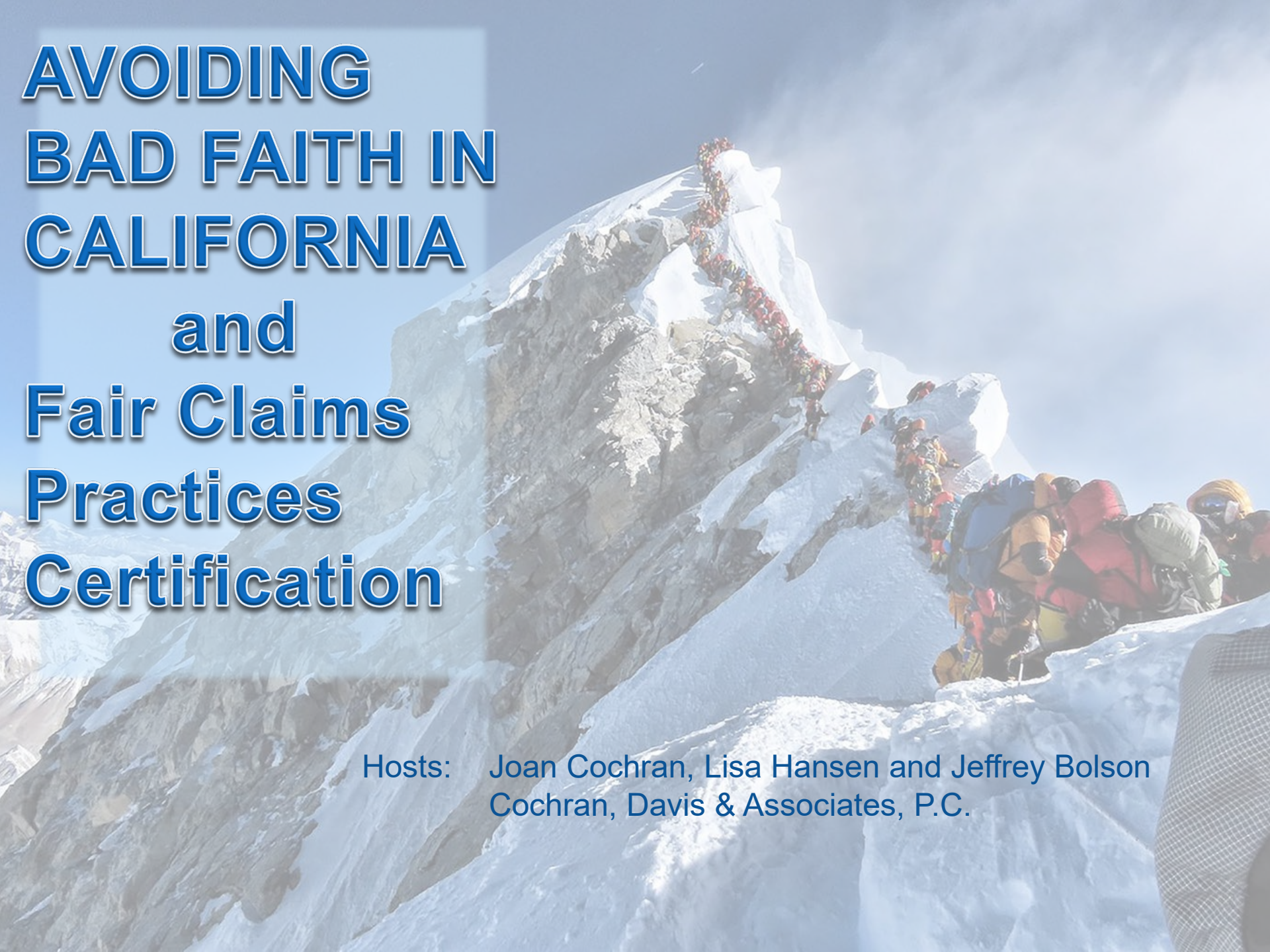

AVOIDING BAD FAITH IN CALIFORNIA and Fair Claims Practices Certification

Hosts: Joan Cochran, Lisa Hansen and Jeffrey Bolson
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Cutting Edge Trends in California

- What is Bad Faith?
- Defenses to Bad Faith
- Implement Proper Claims Handling Practices
- Evaluate California Fair Claims Practices Regulations

Timing is Everything

Jury Awards $4 Million in Punitive Damages against GEICO in Bad Faith Case For Failing to Pay the Policy Limit of $50,000 for an Underinsured Motorist Claim by its Insured

***Mazik v. GEICO*, 36 Cal.App.5th 455 (2019)**

- A jury concluded that GEICO unreasonably delayed paying its policyholder Mazik the policy limits of $50,000 on an underinsured motorist claim after Mazik was injured in a serious automobile accident.
- The jury awarded compensatory damages of $313,508 and punitive damages in the amount of $4 million. The trial court subsequently reduced the punitive damages to $1 million.

GEICO's Appeal

- GEICO appealed a judgment for $4 Million in punitive damages for bad faith breach of the insurance contract. The jury concluded that GEICO unreasonably delayed paying the policyholder Mazik the policy limits of $50,000 on an underinsured motorist claim after the insured, Mazik, was seriously injured in an auto accident.
- GEICO argued (1) the evidence was insufficient to show that any "officer, director, or managing agent" was involved in any act of bad faith as required under Civil Code Section 3294(b), (2) the evidence was insufficient to show the officer, director or managing agent was personally engaged in "oppression, fraud or malice" or authorized or ratified such conduct by an employee, and (3) the punitive damage award was excessive.

Underlying Facts

- Mazik had been severely injured as a result of a head-on collision while driving on a highway in Riverside County. As a result of the collision, Mazik was diagnosed with a "grossly comminuted fracture of the left calcaneus," i.e., heel bone.
- The insured's expert Dr. Tauber opined that Mazik faced a lifetime of chronic pain and issues related to his heel injury. Essentially, as a result of the accident, his heel bone had exploded into numerous pieces preventing surgery to repair the bone. As such, Mazik was in constant pain.

Medical Evidence

- The insured's expert Dr. Tauber opined that surgery was not a good option for Mazik because Mazik's bone had "burst into too many pieces."
- The best option was the treatment that Mazik had received, which was to splint him until the fracture healed in "whatever deformed state" and consider a fusion in the future if "you can't take the pain."
- Dr. Tauber testified it was his opinion that Mazik would "have a lifetime of chronic pain and issues related to" his heel injury.

Insured's Settlement Offer

- Mazik received $50,000 from the insurer for the driver of the other car who was at fault in the accident. That sum amounted to the full value of the driver's policy.
- On December 31, 2009, Mazik's attorney submitted a UIM claim to GEICO under Mazik's auto policy which had a policy limit of $100,000.
- The letter included medical records and Mazik's treatment to date, along with other supporting documentation. In light of the severity of the damages and the residual effects of the injuries, the letter requested compensation of $50,000, representing the full policy amount with an offset of the $50,000 payment Mazik already received.

