Contract Law: Insurance Applications

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SPECIAL CHARACTERISTICS OF INSURANCE CONTRACTS

Insurance contracts must contain all the necessary elements of a legally enforceable contract and are in many ways similar to other contracts. However, insurance contracts have distinctive features and their own body of law.

In addition to having the four essential elements of all contracts, insurance contracts have certain special characteristics:

- They are conditional.
- They involve fortuitous events and the exchange of unequal amounts.
- They are contracts of utmost good faith.
- They are contracts of adhesion.
- They are contracts of indemnity.
- They are nontransferable.

Conditional Contract

An insurance policy, in addition to having the four essential elements of all contracts, is a **conditional contract**. Whether the insurer pays a claim depends on whether a covered loss has occurred. Additionally, the insured must fulfill certain duties before a claim is paid, such as giving prompt notice to the insurer after a loss has occurred. See the exhibit "Elements of a Contract."

Conditional contract
A contract that one or more parties must perform only under certain conditions.

A covered loss might not occur during a particular policy period, but that fact does not mean the insurance policy for that period has been worthless. In buying an insurance policy, the insured acquires a valuable promise—the promise of the insurer to make payments if a covered loss occurs. The promise exists, even if the insurer's performance is not required during the policy period.

Contract Involving Fortuitous Events and the Exchange of Unequal Amounts

While noninsurance contracts involve an exchange of money for a certain event, such as the provision of goods or services, insurance contracts involve

Elements of a Contract

A contract must have each of these elements to be legally enforceable:

- Agreement
- Capacity to contract
- Consideration
- Legal purpose

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an exchange of money for protection upon the occurrence of uncertain, or fortuitous, events. Insurance contracts involve an exchange of unequal amounts. Often, there are few or no losses, and the premium paid by the insured for a particular policy is more than the amount paid by the insurer to, or on behalf of, the insured. If a large loss occurs, however, the insurer's claim payment might be much more than the premium paid by the insured. The possibility that the insurer's obligation may be much greater than the insured's makes the insurance transaction a fair trade.

For example, suppose an insurer charges a $1,000 annual premium to provide auto physical damage coverage on a car valued at $20,000. Three situations may occur:

- If the car is not damaged while the policy is in force, the insurer pays nothing.
- If the car is partially damaged, the insurer pays the cost of repairs, after subtracting a deductible.
- If the car is a total loss, the insurer pays $20,000 (minus any deductible).

Unless, by chance, the insurer's obligations in a minor accident come to exactly $1,000, unequal amounts are involved in all three of these cases. However, it does not follow that insureds who have no losses—or only very minor losses—do not get their money's worth or that insureds involved in major accidents profit from the insurance.

The premium for a particular policy should reflect the insured's share of estimated losses that the insurer must pay. Many insureds have no losses, but some have very large losses. The policy premium reflects the insured's proportionate share of the total amount the insurer expects to pay to honor its agreements with all insureds having similar policies.

Contract of Utmost Good Faith

Utmost good faith
An obligation to act in complete honesty and to disclose all relevant facts.

Because insurance involves a promise, it requires complete honesty and disclosure of all relevant facts from both parties. For this reason, insurance contracts are considered contracts of **utmost good faith**. Both parties to an

insurance contract—the insurer and the insured—are expected to be honest and forthcoming in their dealings with each other.

The insured has a right to rely on the insurer to fulfill its promises. Therefore, the insurer is expected to treat the insured with utmost good faith. An insurer that acts in bad faith, such as denying coverage for a claim that it knows is clearly covered, could face serious penalties under the law.

The insurer also has a right to expect that the insured will act in good faith. An insurance buyer who intentionally conceals certain information or misrepresents certain facts does not act in good faith. Because an insurance contract requires utmost good faith from both parties, an insurer could be released from a contract because of concealment or misrepresentation by the insured.

Concealment is an intentional failure to disclose a material fact. Courts have held that the insurer must prove two things to establish that concealment has occurred. First, it must establish that the failure to disclose information was intentional, which is often difficult. The insurer must usually show that the insured knew that the information should have been given and then intentionally withheld it. Second, the insurer must establish that the information withheld was a material fact. In the case of an auto insurance applicant, for example, material facts include the use of the applicant's autos, the identity of the drivers, and the ages and driving records of the drivers. If an insured intentionally conceals the material fact that her sixteen-year-old son lives in the household and is the principal driver of one of her cars, the insurer could avoid (reject) the policy based on that concealment.

Insurers carefully design applications for insurance to include questions regarding facts material to the underwriting process. The application includes questions on specific subjects, which the applicant must answer. These questions are designed to encourage the applicant to reveal all pertinent information.

In normal usage, a misrepresentation is a false statement. As used in insurance, a **misrepresentation** is a false statement of a material fact on which the insurer relies. The insurer does not have to prove that the misrepresentation is intentional.

Misrepresentation

A false statement of a material fact on which a party relies.

For example, assume an applicant for auto insurance has had two speeding tickets during the eighteen months immediately before he submitted his application for insurance. When asked whether any driving violations have occurred within the past three years (a question found on most auto insurance application forms), an applicant giving either of these answers would be making a misrepresentation:

- "I remember having one speeding ticket about two years ago."
- "I've never been cited for a moving violation—only a few parking tickets."

The first response provides incorrect information, and this false statement may or may not be intentional. The false statement made in the second response is probably intentional. The direct question posed in the application requires a full and honest response from the applicant because the insurer relies on the information. Anything less is a misrepresentation, whether intentional or not. As with concealment, if a material fact is misrepresented, the insurer could choose to avoid the policy because of the violation of utmost good faith. The laws regarding concealment and misrepresentation can vary by jurisdiction. An insurance practitioner should consult with competent legal counsel before attempting to avoid an insurance contract.

In insurance, it is customary for the parties to agree that they will not contest the validity of the contract after a certain period even if the contract is based on a material misrepresentation or the concealment of a material fact. This agreement in an insurance contract, the **incontestable clause**, is required by all states in life, accident and health, and group life insurance policies.

Incontestable clause

Clause that states that the insurer cannot contest the policy after it has been in force for a specified period, such as two years, during the insured's lifetime.

Unique to insurance, the incontestable clause is contrary to one of the basic maxims in contract law: that "fraud vitiates [negates] consent." Genuine assent cannot be based on fraud. In life insurance and accident and health insurance, the maxim is that "fraud vitiates consent, except in an insurance contract after the contestable period has expired." Therefore, an insurer cannot assert material misrepresentation, concealment, or fraud in connection with life insurance applications when the policy has been in force longer than the **contestable period**, usually two years, during the insured's life. The contestable period is a period during which an insurer can challenge the validity of a life insurance policy. The insurer agrees to waive these defenses after this period. Incontestable clauses are considered valid because the insurer has reasonable opportunity to investigate an applicant's statements during the contestable period.

Contestable period

A period during which an insurer can challenge the validity of a life insurance policy.

Although the incontestable clause applies to fraud, if the fraud is particularly vicious, a court can permit proof of fraud even after the contestable period has expired and can find the policy was invalid at the outset. For example, when one purchases a life insurance policy to profit from the murder of the insured, or when another person takes the insured's medical examination, the incontestable clause will not prevent the insurer from legally refusing to pay insurance proceeds. The public policy against these flagrant wrongs outweighs the reasons for the incontestable clause.

Contract of Adhesion

The wording in insurance contracts is usually drafted by the insurer (or an insurance advisory organization), enabling the insurer to use preprinted forms for many different insureds. Because the insurer determines the exact wording of the policy, the insured has little choice but to "take it or leave it." That is, the insured must adhere to the contract drafted by the insurer. Therefore, insurance policies are considered to be **contracts of adhesion**, which means

Contract of adhesion

Any contract in which one party must either accept the agreement as written by the other party or reject it.

one party (the insured) must adhere to the contract as written by the other party (the insurer). This characteristic significantly influences the enforcement of insurance policies.

If a dispute arises between the insurer and the insured about the meaning of certain words or phrases in the policy, the insured and the insurer are not on an equal basis. The insurer either drafted the policy or used standard forms of its own choice; in contrast, the insured did not have any say in the policy wording. For that reason, if the policy wording is ambiguous, a court will generally apply the interpretation that favors the insured.

Contract of Indemnity

The purpose of insurance is to provide indemnification—that is, to indemnify an insured who suffers a loss. To indemnify is to restore a party who has had a loss to the same financial position that party held before the loss occurred. Most property and liability insurance policies are **contracts of indemnity**.

