Bad Faith Litigation in Alabama

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Table of Contents

I. THE ELEMENTS OF BAD FAITH 1
- A. Bad Faith Failure to Pay 5
- B. Bad Faith Failure to Investigate 21
- C. Bad Faith Offer to Settle With Insured 33
- D. Bad Faith Failure to Settle for Insured/Tort-Feasor 33
- E. The Unfair Claims Settlement Practices Act 34
- F. The Consumer Protection Act 34

II. RELATED CAUSES OF ACTION 35
- A. Breach of Contract 37
- B. Fraud 81
- C. Negligence 86
- D. Statutory Breach 87

III. PRE-SUIT INVESTIGATION 89
- A. Gathering Information From the Client 91
- B. Dealing With the State Insurance Department 93
- C. Contacting the Insurance Agent 94
- D. Recent Decisions 96

IV. THE INS AND OUTS OF DISCOVERY 101
- A. Plaintiff's View 103
  1. The Importance of Interrogatories and Examining the Insurance Claim File . 103
  2. Don't Leave Out the Request for Materials Beyond the Claim File 106
  3. Narrowing the Issues With Request for Admissions 108
  4. Coming to Court With "Clean Hands" When Responding to Paper Discovery 109
  5. Depositions - Typical Witnesses That Need to be Deposed 110
- B. Defendant's View 113
  1. How to Utilize Interrogatories to Obtain Documents and Determine Reasons for Plaintiff's Claim 113
  2. Covering All the Bases When Requesting Production of Documents 113
  3. Eliminating the Necessity of Obtaining Records for Trial by Using a Request for Admission 115
  4. Narrowing the Information Requested for Paper Discovery While Still Looking Out for the Best Interest of Your Client 116
  5. Depositions — Who to Depose in the Order of Depositions 116

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V. **ETHICS — IT'S LEGAL, BUT IS IT RIGHT?** **119**
A. Rules of Professional Conduct 121
B. Conflicts of Interest 135
C. Zealous Representation Vexatious Practices 136
D. Lawyer Liability 136

VI. **TRIAL STRATEGY — THE BEGINNING OF THE END** **137**
A. Voir Dire — The First Essential Step in Winning the Case 139
B. Opening Statements 141
C. Order of Witnesses 141
D. Use of Experts; Advise of Counsel 146
E. Exhibits — Using the Plaintiff's Evidence to Sway Fence-Sitting Jury Members 153
A. Voir Dire — The First Essential Step in Winning the Case 155
B. Opening Statements 157
C. Order of Witnesses 159
D. Use of Expert; Advice of Counsel 160
E. Exhibits — Using the Plaintiff's Evidence to Sway Fence-Sitting Jury Members 161
F. Closing Arguments 162

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I. THE ELEMENTS OF BAD FAITH

Chavers v. National Security Fire & Casualty Company, 405 So.2d 1 (Ala. 1981), was a 5-4 decision in which the Alabama Supreme Court first recognized a first-party claim for bad faith. The case involved the denial of a claim on the basis of arson, though there was questionable involvement on the part of the insured. The jury returned a verdict in favor of the plaintiff, the trial court entered JNOV, and the Supreme Court of Alabama reversed.

The court held that to prove a claim for bad faith, the plaintiff must show a denial with "no lawful basis for the refusal coupled with actual knowledge of that fact" or "intentional failure to determine whether or not there was any lawful basis for" the denial. The court noted that intent could be proved by circumstantial as well as direct evidence, and that recoverable damages included mental anguish and economical loss.

In reviewing the Chavers' claim, the court addressed several significant issues relating to bad faith cases. First, the lawful basis upon which the insurer relies in denying the claim must be supported by admissible evidence. Also, advice of counsel prior to denial is not an absolute defense though it is evidence of good faith. Again, counsel

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must have been provided complete information and base his or her opinions on admissible evidence. Also, Chavers tends to indicate that an insurer can avoid bad faith by filing a declaratory judgment action since a justiciable controversy will equal a valid reason not to pay.

Breach of Insurance Contract

Hicks v. Alabama Pest Services, Inc., 548 So.2d 148 (Ala. 1989), essentially involved a claim of inadequate termite treatment. The court held that since there was no insurance contract, there could be no conduct which would support a claim for bad faith.

Bad Faith Outside Insurance Context

In Schoeflin v. Tender Loving Care Corporation, 631 So.2d 909 (Ala. 1993), the Alabama Supreme Court held that for the purposes of a bad faith claim, an extended warranty or service contract was an insurance contract.

No Claim for Negligent Adjustment of Claim

In Kervin v. Southern Guaranty Insurance Company, 667 So.2d 704 (Ala. 1995), the insurance carrier determined that certain property damage suffered by the insured was covered. However, the covered damage did not meet the policy deductible

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and no payment was made. The insured claimed bad faith alleging that the claim was not properly investigated and the results were not subjected to a cognitive review and evaluation. However, the insurer was granted summary judgment which was affirmed by the Alabama Supreme Court based upon the facts of this case. The key holding was the rejection of a cause of action for negligent or wanton handling of an insurance claim again holding that bad faith is an intentional tort.

A. Bad Faith Failure to Pay

Arson

In National Security Fire and Casualty Company v. Bowen, 417 So.2d 179 (Ala. 1982), a $250,000.00 bad faith verdict was reversed. The coverage at issue was property coverage purchased along with a log skidder. The skidder was stolen and discovered later under water in a creek. National Security paid the claim relating to this incident. A second claim was made when the log skidder was found burned. The carrier concluded that the loss was the result of arson by Bowen. It paid the lienholder but not Bowen. In reversing the bad faith finding, the held that an insurance carrier can avoid bad faith in an arson case if it has admissible evidence

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of an intentionally set fire, motivation on the part of the insured, and opportunity for the insured to have been involved in the loss.

Insurer "Frozen in Time" When Reviewing Decision to Deny

In National Life Insurance Company v. Dutton, 419 So.2d 1357 (Ala. 1982), the Supreme Court of Alabama reversed a bad faith verdict and confirmed that the insurer's conduct will be judged based on the information in hand at the time the decision to deny was made. Also, the court noted the "heavy burden" faced by a plaintiff in a bad faith action.

Inference of Intent

In Affiliated F. M. Insurance Company v. Stephens Enterprises, 641 So.2d 780 (Ala. 1984), a $250,000.00 bad faith award was affirmed. The carrier had made payment for a roof loss only to the tenant and not the mortgagee, even though the policy indicated that the plaintiff had a mortgage interest in the property and, therefore, the proceeds of the policy. This case presents an example of where the plaintiff insured proved intent through an inference or circumstantial

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evidence. The court held that the jury could have concluded that the carrier had notice of the lack of a debatable reason since its own documents revealed that the mortgagee had an interest in the policy.

Advice of Counsel

In Davis v. Cotton States Mutual Insurance Company, 604 So.2d 354 (Ala. 1992), the Supreme Court of Alabama affirmed summary judgment on the bad faith claims. The extra-contractual allegations arose out of an uninsured motorist claim. The plaintiff's son was riding a motorcycle and was injured in a collision with a car. Cotton States filed a declaratory judgment action and plaintiff counter-claimed for bad faith. Cotton States maintained that a "trail bike" or "dirt bike" was not a "motor vehicle" as defined by Alabama law. The court disagreed finding that the policy was ambiguous thus the claim was covered. However, in part based on the filing of a declaratory judgment action, the court found no "conscious intent to injure" on the part of Cotton States thus precluding the claim for bad faith. Also, the court again held that advice of counsel can be used as evidence of good faith.

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Interpleader

Gilbert v. Congress Life Insurance Company, 646 So.2d 592 (Ala. 1994) involved a situation where the insurer received two applications for coverage listing two different beneficiaries to a life insurance policy. Upon death of the insured, Congress Life interplead the benefits of the policy. One of the beneficiaries, identified on the second application, filed suit for breach of contract and bad faith. Summary judgment on the extra-contractual claim was affirmed. The court found that there had been no denial of the claim therefore there could be no bad faith. Also, plaintiff could not show a fairly debatable reason for refusing to pay the policy proceeds to her. As a general rule, interpleader amounts to an admission that benefits are owed and that the insurer is willing to pay therefore there can be no bad faith liability.

Breach of Contract Required

Mitchell v. State Farm Fire and Casualty Company, 642 So.2d 462 (Ala. 1994), involved a third-party action to recover for bad faith. Fire had damaged the insured's house and the State Farm adjuster told her that she would need to

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remove the contents from the house and protect the house from the winter elements. The adjuster recommended a contractor to assist; however, State Farm did not hire the contractor. A check for the work done by the contractor was made out to both the insured and the contractor. A dispute arose about the contractor's work and the insured would not endorse the check. The contractor sued her to recover for the work done and the insured brought a third-party claim for bad faith against State Farm.

Essentially, the insured claimed that State Farm should have supervised the contractor. However, the court found that State Farm had no duty to do so in the contract. There was no breach of the contract, therefore there was no bad faith.

Value Dispute Does Not Equal Bad Faith

In Emanuelsen v. State Farm Automobile Insurance Company, 651 So.2d 29 (Ala. Civ. App. 1994), the Court of Civil Appeals affirmed a directed verdict finding that mere non-payment of a claim does not amount to bad faith. The hood of plaintiff's car had been damaged when a tree limb fell on it. Plaintiff did not allow the estimator to fully inspect the car and, apparently frustrated with the estimator's efforts, told him to "forget about" the claim. State Farm, nonetheless,

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attempted to pay for repairs to the vehicle though plaintiff disputed the adequacy of State Farm's estimate. Plaintiff said the estimator did not consider the proper painting used on his car when preparing the estimate. Nonetheless, because there was a dispute about the adequacy of the estimate, plaintiff was not entitled to a directed verdict and, therefore, there could be no bad faith.

Directed Verdict Test

Smith v. MBL Life Assurance Corp., 589 So.2d 691 (Ala. 1991), involved a life insurance policy. The insured died after getting a pre-payment receipt but before receiving the policy. After review of the application, the insurer rejected it and, therefore, asserted that there was no coverage. The jury, on the other hand, found coverage and awarded a $250,000.00 verdict on the contract claim. However, since this was not an extra-ordinary case plaintiff was not entitled to a directed verdict therefore could be no bad faith.

Mistake of Law

Harrington v. Guaranty National Insurance Company, 628 So.2d 323 (Ala. 1993) arose out of an uninsured motorist claim. Plaintiff had been run off the road by a phantom

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driver. Initially, Guaranty National said the claim was not covered because the policy had a contact requirement endorsement. Plaintiff's attorney wrote and advised the insurer of the Alabama Supreme Court decision of State Farm Fire and Casualty Company v. Lambert, 291 Ala. 645, 285 So.2d 917 (1973), where the contact requirement had been found void as against public policy. The carrier then advised that it would pay the claim.

Plaintiff went ahead and filed suit before the claim was settled. The court determined that a mistake of law does not equal bad faith. Because Guaranty National had no actual knowledge of the absence of a reasonably legitimate or arguable reason for denial could not be guilty of bad faith. The court noted that there must be a "conscious intent to injure".

Delay in Payment

In Georgia Casualty and Surety Company v. White, 582 So.2d 487 (Ala. 1991), the facts revealed that White was driving a truck on the job when he was struck by an uninsured motorist. White's employer had 12 trucks. Each truck had $10,000.00 in uninsured motorist coverage. White initially settled his claim for $10,000.00; however, he then filed suit

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asserting that he was entitled to $120,000.00. He asserted that Georgia Casualty had committed fraud by telling him he could only recover a maximum of $10,000.00. Also, he alleged that Georgia Casualty was guilty of bad faith because it initially offered him $7,500.00 even though it evaluated the loss at $10,000.00. Moreover, White claimed that Georgia Casualty acted in bad faith by refusing to pay $110,000.00 after a prior appellate decision held that he could stack his employer's coverage.

Summary judgment was granted for plaintiff on the coverage issue and he was awarded $110,000.00 in damages. A jury returned a $2.0 million punitive award; however, it was reversed. Regarding the claim that Georgia Casualty initially offered less than its evaluation, the court noted that White died during the pendency of this litigation and this claim was unfiled when he died. Therefore, the claim did not survive. The claim of refusal to pay $110,000.00 survived because the conduct occurred after his death. Once the appellate court had found that stacking was allowed there was no longer a question about whether the claim was owed. A jury question was presented, however, on whether Georgia Casualty intentionally delayed its payment. The court, however, reversed the verdict finding that the jury's verdict may have

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been based on the "bad count".

Failure to Pay Premiums

In Redden v. Alfa Mutual Fire Insurance Company, 631 So.2d 976 (Ala. 1994), summary judgment on breach of contract, bad faith, and fraud counts was affirmed. The case involved a fire insurance policy which expired before the loss. The policy had effective dates of June 3, 1991 to December 3, 1991. On November 15, 1991, Alfa sent a "premium due" notice to the insureds. On December 12, 1991, plaintiffs received an expiration notice dated December 9, 1991. Notably, plaintiffs did not open the envelope until after the fire which occurred on December 15, 1991. Plaintiffs mailed the check on December 18, 1991; however, it was returned by certified mail on December 19, 1991.

Alfa's policy contained a provision that notice would be given 10 days before cancellation. However, here the policy expired and there was no cancellation. The court found that the policy unambiguously expired on December 3, 1991.

Compulsory Coverage/Mistake of Law

In Aplin v. American Security Insurance Company, 568 So.2d 757 (Ala. 1990), plaintiff's claim arose out of the

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refusal by American Security to defend and indemnify Aplin against an action filed against her and to pay her claim arising out of an automobile accident. Summary judgment on the contract claim in favor of Aplin was affirmed while summary judgment in favor of the insurer on the bad faith claims was likewise affirmed.

Plaintiff did not timely renew her policy. She paid the premium late -- the day of the accident. American Security therefore asserted that coverage was prospective only. However, this was a compulsory policy which Aplin was required to have in place to reinstate a suspended license. The court held that in the case of compulsory liability policy, the carrier must give ten days notice before cancellation or termination to the Department of Public Safety. American Security did not do so so coverage remained in effect by operation of law. However, the court found that there was no bad faith because American Security asserted that its duty to provide notice had expired since the policy had been in place more than three years. The court held that American Security had misinterpreted the Alabama law requiring notice but a mistake of law is not tantamount to bad faith. Also, American Security had a debatable reason for denying the claim since plaintiff failed to renew the policy in a timely manner.

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No Denial of Claim/Litigation Response

In Jemison v. Scottsdale Insurance Company, 646 So.2d 1389 (Ala. 1994), plaintiff had a grocery store policy which covered gasoline pumps which were destroyed in a wind storm. The insurer paid for the pumps though deducted 50% of the replacement cost as depreciation. The insurer sent a check for the estimate less the depreciation to the insured's attorney with a letter encouraging plaintiff or his attorney to contact the insurer if they did not feel that they had been adequately compensated. The insured did not undertake any further contact; instead, he filed suit. Finding that there was no denial of the claim, the court held that summary judgment on the bad faith allegation should be affirmed.

Insured's Contractual Duties

Nationwide Insurance Company v. Nilsen, 745 So.2d 264 (Ala. 1998), plaintiff obtained summary judgment on the contract and Nationwide obtained summary judgment on the bad faith claim. Both appealed and the Alabama Supreme Court reversed and rendered plaintiff's judgment on the contract. In doing so, the court found that plaintiff failed to meet conditions precedent by not appearing for an examination under oath. The court noted that a deposition is not a substitute

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for an examination under oath and does not excuse plaintiff's failure to submit to an examination under oath. Further, as plaintiff was not entitled to a directed verdict on the contract, there could be no bad faith.

Insurer Cannot Use Ambiguity to Deny Coverage

In Employees' Benefit Association v. Richard D. Grissett, 732 So.2d 968 (Ala. 1998), written by Justice Lyons, the Alabama Supreme Court conditionally affirmed a verdict in favor of Plaintiff. The jury had returned a verdict in the amount of $880.00 in compensatory damages and $150,000.00 in punitive damages. The punitive award was reduced to $15,000.00.

Plaintiff was a truck driver employed by Consolidated Freightways, Inc. Employees' Benefit Association ("EBA") was a corporation formed to provide benefits to employees of Consolidated Freightways. Membership in EBA was voluntary. EBA provided modest benefits in the event of various occurrences, including accidental death and disability.

Plaintiff suffered a cerebral aneurysm at his home. As this event was not related to his employment, plaintiff was eligible for the disability benefits provided by EBA. Plaintiff was off work for a number of months. He made

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several claims seeking benefits, all but two of which were paid. EBA refused to pay two of the claims, totalling $880.00, asserting that the claims were submitted untimely. Plaintiff took the position, however, that EBA's filing requirements were ambiguous as the requirements provided that filings "should" be made at least every four weeks. The appellate court agreed determining that the trial court properly submitted the contract claim to the jury because of the ambiguity. Moreover, as regards the bad faith claim, the court confirmed that an insurer cannot use an ambiguity in the contract as a basis for claiming a debatable reason not to pay the claim.

The court also found that plaintiff had submitted substantial evidence allowing him to establish bad faith refusal to pay because EBA had not investigated plaintiff's claims and the reasons he had for being late. Plaintiff had offered evidence to EBA and its trustees that his payments were late because of his disability as he was required to seek confirmation of his condition from his employer and physician by mail which delayed his submissions. EBA did nothing to investigate the validity of this excuse and this was sufficient to submit the extra-contractual claim to the jury.

Regarding the amount of the punitive award, the court

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found, applying both the factors outlined in BMW of North America, Inc. v. Gore, 517 U.S. 559 (1996) and Hammond v. City of Gadsden, 493 So.2d 1374 (Ala. 1986)/Green Oil Co. v. Hornsby, 539 So.2d 218 (Ala. 1989), that a substantial reduction was required. The court focused on the low degree of reprehensibility of the conduct of EBA as there were no false representations or malicious intent to injure, as well as the lack of profit on the part of EBA from its misconduct as there was no evidence EBA recognized any profits from its failure to pay, and if it did, the punitive damages award both removed and exceeded that profit.

Cooperation of Insured

In Turner v. Liberty National Fire Insurance Company, 681 So.2d 589 (Ala. Civ. App. 1996), the insured appealed a directed verdict in favor of Liberty National on a complaint alleging bad faith refusal to pay an insurance claim. Liberty National's insured, Turner, had sustained a total fire loss which was described as "extremely suspicious". The insured was uncooperative in that he refused to answer questions concerning his income, refused to tell the adjuster how he paid for the building, refused to tell the adjuster where he purchased construction materials, refused to read a letter

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sent to him by Liberty National regarding his cooperation, never returned any verification of questioned contents on his list, and refused to allow Liberty National to obtain a sworn statement from his wife. He also refused to answer under oath where he banked and refused, or ignored, seven requests to sign a financial information release form. The court affirmed the directed verdict finding that the insured's failure to cooperate provided legal and/or factual defenses to the claim of bad faith.