GEICO's Settlement Offer

- In response, GEICO initially offered $1,000 to settle Mazik's UIM claim. However, GEICO's evaluation of such claim omitted important information from the medical records that Mazik provided to GEICO. Thereafter, in September 2010, GEICO increased its settlement offer to $13,800. Four months later, on January 22, 2011, GEICO increased its offer to $18,000. GEICO's independent medical examiner found that Mazik did not need surgery and his injuries did not restrict his occupation as a teacher, such that no further medical care was needed. Thereafter, GEICO served a statutory offer to compromise Mazik's claim for $18,887.
- Mazik rejected the offer and reasserted his demand for policy limits. GEICO did not make any additional settlement offers. The regional liability claims administrator, Grothen, explained that GEICO declined to do so, even though he had authorized payment of more money, because there was no negotiation from the other side. GEICO refused to "bid against itself" to settle the claim.

Arbitration and Jury Award

- On August 31, 2012, notwithstanding receiving additional medical records in support of Mazik's claim, GEICO authorized such claim to move to arbitration. Thereafter, in April 2013, the arbitration took place and Mazik was awarded the full policy limits of $50,000.
- Subsequently, he filed a bad faith action against GEICO. After a jury trial, an award of compensatory damages was made in favor of Mazik in the amount of $313,508. In addition, an award of punitive damages in the amount of $4 million (reduced to $1 million) was also imposed on GEICO.

Court of Appeal Ruling on Employee as Managing Agent

- In affirming the judgment against GEICO, the Court of Appeal held that regional liability claims administrator, Grothen, acted as a managing agent on behalf of GEICO who ratified GEICO's wrongful conduct of evaluating the claim based on a selective review of medical records.
- The Court of Appeal defined an employee as a managing agent "if he or she exercises substantial independent authority and judgment in his or her corporate decision-making such that his or her decisions ultimately determine corporate policy."

Adjuster Omitted Material Facts

- The GEICO claims adjuster admitted that GEICO's initial claim evaluation summary omitted important information that appeared in Mazik's medical records.
- The omitted information included that (1) Mazik was still on crutches and had a cast several weeks after his accident; (2) Mazik had back pain despite no history of back problems; (3) the fracture to Mazik's calcaneus (i.e., heel bone) was "severe"; (4) as of January 20, 2009, over five months after the accident, Mazik's symptoms were worse with walking and he had significant discomfort in his cast and was medicating with Vicodin and Ibuprofen; (5) Mazik had limited joint motion nearly three months after the accident; (6) Mazik's pain level had decreased by November *only* when he was not using his foot, not in general as the summary implied; and (7) as of the end of December 2008, Mazik still had current pain complaints and functional limitations and was continuing physical therapy.

Adjuster Trivialized Treatment

- Another pre-arbitration summary dated June 12, 2012, noted as "strengths of case" that there had been "no medical treatment since May 2009, then went back to a Dr. Yee for 5 visits between 1/10/12 and 3/23/12. This appears to be for fitting of shoes." This summary grossly trivialized Dr. Yee's diagnosis and treatment.
- Dr. Yee's records showed that special shoes were not simply a convenience, but were necessary because of ongoing "problems walking and working due to the pain."
- They noted that Mazik has "undergone significant trauma to the left heel and foot which has resulted in a rearfoot deformity." While a New Balance shoe helped to solve this problem to a "great degree," Mazik was "still having problems due to a sensation that he is inverted." Orthotics were necessary for a "persistent sensation of falling to the outside" that "appears to be overwhelming him."

Bad Faith to Ignore Facts that Support a Claim

- "An insurer is not permitted to rely selectively on facts that support its position and ignore those facts that support a claim. Doing so may constitute bad faith." (*Wilson v. 21st Century Ins. Co.*; *Maslo v. Ameriprise Auto & Home Ins.*)
- When sufficiently egregious, an insurer's intentional disregard of facts supporting a claim also meets the standard for punitive damages. (*Egan v. Mutual of Omaha Ins. Co.*)
- Viewing the record in light of the substantial evidence standard, the jury reasonably could have found that Grothen ratified such egregious conduct in approving settlement offers that ignored Mazik's serious and permanent injuries."

Appellate Court Ruled:

- We reject GEICO's arguments and affirm. There is sufficient evidence in the record to show that GEICO's managing agent ratified conduct warranting punitive damages.
- In concluding that Mazik's claim was worth far less than the policy limits, GEICO disregarded information provided by Mazik showing that he had a permanent, painful injury, and instead selectively relied on portions of medical records that supported GEICO's position that Mazik had fully recovered.
- As reduced by the trial court, the $1 million in punitive damages (approximately three times the amount of compensatory damages) is within the constitutionally permitted range in view of the degree of reprehensibility of GEICO's conduct.

Adjuster who denied a claim and failed to consider all material evidence

Main Areas of Bad Faith

- Defenses to Claims of Bad Faith
- Failure to Conduct a Thorough Investigation
- Delay Payment of Legitimate Claim
- Improper Denial of a Claim
- Failure to Settle Within the Policy Limits
- Fair Claims Practices Certification

Can An Insurer in California Choose to only Defend Covered Claims?

1. Yes, as long as the insurer issues a reservation of rights letter to the insured stating it will not defend excluded claims.
2. No, the insurer must defend both covered and excluded claims and issue a reservation of rights to the insured to reserve coverage defenses.

Reservation of Rights to Reserve Coverage Defenses

An insurer may agree to defend a suit subject to a reservation of rights. (*Truck Ins. Exchange v. Superior Court*, 51 Cal.App.4th 985, 994 (1996).) In this manner, an "insurer meets its obligation to furnish a defense without waiving its right to assert coverage defenses against the insured at a later time." (Croskey et al., Cal. Practice Guide: Insurance Litigation (The Rutter Group 2000) ¶ 7:723, p. 7B–61.) As stated 35 years ago, "if the insurer adequately reserves its right to assert the noncoverage defense later, it will not be bound by the judgment. If the injured party prevails, that party or the insured will assert his claim against the insurer. At this time the insurer can raise the noncoverage defense previously reserved." (*Gray v. Zurich Insurance Co.*, 65 Cal.2d 263 (1966).)

What are the Defenses to Allegations of Bad Faith?