Contract of indemnity
A contract in which the insurer agrees, in the event of a covered loss, to pay an amount directly related to the amount of the loss.

Property insurance generally pays the amount of money necessary to repair covered property that has been damaged or to replace it with similar property. The policy specifies the method for determining the amount of the loss. For example, most auto policies, both personal and commercial, specify that vehicles are to be valued at their actual cash value (ACV) at the time of a loss. If a covered accident occurs that causes a covered vehicle to be a total loss, the insurer will normally pay the ACV of the vehicle, less any applicable deductible.

Liability insurance generally pays to a third-party claimant, on behalf of the insured, any amounts (up to the policy limit) that the insured becomes legally obligated to pay as damages due to a covered liability claim, as well as the legal costs associated with that claim. For example, if an insured with a liability limit of $300,000 is ordered by a court to pay $100,000 for bodily injury incurred by the claimant in a covered accident, the insurer will pay $100,000 to the claimant and will also pay the cost to defend the insured in court.

A contract of indemnity does not necessarily pay the full amount necessary to restore an insured who has suffered a covered loss to the same financial position. However, the amount the insurer pays is directly related to the amount of the insured's loss. Most policies contain a policy limit that specifies the maximum amount the insurer will pay for a single claim. Many policies also contain limitations and other provisions that could reduce the amount of recovery.

For example, a homeowners policy is not designed to cover large amounts of cash. Therefore, most homeowners policies contain a special limit, such as $200, for any covered loss to money owned by the insured. If a covered fire destroys $1,000 in cash belonging to the insured, the homeowners insurer will pay only $200 for the money that was destroyed.

Principle of indemnity
The principle that insurance policies should provide a benefit no greater than the loss suffered by an insured.

Insurance policies usually include certain provisions that reinforce the **principle of indemnity**. For example, policies generally contain an "other insurance" provision to prevent an insured from receiving full payment from two different insurance policies for the same claim.

Insurance contracts usually protect the insurer's subrogation rights. Other insurance provisions and subrogation provisions clarify that the insured cannot collect more than the amount of the loss. For example, following an auto accident in which the insurer compensates its insured when the other driver is at fault, the subrogation provision stipulates that the insured's right to recover damages from the responsible party is transferred (subrogated) to the insurer. The insured cannot collect from both the insurer and the responsible party.

Another factor enforcing the principle of indemnity is that a person usually cannot buy insurance unless that person is in a position to suffer a financial loss. In other words, the insured must have an insurable interest in the subject of the insurance. For example, property insurance contracts cover losses only to the extent of the insured's insurable interest in the property. This restriction prevents an insured from collecting more from the insurance than the amount of the loss he or she suffered.

Likewise, a person cannot buy life insurance on the life of a stranger, hoping to gain if the stranger dies. Insurers normally sell life insurance when there is a reasonable expectation of a financial loss from the death of the insured person, such as the loss of an insured's future income that the insured's dependents would face. Insurable interest is not an issue in liability insurance because a liability claim against an insured results in a financial loss if the insured is legally responsible. Even if the insured is not responsible, the insured could incur defense costs.

Valued policy
A policy in which the insurer pays a stated amount in the event of a specified loss (usually a total loss), regardless of the actual value of the loss.

Some insurance contracts are not contracts of indemnity but instead are **valued policies**. For example, a fine arts policy might specify that it will pay $250,000 for the loss of a particular painting or sculpture. The actual market value of the painting or sculpture may be smaller or greater than $250,000, but the policy will pay $250,000 in either case. In most valued policies, the insurer and the insured agree on a limit that approximates the current market value of the insured property.

Nontransferable Contract

The identities of the persons or organizations insured are extremely relevant to the insurer, which has the right to select those applicants with whom it is willing to enter into contractual agreements. After an insurance policy is in effect, an insured may not freely transfer, or assign, the policy to some other party. If such a transfer were allowed to take place, the insurer would be legally bound to a contract with a party it might not wish to insure. Most insurance policies contain a provision that requires the insurer's written permission before an insured can transfer a policy to another party.

Traditionally, insurance textbooks used the language that "insurance is a personal contract" to indicate its nontransferable nature and have cited clauses in property policies to illustrate the principle. The policy language does differ between typical property and liability policies, but in both types, the intention is to prohibit the insured from transferring the policy to another party without the insurer's consent.

INSURANCE CONTRACT FORMATION

An insurer and insured form an insurance contract, by which the insurer provides protection if the insured suffers specified losses. When the insurance contract becomes a formal written document, it is an insurance policy.

An insurance contract has unique characteristics with regard to these aspects:

- Agreement, including issues concerning offer and acceptance, effective date, and silence or delay
- Content, which can be oral or informally written, must include necessary terms, can include implied terms, and must include insurer designation
- Delivery, which is the placement of the policy in the insured's control

Agreement

Insurance sales are almost always handled by insurance producers, who represent insurers as agents and insureds as brokers. Insurers rely on agents to solicit business, take applications, and sometimes issue policies. Agents can create contract liability for insurers even though the insurer may not have intended to be bound. Under the law of agency, insurance agents' commitments can be binding on insurers. An insurance policy, like any other contract, must contain the four necessary elements of a contract. See the exhibit "Elements of a Contract."

Elements of a Contract

A contract must have each of these elements to be legally enforceable:

- **Agreement**
- **Capacity to contract**
- **Consideration**
- **Legal purpose**

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Offer and Acceptance

When a producer contacts a prospective insured to sell an insurance policy, is the producer making an offer to contract or merely soliciting offers? Generally, the producer's selling efforts are merely a solicitation of offers that the insurer might not accept and are not offers themselves. The insurance application, signed by the applicant and sent to the insurer through the producer, is the offer. The insurance policy issued later is the acceptance. If the policy issued does not conform to the application—the initial offer—the policy is a counteroffer requiring the applicant's specific acceptance.

Often the insurance applicant does not make an offer but merely invites the insurer to make an offer. For example, if an applicant has not decided to take the insurance but submits an application to determine whether the insurer will accept the risk, the application is not an offer. In that case, when the insurer issues the policy and the insured accepts it by paying the premium, they have concluded an offer and acceptance. Similarly, if the policy as issued does not comply with the coverage or rates the applicant requested, the policy is a new offer that the applicant can then accept or reject.

As with contracts in general, the communication of the offer to the offeree is essential in an insurance agreement. Only the person to whom an offer is addressed, or that person's agent, can accept an offer. For example, if a proposed insured has died before taking action to accept a policy, the widowed spouse cannot accept the offer.

The mailing of an acceptance binds an insurance contract at the time of mailing, whether or not the other party receives it. Thus, if the insurer's issuance of a policy is the offer, the insured's mailing the premium in response to that offer is the binding acceptance.

For property and casualty, oral insurance contracts are as binding as written ones. When the insurance producer has authority to enter into oral agreements to bind coverage, the parties' words and conduct govern the offer and acceptance just as with any other contract. Generally, acts or words of intent to offer and accept establish a binding insurance contract. For example, Mary calls her insurance agent asking to increase the limits on her policy, and the agent tells her, "Done! We'll send you the revised policy in the mail." Before Mary receives the policy, she suffers a loss that exceeds the previous limits of her policy. The agent's oral promise is binding and will hold the insurer responsible for the promised higher coverage limits. In property-casualty insurance, oral applications and contracts are common.

When an agreement between a producer and a prospective insured for a property-casualty insurance policy does not specify immediate coverage, examination of the parties' conversations, as well as the producer's authority, is necessary to determine when the policy became effective. Without the immediate coverage requirement, the application is an offer that the insurer can accept by issuing a policy conforming with the offer.

Effective Date

Determination of the exact moment when insurance contract coverage begins and ends can be crucial in some cases when a loss occurs. Unless a loss occurs within the policy coverage period, no benefits are payable.

The general rules of contract law concerning the time at which acceptance becomes effective also apply to the insurance contract. Frequently the policy itself specifies the effective date and time of the contract. Binders and conditional receipts have both aided and complicated the law with respect to the effective dates of insurance contracts. **Binders** frequently apply to property-casualty insurance, and conditional receipts apply to life insurance.

Binder

A temporary written or oral agreement to provide insurance coverage until a formal written policy is issued.

The binding slip, or binder receipt, although temporary in nature, provides evidence of insurance and interim coverage until the policy is issued. Binders are informal written contracts summarizing the basic coverages and terms of the insurance agreement. They frequently provide extension of coverage for thirty days, pending issuance of the policy.

