3 – Handling Coverage Issues

**1 – Avoiding Mistakes in Coverage decisions**

**Objective**: Explain how claim reps can avoid mistakes in reaching coverage decisions

Learning the best ways to review an insurance policy and investigate a claim helps claim reps correctly apply policy provisions and avoid mistakes when making coverage decisions.

Mistakes in coverage decisions can be costly. They can lead to bad-faith wards, litigation, loss of customer satisfaction, and increased loss ratios. **Common mistakes that claim reps should try to avoid include:**

* **failing to understand policy provisions**
* **Not considering jurisdictional differences**
* **Making a decision without all the facts**
* **Assuming that the policy is worded clearly**
* **Letting emotions affect decisions**
* **Improperly explaining coverage**
* **Overcommitting to a coverage decision**

**Failing to Understand Policy Provisions**

Insurance policies often contain numerous and complex provisions. **It’s easy for a busy claim rep, who are familiar with a policy in general terms, to overlook certain specific provisions. As a result, they may apply coverage based on how they think the policy reads rather than how it actually reads. This can lead to wrongful claims denials.**

Claim reps must always make sure they based coverage decisions on what policies say. Even the most experienced reps are unlikely to memorize every word of every policy. Therefore, they should all review policy wording before making a coverage decision. The consequences of a wrong coverage decision make the risk of not double-checking the policy too great.

**Not Considering Jurisdictional Differences**

Two different jurisdictions, or states, can interpret the same policy in two different ways. Claim reps who handle claims in multiple states should be sure to consider such differences, and identify provisions that commonly have varying interpretations. They should also solicit information from claims management or legal counsel regarding changes to coverage interpretations.

**The jurisdictions overseeing a coverage determination is generally the one in which the contract was entered. In other words, it’s usually where the policy was issued or delivered to the insured. Understanding that state’s laws, and how the courts in that jurisdiction have addressed similar coverage issues, can help claim reps decide whether to settle a case or defend it**.

**Making a Decision Without All the Facts**

Coverage decisions are made by applying facts to policy provisions. So it stands to reason that if they fail to gather all the facts, claim resp might make poor coverage decisions.

**Claim reps should always obtain a detailed account of the relevant facts before committing to coverage. If an insured initially provides insufficient detail to make a coverage decision, the rep may need to reserve the insurer’s right to apply coverage defenses and then conduct a more extensive investigation**.

**Assuming the Policy is Worded Clearly**

**A claim rep who has read an insurance provision may assume that everyone interprets it as he or she does. But claim reps’ technical vocabulary and coverage perspectives often differ from most policyholders’.**

**Sometimes the rep can overcome these differences by thoroughly explaining a provision to the policyholder. At other times, the difference cannot be overcome because the policyholder’s interpretation is just as valid as the rep’s.**

**Claim reps should therefore concede that some policy wording may be subject to different interpretations. When policyholders raise viable alternative coverage interpretations, reps should analyze those interpretations and inform claims management**.

**Letting Emotions Affect Decisions**

**Claim reps must separate their personal feelings about a claim or an insured from their coverage decisions.**

**Claim reps sometimes encounter insures who are unpleasant, obnoxious, or unsavory. Sometimes insureds make unusual claims, such as for damage from drive-by shootings, which may not have been contemplated by the policy writers. But no matter the situation, coverage decisions should be based on the application of facts to policy wording, not on the personality of the insured or the insured’s attorney. In addition, coverage decisions should not be based on a reps opinion of whether insurance, in general, should apply to certain acts.**

Claim reps should gather all the information about an incident before analyzing whether coverage applies. Sometimes coverage applies when it doesn’t seem like it should. This may occur, for example, if an insured seeks a defense for intentional acts with seemingly intentional injuries. Because of the long-standing principle that the duty to defend is broader than the duty to indemnify, the determination of coverage can be contentious.

