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What is Insurance Bad Faith?

A comprehensive overview of insurance bad faith and understanding why it is crucial to protect your rights and hold insurers accountable when they act in bad faith.

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What is Insurance Bad Faith?

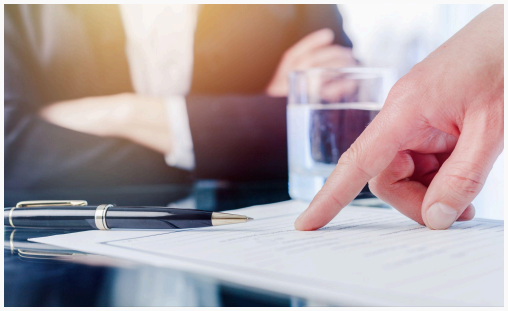
Buying insurance is different than buying a car or some other physical product. With insurance, the product that a person is buying is the insurance company's promise to pay claims that are covered by the insurance policy. When a claim arises, the insured has already paid premiums and has lived up to his or her end of the bargain. Because of this, the insurance company must then live up to its end of the bargain: it cannot try to cheat the insured to give itself an advantage. This concept is known as the duty of good faith. In other words, an insurance company must treat the interests of its insured with equal regard to its own. When an insurance company tries to tilt the claims process in its own favor and interpret policy provisions or conduct an investigation in such a way that will support a denial or lessening of the insurance claim, it is committing bad faith.

Bad faith arises from the fundamental contractual precept that every contract includes "an implied covenant that ***neither party shall do anything which will have the effect of destroying or injuring the rights of the other party to receive the fruits of the contract***; ... in every contract, there exists an implied covenant of good faith and fair dealing." *Lloyd Noland Found., Inc. v. City of Fairfield Healthcare Auth.*, 837 So. 2d 253, 267 (Ala. 2002)(emphasis added); *See Chavers v. National Sec. Fire and Cas. Co*, 405 So. 2d 1, 6 (Ala. 1981)(adopting the tort of bad faith and stating "to hold otherwise would render meaningless the long-standing legal principle in this state which holds that every contract carries with it an implied in law duty of good faith and fair dealing."). "For the insurer to fulfill its obligation not to impair the right of the insured to receive the benefits of the agreement, it ...must give as much consideration to the latter's interest as it does its own." *Egan v. Mutual of Omaha Ins. Co.*, 14 Cal.3d 809, 818-19 (Cal. 1979).

An insurance company may only deny a claim based on language in the policy and after conducting a thorough and unbiased investigation. Its reason for denial also must be a result of this investigation. In *Anderson v. Continental Insurance Company*, the Wisconsin Supreme Court further elaborated on the insurer's claims investigation and observed that it was the "duty of an insurer to assess claims as a result of an appropriate and careful investigation and that its conclusions should be the result of the weighing of probabilities ***in a fair and honest way***." 271 N.W.2d 368, 375 (Wis. 1978); *see also State Farm Fire & Cas. Co. v. Slade*, 747 So. 2d 293, 315, 316 (stating "an insurance company has a 'responsibility to marshal all...facts' necessary to make a determination as to coverage 'before its refusal to pay'").

How Does Bad Faith Occur?

Bad faith can occur in many different ways and with any type of insurance policy. It can occur when an insurance company does not conduct a proper investigation, for instance when it fails to take statements or follow up on information that has been provided by the insured. An improper investigation can also involve the insurance company just looking for information that favors a denial of the insurance claim and not looking for or even ignoring information that would support paying the insurance claim.



Another type of bad faith occurs when an insurance company interprets a vague policy exclusion or other policy language in a way that favors the insurance company. Insurance policies sometimes have very vague language that can be interpreted in more than one way. When this occurs, the insurance company is supposed to interpret it in favor of the policyholder. However, we have seen many instances where they do the opposite and interpret the language in a way that supports a denial of the claim. For instance, I had a Farmers Insurance claim once where Farmers tried to claim that damage caused by a backed-up toilet and washing machine was excluded by an exclusion that excluded coverage for sewer and water that came into the house from outside.