Even though a binder is usually evidence of an insurance contract, the insurer can produce evidence to prove that the parties orally agreed that the insurance was not to take effect until a specific condition was met. For instance, the parties might have agreed that temporary coverage was not to be effective until another insurer assumed part of the risk.

Absent such conditions, all policy provisions are effective the moment the binder is created. The binder is effective until actual notice of cancellation or until a policy is issued. An insurer's cancellation of a binder must conform to the methods the policy prescribes.

In property-casualty insurance, binders provide immediate coverage when issued by authorized agents. Most insurers have written policies that control the binder's actual coverage. Although brief, the binder must contain the basic information needed for an agreement and must indicate types of coverage.

The binder should identify the insurer and the insured. If an object such as a car is insured, the binder should describe the car briefly and indicate the amounts of coverage clearly enough to establish policy limits. With agreement on these basic points, the more detailed policy provisions can be determined by referring to the policy the insurer will issue.

Silence or Delay

Contract law requires unequivocal manifestation of both parties' mutual assent, by either words or conduct. At common law, courts consider either a party's silence or a party's delay as equivocal and insufficient acceptance to form a contract.

This rule was subject to the qualification that if a prior course of dealings indicated that silence was acceptance, those prior dealings would determine

acceptance. For example, Gina, a producer, has for many years handled insurance on Mike's property under annual policies. At the expiration of a policy, and consistent with prior dealings, Gina sends Mike a renewal policy and a bill for the premium. This year, Mike holds the policy for two months, remaining silent, and then refuses to pay the premium on demand. Mike is liable for the premium that accrued before his rejection. The course of prior dealings between the parties gave Gina, the offeror producer, a reasonable basis for concluding that silence would constitute acceptance.

Assume instead that Gina directs a letter to Mike indicating that "Your homeowners insurance policy will be renewed for another three years unless I hear from you to the contrary." Mike does not reply. Because there was no prior course of dealings indicating that Gina could infer acceptance by silence, continued coverage does not result automatically. Mike's silence is not an unequivocal promise to accept Gina's promise to renew and is not sufficient to infer acceptance.

Another reason for the contract rule that mere silence is not an acceptance of an offer involves unsolicited offers. If silence were always acceptance of an offer, salespeople could flood consumer mail with offers that would bind recipients to buy unless they expressly rejected the offer. The law prohibits sellers from forcing prospective buyers to reject or return offered goods or services. The enterprising insurance agent who mails policies to everyone in the area advising, "Unless I hear from you in a week, I will assume that you accept this coverage" imposes no duty to respond on the recipients of the offers. If a merchant mails an unsolicited item to a person's home, the recipient has no duty to respond or to return the item.

Similarly, when an applicant submits an application for coverage to an insurer and the insurer fails to act within a reasonable time, the insurer's silence or delay is not acceptance. An insurer, however, can be liable under its contract if it delays action on an application beyond a reasonable time. Courts apply the rationale in this situation that insurance is a business affected with a public interest. Because insurers have generally solicited these offers, and because applicants frequently pay premiums in advance, the insurer must act promptly in accepting or rejecting the offer.

The nature of the insurance business imposes a duty to act on the insurer when considering applications for insurance. Some courts consider the obligation an implied contract, while others assert that after the lapse of a reasonable time, the insurance company should be estopped, or prevented, from claiming that the application was not accepted. Most courts, however, base recovery on the theory that the insurer has been negligent, having breached its duty to act on the application without unreasonable delay. If the applicant suffers a loss as a result, then the insurer can be held liable. The court bases recovery on the tort of negligence instead of on contract law. What consti-

tutes unreasonable delay is a question of fact, not law. A court will consider some important facts:

- The distance of the insurer's office from the agent's office at which the applicant submitted the application
- Special difficulties in underwriting the risk
- The insurer's seasonal or other workload problems
- The type of coverage involved

Some state statutes prescribe the time limits within which an insurer must act on an application. The issue of unreasonable delay can arise despite the immediate coverage provided by property-casualty binders or life insurance conditional receipts. Property insurance binders often stipulate coverage for "thirty days only." Life insurance conditional receipts can be conditional and might not provide any interim coverage. In either case, an unreasonable delay in acting on the application could result in the insurer's liability for coverage.

Insurance Policy Content

The insurance contract is usually a result of negotiations. A frequent question concerns which papers and conversations form the ultimate contract. Once an insurer writes the policy, courts consider all prior negotiations or agreements, written or oral, as merged into the writing. Every contractual term in the policy at the time of delivery, as well as those written in afterwards as policy riders or endorsements with both parties' consent, are part of the written policy. The policy must refer to conditions, endorsements, applications, and other papers if they are to be part of the policy.

Insurers' advertising materials and circulars are not part of a policy unless the contract expressly states that they are. If these materials contain false representations, an insured can sue the insurer for fraud, but courts do not usually allow the wording of advertising materials to change actual policy terms.

Written Versus Oral and Informal Written Contracts

Even though oral insurance contracts are valid, written policies are preferable. Oral agreements often give rise to lawsuits, usually involving the insurer's word against the insured's, with a court making final judgment. An insured who does not have a written policy may be unable to recall an oral conversation with sufficient accuracy to persuade a jury of its content.

Oral contracts to write property-casualty insurance are common, particularly when the applicant completes the application process and binder by telephone. In all oral insurance contracts, as well as in the case of informal written contracts, such as preliminary binders and conditional receipts, the final contract is the policy form itself. The crucial question is what contract language is in force from the time of the original oral agreement or informal written contract until the insurer writes the insurance contract into a policy.

Necessary Terms in Insurance Contracts

To be effective, an agreement to insure, whether oral or written, must have these components:

- The types of coverage sought—The risks or events covered must be specific, such as fire, accident, liability, or life.
- The object or premises, if any, to be insured—If liability insurance in connection with ownership of property is involved, for example, the address of the premises must be clear. If the policy says only "my residence" and the proposed insured has several residences, the identification is ambiguous and can result in no coverage.
- The amount of insurance—This component establishes policy limits and the insurer's liability.
- The insured's name—While it is necessary to identify the insured, the establishment of the insurer's identity at the moment of the agreement is not necessary (as when a producer acts for an insurer).
- The duration of coverage—In some cases, duration of coverage might be implied from the parties' past dealings.

Implied Terms in Insurance Contracts

If the parties have agreed to the basic elements, then they and the courts can turn to several other sources, including previous dealings between the parties, customary usage of terms, and legal requirements, to establish the terms from the oral or informal written agreement.

Previous dealings between the parties provide the most accurate bases for determining implied terms of an insurance contract. If an insured has requested that a producer "renew my fire policy," the renewed policy implies all the terms of the previous policy, including the coverage and premium amounts. Provisions of renewal contracts by implication are the same as those of an existing policy. An insurer's customary usage of terms provides another important source for establishing terms the parties have not mentioned explicitly, such as the type of policy an insurer usually issues in a given situation or the type of policy most insurers usually issue.

The policy language and conditions set forth in the insurer's other policies are a good source for supplying implied terms. If the insurer does not usually provide a certain coverage, it is implied that the policy in question contains the provisions of policies the insurer customarily issues for the unclear coverage. When the parties have not specified the premium amount and the insurer and insured have had no previous dealings, a court will conclude that the contract implies the rate the insurer has filed with the insurance regulatory authorities or the rate the insurer usually charges others for the same type of risk.

Finally, courts consider the insured's coverage needs and practices by comparing them with those of others engaged in similar endeavors. Even so, while

these needs and practices can bear on the implied terms, an insured's unique situation might not necessarily result in implied insurance provisions.

In many lines of coverage, statutory and administrative requirements have prescribed policy language. When an oral contract or a binding receipt for homeowners insurance is involved, statutory provisions usually contain all applicable language. State law prescribes many provisions, such as definitions of terms, the right to convert group life insurance to other types of coverage, and life insurance coverage in the event of suicide.

Insurance Company Designation

A producer representing two or more insurers can agree to provide coverage to an applicant without designating the insurer's identity at the outset. If a loss occurs before an insurer issues a policy, a question can arise as to which insurer the producer intended to bind coverage.

If a producer has placed previous business or oral renewals for an insured with a particular insurer, that producer's acceptance of another oral agreement usually binds the same insurer. The parties' previous dealings imply that insurer's liability. However, when the parties have had no previous dealings, or when the producer has changed insurers several times for renewals, more difficult problems arise.