1. Statute of Limitations
2. Policy Provision Limiting Time to Sue
3. Advice of Counsel
4. No coverage due to insured's conduct that contributed to the loss
5. Genuine Dispute Doctrine
6. Collusion by the Insured

(a) None of the Above
(b) All of the Above
(c) 1., 2., and 3. Only
(d) 4., 5., and 6., Only

Applicable Statute of Limitations

- 2-year statute of limitations for breach of the implied covenant of good faith and fair dealing. The applicable statute is determined by the nature of the action, not by the damages sought. Thus, although emotional distress and punitive damages may be sought, breach of implied covenant actions are subject to the 2-year statute applicable to tort actions generally. [*Richardson v. Allstate Ins. Co.* (1981) 117 CA3d 8, 13, 172 CR 423, 426; *Smyth v. USAA Prop. & Cas. Ins. Co.* (1992) 5 CA4th 1470, 1477, 7 CR2d 694, 698]

- 3-year statute for claims based on fraud or mistake (CCP § 338(d))

- 4-year statute of limitations for breach of contract. By suing on a breach of contract theory, the insured may obtain the benefit of a longer statute of limitations. The action will be governed by CCP § 337, which provides a 4-year limitations period for actions "upon any contract, obligation, or liability founded upon an instrument in writing." [*Frazier v. Metropolitan Life Ins. Co.* (1985) 169 CA3d 90, 101, 214 CR 883, 889; *Archdale v. American Int'l Specialty Lines Ins. Co.* (2007) 154 CA4th 449, 471-472, 64 CR3d 632, 651-652]

Policy Provisions Limiting Time to Sue

- The insurance policy may contain provisions limiting the time to sue the insurer to a shorter period than the statute of limitations. Such provisions "create enforceable contractual limitations periods for bringing suit on an insurance contract." [*Wetzel v. Lou Ehlers Cadillac Group Long Term Disability Ins. Program* 222 F.3d 643, 647-648 (9th Cir. 2000)(en banc) (applying Cal. law).]
- For example, the statute of limitations may require suit to be commenced within four years after a claim for benefits is denied, whereas the policy may require suit to be commenced within three years after notice or proof of loss. [See *Wetzel v. Lou Ehlers Cadillac Group Long Term Disability Ins. Program*, 222 F.3d at 650.]

Advice of Counsel Defense

An insurer may offer proof that it acted in good faith reliance on advice of competent counsel for several purposes in bad faith litigation:

— to negate allegations that it acted in "bad faith" toward its insured;

— to negate that it had the requisite scienter or other state of mind required for any alternative tort claim based on its handling of the case (fraud, intentional infliction of emotional distress, etc.); and

— to negate claims that it acted with the requisite "oppression, fraud or malice" for an award of punitive damages.

G. Insurer's Reliance on Advice of Counsel, California Practice Guide: Insurance Litigation Ch. 12D-G

No Coverage due to Insured's Own Acts which Contributed to the Loss

- Where the insured's own acts have contributed to a loss, the insurer may raise certain affirmative defenses based on such acts. Alternatively, the insurer may file a *cross-complaint* or a *separate suit* against the insured. Acts by the insured that breach policy provisions may give rise to a contract action; and intentionally fraudulent conduct may give rise to an action for tort damages.
- Evidence of the insured's failure to comply with policy conditions may establish contract defenses to a bad faith action, e.g., acts constituting a *breach of the cooperation clause* or other express obligation under the terms of the insurance policy may void coverage entirely; and without coverage, there can be no liability for bad faith on the part of the insurer. *Kransco v. American Empire Surplus Lines Ins. Co.*, 23 Cal.4th 390 (2000).

Genuine Dispute Doctrine

- "Before an insurer can be found to have acted in bad faith for its delay or denial in the payment of policy benefits, it must be shown that the insurer acted unreasonably or without proper cause." (*Jordan v. Allstate Ins. Co.*, 148 Cal.App.4th 1062, 1072 (2007).) "Where there is a genuine issue as to the insurer's liability under the policy for the claim asserted by the insured, there can be no bad faith liability imposed on the insurer for advancing its side of that dispute. (Citation.)" (*Id.*) "The 'genuine dispute' doctrine may be applied where the insurer denies a claim based on the opinions of experts." (*Fraley v. Allstate Ins. Co.*, 81 Cal.App.4th 1282, 1292 (2000).)

Genuine Dispute Doctrine as a Defense And Testimony that Prevents the Defense

- Under California law, expert testimony does not automatically insulate insurers from bad faith claims based on biased investigations under genuine dispute rule if:

(1) the insurer is guilty of misrepresenting the nature of the investigatory proceedings,

(2) the insurer's employees lie during the depositions or to the insured;

(3) the insurer dishonestly selects its experts;

(4) the insurer's experts are unreasonable; and

(5) the insurer fails to conduct a thorough investigation.

Make Sure You Select Competent Unbiased Experts

- An insurer is not entitled to summary judgment when there is evidence that the insurer's investigation and experts are biased. (*Wilson*, 42 Cal.4th at 719; *Brehm v. 21st Century Insurance Company*, 166 Cal.App.4th 1225, 1240 (2008).
- Confirm procedures for hiring an "approved panel expert."

Hiring Experts

- To maintain the genuine dispute doctrine as a defense , an expert hired should not be a "hired gun."
- Make sure the practice and procedures for hiring experts reflect the need to hire reputable experts with the proper background and experience to reach a well-reasoned opinion based upon the evidence.
- Avoid using vendor lists and hiring the same experts.
- Make sure the expert has a background of testifying for both the policyholder and the insurer.
- Using the same experts over and over again to review claims and defend the insurers will likely establish a pattern of bias in the expert's work.
- Goal: to show the expert is truly "independent" of the insurer, and not a hired gun.

Collusion by the Insured

- When a liability insurer fails or refuses to defend an action against its insured, the insured may settle directly with the third party claimant, including a stipulated judgment with a covenant not to execute. The stipulated judgment is not binding on the insurer, however, if "the settlement was unreasonable, or the product of fraud or collusion." [*Pruyn v. Agricultural Ins. Co.,* 36 Cal.App.4th 500, 515 (1995).]
- "In this context, collusion occurs when the insured and the third party claimant work together to *manufacture a cause of action* for bad faith against the insurer or to *inflate the third party's recovery* to artificially increase damages flowing from the insurer's breach ... The insurer may raise collusion as a defense in a subsequent bad faith action." [*Safeco Ins. Co. of America v. Parks,* 170 Cal.App.4th 992, 1013-1014 (2009); see also, *In re Estate of Prindle,* 173 Cal.App.4th 119, 134 n. 3 (2009).]

Relevant factors: In determining whether the insured's settlement with the third party is collusive, courts may consider various factors, including:

- — the amount of the overall settlement in light of the value of the case;
- — a comparison with awards or verdicts in similar cases involving similar injuries;
- — the facts known to the settling insured at the time of the settlement;
- — the presence of a covenant not to execute as part of the settlement; and
- — the failure of the settling insured to consider viable available defenses." [*Andrade v. Jennings,* 54 Cal.App.4th 307, 331 (1997); see *Safeco Ins. Co. of America v. Parks*, 170 Cal.App.4th at 1013.]

You receive a deposition notice for a claim you denied three years ago. You do not remember the claim. You read the claim file and the coverage opinion from coverage counsel to prepare. In deposition you are asked what you read to prepare for your deposition and you testify that you read coverage opinion.
Can the attorney ask you to produce coverage counsel's reports?

A. No, because Counsel's coverage opinion letter is subject to the attorney-client privilege.
B. Yes, because you read it in preparation for your deposition.

Documents used to Refresh Memory Must Be Produced At Deposition

- Evidence Code Section 771 provides if a witness, "either while testifying or prior thereto, uses a writing to refresh his memory with respect to any matter about which he testifies, such writing must be produced… at the request of the adverse party." Moreover, opposing counsel cannot refuse to produce documents shown to deponent (party or non-party) to refresh his or her recollection in preparation for the deposition. (*International Ins. Co. v. Montrose Chemical Corp.*, 231 Cal.App.3d 1367, 1332-1333 (1991).) As you can glean, there is no easy way to reconcile the two competing interests.