Directed Verdict Test

Bush v. Ford Life Insurance Company, 682 So.2d 46 (Ala. 1996) stemmed from a dispute over credit life insurance. On the application, the insured maintained that she was in "good health". After she died, the insurer found that the insured had a two-year history of heart problems. The beneficiary filed suit against Ford Life for breach of contract and bad faith and against the dealership for negligent procurement of credit life insurance.

The plaintiff claimed that Ford had created an "automatic debatable reason" since the term "good health" was not defined on the application nor were any further guidelines given. The court held, however, that Ford Life had reserved the right to

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review medical records if the insured died within one year of the effective date of the policy and as such the plaintiff was not entitled to a directed verdict on the breach of contract claim.

No Bad Faith for Enforcement of Exclusion

In Altiere v. Blue Cross and Blue Shield of Alabama, 551 So.2d 290 (Ala. 1989), co-plaintiff, Mr. Altiere, was employed by Auburn University. He and his wife were eligible for benefits under the university's employee health plan. Both were covered by that plan when Ms. Altiere conceived. Before she gave birth Mr. Altiere changed jobs and became eligible for benefits under a different plan. That plan defined pregnancy as a pre-existing condition which was not covered until after a waiting period.

Finding that "[c]ourts are not at liberty to re-write policies to provide coverage not intended by the parties" the Alabama Supreme Court affirmed summary judgment in favor of Blue Cross.

The court also held that generally, "insurance companies have the right to limit their liability and write policies with narrow coverage."

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B. Bad Faith Failure to Investigate

Extraordinary Submission to Jury

Intercontinental Life Insurance Company v. Lindblom, 571 So.2d 1092 (Ala. 1990) involved a life insurance policy. The policy provided a 31-day grace period for the payment of premiums. Actually, Intercontinental would extend the grace period by an additional 14 days, thereby totaling 45 days. Plaintiff was, however, not told of the extra time.

At some point, the plaintiff changed the payment plan from monthly to quarterly. The carrier continued to accept her payments but maintained she missed the first payment after the change was made. It, therefore, "back applied" her payments. Eventually, because of an error in posting payment, Intercontinental determined that the policy had lapsed. Plaintiff complained to the agent, showing him cancelled checks, and he said that the policy remained in effect. Ultimately, plaintiff's husband died. She filed a claim, and the claim was denied.

The court found that this was an "extra-ordinary" case of bad faith. Plaintiff was not entitled to a directed verdict; however, Intercontinental Life could not suddenly stop using the unwritten, undisclosed grace period to avoid coverage. Also, Intercontinental failed to investigate the payment

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history and to advise plaintiff of the possible lapse.

Failure to Submit Investigative Materials to Cognitive Review

Continental Assurance Company v. Kountz, 461 So.2d 802 (Ala. 1984) involved a health policy which did not cover dental care, except where necessitated by accidental bodily injury. Plaintiff was struck in the mouth by a robbery attempt. One tooth was knocked out, several were loosened, and plaintiff's mouth bled. Later, it was determined that plaintiff had chronic deterioration of her gums. A dentist removed 8 front teeth, because of the blow to the mouth, and plaintiff was told by her agent that this procedure would be covered. She also underwent surgery for further repair to her mouth; however, both claims were denied.

The Alabama Supreme Court affirmed a bad faith verdict against Continental. It noted that even though Plaintiff did not move for a directed verdict, she was entitled to such on the contract claim. Nonetheless, the bad faith verdict was supported by evidence that Continental Assurance did not have the medical records reviewed by someone with dental experience. The court stated that Continental Assurance could not arbitrarily choose a non-payable potential cause in order

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to avoid payment. Also, Continental Assurance had initially denied the claim saying that there was no accidental injury even though it already had a copy of the accident report.

Failure to Obtain Necessary Medical Evidence

In Aetna Life Insurance Company v. Lavoie, 470 So.2d 1060 (Ala. 1984), Aetna failed to pay a portion of a medical claim asserting that the treatment was not necessary and various procedures associated with the treatment were not customary for the diagnosis suffered by Plaintiff. However, a $3.5 million punitive damage award was affirmed by the Supreme Court of Alabama which found that Aetna did not consider all of the facts associated with the claim and did not comply with its own rules and procedures. Aetna made its decision without all of the records and did not obtain all necessary records. Thus, this was an "extra-ordinary" bad faith claim.

In Lavoie, the court made a number of other significant statements about bad faith claims. First, the court again confirmed that the insurer's conduct will be measured based on the facts known at the time of denial. Also, an insurer cannot retrospectively create an issue of fact on a contract claim. Moreover, partial payment of a claim is not a defense to a bad faith allegation.

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Debatable Reason Precludes Investigation Claim

In Gulf Atlantic Life Insurance Company v. Barnes, 405 So.2d 916 (Ala. 1982), a bad faith verdict was affirmed with a remittitur from $1.1 million to $100,000.00. The case involved a $1,000.00 life benefit (children's rider benefit in a life policy). The policy was paid through the insured/beneficiary's credit union. After outlining complicated facts in the opinion, the court noted that Gulf Atlantic had made errors in coding which resulted in a dispute about the amount owed by the carrier. The most significant language in the opinion, written by Justice Beatty, provides that if a lawful basis for denial exists, there is no need to look further at the investigation undertaken by the insurer.

Duty to Investigate

In Blackburn v. State Farm Automobile Insurance Company, 652 So.2d 1140 (Ala. 1994), summary judgment on the bad faith claim was affirmed. The plaintiff suffered a loss to his automobile. The plaintiff's deductible was $1,000.00 and State Farm estimated that the damage totaled $1,052.00. Eventually, plaintiff had the vehicle repaired for $730.00, less than the deductible.

The parties to the accident which caused the damage were

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both insured by State Farm. State Farm found that plaintiff Blackburn was at fault. It therefore settled the other insured's claims. Blackburn sued alleging a failure to determine if there was a lawful basis for payment to the other party and for failing to obtain an independent adjuster and investigate the other party's claim. The court held that failing to make any payment to plaintiff Blackburn did not amount to bad faith since repairs did not exceed the deductible. Also, there was no bad faith in settling the claims of the other party since the policy allowed State Farm to make decisions regarding settlement and, for the same reason, there was no need to hire an independent adjuster to determine liability.

Review of Insurer's Investigation

In Hyde v. Humana Insurance Company, Inc., 598 So.2d 876 (Ala. 1992), summary judgment on plaintiff's bad faith claim was reversed by the Supreme Court of Alabama. A group insurer, Humana, had denied coverage for a liver transplant for plaintiff Hyde. Plaintiff was, notably, not only an insured, but was also an agent of Humana. Humana had denied coverage by application of the "transplant coverage criteria" which it maintained though this report was not a part of the

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policy. The policy only referred to criteria established by Humana's "Medical Affairs Department". The court, therefore, found that the policy was ambiguous since it was unclear if the actual criteria document was incorporated into the policy by reference. Summary judgment on plaintiff's bad faith claim was reversed because there was evidence that the transplant was medically necessary, that the transplant was no longer considered experimental, and that neither of these factors was considered by Humana. Therefore, there was a question of fact whether Humana had a legitimate or debatable reason to deny coverage.

Mistake or Complication Does Not Equal Bad Faith

Blue Cross and Blue Shield of Alabama v. Granger, 461 So.2d 1320 (Ala. 1984), the Alabama Supreme Court reversed a jury verdict on a bad faith claim. Granger's child had been injured in an automobile accident. Blue Cross did not pay the Emergency Department physician's bill of $120.00. The jury returned a $500,000.00 bad faith verdict.

The child had been treated at Baptist Medical Center which had a computer system allowing it to submit bills directly to Blue Cross or enter them into Blue Cross' computer system. This bill was never correctly entered resulting in

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collection efforts against plaintiff. In reversing the verdict, the court noted that the plaintiff was subjected to unnecessary inconvenience and worry but there was no intentional wrongful conduct on the part of Blue Cross. An unnecessarily complex computer system which resulted in an unintentional failure to pay does not equal bad faith.

Duty to Investigate Unsubmitted Claims

In United Insurance Company of America v. Cope, 630 So.2d 407 (Ala. 1993), United failed to pay a $160.00 claim which resulted in a $1.0 million compensatory and $3.0 million punitive bad faith verdict. This verdict was, however, reversed.

The policy at issue was a cancer policy. Cope's medical providers submitted various bills which were paid; however, a $160.00 physician's bill was never submitted. The court held that an insurer has no obligation to pay or evaluate a claim until it has been submitted by the insured pursuant to policy provisions. Here, where other provider's bills had been submitted, the insurer had no duty to search out or investigate other outstanding claims even if, as in this case, it knew the name of the doctor from other records and bills.

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Investigation of Health Claim

In Brantley v. Proactive Insurance Company, 632 So.2d 969 (Ala. 1994), plaintiff underwent surgery to remove an ovarian cyst and also had a hysterectomy. She sought coverage under her health insurance policy which provided that there would be no coverage for one year for pre-existing conditions. Pre-existing was defined as "incurred or suffered by a covered person which existed within five years prior" to the effective date of the policy. Proactive denied the claim on the basis of the pre-existing condition provision. Plaintiff then sued prompting Proactive to go ahead and pay the medical bills. These bills were paid directly to the healthcare providers.

Summary judgment on the bad faith claim was reversed. The court noted that the plaintiff had suffered similar symptoms prior to the effective date of the policy; however, there was no proof that the same condition existed. A jury question existed whether coverage was afforded; however, the case presented an extra-ordinary bad faith claim since there were questions about whether Proactive adequately investigated the claim and properly interpreted information in hand.

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Excess Investigative/Constructive Denial

In Livingston v. Auto-Owners Insurance Company, 582 So.2d 1038 (Ala. 1991), summary judgment in favor of the insurer on the bad faith claim was reversed by the Alabama Supreme Court. The insured had suffered a fire and the carrier investigated potential involvement of the insured. The court held, however, that the ongoing investigation constituted a constructive denial which would support a claim for bad faith.

Duty to Insured

In Standard Plan, Inc. v. Tucker, 582 So.2d 1024 (Ala.1991), plaintiff applied for automobile coverage and was issued a binder. Plaintiff was then involved in an automobile accident and the binder was rescinded because of a misrepresentation on the application. Plaintiff alleged that the agent had been negligent in completing the application.

The court held that a $500,000.00 punitive damage award on the bad faith claim was supported because the insurer had not undertaken a cognitive review of the evidence surrounding the claim. It had records relating to prior accidents involving the insured; however, it undertook no effort to determine whether plaintiff had been at fault as this was the issue which would have governed whether or not coverage could

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be provided under the insurer's underwriting guidelines. Also, the insurer had an arbitrary approach to questions such as the one presented in this case. If an accident appeared on the applicant's motor vehicle records, but the records did not reflect who was at fault, the insurer would assume that the applicant had been at fault.

Notice of Agent

In National Security Fire & Casualty Company v. Coshatt, 690 So.2d 391 (Ala.Civ.App. 1996), National Security appealed from a judgment in favor of its insureds for breach of contract and bad faith refusal to pay. A snow storm had damaged the Coshatts' home and they made a claim under the policy. The Coshatts contacted their agent who advised them to make any necessary repairs. The claim was, however, denied by National Security when its retained independent adjuster could not investigate the cause and extent of the loss since the repairs had already been made. The appellate court held that notice to the agent was notice to National Security and as such the claim should not have been denied. The court affirmed the trial court's directed verdict in favor of the Coshatts on the breach of contract claim thus permitting the bad faith claim to go to the jury given other evidence

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supporting an inference that National Security had actual knowledge that it had no legitimate basis for denying the claim.

Lack of Consistent Policies and Procedures

Loyal American Life Insurance Company v. Mattiace, 679 So.2d 229 (Ala. 1996) involved the denial by Loyal American of a claim for life insurance benefits submitted by the beneficiary of a policy purchased by Joseph F. Mattiace. Mattiace denied having been arrested for the use of or driving under the influence of alcohol or drugs within the past five years of the time of application. However, after Mattiace's death it was learned by Loyal American that he had been convicted of DUI approximately 8 months before he applied for the life insurance policy. Loyal American had reserved in the policy the right to investigate and determine the truthfulness of the answers on the application form since Mattiace had died within two years of the policy's date.

Upon learning of the misrepresentation on the application, Loyal American rescinded the policy. However, during litigation it was learned that Loyal American did not have an underwriting manual which applied to this policy and depending on which re-insurer's manual was used, Loyal

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American may or may not have charged a higher premium given Mattiace's DUI conviction. The court found that Loyal American's inconsistent underwriting practices could not be used to create a debatable reason for denial of the claim.

Another important ruling in this case was the court's decision that the trial court's finding that the cause of Mattiace's death, an alcohol-related automobile accident, was inadmissible was not an abuse of discretion. Certainly, the reverse should be true when the plaintiff in a claim such as this tries to show that the cause of death was not related to the medical condition misrepresented on the insurance application.

No Duty to Investigate Until Claim Submitted

In Huff v. United Insurance Company of America, 674 so.2d 21 (Ala. 1995), United denied life insurance coverage because of misrepresentations on the policy application. The plaintiff sued alleging fraud, bad faith, and breach of contract. The Alabama Supreme Court affirmed the entry of summary judgment finding that there is no requirement under Alabama law that an insurer investigate the answers or other health information provided by an insured prior to the death of that individual.

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Latent Ambiguity/Failure to Submit to Cognitive Review

In Thomas v. Principal Financial Group, 566 So.2d 735 (Ala. 1990), Principal found that a child was not "attending school on a full-time basis" and thereby not a "dependent" for purposes of a life insurance policy. Although the child was enrolled in school, she was unable to attend because of ovarian cancer, the same disease which ultimately took her life. The court found that the words "attending school on a full-time basis" were not patently ambiguous but that a latent ambiguity existed in light of the facts of this case. The Alabama Supreme Court held that the trial court did not err in allowing the jury to decide whether the child was "attending school on a full-time basis."

C. Bad Faith Offer to Settle with Insured

See Section A. above.

D. Bad Faith Failure to Settle for Insured/Tort-Feasor

Long before recognizing a claim for first-party bad faith, Alabama courts held that an insurance company could be guilty of bad faith for failure to settle a claim on behalf of the insured. The rationale expressed in Waters v. American Casualty Company of Reading Pa., 261 Ala. 252 73 So.2d 524 (1953), is that the insurance contract gives the insurer the

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exclusive right to make a settlement and, thus, the duty on the insurer is heightened because of the possibility of an excess verdict. In the event of an excess verdict, not only can the insurer be liable for the amount of the verdict but, if the carrier intentionally fails to settle without a reasonable basis to do so or fails to make a complete investigation and submit same to cognitive review, liability may be found for bad faith. Notably, the elements of a bad faith claim as expressed in first-party cases were derived from the prior third-party law.

E. The Unfair Claims Settlement Practices Act

None in Alabama.

F. The Consumer Protection Act

None in Alabama.

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RELATED CAUSES OF ACTION

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II. RELATED CAUSES OF ACTION

A. Breach of Contract

1. Contract Interpretation

Policy to be Construed Liberally in Favor of Insured

In Trans-Continental Mutual Insurance Company v. Harrison, 78 So.2d 917 (Ala. 1955), the court considered whether the named insured was "operating" an automobile though he had given permission to a passenger to drive. The passenger was actually driving the automobile at the time he (the passenger) fell asleep at the wheel causing an accident. The underlying plaintiff, another passenger, obtained a judgment against the insured owner of the car even though the owner was not actually driving the automobile at the time of the accident.

Although the policy provided that there would be no coverage unless the named insured was "operating" the automobile, the court found that the term "operating" was ambiguous and as such it should be construed against the insurer and in favor of the insured. The court held ". . . it must be construed most strongly against the insurer and liberally in favor of the contention of the insured." The

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Alabama Supreme Court affirmed the trial court's finding that the insured was "operating" the vehicle although he had requested another passenger to drive and he was sitting in the rear seat of the automobile with his date.

Another instructive Alabama decision is St. Paul Fire and Marine Insurance Company v. Edge Memorial Hospital, 584 So.2d 1316 (Ala. 1991). In this case, before Edge moved its liability coverage from St. Paul to Mutual Assurance Company of Alabama, Inc. ("MASA"), MASA suggested that the hospital search its records for potential claims which it would then report to St. Paul prior to the end of the insurance term for the St. Paul claims-made policies. St. Paul denied coverage with respect to several of the claims reported asserting that the potential claims outlined by the hospital did not constitute claims under the language of the policy. However, the court found that St. Paul had failed to define the term "claim" which was ambiguous since there was no indication whether St. Paul meant "insurance claims" or "legal claims". The court held that St. Paul certainly had the opportunity to draft the policy to limit the term "claim" by defining it to mean a legal claim such as a lawsuit, but it did not and thus the ambiguous term was required to be construed liberally in favor of the insured and strictly against the insurance

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company. The court found that the insured hospital's letters reporting the potential claims (even in cases where there had been no specific indication that a claim would be forthcoming) constituted claims requiring that St. Paul defend and indemnify.

Courts Cannot Re-write Policies

In Altiere v. Blue Cross and Blue Shield of Alabama, 551 So.2d 290 (Ala. 1989), co-plaintiff, Mr. Altiere, was employed by Auburn University. He and his wife were eligible for benefits under the university's employee health plan. Both were covered by that plan when Ms. Altiere conceived. Before she gave birth Mr. Altiere changed jobs and became eligible for benefits under a different plan. That plan defined pregnancy as a pre-existing condition which was not covered until after a waiting period.

Finding that "[c]ourts are not at liberty to re-write policies to provide coverage not intended by the parties" the Alabama Supreme Court affirmed summary judgment in favor of Blue Cross.

The court also held that generally, "insurance companies have the right to limit their liability and write policies with narrow coverage."

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Court to Enforce Unambiguous Policy as Written

"Although insurance policies containing ambiguities are to be construed in favor of the insured, it is imperative that the courts enforce unambiguous policies as written." In Best v. Auto-Owners Insurance Company, 540 So.2d 1381 (Ala. 1989), the plaintiff, a South Carolina resident, was involved in an automobile accident in Blount County, Alabama. South Carolina required uninsured motorist coverage though underinsured motorist coverage was optional. The court found that under the terms of the policy, accepted in South Carolina, the plaintiff was not entitled to recover underinsured motorist benefits.

In Amerisure Insurance Companies v. Allstate Insurance Company, 582 So.2d 1100 (Ala. 1991), the Alabama Supreme Court further stated: "It is equally recognized that if the policy terms are plain and free from ambiguity, then there is no room for construction and it is the court's duty to enforce the policy as written". In that case, the Court held that Allstate's policy provided coverage for a trailer being towed at the time of the subject accident. Although Allstate had asserted that since the Alabama Department of Revenue had issued a "TR" tag which is normally provided for large

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trailers designed with no front wheels and having a combination gross vehicle weight of more than 12,000 lbs., the fact that this designation was made, and a "UT" tag was not issued, did not modify the language of Allstate's policy which provided coverage for trailers which were "designed for use with a private passenger auto or utility auto."