Still, another type of bad faith occurs when an insurance company fabricates a reason to deny a claim. I have seen instances where insurance companies have claimed that a certain exclusion barred coverage for a claim when that exclusion was actually not in the original policy. Another way that an insurance company can manufacture a reason to deny a claim is shown in the Arizona case of *Deese v. State Farm* in which evidence suggested that State Farm set up a bogus chiropractor review panel to specifically deny and reduce chiropractor charges submitted by policyholders who had been hurt in car wrecks. Similarly, Unum Provident also was caught setting up a false medical review process that was designed to reduce disability insurance payments. In the short-term health insurance context, I have seen short-term health insurers claim that they did not receive medical records that had actually been sent to them and also claim that certain health conditions were pre-existing conditions, when clearly they were not. The essence of all of these types of bad faith is that the insurance company is tilting the claims process in its own favor.

How often does bad faith occur?

Bad faith used to be something that was believed to occur very rarely. Unfortunately, due to changes in the insurance industry, it seems to occur more and more. One of these changes relates to the increased focus by insurance companies on reducing claims expenses. Beginning in the early 1990's, with a report provided by a consulting firm called McKinsey & Co to Allstate called "From Good Hands to Boxing Gloves," insurance companies realized that the best way of making sure that they were profitable was by reducing the amount that they paid out in claims. Before this time, insurance companies generally believed that the only ways they could make sure that they made a profit were by pricing their insurance policies fairly and by investing the premiums they received wisely. However, with this new approach, they could guarantee a profit even while trying to attract consumers through low prices and making poor decisions with their investments.

To support this effort, a whole cottage industry has arisen. There are engineering companies that market themselves exclusively to insurance companies and provide reports that tend to support the denial or minimization of insurance claims. There are computer programs designed to estimate the value of a claim, often in a way that reduces the amount of the claim payment made by the insurer.

Another factor that has led to the increased incidence of bad faith is a reduction in training and reduction of claims workforces. At one point in time, insurance companies took great pride in providing extensive training to their claims representatives. These claims representatives would usually receive weeks if not months of training before they were ever allowed to make a decision on an insurance claim. This training included specific training on the duty of good faith and ensuring that the policyholder was treated fairly. However, over the past couple of decades, this level of training has slipped. Insurance companies provide less and less training and sometimes have new hires adjusting claims under the supervision of someone else almost immediately. Some companies have also stopped using claims manuals. Claims manuals are guidelines that help ensure that the company claims representatives adjust claims correctly. If a company does not have a claims manual, then it is less likely that it will consistently adhere to good faith claims handling practices.

Many companies have also been reducing the number of claims people that they employ. For instance, over the last seven years, State Farm has drastically reduced its claims workforce and has closed many of its claims offices. As a result, claims representatives are left dealing with more and more claims and can be stretched thin. COVID-19 made this trend worse with many companies

hiring fewer full-time adjusters and having adjusters working from home and not around more experienced adjusters.

Yet another factor that can create an incentive for an insurance company to commit bad faith is the way that it pays bonuses and other compensation to its employees. Many insurance companies have been caught paying bonuses and otherwise encouraging claims employees to reduce their claims expenses or to deny more claims. For instance, in the Arizona Supreme Court case of *Zillich v. State Farm*, evidence surfaced showing that State Farm was incentivizing its claims people to reduce claims. Unum Provident also has been caught doing this.

What Types of Insurance Policies Are Involved in Bad Faith?

The short answer here is that ANY insurance policy can give rise to a claim of bad faith. However, here are some examples that we see in specific types of policies:

Homeowner's Policies If you are a homeowner, you know how important your insurance policy is. Your home is your safe place and you want to do anything you can to protect it. As a result, homeowner's insurance is one of the most important types of insurance. Homes can often be damaged or destroyed by events like fires, tornadoes, and hurricanes. When an insurer tries to deny a claim for an unsupported reason or minimize its payment, you may have a bad faith claim. Here are some potential examples in this context.

- Claiming the fire is arson based on an incomplete or biased investigation
- Ignoring an engineering report, photos or other proof submitted by an insured.
- Twisting the facts or the law to claim that the damages, or some of them, are not covered
- Cutting off payment of Additional Living Expenses for reasons not in the policy
- Not interviewing key witnesses.