True or False

The Insurer Owes a Fiduciary Duty to the Insured.

1. False, while there is a special relationship between the insurer and the insured, there is not a fiduciary relationship because the insurer does not need to disregard its own interests.
2. True, the insurer through insurance industry practice and California law has a fiduciary duty to segregate their coverage investigation from their liability claims handling.

Failing to Conduct a Thorough Investigation

To protect the insured's peace of mind and security "an insurer cannot reasonably and in good faith deny payments to its insured without thoroughly investigating the foundation of its denial." *Egan*, 24 Cal.3d at 819; *Wilson*, 42 Cal.4th at 721.

"For the insurer to fulfill its obligation not to impair the right of the insured to receive the benefits of the agreement…it is essential that an insurer fully inquire into possible bases that might support the insured's claim." *Egan*, 24 Cal.3d at 819.

A jury could find that the insurer acted unreasonably, and hence in bad faith, when the insurer denies a claim "on a basis unfounded in the facts known to the insurer, or contradicted by those facts." (*Wilson*, 42 Cal.4th at 720.) A jury can also find that the insurer acts unreasonably if it ignores evidence available to it that supports the claim. (*Id.*) "The insurer may not just focus on those facts which justify denial of the claim." (*Id.*).

An insurance company's duty to conduct a thorough investigation may include the duty to interview witnesses. *Downey Sav. & Loan Ass'n v. Ohio Cas. Ins. Co.*, 189 Cal.App.3d 1072, 1084 (1987).

What is a Reasonable Investigation?

- Reasonableness of the investigation is determined by what was known or reasonable available to the insurer, and not based on hindsight or subsequent retentions of experts.
- What other investigation could have been done and confirm why it was not done.
- Was it reasonable not to have done a further investigation.

Delay or Unreasonable Withholding of Benefits

"[W]hen benefits are due an insured, 'delayed payment based on inadequate or tardy investigations, oppressive conduct by claims adjusters seeking to reduce the amounts legitimately payable and numerous other tactics may breach the implied covenant because' they frustrate the insured's right to receive the benefits of the contract in 'prompt compensation for losses.'" *Waller v. Truck Ins. Exch.*, 11 Cal.4th 1, 36 (1995) (emphasis added)

When the insurer unreasonably and in bad faith withholds payment of the claim of its insured, it is subject to liability in tort." (*Wilson v. 21st Century Ins. Co.*, 42 Cal.4th 713, 720 (2007).) The "withholding" referenced in the foregoing sentence means either refusing to pay the claim outright, or delaying payment of the claim. (42 Cal.4th at 723 [an insurer's unreasonable denial of or delay in paying benefits gives rise to tort damages].)

Recent Bad Faith Jury Verdict

Lopez v. National General Assurance

- On December 22, 2017, Plaintiff Octavio Lopez suffered a fire loss to his RV. On that same day, Plaintiff made a claim to his insurance company, National General Assurance Company for his loss. After providing defendant with all information requested, and participating in an Examination Under Oath, plaintiff's claim was denied based on alleged misrepresentations made during the claim.

Plaintiff asserts that initially, National General received a fire investigator report that the cause of the fire was electrical and there was no sign of arson. Plaintiff claims that it was only after National General discovered Plaintiff had an endorsement on his insurance policy which covered the loss potentially up to the purchase price of the RV, that National General sought another inspection and suddenly concluded that the fire was intentionally caused by the action of an unknown person. Plaintiff argued that the EUO was conducted solely to find reasons to deny his claim and was used for the sole purpose of manufacturing and fabricating material misrepresentations so that the insurer would deny the claim.

Plaintiff contends that National General failed to follow the California Fair Claims Act and acted with malice, oppression or fraud during the claims handling, investigation and ultimate denial.

Defendant contends that it reasonably relied on expert reports, independent witnesses and statements made by plaintiff during the investigation and claims handling. Defendant contends that its decision to deny the claim based on material misrepresentations plaintiff made concerning the facts of loss was reasonable and that it did not violate the California Fair Claims Act and did not act with malice, oppression or fraud.

Plaintiff asserts he suffered loss of RV and emotional distress

- The jury found in favor of plaintiff and awarded $8,463,833. This sum was comprised of $147,333 in insurance benefits withheld by defendant, $250,000 in past non-economic damages, $66,500 in future non-economic damages and $8 million in punitive damages.

Misrepresenting The Nature Of The Investigation

Bad faith may exist stemming from misrepresentations by the insurer when communicating with the insured regarding the investigation. *Tomaselli v. Transamerica Ins. Co.*, 25 Cal.App.4th 1269, 281 (1994).

"The mere conducting of an EUO evidenced bad faith: EUO's are ordinarily administered to investigate fraudulent claims, and Watanabe ordinarily did not use EUO's early in an investigation. However, use of the EUO was early here, and was recommended just two weeks after Watanabe had commented that he believed Tomasellis were "not previously aware of any soils-related distress." Moreover, Watanabe misled Tomasellis about the EUO, since (1) he assured them it was a simple procedure to help settle the claim, (2) he dissuaded them from having an attorney present, and (3) he failed to inform them that the purpose of the EUO was to search for information of policy violations." *Id*.

Disclose Purpose for Information Being Requested and Provided

Make sure the claim file, correspondence, or oral communications with the insured demonstrate you are not hiding any issues.

Full disclosure in reservation of rights letter if investigating rescission issues.

Only exception under the California Regulations if investigating fraud.

What can an Insurer Consider When Evaluating a Settlement Offer in a Personal Injury Lawsuit?

1. Whether or not the claim is covered under the Policy.
2. The Policy Limits.
3. A desire to reduce the amount of future settlements.
4. Whether, in light of the victim's injuries and the probable liability of the insured, the ultimate judgment is likely to exceed the amount of the settlement offer.

A. 1. and 2.
B. All the Above.
C. 4 Only.
D. 3 Only.

Johansen

- *Johansen* involved an insured that was sued as a result of an automobile accident. In *Johansen* the court found that the insurer refused to settle in bad faith when, faced with a substantial likelihood of an excess judgment, the insurer refused to settle within policy limits.

- The insurer did not settle because it believed that the automobile accident was not covered by the terms of the policy. Although the insurer had a good faith basis to believe that coverage was not afforded under the policy, the outcome of a declaratory relief action determined that the insured's policy did, in fact, cover the accident. The court found that liability will attach even where the denial of coverage was made in good faith. *Id.* at 13.

- Such factors as:
[1] the limits imposed by the policy,
[2] a desire to reduce the amount of future settlements, or
[3] a belief that the policy does not provide coverage,
should not affect a decision as to whether the settlement offer in question is a reasonable one." (*Id*., at p. 16, italics added.)

- The court did, however, expressly reserve in a footnote the question of the extent that a coverage dispute might be taken into account by an insurer in a case where there were *multiple claims* asserted by the insured, some of which were indisputably *not covered*.