Not Against Public Policy to Require Insurer to Defend Against Claims of Intentional Conduct

In Burnham Shoes, Inc. v. West American Insurance Company, 504 So.2d 238 (Ala. 1987), the Alabama Supreme Court answered certified questions from the United States Court of Appeals for the Eleventh Circuit. The first question related to whether it was against public policy to require an insurer to defend its insured against claims alleging intentional wrongs. The court answered in the negative finding that since the duty to defend is more extensive than the duty to pay that there was no violation of public policy requiring an insurer to do so. The court did not, however, address whether an insurer's agreement to indemnify its insured for intentional acts violates the public policy of the State of Alabama.

Burnham Shoes is perhaps better known for the response the court gave to the second certified question.

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Specifically, the court found that if an insurer undertakes to defend an insured without reserving the right to withdraw its defense, it waives its right to do so.

Different Constructions Do Not Create an Ambiguity

In Gregory v. Western World Insurance Company, 481 So.2d 878 (Ala. 1985), Western World filed a declaratory judgment action to determine its rights and duties with respect to its insured, Big Daddy's Lounge. The underlying plaintiff claimed that a patron committed assault and battery on him while he was at the bar. The nature of his claim was that the bar was guilty under the dram shop statute as it served alcohol to the obviously intoxicated striking patron.

The insured claimed that the policy was ambiguous since it provided coverage for dram shop liability though a separate provision excluded coverage for claims arising out of an assault and battery caused by a patron. Finding that the claim was excluded the court held that the parties' different constructions did not mean that the disputed language was ambiguous.

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Ambiguity May be Patent or Latent

In Thomas v. Principal Financial Group, 566 So.2d 735 (Ala. 1990), Principal found that a child was not "attending school on a full-time basis" and thereby not a "dependent" for purposes of a life insurance policy. Although the child was enrolled in school, she was unable to attend because of ovarian cancer, the same disease which ultimately took her life. The court found that the words "attending school on a full-time basis" were not patently ambiguous but that a latent ambiguity existed in light of the facts of this case. The Alabama Supreme Court held that the trial court did not err in allowing the jury to decide whether the child was "attending school on a full-time basis."

Policy Exclusion Does Not Alone Create Ambiguity

In Green v. Merrill, 293 Ala. 628, 308 So.2d 702 (1975), Green was injured when he was struck by a motor boat operated by Merrill. Green obtained a judgment and later pursued garnishment against Merrill's homeowner's insurer. Coverage under the homeowner's policy was excluded for watercraft "with inboard motor power exceeding fifty horsepower." The trial court found that coverage was excluded and the Alabama Supreme Court affirmed holding that the exclusion in and of itself did

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not create an ambiguity.

Ambiguity is Question of Law for Court

In Garrett v. Alfa Mutual Insurance Company, 584 So.2d 1327 (Ala. 1991), the Alabama Supreme Court reversed a summary judgment entered in favor of Alfa finding coverage under a farm owner's policy. A group, including the owner of a Ford Bronco, had gone on a hunting trip. One of the group fell off of the Bronco and was injured. He filed suit against the owner who in turn sought coverage from Alfa under his farm owner's and automobile policies. While the Ford Bronco was clearly not covered by the automobile policy, Garrett took the position that the Bronco was a farm implement which was covered by the farm owner's policy. Accepting evidence that the Bronco was used to tow corn and hay wagons and to pull out stuck tractors, and that it was equipped with a winch and "mud tires," the court found that a jury question existed since the policy term was ambiguous.

Terms to be Given Rational Construction

Anderson v. Brooks, 446 So.2d 36 (Ala. 1984) involved the sale and division of business property which was subsequently destroyed by fire. The Alabama Supreme Court, as stated

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numerous times before, held "[t]he terms in a policy of insurance are to be given a rational and practical construction."

Ejusdem Generis

In Bly v. Auto-Owners Insurance Company, 437 So.2d 495 (Ala. 1983), Auto-Owners denied a claim brought by the insureds who alleged that vibrations from logging trucks running on a nearby road damaged their house. Auto-Owners took the position that there was no coverage because of an exclusion which provided that losses were not covered if caused by:

> . . . earth movement, including but not limited to earthquake, volcanic eruption, landslide, mud flow, earth sinking, rising or shifting . . . .

The court found that under the doctrine of ejusdem generis which "ordinarily limits the meaning of general words and things to the class or enumeration employed" that all of the types of earth movement in the exclusion were natural phenomena as opposed to the vibrations described by the insureds and as such the vibrations were not excluded from coverage.

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Reasonable Expectations

In Aetna Casualty and Surety Company v. Chapman, 200 So. 425 (Ala. 1941), the Alabama Supreme Court held that an insured is entitled to protection which he reasonably expects from the terms of the policy. However, reasonable expectations were not met in this case which involved a grocer who, after leaving his truck for repairs and while driving a truck borrowed from the garage, struck and killed a child. The policy provided automatic coverage for newly acquired vehicles though the court found that that provision did not apply to a truck borrowed while the insured's vehicle was being repaired.

In Guaranty National Insurance Company v. Marshall County Board of Education, 540 So.2d 745 (Ala. 1989), the Alabama Supreme Court found coverage in favor of four employees of the Marshall County Board of Education sued by the administrator of another deceased employee's estate. Specifically, the underlying plaintiff alleged that the four supervisory defendants had failed to provide plaintiff's decedent a safe place to work and/or a reasonably safe work environment.

The court found that "reasonable men" would expect claims such as these to be covered. Specifically, it found that it was reasonable to assume that the Marshall County Board of

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Education sought to protect its supervisory employees from lawsuits charging them with negligence in the management of the school system. Also, the court found that two exclusions raised by the insurer were inapplicable. The first exclusion related to the ownership of an automobile; however, the four defendant supervisory employees did not own the mini van in which plaintiff's decedent was riding. Also, the court found that the policy provision excluding coverage against claims resulting from bodily injury or death to employees of the named insured (Marshall County Board of Education) was inapplicable since plaintiff's decedent was not employed by the four supervisory defendants.

Endorsements

Generally, under Alabama law, endorsements added to the policy will supersede provisions otherwise printed in the policy. "Where there is added to a printed form a written or typewritten clause, that clause should be considered as superseding those clauses in conflict which are printed in the form." Continental Standard Insurance Company v. General Trucking, 423 So.2d 168 (Ala. 1982).

In Continental Standard, the Alabama Supreme Court also reiterated that the general rule that an ambiguity in an

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insurance contract should be interpreted in favor of the insured and against the insurer applies even where the dispute is between two insurance carriers. See also Georgia Casualty and Surety Company v. Universal Underwriters Insurance Company, 534 F.2d 1108 (5th Cir. 1976).

Printed Versus Written Provisions

Commercial Standard Insurance Company v. General Trucking Company, 423 So.2d 168 (Ala. 1982), involved a truck-pedestrian accident. The owner-operator (driver) entered into a lease agreement with Lane Trucking Company. Lane was obligated to obtain liability insurance and the owner-operator was to be responsible and liable to Lane for damage to property or persons. Lane was insured by Commercial Standard Insurance Company.

At the time of this accident, Lane was hauling cargo between Alabama and Tennessee under General Trucking Company's authority. General Trucking Company was insured by Royal Globe Insurance Company. Under the Commercial Standard policy, the owner-operator was excluded as an insured because it was a "hired automobile" as a result of the agreement whereby the load was being carried under General Trucking's authority. However, the same policy included an endorsement

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which scheduled vehicles as insured, including the owner-operator's truck.

In determining whether or not Commercial Standard's policy provided coverage, the Alabama Supreme Court first determined that endorsements, such as the schedule, should take priority. Specifically, the court stated:

> Where there is added to a printed form a written or type-written clause, that clause should be considered as superseding those clauses in conflict which are printed in the form.

423 So.2d at 170, *citing* Pearl Assurance Company v. Hartford Fire Insurance Company, 239 Ala. 515, 195 So. 747 (1940). While stating this general rule, the court based its finding that Commercial Standard provided coverage on the ambiguity created by the listing of the owner-operator's vehicle as an "owned automobile" in the schedule. Notably, the court also determined that the rule that an ambiguity in an insurance contract should be interpreted in favor of the insured and against the insurer should also be followed in cases where the dispute is between two insurance carriers.

Binders

In Montz v. Mead & Charles, Inc., 557 So.2d 1 (Ala. 1987), the Alabama Supreme Court addressed a question

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involving whether an insurance broker could be held liable for a loss after issuing a binder to the purported insured. At the outset, the court noted that a binder is generally thought to be "a written memorandum of the important terms of contract of insurance which gives temporary protection to insured pending investigation of risk by *insurance company* or until formal policy *is issued*". 557 So.2d at 3. Here, plaintiff Montz purchased a truck and shortly thereafter paid the first years insurance premium to Mead & Charles. Mead & Charles issued a binder effective July 13, 1983. In this transaction, Mead & Charles was a broker who contacted Gulf Agency who in turn sought coverage from the insurance carrier, Sovereign Marine.

Mead & Charles asserted that a policy had been issued by Sovereign Marine though Plaintiff Montz said that he did not receive the policy. Additionally, the policy was apparently cancelled because underwriting information was not received though, again, Montz did not receive the cancellation notice. Approximately 2 ½ months after the cancellation, the insured vehicle was in an accident. When Montz notified Mead & Charles of the loss, he was told that the policy had been cancelled and two weeks later his premium was refunded.

The court reversed summary judgment in favor of Mead &

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Charles finding that there was a scintilla of evidence that it was under a contractual obligation to provide insurance since the binder did not identify a specific insurance company and because it provided that it would only expire "upon receipt of the policy" as opposed to upon issuance of same.

Size of Type

Southern Guaranty Insurance Company v. Gipson, 156 So.2d 630 (Ala. 1963), involved a question of whether a defendant in suits arising out of an automobile accident was excluded from coverage by a policy provision specifically stating that the coverage did not apply to bodily injury to the insured or any member of the family of the insured. In deciding this question, the court addressed an argument made by the putative insureds that the exclusionary provision was obscure and difficult to find due to the size of the type used to incorporate the exception in the policy. The court noted that there was no variation in the size of the type except the introductory part of the policy had bolder printing. Specifically, the court held that absent a statutory requirement regulating the size and other characteristics of the type employed in the policy, an insurance policy or application may be printed in any size of type or color of

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printing.

2. Identifying the "Insured"

Insurable Interest

In Allstate Insurance Company v. Moore, 429 So.2d 1087 (Ala. Civ. App. 1983), Walter W. Moore and Peggy K. Moore were divorced. The decree included a separation agreement which awarded a 1979 Mustang Cobra to Ms. Moore. During the marriage the Mustang had been jointly owned by the Moores and had been insured by Allstate. Thereafter, Ms. Moore was injured in an accident and Allstate took the position that when the Mustang was transferred to Ms. Moore in connection with the divorce, Mr. Moore lost his insurable interest in the automobile, and Ms. Moore lost her ability to claim under him as a resident spouse. The court agreed finding that since Ms. Moore owned the automobile outright at the time of the accident her former husband had no insurable interest and she had no authority to make a claim under his policy.

Insurable Interest

Brewton v. Alabama Farm Bureau Mutual Casualty Insurance Company, Inc., 474 So.2d 1120 (Ala. 1985) involved a question of whether the plaintiffs had an insurable interest in a house

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and property which was destroyed by fire. Plaintiffs, the Brewtons, purchased a policy of insurance on a home and its contents owned by Mrs. Angeline Browning. Mrs. Brewton testified that she told State Farm's agent that Ms. Browning owned the home but that she intended to "will the house" to the Brewtons. She also said that she told the agent that the Brewtons would be responsible for the insurance premiums even though Ms. Browning lived in the house. It was, however, undisputed that the Brewtons had no title to the property and no actual or constructive possessory interest in it. Moreover, neither was related to Ms. Browning and they were aware that Ms. Browning had sisters living. The court thus found that the Brewtons had no insurable interest in the property and, as such, the policy was void *ab initio.* Even though the Brewtons expected Mrs. Browning to make a testamentary disposition of the property to Mr. Brewton, since she had raised him, this expectation did not create an insurable interest. The court stated that "mere love and affection for the true owner, though laudable, do not constitute the required insurable interest". 474 So.2d at 1123.

Even though the court found that the Brewtons could not recover under the policy, summary judgment on their

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counterclaim for fraud was reversed. The Brewtons had claimed that the agent, with knowledge of their claimed interest, advised that a policy could be obtained. The court further stated that the payment of premiums by Mrs. Brewton was sufficient to prove damage, one of the necessary elements of the fraud claim.

Household Members

In Harmon v. United Services Auto Association, 555 So.2d 114 (Ala. 1989), the injured party, Timothy Harmon, sought coverage for uninsured motorist benefits under his brother's, policy with USAA. The court found no coverage since Timothy was not a resident of his brother Darrell's household. It is noteworthy that while Darrell and Timothy both lived under their mother's roof for a brief period prior to the accident, the court found that Darrell's temporary stay at his mother's house did not make him a resident there, thus Timothy was not a resident in the same household as Darrell.

In affirming summary judgment, the court cited several rules applicable to such situations. First, a resident is one who is a member of a family who live under the same roof. "Residence emphasizes membership in a group rather than an attachment to a building. It is a matter of intention and

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choice rather than one of geography." However, to be a resident, an individual must "be more than a temporary or transient visitor, and must actually live with the others in the same household for a period of some duration." In this instance, the fact that Darrell did not intend to become a member of his mother's household, evidenced by his failure to move any of his furniture to his mother's home and decision to only take personal hygiene items and clothing with him, precluded coverage for his brother who was a resident of his mother's house.

In Fleming v. Alabama Farm Bureau Mutual Casualty Insurance Company, 293 Ala. 719, 310 So.2d 200 (1975), the Alabama Supreme Court reversed summary judgment granted in favor of Alabama Farm Bureau, the liability insurance carrier for Ms. Fleming. Ms. Fleming was the grandmother of the injured party who was riding with her at the time of the accident.

The subject policy did not provide coverage for bodily injury to the insured or any member of the insured's family residing in the same household. In this instance, Ms. Fleming and her husband, as well as her son, the minor plaintiff's father, as well as her daughter-in-law and another grandson all lived in the same house. Although there was evidence that

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the two families (Farm Bureau's insured, Ms. Fleming and her husband, as well as her son's family) maintained separate households within the building. However, the court found that summary judgment was not proper since there was evidence reflecting also that all of the parties were in fact members of the same "family circle". For example, the house had only one bathroom which was shared by all. Likewise, the evening meal was usually shared by all. This decision points out the case-by-case analysis generally applicable to such questions.

Previously, the Alabama Supreme Court upheld a finding excluding coverage where the plaintiff's decedent resided in the same house as the underlying defendant, State Farm's insured. In Blow v. State Farm Mutual Automobile Insurance Co., 284 Ala. 687, 228 So.2d 4 (1969), State Farm's insured, Ellison, lived in the same house with his wife and sister-in-law. His wife and sister-in-law owned the house. Each had lived there for many years. In particular, the court rejected the argument by the Plaintiff that a "blood relationship" must be proven for this exclusion to be applicable.

In another decision addressing this same exclusion, the court found that a college student was "in residence" at the college, as opposed to being a resident of his parent's house. State Farm Automobile Insurance Company v. Hannah, 166 So.2d

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872 (Ala. 1964).

Innocent Co-Insured

In Hosey v. Seibels Bruce Group, 363 So.2d 751 (Ala. 1978), the Alabama Supreme Court held that even though a co-owner/co-insured has willfully set jointly owned and insured property on fire and otherwise committed fraud, the innocent co-insured is still permitted to recover since the interests of the two are severable. The court stated "the defense of arson or willful burning will generally not operate to defeat an insured's recovery under a fire policy where, as here, there has been no finding that the insured directly set the fire, had knowledge and authorized its setting or later ratified the wrongful act". Likewise, wrongful conduct is not attributed to the insured solely by virtue of the marital relationship with the co-insured who is guilty of fraudulent or wrongful conduct.

3. Identifying the Cause of the Loss

Insured's Burden

Generally the insured bears the burden of proving that a covered accident occurred and caused the damage. Fireman's Insurance Company of Newark v. Robbins Coal Company, 288 F.2d

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349 (cert. den. 82 S.Ct. 122, 368 U.S. 875, 7 L.Ed.2d 77 (5th Cir. 1961). This case involved a claim by the insured that a landslide caused damage to two large coal bins.

4. Timing Issues

Notice

In Southern Guaranty Insurance Company v. Thomas, 334 So.2d 879 (Ala. 1976), the Alabama Supreme Court addressed the reasonableness of notice given to the carrier of a claim. Here, on December 5, 1973, the insured strung a cable across a trail to discourage trespassers on his property. The next day it was reported to the insured that someone had been knocked off a motorcycle and injured as a result of the cable being strung across the trail. Two weeks later, the insured received a letter from an attorney suggesting that a claim would be made and that the insured should notify his homeowner's insurance carrier. According to the insured, a day or so later he read his policy. After doing this he went to his lawyer who told him to check with the agent to see if such a claim would be covered. He did not go see the agent. Suit was filed in June 1974.

The court stated that the reasonableness of an insured's delay in providing notice is generally a question for the

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jury. However, such a decision can be made as a matter of law where the insured provides no excuse which would justify the delay. Here, the insured testified that he did not provide notice because he did not believe the claim was covered, did not believe he would be found liable, and did not believe that suit would be filed. The court found that it was not the insured's place to make such judgments and notice should have been provided pursuant to policy terms. The six month delay was unreasonable as a matter of law.

8 MONTHS

In Pharr v. Continental Casualty, 429 So.2d 1018 (Ala. 1993), the Alabama Supreme Court addressed the reasonableness of notice given by the underlying defendant to the carrier, Continental Casualty. The insured, Russellville Steel Company (Rustco), contracted to repair Pharr's tractor-trailer on January 2, 1979. Suit was filed on September 7, 1979 alleging negligent repair, breach of contract, and breach of warranty. Rustco was served with the Complaint on October 19, 1979. Notice was given to Continental Casualty Company on June 10, 1980.

The policy provided that the insured (Rustco) was to give notice of an occurrence "as soon as practicable". Also, Rustco was obligated to provide notice of any suit "immediately". The Alabama Supreme Court has previously held

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that a reasonable standard applies to such provisions and in determining what is reasonable the courts will consider the length of the delay and the reasons for same. In this case, citing Southern Guaranty Insurance Company v. Thomas, 334 So.2d 879 (Ala. 1976) (six month delay in providing notice found to be unreasonable), the court found that the eight month delay on the part of Pharr was unreasonable as a matter of law. Further, the court confirmed that the insurer need not show prejudice as a result of the delay in order to find failure on the part of the insured to meet a condition precedent to coverage.

