, ordinarily brought under a subrogation clause, is usually brought in the name of the insured although, in some other instances, it may be brought in the name of the insurance company. A loan receipt is sometimes obtained for the purposes of:

-Permitting the insurer to bring an action against the wrongdoers in the name of the insured where this might otherwise be contested.

-In order to enable the insurer to pay the claim promptly because third party liability has been established.

-To further protect the insurer's rights of subrogation.

After a first party claim has been paid by an insurance case recovery against the wrongdoer, it becomes a primary concern of the insurer. Since the insured cannot make double recovery, it is obvious that his or her interest in any further action is greatly diminished, if it is not altogether extinguished. In view of the fact that the insurance company now becomes – under the laws of most states – the real party in interest, action must be prosecuted against the wrongdoer in its own name.

Judgment must be used in determining whether or not to press any subrogation rights that the company may have. If the amount involved is small and the liability doubtful, it would be patently unwise to press subrogation rights when by so doing an otherwise quiescent claim for bodily injury or extensive property damage may be activated. Even if the amount involved is substantial, it is sometimes inadvisable to press subrogation rights if this might result in a retaliatory claim for serious bodily injury on a case of doubtful liability. Any question about the advisability of asserting subrogation rights should ordinarily be discussed with the claims manager or home office before taking any definite action.

Factors Relating to Subrogation
Some factors which should be given consideration before making a final decision concerning subrogation are:

-The amount recoverable – A substantial amount will warrant the expenditure of more time and effort than will a nominal amount.

-Expense – The effort and expense involved in an attempt to recover should be warranted by the amount recoverable. It is not common sense to spend $20 worth of time in an effort to recover $10. This does not mean that no effort should be made to collect claims involving small amounts if this can be done through minimal efforts and without undue expense. Some effort should always be extended to make recovery by mail, telephone or personal contact when warranted. Expense factors to be considered are:

- -Cost of investigation in both time and money.
- -Legal fees.
- -Suit expenses such as reimbursement for witnesses' testimony and so forth.

-Insurance – An attempt should always be made to find out whether the wrongdoing third party carries insurance and if so with what company and to what extent.

-Identity of the third party – It is essential to establish the exact identity of the wrongdoer and determine whether he is an agent or an individual, co-partnership, corporation or whatever.

-Financial responsibility – If the individual or his principal did not have insurance, an investigation should be made, in cases that warrant it, to determine the extent of financial responsibility of both the individual and his principal. This can be done fairly easily through one of the companies that specialize in this sort of work. There is little point in spending time and money to obtain a worthless judgment.

-Potential antagonisms – The claims person should check with the insured to determine whether there will be any business repercussions if an action is brought against the wrongdoer. In some instances, the insured's right may arise out of a manufacturer- wholesaler, manufacturer-retailer, or similar relation-ship, in which the goodwill of the wrongdoer may be important to the insured in a business way. Although this should not be the determining factor in the final analysis, as far as the claims department is concerned, it is always good business practice to discuss such matters with the underwriting department so that they can have the opportunity to decide whether any possible recovery would be worth the antagonism that might be created.

-Retaliation – Give primary consideration to the possibility that prosecution of subrogation rights might provoke a retaliatory property damage or bodily injury claim.

-Liability – Even though other factors prove favorable to pressing a subrogation action, lack of liability on the part of the third party can of course defeat all other considerations. It is usually inadvisable to spend the time, effort and money to press a subrogation claim unless it is felt that the chances of success are at least 50-50 or better.

The right of subrogation arises normally through common law, but as we have previously stated, is reaffirmed in the policy provisions. Actually a subrogation receipt adds nothing to the subrogation clause already provided for in the policy. In the event that the claims person may encounter the unusual circumstances in which there is no subrogation provision in the policy, he would be wise to obtain a subrogation receipt. Such receipt may be worded as follows:

"Received from [insured] through [insurer] Dollars in full satisfaction, compromise and discharge all claims for loss and expense sustained to property insured under Policy No. [X] by reason of [describe the accident] which occurred [date] and in consideration of which the undersigned hereby assigns and transfers to the said company each and all claims and demands against any person, persons, corporation or property arising from or connected with such loss or damage and the said company is subrogated in the place of and to the claims and demands of the undersigned against the said person, corporation or property in the premises to the extent of the amount above named."

Knock for Knock Agreements

Agreements whereby the insurer does not press subrogation rights against another insurer as a matter of reciprocity are prevalent in the British Commonwealth of Nations and are known as "Knock for Knock Agreements." Such agreements assume that in the long run, the subrogation rights which an insurer may have are equalized by the claims which might be made against it as a result of which both parties avoid the time and expense necessary to press subrogation rights against each other.

There are several kinds of "Knock for Knock Agreements" that operate in various parts of the world. Sometimes in the United States, the idea is sponsored by local claim associations of various kinds.

A claim executives' association in Wisconsin designed a subrogation agreement that would apply to insurers who had claims against each other. This agreement outlines some thirteen specific instances which illustrate applicability of subrogation rights and the percentages of recovery in each instance. The same agreement or others patterned after it were adopted by other claim organizations. The advantage of these agreements is obvious in that it not only avoids unnecessary time and expense of individual collections, but also avoids cluttering the courts with numerous property damage claims that are disposed of without the necessity of litigation.

One of the programs sponsored by the American Insurance Association is the Inter-Company Arbitration Agreement. The purposes of this agreement are to improve claims service, to afford relief to the courts and to prevent litigation of disputes between member companies as much as possible, thereby enhancing the confidence of the public in the insurance industry.

The vast majority of inter-company cases can and are quickly resolved by arbitration. These comprise, for the most part, property damage claims, usually in relatively small amounts, that would otherwise tend to clog the court calendars unnecessarily. There is also arbitration machinery that avoids legal expense and tends to lessen misunderstandings and friction among companies in the insurance industry, in addition to other advantages previously mentioned.

Practically all motor vehicle policies today covering collision losses are written on a deductible basis. Ordinarily, an insurer has no right to represent an insured in pressing the insured's claim against the third party. As a practical matter, the deductible feature of the policy is usually the smallest part of the claim and is tied in with the subrogation claim of the insurer. The general practice is for both carriers to treat the claim as a unit and dispose of the insured's (as well as the insurer's) claims in any settlement negotiations.

Where recovery for the deductible amount has been made, the amount due to the insured is to be

determined by the general practice followed in any particular locality. In some areas, legal fees involved in the recovery are apportioned. In others, the insured will receive a proportionate share in the settlement and, by agreement in some jurisdictions, the insured's deductible is paid first and the remainder kept by the insurance company. The amount involved is so small that there is no legal precedent to follow. It becomes a matter of business and public relationships in each particular area.

Ordinarily, any recoveries made by a carrier under a subrogation action would make the excess carrier whole first. Under a district court decision in New York, the court permitted first recovery by the primary insurer because the primary insurer had taken a loan receipt. The court stated that the position of the excess insurer is no better than that of the insured. The decision gave no weight to the "custom" in the insurance industry for the proceeds of a subrogation recovery to be applied first to the payment made by the excess underwriter.

Salvage

Property upon which the total value has been paid as a result of a claim under an insurance policy is known as salvage and rightfully belongs to the insurer. Properly handled, it can be an important source of revenue for an insurance company. Despite the fact that an article may be considered a total loss for settlement purposes, more often than not, the damaged article has some monetary value. It sometimes takes a little ingenuity to find a market for some articles, but it can ordinarily be done with the use of a little imagination and effort.