Johansen also expressly described the standard that is to be applied to determine if a settlement offer is "reasonable":

"[T]he *only permissible* consideration in evaluating the reasonableness of the settlement offer becomes whether, in light of the victim's injuries and the probable liability of the insured, the ultimate judgment is likely to exceed the amount of the settlement offer."

Johansen

- The *Johansen* court found that an insurer must weigh the interests of the insured with equal weight as its own when evaluating a reasonable settle demand. To that end, the court said,

- " California authorities establish that an insurer who fails to accept a reasonable settlement offer within policy limits because it believes the policy does not provide coverage assumes the risk that it will be held liable for all damages resulting from such refusal, including damages in excess of applicable policy limits." *Id.* at 13.

Can Refusal to Settle be in Bad Faith if No Exposure to an Excess Judgment?

1. Yes
2. No

Yes!

- In *Bodenhamer v. Superior Court*, 192 Cal.App.3d 1472 (1987), the court found that an insurer may be sued for bad faith where there was no exposure to an excess judgment. In that case, the insured, a jewelry store was robbed. As a result of the robbery, the insured submitted a claim for third party actions against it and also a claim for the stolen jewelry.
- The insured alleged that the insurer knew that the claims were valid, but still deliberately delayed payment to the insured. The insurer argued that liability could only be found where there was an unreasonable refusal to settle *and* an excess judgment. However, the court refused this position. The court permitted the insured to bring a bad faith action for refusal to settle even without an excess judgment.

Can Insurer Consider Coverage When Evaluating Settlement in Mixed Action?

- In *Camelot By The Bay Condominium Owners' Association, Inc. v. Scottsdale Insurance Company,* 27 Cal.App.4th 33 (1994), the insured tendered its defense to Scottsdale who agreed to defend Breihan under a reservation of rights. Scottsdale believed that certain construction defects alleged by Camelot were not covered under the policy. However, Scottsdale did not bring a declaratory relief action against Breihan on these coverage issues. Camelot initially demanded $300,000 to settle the underlying dispute. The defense attorney for Breihan, hired by Scottsdale, informed Scottsdale that in her opinion any judgment against Breihan would likely exceed $300,000. Thus, defense counsel requested $300,000 in settlement authority. Scottsdale refused to settle.

1. Yes
2. No

ANSWER: YES!

- **It appears that the court found there was no bad faith in *Camelot By The Bay* because the court recognized that some of the claims actually were not covered.** Thus, the court distinguished that factual scenario from *Johansen* and *Communale* because in those cases it was determined that coverage actually did exist under the policy. Thus, *Camelot By The Bay* can still be read in harmony with prior case law which found that an insurer denies coverage at its own risk. The court said,

- "In *Comunale, Johansen,* and *Samson*, the basic coverage dispute was whether the particular vehicle involved in the accident was covered at all by the policy; that is a very similar basic coverage problem to that involved here, whether particular property damage fell at all within the scope of the policy provisions. However, in those cases, coverage was found; **in this case, only partial coverage existed**" *Camelot By The Bay,* at 34 footnote 8.

Did the Insurer Act in Bad Faith By Failing to Effectuate Settlement in Absence of a Settlement Demand When Liability is Clear?

A. Yes.

B. No.

Does the Insurer Has the Duty to Effectuate Settlement?

- ***Du v. Allstate Insurance Company, No. 10-56422 (9th Cir. June 11, 2012).***
- 9th Circuit: Good Faith and Fair Dealing Requires Insurer to Settle When Liability Is Clear
- The Ninth Circuit held that even in the absence of a settlement demand an insurer has a duty to effectuate settlement in instances where liability is reasonably clear under the implied covenant of good faith and fair dealing of California law. The lower court had ruled that a jury instruction stating this principle of California Law was incorrect and should not be used in the circumstance presented. The Ninth Circuit reversed the ruling that the statement of the law was incorrect, but determined that the lower court had not abused its discretion in disallowing the jury instruction based on the facts in question.

In October, 2012, Du case Amended, So Is there a Duty of the Insurer to Initiate Settlement Talks?

- On October 5, 2012, the Ninth Circuit issued a further amended opinion expressly refusing for now to determine whether breach of the covenant of good faith duty to settle has occurred without there first being a settlement demand within limits. As a result, *Du* may no longer be cited for this proposition that the insurer must effectuate settlement in the absence of a demand when liability is clear. There is still uncertainty which remains as to whether an insurer can be exposed to liability under California law for breach of the covenant of good faith and fair dealing if it fails to settle in the absence of a within limits settlement demand.

- Insurers should take a Proactive Approach when liability is clear.

California Fair Claims Practices Certification

FAIR CLAIMS PRACTICES REGULATIONS

- History and Scope
- Preamble
- Definitions
- Record Keeping
- Representations of Policy Provisions and Benefits
- Duties Upon Receipt of Claim
- Training and Certification
- Standards for Prompt Fair and Equitable Settlements
- Penalties

FAIR CLAIMS PRACTICES REGULATIONS

- History
  - First took effect on January 14, 1993
    - » Amended Twice (1) May 10, 1997 (2) July 23, 2003
    - » All insurers including non-admitted insurers must "adopt and communicate" to all claims agents, written standards for prompt investigation and processing of claims and shall do so within 90 days after the effective date of the regulations or revisions.
  - Why Regulations Implemented?
    - Royal Globe (1979)
    - Moradi Shalal (1988)
    - Response to Proposition 103
    - » Ray Bouhris sued Insurance Commissioner Gellespie and Department of Insurance to enforce regulations
    - » Garamendi wanted more stringent regulations:

    (1) Annual certified reports showing number of : claims, denials, settlements, claims against insurers, fraudulent claims, timely responses, claims where additional time requested, timely payments.

Violations of the Insurance Code Can Serve as Basis for Cause of Action Against Insurer

It is true that Moradi-Shalal v. Fireman's Fund Ins. Companies, 46 Cal.3d 287 bars private causes of action based on section 790.03. But violations of the section "may evidence the insurer's breach of duty to its insured under the implied covenant" of good faith and fair dealing with its insured. (Croskey et al., Cal. Practice Guide: Insurance Litigation, *supra,* P 14:45.21, p. 14-15.)

In Hughes v. Progressive (July 2011) the Appellate Court ruled Progressive's failure to apprise insured of his right to choose his own repair shop was a violation of the Insurance Regulations. Such Violation served as a predicate to the insured's cause of action for Unfair Competition against Progressive.