If the producer has made a note or memorandum indicating that an insurer will write the coverage, the note is sufficient to bind that insurer. The producer must have made some outward indication of intent. For instance, a calendar notation might be a sufficient record. The producer's mere mental resolve to place business with "Insurer A tomorrow" is not sufficient to bind Insurer A if the loss occurs before the producer makes an actual notation.

The needs of modern business require and justify reliance on insurance producers' oral agreements formed while acting within their apparent authority. Courts reason that producers have considerable latitude in granting oral binders.

Delivery of Insurance Policies

Delivery is placing an insurance policy in the insured's control. Key legal issues concerning delivery involve whether the parties have intended a contract to become effective before delivery of the final contract. General contract law does not require delivery of a contract for it to be enforceable.

In most bilateral contracts involving the exchange of promises, delivery is not essential to contract formation. In unilateral contracts involving an offeree's performance of an act, delivery of goods or services may be necessary as acceptance.

In the case of insurance contracts, no common law or statutory enactment requires delivery of an insurance policy to complete its formation. Still, in

cases in which no oral agreement, binder, or other written memorandum exists, the contract usually does not bind the insurer until delivery of the policy and the first premium payment. Delivery provides evidence of contract formation and communication of the insurer's acceptance of the insured's offer. The insurance policy is binding only upon delivery.

In property-casualty insurance, delivery is rarely in dispute. The wide use of preliminary oral agreements and written binders gives rise to effective dates of coverage that seldom involve the question of policy delivery.

A property-casualty insurance producer usually collects one of these at the time the applicant completes the application and the producer provides the binder:

- A down payment on the premium
- Complete payment of the premium
- A promise of payment by means of a payment plan or a premium financing arrangement

As in the case of policy delivery, the insurance contract parties can stipulate that the policy is not effective until the first premium payment is made. In the absence of a clear and express agreement, generally the first premium payment is not necessary to establish the validity of an oral preliminary contract, but payment will occur upon policy delivery.

Even in the absence of an express promise to pay a premium, an implied promise to pay a reasonable premium is sufficient consideration to support an insurance contract. However, if the parties clearly intend that no contract is to form until the first premium payment, then that intent is the determining factor. See the exhibit "Practice Exercise."

Practice Exercise

Case Facts

Yates has purchased all his property and liability policies from Alpha Insurance Company through Al's Agency, which represents Alpha, Beta, and Omega Insurance Companies. Al's Agency, having learned that Yates purchased a boat, mailed Yates a letter suggesting insuring the boat for $10,000 and quoting the premium for this coverage. Before receiving that letter and wanting to protect his new boat, Yates wrote to Al's Agency requesting $10,000 of boat insurance and offering to pay whatever the premium might be. Yates's boat sustained a fire loss before either party received either letter.

Is Yates's loss covered? Why or why not? Assuming that Al's Agency received Yates's letter before the fire and that it has not started to process his application, which, if any, of the three insurers is liable for the loss? Explain.

Case Analysis Steps and Answer

To be enforceable, an insurance contract must have four elements:

- Agreement
- Capacity to contract
- Consideration
- Legal purpose

Failure to conform to any one of these four elements renders the insurance contract unenforceable.

Yates's loss is not covered. Al's Agency's initial letter suggested that Yates obtain the $10,000 in coverage and quoted a premium. Yates wrote a letter that crossed in the mail with Al's Agency's letter. In effect, two offers were made, but no acceptances occurred, so no agreement resulted.

Assuming that Al's Agency received Yates's letter and had not started to process the application, no liability would arise unless either the insurer or the agent were negligent in delaying the application processing. No evidence indicates that any insurer is preferred for this policy, although past practices indicate that Alpha would be the assumed insurer in the absence of evidence to the contrary.

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INSURANCE AS THIRD-PARTY BENEFICIARY CONTRACT

Insurance contracts provide many examples of how third parties can benefit from agreements. In a life insurance policy, for example, the contract between the insured and the insurer is for the benefit of a third person, the beneficiary. Property insurance also can provide benefits to third parties in some circumstances, particularly when property interests are being transferred or when interests in real estate are limited or shared.

An insurance contract can benefit a third party, other than the insured under the policy, in two primary ways:

- Insurance contracts can protect third parties in cases of injury or damage.
- Insurance contracts can protect third parties in real estate sales and mortgages, as well as limited interests in realty, such as lease interests and life estates.

Third-Party Interests in Liability Insurance

Liability insurance protects against loss resulting from the insured's causing injury or damage, usually by negligence, to a third person. Although a named insured obtains the policy, the protection can extend to others, such as additional drivers of an insured's car.

Direct-action statute
A law that permits a negligence victim to sue an insurer directly or to sue both the insurer and wrongdoer jointly.

The victims of an insured's negligence also benefit from liability coverage. In recent years, some states have adopted **direct-action statutes.** In most jurisdictions, however, the purpose of liability insurance is to indemnify only insureds for their losses in paying damages to the victims. In these situations, the third-party victims cannot sue under the liability policies until courts have ordered judgments against the insureds. If an insurer denies claim payments after a judgment, then a third party can sue an insurer directly.

Real Estate Sellers and Buyers

Real estate buyers have loss exposures, even though they may be unaware of them. A real estate buyer obtains an equitable interest in the property as soon as both parties sign the agreement of sale. The real estate belongs to the buyer, subject to the payment of the purchase price, under the doctrine of equitable conversion. One result of this equitable ownership is that the buyer bears the risk of loss. If the property is destroyed before it is legally transferred, the buyer must still pay the full purchase price.

The buyer can avoid bearing the risk of loss by including in the contract a provision that places the burden of any loss on the seller until actual title transfer. After transfer, of course, the loss exposure goes to the buyer, and the seller's risk terminates.

The loss exposure can be on the buyer in three situations:

- Only the seller has property insurance—This arrangement is most common in residential sales. If fire damages or destroys the property, the sale still goes through. Which party receives the insurance proceeds depends on the sales contract terms.
- The seller and buyer each have property insurance to protect their respective interests—This arrangement is typical in commercial transactions and in some residential sales. It is good for the buyer, who then controls

the type and amount of coverage and the selection of insurer. Both seller and buyer can recover to the extent of their respective losses.

- The seller and buyer purchase a policy together—This arrangement is the most sophisticated. If the seller and buyer together have purchased homeowners insurance covering their respective interests in the property, insurance proceeds go to make each party whole. For example, the seller collects policy proceeds to the extent of the unpaid purchase price, and the buyer collects proceeds to the extent of the deposit.

Some states have adopted the Uniform Vendor and Purchaser Risk Act, under which innocent losses occurring during the contract period are allocated to the seller unless the buyer has taken possession before closing. The risk of loss is on the person in possession as the person in the best position to take care of the property.

Mortgagor's and Mortgagee's Interests

Both the mortgagor and mortgagee have separate and distinct insurable interests in mortgaged property. The mortgagor is the property buyer who provides a mortgage (claim against the property), and the mortgagee is the lender who receives the mortgage in return for providing the funds to purchase the property. It is customary for the parties to agree in the mortgage on who will obtain insurance on the property. If such a provision is not included on the mortgage, one of three situations can occur:

- The mortgagor can obtain separate insurance on the property, solely for the mortgagor's benefit.
- The mortgagee can obtain separate insurance on the property. If so, money the insurer pays in the event of loss does not accrue to the mortgagor's benefit and therefore is not payable to the mortgagor.
- The mortgagor can obtain insurance for the mortgagee's benefit by either assigning the policy to the mortgagee or including on the policy a standard mortgage clause making any proceeds under the policy payable to the mortgagee "as the mortgagee's interest may appear."

Mortgage, Mortgagor, and Mortgagee

What is a mortgage? Many people commonly use mortgage as a synonym for loan. A mortgage represents a financial claim against property such as real estate. The mortgagor/borrower signs a document providing a lien or title (claim) to the lender (mortgagee). Many people commonly (but inaccurately) say that the borrower "gets" the mortgage, but the borrower is the mortgagor, who is the pledger of the interest. The mortgagee "gets" the mortgage.

[DA06177]

Limited Interests in Realty

Legal issues often arise with respect to limited interests in real property. Limited interests are any interests in real property short of legal ownership, such as lease interests or life estates.