In Midwest Employers Casualty Company v. East Alabama Health Care, 695 So.2d 1169 (Ala. 1997), released May 30, 1997, the Supreme Court of Alabama addressed a certified question from the United States District Court for the Middle District of Alabama. The excess workers' compensation carrier filed a declaratory judgment action asserting late notice of the subject claim. Although Alabama law generally provides that an insurance carrier need not prove prejudice as a condition for a finding of late notice as a bar to coverage, the court held that the excess insurer was required to show prejudice from untimely notice. The rationale was the primary insurer must have timely notice to form an intelligent

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estimate of its rights and liabilities, to afford it an opportunity for investigation, to allow it to participate in the litigation, and to prevent fraud. The excess insurer does not generally have these duties. The court, in an opinion written by Justice Butts, noted that Alabama's law holding that a primary carrier need not prove prejudice is the minority position. This could signal a future change in the law relating to primary carriers though Chief Justice Hooper dissented asserting that requiring the insurer to show prejudice allows the insured to avoid compliance with policy terms.

Time of Damage

In USF&G v. Warwick Development Company, Inc., 446 So.2d 1021 (Ala. 1994), the underlying plaintiffs brought suit against USF&G's insured claiming defects in a home sold by Warwick as well as fraud and misrepresentation. Warwick filed a third-party complaint against USF&G and Northern Assurance Company of America claiming both were liable under comprehensive general liability policies issued to Warwick. The court held, among other things, that "as a general rule the time of an 'occurrence' of an accident within the meaning of an indemnity policy is not the time the wrongful act was

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committed but the time the complaining party was actually damaged."

5. Exclusions

Exclusion Also Given Reasonable Construction

In Woodall v. Alfa Mutual Insurance Company, 658 So.2d 369 (Ala. 1995), Woodall owned a convenience store where he sold beer and wine. Alfa issued Woodall a CGL policy for the business and also provided homeowner's coverage for Woodall's residence. A wrongful death action was filed against Woodall alleging that he furnished or sold alcohol to a minor. The policies excluded coverage for such a claim only if the insured was "in the business of manufacturing, distributing, selling, or furnishing alcoholic beverages." Woodall argued that he was in the business of operating a grocery or convenience store, not only selling alcoholic beverages. The court rejected this argument and also found the clause unambiguous. Coverage was also excluded under the homeowner's policy because it included a business pursuit exclusion.

The Alabama Supreme Court held "[t]he language in an exclusion should be given the same meaning 'that a person of ordinary intelligence would give it'." These terms are also

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to be given a rational and practical construction.

Woodall also argued that Alfa was estopped from denying coverage because of statements he alleged Alfa's agent made to him. The court held, however, that the doctrine of estoppel "is not available to bring within the coverage of a policy risks not covered by its terms or risks expressly excluded therefrom." The court further held "[i]f a coverage provision or an exclusion is unambiguous, it is not subject to waiver or estoppel."

6. Coverage Under a Comprehensive General Liability Policy

Accident

In USF&G v. Bonitz, 424 So.2d 569 (Ala. 1982), the Alabama Supreme Court addressed a situation where Bonitz entered into a contract with the City of Midfield, Alabama, for the construction of the roofing and insulation on a gymnasium as a part of a larger school construction project. After completion of the project, the roof leaked. The City of Midfield filed suit against Bonitz alleging that Bonitz breached his contract by failing to perform in a good an workmanlike manner and by failing to follow specifications in the installation of the roof.

Significantly, Bonitz's insurers contended that the

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leaking did not constitute an occurrence under policies issued to Bonitz. The policies written by USF&G and Employees Mutual Liability Insurance Company of Wisconsin both defined "occurrence" as "an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured". USF&G took the position that negligent installation of the roof did not constitute an "accident" or "occurrence" though the court disagreed finding that since Bonitz was charged with negligence in installing the roof, there was no evidence that it either expected or intended the roof to start leaking.

Expected or Intended by the Insured

Alabama Farm Bureau Mutual Casualty Insurance Company v. Dyer, 454 So.2d 921 (Ala. 1984) involved a case where the insured, Wayne Dyer, shot and killed his brother after the two argued about a water ski that Wayne had sold to his brother for $20.00. Wayne died of a self-inflicted gunshot wound shortly thereafter.

The brother's estate filed a wrongful death action against the estate of Wayne Dyer. Farm Bureau provided homeowner's coverage to Wayne Dyer and it filed a declaration

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judgment action to determine its obligation, if any, to defend and cover the estate of Wayne Dyer in the wrongful death action.

The court affirmed the trial court's finding that Farm Bureau was obligated to defend and provide coverage since Wayne Dyer's shooting of his brother was neither expected nor intended from the standpoint of the insured. The court held that a purely subjective standard applies to a question of whether the insured intended to inflict bodily injury. Specifically, the court stated:

> Under this subjective test, an injury is "intended from the standpoint of the insured" if the insured possessed the specific intent to cause bodily injury to another, whereas an injury is "expected from the standpoint of the insured" if the insured subjectively possessed a high degree of certainty that bodily injury would result from his or her act.

454 So.2d at 925. The court noted that the presumption in tort and criminal law that a person intends the natural and probable consequences of his or her intentional acts has no application to the terms included in such an insurance policy.

7. Exclusions From Coverage

Liability Assumed Under Contract

In Ajdarodini v. State Auto Mutual Insurance Company, 628

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So.2d 312 (Ala. 1993), the Alabama Supreme Court applied an exclusion under a general liability policy which provided that there was no coverage for "liability assumed by the insured under any contract or agreement". In this instance, the underlying plaintiffs filed suit alleging breach of contract arising out of a construction contract. Finding that the policy clearly excluded breach of contract claims from coverage, the court affirmed summary judgment in favor of State Auto.

Sexual Discrimination

Although not necessarily dealing with an exclusion, the Alabama Supreme Court determined in Jackson County Hospital v. Alabama Hospital Trust, 619 So.2d 1369 (Ala. 1993) that claims against the insured hospital for sexual discrimination were not covered under AHAT's general liability policy. The court found that a claim for sexual discrimination necessarily requires intent on the part of the employer to act in a discriminatory fashion and thus such claims are not covered since the policy defined an "occurrence" to include only unintentional acts.

In this first Jackson County Hospital decision, the court also reversed summary judgment in favor of AHAT regarding the

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hospital's request that it defend and indemnify against the plaintiff's retaliatory discharge claims. The court held that such a claim is not a worker's compensation action, but instead is in the nature of a traditional tort. In the second decision relating to this matter, Jackson County Hospital v. Alabama Hospital Association Trust, 652 So.2d 233 (Ala. 1994), the court held that claims for wrongful discharge do not involve an "occurrence". As indicated above, a former employee alleged that the hospital fired her in retaliation for filing a workers' compensation claim. In an analysis similar to that above, the court found that since the wrongful discharge claim was based upon an action alleged to be intentional on the part of the hospital there was no coverage.

Damage to Insured's Own Product

In Aetna Insurance Company v. Pete Wilson Roofing and Heating Company, Inc., 289 Ala. 719, 272 So.2d 232 (1972), the policy at issued provided coverage for contractual liability to Pete Wilson. However, the policy specifically provided that contractual liability "shall not be construed as including liability under a warranty of the fitness or quality of the named insured's products or a warranty that work performed by or on behalf of the named insured will be done in

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a workmanlike manner". In this instance, the underlying plaintiff claimed that a roof constructed by Pete Wilson leaked. The court found that the roof was Wilson's "product" which is necessarily the end result of one's labor. As such, coverage was excluded.

Likewise, the court found that the claimed damages, expenses related to repair and replacement of the roof, were excluded. The policy specifically excluded "property damage to the named insured's products arising out of such products or any part of such products" and "damages claimed for the withdrawal, inspection, repair, replacement, or loss of use of the named insured's products or work completed by or for the named insured".

Further, the court confirmed that coverage cannot be created by waiver or estoppel.

In USF&G v. Andalusia Ready Mix, 436 So.2d 868 (Ala. 1983), the Alabama Supreme Court addressed USF&G's request for declaratory relief. Specifically, USF&G sought a declaration of its obligation to defend and indemnify Andalusia Ready Mix against a lawsuit brought by Will M. Gregory, Inc. Andalusia Ready Mix had sold Gregory grout for use in constructing a water sewage treatment plant. The underlying plaintiff alleged that the grout was defective and extensive repair and

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remodeling of the treatment plant was required.

The court found that USF&G had an obligation to defend and indemnify the insured except with respect to damages for removal and replacement of the defective grout itself given the inclusion in the liability policy of an exclusion relating to damage to the insured's own product.

Completed Operations

"'Completed operations' is a term referring to the liability of a business entity, generally a contractor, which arises after he has completed his work and after the subject matter has been accepted by a third party". American Cast Iron Pipe Company v. Commerce & Industry Insurance Company, 481 So.2d 892 (Ala. 1995). In this instance, the underlying plaintiff was injured while at work for American Valve. American Valve was owned wholly by ASIPCo, the named insured under the policy. Since ASIPCo owned 100% of the stock of American Valve the court found that the premises where the underlying plaintiff was injured were actually those of ASIPCo and thus the claim was not excluded by the "completed operations" provision.

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Sistership Exclusion

In Commercial Union Assurance Company v. Glass Lined Pipe Company, Inc., 372 So.2d 1305 (Ala. 1979), the Alabama Supreme Court enforced the "sistership" exclusion contained within Commercial Union's comprehensive general liability insurance policy. This provision relates to claims for damages for the withdrawal, inspection, repair, replacement, or loss of use of the named insured's products. In this case, the underlying plaintiff sought damages for costs to replace pipe manufactured by Glass Lined and installed in a sewage disposal plant.

Alcohol

See Woodall v. ALFA Mutual Insurance Company, 658 So.2d 369 (Ala. 1994) above.

Owned Property Exclusion

In Safeco Insurance Companies v. Sessions Company, Inc., 455 So.2d 5 (Ala. 1984), a peanut farmer entrusted physical possession of his peanuts to a processing company. The processing company failed to achieve the proper sales price and then was sued by its bailor. It was alleged that the actions of Sessions constituted either an innocent, reckless,

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or intentional misrepresentation of a material fact. The insurance company denied coverage and filed a declaratory judgment action. The court applied the "owned property" exclusion since Sessions would be deemed the owner of the peanuts.

This particular exclusion has been used to address first party coverage for environmental damages. Note, however, that at least two cases have held that this exclusion will not bar coverage in these type cases. See New Castle County v. Continental Casualty Company, 725 F.Supp. 800 (D. Del. 1989), affirmed in part and reversed in part on other grounds, New Castle County v. Hartford Accident and Indemnity Company, 933 F.2d 1162 (3rd Cir. 1991) and United States v. Conservation Chemical Company, 653 F.Supp. 152 (W. D. Mo. 1986).

Pollution Exclusion

In Hicks v. American Resources Insurance Company, Inc., 544 So.2d 952 (Ala. 1989), the Alabama Supreme Court found the pollution exclusion unambiguous. In that case, it was claimed that water became contaminated because of run-off and seepage of acids, alkalies, and toxic chemicals from a strip mining operation.

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Regulatory Estoppel

In a very important opinion in the environmental context, the Alabama Supreme Court held that the standard pollution exclusion, which excludes coverage for the release of pollutants except when the release is sudden and accidental, is ambiguous. This decision, released on December 20, 1996, came after the plaintiff sought a re-hearing of the court's initial finding that the exclusion was unambiguous.

In reversing its prior ruling, the court found that the word "sudden" is ambiguous and may mean "unexpected and unintended". The court seems to have relied upon the plaintiffs' "regulatory estoppel" theory in which the plaintiffs asserted that insurers and the insurance industry as a whole misrepresented the purpose of the standard pollution exclusion when it was first incorporated into the standard ISO general liability form. The plaintiffs claimed that insurers told administrative and regulatory bodies that the exclusion would not result in a reduction in coverage but was simply a "clarification" that the policies did not provide coverage for intentional polluters.

In this opinion, the court also reversed summary judgment in favor of the agent, HRH. The court found that the plaintiffs presented evidence that HRH had advised plaintiffs

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that there was no coverage for environmental liability and based on this representation plaintiffs failed to give notice of claims by the Alabama Department of Environmental Management directly to insurers. Moreover, the court found that USF&G was not entitled to summary judgment based upon late notice since notice by plaintiffs to HRH would constitute notice to USF&G given the agency relationship.

Denial of Claim for Arson

In Day v. Alfa Mutual Insurance Company, 659 So.2d 32 (Ala. 1995), Alfa filed a declaratory judgment in an arson case involving the insured's dwelling. The court again confirmed that to prove a prima facie case implicating the insureds in the arson of the insured dwelling the carrier need only show:

(1) Arson by someone;

(2) Motive by the insured; and

(3) Unexplained surrounding circumstantial evidence implicating the insured.

Permissive User

In Universal Underwriter's Insurance Company v. Sherrill, 544 So.2d 923 (Ala. 1989), the insurer filed a declaratory

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judgment action regarding its rights and duties with respect to an accident in which a passenger in an automobile driven by an employee of the insured dealership was injured. While working as a mechanic for the dealership, Scott drove a dealership employee vehicle home to show his wife because was considering purchasing the car. On the way home he picked up a friend, Sherrill, and both were involved in an accident when Scott lost control of the car and left the road at approximately 75 to 100 m.p.h. Scott died from the injuries and Sherrill was seriously injured.

Sherrill sued the dealership who in turn sought coverage from Universal Underwriters. The court found that Scott was given permission to take the car home though there was insufficient evidence to show a major deviation by Scott from the permission given by the dealer. As such the accident was covered.

In Ward v. Universal Underwriter's Insurance Company, 548 So.2d 150 (Ala. 1989), the court again addressed whether an employee of an automobile dealership was acting within the line and scope of his duties when involved in an automobile accident killing the plaintiff's decedent. The employee had been hired by the dealership though because of a conviction for driving under the influence he had no valid driver's

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license. Despite this he arranged to purchase a vehicle from his employer though before the purchase was made he took the car to pick up his son as he could not arrange other transportation. The extent of his "permission" involved his shaking the keys to the car in front of several other employees as he left work. The day after he borrowed the vehicle he was involved in an automobile accident after drinking.

The plaintiff claimed that silence on the part of others at the dealership when the employee shook the keys amounted to implied permission to use the vehicle. The court rejected this argument though because there had been no reply of any kind by others at the dealership when the employee shook the car keys.

Coverage was found under an automobile dealership garage liability policy where the driver had been given permission to use a vehicle owned by the dealership while her automobile was having warranty repairs made. In Universal Underwriter's Insurance Company v. Burrows, 622 So.2d 342 (Ala. Ct. Civ. App. 1992) the Court of Appeals cited Wiggins v. Universal Underwriters Insurance Company, 539 So.2d 144 (Ala. 1988) in holding that where the driver was driving the vehicle with the permission of the dealer there was coverage under the dealer's

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policy.

Completed Operations Exclusion

In Ketona Chemical Corporation v. Globe Indemnity Company, 404 F.2d 181 (1968), the primary question was whether liability was excluded by the "products hazard" exclusion contained within the comprehensive general liability policy. The insured was a manufacturer of agricultural chemicals which were shipped in leased railroad tank cars. During the process of unloading one of these cars, a worker was injured when pressurized fumes were expelled. Globe denied coverage and after settling the underlying suit Ketona filed an action against Globe. The court concluded that the products of the insured were excluded in view of the "completed operations" portion of the exclusion because at the time of the accident the product had been sold and the tank car had been sub-leased to the product purchaser who unloaded the chemical from it as needed.

Property in the Control of the Insured

Asam v. American Liberty Insurance Company, 413 So.2d 1056 (Ala. 1982) involved a claim by Julia Asam alleging that the insured breached an agreement to feed, water, care for,

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and transplant 250 white mice which were being used in a cancer research project. Asam obtained a default judgment against the insured then instituted a garnishment claim against American Liberty. The court held that coverage was excluded by the unambiguous policy provisions relating to damage to property in the care, custody, or control of the insured, liability assumed by contract, and the loss of use of tangible property which has not been physically injured or destroyed.

Mental Anguish

In State Farm Fire and Casualty Company v. Gwin, 658 So.2d 426 (Ala. 1995), the Alabama Supreme Court held that claimed mental anguish must fall within the policy period to trigger coverage. The Gwins sold properties to the Dobsons. The dwellings on the properties were insured by State Farm. At the time of the closing, State Farm transferred coverage from the dwellings to the Gwins' new residence. After the sale it was discovered that one of the properties was infested with termites, that the roof leaked, and that the electrical wiring in the home was defective. The Dobsons sued the Gwins alleging fraud and misrepresentation.

State Farm filed a declaratory judgment action to

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determine if it had an obligation to defend or indemnify the Gwins. The court found that the alleged misrepresentations did not constitute an occurrence based upon its prior decision of United States Fidelity and Guaranty Company v. Warwick Development Company, 446 So.2d 1021 (Ala. 1984). Additionally, the court specifically held that "any emotional distress related to the alleged misrepresentations would have occurred after the termination of the policy" thus barring coverage.

Following Gwin, the court again found that an injury, specifically mental anguish, "must fall within the policy period for it to be covered". In American States Insurance Company v. Martin, 662 So.2d 245 (Ala. 1995), Murray and Roberta Berger invested in businesses owned by Donald Martin. After the failure of Martin's businesses, the Bergers sued Martin and his companies alleging negligence and misrepresentation resulting in the loss of the Berger's investment. American States provided business owners and commercial general liability insurance to Martin and the companies named in the underlying lawsuit.

American States brought a declaratory judgment action to determine whether it was obligated to defend and indemnify Martin. The Alabama Supreme Court held that since the

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Berger's did not stop receiving payments from Martin until mid-1990, and the American States' policies had been cancelled in 1989, any mental anguish did not occur during the policy periods and as such there was no coverage for the claimed "bodily injury".

The Martin decision also provided that the underlying plaintiffs' claimed economic losses were not tangible property and as such an obligation to defend and indemnify was not invoked.

Co-Employee Claims

In 1983, the Alabama Supreme Court decided Southern Guaranty Insurance Company v. Pittman, 439 So.2d 7 (Ala. 1983), a case in which the insurer issued a general liability policy to a corporation. The policy insured "any employees, director, or stockholder of the named insured while acting within the scope of his duties as such;" however, the policy excluded "any person while engaged in the business of his employer with respect to bodily injury to any fellow employee of such person injured in the course of his employment."

The plaintiff seeking coverage was a vice-president of the corporation, a stockholder owning 1/3 of the corporation's outstanding shares, a director, and a day-to-day manager of

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the business. He was named in a co-employee suit and the carrier denied coverage based upon the above exclusion. The Alabama Supreme Court applied the exclusion citing Home Indemnity Company v. Reed Equipment Company, Inc., 381 So.2d 45 (Ala. 1980). There the court stated:

> The language of this definition, by its plain wording, excludes as an insured an employee who is sued by a co-employee as a result of bodily injury sustained in the course of employment. We find no ambiguity in this . . . .