Note: Homeowner's policies also include liability coverage, which is coverage that may pay for an attorney or to settle a case when a claim is made against the homeowner. The claim does not always have to involve the home.

Health Insurance Policies (Not Purchased Through Work) While you

can't have a bad faith claim relating to most employer-provided health plans, if you have an individual plan, including short-term health insurance or limited benefit indemnity insurance, you may have a bad faith claim if your claim is denied. Here are some types of bad faith we see here:

- Claiming treatment is for a pre-existing condition when it is not
- Delaying payment of claims for many months
- Claiming that they have not received medical records that have been sent to them

Individual Disability Insurance Policies

While you generally cannot pursue a bad faith claim for a work-provided disability policy, you may be able to pursue such a claim if you purchase the insurance yourself and the company refuses to pay or to pay the right amount.

Make sure to check with a knowledgeable policyholder lawyer to determine whether you have a bad faith claim with this type of policy because this determination may involve several factors.

Life Insurance/Accidental Death

There are few times in a person's life when insurance is more important than when a person loses a loved one. Despite this fact, whenever someone insured by a life insurance policy dies within two years of buying life insurance, the insurance company will conduct a "contestable claims investigation," look at all of the medical records, and attempt to find items that they claim are misrepresentations in order to find a way to avoid paying a claim. Here are some common ways they commit bad faith in this context:

- Ignoring information that the insured gave them when the policy was purchased
- Nitpicking the medical records for minor medical conditions would not really have made a difference anyway
- Ignoring their own failure to investigate and ask questions before they issued the policy.

Under Alabama law for instance, an insurer cannot use a so-called misrepresentation by an insured to deny coverage when the insurer had enough information when the policy was issued to make them aware that they needed to investigate further and could have discovered the information on their own.

Automobile Insurance Policies

In the automobile insurance context, the most common insurance claims involve property damage, liability coverage, or uninsured motorist/uninsured motorist coverage. The property damage part of your policy pays for damage to your car when you are in a wreck, your car is stolen, and a few other instances. Liability coverage pays to defend you or settle a claim against you if a claim is brought against you from a wreck. Uninsured/underinsured motorist coverage is a type of coverage that is mandated by law and pays money for your injuries when another party is at fault but does not have insurance or does not have enough insurance to cover all of the damages. Some examples of bad faith in this context are:

- Refusing to provide a defense to the insured because the insurance company claimed that the driver bringing the claim was negligent (it doesn't matter-they still had an obligation to defend)
- Refusing to pay medical payments coverage or pay enough in medical payments coverage even though liability and damages were clear.

Commercial Property/Commercial General Liability Policies

Many businesses have (and should have) a policy that covers property damages and a policy that covers the business for lawsuits and claims arising because of an accident or occurrence. These policies are called commercial property policies and commercial general liability policies. Sometimes they are sold as part of the same policy called a business owner's package policy, or something similar. Some instances of bad faith in this instance are:

- An insurance company refuses to defend a contractor when improper work causes other damage to the property.
- An insurance company refused to defend business owners who had been accused of intentionally shooting someone but who claimed that the shooting was accidental.
- An insurance company refusing to pay roof damage covered by the policy after originally admitting it was covered.

Other Miscellaneous Policies

Other types of policies include professional liability insurance (covering professionals like lawyers, doctors, accountants, and pharmacists) for claims that they did their work incorrectly), errors & omissions policies (similar to professional liability and covering businesses like real estate agents and insurance agents), directors & officers liability policies (covering the directors and sometimes the company for claims of wrongful conduct), boiler and machinery policies (covering damages caused by failure of heavy

equipment), and employment practices liability (covering suits and claims by employees and former employees for job-related claims). When the insurance company breaches its obligations under these policies, often by failing to investigate or by conducting a biased investigation, the breach could give rise to a bad faith claim.

How is Insurance and Bad Faith laws different from other Types of Law?

Insurance cases have to be handled differently than personal injury and other cases because insurance companies have their own special legal rules and the insurance industry has its own unique structure and regulations. Knowledge of these unique qualities is important to handling bad faith cases.