Lease Interests

Courts are divided with respect to the lessor's and the lessee's rights to recover under property insurance policies. The lessor is the owner of the leased property, and the lessee is the tenant or renter.

Until relatively recently, lessors' fire insurers did not make subrogation claims against lessees for the lessees' liability in causing fire damage to insured property. Protection can now take several forms:

- The insurer waives its subrogation rights against the lessee by endorsement to the lessor's fire policy.
- A lease provision placing "all-risks" loss on the lessor is included on the policy.
- The lessee is included as an additional insured on the lessor's policy.
- The lessee purchases an insurance policy protecting against liability for causing damage to the lessor's property.
- The lessee purchases a separate fire policy covering the leased premises.

Life Estates

A life estate is an interest in real property for the duration of a person's life. The person having that interest is a life tenant, and the person who has an interest in the property after the life tenant's death has a remainder interest.

The general rule is that, if a building has been insured before the creation of a life tenancy and is destroyed afterward, the interests in the property are converted to interests in personal property, and the life tenant has a life estate in the insurance contract proceeds. In other words, the life tenant's interest is no longer in the building or land, but only in its monetary worth. This arrangement is not satisfactory from the life tenant's or the remainder person's standpoint; it would be better if specific arrangements were made in advance for insurance coverage to apply toward repairs.

Assume a life tenant holds a policy in his own name and does not designate the remainder person as an additional insured. If the property is destroyed, the life tenant can recover the entire value of the property, even if it exceeds the cash value of the life estate. Insurers often choose to overlook this deviation from the principle of indemnity. Otherwise, they would be asserting a position inconsistent with having collected the premium that corresponds to the full value of the property.

Furthermore, the amount saved by resisting the life tenant's claim might not be worth the defense cost in expense and loss of goodwill. In addition, the life tenant could be the named insured on the policy, possessing a representative insurable interest on behalf of the remainder person. In this case, if a loss occurs, some of the proceeds would go to the remainder person.

Generally, in the absence of specific provisions to the contrary, the life tenant is not required to insure the premises for the remainder person's benefit and is not required to repair accidental damage to the property that does not result from his or her actions.

REPRESENTATIONS AND WARRANTIES IN INSURANCE

Statements on an insurance application are usually categorized as either representations or warranties.

Representations are oral or written statements made by an insurance applicant concerning a loss exposure that induce an insurer to enter into the insurance contract. In insurance contract law, warranties are statements or promises in a policy that, if untrue, would render the policy voidable, whether or not they are material. In the past, strict application of this common-law definition of a warranty frequently resulted in insurers attempting to escape liability for reasons not material to the person or property involved. In response, courts, whenever possible, have interpreted statements as representations rather than as warranties.

Representations

Representations precede and accompany an insurance contract and are not matters about which the parties contract. For example, to induce an insurer to issue an auto policy, a prospective insured might represent on an application that he or she has no history of traffic violations or accidents. The representation, however, is not the subject matter of the contract. False representation, or misrepresentation, makes an insurance contract voidable. An insurer's detriment is presumed in cases of false representation because the insurer has issued a policy in reliance on the false information. Misrepresentations are misstatements of past or present facts.

Elements Required to Establish False Representation

Three elements are required for a plaintiff insurer to establish false representation:

- A statement is made that is false or misleading.
- The statement relates to a material fact.
- The insurer relies on the false or misleading statement in issuing the policy.

The lack of intent to deceive or reckless disregard for the truth distinguishes misrepresentation from fraud. Even an innocent misrepresentation, if material and if relied upon by the insurer, makes the contract voidable. Statutory language sometimes specifies that the misrepresentation must be willful or intentional.

Representations and misrepresentations refer only to those conditions existing at the time the parties form the contract. Promises or statements about conditions that will exist after the contract completion do not involve representations. An applicant can withdraw representations found untrue at any time before the completion of the contract, but not afterwards.

The first element required to prove misrepresentation is that a false or misleading statement has been made. While an insurer might easily verify some facts, such as a type of building construction, the make of a car, or the location of property, other facts are not so easily verifiable and depend on the applicant's word.

Most of the confusion in law regarding misrepresentation has arisen in automobile insurance cases. For example, in completing an application for auto insurance, the applicant must indicate where the car is principally garaged and whether he or she has had an accident within the past five years. The applicant answers that the car is garaged in a suburb, when it is really in a large city that is a higher risk area. Because the insurer might not have issued the policy had it had the correct information, the representation is material. However, if the applicant has answered in good faith, mistakenly believing the car is in the suburbs, the insurer cannot avoid the policy.

Some expressions of opinion raise issues regarding misrepresentation. Statements of opinion and belief involve matters of judgment, possible inaccuracy, and personal viewpoint, rather than objective fact. Because an insurer should recognize subjectivity, courts frequently require evidence of fraudulent intent before they permit avoidance of the policy. In insurance law, therefore, it is important to determine whether the misrepresentation was of fact or of opinion.

Statements of opinion are false only if the person does not hold the opinion stated. Thus, the insured's intent is important, and the insurer must establish that the insured spoke fraudulently. For example, a person owns a building with an actual value of $150,000, carrying a mortgage of $75,000. In apply-

ing to insure the building, the owner represents that the building is worth $175,000, with an outstanding mortgage of $75,000. The representation of the building's value is an opinion and, although the amount estimated is far from accurate, that fact alone does not justify the insurer's avoidance of the policy. The insurer must show that the applicant actually did not hold this opinion but fraudulently misrepresented its value.

Mere silence on the insured's part is not a representation. A representation requires an active statement or conduct, such as shaking one's head. However, mere silence can give rise to the defense of concealment. A duty to speak exists in cases involving concealment, but no such duty applies to misrepresentation. Concealment requires fraudulent intent.

The second element required to prove misrepresentation is that the false statement relates to a material fact. The test for materiality is whether the insurer was influenced or induced to enter into the contract in reliance on the representation.

For example, a homeowners insurance application that represents a house to be brick when the house actually is wood has a misrepresentation of a material fact. The insurer assumes a much different loss exposure than the applicant represented. The insurer could avoid the policy, assuming that its reliance on the representation was reasonable. If, however, the applicant says the house is white when it is blue, the statement involves a false representation but does not relate to a material fact.

Depending on the jurisdiction, a court may determine materiality on two different bases:

- Using the objective reasonable insurer standard, the court asks, essentially, "What would a reasonable insurer have done with knowledge of the true facts?" The court examines what most insurers would have done in a similar situation.
- Using the subjective individual insurer standard, the court asks, essentially, "What should this insurer have done with knowledge of the facts misrepresented?"

Proof of misrepresentation also requires showing that the insurer relied on the statement. If an investigation reveals the insurer had the duty to conduct further inquiry, then it is difficult for the insurer to show reasonable reliance. An insurer that discovers the falsity of a representation before issuing a policy cannot then claim reliance on it.

Statutory Approaches to Misrepresentation

State statutes limiting an insurer's misrepresentation defense may require that the misrepresentation be intentional or material, or both. Many states have similar provisions for life insurance and set forth alternative requirements that the misrepresentation must either have been made with the "intent to deceive" or have affected or materially increased the likelihood of loss. Under

such statutes, a statement of fact is material if it might have influenced the insurer's appraisal of the risk or influenced the premium rate.

Many states have enacted statutes to permit a materiality defense based on the effect of an alleged misrepresentation. These statutes fall into two groups, requiring proof of either an increase of the insurer's risk or of contribution to the insurer's loss, to prove materiality:

- Increase-of-risk statutes are more common and can set either an objective or a subjective standard for determining materiality. Under such a statute, an insured's representation that, contrary to fact, no driver under twenty-five years of age lives in his or her household would be misrepresentation of a material fact.
- The less common contribute-to-loss statutes modify the law more radically. The rule under most of these statutes is that, regardless of materiality, a misrepresentation does not allow an insurer to avoid the contract if, from its very nature, it could not contribute to the loss. Using this theory, a court could find, for example, that a contribute-to-loss statute prohibits an insurer from avoiding a homeowners insurance policy if the misrepresentation relates to a statement that the insured had never been refused other insurance or to the fact that an insured had other, concurrent, or additional insurance in violation of the policy.

Construction of Representations

Misrepresentation of facts, ideas, and circumstances can assume many forms. The problem of when a representation becomes a misrepresentation sufficient to justify avoidance of an insurance policy can be complex. Courts often interpret representations in favor of insureds. Even when a representation is not literally true, it is not a misrepresentation if it is substantially true, that is, more true than false.