8. Recent Developments Under the Comprehensive General Liability Policy

Indemnity Agreements

In Goodyear Tire and Rubber Company v. J. M. Tull Metals Company, 629 So.2d 633 (Ala. 1993), the Alabama Supreme Court overruled Paul Krebs & Associates v. Matthews & Fritts Construction Company, 356 So.2d 638 (Ala. 1978) and its progeny finding that enforcement of an express indemnity agreement against an employer by a third party does not violate the exclusive remedy provision of the Alabama Workers' Compensation Act. In that case, Goodyear sued Tull Metals seeking indemnity for amounts paid to an employee of Tull for injuries suffered during the course of his employment with Tull, due to the negligence of Goodyear. The Tull employee was injured on Goodyear's premises while making a delivery.

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However, Tull specifically contracted to indemnify Goodyear against claims relating to the delivery of its products.

B. Fraud

Duty When Carrier Insures Both Parties to Accident

In Spooner v. State Farm Mutual Automobile Insurance Company, 709 So.2d 1157 (Ala. 1997), State Farm insured both parties to an automobile accident. Therefore, State Farm was placed in a "double with claim" situation and was held to have a fiduciary relationship with its insureds. See State Farm Mutual Automobile Insurance Company v. Ling, 348 So.2d 472 (Ala. 1977).

In this opinion, released October 31, 1997, summary judgment in favor of State Farm on plaintiff's suppression and misrepresentation claims was reversed. The court found that there was evidence that State Farm failed to inform the plaintiff that she had a two-year Statute of Limitations within which she was required to file suit against the striking driver. Further, the court found that there was evidence that State Farm misrepresented to plaintiff that she had three years to sue the striking driver and that she had executed a property release when she actually signed a general release.

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Duty to Disclose is Question of Law

In State Farm Fire and Casualty Company v. Owen, 729 So.2d 834 (Ala. 1998), Chief Justice Hooper authored this opinion released on August 21, 1998. Plaintiff had brought a suppression claim against State Farm alleging that she was not advised that under a "replacement cost" policy the carrier had the option to pay the lower of the policy limits or the amount it would cost to replace the personal property, here a diamond ring. Further, plaintiff alleged that she was not told that her premium was based on the appraisal value of the ring though she claimed State Farm would never pay more than its discounted replacement cost.

The court made three key rulings in this decision. First, it confirmed that the question of the existence of a duty to speak is a question of law for the trial judge, not the jury. This issue had become confused in several opinions released during the past two decades. Further, the court found no "confidential relations" or "special circumstances" requiring disclosure in this instance. Although State Farm had superior knowledge, the plaintiff had an opportunity to ascertain this information as the application she signed described the payment options. Finally, the court held that State Farm had no duty to explain its internal procedures.

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Specifically, the court stated:

> To uphold Owen's claim, we would have to rule that it is the responsibility of every insurer at the point of sale to explain fully to potential customers the insurer's internal procedures, its rate making process, and its business practices. To impose that responsibility strikes us as highly impractical, and it is a responsibility we have not imposed in the past.

Reliance Given Plaintiff's Failure to Read Policy

In Richardson v. Liberty National Life Insurance Company, 750 So.2d 575 (Ala. Civ. App. 1999), plaintiff brought this action against Liberty National and its agent alleging that the agent fraudulently misled plaintiff into believing that he was buying a "burial policy" and that the policy would pay full death benefits immediately upon issuance. To the contrary, the policy provided reduced benefits during the first three policy years. The appellate court affirmed summary judgment in favor of the defendants finding insufficient reliance on the part of plaintiff.

Significantly, the "justifiable reliance" standard was applied in this action though the Alabama Supreme Court replaced this standard with the "reasonable reliance" standard in 1997. Here, the court found there could be no justifiable reliance because plaintiff, who could read and write, did not

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read any of the documents provided to him or his father (the insured), including the policy itself and a letter mailed to his father, specifically outlining the procedure for benefits payment. As such, the court found that the plaintiff "must have closed his eyes to avoid the discovery of the truth" in failing to take advantage of the written explanations given to him about how the benefits were paid under the policy.

Plaintiff Entitled to Broad Discovery in Fraud Cases

In Ex parte Stephens, 676 So.2d 1307 (Ala. 1976), the plaintiff filed a Petition for Writ of Mandamus challenging a protective order entered by the trial court limiting contact with former policyholders of the defendant insurance company, Life Insurance Company of Georgia. The protective order had provided that whenever any former policyholder was contacted by a party, a representative for the other party had to be present. The order also provided that the plaintiff could not communicate to the former policyholder the allegations made by plaintiff.

The Alabama Supreme Court found that the trial court abused its discretion in entering this order. Citing the prior Ex parte Clarke, 582 So.2d 1064 (Ala. 1991) decision, the court found that in fraud cases, the party alleging fraud

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is entitled to a broader range of discovery than is usually allowed, because of the greater difficulty in proving fraud. The court found that the order requiring that a representative of the defendant be present when former policyholders were contacted violated the attorney work product doctrine despite the defendant's argument that such contacts would be multiple and annoying, could affect the insurer's business interest, and could result in improper solicitation of the former policyholders. The court further found that the restriction preventing the plaintiff's attorney from communicating the plaintiff's allegations would prevent "meaningful discovery".

Duty to Disclose to Others

In Bulger v. State Farm Mutual Auto Insurance Company, 658 So.2d 425 (Ala. 1995) the plaintiff was involved in an automobile accident. The other driver was insured by State Farm. The plaintiff filed suit against State Farm claiming that it defrauded her by failing to inform her that she could receive the costs of a rental car under the striking driver's policy. The court affirmed summary judgment finding no duty to disclose to the plaintiff on the part of State Farm because she was not State Farm's insured.

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Damages in Suppression Claim

In Liberty National Life Insurance Co. v. McAllister, 675 So.2d 1292 (Ala. 1995), the plaintiff sued claiming that Liberty National had induced her to switch from an old cancer policy to a newer, more expensive policy while concealing that the new policy reduced or eliminated benefits available under the old policy. The jury awarded a $1,000.00 in compensatory damages and $1.0 million in punitive damages. The Alabama Supreme Court affirmed holding that the jury could have found that Liberty National had a duty to compare the benefits provided under the two policies.

Notably, the court also found that a plaintiff in a suppression case "need not prove an intent to deceive," instead, the plaintiff need only show a breach of the defendant's duty to disclose. In addition, the court found that McAllister had been damaged even though she had never submitted a claim under her substituted Liberty National cancer policy. "[T]he damage was McAllister's payment of premiums on the substituted policies while receiving reduced coverage or no coverage for certain treatments that had been covered by the earlier policies."

C. Negligence

See Kervin above.

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D. Statutory Breach

Generally none.

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PRE-SUIT INVESTIGATION

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III. PRE-SUIT INVESTIGATION

A. Gathering Information From the Client

A prudent litigator should take the time for a quick review of the elements required for a valid claim of bad faith before the initial investigation and gathering of information from a perspective bad faith client. The elements of a bad faith case were set out by the Supreme Court of Alabama in *National Security Fire & Casualty Co. v. Bowen*:

(a) An insurance contract between the parties and a breach thereof by the defendant;
(b) An intentional refusal to pay the insured's claim;
(c) The absence of any reasonably legitimate or arguable reason for that refusal (the absence of a debatable reason);

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(d) The insurer's actual knowledge of the absence of any legitimate or arguable reason;
(e) If intentional failure to determine the existence of a lawful basis is relied upon, the plaintiff must prove the insurer's intentional failure to determine whether there is a legitimate or arguable reason to refuse to pay the claim. *National Security Fire & Casualty Co. v. Bowen*, 417 So.2d 179 (Ala.1982)

Since recognizing the tort of bad faith in Alabama the Court has held that proof of mere negligence or mistake is not sufficient to support a claim of bad faith; there must be a refusal to pay, coupled with a conscious intent to injure. See *King v. National Found. Life Ins. Co.*, 541 So.2d 502 (Ala. 1989). This should be a foremost consideration in evaluating and selecting the proper bad faith case, and more importantly, your bad faith client.

The initial interview with the client should be conducted with an eye towards punitive damages and more specifically, finding a "pattern and practice" of similar wrongful conduct if it exists. It is important to listen to what the client feels that the insurance company has done wrong, as the client's perspective is oftentimes indicative of how the jury will perceive the action or nonaction. During the client meeting or immediately thereafter, the lawyer should obtain all written documents regarding the claim denial including the entire policy of insurance at issue, any claims made under the policy and any correspondence sent to or received from the insurance company. Use of these documents in the preparation of the complaint is critical to sufficiently allege a bad faith claim.

The lawyer should also determine whether the client knows any other persons who have had similar experiences with the same insurance company which could provide evidence of "pattern and practice" of intentional conduct. Additionally, the lawyer needs to obtain the full name and address of the selling agent. The local agent may admit that the claim should have been paid or provide names of policyholders whose claims have been denied.

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Finally, the lawyer should be candid with the client regarding the strengths and weaknesses of the potential bad faith claim to ensure cooperation throughout the case. A lawyer should not be discouraged if the size of the client's contract claim is small. The fact that an insurance company denied payment of an small amount, makes the conduct seem more reprehensible.

B. Dealing With the State Insurance Department

An essential source of information at the onset of any bad faith failure to pay a claim suit is obtainable from the Alabama Department of Insurance. Limited information is available from the Alabama Department of Insurance website (www.aldoi.org); such as, addresses of insurance companies licensed to do business in the state, licensing information on agents, and registered agents which may be of assistance in the service of process. However, contacting the Department of Insurance (334-241-4141) regarding your targeted insurer is an imperative discovery tool in properly litigating a bad faith claim.

The Department of Insurance maintains files of complaints filed against insurance companies doing business in the state, files referable to each policy or contract written by insurance companies within the state and files containing the licensing status of insurance agents within the state. Complaints and formal charges brought against companies and agents also are kept at the Department of Insurance. The plaintiff's lawyer should obtain the following documents from the Department of Insurance:

1. Copies of all complaints filed against the defendant insurance company by its policyholders. Surprisingly, a great number of people write to the State Department of Insurance to complain of treatment they perceive as unfair by insurance companies. This type of evidence is admissible now on the issue of "pattern or practice."

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2. The file on the policy or contract of insurance involved. This file will indicate what changes were required by the State Department of Insurance before the policy could be sold to state residents.

3. The file on the defendant agent. The Department of Insurance maintains a file on insurance agents in the state. This should contain the licensing history of the agent and any complaints filed against the agent.

4. Copies of all formal charges brought by the State Department of Insurance against the insurance company or any of its agents, along with the final disposition of the charges.

5. All correspondence between the State Department of Insurance and any officer or employee of the insurance company.

6. A complete list of all agents licensed to sell for the insurance company for a period beginning five years prior to the claim denial. These former agents should be contacted and questioned about the company's claim payment history. A cooperative agent may be a vital weapon in your case against a bad faith insurer. Especially, if such agent is in agreement that your client's claim should have been honored or that similar claims have been paid.

C. Contacting the Insurance Agent

Another vital source of information is the insurance agent who handled, or in reality mishandled, the insured's claim which is the basis for the bad faith failure to pay claim. Although at first glance discussions between an adjuster and the bad faith insured's attorney would seem to be destined to be argumentative, every effort should be taken to keep the tone of the conversation congenial to facilitate an open exchange of information. A helpful adjuster could be a valuable source of information at later depositions and even the star witness at the ultimate trial.

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This pre-suit opportunity to speak with the adjuster should be used to ensure that the adjuster had available all medical records, or other records relevant to the type of insurance policy at issue or the loss involved, in making it's determination of payment or non-payment of the claim. Additionally, the attorney may be able to offer explanations or additional information that may have been misconstrued by the adjuster in his determination. The Supreme Court of Alabama has held that whether an insurance company is justified in denying a claim under a policy must be judged by what was before it at the time the decision was made. *National Savings Life Insurance Co. v. Dutton*, 419 So.2d 1357 (Ala.1982). In *Clay, supra*, for example, our Supreme Court found that evidence as to a dispute over the amount of benefits owed the insured was not relevant to the propriety of the conduct of the insurance company because the issue surfaced after the time at which the insurance company denied the disability claim. *Nationwide Mutual Insurance Co. v. Clay*, 525 So.2d 1339, 1342 (Ala. 1987). Further, the attorney has the opportunity to obtain copies of the claim denial or a copy of the policy from a cooperative adjuster.

Most important is the notice requirement of a valid bad faith claim. If your wronged insured has failed to notify its insurer of its dissatisfaction with the claim payment or nonpayment, your otherwise valid claim could be barred. *Jemison v. Scottsdale Ins. Co.*, 646 So.2d 1389 (holding that an insured's failure to notify its insurer of its dissatisfaction with a claim payment before filing suit would serve to bar a claim for bad faith refusal to pay). The prudent litigator should take the opportunity to speak with the claims adjuster, or the supervisor of the adjuster in some instances, to ensure that the client's dissatisfaction with the claim handling or payment is documented. Preferably this should be followed up with written confirmation, so it can be included in your initial pleadings and evidence at trial.

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D. Recent Decisions

Over a dozen years have passed since the Supreme Court of Alabama recognized the intentional tort of bad faith in first party insurance actions. However, the Court in *Chavers v. National Security Fire & Casualty Co.* failed to anticipate that the tort would return to challenge and confound the Court in the following years. 405 So.2d 1, 6 (Ala.1981). As Justice Shores remarked in her opinion in *United Ins. Co. of Am. v. Cope*, 630 So.2d 407, 412 (Ala.1993), "[w]hen this Court recognized the tort of bad faith refusal to pay a valid insurance claim, it anticipated that such claims would be rare. That has not been the experience." Bad faith has been substantially delineated in the past decade, and continues to be redefined in the present.

In *State Farm Fire & Casualty Company v. Slade*, 747 So.2d 293 (Ala. 1999), the Supreme Court revisited and confirmed the standards involved in a bad faith claim. *Slade* involved a complex set of facts surrounding extensive property damage to the plaintiffs' home allegedly resulting from a lightning strike and earth movement. During its initial investigation, State Farm consulted several engineers and experts to justify its refusal to cover the loss. However, in fear of a lawsuit, State Farm opted to send a "reservation of rights" letter to the Slades notifying them of the concerns with coverage and requested additional inspections and expert opinions. While all of the reports indicated that soil had shifted or settled under the home causing damage, State Farm informed the Slades of its decision to deny coverage. *State Farm Fire & Casualty Co. v. Slade*, 747 So.2d at 298, 299.

The Slades sued State Farm for fraud, breach of contract and bad faith. At the trial, the jury returned a verdict in favor of the plaintiffs on their claims for fraud and bad faith and in favor of State Farm on the breach of contract claims. On appeal, State Farm argued that the trial court had erred in refusing to grant a judgment as a matter of law in its favor. Even though State Farm had

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prevailed on the contract issue, the fact that the breach of contract claim had gone to the jury laid the predicate for the bad faith claim. *Slade,* 747 So.2d at 314. In response, the Slades argued that they did not have to win on the contract claim for three reasons:

(1) When the jury found for the Slade on the bad faith claim, it implicitly found that coverage existed.

(2) In a bad faith failure to investigate claim, the jury need not find contractual coverage; and

(3) The Court should recognize that bad faith on the part of the insurer does raise a cause of action separate and independent from the insurance contract because the law imposes upon an insurance company a duty to act in good faith. *Id.* at 316.

State Farm, however, argued that the jury should not have been allowed to consider the bad faith claim because this was the "normal" case wherein State Farm had a legitimate reason to deny the claim. *Id.* at 316.

In agreeing with State Farm, the Court explained the tort as follows:

> A plaintiff can establish a bad-faith refusal to pay an insurance claim by two theories: (1) the that the insurer had no lawful basis, or (2) that the insurer intentionally failed to determine whether there was nay lawful basis for refusing to pay. This Court has described the first theory as the "normal" bad-faith case, and the second as the "abnormal" case.

The Court went on to say that in the "normal" case, the plaintiff's contract claim had to be strong enough to entitle him to a directed verdict, whether or not the trial court actually granted the directed verdict. The Court looked to the holding in *Thomas v. Principal Financial Group*, 566 So.2d 735 (Ala. 1990) which stated that "ordinarily, if the evidence produced by either side creates a fact question with regard to the contract claim, the bad faith claim must fail." In "abnormal" cases, however, the plaintiff would not have to be entitled to a pre-verdict judgement as a matter of law on the contract claim "if the insurer had recklessly or intentionally failed to properly investigate a claim

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or subject the results of its investigation to a cognitive evaluation." *Id.* at 304.

The Slades argued that there was a constructive denial because State Farm delayed payment with a wrongful intent. They claimed the wrongful intent was evidenced by State Farm's investigating solely to find a lack of coverage; misrepresenting that it was still considering coverage when a claims committee had already voted to deny coverage; and its refusal to turn over an engineer's report. The Supreme Court refused to accept the Slades' arguments. In so holding, the Court stated:

> If we accepted the Slades' contention, we would require an insurance company to publish its initial conclusions as early as possible, without completing a thorough investigation, lest it be found to have a "wrongful intent" in conducting a deeper investigation that reinforces an earlier conclusion. We will not subject an insurance company to a choice between liability under a bad-faith-failure-to-investigate theory for publication of a denial of coverage without an adequate investigation, and liability for a constructive denial imposed after it has conducted a more thorough investigation that confirms an earlier determination of no coverage on the theory of delay coupled with a wrongful intent.

Id. at 315, 316.

The Slades also argued "that bad faith on the part of an insurer should be recognized as a cause of action that arises separately from, and independently of, any claim for benefits under the insurance contract, on the basis that the law implies a duty of good faith in every insurance contract." The Court rejected these arguments as stated:

> [T]his Court has consistently refused to recognize a cause of action for the improper handling of an insurance claim in the first-party context beyond the situation in which the insurer denies the claim and thereafter generates evidence to support its denial. Furthermore, the purpose of the tort of bad-faith failure to pay a claim is to ensure that both parties receive the benefits due them under the policy, and not to provide an extra-contractual remedy.

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Id. 316

While *Slade* discussed some fact-specific situations in which the "directed verdict" rule might not apply, no such situation was presented in *Slade*. The Civil Court of Appeals has recently held that a claim of bad faith refusal to pay requires a preliminary finding that the insurance contract was breached. Therefore, a jury's finding for the insurer on a breach of contract claim and for the insured on the bad faith claim is inconsistent and the judgment is reversible. *See Poarch v. Alfa Mutual Insurance Company*, 2000 WL 127167 (Ala.Civ.App. Feb. 4, 2000).