First, insurance policies have to be interpreted using special rules of contractual interpretation. One of these rules is called *contra preferendum*, which is a Latin phrase that basically means that since the insurance company drafted the policy, anything that is unclear in the policy ("an ambiguity") will be interpreted against the insurance company. Policy language is ambiguous when it has more than one reasonable meaning. If there are two or more meanings of policy language, the one favoring the policyholder must be applied.

In an insurance policy, there will always be some broad language that talks about the types of things that are covered by the policy. This is called the covering or coverage section. After this, the policy will list a set of events that are not covered by the policy. These are called exclusions. While the policyholder has the burden of proving that his or her accident comes within the policy coverage, the insurance company has the burden of proving that any of its "exclusions" apply. An experienced bad-faith insurance attorney will be aware of and use these rules.

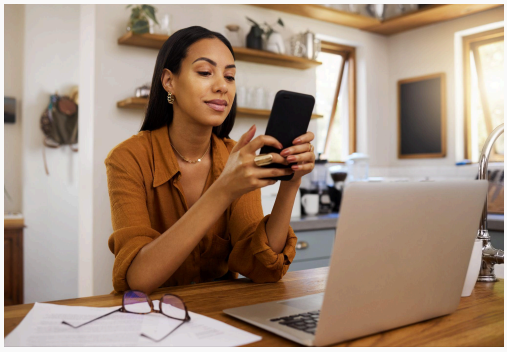
Bad faith law is also its own unique legal specialty. Relatively few lawyers take these cases because they can be difficult, require a lot of work, and are much riskier than most car wreck cases. First, bad faith requires more than just a mistake; it requires showing intentional or reckless conduct. This means that the skilled bad-faith attorney must look for patterns in the evidence and similar conduct to show that the company knew at some level that it was putting its interests above that of its

policyholder in order to make money. The policyholder must prove that the insurance company intentionally denied a covered claim while knowing that it did not have a reasonable reason to do so or without conducting a thorough and fair investigation to find out. It also cannot make up a good-sounding reason after denial in an effort to justify its denial. These are some of the concepts that separate bad faith cases from other types of law.

How an Insurance Company is Supposed to Work

These unique laws result from the special structure of the insurance company. An insurance company has employees called actuaries and underwriters. Actuaries are people who calculate the risk of different events happening, for instance, the risk of a fire or tornado, and help come up with pricing that allows the insurance company to take in more money in premiums than it pays out in claims. Underwriters look at individual insurance applications and determine if individuals qualify for the policy or rate classification. For instance, in the life insurance context, an actuary would be responsible for coming up with mortality tables and other information upon which the insurance company would base its rates and would also be responsible for determining the qualifications for a preferred rate, for a standard rate, and for a smoker's rate. An underwriter, on the other hand, would determine which policy, if any, a particular applicant qualified for.

The insurance company has a sales and marketing department also that has a hand in pricing the policy in order to make sure the company makes a profit. This department will also be responsible for placing advertisements and selling the policy. These first two departments resemble the functions of any normal business.



When an insurance company generates premiums, it then invests these premiums. As a result, insurance companies have large investment departments. Along with the sales/marketing and the actuarial/underwriting functions, the investment department is responsible for generating a profit for the company.

The final major division of an insurance company is the claims department. The claims department is actually the product that the insurance company is selling and is responsible for fulfilling the company's promises under the insurance policy. Because of the insurance company's duty of good faith to deliver its contractual promises the

claims department cannot be used to try to make a profit for the insurance company. Unfortunately for consumers, insurers have been systematically doing this since the '90s.

Insurance companies also are heavily regulated by state departments of insurance. For instance, states require insurance companies to have sufficient amounts of money, called reserves, to pay claims that might be filed with the company. In addition, departments of insurance decide which companies can sell insurance in a state, approve the insurance company's rates, and even approve specific policy language. Consumers can complain to the Department of insurance is they feel that they are being treated unfairly. State departments of insurance can also conduct investigations into the claims practices or other practices of insurance companies. These are called market conduct examinations. Finally, state departments of insurance impose record-keeping requirements on insurance companies. For example, an insurance company must document all significant actions taken on a claim in the claims file so that the department can reconstruct what happened during a claim if it needs to.