**Improperly explaining Coverage**

In today’s claim environment, clam reps are busy, and policyholders may be difficult to reach. These factors can contribute to poor explanations of coverage; often provided through brief voicemails or emails from claim reps who have been unsuccessful in making person-to-person contact with the insured. These messages may not be detailed enough to property explain the coverage.

**When claim reps do not speak directly with the insured, they should follow up with detailed letters or emails summarizing the conversation.**

**Most states require coverage denials to be in writing. When insureds report only minor property losses with no accompanying injury claims, some insurers believe that explaining denials in conversations with each insured is adequate if the insured understands and agrees with the reasoning. But, claim reps should still provide full, written coverage explanations to insureds**.

**Overcommitting to a Coverage Decision**

**Claim reps or management personnel may overcommit to their initial coverage position** and then have difficulty changing that position later. **This can occur when they take an initial coverage position on a high-profile claim or authorize the expenditure of many resources to help establish support for their own coverage opinion.**

Example; arson and fraud cases require extensive and costly investigation by specialists, private investigators, and other experts. **Sometimes claim reps and managers convince themselves that once they have spent a great deal of money on investigations, they should deny coverage. This can lead to poor coverage decisions.**

**Coverage investigations won’t always prove what the claim reps suspect. Claim reps should perform investigations to learn the truth, not to support preconceived notions. The cost of the investigation should influence a coverage decision. Bad-faith awards, loss of customer goodwill, and costs to defend a bad decision are far more costly than a good investigation preceding a coverage decision**.

**2 – Avoiding Waiver and estoppel**

**Objective**: Explain how waiver and estoppel can occur when resolving property coverage issues and how to avoid waiver and estoppel

Claim reps need to know what actions can trigger a waiver of rights under a policy or result in an insurer being estopped from asserting its rights under a policy. They also need to know the tools they can use to avoid waiver and estoppel. Becoming familiar with these elements will help claim reps make appropriate and timely coverage and settlement determinations while avoiding potentially costly mistakes.

When investigating claims and resolving coverage issues, a claim rep must look for facts that will either confirm coverage or show that a coverage denial is appropriate. Until these matters are resolved, the claim rep and insurer must avoid actions that would lead an insured to mistakenly believe that a claim will be covered and paid. If this occurs, a waiver of rights or an estoppel could be triggered, which may result in the insurer paying for claims that wouldn’t have been covered under the policy otherwise. Frequently, the doctrines of waiver and estoppel are so closely related in meaning that courts often fail to distinguish them and simply hold that a result is based on the doctrine of waiver and estoppel.

**Waiver**

**Waiver is voluntary and can be made expressly or by implication. It can be oral, written, or inferred through any conduct of the claim rep or the insurer that is inconsistent with a particular right**.

A waiver can occur under various circumstances. Example, when the claim rep or insurer makes an unconditional offer to pay a claim and becoming aware of a coverage defense or a basis for denying liability, the insurer waives its right to deny the claim. This is true regardless of whether the coverage defenses reveal a right to rescind the policy because of an insured’s misrepresentation on the insurance application, a cancellation of coverage before the loss, or the lack of coverage for the loss. Payment or an offer of settlement waives a coverage defense.

Waiver can also occur following a claim denial. The insured might allege that the insurer, upon denial of the claim, breached its obligation, thereby waiving the continued application of the policy conditions. This would mean the insured would be relieved of any further obligation to comply with the conditions. The claim rep or insurer can waive the insured’s compliance by offering to pay the loss before the insured has complied with the policy conditions.

In some jurisdictions, the insurer-waives the proof of loss condition by failing to provide a proof of loss form to the insured or failing to request a proof of loss from the insured within the time limits established by the insurance code. Additionally in, in some jurisdictions, a claim investigation in which the claim rep obtains a detailed statement from the insured covering the facts and extent of loss waives the proof of loss and examination under oath conditions, because the insurer is deemed to be fully aware of the information required to be produced by these conditions.