Salvage is a matter to be considered not only in the disposition of first party claims but in the settlement of third party claims as well. The claims person will often find that a claimant may be willing to settle a claim for a lesser amount if permitted to keep the article that the company is paying for. In such an event, it is usually more practical and economical to permit the claimant to retain the salvage if adequate deduction is being made for the value of the property in its damaged condition. Automobile salvage is a highly specialized field in which there is usually some buyer available whether the market be high or low at the time. It must become part of a claim person's routine to become acquainted with dealers in wrecked cars so that he or she can always obtain a number of competitive bids on automobile salvage.

If the salvage involves a large object like an automobile, make sure that it is protected from weather damage as well as from theft. It is, of course, important that the claims person arranges for economical storage until such time as he can dispose of the article so that the eventual amount recovered will at least be more than the storage charges. For this reason, it is also advisable to dispose of salvage as soon as possible after having carefully explored the available market.

Handling Salvage Claims

The following summarization is an outline of steps to be considered in the handling of a claim involving salvage:

-Whenever you have paid for the total loss of an article, either obtain credit for it from the claimant or take it in salvage, assuming that it is available and has some value.

-Protect the salvage from theft, further deterioration and the elements.

-Arrange for storage at the lowest possible cost.

-Explore the market for all possible buyers.

-Dispose of the salvage as soon as possible. Retention increases depreciation as well as storage charges.

-Ordinarily, avoid selling salvage to coworkers or to yourself. You may both become dissatisfied customers and may in addition leave yourself open to unwarranted suspicion.

Contribution

Although the subject of contribution does not properly belong in the category of subrogation or salvage, proper attention to it can be an important item of possible financial gain to a company. This is reason enough to make some mention of it here. The good claims person should always be conscious of the possibility that someone else's responsibility for the payment of a loss may be equal to his company's or even greater than it. In many instances, the automobile and public liability policies may overlap – the claims person must be awake to the possibility of such a situation. For example, an insured's automobile may have been involved in an accident while on the premises of the insured.

Ordinarily (excluding the operation of guest statutes), a passenger involved in a two-vehicle accident has a right of action against the owner and driver of the car in which he was a passenger as well as the owner and driver of the opposing car. Sometimes two cars will collide and injure a pedestrian or damage property belonging to someone else. Occasionally, there will be two similar policies covering the same insured. There may be other instances, as well as these mentioned, in which it is advisable to check the possibility of contribution. This should be prominent in the thinking of the claims person during the investigation of any casualty claim.

Obtaining the Medical Information for Claims Handling

The first time a trainee copies a hospital report, he or she may come out of the experience quite bewildered. Five years later, the individual may be inclined to criticize the diagnosis and question the treatment.

The truth of the matter is that the average person can, with some diligent study, acquire a good working knowledge of medical terminology and enough of an understanding of the field in which he is interested to discuss injuries, and even treatment, quite intelligently. Of course, the physician who has spent years of his or her life studying and practicing medicine knows more than the claims person about medical problems. Therefore, while he or she should learn as much as possible, the claims person should never try to replace the physician.

Medical and legal textbooks should be available to the claims person, and he or she should be able to discuss medical problems with a resident or examining physician, or with the home office. Even if the office out of which he or she is working maintains a resident physician on its staff, there is still need for the claims person to have a certain familiarity with injuries or diseases which may result from, or may become aggravated by, accidental injury. The individual must, in any event, be able to:

-Evaluate the injury – This can be done only if he or she is able to understand the medical reports and appraise their significance. If he cannot evaluate the injury, he obviously cannot evaluate the claim and must therefore, depend entirely upon his supervisor to set a figure on its value.
Help detect fraud or malingering – Unless he or she has at least some fundamental knowledge of symptoms, causes, and effects, he or she will be completely unprepared to determine the appropriateness of a particular claim.

-Help determine whether proper treatment is being given – This is especially important in compensation claims. Claim adjusters, quite obviously, are human. They do become emotionally involved in their claims. It is natural, therefore both from the humanitarian and business point of view, for the claims person to be anxious for the claimant to receive the best possible treatment, so that he can make the quickest possible recovery.

-Learn when to order a medical examination and by whom it should be made – Ordering an

examination shortly after a claimant has received a fracture and is still in a cast is not only useless, but is a complete waste of money if there does not appear to be a question about the genuineness of the injury or the honesty of the claim. On the other hand, if there is or may be an element of fraud or malingering, the claims person may find it advisable to assign a medical examination as soon as possible, or at least after enough time has passed so that any subjective complaints would have materialized.
The best time to obtain medical information and a written authorization from the claimant to procure medical information is when the claims person first interviews the claimant.

Authorization should be phrased in simple language, and should avoid legal terminology. The authorization should state that the bearer is authorized to receive a medical report on the accident from the doctor or hospital involved, and should be signed by the claimant. Enough copies should be given so that medical information can be obtained from each attending physician, hospital, clinic, or any other person or organization that rendered medical services.

Components of Medical Information
Medical information obtained from the claimant should preferably be incorporated in a signed statement obtained from him. Whether obtained orally or in writing, the information should include:

-Detailed description of all objectives (noticeable evidence of injury).
-Detailed account of any unconsciousness, giving exact duration.
-Complete list of subjective complaints (not accompanied by noticeable evidence of injury), when they first developed, and their duration.
-Assistance rendered at the scene of the accident.
-First aid rendered and by whom.
-Name of hospital or doctor to whom the claimant was taken immediately after the accident.
-Name and address of family physician who subsequently treated the claimant.
-Name and address of any specialists who were called in for consultation and treatment
-Dates of all visits to physicians, specialists, hospitals or clinics.
-Dates of visits made by doctors or specialists to the home of claimant.
-Dates of admission to and discharge from a hospital.
-Information concerning X-rays – taken by whom, when and what part of the body they covered.
-Details of operations or casts.
-Details of the nature of the treatment rendered.
-Exact duration of confinement to bed.
-Exact duration of confinement to the home.
-Exact length of disability from work.
-Exact nature of present complaints, if any.
-Description of any scars or disfigurements (include snapshots or photographs, if obtainable).
-Complete details of previous medical history:
-Family history, including inherited tendencies or weaknesses and the history of family deaths that might have a connection with the present or future disability of the claimant.
-Names and addresses of all doctors and hospitals that were involved in previous serious ailments that might have a connection with the present disability or which might have been aggravated by the accident.
-Complete list of previous operations, with full details, including previous X-rays taken.
-Details concerning any previous protracted treatments.
-General observations regarding obesity, undue nervousness, unusual despair or other indications of a similar nature that may have a direct bearing on the injury, disability or recovery.
-History of previous disease, such as cancer or heart condition, which may have been aggravated as a result of the accident.
-History of previous ailments or diseases which might have left after-effects, such as scarlet fever, measles, and so on.
-History of any previous diseases which might affect healing in any manner, such as tuberculosis,

syphilis, gonorrhea, diabetes and so on.
-Special emphasis on previous injury to eyes, ears or any part of the body that may have impaired complete function or contributed to the cause of the accident.
-Previous dental history, if applicable.
-History of all extensive previous physical examinations, such as for life insurance, armed forces, or induction to the armed forces, employment, or school examinations.