Duties that Your Insurance Company Owes to You to Avoid Committing Bad Faith in Handling Your Claim.

Because of all of these unique factors, insurance companies have unique duties in investigating a claim. These duties include:

- Thoroughly investigating the claim.
- Conducting a thorough evaluation of the claim.
- Gathering all of the facts before making a coverage decision.
- An insurance company cannot just gather facts that will support a denial of coverage.
- Treating its policyholders' interests with equal regard as its own interests. The claims process is not an adversarial process
- It cannot create a reason to deny a claim.

See NAIC Model Unfair Claims Settlement Practices Act, §4, *Gruenberg v. Aetna Insurance Company,* 510 P.2d 1032, 1037-38 (Cal. 1973); *Anderson v. Continental Insurance Company,* 271 N.W.2d 368, 375-78 (Wisc. 1978); *Egan v. Mutual of Omaha Insurance Company*, 620 P.2d 141, 24 Cal. 3d 809, 817-21 (Cal. 1979); *Noble v. National American Life Insurance Company*, 624 P.2d 866, 867-68 (Ariz. 1981)*; Gulf Atlantic Life Insurance Company v. Barnes*, 405 So. 2d 916, 924-26 (Ala. 1981).

In addition to these general duties, an insurance company might have specific duties depending on the situation. For instance, in a situation where a policyholder is being sued or has a claim brought against them, the insurance company should

communicate any settlement demands that possibly exceed the policy limits. The company should also keep its insured informed about any settlement negotiations. If the insurance company is claiming that a claim may not be covered by the policy, it must send a "reservation of rights" letter to the policyholder as soon as the company knows there is a coverage question so that the policyholder knows that the insurance company has questions and can protect his or her interests.

How Do We Get the Insurance Companies to Admit They Owe a Duty of Good Faith to Their Policyholders?

While the insurance companies have special duties, they often deny the existence of these duties in discovery. For instance, generally, State Farm claims specialists and team managers will respond to questions about duties and standards by saying that "each claim is handled on its own merits" and acting as if there are no principles that are applicable to claims in general. So how do lawyers establish the existence of these duties when the insurance company attempts to deny them?

Method One for Proving Bad Faith: Looking at State Laws, Including Cases, Statutes and Regulations.

One way is to examine the statutes, regulations, and caselaw of your state. In states that have bad faith, the Courts have spoken and defined some of the behaviors that characterize bad faith. We analyze the applicable court cases that have dealt with insurance bad faith and look at fact patterns showing bad faith and what types of conduct the courts have said is bad faith. Here are some cases that discuss fact patterns involving bad faith and applicable rules:

- *Wilson v. 21st Century Ins. Co.*- 171 P.3d 1082 (Cal. 2007)- The California Supreme Court found that the insurance company's rejection of an underinsured motorist claim was bad faith because the insurance company's claims represented ignored medical evidence that favored the insured and substituted his own. The Court summed up the applicable duties of an insurance company: "The implied promise requires each contracting party to refrain from doing anything to injure the right of the other to receive the agreement's **1087 benefits. To fulfill its implied obligation, an insurer must give at

least as much consideration to the interests of the insured as it gives to its own interests." 1086-87. "To protect its insured's contractual interest in security and peace of mind, 'it is essential that an insurer fully inquire into possible bases that might support the insured's claim' before denying it. (*Egan v. Mutual of Omaha Ins. Co.* (1979) 24 Cal.3d 809, 819, 169 Cal.Rptr. 691, 620 P.2d 141.) By the same token, denial of a claim on a basis unfounded in the facts known to the insurer, or contradicted by those facts, may be deemed unreasonable. 'A trier of fact may find that an insurer acted unreasonably if the insurer ignores evidence available to it which supports the claim. The insurer may not just focus on those facts which justify denial of the claim."" 1087.

- *Egan v. Mutual of Omaha Ins. Co,* 24 Cal. 3d 809 (1979)- In this case, which was one of the leading cases defining insurance bad faith, the insurer's claims representative called the insured a fraud and laughed at him. When the insured complained about not having money to buy Christmas presents, the claims representative made him cry in front of his child. The insurance company also tried to improperly terminate his policy and did not adequately investigate. The Court stated: ."). "For the insurer to fulfill its obligation not to impair the right of the insured to receive the benefits of the agreement, it ...must give as much consideration to the latter's interest as it does its own." *Egan v. Mutual of Omaha Ins. Co., Id* at 818-19.