Whether an inaccurate objective fact is substantially true depends on its materiality to the agreement. The test of materiality, in turn, is whether the contract would have formed had the applicant told the truth.

Warranties

Like representations, warranties also affect a contract's creation and voidability. Warranties are statements or promises that, if untrue, could render a policy voidable. For a promise to be a warranty, two requirements must be present:

- The parties must have clearly and unmistakably intended it to be a warranty.
- The statement must form a part of the contract itself.

In the absence of these requirements, the stated fact or promise is a representation, rather than a warranty. An insurer can require an applicant to agree to a policy provision that statements of fact or promises in the application

are warranties. Therefore, if the facts the applicant stated are wrong in any respect, the insurer can avoid the policy. Examples of this are a warranty of seaworthiness or a jewelers block policy in which the application becomes part of the policy and the statements made in the application are warranties.

Warranties Distinguished From Representation

The different legal requirements and consequences of warranties and representations make it important to distinguish them clearly:

- Warranties are part of the final insurance contract. Representations are merely collateral, or indirect, inducements to the contract.
- The law presumes warranties to be material, and their breach makes the contract voidable. To constitute a valid defense, representations must be proven to be material.
- Insurers either write warranties in the policy or incorporate them by reference. Representations can be oral, written in the policy, or written on another paper and need not be incorporated by reference expressly.
- Warranties require strict compliance, but representations require substantial truth only.

Classification

A warranty is a written or an oral statement in a contract that certain facts are true. Warranties can take any one of three forms:

- Affirmative
- Continuing (promissory)
- Implied

An affirmative warranty states that specific facts exist at the time the contract forms. A continuing, or promissory, warranty states that the parties will do certain things or that certain conditions will continue to exist during the policy term.

Because they relate only to conditions that existed at the time of the contract, affirmative warranties are less strict than continuing warranties, and courts prefer to interpret warranties as affirmative. This approach is consistent with the general rule that if an insurance policy has two interpretations, a court will apply the interpretation favorable to the insured. If an insurer wants a continuing warranty, the policy language must state clearly that the warranty is to apply to future and continued use.

For example, a commercial property insurance application asks, "Who sleeps in the store?" The applicant writes, "A guard on premises at night." This statement is an affirmative warranty of conditions at the time of contract formation. If a guard slept on the premises at the application time, but not later, the insured has not breached the affirmative warranty. If the insurer wants a guard on the premises at night during the policy term, the policy language

must clearly say so. Language referring to the future (continuing), such as "a guard will be on the premises at night," is necessary.

An implied warranty is an obligation that the courts impose on a seller to warrant certain facts about a product, even though they are not expressly stated by the seller. Implied warranties are considered to exist in order to render transactions reasonable and fair, particularly in sales of goods transactions. For example, safety is generally an implied warranty for all products. All warranties in insurance law, however, are generally expressed in the policies or incorporated by reference.

Lessening Warranty Effects

Insurers prefer that courts interpret the insured's statements as warranties rather than as representations because a representation must be material to be grounds for an insurer's avoidance of a policy. Insurers also prefer that warranties be continuing and that they therefore extend through the policy period.

State laws usually require that insureds' life insurance statements be considered representations. Although the principle that insureds' statements are usually warranties applies, courts have reduced the harsh effects this doctrine can cause by interpreting statements as factual representations and not as warranties, whenever possible. They also prefer to interpret warranties as affirmative rather than as continuing.

When possible, courts also interpret policies as severable. If one policy provision is invalid, it need not invalidate the entire policy but can be severed, or separated, from other provisions. Therefore, noncompliance with a warranty concerning one type of covered property will not defeat coverage for another type of property to which the warranty does not relate.

The parties' intention determines whether a policy statement is a warranty or a representation. A court interprets a policy as a whole, including the hazards insured, the language used, and the parties' situations. A court does not consider the use of the word "warranty" or "representation" as conclusive. For instance, a declaration that factual statements are warranties might have no effect if no other provisions or circumstances indicate this characterization as the parties' intention. A statement is a representation rather than a warranty unless the language unequivocally states that it is a warranty. When any doubt exists, the statement is not a warranty.

Some state statutes prevent insurers from specifying that representations have the same effect as warranties. Other statutes relate to the strict compliance aspect of warranties and specify that only substantial compliance is necessary. Still other statutes relate to the time at which the breach of warranty existed and prevent avoidance of the policy unless the warranty existed at the time of the loss.

WAIVER, ESTOPPEL, AND ELECTION

Insurance law uses the doctrines of waiver, estoppel, and election more frequently than any other field of the law. The three doctrines apply to almost every ground on which an insurer can successfully deny liability.

In insurance, the issues of waiver, estoppel, and election usually arise when an insured sues for payment of damages under the policy and the insurer asserts a defense, such as fraud, misrepresentation, concealment, mistake, or breach of a condition. In turn, the insured argues that the insurer has forfeited or is prevented from asserting the defense by any of these actions:

- Waiver of the defense
- Estoppel from asserting the defense
- Election not to take advantage of the defense

Waiver

A **waiver** can be express or implied, depending on the circumstances. In insurance, waiver means that an insurer's conduct has the legal effect of giving up a defense to a lawsuit. It applies to defenses based either on the insured's noncompliance with a condition or on misrepresentation.

Waiver
The intentional relinquishment of a known right.

For example, a homeowner makes a claim for water damage to the contents of his basement. The adjuster instructs the homeowner to make a list of the damaged items, then tells the homeowner to throw the items out. Under these circumstances, the adjuster's instructions result in a knowing waiver of the insurer's right to inspect the contents, which are no longer available. The insurer cannot later deny the claim on the basis that the insured failed to make the contents available for inspection.

Use of Waivers

A party can waive almost any contractual right or privilege. An insurer can waive any policy provision (providing it involves a right), standard policy language, and even a policy provision that specifically prohibits waivers. Producers, for example, can waive these rights and privileges:

- Notice of loss or proof of loss requirements
- Property inspection or medical examination requirements
- Policy suspension for premium nonpayment
- Occupancy requirements for insured property

For waiver to occur, an insurance policy must exist. A statement made before an insurance contract comes into existence is not a waiver of a known right, but an attempted waiver of a future right. For example, Carmen applies for an inland marine insurance policy that allows the insurer to declare the policy void if the insured fails to maintain the security system at the insured prem-

ises. In the application, Carmen expresses the intent to disconnect the system later, and the producer tells her that the insurer does not intend to enforce the security system clause. The producer is attempting to waive a future request in a policy that does not yet exist. The producer's attempted waiver of the clause is also ineffective because the parol evidence rule would exclude evidence of the conversation; therefore, the policy itself would represent the entire contract.

Insurers cannot waive some matters, including privileges that further public policy, such as the requirement that an insured have an insurable interest in the insured property or life. Insurers also cannot waive actual facts.

By definition, an exclusion of a cause of loss cannot be waived. Waiver applies only to the relinquishment of a right. An exclusion represents not the insurer's right not to cover a cause of loss, but a duty the insurer has chosen not to assume. For example, if an insurance policy excludes coverage for earthquake damage, the insurer has expressly chosen not to assume the duty of paying an earthquake loss under the policy. It cannot then waive the exclusion and assume the duty.

A producer's representation that a policy covers something it does not actually cover does not constitute a waiver. For example, a producer tells an insured that a policy applies when the insured is driving an employer's car. In reality, the policy contains a nonowned automobile clause excluding such coverage. The producer might be liable for the misrepresentation, but the insurer would not be liable.

Consideration

In general contract law, voluntary waivers are not binding, and a binding waiver requires consideration. In insurance law, some waivers are binding without consideration. For example, an insurer pays for a loss after the policy period for filing proof of loss has elapsed and without having received proof of loss. The insurer has waived its right to proof of loss and has received no consideration from the insured in exchange for the waiver.

Knowledge Requirement

An insurer must know of a breach of condition under the policy before it can waive that condition. Once it has knowledge of a breach, the insurer must act immediately to avoid a waiver. Whether the insurer has waived a right depends on the facts of each case.

Only pertinent knowledge can form the basis for a waiver. For example, a producer knows that an insured is constructing an addition to an insured building that has a sprinkler system to control the spread of fire. The producer, however, does not know that the building contractor will shut off the sprinkler system temporarily during construction. The producer's failure to act is not a waiver of the automatic sprinkler clause. But if the producer learns that the sprinkler system has been turned off and fails to inform the insured that coverage will be affected, the producer has waived the clause.