In reporting the medical information, some comment should be made concerning the competency, qualifications, and reputation of the claimant's attending physician or physicians. If these are unknown to the claims person, the qualifications of the attending doctors should be checked in the local medical directory or directory of medical specialists.

Lien Laws
Congress (Veteran's Hospitals) and a number of state legislatures have, by statute, given hospitals and doctors a means of legally protecting their bills for services rendered in connection with casualty claims by allowing them to file a lien. Such a lien requires the party on whom it is served to pay the medical bills out of any money paid in settlement of a third-party claim.

These statutes are known as lien laws. Where applicable, they require notice of lien to be given by hospitals or doctors to third parties alleged to be liable for the injuries received by the claimant. In some instances, notice is required to be given to the third party insurance carrier, if known. Sometimes the liens must be filed in the county clerk's office in order to become effective.

Failure to comply with the provisions of the lien law after notice obligates the third party or his insurance carrier to reimburse the hospital or doctor for the bills covered in the lien, regardless of any settlement which may have been made with the claimant. Accordingly, it is obviously important to note the existence of any lien and take whatever steps may be necessary to insure payment of the bill before settlement is consummated. This may be done by issuing a separate draft to the claimant and the doctor or hospital for the amount of the bill at the time of settlement, if it is still unpaid.

In many jurisdictions, recognition of the lien will permit the claims person to obtain medical information from a hospital. Usually, there are certain prescribed forms which must be completed before the information will be released. The filing of a lien can sometimes be used to advantage when all other avenues for obtaining medical information have previously failed.

Getting Medical Information
One of the most important steps in the investigation of bodily injury claims is the problem of obtaining complete medical information from the claimant's attending physician as soon as possible. Most companies provide some sort of printed form for obtaining this information. We will shortly discuss some of the items of information that should be contained in a physicians' report. No definite rules can be established concerning the advisability of using such form, or the manner in which it is to be used. This will depend entirely on the claims person's knowledge of the attending physician. He should get to know his local physicians and their secretaries as soon as possible. The latter are often the guardians of the physician's time and records.

In some cases, a mailed request enclosing the form with a stamped, addressed envelope will suffice. In others, it may be necessary to call the physician on the telephone before sending such a form. Sometimes, especially where the injury is severe, the claims person should see the doctor personally. In such instances, there is no substitute for a personal interview.

If it is believed that the reaction to the request will be favorable, the claims person should arrange by telephone for a personal interview at the physician's convenience. In other instances, it may be advisable to call on a doctor during his office hours and wait until he has finished with his last patient. In no event should an attempt be made to interview a doctor while a patient is waiting to

see him, unless the doctor invites the interview. Even if the doctor refuses written information, he may provide some verbal information that could be valuable. When a definite appointment has been made, a claims person should be absolutely sure that the appointment is kept promptly, and should never keep a doctor waiting. If at all possible, a medical report form should be completed during the interview. If the doctor is pressed for time he may request that the form be left with a stamped, addressed envelope to be forwarded at his earliest convenience.

Prompt medical information obtained from the claimant's attending physician will help to determine the need for a physical examination, and give the claims person an opportunity to prepare the case properly for defense, if necessary. If the attending physician's qualifications and integrity are unquestionable, settlement can often be effected based on his information without the delay and expense of a physical examination. It is equally important to obtain the attending doctor's report where a physical examination is needed, so that the examining physician may have the benefit of the medical allegations before making his examination.

Most casualty claim departments have some printed or copied medical report form to be completed by attending doctors. In many instances these are so detailed that they discourage a busy doctor. He may either ignore them completely or fill them out in a sketchy manner. In other instances, forms have been so whittled down that they lose much of their potential value.

Components of Effective Medical Forms
To be most effective, the medical form should contain at least the following categories:

Personal and descriptive data – This should include notation of the date, time, and place where the initial examination was made. It should also include at least the name, address, marital status, age, weight, height and occupation of the claimant.

History of the accident – Whether or not detailed questions concerning the time, place, location, and other factual details of the accident itself should be printed on the form is a matter of judgment. Suffice it to say that some provision must be made for the history or factual details concerning the accident.

Previous medical history – Here the details included in the form may vary. For a checklist of the information that can be obtained under this category, see the list provided under "Medical Information to Be Obtained from the Claimant," discussed previously.

Details concerning the initial examination – This includes any X-rays or laboratory test reports, and consultant's reports.

Treatments rendered – This includes the type and the dates of all office and home visits.

Diagnosis – This should include a detailed account of the doctor's findings concerning ailments and disability, with special emphasis on trauma.

Prognosis – This concerns the estimated disability and possibility or probability of partial or ultimate recovery with emphasis on a possible partial or permanent disability.

Conclusion and recommendations – Here the doctor should comment on recommendations concerning future treatments, operations, or further hospitalization, as well as any other details that affect the medical picture.

Diagrams – Diagrams of various parts of the body are usually imprinted on the opposite side of the medical form to enable the doctor to show scars or indicate the location of fractures, burns, or other injuries.

Doctor's bill – Provision should always be made for the doctor to show the amount of his bill up to the time the report is made, with provision for estimated future medical expense.

Dental History
In all cases involving injury to teeth, a claims person should obtain as complete a dental history as possible, including the general condition of the subject's teeth immediately before the accident, an account of any diseases of the mouth, details concerning bridge work or plates, pivots or caps, and any other information that might have a bearing on the injury allegedly sustained as a result of the accident under investigation. For instance, it is not unusual to find that teeth which may have been knocked out as a result of an accident were in advanced stages of decay.

Components of Hospital Records
When investigating serious accidents, a claims person should make a transcript of the complete hospital record. He should not be content with an abstract of the hospital records merely because the abstract will save him the bother of copying the record. This copying is admittedly a time-consuming and tedious chore, but it pays off often enough to make it worthwhile. An abstract is ordinarily only a very brief digest of the information contained in the record. If a case is important enough to warrant such an examination, every paper in the hospital records should be carefully scrutinized. The hospital records will usually contain:

Admission information – Beside the ordinary information about the date of admission and the history of the accident as given by the patient, there may be welfare board reports concerning the financial background of the claimant, policy reports, an itemized list of the clothes and possessions of the claimant at the time of admission, condition of the clothes, and other extremely valuable information. The history of the accident as given by a claimant to a hospital attendant immediately after an accident can be of extreme importance if the claimant seems inclined to change his story later.

Examination reports – These are reports by attending physicians and interns, X-ray reports, notes and instructions by interns and doctors, details concerning treatment, pathologists' and laboratory reports.

Nurses' notes – Such notes, made for the benefit of the attending doctors and interns, contain comments that are often pertinent concerning a patient's attitude and morale and will also indicate what drugs have been administered.

Diagnoses and prognoses – These must be gathered from the various attending physicians and specialists, along with the date and circumstances under which the patient left the hospital. An alert investigator should not miss the opportunity to obtain information from nurse either. Nurses typically spend more time with patients and get to know them in a much more personal manner that doctors who rarely have time to listen to a patient's subjective emotions.