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THE INS AND OUTS OF DISCOVERY

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IV. THE INS AND OUTS OF DISCOVERY

A. Plaintiff's View

1. The Importance of Interrogatories and Examining the Insurance Claim File

Well-crafted interrogatories provide the plaintiff's counsel with important information regarding the claim, the claim review process, and the reason for denial of the claim. The Alabama Rules of Civil Procedure allow a broad and liberal discovery, within reason. Rule 26(b)(1), *Ala. R. Civ. P.*, allows discovery of "any matter, not privileged, which is relevant." However, at the same time, an overactive plaintiff's attorney in drafting interrogatories may provide the defendant's counsel with some insight to the plaintiff's theories of the case. Accordingly, caution and restraint should be exercised in drafting pointed interrogatories, reserving the probing questions for depositions. Additionally, the plaintiff's attorney must be mindful of the restrictive limitations on the number of interrogatories under *Ala. R. Civ. P.*, Rule 33(a), as interrogatories may be more beneficial to the plaintiff after depositions and other discovery.

The plaintiff's attorney need also be aware of the limitations of the content of the interrogatories. In *Ex parte O'Neal*, 713 So.2d 956 (Ala. 1998), the Alabama Court held that an

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interrogatory relating to prior lawsuits against an insurance company defendant may be proper. In *O'Neal,* the plaintiff's complaint included allegations for fraud, and pattern and practice of fraud as well as bad faith. Due to the wide latitude during discovery, the Court granted the plaintiff access to inquire about the defendant's prior lawsuits. Similarly, in *Ex parte Union Security Life Insurance Co.*, 723 So.2d 34 (Ala. 1998), the Court held that it was not an abuse of discretion for the trial court to order production of the insurance company's credit life and disability applications for the last five years or the consumer complaints concerning credit life and/or disability insurance in Alabama received in the last five years.

Depending on the type of bad faith case, the following items should be helpful to the plaintiff's case in developing it for trial:

1. The date the plaintiff first made a claim for benefits;

2. The amount of benefits that would have been payable, but were denied;

3. Each and every reason for the denial;

4. Each and every fact upon which the reason(s) for denial were based;

5. The names and address of persons "most knowledgeable" about the claim (the importance of this information early on will be discussed infra.);

6. The name(s), address(es), and title(s) of the persons who made the decision to deny the claim;

7. The name and address of each person who dealt with the claim, including the work performed on the claim and the authority guidelines of each such claim adjuster and/or supervisor.

8. Identify and every contact with the plaintiff (or plaintiff's representative), whether that contact be by correspondence, facsimile, by e-mail, in person, by phone, or otherwise.

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9. Whether there are regular claims processing procedures for investigating a claim similar to the plaintiff's, and, if so, explain those procedures.

10. Any contentions that the plaintiff has failed to meet his or her obligations under the insurance policy, including any facts upon which the defendant bases these contentions.

11. Do you contend that you made an adequate investigation into the plaintiff's claim? If so, please describe in detail the investigation, identifying each act, the date of each act, and the person performing each act in the investigation.

12. Identify each and every piece of correspondence from any third party (witness), medical report, etc., that you reviewed prior to denying the claim.

13. Identify every tape recorded conversation with any person concerning this claim.

14. Do you contend that the person who denied the claim had the proper authority to deny the claim?

15. Do you contend that the person denying the claim acted properly?

16. Interrogatories seeking similar claims and lawsuits. (In *Ex parte Finkbohner III*, the Supreme Court of Alabama held that an insured in a bad faith denial of claim suit were entitled to discovery of any bad faith suits filed against the insurer. *Ex parte Finkbohner III*, 682 So.2d 409, 413 (Ala. 1996). However, the Court qualified this broad grant of discovery with a limitation on the insured's discovery regarding bad faith "claims" against the insured. *Ex parte Finkbohner III*, 682 So.2d at 413.)

Equally important as well-drafted interrogatories are thorough requests for documents directed to the defendants. The most important request in discovery of a bad faith claim is for the insurer's insurance claim file. The claims file will provide the basis for the defendant's evaluation

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and handling of the client's claim. The plaintiff's attorney is best to research the common objections of attorney work product and privilege which will be imminent upon defendant receipt of this request. However, in first party insurance bad faith claims this request fits squarely within the permissible discovery and is essential to a successful bad faith claim.

2. Don't Leave Out the Request for Materials Beyond the Claim File

Additional critical information and documents should always be requested in carefully drafted requests for production, including the following:

1. Any and all internal memorandums, recordings or writings of any type growing out of the handling of the claim involved and/or the decision to deny said claim. Many insurance companies require their claims employees to document, through taped recordings or writings, all conversations with the insured concerning the denial of a claim. The "smoking gun" memorandums or recordings, although rare, might reveal a particular claims employee recommended that the claim be paid or represented to the insured that the claim would be paid.

2. A listing of current and prior lawsuits against the insurance company alleging bad faith, fraud, outrage, misrepresentation, and breach of contract. The list should include the jurisdiction of the lawsuit, the date on which it was filed and the name of the plaintiff. Such information is clearly discoverable, and perhaps even admissible, by virtue of the "pattern and practice" exception found in § 6-11-21(1).

3. Copies of all policyholder complaints sent directly to the insurance company or received by the company through the State Department of Insurance. Most state departments of insurance send copies of policyholder complaints to the insurance companies involved. Such complaints may also be relevant to show "pattern and practice" and, also, to show prior notice of a problem by the

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insurance company.

4. Information concerning whether the policy or contract at issue has been declined or amended by any state departments of insurance.

5. A copy of the actuarial memorandum or memorandums generated when the policy was first compiled. Insurance companies use such memorandums to set premiums and insure profitability.

6. A copy of the Loss Experience Exhibit concerning the same type of policy or contract for the years prior to and including the sale of the policy at issue. This document is required by almost all insurance departments and shows the ratio between premium dollars received versus claims paid. The Loss Experience Exhibit may contain evidence that the insurance company does not pay its claims, does not meet state ratio requirements or that the policy value is minimal.

7. The corporate history of the insurance company, including all sister and parent companies. This is usually ascertainable from the Department of Insurance website.

8. All reprimands or written evidence of any disciplinary actions against the insurance company or its agents by officials of any state.

Another important discovery request is for the insurer's insurance claims procedure and policy guidelines and manuals which govern the handling of claims, including all training materials. A plaintiff's lawyer can use these materials to show that the insurer deviated form its guidelines or that the guidelines were inadequate to properly protect the insured. Along with the policy and guidelines, the insurance adjuster handling your client's claim probably had available a book or pamphlet interpreting the policy provisions meanings. Obtaining this document is important information for the plaintiff lawyer to have in the upcoming deposition of the adjuster and

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supervisors who handled the claim

Further a request should be made for the personnel files of the individuals involved in the handling of the claims process for the insurer. The personal files, which will probably require a hearing and most likely a protective order, will show promotions, demotions, reprimands and methods of compensation of the claims adjusters and supervisors making the determination of the claim subject to your bad faith suit.

If there is an "appeal" process where the denial of a claim is reviewed by a supervisor, the documents evidencing the process will also need to be obtained. If the decision to deny a claim is based upon an interpretation of the policy, a request for the production of the underwriting documents relevant to the interpretation of that policy provision should be filed. Normally, the insurance adjuster will have a pamphlet or book that is used to interpret policy provisions.

Finally, in medically related claims, the compete medical history of the plaintiff needs to be obtained. These records can be compared to the records received by the insurance company.

3. Narrowing the Issues With Request for Admissions

The plaintiff can narrow the items that will require proof at trial, and possible gain enough ammunition for a directed verdict with carefully tailored request for admissions. These requests should include, among other things:

1. That the plaintiff was, in fact, an insured;
2. That the policy of insurance was in effect;
3. That a claim was properly filed;
4. That the claim was denied;
5. The date of the denial;

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6. The reason for the denial;

7. The person who made the denial decision;

8. The amount of premiums paid by the insured for the coverage.

Requests for admissions, as with interrogatories, can be read to the jury in the form of a stipulation or otherwise. The plaintiff's lawyer must be very careful to draft requests for admissions narrowly and precisely to elicit the desired response.

4. Coming to Court With "Clean Hands" When Responding to Paper Discovery

The prudent plaintiff's attorney must be persistent in order to obtain adequate responses to interrogatories and requests for production. rarely will the defendant adequately and completely respond to initial discovery. The plaintiff lawyer who accepts inadequate responses or objections and does not follow up with appropriate motions simply rewards the defendant for this practice.

As noted above, the defendant will often refuse or object to providing portions of the claims file as well as other requested material. Some typical objections in discovery requests include the attorney work product and attorney-client privileges. Oftentimes, a hearing will be conducted on a plaintiff's motion to compel production, therefore, the plaintiff's counsel must take care that he is not viewed as having been dilatory in having responded to defendant's discovery.

Additionally, the plaintiff's attorney must provide a showing of "substantial need" and the "unavailability" of obtaining the requested information form any other source. The plaintiff's attorney must be ready to show his "clean hands" to the Court by proving that he is "unable without undue hardship to obtain the substantial equivalent of materials by other means." *Ala.R.Civ.P.*, Rule 26(b)(3). The plaintiff's attorney may be requested to identify other possible means to gather the information requested and the ineffective means to do so.

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5. Depositions - Typical Witnesses That Need to be Deposed

The plaintiff's lawyer must decide which individuals with the insurance company should be deposed. Secondly, a decision should be made regarding the order of deposing those witnesses. The advantage of deposing the lower level claims personnel first is that while they have better knowledge of the plaintiff's claim, they may not be as familiar with the company policies and claim process. Therefore, the claims adjuster, or higher level personnel may be put in a position to agree with or contradict the statements made by a lower level employee. Every person involved in the decision to deny the claim and in the sale of the policy should be deposed. Also, the plaintiff's lawyer should consider taking the depositions of the insurance company's highest executive officers. When starting from the top-level personnel, the plaintiff's lawyer will get beneficial information concerning the client's claim from an individual who may not be very familiar with the claim.

The plaintiff's lawyer should frame his or her notice for deposition under ARCP 30(b)(5) and (6) so as to include all documents not covered during initial paper discovery. Of course, where time is short, a 30(b)(5) and (6) deposition notice may be used as a substitute for requests for production.

The witnesses from the insurance company that need to be deposed include the following:

1. The agent who actually sold the policy;

2. The initial claim's adjuster of the plaintiff's claim;

3. The claim's adjuster's supervisor and all individuals having direct contact with the plaintiff;

4. Executive personnel who will speak to the policies of the insurance company, including their job qualifications, education, and any special courses concerning claims procedures;

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5. An underwriting executive with the insurance company;

6. The custodian of records of the insurance company, unless otherwise stipulated;

7. Any expert used to render an opinion concerning why the claim was or should have been denied or paid;

8. If a medical opinion was obtained by the insurance company to evaluate a claim, that individual will need to be deposed.

Prior to the start of the deposition, simply read the official "most knowledgeable" notice served to the person (or persons) the defendant sent to appear. *See Ala. R. Civ. P.* 30(b)(6) Next, ask which person in the room most closely matches the description in the notice. If anyone responds to this, proceed by asking appropriate questions delineating the carrier's conduct.

Ideally, the person who steps forward will speak for the company at trial. But typically, a defendant also seeks outside experts to explain away its conduct. These outside experts may disagree with in-house experts obtained under the "most knowledgeable" deponent request.

However, a deponent put forth by the defendant is not always comfortable admitting that he is the "most knowledgeable" person in the company on a subject. After you read the notice, the person may reply that neither he nor anyone else in the entire company is the "most knowledgeable" on the subject at issue. In this situation, the defendant company at least looks awkward and probably ignorant about its own procedures. Because this deposition notice format requires the company to put forward one or more officers, directors, or managing agents who can speak authoritatively on behalf of the company, when the person put forward will not or cannot speak for the company, the company loses credibility when trying to justify its conduct towards the insured or claimant at trial.

The claims evaluator should provide the best possible explanation as to why the client's

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claim was denied. It is important to review the claims file and any claims manual or other documents concerning the evaluation of claims before taking the claims evaluator's deposition.

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B. Defendant's View

1. How to utilize interrogatories to obtain documents and determine reasons for plaintiff's claim

The primary rationale for using interrogatories to determine the nature of plaintiff's claims is that generally the plaintiff must provide evidence available to him or her as opposed to simply known by plaintiff. Therefore, the defendant can discover plaintiff's theory of bad faith as outlined by counsel as opposed to the statements of the party only. Interrogatories, even when related to the legal claims of the plaintiff, should be drafted concisely. For the most part, it is better to have fewer, more basic interrogatories which seek specific information such as witnesses, expert witness information, basic facts, medical history, and the like.

2. Covering all the bases when requesting production of documents

Obviously, production requests will vary depending on the type of case. It is, clear, that in any extra-contractual claim the defendant will want to request the original of any documents received from the insurance company or any involved agent. Again, precise wording is important in preparing the

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request. While the tendency is to prepare very broad requests which will net any possible document, the more likely response is an objection which will require further review and potentially arbitrary limitation by the Court. Narrower requests and requests for specific documents may be more appropriate.

Discovery of Policy Limits

Alabama Rule of Civil Procedure 26 provides that the contents of an insurance agreement are discoverable though it does not address specifically whether the limits of liability must be disclosed. The Supreme Court of Alabama held on February 19, 1999 that policy limits are discoverable. (Ex parte Badham, 730 So.2d 135 (Ala. 1999))

Discovery of Information Regarding other Insureds

In Ex parte American National Property and Casualty Company, So.2d 742 1212 (Ala. 1999), Justice Houston authored this opinion released on August 27, 1999. American National had filed a petition for writ of mandamus following entry of a discovery order by the trial court requiring production of various information about other insureds. The plaintiff-insureds had filed a declaratory judgment action against

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American National after American National denied coverage under an automobile insurance policy. Plaintiff Barbara Johnson was insured by the policy. The policy stated that her "spouse" was also covered but only "if living in the same household". At the time the declaratory judgment action was filed, Barbara Johnson was married to Charles Johnson, against whom two default judgments totaling over $1 million had been obtained by individuals injured in an accident involving Charles Johnson. The court determined that since the question before the trial court was simply one of contractual interpretation, that is whether Charles Johnson was "living in the same household" with Barbara Johnson so as to invoke coverage, information about other insureds was not relevant or reasonably calculated to lead to the discovery of evidence relative to this question.

3. Eliminating the necessity of obtaining records for trial by using a request for admission.

The most common use for request for admissions in preparation for trial relates to authentification of medical records. Such may be necessary in a bad faith claim where the case involves injury or medical condition. Requests for admission can also be used as a discovery tool by asking the plaintiff to admit that he or she has no facts supporting

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various counts in the complaint or addressing specific factual issues.

4. Narrowing the information requested for paper discovery while still looking out for the best interest of your client.

As indicated above, written discovery requests should be short, precise, and limited. Excessive interrogatories will simply provide plaintiff's counsel an opportunity to provide his or her version of the claims. Also, extensive, specific contention interrogatories may highlight areas which plaintiff's counsel will address with his or her client before they are deposed. Basic information can be obtained from interrogatories which will allow for discovery directly at the plaintiff's deposition or through other tools such as subpoenas, witness interviews, etc.

5. Depositions -- who to depose in the order of depositions.

In almost every extra-contractual case, defense counsel can expect that plaintiff will request the depositions of various insurance company employees. Obviously, with rare exception, defense counsel will depose the plaintiff. On the other hand, defense counsel may well not want to depose helpful witnesses. This is especially true if a signed or

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recorded statement has been obtained. A deposition will allow plaintiff's attorney a chance to strongly cross-examine the witness. This ability may be limited during trial. On the other hand, adverse witnesses may require deposition simply because of lack of cooperation. Also, if the hostile witness is an ex-employee, defense counsel may be forced into a deposition to determine what types of harmful statements may be made and to prepare for cross-examination at trial.

Generally, lay witnesses should be deposed before expert witnesses. Any expert identified by Plaintiff should generally be deposed. Many times, plaintiff's counsel will insist in deposing a representative of the defendant first, frequently after filing a Rule 30 Deposition Notice with the Complaint. Many times it is to the advantage of defense counsel to allow a representative of the insurance company to be deposed first since questioning of the plaintiff at his or her deposition will educate plaintiff's counsel about theories of defense which will in turn be passed on to the plaintiff.

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ETHICS — IT'S LEGAL, BUT IS IT RIGHT?

WALTER J. PRICE III

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V. ETHICS - IT'S LEGAL, BUT IS IT RIGHT?

A. Rules of Professional Conduct

Rule 1.1

Competence

A lawyer shall provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation.

Rule 1.3

Diligence

A lawyer shall not willfully neglect a legal matter entrusted to him.

Rule 1.4

Communication

(a) A lawyer shall keep a client reasonably informed about the status of a matter and promptly comply with reasonable requests for information.

(b) A lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation.

Rule 1.6

Confidentiality of Information

(a) A lawyer shall not reveal information relating to

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representation of a client unless the client consents after consultation, except for disclosures that are impliedly authorized in order to carry out the representation, and except as stated in paragraph (b).

(b) A lawyer may reveal such information to the extent the lawyer reasonably believes necessary:

(1) to prevent the client from committing a criminal act that the lawyer believes is likely to result in imminent death or substantial bodily harm; or

(2) to establish a claim or defense on behalf of the lawyer in a controversy between the lawyer and the client, to establish a defense to a criminal charge or civil claim against the lawyer based upon conduct in which the client was involved, or to respond to allegations in any proceeding concerning the lawyer's representation of the client.

Rule 1.7

Conflict of Interest:

General Rule

(a) A lawyer shall not represent a client if the representation of that client will be directly adverse to another client unless:

(1) The lawyer reasonably believes the representation will not adversely affect the relationship with the other

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client; and

(2) each client consents after consultation.

(b) A lawyer shall not represent a client if the representation of that client may be materially limited by the lawyer's responsibilities to another client or to a third person, or by the lawyer's own interests, unless:

(1) the lawyer reasonably believes the representation will not be adversely affected; and

(2) the client consents after consultation. When representation of multiple clients in a single matter is undertaken, the consultation shall include explanation of the implications of the common representation and the advantages and risks involved.

Rule 1.8

Conflict of Interest:

Prohibited Transactions

(a) A lawyer shall not enter into a business transaction with a client or knowingly acquire an ownership, possessory, security or other pecuniary interest adverse to a client unless:

(1) the transaction and terms on which the lawyer acquires the interest are fair and reasonable to the client and are fully disclosed and transmitted in writing to the

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client in a manner which can be reasonably understood by the client;

(2) the client is given a reasonable opportunity to seek the advice of independent counsel in the transaction; and

(3) the client consents in writing thereto:

(b) A lawyer shall not use information relating to representation of a client to the disadvantage of the client unless the client consents after consultation, except as permitted or required by Rule 1.6 or Rule 3.3.

(c) A lawyer shall not prepare an instrument giving the lawyer or a person related to the lawyer as parent, child, sibling, or spouse any substantial gift from a client, including a testamentary gift, except where the client is related to the donee.