A waiver of the insurer’s option to repair or replace property can occur when the insurer elects to pay the claim in money or enters into a formal appraisal of the amount of loss. Making payment or initiating appraisal also waives any coverage defenses unless the insurer expressly advises the insured that it is reserving its right to investigate further and assert policy conditions.

**Estoppel**

A claim rep or an insurer’s conduct might result in estoppel. **For estoppel to occur, the insured must rely on the insurer’s conduct**. Example, the insured might change his or her position about the policy, might incur some expenses, or might be led into breaching a policy conditions **as a result of relying on the representations or conduct of the claim rep or insurer. When this happens, it’s called detrimental reliance**.

To permit an insurer to assert a coverage defense in such cases would be improper. Estoppel prevent an insurer from claiming its right, privilege, or defense if it would be inequitable to do so because of the insurer’s conduct toward the insured.

These are examples of when estoppels can apply:

* When a claim rep tells an insured to repair a structure or to replace or repair some personal property, causing the insured to incur expenses, the insurer will be estopped (prohibited) from raising any coverage defense or exclusion.
* The insurer will be estopped from claiming a breach of the proof of loss condition when the claim rep has told the insured that the proof of loss doesn’t need to be filed until a settlement has been agreed upon.
* The insurer is estopped from exercising its right to have the insured show or exhibit the property or to take all or part of the damaged property as salvage if the claim rep has advised the insured to discard or sell the damaged property.

In these circumstances, there has been a waiver and estoppel; the insurer is estopped from asserting that the insured breached to policy because the insured relied on the insurer’s direction. Anything a claim rep or an insurer says or does that causes the insured to reasonably conclude that coverage applies or that nothing more is required of the insured in order to collect under the policy can constitute a waiver and can estop the insurer from asserting coverage defenses or policy conditions.

Courts have consistently ruled that a claim rep, as the insurer’s agent or apparent agent, can waive policy conditions, either orally or through behavior. This is the case even though all standard property insurance policies contain provisions (or general conditions) against a waiver or change of policy provisions, unless the insurer consents to waive or change a provision in writing.

**Measures for Avoiding Waiver and Estoppel**

Claim reps can avoid waiver and estoppel with timely nonwaiver agreements or reservations of rights letters, followed by prompt investigation and, when appropriate, a carefully considered denial of coverage or a retraction of the reservation of rights. Whenever a claim rep makes advance payments while a coverage issue is pending, he or she should include nonwaiver language in the advance payments receipt. However, because of jurisdictional differences, claim reps should check the law to determine the proper nonwaiver language.

**Nonwaiver Agreements**

**Nonwaiver agreements and reservation of rights letters both serve these general purposes**:

* To advise the insured that any action taken by the insurance company in investigating the cause of loss or in ascertaining the amount of loss is not intended to waive or invalidate any policy conditions
* **To clarify that the agreement’s intent to permit an investigation of the claim and that neither the insured nor the insurer will thereby waive any of its respective rights or obligations**.

The two types of nonwaiver agreements are general and specific. A general nonwaiver agreement includes the above two items mentioned. This types of agreement is commonly used in daily claims adjusting whenever the insured has substantially complied with the policy’s duties aft loss conditions.

A specific nonwaiver is used whenever the insurer becomes aware of a specific coverage problem or defense. This might occur because of information provided in the initial report, during initial contact with the insured, or during an inspection of the damaged property. A specific nonwaiver agreement contains the same provisions as the general nonwaiver agreement, but it includes the specific policy provisions or exclusions that raise questions regarding coverage. The claim rep should explain to the insured the reasons for requesting a nonwaiver agreement, ask that the insured sign it, and provide the insured with a copy of the agreement.