Objectives of the Medical Examination
A proper medical examination can be an important source of information. It is also a valuable defense weapon but it should not be ordered indiscriminately. Consideration should be given to the ultimate objectives which are to:

-Help to determine if the allegations of disability are true and to corroborate the injuries sustained.
-Help to determine if the alleged injuries or disability resulted from the accident.
-Help to determine the true extent of any disability.
-Help to determine if the claimant is receiving proper, sufficient or too much treatment.
-Obtain the history of the accident as given to the examining physician or corroborate any conflict with the previous information he gave to the hospital or other doctors.
If the object of the examination is merely to corroborate information, then the hospital records,

the reputation of the claimant's attending physician and the information he gives may be sufficient. However, in order to avoid second-guessing, where there is no allegation of further injury or disability, an attempt should be made to obtain a signed statement or report from the doctor.

Medical examinations should never be assigned routinely as a matter of course. It is a costly measure at best. When deciding on the advisability of a physical examination, the claims person should obtain as much medical information as he can from the attending physician, hospital records or other sources. Otherwise, the examining doctor may be concentrating on the effect of a fracture and completely miss a subsequent allegation of neurosis. The claims person must never forget that a medical examination can be a double-edged sword. Made by the wrong doctor at the wrong time, or without sufficient preparation, it can do more harm than good. Obviously, the doctor will be able to make a much more thorough examination, and one of greater value, if he is familiar at the outset with all the allegations and complaints.

Local custom and statutes vary with reference to the obtaining of physical examinations. When a case goes into suit, at least one physical examination is ordinarily permitted by law. However, in view of the fact that both the claimant and any attorney which he may have engaged are ordinarily anxious to obtain a settlement, they will in most instances cooperate to the extent of permitting at least one examination even when the case is not in suit. Since this may be the only examination that is permitted, the claims person must be intelligent about its use.

He or she must make the best use of the examination that is permitted. Except in the unusual or long disability case, it would be difficult to justify more than one examination. Reluctance on the part of either the claimant or his attorney to permit a medical examination is usually an indication that some attempt at exaggerating the injuries or the disability may be made. As has been said before, judgment must be used in determining when a physical examination should be made. If there is no question of fraud or malingering, or the propriety or necessity for further treatment, an examination should be delayed until the maximum healing has taken place.

Otherwise, a physical examination should be obtained as soon as enough time has elapsed to develop any subjective complaints that might be alleged in the future.

The physician making the examination should be properly qualified, impartial, honest, and should make a good impression as a witness. If the allegations require the services of a specialist, get a specialist to make an examination. Barring unusual circumstances, a jury will not give as much credence to a general practitioner as it will to a specialist. This can cause disaster if the specialist is testifying for the opposition. The claims person should not use doctors who may be even unconsciously biased in his favor. He should make arrangements with a physician who is thorough and competent, but not too busy to make a proper examination and give a proper report.

It is also important to remember the examining physician may have to testify at trial. Because some specialists rate their services quite highly, you should accordingly have an understanding with the doctor concerning costs before engaging his or her services. When the claims person has decided on a doctor, he or she should be given all the information available before the examination takes place. Under no circumstances should an examining physician advise the claimant about treatment, or suggest a course of treatment to him. Under rare circumstances, the attending physician may wish to consult with the doctor who made an examination for the company, but even here the situation must be handled with the greatest tact and diplomacy to avoid putting the company in a position where it may be accused of practicing medicine.

Finally, the claims person should make sure that the examining doctor's report is intelligible and that he or she thoroughly understands it. If not, it is important to discuss it with the doctor until all questionable points are cleared up.

The claims person, in making an assignment to a physician for a medical examination, or the claimant's physician, in evaluation, should know how to interpret information obtained from the American Medical Directory, or from other medical directories published in this country or abroad. Such directories give information concerning the school or university from which a doctor graduated; the year of graduation; any specialties which he practices; any fellowships or special degrees or honors; any medical societies to which he belongs; his staff and hospital associations and other such valuable information that can help to determine a doctor's experience, education and competence.

However, it is important to remember that such background information, while exceedingly important, is not the complete picture. There are many general practitioners who are extremely competent medical practitioners, despite their lack of a specialty or higher degree, and despite the fact that they may not have graduated from a prestigious university or medical college.

Specialties
The development of medicine is marked by an ever-growing list of specialties to which practicing physicians more and more confine themselves. In fact, general practice is itself becoming a specialty. In rural areas, a country doctor must be a good practitioner who has some familiarity with all types of medicine, including surgery. In highly-populated cities, more and more medical professionals continue their studies along very specialized lines. With the growth of large clinics and medical centers, specialization is now commonplace.

In order to be able to determine the particular specialist to whom the claims person may wish to assign a physical examination, he or she should have at least some familiarity with the more common specialties which are being practiced today. Selecting a doctor that specifically specializes in the area that needs to be examined can give the adjuster significantly more information, while selecting the wrong type of medical specialist can be a complete waste of time and resources.

Veterans' Records
While some selective service records are privileged, the part of the record concerning physical disability and injury can usually be obtained without undue difficulty. This information usually contains a complete medical history and a record of any injuries, ailments, or treatments while in the service, particularly where there may have been any disability resulting in a pension. These records are most important where there is any allegation of neurological or psychiatric complications and can, if necessary, be subpoenaed in an action in federal court. In state courts, the power of subpoena with reference to such records is at the discretion of the judge.

Veteran records concerning disability are ordinarily very comprehensive and include among other items:

-Name, age and other personal data.
-Military record.
-A complete chronological medical history, including examination of admission, treatments and examination on discharge.
-A history of all accidents or injuries.
-Medical history.
-Nurses' notes, doctors' progress notes and doctors' orders.
-Laboratory tests, X-rays, electrocardiograms, etc.
-Clinical notes and outpatient records.
-Consultation records.
-Report of the Board of Medical Service.

Chapter 4 Claims-Made Insurance Policies

When no contract is involved, or can be implied, "fault" is often determined by the courts.

Negligence is the primary reason a professional is sued. When looking at the history of the United States, we can see the expansion from strict adherence to contract law to the emergence of the concept of fiduciary duty owed by a professional to his or her client. If the professional breaches one or more of his or her fiduciary duties, he or she can be found guilty of negligence in a court of law. It is evident that the concept of negligence has loosened up and the requirements for a lawsuit have become easier to meet.

It is in a tort action for negligence that the standard of care required of a professional comes into play. Basically, the legal question asked by the courts is: "Did the professional have a duty to the client to conform to a required standard of conduct and if so, did the professional fail to conform to that standard?"

There must be reasonable evidence of negligence but that has become increasingly acknowledged in areas that were previously unheard of. In today's world, professionals are foolish not to carry some type of coverage. The name of the coverage may vary slightly but in all cases, the goal is to have claims covered if the lawsuit is successful and the costs of litigation provided by the insurance policy. A professional liability policy does not typically declare precisely what the professional must do in his or her professional activities except to say whatever you do, do it conscientiously and well. In fact, many professionals feel the policy exclusions say more about what the policy covers than the rest of the contract.

This type of liability insurance coverage may be called errors and omissions coverage (E&O), professional liability coverage or malpractice insurance. Whatever the name, the goal is to provide the individual with protection from lawsuits and the court costs that go along with that.

There are two types of professional business insurance policies: claims-made and occurrence policies. Of the two, occurrence policies are the more expensive due to how the coverage is provided. Occurrence policies carry greater risk for the issuing insurer, so they are most likely to offer claims-made coverage.

Claims-made Policy
"Claims-made" insurance policies are defined as an insurance policy that provides coverage only if a claim is made during the policy period or any applicable extended reported period. A claim made during the policy period could be charged against a claims-made policy even if the injury or loss occurred many years prior to the policy period. If a claims-made policy has a retroactive date, an occurrence prior to that date is not covered.