FAIR CLAIMS PRACTICES REGULATIONS

- Scope
  - Applies to all insurers including non-admitted insurers
  - Applies to sureties
  - Surplus Lines broker considered licensee and/or claims agent
  - Attorneys handling and settling claims considered claims agent
  - Insurers retaining adjusters subject to regulations
  - Insurers with no hands on involvement must "adopt and communicate to insurance agents the standards for prompt investigation and processing of claims."
  - Agents and brokers subject to the regulations, even if activities are receiving and transmitting notices of a claim. Therefore must:

    (1) Send notices of claim immediately but no later than 15 days to the insurer

    (2) Must provide training to individuals responsible for transmitting such notices

    (3) Must maintain records of claims handling activities and respond to Insurance Commissioner inquiries

FAIR CLAIMS PRACTICES REGULATIONS

- Preamble (Section 2695.1)
  - To delineate minimum standards for the settlement of claims which if violated knowingly on a single occasion or repeatedly constitute an unfair claims settlement practice under Insurance Code Section 790.03(h)
  - To promote "good faith, prompt, efficient and equitable" settlements on a cost effective basis
  - To discourage the filing of fraudulent claims
  - To encourage prompt investigation of fraudulent claims

How do you treat the insured when Handling their Claim?

1. I give the insured as much consideration as I do the insurer's interest when I investigate, process and settle claims.
2. I make sure our policy provisions when investigating, processing and settling claims are consistent with insurance regulations or more favorable to the insured.
3. I only pay legitimate claims.

FAIR CLAIMS PRACTICES REGULATIONS

- Misconduct of claims agent can be imputed to insurer
  - » Therefore, insurer should make sure every entity that investigates, handles or settles California claims complies with these regulations
  - » Example: Regulations require insurer and non-admitted insurers to:

    (1) Refrain from using polygraph tests unless authorized by the policy. Must however still comply with state and federal rules regarding polygraph tests

    (2) Refrain from requiring unnecessary medical examinations

FAIR CLAIMS PRACTICES REGULATIONS

- The Preamble of the Regulations state:
  - "Policy provisions relating to the investigation, processing and settlement of claims shall be consistent with or more favorable to the insured than the provisions of these regulations."

FAIR CLAIMS PRACTICES REGULATIONS

- Types of insurance exempted:
  - Workers Compensation
  - Liability insurance for the professional malpractice of health care providers (clinic, dispensary or health facility)
  - ERISA plans

FAIR CLAIMS PRACTICES REGULATIONS

- Types of Insurance newly subject to the Regulations:
  - Sureties (before treated separately)
  - Home Protection Contracts and Home Protection Companies
  - Medical Malpractice (no longer excluded)

FAIR CLAIMS PRACTICES REGULATIONS

- **Definitions (Section 2695.2)**
- **"Claimant" means a first or third party claimant**
- **"Licensee" means "any person that holds a license. . . . or other entity for whom the Insurance Commissioner's consent is required before transacting business in the state . . ."**
- **"Notice of Claim"**
  - **"any written or oral notification to an insurer or its agent that reasonably apprises the insurer that the claimant wishes to make a claim against a policy . . . and that a condition giving rise to the insurer's obligations under that policy may have arisen." It shall not include "any written or oral communication provided by an insured . . . solely for informational or incident reporting purposes."**

FAIR CLAIMS PRACTICES REGULATIONS

- **Definitions (cont.)**
  - **"Insurer" means "a person licensed to issue or that issues an insurance policy or surety bond in this state, or that otherwise transacts the business of insurance in the state. . . . The term "insurer" for purposes of these regulations includes non-admitted insurers . . .The California Earthquake Authority, . . . home protection companies . . . The term insurer shall not include insurance agents and brokers, surplus line brokers and special lines surplus line brokers"**
  - **"Claims agent" means "any person employed or authorized by an insurer, to conduct an investigation of a claim on behalf of the insurer . . ."**

FAIR CLAIMS PRACTICES REGULATIONS

- RECORD KEEPING (Section 2695.3)
  - All insurers shall:
    - "Maintain claim data that are accessible"
      - Claim number
      - Date of loss
      - Line of coverage
      - Date of payment of claim
      - Date of acceptance
      - Denial or date of closed without payment
    - Maintain data for 4 years

FAIR CLAIMS PRACTICES REGULATIONS

- RECORD KEEPING (Section 2695.3)
  - Maintain hard copy files or maintain claim files accessible for the current year and past 4 years.
  - Licensees must record in the file the date the licensee received, dates the licensee processed and the date the licensee transmitted or mailed every material and relevant document in the file.
  - Ability to reconstruct critical dates

If a Policy Requires a One Year Time Limitation to Bring a Claim, Must the Insurer Give An Insured Written Notice to Bring a Claim before such Policy Provision is Enforceable?

1. Yes
2. No, because an insured is charged with constructive knowledge of policy language which is plain, clear and conspicuous.

Must Give Written Notice of Policy Provisions

- **By its terms, Section 2695.4(a)requires the insurer to "disclose to" a claimant insured all policy "time limits". This obviously implies a type of notice, communicated independent of the policy itself, which is calculated to achieve actual rather than constructive knowledge. The implicit assumption of the regulation is that the mere existence of the policy provision is not enough, no matter how "plain, clear and conspicuous." The whole purpose of such notice is to assure *actual,* not merely constructive, knowledge, of the contractual limitations period within which suit must be brought by an insured. To permit an insurer to enforce a time limit provision based solely on evidence of constructive notice would eviscerate the purpose of the regulation. AIIC cannot rely on the traditional doctrine deeming the insured to have constructive knowledge of policy provisions.**

Question

Does the Insurer or agent of the insurer have a duty to inform the insured of right to purchase the Extended Reporting Period?

1. YES.
2. NO.

Must Notify a First Party and Third Party Claimant of the Statute of limitations

- **Cal. Code Regs. § 2695.7(f) requires an insurer to notify a claimant of any statute of limitations and any 'other time period requirement upon which the insurer may rely to deny a claim.**
- **Such notice must be given to the claimant not less than 60 days before the expiration date. Section 2695.7(f) requires notice not only to the insured claimants, but also to third party claimants asserting claims against the insured.**

FAIR CLAIMS PRACTICES REGULATIONS

- REPRESENTATION OF POLICY PROVISIONS AND BENEFITS (Section 2695.4)
  - No insurer shall misrepresent, conceal or fail to disclose to a first party claimant or beneficiary all benefits, coverages, time limits and other provisions.
    - When additional benefits may reasonably be paid, the insurer shall immediately communicate this fact to the insured and cooperate.

FAIR CLAIMS PRACTICES REGULATIONS

- REPRESENTATION OF POLICY PROVISIONS AND BENEFITS (Section 2695.4)
  - No Insurer shall deny a claim on the basis of the claimant's failure to exhibit property, unless there is documentation in the file (1) of demand by the insurer, and unfounded refusal by the claimant to show property, or (2) breach of any policy provision requiring disclosure of property.

FAIR CLAIMS PRACTICES REGULATIONS

- REPRESENTATION OF POLICY PROVISIONS AND BENEFITS (Section 2695.4)
  - Except where a time limit is specified in the policy, no insurer shall require a first party claimant to give notice of a claim or proof of claim within a specified time.
    - Make sure policy wording is clear

FAIR CLAIMS PRACTICES REGULATIONS

- REPRESENTATION OF POLICY PROVISIONS AND BENEFITS (Section 2695.4)
  - No insurer shall:

    1. Request claimant to sign a release that extends beyond the subject matter which gave rise to the claim, unless fully explained in writing and claimant not represented by counsel.