**Reservation of Rights Letters**

**Reservation of rights letters serve the same purpose as nonwaiver agreements, but they are in letter form**. They contain the same general provisions and might include more specific reason for the coverage questions. Like a specific nonwaiver agreement, a reservation of rights letter should list the specific coverage part, provisions, or exclusion that applies to the situation in questions. Some claim supervisors attach photocopies of the specific policy provisions at issue. Reservation of rights letters are also worded to reserve the insurer’s right to raise other coverage issues later if they become known.

**Reservation of rights letters are usually sent to all named insureds (sometimes with copies to loss payees) by certified mail with return receipt. Some are hand-delivered so that the insurer has evidence of the insured’s receipt of the letter. They are used whenever face—to-face contact cannot be made to obtain a nonwaiver agreement or whenever the insured has refused to sign a nonwaiver agreement.**  A reservation of rights letter is as effective as a nonwaiver agreement as long as it can be proved that the insured received it. Some claim supervisors prefer to use both nonwaiver agreements and reservation of rights letter to ensure that the insured has received notice of the coverage questions.

**Further Investigation**

Once the insured has signed a nonwaiver agreement or acknowledged receipt of a reservation of right letter, the claim rep can investigate the cause and extent of the loss without concern about waiving either party’s rights. The information obtained through the investigation can then be provided to claims management so that an informed decision can be made regarding coverage.

Many clam reps treat nonwaiver agreements and reservation of rights letters as ends in themselves (rather than as ways to help further the resolution process. This is a mistake. Both are tools that enable a claim rep to further investigate and evaluate a claim. The coverage issue must be resolved as quickly as possible, and the insured must be informed of the resolution.

**Denial Procedures**

Most insurers have established guidelines and strict procedures for denying claims that aren’t covered under the policy. For example, the claim reps supervisor or a file examiner might review smaller claims before the claim rep is authorized to deny them. Other claims, depending on the insurer’s procedures require review at the branch office claims manager level. More serious claims and claims involving certain types of policies or types of business are typically referred to regional claims manager or are reported to home office claims staff.

To assist claim staff with difficult or questionable claims, many insurers have established claim committees within their branch, regional, and home offices. These committees consist of personnel with extensive experience in claims, usually supervisors and claims managers. A claim representative handling a challenging claim presents the claim at a committee meeting. The claim file can then be reviewed an discussed. If the claims committee thinks additional information is necessary to reach a decision regarding the claim, the committee will give the claim rep suggestions for further investigation. The committee might also require a legal opinion form an attorney before making a final recommendation.

The claims committee might decide that the claim is covered and should be paid, or it may decide that denial is appropriate. If denial is deemed appropriate, the insurer has two options (1) the claim can be denied by letter, specifying the reasons for the denial and citing specific provision of the policy, or (2) the insurer may file a declaratory judgement action – a legal action in which the insurer (or insured) presents a coverage question to the court and asks for the court to declare the right of the parties under the applicable insurance policy.

In a declaratory judgement action, the insurer requests a court to review the evidence and determine the parties’ duties and obligation under the policy. Determining coverage through this type of legal action is usually done only when the law is unclear or undecided or when the exposure on the claim is high.

**Advance Payment Receipts**

**Partial payments of claims are sometimes advanced to insured when they demonstrate the need, and request an immediate payment, for emergency reasons**. Example, in a homeowners losses, insured and their families might need temporary housing or money for food and clothing.

Advance payments are usually made during the first few days after a loss, before both the insurer can fully investigate the cause and the insured has fully complied with conditions. Because the courts have held that payment waives coverage defenses, including the insured’s failure to comply with policy conditions, the insurer must act to avoid a waiver. This is accomplished with an advance payment receipt.