The extended reporting period referred to means a period of time allowing for making claims after expiration of a claims-made policy, also known as a "tail."

Occurrence Policy
An "occurrence policy" is one in which the insured has liability coverage only for injury or damage that occurs during the actual policy term, regardless of when the claim is filed. A claim made in the current policy year could be charged against a prior policy year, or may not be covered, if it arises from an occurrence prior to the effective date.

For any risk to be insurable, certain criteria must exist. The first requirement is a sufficiently large number of exposure units to make the potential loss reasonably predictable. In the case of errors and omissions insurance for example, if a significant number of professionals did not buy the insurance, it would be difficult for the insurance company to estimate future loss. The second requirement is that the loss produced must be definite and measurable. The insurance company must be able to identify when a loss has taken place and must be able to determine the dollar amount of the loss. The third requirement is that the loss must be accidental. It cannot be an inevitable fact that each professional who is insured will be sued (although in today's world it certainly feels like that is the case). It must be an occurrence that may or may not happen. The

final requirement is that the loss must not be catastrophic. In other words, the loss should not occur to a large number of policyholders at the same time. If an insurer, for example, found that a large number of a particular group of professionals were consistently sued, the company may decide to discontinue such coverage; in this case the insurer would decide that the risk of providing insurance to the professional group is too great.

The reason insurance companies are more likely to offer claims-made insurance over occurrence insurance has to do with the risk involved. Since occurrence insurance continues to be open to lawsuit payouts past the termination of the policy, insurers find it more difficult to measure their potential future losses. As the reader continues with this course, the reasons why will become clear.

Liability Awareness

In a claims-made liability insurance policy, coverage is triggered by the date the insured first becomes aware of the possibility of a claim. This awareness might be the result of a claim that is actually filed or it may be the result of a conversation with another individual demonstrating that a claim is a possibility. Whatever the case, the insurer should be notified as soon as such awareness or knowledge is acquired.

The typical claims-made policy protects the insured for wrongful acts or negligence that occur and are reported to the insurance company while the claims-made policy is in continuous force or in any extended reporting period under a tail insurance provision. As long as the insured has maintained continuous coverage, the issuing insurance company will be responsible for paying any covered claims, subject to policy limitations.

Claims-made contracts are often selected over occurrence contracts since claims-made are less expensive to purchase. Premiums are typically discounted the first few years since there may be significant time between the negligent event or omission and the time a claim is actually filed. As a result, claims-made policy premiums are structured to start out lower and then become progressively more expensive. In effect, the rising premiums are a reflection of the rising risk of a claim being filed against the insured. Pricing is typically more reliable for a claims-made policy versus an occurrence policy, so it is easier for the professional to budget for the premium costs, even when considering the increased cost over the first few years.

Since most claims-made policies provide coverage on an annual basis – that is, one year at a time – insured should never assume that their renewal policy will be identical to the ending policy. It is always possible that there could be coverage changes. If the insured decides to change to another company upon policy renewal and the ending policy does not include tail insurance to cover claims filed after the policy lapses or is canceled, this must be considered as a separate option. There are also policies known as Prior Acts Coverage, which is designed to protect the insured that had a claims-made policy immediately prior to the current policy period, but it is issued from a different insurer than the one that issued the lapsing or canceled policy. In other words, tail insurance would be issued by the company that had the original policy while Prior Acts Coverage would be issued by the newly purchased insurance company.

There is a big difference between a claims-made and an occurrence coverage policy. An occurrence coverage policy is one that provides liability coverage only for injury or damage that happened (occurred) during the actual policy term, regardless of when the claim is finally filed. Under an occurrence policy, a claim made in the current policy year could be charged against a prior policy year, and therefore may not be covered if it arises from an occurrence prior to the effective date. In other words, under an occurrence policy the claim must have originated during the actual policy term - when the claim is finally filed does not matter – only the date the incident actually took place or occurred matters.

Claims-made policy

Claims-made policies are more rigid than occurrence policies, but claims-made contracts have gradually become the norm in the professional liability field, states Cheryl Toman-Cubbage, author of "Professional Liability Pitfalls for Financial Planners." Under a claims-made policy the insured individual is covered only for claims filed or announced (when the claim was "made") during the actual policy term. Under an occurrence policy, the insured individual is covered for any injury or damage that happened during the policy period; it does not matter when the claim itself is filed. In both cases, however, the validity of the claim is determined based on a date: either the date the claim occurred (occurrence policies) or the date the claim is filed (claims-made policies).

Occurrence policies pay based on the date the event that caused the loss occurred while

Claims-made policies look at the date the claim is actually made (filed or announced).

Occurrence policies do not provide coverage for prior acts but coverage remains available for claims that arise years after the policy has expired, as long as the event that caused the loss occurred during the time the policy was active. It is this protection against future claims that make these policies so valuable (and expensive to purchase).

Claims-made policies may reach backwards in time (based on policy language) providing coverage for claims made today from negligent acts, errors, or omissions that occurred years before the policy was even purchased. Of course, policy conditions must be met before prior acts coverage is granted. Claims-made contracts are easier for insurance companies to analyze and determine their potential profit or loss. The insurer can close a policy and determine these things immediately. Under an occurrence policy profit or loss cannot be determined since the insurer's liability (risk) continues on, sometimes for decades, because of possible incurred-but-not-reported claims.

Many professionals feel the occurrence policies are much easier to understand: if a potential loss to a client occurs during the policy term, it will be covered regardless of when the claim is actually filed. Claims-made policies are much more difficult or complex because the insured must fully understand that once the policy ends or is terminated no coverage exists, even if the claim originates from an event that happened during the policy term when coverage was active. This fact puts the writing agent in a difficult position and makes the purchase of proper coverage even more important for the buyer.

A particular disadvantage for claims-made policies happens when the buyer decides to change companies or discontinue carrying coverage altogether. The disadvantage is the necessity of following precisely the notification procedures for claims and potential claims situations. Coverage is triggered by the insured's awareness and notification to the insurer of a claim or potential claim situation. Failing to properly notify the insurer will eliminate coverage. If the insured is changing insurance companies and fails to notify either company of a potential claim, he or she could easily end up with no coverage at all when the claim is finally filed.

For example, Emily is a professional that decides to change professional liability carriers. Unfortunately she fails to notify the expiring carrier of her knowledge of a potential claim situation. Another professional has warned her that a particular client seems to like the idea of suing professionals and this person recently transacted business with Emily. This troublesome client eventually decides to sue Emily after she has made the change in claims-made coverage from one insurer to another to reduce her premium costs. Both the old and the new carrier deny coverage. The old carrier denies coverage because the potential lawsuit was not disclosed and officially stated during the time the policy was in force. Their policy is no longer in force at the time the claim against Emily is filed. The new carrier denies coverage based upon the breach of notification requirements. In short, both companies wanted notification of the potential lawsuit and Emily failed to notify either company. Changing insurers does not need to be complicated but in order to do so without gaps in coverage, all contract provisions must be known and followed.