Policy Provisions

Courts generally do not enforce policy provisions requiring all waivers to be in writing, even though waiver is based on the contract principle that courts will enforce valid contractual provisions. Permitting insurers to negate the defense of waiver simply by inserting provisions in the policies would defeat the law of waivers entirely. Even if a nonwaiver clause is enforceable, however, it may contain loopholes. For example, if a producer who has the authority to make written and oral changes in a policy makes an oral change that results in a waiver, the producer's authority may negate the waiver provision.

Acts Constituting Waiver

Any words that express, or acts that imply, an insurer's intention to give up the right to assert a known defense can constitute a waiver. The insurer must know of the breach in a policy condition before it can waive it. With knowledge of the breach, the insurer has the option of declaring the policy void. If the insurer does not do so, a waiver occurs. Insurers' acts that can show an intent to continue a contract in force, therefore constituting waivers, include, but are not limited to, these:

- Receipt of a premium with knowledge of a breach of policy conditions.
- Demand for appointment of appraisers or submission of a dispute to arbitration according to policy provisions, or any other demand the insurer is entitled to only if the policy is in force.
- Request for proof of loss after knowledge of a breach in a contract without a nonwaiver agreement.
- Silence beyond a reasonable time after learning of a breach. For example, when a proof of loss is defective, the insurer's silence concerning the defect beyond a reasonable time constitutes a waiver.

Parol Evidence Rule

Waivers are subject to the parol evidence rule. The parol evidence rule prohibits the introduction into evidence at trial of any oral agreements made before, or contemporaneous with, the formation of a written contract. The law assumes that final written insurance policies contain all waiver agreements that have arisen from words or acts before or during the writing of the policy.

Thus, oral evidence of agreements preceding or accompanying a written insurance policy cannot be used to prove a waiver. An agent's oral promise to waive future breaches before or during the finalizing of a policy is ineffective as a waiver because of the parol evidence rule and is not admissible as evidence. On the other hand, parol evidence is admissible to prove waiver agreements made after the policy has been written and properly authorized.

Estoppel

Estoppel
A legal principle that prohibits a party from asserting a claim or right that is inconsistent with that party's past statement or conduct on which another party has detrimentally relied.

Estoppel is a legal principle that prohibits a party from asserting a claim or right that is inconsistent with that party's past statement or conduct on which another party has detrimentally relied. For example, Kim makes a statement to Carlos. Carlos relies on the statement and takes action as a result of the reliance. Kim refuses to abide by the statement, while Carlos suffers injury or detriment because of having relied on the statement. Carlos, in a lawsuit, might assert that Kim is estopped from acting in contradiction to the original statement. Parol evidence is admissible to prove estoppel, and it is immaterial whether the words or acts occurred before or after the making of the written contract.

Insurance Law and Estoppel

Estoppel arises in insurance law from this sequence of events:

1. False representation of a material fact
2. Reasonable reliance on the representation
3. Resulting injury or detriment to the insured

Distinguishing Estoppel From Waiver

In insurance law, the distinction between waiver and estoppel is often ambiguous. Although the legal effect of the two defenses is the same, they are different in these ways:

- Waiver is contractual in nature and rests upon agreement between parties. Estoppel is equitable in nature and arises from a false representation.
- Waiver gives effect to the waiving party's intention. Estoppel defeats the inequitable intent of the estopped party.
- The parol evidence rule applies to waiver and does not apply to estoppel.

Factors Establishing Estoppel

When an insurer knows that an insured has breached a policy condition, any of the insurer's words or acts that the insured can reasonably interpret as representations that the contract is still valid will prevent the insurer from avoiding the contract. The insured asserting estoppel, however, must come to court with "clean hands," that is, must not have committed fraud or have acted in bad faith.

The insured also must show that he or she acted in good faith and in reasonable reliance on the insurer's representation.

Estoppel applies when an insurer's producer misinterprets questions or falsifies answers in an application and the insurer issues a policy based on the misleading information. Because the producer made the misrepresentation, the insurer cannot deny (is estopped from denying) the truth of the statements.

Practice Exercise

An insurer issues a fire insurance policy covering a building on leased land, a fact the insured disclosed on the application. The producer delivers the policy to the insured, saying, "Here is the policy, and it fully covers your building." The policy expressly provides that it is void if the building insured is located on leased land. The insured accepts the policy without reading it and puts it with other valuable papers. When the building later burns, the insurer denies the claim. Are the elements leading to estoppel present in this case?

Answer

All the elements leading to estoppel are present in this case. The insurer, through its producer, made a false representation by stating that the policy covered the building. The insured reasonably relied on the representation by accepting the policy and not purchasing other insurance. The insured's failure to read the policy does not mean reliance is unreasonable. For the insurer to defend its actions based on the policy would harm the insured, who would have no insurance coverage. The insurer is prevented, or estopped, from denying that coverage exists. The producer's statement was not a waiver, because the insurer did not intend to give up any right under the policy.

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Similarly, if an insurer's producer states that agreed-on acts, such as including a certain policy endorsement, have occurred when they have not, that representation might be subject to estoppel. For example, if a producer states that an endorsement will be added to a policy to permit a building to be unoccupied for certain periods, and the policy issues without that endorsement, the insurer cannot deny the validity of the intended endorsement. That the insured failed to check the policy does not negate the element of reasonable reliance. Oral evidence is admissible in court to prove the facts.

Election

Election is the voluntary act of choosing between two alternative rights or privileges. A choice of one available right can imply a relinquishment of the right not chosen. For example, an insurer that treats a contract as valid for the purpose of collecting premiums cannot treat it as invalid for the purpose of covering a loss. The essence of the election doctrine is that an insurer or insured cannot adopt a "heads I win, tails you lose" position.

Election

The voluntary act of choosing between two alternative rights or privileges.

Application

Waiver, estoppel, and election are not interchangeable doctrines. Application of the doctrine of election limits a party's range of choices. Election requires proof of neither the waiver requirement of voluntary relinquishment of a known right nor the estoppel requirement of detrimental reliance.

Practice Exercise

One of an insured's duties is to report a loss promptly. This notice should include how, when, and where the loss happened and also should include any injured parties' and witnesses' names and addresses. The insured's failure to meet this obligation could result in a denial of coverage.

Facts

An insurer accepts a notification that the insured experienced a loss. This notice came from a party to the loss, not the insured. However, it is sufficient for the claim department to create a file and begin an investigation. Is there the potential for waiver and estoppel to apply here?

Answer

If the insurer begins an investigation without issuing a reservation of rights letter to the insured, the insurer has waived its right to deny coverage on the basis of the insured's failure to fulfill the obligation to report the loss fully.

In this case, estoppel also applies. The insurer has accepted whatever notice was given and begins an investigation without a reservation of rights letter. Relying on the belief that the insurer will fulfill its contractual obligation to indemnify and defend, the insured takes no further action, neither investigating the loss further or preserving the evidence. The insurer cannot use the defense of insufficient notice to deny its duty to indemnify and defend. Denial would put the insured in a detrimental position, and the insurer would be estopped from denying coverage.

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An example of election involves choosing between alternative rights under a fire policy, which usually gives an insurer the option to repair or rebuild instead of paying monetary compensation for a loss. An insurer whose words or acts have led an insured to expect monetary compensation has elected that method of discharging its duty under the policy. The insurer has reserved the right to elect between two alternative duties and, having elected one (monetary compensation), has lost the right to choose the second alternative (repairing or rebuilding). Election applies even though the insurer has not voluntarily relinquished a known right, as would occur with a waiver, and no detrimental reliance applies that would lead to estoppel.

Insured's Election

The doctrine of election also applies to choices by the insured. In many instances, the insured must choose between two inconsistent legal remedies. Having elected one course of action, the insured cannot pursue the other. For example, an insurer cancels a life insurance policy including provisions for the payment of disability benefits. The insured elects to sue the insurer for fraudulent breach of the contract and receives damages, but not reinstatement of the policy. Later, the insured attempts to sue to recover disability benefits that would have accrued before the previous lawsuit had it not been for the insurer's cancellation of the policy.

In the first suit, the insured alleged a breach of contract and a right to damages. In the second suit, the insured demanded benefits that would have been payable absent a breach of contract. Election of the first remedy bars the insured's right to use the second remedy. The insured elected to treat the policy as canceled and demand damages in the first lawsuit. Therefore, the insured is barred from pursuing the second remedy, disability benefits, on the assumption that the policy had not been canceled. See the exhibit "Distinguishing Factors of Waiver, Estoppel, and Election."