    2. Be precluded from including Civil Code Section 1542 release language, provided Section 1542 release language is explained if claimant not represented by counsel.

FAIR CLAIMS PRACTICES REGULATIONS

- DUTIES UPON RECEIPT OF COMMUNICATION (Section 2695.5)
  - Immediately or within 15 days respond to a claimant's communication with a complete response based on the facts known to licensee.
  - Respond to inquiry by Dept. of Insurance within 21 days.

FAIR CLAIMS PRACTICES REGULATIONS

- DUTIES UPON RECEIPT OF COMMUNICATION (Section 2695.5)
  - Upon receiving notice of a claim the licensee must:
    - Immediately transmit notice to the insurer (2695.5(d) The following was stricken: Failure of the licensee or claims agent to immediately transmit notice of claim to the insurer shall constitute a separate and distinct violation . . .”

    Immediately, but no more than 15 days (2695.5(e)):
    - Acknowledge receipt of such notice
    - Provide necessary claim forms
    - Begin necessary investigation of claim
    - Now applies to Disability Insurance.
    - No requirement that notice be in writing unless policy specifies (2695.5(f)).

FAIR CLAIMS PRACTICES REGULATIONS

EXEMPTION TO 15 DAY RESPONSE FOR NOTICE OF CLAIM DEADLINE IF:

1. **EXTRAORDINARY CIRCUMSTANCES WOULD SEVERELY AND MATERIALLY AFFECT COMPANY'S ABILITY TO CONDUCT NORMAL OPERATIONS TO MEET COMPLIANCE.**

2. **NOTICE OF LEGAL ACTION AGAINST INSURER OR INSURED.**

FAIR CLAIMS PRACTICES REGULATIONS

- Training and Certification (Section 2695.6)
  - "Every insurer shall adopt and communicate to all its claims agents written standards for the prompt investigation and processing of claims and shall do so within ninety days after the effective date of these regulations and any revisions thereto."

FAIR CLAIMS PRACTICES REGULATIONS

- Training and Certification (Section 2695.6)
  - All licensees shall provide thorough and adequate training regarding these regulations to all their claims agents. Licensees shall certify that their claims agents have been trained regarding these regulations and any revisions. Licensees need not train or certify "duly licensed attorneys."

FAIR CLAIMS PRACTICES REGULATIONS

- Training and Certification (Section 2695.6)
  - All licensees shall demonstrate compliance by:
  1. Individual Licensee must annually certify under penalty of perjury that she has read and understands the regulations and amendments
  2. The principal of an Entity Licensee must annually execute a certification under penalty of perjury
     A. THAT THE LICENSEE'S CLAIMS ADJUSTING MANUAL CONTAINS A COPY OF THESE REGULATIONS
     B. THAT CLEAR WRITTEN INSTRUCTIONS REGARDING THE PROCEDURES TO BE FOLLOWED TO EFFECT PROPER COMPLIANCE WERE PROVIDED TO ALL CLAIMS AGENTS.

FAIR CLAIMS PRACTICES REGULATIONS

- Training and Certification (Section 2695.6)
  - All licensees shall demonstrate compliance by: (Cont.)

  3. Where the licensee retains insurance adjusters (independent stricken), the licensee must provide training to the insurance adjusters regarding the regulations and annually certify under penalty of perjury that such training is provided. Alternately, the insurance adjuster may annually certify in writing, under penalty of perjury that he or she has read and understands the regulations and all amendments or has successfully completed a training seminar which explains these regulations.

FAIR CLAIMS PRACTICES REGULATIONS

- Training and Certification (Section 2695.6) (Cont.)
  - All licensees shall demonstrate compliance by:

    4. A copy of the certification required shall be maintained at the principal place of business of the licensee.

    5. The annual certification must be completed by September 1 of each calendar year.

STANDARDS FOR PROMPT, FAIR AND EQUITABLE SETTLEMENTS (Section 2695.7(a))

- No insurer shall discriminate in its claims settlement practices based upon the claimant's age, race, gender, income, religion, language, sexual orientation, ancestry, national origin, or physical disability or upon the territory of the property or person insured.

STANDARDS FOR PROMPT, FAIR AND EQUITABLE SETTLEMENTS (Section 2695.7(b))

- Upon receiving proof of claim, every insurer shall immediately but in no event more than 40 days later, accept or deny the claim, in whole or part. The amounts accepted or denied shall be clearly documented unless claim denied in its entirety. (2695.7(b)).
- If more time is required than is needed to determine whether a claim should be accepted and/or denied in whole or in part, every insurer shall provide the claimant written notice of the need for additional time and information. Written notice shall be provided every 30 days until the claim is resolved. (2695.7(c)).

STANDARDS FOR PROMPT, FAIR AND EQUITABLE SETTLEMENTS (Section 2695.7(b)(1)) Denial or Rejection of Claim in Whole or in Part

- If denied or rejected in whole or in part:
  - Must be in writing
  - Statement listing all bases for such rejection or denial
  - Factual and legal bases for each reason within insurer's knowledge
  - Policy references to provision, condition or exclusion must be given if denial or rejection of a first party claim
  - Must provide an explanation of the application of the provision, condition or exclusion.
  - Denial, rejection, dispute of liability or damages of a third party claim must be in writing

STANDARDS FOR PROMPT, FAIR AND EQUITABLE SETTLEMENTS (Section 2695.7)

Denial or Rejection of Claim in Whole or in Part

- Must include a statement that if claimant believes all or part of the claim has been wrongfully denied or rejected he or she may have the matter reviewed by the California Department of Insurance and include the address and telephone number.
- No disclosure required if it would reasonably be expected to alert a claimant to the fact that the claim is suspected to be fraudulent
- Every insurer shall conduct and diligently pursue a thorough, fair and objective investigation and shall not persist in seeking information not reasonably required for or material to the resolution of a claim dispute. Section 2695.7(c)(2)(d)

- 2695.7(r) Ensuring the Accuracy of Data
  " A Strict Liability Standard"

  The proposed section specifies that insurers must take reasonable steps to ensure the accuracy of data used in evaluating and settling claims. Although insurers are permitted to use third party vendor services to determine damages, they are required by law to offer adequate, accurate settlements no matter what information and resources are used to establish damages.