Leaving a profession also has its complications when it is a profession that has liability issues. In the case of insurance, for example, individuals commonly leave the insurance profession in search of greener (and easier) pastures. Emily has tired of trying to sell policies to people that seem uninterested. After two years of trying to make an insurance living Emily gets a job at a local department store and allows her insurance license to lapse. She also allows her claims-made errors and omissions insurance to lapse since it was provided by her employer. Not wishing to pay the premiums herself, she merely allows the policy lapse without seeking or buying tail insurance. With the lapse of her claims-made E&O coverage, she has no protection from lawsuits even if the bad act occurred during the time the policy was active. A year later, a previous client dies. His heirs decide that Emily committed an omission by not actively seeking to place a specific type of policy. They file a lawsuit and Emily discovers that she is without coverage and must pay the costs of litigation personally. If the family wins their lawsuit Emily will also have to pay awarded damages out of her own pocket.

It is easy to understand why insurers would prefer the claims-made policies over occurrence contracts. A claims-made policy has a specific time limit during which the insurance company has liability (risk). Under an occurrence policy, the insurance company's liability (risk) could potentially go on forever. Obviously, this is not the ideal position for the insurer, since the insurer could be held liable on a policy that expired ten years previously. The following is a quotation from an insurance textbook:

"The phenomenon of latent injury is illustrated by asbestosis, an occupational lung disease incurred by workers in a variety of industries. Persons who suffer asbestosis may not discover the injury until long after it occurs. Medical experts testify that injury occurs at the first "insult to the body" – that is, when asbestos fibers first enter the lungs. Employees who began working with asbestos in the 1950's did not discover they had the disease until the 1970's or 1980's. The insurers who provided liability coverage for asbestos manufacturers on an occurrence basis were paying for losses in the 1980's on policies that had long since expired."

In today's lawsuit prone society, it is a daily occurrence to see advertisements on television by legal groups seeking to file class action lawsuits, hoping to draw in large enough numbers of people to receive the next great payout from wrong-doers and their liability insurance carriers.

The general business professional is unlikely to be involved in the type of class action lawsuit that asbestos generated, but there is always the possibility that an unintended error could cause the filing of a claim against them. Just as automobile owners and drivers purchase liability insurance in case they cause an accident, professionals should purchase insurance coverage for their business activities. Buying business liability insurance is not an admission that an error will be made; it is protection from those "what if's" in the business world.

When considering the insurer's potential risk it is easy to understand why insurance companies are now issuing primarily claims-made liability policies:

Claims-Made Policies

Limits of Coverage

Coverage will respond to incidents arising on or after the policy retroactive date and which are reported during the term of the policy.

Prior Acts or Retroactive Coverage

Policy may be endorsed to respond to incidents that occurred prior to the policy start date. This is referred to as the policy retroactive date.

Extended Reporting (Tail Coverage)

Tail coverage provides benefits for incidents that have not been reported to the company during

the policy term. Some companies offer a fee tail at retirement, subject to policy conditions. This should never be assumed by the insured; contract provisions will give exact terms of coverage.

Cost
Claims-made coverage involves a step process with premium increases over the first five years of coverage in increments proportional to the claims reporting for that experience. The initial premium and subsequent years' premiums are substantially lower than an occurrence policy, for obvious reasons. By the fourth or fifth year the claims-made premium reaches a mature level and premium adjustments are based on annual rate changes only.

Occurrence Policies

Limits of Coverage
Coverage will respond to incidents arising from the coverage period regardless of when the claims are actually reported.

Prior Acts or Retroactive Coverage
No prior acts coverage is needed due to the way the policy covers claims.

Extended Reporting (Tail Coverage)
No tail coverage is needed because incidents that occurred during the policy period are covered no matter when they are actually reported.

Cost
Occurrence coverage tends to be very expensive because the insured is pre-paying for tail costs whether the tail gets used or not.

Claims-made policies are sometimes called Discovery Policies because the contract indemnifies against all claims made (filed) during a specified period, regardless of when the actual incidents occurred causing the claims to be reported at a later date. The coverage is effective if the negligent or omitted act is discovered and brought to the attention of the insurance company during the policy term. Sometimes an occurrence policy will also be referred to as a discover policy if the negligent act or omission happened during the policy term, regardless of the date of discovery, but most agree it should only be used for claims-made contracts. Using the discovery policy term can, therefore, be confusing and it is best to use the terms claims-made or occurrence policies to avoid such confusion.

Based solely on cost, claims-made policies are the most popular. However, it is unwise to ignore the restrictions these policies carry. As an insurance agent with a claims-made policy, if you make a mistake in January that adversely affects your policyholder but your client does not discover your error until a year later, your claims-made errors and omissions policy may only cover your claim if you are still with the same insurer, both when the error happened and when the claim was filed. If you could not have known the error happened nor had any knowledge that it provoked a potential claim, your current company will likely cover it. If you knew or should have known that the incident could bring about a claim, then the new company must be notified at the time of policy application. Failure to notify the new insurer could mean neither company will cover the loss. The lapsed policy would not cover it because no claim or notification was made during the policy term. The new policy may not cover if known information regarding the possibility of the claim was withheld at the time of application.

On the other hand, if you held an occurrence errors and omissions liability policy at the time that the error was made, you will be covered for the liability claim even if you have since abandoned the policy and allowed it to lapse for nonpayment of premium. As long as the occurrence policy was in effect at the time of the error, coverage remains. Obviously occurrence policies carry much greater risk for the issuing insurance company so the premiums will reflect this additional risk on the insurer's part.

Policy Triggers

"Trigger" is an insurance term referring to the event that activates coverage under the policy. Courts often look to trigger theories when the insured's burden to prove coverage under his or her policy seems insurmountable due to the difficulty in determining when the underlying injury or damage actually happened.

A professional liability policy has no value until a claim is filed. Until that point it is merely a promise of protection; it is the filing of a claim that gives the contract value. It is important to note that the filing of a claim does not necessarily mean that the liability policy will pay the claim. For that to happen, the claim must fall within the scope of the policy. It must be determined if the wrongful act is of the type covered and within the dates required by the policy.

Different types of insurance policies have different types of benefit triggers. In professional liability contracts it is all about the dates involved, either the date the wrongful act occurred or the date the claim is indicated or filed.

Policy triggers are tied to the date of the event or accident causing the loss and eventually the filing of the claim against the professional and their insurance company. The coverage mechanism, referred to as the trigger, is the determination that there has been a claim for loss. In the case of "occurrence" forms, the loss event must occur during the time the policy was in force and in "claims-made" forms the claim must be filed or made during the policy term. It is the date of the loss or claim that triggers policy payment, if payment is owed.

There are four generally accepted trigger-of-coverage theories:

-Exposure
-Manifestation
-Continuous trigger
-Injury in fact
-Exposure Coverage Trigger Theory

The exposure theory has primarily been applied in asbestos bodily injury cases and other events similar to this. The Forty-Eight Insulations court explained that coverage is triggered under the exposure theory when the first injury-causing conditions occur. In the case of asbestos, that would be upon the first inhalation of asbestos fibers. Of course, the claims did not show up until years later.

Manifestation Coverage Trigger Theory

The manifestation or discovery trigger activates policy coverage when the personal injury or property damage becomes known, or is discovered by the person filing the claim. Even when courts apply the manifestation theory, they do so without the consistency one would expect. Some courts consider the policy triggered when the damage is actually discovered while others consider the trigger to be when the damage could or should have been discovered.