Distinguishing Factors of Waiver, Estoppel, and Election

	Waiver	Estoppel	Election
Defined	Insurer's voluntary and intentional relinquishment or abandonment of a known right	Insurer's prohibition from enforcing certain conditions of a policy when insurer's representation, express or implied in words or conduct, caused insured to rely on the representation	Insurer's voluntary choice of an inconsistent alternative, which precludes subsequent selection of the other alternative
Relative advantages for insured	Requires no proof of insured's reliance and resulting detriment	Requires no proof of the insurer's voluntary relinquishment of a known right	Requires no proof of either voluntary relinquishment of a known right or detrimental reliance
Relative disadvantages for insured	Requires proof of the insurer's voluntary relinquishment of known right	Requires proof of detrimental reliance	Difficult to prove
Other distinguishing characteristics	Requires proof of insurer's act or conduct	Requires proof of act or conduct of both parties to the contract: • Insurer's representation of a fact • Insured's reliance on the representation and resulting detriment	Requires proof of insurer's act or conduct

[DA04622]

NONWAIVER AGREEMENTS AND RESERVATION OF RIGHTS LETTERS

Insurers use nonwaiver agreements and reservation of rights letters to preserve certain defenses against liability that they might have under policy terms. Claim personnel frequently use them when loss investigation reveals the possibility that the insurer might deny coverage under the policy.

The possibility of denying coverage poses a dilemma for the insurer. If the insurer continues to investigate a loss on its merits without determining whether it can legitimately deny coverage, its rights might be prejudiced. Such actions can raise issues of waiver, estoppel, or election that could negate the insurer's lack of coverage defense. However, if the insurer does not investigate, it might forfeit all defenses, and the loss can increase.

Nonwaiver agreement
A signed agreement indicating that during the course of investigation, neither the insurer nor the insured waives rights under the policy.

Reservation of rights letter
An insurer's letter that specifies coverage issues and informs the insured that the insurer is handling a claim with the understanding that the insurer may later deny coverage should the facts warrant it.

Both a **nonwaiver agreement** and a **reservation of rights letter** prevent subsequent claims of waiver, estoppel, election, and any other theories of rights that vary with policy provisions.

Use of Nonwaiver Agreements and Reservation of Rights Letters

Nonwaiver agreements and reservation of rights letters help solve the insurer's dilemma of whether or not to investigate a loss. They inform an insured that the insurer's activities regarding the loss are not the relinquishment of its right to stand on policy provisions. An insurer might be able to establish that it is not liable under the policy. The insurer can continue to investigate and evaluate the loss on its merits, an activity beneficial to both the insurer's and insured's interests. Simultaneously, the insurer can determine whether the insured has violated policy terms and whether the insurer will accept liability under the policy. When the insurer, knowing of grounds for forfeiture or noncoverage, manages the defense of a lawsuit against its insured without giving timely notice of its reservation of rights, it cannot refuse coverage on those grounds.

Nonwaiver Agreements

A nonwaiver agreement, which must be signed by both parties, protects the insurer from estoppel by reserving the right to deny coverage based on information developed during the investigation. It also alerts the insured to a potential coverage problem. The nonwaiver agreement is usually used when the claim representative is concerned about investigating a claim before the insured has substantially complied with the policy conditions or when there appears to be a specific coverage problem or defense. Such concerns can be identified from the initial claim report, during initial contact with the insured, or at any point during the claim investigation. For example, a claim representative may offer a nonwaiver agreement when the insured reports the theft

of an auto but refuses to make a police report about the theft. If the insured refuses to sign the nonwaiver agreement, the claim representative can use a reservation of rights letter to protect the insurer's rights.

The insurer should attempt to enter into a nonwaiver agreement with the insured as soon as the potential coverage question surfaces. Occasionally, practical difficulties arise in the attempt to secure the insured's consent and signature:

- The insured might refuse to sign a nonwaiver agreement, even after the claim representative has clearly explained its significance. This refusal can delay the investigation of the loss.
- The insured could challenge the nonwaiver agreement if the claim representative has not explained the importance of the agreement fully and fairly. The lack of adequate explanation can lead an insured to claim lack of contractual intent, misunderstanding, duress, or other defenses that can jeopardize the agreement's validity.

Reservation of Rights Letters

A reservation of rights letter serves the same purpose as a nonwaiver agreement but is in letter form, and it is a unilateral document, meaning it does not require the insured to sign or agree to the contents of the letter. It simply advises the insured of the potential coverage issue. Nevertheless, a reservation of rights letter can be as effective in protecting the insurer's rights to policy defenses as a nonwaiver agreement if the insurer has drafted the letter carefully and can show that the insured received it.

Requirements for Nonwaiver Agreements and Reservation of Rights Letters

Certain elements must be present for a nonwaiver agreement or reservation of rights letter to be effective. First, the insurer must communicate the nonwaiver agreement or reservation of rights notice to the insured, usually by letter. Oral notice is not advisable because it would be too difficult to prove oral notice. Second, the notice must be timely. A nonwaiver agreement or reservation of rights letter prevents estoppel because it gives the insured the option to hire a lawyer to take over the defense from the insurer. Because the notice must give the insured reasonable time to find alternative defense, the insurer's safest course is to give notice as soon as it obtains knowledge of the policy defense.

The notice must inform the insured fairly of the insurer's position, citing the policy provisions on which the insurer relies and the facts that, if proven, would result in a denial of liability.

If the insurer has acted in good faith and used every reasonable method to contact the insured, the insurer can assert its policy defense. For example, a

liability insurer who questions coverage under an automobile policy writes six letters to the insured informing him or her that it will defend an action but with express reservations of its rights to contest the policy. The insured contends nonreceipt of the letters. Because the letters were addressed to the insured at both the insured's residence and workplace, a presumption arises that the letters were received.

Nonwaiver agreements and reservation of rights letters are usually sent by certified mail, with a return receipt requested, so the insurer has evidence of the insured's receipt. If the insured refuses to sign a nonwaiver agreement, the only way the insurer can protect itself against subsequent claims of variance is to resort to the reservation of rights letter. This unilateral declaration gives notice to the insured that the insurer intends to safeguard its rights to dispute liability under the policy terms and that its conduct in investigating the loss should not be interpreted contradictorily in this respect.

In most jurisdictions, nonwaiver agreements and reservation of rights letters are sent only to the insured and can be used on any type of first-party claim. Usually, they are not sent to third-party claimants because third parties have no obligation under the policy. However, there are some jurisdictions that require they be sent to third-party claimants. It is prudent to seek the advice of coverage counsel when contemplating the use of a nonwaiver agreement or a reservation of rights letter.

SUMMARY

Insurance contracts have special characteristics that distinguish them from other contracts. An insurance policy is a conditional contract; a contract involving fortuitous events and the exchange of unequal amounts; a contract of utmost good faith; a contract of adhesion; a contract of indemnity; and a nontransferable contract.

An insurance contract has unique characteristics with regard to these aspects: agreement, including issues concerning offer and acceptance, effective date, and silence or delay; content, which can be oral or informally written, must include necessary terms, can include implied terms, and must include insurer designation; and delivery.

An insurance contract can benefit a third party, other than the insured under the policy, in cases of injury or damage (primarily from negligence) and in real estate sales, mortgages, lease interests, and life estates.

Statements on an insurance application are usually either representations or warranties. Representations are oral or written statements made by an insurance applicant concerning loss exposures that induce an insurer to enter into the insurance contract. Warranties are statements or promises in an application that, if untrue, would render the policy voidable, whether or not they are material.

A waiver is the intentional relinquishment of a known right, requiring knowledge of the facts and relinquishment of a right based on knowledge of those facts. In insurance law, estoppel is one party's representation of fact that the other party relies upon, making it unfair to allow the first party to refuse to be bound by the representation. Election is voluntarily choosing between alternative rights or privileges. An insurer's or insured's choice between available rights can imply a relinquishment of the right not chosen.

Insurers use nonwaiver agreements and reservation of rights letters to protect certain defenses against liability that they might have under the policy terms from insureds' assertions of waiver, estoppel, or election. These notices and agreements allow insurers to advise insureds that the insurers' activities regarding losses do not waive their rights to stand on policy provisions. An insurer can continue to investigate and evaluate losses on their merits.