The receipt is essentially a nonwaiver agreement, but it also serves to advise the insured of these stipulations:

* The insurer has neither accepted nor denied the claim
* Payment is not an admission of liability
* Payment is made in response to the insured’s good-faith representation regarding the loss and request for payment
* The insurer does not waive any conditions and expects full compliance under the policy
* If the claim is not covered or is invalid, the insured agrees to repay the insurer the amount advanced
* If the claim is valid, the advance will be deducted from or credited against any covered claims

Advance payment receipts are used routinely, even when the policy clearly covers the cause of loss and the circumstances surrounding the loss. As a practical matter, they help track payments mad under certain coverages, help comply with unfair claim practices acts, and clarify to the insured that the advance payments will be applied against the final claim.

Such receipts are essential when handling losses involving suspected arson and insurance fraud; without them, payment of such claims would waive any defense against the insured’s breach of conditions, such as false swearing, fraud, and concealment. Although advance payment demonstrates the insurer’s good faith, they should not be made unless the claim rep obtains a receipt.

**3 – Coverage Denials**

**Objective**: Analyze the issues related to coverage denials

Claim reps need to know when and how to issue coverage denial letters – and to deal with the issues that accompany them. Gaining this expertise will allow insurer to comply with the laws governing unfair claims practices, as well as provide valuable information to customers.

After a claim rep has completed a thorough claim investigation, analyzed the fact and coverage does not exist for the claim, the rep needs to issue a coverage denial letter.

**Denial letters take two forms:**

* **A general denial reserving an insurer’s right to all possible policy defenses that could apply to a claim**
* **A denial based on specific coverage defense that clearly and specifically details why the insurer is denying coverage.**

General denial letters invite litigation and may be rejected by courts because they don’t adequately explain why coverage is being denied. As a result, most insurers prefer to specifically cite all applicable coverage provisions when making a denial.

In fact, some courts require insurers to specifically list the reasons for denying coverage in the denial letter. This is because it allows the policyholder to know what the insurer’s coverage defenses are and to prepare to address those defenses. Those courts feel a general denial can put the policyholder at a disadvantage because it can make it impossible for the policyholder to know what defenses the insurer will raise which can prevent the policyholder from properly investigating those coverage issues and prepare for them.

Still, some insurers hesitate to issue denials that state specific coverage defenses because they believe the risk of being specific in the denial forfeits their right to raise any other policy defenses later. However, this is largely unfounded fear, as only a select few states don’t permit insurers to raise additional coverage issues that aren’t addressed in the denial letter.

Most states allow insurers to raise other defenses as long as they insured was not prejudiced (adversely affected, or put at a disadvantage) by the denial. Unfortunately, proving this can be difficult and costly. As a result, claim reps should attempt to list in the initial letter all of the reasons coverage was denied.

For claim denied on the basis of arson and fraud, it’s wise to mark “personal and confidential” on the outside of the denial letter’s envelope. Insured have sued insurers, claiming they were defamed when other parties read their letters and that the insurer failed to keep their denial letters confidential. For this reason, some insurers don’t send denial letters to the insured’s agent.

**Denials and Unfair Claims Practices**

**All states require that claim denials be prompt, timely, and fair**. Some states’ unfair claims practices laws specifically outline how denials should be made, including setting time periods (usually 30 days) to either accept or deny a claim, or to provide a detailed explanation of why the insurer needs more time to make a decision. These are examples of other potential state requirements:

* Provide a detailed explanation of all coverage denials
* Provide a reasonable explanation of the specific facts, law, or part of the policy that formed the basis of a coverage denial
* Clearly inform claimants of the insurer’s position on any disputed matter

Claim reps need to review their state’s specific laws prior to issuing coverage denial letters.

**Policy Violations**

Even claims that fall withing the insuring agreement and are not specifically excluded by the policy may not be covered if the insured violated policy conditions. **Beside fraud, the two most common policy violations leading to coverage disputes are an insured’s late reporting of losses and failure to cooperate with the insurer.**

The insured has a duty to promptly notify the insurer of a loss. The purpose of this notice requirement is to give the insurer time to determine its rights and liabilities, investigate the claim, protect against fraudulent claims, and secure early settlements.