Continuous Coverage Trigger Theory

The continuous trigger, also referred to as the multiple trigger or triple trigger, originated in asbestosis cases where bodily injury progresses and becomes more serious over time. The court in Keene Corp. v. Insurance Co. of N. Am., 667 F.2d 1034 (D.C. Cir. 1981), illustrated the origin of the multiple trigger in the following manner:

In sum, the allocation of rights and obligations established by the insurance policies would be undermined if either the exposure to asbestos or the manifestation of asbestos-related disease were the sole trigger of coverage. We conclude, therefore, that inhalation exposure, exposure in residence, and manifestation all trigger coverage under the policies. We interpret "bodily injury"

to mean any part of the single injurious process that asbestos-related diseases entail.

Keene at 1047.

Owens-Illinois, Inc. v. United Ins. Co., 650 A.2d 974 (N.J. 1994), applied a continuous trigger to "the small percentage of [the insured's] asbestos related expenditures" on property damage claims. In the primarily bodily injury case, the court explained that here, where none of the parties suggested the process was anything but continuous, "claims of asbestos-related property damage from installation through discovery or remediation (the injurious process) trigger the policies on the risk throughout that period." The court refused to address when "the injurious process" ends.

Injury-in-fact Coverage Trigger Theory
When applying an injury-in-fact, or actual injury trigger, coverage under a general liability policy is triggered when the personal injury or property damage underlying the claim actually occurs. GenCorp., supra, held that the appropriate trigger for claims arising out of the disposal of hazardous waste was:

A continuous trigger employing injury-in-fact as the initial triggering event is the applicable theory in this case if GenCorp can substantiate its claim that the injuries were continuing in nature. In the absence of such a showing, injury-in-fact will be the governing trigger. In addition, since there is no indication that the initial point of injury in this case is difficult to ascertain - GenCorp's expert has even opined on the matter - it appears that injury-in-fact rather than exposure should be the event that is deemed to trigger continuous coverage. That is, depending on the evidence presented at trial, coverage will be triggered for the periods between the first point of injury-in-fact and manifestation.

Insurance Agent's E&O Claim Trigger
Some professionals feel that a subpoena is a benefit trigger for a professional's errors and omissions policy. While this is not necessarily the case, it is still wise to report the subpoena to the issuing insurer. The receipt of a subpoena by itself does not constitute a claim under most errors and omission policies but it is certainly a risk indicator of a pending claim. It is always wise to be cautious in such situations and obtain the benefit of expert advice if it is available from the insurer.

While it might seem obvious that a subpoena is a trigger for an E&O claim that is not always true. All definitions of "claim" in errors and omission policies are similar but not exactly the same; it is necessary to review precisely what the individual policy states. For example, one policy states: "Claim means a demand for monetary damages arising out of a professional service made against the insured."

In this case, the key wording is the "demand for monetary damages." The subpoena is not a demand for monetary damages, and would therefore not trigger a claim under this policy example. Even so, most policies have some mechanism to report an incident which might lead to a claim. For example, one policy states "an event about which an insured obtains knowledge which might result in a claim should be reported in writing to us." As every agent should know, it is always wise to read and fully understand a policy, and this applies to agent errors and omissions policies as well as those agents sell to the general public.

A subpoena should certainly trigger a realization that there is the potential for a demand for monetary damages at a later date even though that is not always the case. In some cases a subpoena simply means the individual must give testimony; it does not necessarily mean the person is himself being sued. Each situation is different, and legal counsel may be necessary to determine if any liability exists.

Trigger Language
It is the contract's language that determines what is covered and what is excluded. Most claims-made contracts allow the insured to report a fact or circumstance that has the possibility of eventually leading to a claim against the insured and his or her insurer at some future date. It is extremely important that such reports be made (when allowed) where a claims-made policy is concerned since reporting of the fact or circumstance can be the difference between having coverage and lack of coverage. If the reported fact or circumstance becomes a filed claim at a later date, the insurer to whom the incident was first reported will treat the claim as having been filed during the policy term. While this may not affect the insured that remained with the same insurance company, it certainly matters to the individual who either changed companies or allowed their coverage to lapse entirely.

There have been cases where insured's attempted to cover themselves by submitting a long list of "potential claims" to their insurer as a means of self-protection. Insurance companies responded by requiring their policyholders to do the following:

-Provide specific details of the act, error, or omission that caused the circumstance for a potential future claim (eliminating vague language when reporting an incident).

-Provide the specific injury or damage that he or she feels may result in a potential future claim.

-Provide the facts by which the insured first became aware of the act, error, or omission that may bring about a circumstance that will cause a future claim.

Reporting the possibility of a future claim is typically called the "Incident Reporting Provision" (IRP) and is not the same as the claim-reporting requirement. An "incident" must be reported in sufficient detail prior to the expiration or lapse of the policy. An IRP that does not provide sufficient information will be regarded as incomplete and is unlikely to accomplish what the policyholder hoped for. Unless otherwise provided in the contract, the insured does not have any additional time to file an incident report beyond the termination of the policy.

Agents and policyholders absolutely must know and understand the difference between an incident report and a claim report. An incident report relates to the possibility of a claim whereas a claim report relates to the actual filing of a claim. A claim that is filed during the time a policy is active is covered under a claims-made policy because it was filed during the policy term. A claim will be covered within the terms of the contract even if the policy then lapses as long as it was filed during the policy term. If the claim was filed with the insured rather than the insurer, the insured may have (depending on exact policy terms) 30 to 90 days to forward the claim on to the insurer. This is true even if the policy lapses during that 30 to 90 day time frame.

Most insurance companies issuing claims-made policies use what is called the "Claims-Made-and-Reported" form for actual claims; it would not be used for incident reports. This form has been in use since the 1990's. It may vary somewhat from company to company but the foundation of the form is fairly uniform. Basically it means that not only must a claim first be made during the policy term, but to obtain policy protection it must also be reported during the policy term or during any extension period allowed under the policy (that 30 to 90 days we talked about). Issuing insurers want to pressure their policyholders into turning in claims as soon as possible and this is one of the functions of the claims-made-and-reported policy provisions.

Chapter 5 Claims Management

Habits for Responsible Claim Management
Proper claims management is a key factor in reducing insurance business costs. Giving claims their due diligence reduces fraud, keeps claimants satisfied (which reduces court costs), and helps defend the insurer against the court cases that do arise (which reduces settlement amounts).

- Don’t be a hero. This advice relates to the futile attempt on the part of a claims adjuster or claims counsel to attempt to economize on a case where the gravity of the injuries and damages of the claimant are so severe in relation to policy limits that it is an obviously futile exercise to attempt to “save” part of those policy limits. It also applies where a company has given authorization for settlement up to a certain amount, and the adjuster or defense counsel unwisely attempts to save a few dollars from the amount authorized when the authorized amount appears to be an appropriate settlement.

- Listen to the advice of defense counsel. The danger is particularly severe, since the claims files on bad faith matters are subject to discovery by the plaintiff’s attorney. Thus, if the claims file is replete with letters saying, “This is a bad one,” “You better look out,” “Pay this,” and “This one could go over the policy,” an insurer’s failure to heed such warnings could result in a powerful claim of bad faith.

- Keep the insured client advised. Relating to the Second Commandment, if claims personnel have received advice regarding the possible outcome or the amount of liability involved, there is an absolute legal obligation to inform the insured. Ad damum excess letter, sent by the insurance company, advise the insured that there is a good possibility that the claim of the plaintiff and a subsequent judgment may exceed the policy limits. It is also safe to say that the insurer is obligated to respond accurately to requests from its insured with reference to the progress of any settlement negotiation.