STANDARDS FOR PROMPT, FAIR AND EQUITABLE SETTLEMENTS

7 FACTORS TO SHOW IF SETTLEMENT IS LOW (Section 2695.7(g))

- **The extent to which the insurer considered evidence submitted by the claimant to support the value of a claim**
- **The extent to which the insurer considered legal authority or evidence made known**
- **The extent to which the insurer considered advice of its claims adjuster as to the amount of damages**
- **Any other credible evidence**
- **The extent to which the insurer considered the advice of its counsel that there was a substantial likelihood of recovery in excess of policy limits**
- **The procedures used by the insurer in determining the dollar amount**
- **Extent to which the insurer considered the probable liability of the insured and the likely jury verdict**

STANDARDS FOR PROMPT, FAIR AND EQUITABLE SETTLEMENTS
(Section 2695.7(p) and (q))

- **Every insurer shall provide written notification to a first party claimant as to whether the insurer intends to pursue subrogation of the claim. Where an insurer elects not to pursue subrogation, or discontinues pursuit of subrogation, it shall include in its notification a statement that any recovery to be pursued is the responsibility of the first party claimant. No notification required if deductible is waived, there is no deductible, the loss does not exceed the deductible or no legal basis for subrogation.**

STANDARDS FOR PROMPT, FAIR AND EQUITABLE SETTLEMENTS
(Section 2695.7(p) and (q))

- **A subrogation demand shall include a first party claimant's deductible. Subrogation Recoveries must be shared on a proportionate basis with first party claimant. No deduction for legal or other expenses unless outside attorney or collection agency retained. (Not applicable to disability or health insurance.)**

Additional Standards Applicable to First Party and Commercial Property Insurance (Section 2695.9)

- When a residential or commercial property insurance policy provides for adjustment and settlement of first party losses the following standards apply:
  - No insurer shall require or suggest that the insured have the property repaired by a specific individual or entity unless referral is requested by the claimant or the claimant has been informed in writing of the right to select a repair individual or entity and the insurer shall cause the damaged property to be restored to no less than its condition prior to the loss and repaired in a manner which meets accepted trade standards for good and workmanlike construction at no additional cost to the claimant other than as stated in the policy. 2695.9(b), (c) (1) and (2)

Additional Standards Applicable to First Party and Commercial Property Insurance (Section 2695.9(d)) (cont.)

- **If losses are settled on the basis of a written scope and or estimate prepared by or for the insurer, the insurer shall supply the claimant with a copy of each document upon which the settlement is based. The estimate prepared by or for the insurer shall be in accordance with applicable policy provisions, of an amount which will restore the damaged property to no less than its condition prior to the loss and which will allow for repairs to be made in a manner which meets accepted trade standards for good and workmanlike construction. The insurer shall take reasonable steps to verify that the repair or rebuilding costs utilized by the insurer or its claims agents are accurate and representative of costs in the local market area.**

Additional Standards Applicable to First Party and Commercial Property Insurance (Section 2695.9(d))

- **If the claimant subsequently contends, based upon a written estimate which he or she obtains, that necessary repairs will exceed the written estimate prepared by or for the insurer, the insurer shall:**
  - **(1) pay the difference between its written estimate and a higher estimate obtained by the claimant; or,**
  - **(2) if requested by the claimant, promptly provide the claimant with the name of at least one repair individual that will make the repairs for the amount of the written estimate. The insurer shall cause the damaged property to be restored to no less than its condition prior to the loss and which will allow for repairs in a manner which meets accepted trade standards for good and workmanlike construction at no additional cost to claimant**

New Regulation

- 10 CCR § 2695.183
- § 2695.183. Standards for Estimates of Replacement Value.
- No licensee shall communicate an estimate of replacement cost to an applicant or insured in connection with an application for or renewal of a homeowners' insurance policy that provides coverage on a replacement cost basis, unless the requirements and standards set forth in subdivisions (a) through (e) below are met:
- (a) The estimate of replacement cost shall include the expenses that would reasonably be incurred to rebuild the insured structure(s) in its entirety, including at least the following:
- (1) Cost of labor, building materials and supplies;
- (2) Overhead and profit;
- (3) Cost of demolition and debris removal;
- (4) Cost of permits and architect's plans; and
- (5) Consideration of components and features of the insured structure, including at least the following:
- (A) Type of foundation;
- (B) Type of frame;
- (C) Roofing materials and type of roof;
- (D) Siding materials and type of siding;
- (E) Whether the structure is located on a slope;
- (F) The square footage of the living space;

PENALTIES
(Section 2695.12)

- The Department has issued penalties from $5,000 to $10,000 per act. (Ins. Code Section 790.035)
- If prior improper conduct, penalties range from $5,000 to $65,000. (Ins. Code Section 790.07)
- Penalties could be as much as $1 Million.
- Revocation of license or halt placement of business with non-complying insurer. Ins. Code Section 790.07)

The California Consumer Privacy Act ("CCPA")
Its Impact and Increased Exposure to Businesses who Collect and Share Personal Data of California Consumers

- The California Consumer Privacy Act of 2018 took effect on January 1, 2020.
- The CCPA is the strictest state-level privacy and data protection law in the United States. It permits any California consumer to see the personal information collected, used, shared or sold by businesses.
- In addition, it requires a full list of third parties with whom the personal data is shared. California consumers have the right to delete any personal information held by businesses or third-party service providers. They also are able to opt-out of the sale of personal information.

Definition of Personal Information is Broad

Personal Information under the CCPA is Broad and Includes the Following Examples:

- Real name, alias, postal address, unique personal identifier, online identifier IP address, email address, account name, Social Security number, driver's license number, passport number, or other similar identifiers.
- Characteristics of protected classifications under California or federal law.
- Commercial information including records of personal property, products or services purchased, obtained or considered, or other purchasing or consuming histories or tendencies.
- Biometric information.
- Internet or other electronic network activity information including, but not limited to, browsing history, search history and information regarding a consumer's interaction with a website, application or advertisement.
- Geolocation data.
- Audio, electronic, visual, thermal, olfactory or similar information.
- Professional or employment-related information.
- Educational information, defined as information that is not publicly available, personally identifiable information (PII) as defined in the Family Educational Rights and Privacy Act (20 U.S.C. section 1232g, 34 C.F.R. Part 99).
- Inferences drawn from any of the information identified in this subdivision to create a profile about a consumer reflecting the consumer's preferences, characteristics, psychological trends, preferences, predispositions, behavior, attitudes, intelligence, abilities and aptitudes.

Fines

- $7,500 per record
- Increased exposure for companies who collect personal information of California Consumers
- Increased Risk of Large Claims

TIME DEADLINES
CALIFORNIA FAIR CLAIMS REGULATIONS

Immediately or w/i 5 Days

Preauthorize Non-emergency Medical

269511.(3)

Agent must notify Insurer of Claim
2695.5 (d)

IMMEDIATELY

Insurer to notify Insured of Statute of Limitations if
Within 60 days before Statutes' expiration. 2695.7 (f)
Not applicable if claimant has legal representation.

15-DAY DEADLINES

- *Insurer to acknowledge claim* 2695.5 (e)(1)
- *Respond to Insured's inquires* 2695.5 (b)
- *Provide necessary claim information to Insured* 2695.5 (e)(2)
- *Commence investigation of claim* 2695.5 (e)(3)
- *Give copy of 790.03 and inform Insured of regulations and website* 790.034 (b)

30-DAY DEADLINES

- *Pay accepted amount of Claim* *2695.7 (h)*
- *If extended time is needed & requested report to Insured every 30 days* *2695.7 (c)(1)*
- *Pay negotiated settlement amount* *2695.7 (h)*
- *Report every 30 days if advised add'l time needed* *2695.2 (c)(1)*

40-DAY DEADLINE → *Accept or deny claim and/or advise if more time needed. 2695.7 (b)*

60-DAY DEADLINE → *Inform claimant of running of Statute of Limitations. 2695.7 (f)*

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