An insurer has the right to investigate coverage and determine its obligation in a timely fashion. When notice of a claim is delayed by an insured, memories fade and important details are forgotten, the opportunity to examine the physical surroundings and take pictures is lost, the ability to find and speak to witnesses is hampered, and the ability to secure an early settlement and avoid litigation becomes more difficult.

Some courts look solely at whether an insured’s notice was unreasonably late and unexcused. The interpretation of what is unreasonable and unexcused varies by state. F physically disabled because of injuries sustained in the accident, an insured might have a legitimate excuse for providing late notice. It’s also important to keep in mind that the meanings of policy terms like “in a timely fashion” and “reasonable delay” are often disputed.

**Many courts examine whether the insurer was prejudiced due to late notice (carrier was adversely affected by the late notice). Claim resp should consider these questions; accordingly:**

* **Was information lost because of the late notice**
* **Was evidence lost, altered, missing, or destroyed because of the late notice**
* **Did damages increase because of late notice**
* **Was the opportunity to settle lost because of the late notice**
* **Was the ability to defend an insured lost because of the late notice**

An insured’s failure to cooperate is another policy violation that can lead to coverage disputes. Failure to cooperate often occurs in complicated losses that require extensive, time-consuming record gathering on the part of the insured. Insurer should consistently and continually seek cooperation from uncooperative insureds until coverage is denied or the claim is transferred to legal counsel for litigation.

**4 – Declaratory Judgment Actions**

**Objective**: Explain when and how to use declaratory judgment actions to resolve coverage disputes

As used in most insurance coverage claims, a declaratory judgment action (“dec action”) is a lawsuit seeking a judicial determination of whether policy coverage applies to a claim.

Insurers normally file declaratory judgment actions to determine whether a claim falls within the insuring agreement, meets the definition of a policy term or falls within an exclusion. However, declaratory judgment actions have also been used to determine whether and to what extent an insured has complied with a duty owed under the policy (such as prompt notice or cooperation.

**Questions Resolved by Declaratory Judgment Actions**

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| Common **questions about whether coverage applies** | Common **questions about the Rights and Duties** under a Policy |
| Does a particular exclusion apply? | **Has the insured violated any policy conditions?** |
| **Do the damages claimed fall within the definition of “bodily injury” or “property damage”?** | **Is the insured required to provide additional financial information in order to meet the policy requirements?** |
| **Do Other insurance policies apply?** | **Is the insured required to submit to more than on examination under oath?** |
| **Is a vehicle an “uninsured motor vehicle”?** | **Is a second named insured (e.g. a spouse) required to submit to a separate examination under oath?** |
| **When did the event take place?** | **Is the insured required t permit the insurer to reinvestigate the premises?** |
| **What are the limits of liability?** |  |
| **Does a policy violation preclude coverage?** |  |

A declaratory judgment action does not always address the issues of fault or monetary damages. A court **will not render “advisory opinions” on coverage** but instead will require that there be an actual case in dispute. **A declaratory judgement action that focuses litigation strictly on the coverage issue may help to avoid costly litigation that involves the defense and investigation of all liability and damage facts of a claim**.

To avoid bad-faith claims, insurers sometimes use declaratory judgment actions as an alternative to coverage denials. States accept this doctrine as a way of avoiding bad faith permit filing a declaratory judgement action as long as a reasonable coverage questions exists.

If the underlying issues of a tort claim can be separated, courts will often permit declaratory judgements. In some cases, the facts and coverage are too closely intertwined to be separated. Example so such cases involve the determination of whether a driver was a “hit-and-run” driver. Another example is determining whether the insured committed an intentional injury (which is excluded). In these cases, courts would generally defer the decision to the court assigned to the underlying tort case. **Declaratory judgment actions do not determine fault. An** insurer could not, for example, file a declaratory judgment action to determine whether an uninsured motorist was liable for an accident. These types of questions are based on facts that must be resolved through liability lawsuits.