- Do not deplete the policy carelessly when there are multiple claims. When an insurer is confronted with multiple claims and is concerned that the policy limits will be inadequate to cover all of the claims, the law usually allows interpleader. When several claimants claim the same fund, and the insurer is uncertain which of the claimants has a right to the fund, the insurer runs the risk that, if some claimants are paid and others are not, it may subsequently incur bad faith liability. Thus, the insurer may file an “interpleader” suit, which requires the claimants to litigate their right to the fund in question. Remember, however, in matters involving insureds, there is always the duty to defend an insured, and an insurer cannot dismiss itself from the claims situation by use of the interpleader device.

- Investigate properly. Since bad faith law may evolve toward imposing liability upon insurers for ordinary negligence, it is clear that the failure to do a good job in investigating the insured’s liability obviously exposes an insurer to liability for ordinary negligence.

- Explore the possibility of settlement. At one time an insurer could sit back, relax and have no duty to initiate settlement discussion. Prior to modern discovery rules, the plaintiff’s attorney usually did not know the policy limits, and it was a cardinal rule that insurers did not volunteer this information in most cases. Consequently, the plaintiff’s counsel usually had insufficient information upon which to base a settlement demand.

- Think bad faith. The possibility of a bad faith action must be considered in all cases. However, it is particularly important in cases where there is a policy with inadequate limits. Demonstrating diligence during the investigation and intelligence during the settlement can insulate against bad faith accusations and help bolster a trial defense. Communication is also key. The adjuster must keep the claimant informed and respond immediately to communications by the claimant and his or her attorney

- Consider a client’s demands and not take all eternity. Waiting for settlements of cases until “reaching the courthouse steps” is no longer advisable. A number of court decisions have expressed impatience at such dilatory tactics, ruling that an insurer violates its fiduciary responsibility in attempting to resolve the case in a timelier manner.

- Don’t induce the insured to contribute. Years ago, some insurance companies would seek a contribution from the insured before the insurer would deplete its policy. This is clearly not tolerated today, and courts have ruled that exhorting the insured to contribute something was in itself “suggestive of bad faith.”

- Consider the insured’s interest. This is the greatest of the commandments since it embraces all of the others. “The law imposes upon the insurer the obligation of good faith— basically the duty to consider, in good faith, the insured’s interests as well as its own when making decisions as to settlements.”

Managing Claims Better with Technology

Cost reduction through automation

The ability to automate, increase productivity, and improve workflow management in claim processing represents a major opportunity to reduce costs. Companies who work to automate processes and tasks traditionally performed by skilled labor will set new productivity standards that competitors will need to adopt to remain in the market.

Improvement in insurer “legacy” computers

The industry is woefully behind the rest of the business community with aging hardware. Most systems are easily a decade old and replacement is too big an expense at this time. Enhanced components will help automate claim management decisions and workflow tools resulting in reduced cycle time and better claim decisions. For the aging and overworked adjuster population such programs could be incredibly helpful.

Electronic and web claims processing

While the paperless claim is not quite here, a growing number of them are being processed electronically over the Internet with great results in efficiency. This is reducing the processing cycle from days and weeks to hours and minutes. This is more important in cases where large case exposure or large sums of money are involved. The same electronic processing may also reduce the prospect of multiple submissions where claims involving fraud are copied from one jurisdiction to another or where requested coverage is made for insured property that doesn’t even exist or it is allegedly stolen.

Managing Claims Better with Information Collection

Identification of exceptional claims

Companies are under more pressure than ever to be more efficient in identifying “exceptional claims” that can be managed better by a skilled adjuster. Finding these claims early so they can be appropriately managed will help prevent losses and identify additional coverages. Examples might include claims with a high probability for subrogation, those need specific reserve limits as well as the ones that represent potential large losses or litigation that can be mitigated early on.

Detection of economic induced fraud

When the economy is out of sorts, a growing number of out-of-work people turn to opportunistic fraud to replace lost wages. Scams include phony workers’ comp claims, auto accidents and staged personal property burglaries. Business are also part of the mix where losses are orchestrated to create insurance windfalls. Uncovering the trends and indicators for this fraud is no small task. Central databases are essential, yet privacy issues create specific and limiting obstacles.

Clients need for privacy is a priority

Privacy issues and potential invasion suits create a high level need to develop security and systems measures to protect personal and financial data collected in the claims process. This is especially acute when one considers that the sharing of claims information is important to the claims management.

Claim Response
Many times, a claim that ends up in appraisal or litigation is found to have the root of its problems traced to the early stages of the claim. In fact, many claim experts feel that the first 48 hours following a loss are unique. This is the time when losses can be minimized and excess claims and client dissatisfaction avoided.

One of the key elements in the early phases of a claim is preserving the evidence. Since recovery by subrogation is the standard in many cases, the carrier's success is dependent on his ability to pinpoint a defective product or negligent action to demonstrate its connection to the loss. Evidence that "clears the air" in a disagreement is also essential. However, in the chaos of a loss site, it is all too easy for well-intentioned individuals to compromise or destroy evidence that would have made the recovery possible.

Documenting the loss site in the earliest cycle of the loss is essential. For instance, the claim of heavy smoke damage was disputed by an adjuster who visited the scene. Unfortunately, since he did not document what he saw with photographs, his testimony at arbitration was discounted. Other times, an early photograph revealed that lost inventory claims were only a fraction of that shown.

The reduction of further building damage is another reason to proceed quickly after a loss. Activities like weather protection, restoration of heating and cooling, removing water and saturated materials, protecting floors and rapid drying as soon as possible can eliminate costly replacement later. Adequate shoring and bracing can save masonry walls from collapse and aggressive drying can save floors and electrical systems that would otherwise be lost. Site security may also be an issue. When alarm systems have been disabled by damage or loss of power, restoring them to service should be a high priority. Chemical and biological hazards pose an equal threat.

Minimizing personal property loss is yet another motivation to act early in the loss cycle. Retrieving or protecting data processing equipment, which can be the lifeblood of a business, should be a high priority. Exposure to a smoke-filled building, for instance, can generate corrosion in electronic circuits and chips in as little as 36 hours. The process is accelerated when the high humidity of fire hoses is added to the mix. What can be done? Special services are available to retrieve data, tent equipment, dehumidify rooms, "scrub the air" and equipment cleaning on short notice.

In the same vein, some companies have major investments in equipment like printing presses, office machines, processing equipment, milling machines and other high-tech production devices. They are all vulnerable to exposure to moisture, smoke, corrosion and mold. Packaged inventories are similarly affected. Airborne moisture can penetrate wrapping and cardboard storage boxes causing penetration, bowing, collapse, and mold growth. However, aggressive treatment in the first 48 hours can avoid costly replacement.

Adequate working environments after a loss are yet another goal to achieve as early as possible. Emergency cleaning and deodorizing of offices, furnishings and equipment can help minimize loss of revenue and jobs.

The role of the professional adjuster in the early stages of a loss is to inspire realistic expectations by explaining provisions and procedures in the claim process. A time line must be developed for the resolution of the claim and cooperation by the insured encouraged so that his personal preferences can be accommodated. Unfortunately, most insureds are conditioned otherwise since many automatically conclude that their best interests will not be represented by the insurer. However, an adjuster who addresses problems of the loss early, with a sense of urgency, will help build confidence and mitigate the chances of further damage or claim.