(d) Prior to the conclusion of representation of a client, a lawyer shall not make or negotiate an agreement giving the lawyer literary or media rights to a portrayal or account based in substantial part on information relating to the representation.

(e) A lawyer shall not provide financial assistance to a client in connection with pending or contemplated litigation, except that:

(1) a lawyer may advance court costs and expenses of

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litigation, the repayment of which may be contingent on the outcome of the matter;

(2) a lawyer representing an indigent client may pay court costs and expenses of litigation on behalf of the client;

(3) a lawyer may advance or guarantee emergency financial assistance to the client, the repayment of which may not be contingent on the outcome of the matter, provided that no promise or assurance of financial assistance was made to the client by the lawyer, or on the lawyer's behalf, prior to the employment of the lawyer; and

(4) in an action in which an attorney's fee is expressed and payable, in whole or in part, as a percentage of the recovery in the action, a lawyer may pay, for his own account, court costs and expenses of litigation. The fee paid to the attorney from the proceeds of the action may include an amount equal to such costs and expenses incurred.

(f) A lawyer shall not accept compensation for representing a client from one other than the client unless:

(1) the client consents after consultation or the lawyer is appointed pursuant to an insurance contract;

(2) there is no interference with the lawyer's independence of professional judgment or with the client-

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lawyer relationship; and

(3) information relating to representation of a client is protected as required by Rule 1.6.

(g) A lawyer who represents two or more clients shall not participate in making aggregate settlement of the claims of or against the client, or in a criminal case an aggregated agreement as to guilty or nolo contendere pleas, unless each client consents after consultation, including disclosure of the existence and nature of all the claims or pleas involved and of the participation of each person in the settlement.

(h) A lawyer shall not make an agreement prospectively limiting the lawyer's liability to a client for malpractice unless permitted by law and the client is independently represented in making the agreement, or settle a claim for such liability with an unrepresented client or former client without first advising that person in writing that independent representation is appropriate in connection therewith.

(i) A lawyer related to another lawyer as parent, child, sibling or spouse shall not represent a client in a representation directly adverse to a person who the lawyer knows is represented by the other lawyer except upon consent by the client after consultation regarding the relationship.

(j) A lawyer shall not acquire a proprietary interest in

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the cause of action or subject matter of litigation the lawyer is conducting for a client, except that the lawyer may:

(1) acquire a lien granted by law to secure the lawyer's fee or expenses; and

(2) contract with a client for a reasonable contingent fee in a civil case.

(k) in no event shall a lawyer represent both parties in a divorce or domestic relations proceeding, or in matters involving custody of children, alimony or child support, whether or not contested. In an uncontested proceeding of this nature a lawyer may have contact with the non-represented party and shall be deemed to have complied with this prohibition if the non-represented party knowingly executes a document that is filed in such proceeding acknowledging:

(1) that the lawyer does not and cannot appear or serve as the lawyer for the non-represented party;

(2) that the lawyer represents on the client and will use the lawyer' best efforts to protect the client's best interests;

(3) that the non-represented party has the right to employ counsel of the party's own choosing and has been advised that it may be in the party's best interest to do so; and

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(4) that having been advised of the foregoing, the non-represented party has requested the lawyer to prepare an answer and waiver under which the cause may be submitted without notice and such other pleadings and agreements as may be appropriate.

Rule 1.9

Conflict of Interest:

Former Client

A lawyer who has formerly represented a client in a matter shall not thereafter:

(a) represent another person in the same or a substantially related matter in which that person's interests are materially adverse to the interests of the former client, unless the former client consents after consultation; or

(b) use information relating to the representation to the disadvantage of the former client except as Rule 1.6 or Rule 3.3 would permit or require with respect to a client or when the information has become generally known.

Rule 1.10

Imputed Disqualification: General Rule

(a) While lawyers are associated in a firm, none of them shall knowingly represent a client when any one of them practicing alone would be prohibited from doing so by Rules

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1.7, 1.8(c), 1.9 or 2.2.

(b) when a lawyer becomes associated with a firm, the firm may not knowingly represent a person in the same or a substantially related matter in which that lawyer, or a firm with which the lawyer was associated, had previously represented a client whose interests are materially adverse to that person and about whom the lawyer had acquired information protected by Rule 1.6 and 1.9(b) that is material to the matter.

(c) When a lawyer has terminated an association with a firm, the firm is not prohibited from thereafter representing a person with interest materially adverse to those of a client represented by the formerly associated lawyer, unless:

(1) the matter is the same or substantially related to that in which the formerly associated lawyer represented the client; and

(2) any lawyer remaining in the firm has information protected by Rules 1.6 and 1.9(b) that is material to the matter.

(d) a disqualification prescribed by this rule may be waived by the affected client under the conditions stated in Rule 1.7.

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Rule 1.13

Organization as Client

(a) A lawyer employed or retained by an organization represents the organization acting through its duly authorized constituents.

(b) If a lawyer for an organization knows that an officer, employee or other person associated with the organization is engaged in action, intends to act or refuses to act in a matter related to the representation that is a violation of a legal obligation to the organization, or a violation of law which reasonably might be imputed to the organization, and is likely to result in substantial injury to the organization, the lawyer shall proceed as is reasonably necessary in the best interest of the organization. In determining how to proceed, the lawyer shall give due consideration to the seriousness of the violation and its consequence, the scope and nature of the lawyer's representation, the responsibility in the organization and the apparent motivation of the person involved, the policies of the organization concerning such matters, and any other relevant considerations. Any measures taken shall be designed to minimize disruption of the organization and the risk of revealing information relating to the representation to

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persons outside the organization. Such measures may include among others:

(1) asking reconsideration of the matter;

(2) advising that a separate legal opinion on the matter be sought for presentation to appropriate authority in the organization; and

(3) referring the matter to higher authority in the organization, including, if warranted by the seriousness of the matter, referral to the highest authority that can act in behalf of the organization as determined by applicable law.

(c) if, despite the lawyer's efforts in accordance with paragraph (b), the highest authority that can act on behalf of the organization insists upon action, or a refusal to act, that is clearly a violation of law and is likely to result in substantial injury to the organization, the lawyer may resign in accordance with Rule 1.16.

(d) In dealing with an organization's directors, officers, employees, members, shareholders or other constituents, a lawyer shall explain the identity of the client when it is apparent that the organization's interests are adverse to those of the constituents with whom the lawyer is dealing.

(e) a lawyer representing an organization may also

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represent any of its directors, officers, employees, members, shareholders or other constituents, subject to the provisions of Rule 1.7 If the organization's consent to the dual representation is required by Rule 1.7, the consent shall be given by an appropriate official of the organization other than the individual who is to be represented, or by the shareholders.

Rule 1.16

Declining or Terminating Representation

(a) Except as stated in paragraph (c), a lawyer shall not represent a client or, where representation has commenced, shall withdraw from the representation of a client, if:

(1) the representation will result in violation of the Rules of Professional Conduct or other law;

(2) the lawyer's physical or mental condition materially impairs the lawyer's ability to represent the client; or

(3) the lawyer is discharged.

(b) Except as dated in paragraph (c), a lawyer may withdraw from representing a client if withdrawal can be accomplished without material adverse effect on the interests of the client, or if:

(1) the client persists in a course of an action involving the lawyer's services that the lawyer reasonably

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believes is criminal or fraudulent;

(2) the client has used the lawyer's services to perpetrate a crime or fraud;

(3) the client insists upon pursuing an objective that the lawyer considers repugnant or imprudent;

(4) the client fails substantially to fulfill an obligation to the lawyer regarding the lawyer's services and has been given reasonable warning that the lawyer will withdraw unless the obligation is fulfilled;

(5) the representation will result in an unreasonable financial burden on the lawyer or has been rendered unreasonably difficult by the client; or

(6) other good cause for withdrawal exists.

(c) When ordered to do so by a tribunal, a lawyer shall continue representation notwithstanding good cause for terminating the representation.

(d) Upon termination of representation, a lawyer shall take steps to the extent reasonably practicable to protect a client's interests, such as giving reasonable notice to the client, allowing time for employment of other counsel, surrendering papers and property to which the client is entitled and refunding any advance payment of fee that has not been earned. The lawyer may retain papers relating to the

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client to the extent permitted by other law.

Rule 2.1

Advisor

In representing a client, a lawyer shall exercise independent professional judgment and render candid advice. In rendering advice, a lawyer may refer not only to law but to other considerations such as moral, economic, social and political factors, that may be relevant to the client's situation.

Rule 3.7

Lawyer as Witness

(a) A lawyer shall not act as advocate at a trial in which the lawyer is likely to be a necessary witness, except where:

(1) the testimony relates to an uncontested issue;

(2) the testimony relates to the nature and value of legal services rendered in the case; or

(3) disqualification of the lawyer would work substantial hardship on the client.

(b) A lawyer may act as advocate in a trial in which another lawyer in the lawyer's firm is likely to be called as a witness, unless precluded from doing so by Rule 1.7 or Rule 1.9.

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B. Conflicts of Interest

Defense Under Reservation of Rights

L&S Roofing Supply Company, Inc. v. St. Paul Fire and Marine Insurance Company, 521 So.2d 1298 (Ala. 1987)

- While operating under a reservation of rights, an insurer has an enhanced obligation of good faith toward its insured in conducting the defense.
- Defense counsel represents only the insured, not the insurance company, while operating under a reservation of rights.
- Counsel retained to defend the insured owes a duty of full and ongoing disclosure to the insured.

Duty to Keep Insured Informed

Shelby Steel Fabricators, Inc. v. USF&G, 569 So.2d 309(Ala. 1990)

- Failure of the insurer to keep the insured informed as to the status of the litigation constitutes failure to meet the enhanced obligation described in L&S Roofing Supply requiring the carrier to indemnify the insured.

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Duty to Defend

Samply v. Integrity Insurance Company, 476 So.2d 79 (Ala. 1985).

- Duty to defend is broader than duty to pay.
- Insurer's duty to defend does not end when carrier tenders its policy limits in to court without effectuating a settlement or obtaining consent from insured.

Duty to Defend Against Claims of Intentional Conduct

Tapscott v. Allstate Insurance Company, 526 So.2d 570 (Ala. 1988)

- Insurer not required to defend in lawsuit where claims all involve intentional acts.
- If the Complaint initially alleges intentional torts, but is later amended to include unintentional acts, the duty to defend will be triggered.
- Insurer must, if defending under a reservation of rights, specifically reserve its right to withdraw defense or this right may be waived.

C. Zealous Representation Vexatious Practices

D. Lawyer Liability

See Waters above.

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TRIAL STRATEGY — THE BEGINNING OF THE END

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VI. TRIAL STRATEGY - THE BEGINNING OF THE END

A. Voir Dire - The First Essential Step in Winning the Case

Beyond asking the obvious voir dire questions, there are a few essential areas that the plaintiff's counsel must address in a bad faith trial. Questions concerning the prospective jurors' employment, former or present, with an insurance company are routine for most litigation purposes, but should be examined more thoroughly during voir dire of a bad faith case. Similarly, counsel will want to identify any prospective panel member who owns stock in an insurance company. An

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inquiry as to the nature and extent of any other relationship, past or present, a prospective juror might have with the business of insurance is also appropriate.

The following questions are not propounded for the purpose of eliciting a substantive response from panel members, but are raised in a manner to create an impression of the plaintiff's case in the prospective juror's mind.

1. Whether a juror believes it is appropriate and normal and reasonable to rely on an agent to explain an insurance policy and its operation without actually reading the policy cover to cover.

2. Whether a juror sees any causative link between the amounts of jury verdicts and increases in insurance premiums.

3. If an insurance company takes your premiums, should it pay you benefits when an event occurs for which the insurance was purchased. (i.e., fire, death, disabled, loss, etc.).

4. Whether an insurance company should deny a claim when it does not have all the facts concerning the claim.

5. Whether an insurance company can deny a claim simply because it does not want to pay.

Somewhere during voir dire, questions involving damages and the jury's feelings about damages should be undertaken. This provides the plaintiff's lawyer with an opportunity to identify those jury members who have been influenced by "tort reform" and "law abuse" propaganda. If the plaintiff's attorney plans to ask for a large sum of punitive damages at the conclusion of the trial, it should be brought up during voir dire. This will eliminate those individuals who are unable to participate in a large punitive award and prevents the eventual jury panel from being surprised when a substantial amount of punitive damages are requested at the end of the case. By discussing damages in the case during voir dire, the plaintiff's counsel has laid a foundation that can be re-

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addressed during closing argument.

B. Opening Statements

This is a very critical stage of the trial and the time should not be wasted on material unrelated to the issues in the case. The plaintiff's counsel should stress the damages issue and spend a considerable amount of time relating the evidence that will be presented to the damages claim. Your primary goal during opening statement should be to persuade the jury. The most effective means to do this is by establishing a theme. In a bad faith case, where the actual damages may be small, but the conduct is wanton or reckless, a theme of punishment is appropriate.

Be very clear about the facts of the case and be precise when asking the jury what you want from them. Addressing the opposing side's strengths and conceding your case's shortcomings will weaken their effect when brought up by the other side. Establishing credibility is a key factor in persuading a jury. Do not overstate your case and do not make promises during openings that cannot be fulfilled during the course of the trial. In fact, your opening statement should provide an outline for your closing argument. Your closing will confirm that you followed through with your commitments made to the jury during opening.

C. Order of Witnesses

Depending upon the nature of your case, possible expert and knowledgeable lay witnesses include:

1. Claims Adjusters, Supervisors, Managers, Investigators, Agents (insurance sales people) etc.;
2. Economists;
3. Professors (knowledgeable about insurance regulations, industry practices, etc.);
4. Attorneys (both plaintiff and defense);
5. Insurance Commissioners;
6. Home Builders, Mechanics, Fire Cause and Origin Specialists, Psychologists,

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Psychiatrists, Advertising Agents, Auto Body Repair Personnel, etc. Just about anyone else who is knowledgeable either by age, training, experience or education concerning the particular subject matter of your insurance bad faith litigation;

7. Teachers and Used Car Salesmen; and
8. Juror Survey and Focus Group Experts.

A. Adjusters

Adjusters are obvious experts to call. Whether the expert chosen is a former adjuster now turned consultant or presently adjusting for a major insurance company, you should have little problem presenting him as an expert. If you use respected retired adjusters or current adjusters holding substantial responsibilities with major insurance companies, defense lawyers will be hard pressed to challenge the testimony because the defendant will likely utilize in-house or retired adjuster consultants to counter the testimony of your experts.

Once chosen and properly qualified, these expert witnesses will be able to educate jurors on a variety of topics including:

1. The insurance carrier's duty to defend;
2. The extent of the duty to defend;
3. The dollar value of any given claim--property, casualty, health or accident claims;
4. Application of the law (including insurance regulations, the Uniform Deceptive Trade Practices Acts and case law) to the facts of the case;
5. Deviations on the part of the claims adjuster from accepted standards of adjusting in the particular line of insurance at issue;
6. Industry customs, practices, and procedures;
7. Comparisons of other insurers' practices (they do communicate with each other); and
8. The quality and quantity of conduct involved in the claims- handling process--including

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whether conduct was intentional, willful, wanton, malicious, or in reckless disregard of the rights of an insured or third party claimant.

B. Economists

The ultimate goal in most of this litigation is to convince the jury (and the judge) that a large verdict or punitive damage award--or both-- ought to be considered to punish, take away the "ill gotten" gain, set an example, or deter future conduct of a like or similar nature. An economist--preferably one who has kept abreast of insurance practices and accounting procedures--may be beneficial to explain why punishing or making an example of a certain insurance company would deter future similar conduct.

Because economists specialize in the field of "crunching numbers," they can explain to the jury the forces of the insurance market place and how and why companies "pad" the bottom line. In some cases, it may be important for the jury to understand how insurance carriers have remained exempt from monopolistic/antitrust laws and how over time these carriers have developed accounting techniques to hide profits. Economists can explain some of the terminology used in the insurance industry such as reserves, incurred losses, retentions, incurred but not reported losses, rates of return, "rated age," and how and under what circumstances insurance companies pay or avoid paying taxes on part of the profits they realize. Utilization of demonstrative evidence aids is essential. Diagrams and flow charts can effectively explain how premium dollars are broken down and siphoned off by insurance carriers. Economic schemes, employed by insurance companies to avoid painting a clear picture of their profitability, must be explored.

One primary use of an economist is to set the stage for a punitive damage award. Economists can perform a pivotal role in convincing a jury how a multi- billion dollar insurance company is

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profiting from reprehensible conduct.

Often, bad faith litigation involves conduct on the part of a carrier which can be described as "chiseling," double-dipping, low-balling, double-dealing or fraudulent. Such conduct often consists of shaving small amounts off every claim--auto, health, disability, property, or fire loss cases; or refusing to pay; or timely paying claims involving health, disability and credit; or mortgage life insurance, based upon hyper technical constructions of policy language; or misrepresentation or outright fraud. Economists are in a unique position to quantify the total dollars saved by a particular carrier's willful conduct over any incremental period of time. Once the economist calculates the savings, he can conduct research to determine internal rates of investment and present day calculations made to show gross profits or savings realized.

C. Professors

Professors at any local college or university can be crucial players in exposing the exploits of these multi-billion dollar carriers. Law professors, especially those with a background in insurance law, are particularly well suited to help expose a carrier's past bad faith cases.

Many insurance law professors have compiled data bearing upon such topic areas as profitability of insurance carriers, the need for more effective regulatory measures, and the failure of past regulatory measures by state insurance commissioners due to ill-equipped, under-staffed and under-funded offices. Law professors can also present historical perspectives to jurors on how the insurance industry in this country operates in an ineffectively regulated environment.

D. Attorneys

Attorneys who practice insurance law can explain technical issues to the jury. If a bad faith case involves the application of a state insurance regulatory scheme or the application of a Uniform

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Deceptive Trade Practices Act to the conduct in question, an attorney experienced in this area can clarify difficult points by explaining how the facts of a case apply to the law in your jurisdiction.

Attorneys who have handled similar claims or have dealt with the same carriers in litigation are well placed to address the pertinent issues. Areas appropriate for discussion may be prior bad conduct, custom and practice, absence of mistake or inadvertence in insurance claim practices, intentional conduct, or similarity of facts vis-a-vis your case with the carrier's prior conduct.

Retaining a defense lawyer who has represented insurance companies for the bulk of his or her professional life is effective. This attorney will be credible to explain the schemes used by companies and how practices in the market place vary from the printed manuals, procedures or guidelines the carriers issue. The attorney can explain the maintenance of "dummy" files or document destruction programs designed to hide the truth or "create" the "truth" a carrier wants conveyed.

E. Insurance Commissioners

Former or current state insurance commissioners can be used as experts. Unfortunately, many of them obtained their education, experience and training working for insurance companies, so caution is in order. Because commissioners oversee state insurance regulatory schemes (and in varying degrees are enforcers of a state's Deceptive Trade Practices Act), no one appears to be in a better position to relate facts and figures concerning industry practices.

An insurance commissioner should be qualified to discuss:

1. The theory of insurance (risk spreading);

2. Adjusting practices in the industry (in general);

3. Adjusting practices of different carriers;

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4. Comparisons between different carriers as far as their adjusting practices on your side are concerned;

5. How different "lines" of insurance are handled;

6. How different insurance companies manipulate claims experience to affect insurance rates;

7. The impact of investment practices (investment malpractice) on insurance rates;

8. Use of deceptive advertising;

9. The lack of any federal control on insurance industry practices and the inability or unwillingness of state insurance commissioners to control abusive practices (e.g., "the rubber stamp" approval process of state insurance commissioners with respect to Insurance Service Office (ISO) form approval, as well as particular insurance policy language approval).

State insurance commissioners are in charge of promulgating insurance regulations in most states. Commissioners also issue informal rulings such as information bulletins or letters to carriers regarding underwriting, the application for and sale of insurance, and claim adjustment. Most states issuing regulations, information letters, and bulletins have them published for public review.

Additionally, Consider exploring the use of knowledgeable lay witnesses as well as conventional experts. "Knowledgeable" lay witnesses who are well versed in insurance industry practices or have themselves been recipients of ruthless insurance company tactics are often the most believable witnesses. As in any litigation, such witnesses must not only be knowledgeable but also credible. Jurors know when a witness is "stretching" the envelope of truth.

D. Use of Experts; Advise of Counsel

If your experts are not credible or overextend themselves, you will suffer a similar fate. The supreme court has yet to define the role of the expert witness in proving or disproving an insured's

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claim of bad faith refusal to pay against his own insurer. Rule 702 of the Alabama Rules of Evidence, effective January 1, 1996, addresses the admissibility of expert testimony and states that "[i]f scientific, technical, or otherwise specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise." The Advisory Committee's notes explain that under Rule 702, "it is possible that an expert opinion or testimony on a question of common knowledge would be admitted by the trial judge as helpful to the trier of fact." This is a departure from the traditional focus of expert testimony in Alabama on subjects that are "beyond common understanding to whether the expert's opinion or testimony will assist the trier of fact." This shift reflects the recent trend in Alabama decisions that "in speaking of expert testimony have increasingly used the words 'helpful to' or 'assist' the trier of fact."

A careful examination of Alabama and other jurisdictions' case law provides helpful insight as to how the supreme court may define the scope of admissibility of expert testimony when the issue eventually comes before the court. In *Macon County Commission v. Sanders*, the Supreme Court of Alabama held that an expert may testify as to the ultimate issue in a case. *Macon County Commission v. Sanders*, 555 So.2d 1054, 1058 (Ala.1990); *See also Harrison v. Wientjes*, 466 So.2d 125 (Ala.1985). However, in *Yarborough v. Springhill Memorial Hospital*, the Supreme Court held that expert witnesses are prohibited from giving their opinions on the ultimate issue of a case. *Yarborough v. Springhill Memorial Hospital*, 545 So.2d 32, 34 (Ala.1989). This position is now codified in Alabama Rule of Evidence 704, which states "[t]estimony in the form of an opinion or inference otherwise admissible is to be excluded if it embraces an ultimate issue to be decided by

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the trier of fact." Accordingly, the rule in Alabama appears to be that an expert witness may give his opinion concerning the ultimate factual issue in a case, but is precluded from stating it in the form of a legal conclusion.

The Supreme Court of Alabama's decision in *Tidwell v. Upjohn Co.*, where the court noted that, in Alabama:

> A ruling on the admissibility of expert testimony is largely within the discretion of the trial court and will not be overturned unless there has been an abuse of discretion. The purpose of expert testimony is to aid the trier of fact where the subject matter is beyond the ken of the average juror. Thus, where a witness has sufficient 'knowledge, skill, experience, or training ... that his opinion will be considered in reason as giving the trier of fact light upon the question to be determined' it should be admitted as expert testimony. *Tidwell v. Upjohn Co.*, 626 So.2d 1297 (Ala.1993).

To date, the only Alabama decision to proximately address this issue is *Thomas v. Principal Financial Group*. In *Thomas*, the mother of a deceased child brought an action against her insurer for breach of contract and bad faith refusal to pay insurance benefits. *Thomas v. Principal Financial Group*,566 So.2d 735 (Ala.1990). The plaintiff, Ms. Thomas, filed a claim after her 24-year-old daughter's death from cancer. The group life insurance policy that Ms. Thomas possessed authorized recovery for the death of a dependent, and defined the word "dependent," in pertinent part, as "each unmarried child who is nineteen years but less than twenty-five years of age provided he is attending school on a full-time basis and is dependent upon the person for his principal support and maintenance." At the time of her death, Melinda Warren, Ms. Thomas's daughter was enrolled full-time in school, but had not attended for the last 22 months because of her illness. The claims examiner for Ms. Thomas's insurer questioned whether Ms. Thomas's daughter was a dependent as defined by the policy, and made the determination that Melinda Warren was not a dependent as

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defined by the policy language. This decision was then confirmed by the examiner's supervisor, and then by the supervisor's supervisor. The insurer notified Ms. Thomas of its refusal to pay the claim, and then reviewed its decision at the request of Ms. Thomas's attorney. Upon learning that the insurer intended to stand by its earlier determination not to pay the claim, Ms. Thomas filed suit. A jury awarded Ms. Thomas $1,000 on her breach of contract claim, and $750,000 on her bad faith claim. The insurer appealed, contending among other things that the trial court had erred in allowing the case to go to the jury as the policy language was not ambiguous regarding Ms. Warren's status, and therefore there was no question of fact to be determined by the jury. *Id.* at 738.

The crux of the insurer's defense was the interpretation of the policy language requiring the dependent to be "attending school on a full time basis." Ms. Thomas argued that the language was ambiguous, and that accordingly she, not the insurer, was entitled to a directed verdict on the contract claim. To prove her case at trial, Ms. Thomas offered an insurance consultant with over 20 years' experience in interpreting group insurance policies as an expert witness in support of her position. The expert testified that Ms. Warren would have been considered a dependent by all other insurers within the industry, and that at least two of the insurer's claims examiners "seemed confused as to exactly what the policy language meant." The Supreme Court found no error in the admission of this testimony.

The Thomas court never directly addressed the issue of whether an expert could be called upon to testify concerning the viability of a bad faith claim. However, the court impliedly accepted this position when, in its holding, it relied upon the testimony of the expert in coming to its conclusion that "according to the custom and practice within the insurance industry, Ms. Warren should have been considered a 'dependent' within the meaning of the policy."*Thomas*, 566 So.2d at

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749. Accordingly, when read in conjunction with Alabama Rule of Evidence 702 and *Tidwell v. Upjohn Co.*, it is apparent that the Alabama Supreme Court will probably admit expert testimony offered to demonstrate the existence or non-existence of bad faith in an effort to facilitate the triers of fact in reaching their ultimate determination.

Handling objections

In many insurance bad faith cases, defense counsel will be highly protective of experts. This is especially true when the expert will testify that the defendant did no wrong, that all company policies and procedures were followed, and that the company did not violate any provisions of the state deceptive trade practices act or any other statutory or common law.

To protect its experts, defense counsel will typically make the following objections during the deposition process:

1. The question asked is beyond the scope of knowledge of this expert;

2. The expert witness is not authorized to speak for or on behalf of the company (many times this objection is interposed even when the insurance company is utilizing one of its own in-house adjusters who adjusted the claim); and

3. The question asked calls for a legal or factual conclusion, and the witness is not a lawyer.

If defense counsel tries to protect an expert or lay witness by interposing any of these objections, you have hit pay dirt.

In the first instance, if you issued your "most knowledgeable" discovery notice prior to these depositions, you will have already uncovered those individuals "most knowledgeable" about the handling of the claim under consideration in relationship to the pertinent facts and law. Since the company has designated--under that discovery rule-- the "most knowledgeable" person, defense

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counsel, in making such an objection, has made the witness out to be a mere lay witness or an uninformed "expert"--a person who, although being the most knowledgeable to speak for the company, cannot speak because he does not know the law or the facts.

One approach to use when confronted with this conduct is to follow up with a series of these questions:

1. Do you adopt the statement of your legal counsel that the question is beyond your knowledge as an expert?

2. You are not authorized to speak for the company, are you?

3. You would agree with me that you are not a lawyer or trained as a lawyer and therefore cannot and should not have made legal decisions or determinations for your company in this claim adjustment (coup de gras).

If the witness makes the appropriate responses, you will have neutralized the defense's expert witness. In the typical case, you will be suing an insurance company along with the adjuster who adjusted the claim. This individual is being put forward as one of the people most knowledgeable about the handling of the claim in relationship to the facts and the law. In a typical automobile accident, it is quite possible that this adjuster handled the investigation, set the value on the property or personal injury loss, assisted in setting the reserves for the personal injury portion of the claim, made preliminary or final determinations as to "liability," and even handled conflicts-of-law questions.

This type of witness typically claims competence to adjust the claim and perform all of those tasks; but then pleads incompetence to testify as to whether the job was performed in accordance with the law. As stated above, defense counsel will undoubtedly object that the witness is not a

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lawyer, that the question goes beyond the scope of the witness' knowledge or calls for a legal conclusion on the part of the witness. The witness will typically adopt the company lawyer's position as advocated by its legal counsel. If the witness adopts the company lawyer's objection, you have caught him and the company in a catch-22. (Caveat: If you have chosen to use a former claims adjuster from a carrier you have sued, objections will undoubtedly be based on a claim that the expert is disqualified due to his prior relationship with the carrier and that he is ipso facto in possession of privileged and confidential information.)

The work product doctrine provides that information prepared in anticipation of litigation is privileged and that courts must guard against disclosure of the mental impressions and legal theories of any party. Counsel for insurance companies argue that because your expert worked in a sensitive position with the carrier before the claim was filed or actually during the claim-handling process, he is tainted by possessing the mental impressions, legal theories, or other information prepared in anticipation of litigation in your case. Typically, claims adjusters do not have law degrees; correspondingly, such a person is generally not privy to the mental impressions and legal theories of in-house or outside legal counsel for a carrier during the claim adjustment process. In most claim adjustments, legal counsel never deal directly with claims people.

Only if the defendant can establish that your expert participated directly with legal counsel in preparing a defense to the case under consideration will the defendant have a chance to exclude your expert. Adjusters simply do not set policy and procedure for major insurance companies. Rather, policies and procedures are set at the home office by high- ranking employees who inform claims adjusters of any changes by memoranda or similar format. However, you should be able to overcome claims that your expert should be disqualified by having the expert present an affidavit

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disclaiming participation in developing any legal strategies and defenses and/or in receiving any knowledge of any mental impressions or conclusions from in-house or outside legal counsel for the carrier.

In *Davis v. Cotton States Mutual Insurance Co.*, 604 So.2d 354 (Ala. 1992), the Supreme Court of Alabama recognized the reliance on advice of an attorney as an arguable reason for denying coverage in a case. Since this is a potential way out for insurers, it is absolutely necessary that the expert-lawyer have full knowledge and command of the law in Alabama effecting his advice. On cross-examination, the plaintiff's counsel will attack the expert lawyer as to virtually every case on point, whey they were important, unimportant, and why they were relied upon. Accordingly, the expert lawyer will be called upon to defend his coverage opinion letter.

E. Exhibits -- Using the Plaintiff's Evidence to Sway Fence-Sitting Jury Members

In making the determination of whether an insurer's conduct amounted to bad faith, the trial court must limit the scope of its examination to the evidence that was before the insurer at the time of its denial of the claim. This is because an insurer is not entitled to deny a claim in the hope that it will later uncover evidence to support its denial. Accordingly, evidence that arises after the denial of the claim is not relevant to the propriety of the insurer's conduct at the time of the denial, and should not be considered by the trial court. *Nationwide Mut. Ins. Co. v. Clay*, 525 So.2d 1339, 1342 (Ala.1987). The supreme court has noted that this rule must be followed regardless of how good subsequently discovered reasons allowing denial might be. *King v. National Foundation Life Ins. Co.*, 541 So.2d 502, 505 (Ala.1989).

The Supreme Court has further stated that an insurer may be guilty of bad faith for failing to properly investigate the facts underlying a claim. *Thomas v. Principal Fin. Group*, 566 So.2d 735

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(Ala.1990). This is also true if the insurer ignores "critical" items necessary to show a "cognitive" evaluation and review. *Carter v. Old Am. Ins. Co.*, 544 So.2d 917 (Ala.1989).] Evidence of an insurer's failure to follow existing guidelines and manuals that are designed to make sure claims are handled in a uniform and predictable format will assist in meeting this burden. *See Aetna Life Ins. Co. v. Lavoie*, 470 So.2d 1060, 1074 (Ala.1985); *National Sec. Fire & Cas. Co. v. Vintson*, 454 So.2d 942 (Ala.1984). While the failure to have any guidelines may also show a reckless approach, there are cases holding that a "sloppy" investigation is not enough. *State Farm Fire & Cas. Co. v. Balmer*, 672 F.Supp. 1395 (M.D.Ala.1987), aff'd. 891 F.2d 874 (11th Cir.1990). A protracted investigation may also support the finding of bad faith. *Livingston v. Auto Owners Ins. Co.*, 582 So.2d 1038, 1043 (Ala.1991).

The Supreme Court determined that an insurer's investigation was "incomplete" and demonstrated a "reckless indifference to facts" in *USAA v.* In *Wade*, the court noted that:

This Court has held that whether an insurance company is justified in denying a claim under a policy must be judged by what was before it at the time the decision is made. *National Savings Life Ins. Co. v. Dutton*, 419 So.2d 1357, 1362 (Ala. 1982). Each of the facts discussed above was before USAA when the decision to deny the Wades' claim or would have been before USAA had it conducted a complete investigation. USAA, however, did not conduct a complete investigation. Therefore, the trial court did not err in holding that USAA acted in bad faith when it denied the Wades' claim under their homeowner's policy.*USAA v. Wade*.544 So.2d 906, 915 (Ala. 1989)

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VI. TRIAL STRATEGY - THE BEGINNING OF THE END

A. Voir Dire - The First Essential Step in Winning the Case

Voir dire is a particularly significant matter in cases involving extra-contractual claims against insurance companies. From experience or unsupported beliefs, many potential jurors harbor negative beliefs about insurance companies. These matters must be addressed head-on, and when attempting to determine if jurors have biases defense counsel for an insurer should seek individual, private questioning as regards problems with claims, prior lawsuits, insurance matters involving relatives, etc.

As in any case, simple observations can provide invaluable information in striking a jury. For example, a person's walk or their body language, particularly in response to questioning by counsel for the insurer, can provide insight. Along those same lines, counsel for an insurance company must be careful to remember that he or she will be placing a face on an insurance company which may be faced with biases as described above.

As in any case, defense counsel will probably want to address whether any of the prospective jurors or family

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members have been involved in prior litigation, have ever served on a jury, have submitted insurance claims, have had "problems" with an insurance company, has any legal training, etc. Defense counsel will have the luxury of questioning the jurors second. This is a luxury because counsel can limit basic questions since much of the information will have already been obtained through juror qualification and plaintiff's attorney's questioning thus allowing defense counsel to be brief, precise, and case-specific.

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B. Opening Statements

Various commentators have opined that a majority of jurors make up their minds about a case during opening statements. Whether this is absolutely true or not, the opening statement remains the most important aspect of the case. Defense counsel can use the opening statement to educate and condition the jurors regarding the case and various nuances about insurance matters which are generally not part of one's common knowledge. Moreover, the opening statement will set the tone for all future proof.

An effective opening statement requires a complete knowledge of the facts involved in the case. There is no substitute for having a complete grasp of all testimony and facts gleaned from documents which then allows the attorney to present a simple, clear outline of the case and respond immediately to remarks of the plaintiff's attorney.

Again, counsel for an insurance company will be the face the jury associates with the defendant carrier primarily during the trial. In order to humanize, the attorney should explain legal theories and factual matters in lay terms as opposed to "legalese". Moreover, instead of simply describing what the evidence will show, it is important to show the evidence through the use of exhibits. Distrust of insurance

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companies can be diminished through an appropriate appearance and statement of defense counsel.

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C. Order of Witnesses

As in any case, the order of witnesses will be determined in large part by the proof submitted by the plaintiff. Nonetheless, in any extra-contractual insurance matter it is likely that the insurance carrier's representative will be called as an adverse witness. The witness must be prepared to respond and defense counsel must, in most cases, be prepared to conduct a direct examination at that time. It is, generally, very effective to submit as much defense evidence as possible during the plaintiff's case.

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D. Use of Expert; Advice of counsel

Since many jurors have some mistrust or lack of understanding of the insurance industry, the use of expert witnesses is imperative. It is very important to educate the jury as to general practices of the industry so that claimed misconduct on the part of the defendant will not be seen as some aberration made solely to injure the plaintiff. In cases involving whether or not a claim should have been paid an expert claims person can frequently give a more complete explanation of the handling of the claim since he or she will have the benefit of all evidence developed during the discovery process.

As indicated above, advice of counsel is not a complete defense to a bad faith allegation. However, it is evidence of good faith. As discussed previously, pleading advice of counsel as a defense will likely require that the pre-suit counsel withdraw and serve as an expert witness. Many point to the old adage that lawyers make poor witnesses; however, frequently lawyers called upon to provide advice to insurance companies are themselves trial attorneys and are, therefore, much more comfortable in providing testimony in a courtroom setting.

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E. Exhibits -- Using the Plaintiff's Evidence to Sway Fence-Sitting Jury Members

Frequently, insureds will have completed applications in their own handwriting, submitted personal claim forms, or documented a loss through photographs, videotapes, etc. This evidence often supports the defenses and, therefore, it should be brought to the attention of the jury at every available opportunity.

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F. Closing Arguments

Closing arguments are generally considered the most fun or exciting part of the trial for the trial attorney. Nonetheless, as outlined above, an opening statement may be the most important time the attorney gets to speak to the jury. An attorney probably will not win a case with an outstanding closing argument. However, the attorney can assist the jurors in providing them with an outline and specific examples supporting the defense which can be used during deliberations. Again, defense counsel will want to personalize the corporation. From the outset, the defendant will want to have a nice corporate representative if possible. Also, it is frequently effective to bring effective witnesses back into court during the closing argument. Also, counsel should always remember to remind the jury that the plaintiff will have the last say during closing arguments.

In extra-contractual actions, the plaintiff will likely want to shock the jury with the claimed outrageous conduct of the insurance company. Defense counsel must respond with a complete, reasoned story which will allow the jury to see the "whole picture". Again, this requires a complete grasp of the facts involved in the case.

Also, as outlined above, the legal burden of proof in a

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bad faith claim is quite high. Defense counsel should remind the jury that to recover for bad faith plaintiff must prove an intent to injure on the part of the defendant. Sloppy claims handling, poor claims handling, disorganization, and the like, do not equal bad faith.

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