- *Zilisch v. State Farm*, 995 P.2d 276, 279, 283 (Ariz. 2000)- In this case, the Court found State Farm guilty of setting improper payment goals and incentives. This bad faith case involved underinsured motorist coverage and the policyholder introduced evidence that "State Farm engaged in a deliberate practice of underpaying claims nationwide. The evidence suggested State Farm set arbitrary claim payment goals for its claims personnel in order to reach the company goal of having the most profitable claims service in the industry. Promotions and salary increases for State Farm claims personnel were based on reaching these goals." The evidence also included an unreasonable delay in evaluating the claim (about two years until payment of the correct amount).

- *Riverside Ins. Co. v. Pedigo*, 430 N.E.2d 796 (Ind. 1982)- The court upheld a finding of bad faith finding that the insurer misled the insured by claiming that the claim was not being paid due to loss forms not being correct when in reality the insurer was conducting a secret arson investigation.

- *Zoppo v. Homestead Ins. Co.*, 644 N.E.2d 397, 400 (Ohio 1994)-The court found that the insurance company failed to conduct an adequate investigation where its investigation focused on the insured (and his suspected arson) and ignored possible other explanations for the fire loss.

- *Merrick v. Paul Revere Life Ins. Co.* , 594 F.Supp. 2d 1158 (D. Nev. 2008). This case was one example of the massive scheme by UNUM and its companies to underpay benefits on policies it had written. This scheme was even featured on an episode of Sixty Minutes! In this case, the court detailed the following evidence of a national scheme to deny claims:

    - Paul Revere restructured its claims-handling practices for financial reasons

    - The company targeted "subjective" disability claims for scrutiny and implemented a requirement that the insured present objective evidence when none in policy. (An example of a "subjective" complaint would be a doctor's record documenting a patient's complaints of pain. An example of "objective" proof would be an MRI);

    - The company had a special "round table" process in which it scrutinized high-dollar claims;

    - The company shifted the burden of claims investigation to the insured when normally it is the company's duty to conduct a thorough and unbiased investigation;

    - The company overvalued the opinions of its in-house medical personnel over the insured's treating physicians and independent medical examinations;

    - In-house medical personnel cherry-picked documents to find reasons for denial;

    - Claims people "piecemealed" claims and did not consider the

totality of circumstances; and

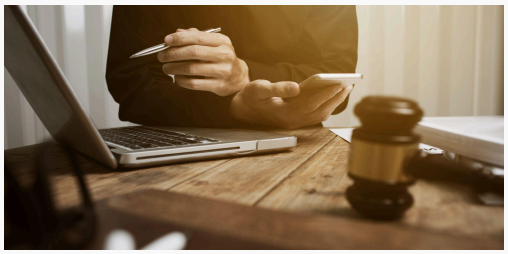
- Claims persons "set targets and goals for claim terminations to obtain financial gain and without respect to claim merit."

- *Crackel v. Allstate Ins. Co.*, 92 P.3d 882, 890 (Ariz. 2004): "Guenther and Drannan presented evidence that Allstate had adopted written policies governing MIST claims (The name given by Allstate to "minor impact soft tissue" claims) directing its adjusters and attorneys to handle these kinds of claims in such a way that it would not be financially feasible for claimants to pursue litigation. Allstate instructed its representatives to "do-whatever-it-takes [sic] to remove any need" for claimants to retain an attorney to assist in settling claims, including making "settlement offers in a range that will make [a] claim economically unacceptable to an attorney." In another manual, Allstate management told personnel to take a "proactive stance on MIST cases" and "force[ ] the attorney and the claimant to think about the obstacles they must overcome to reach a realistic settlement or a walk-away settlement." According to the policy, an increase in Allstate's trial activity would constitute one such "obstacle." The MIST policy further stated that one of its goals was "to send a message to attorneys of our proactive stance on MIST cases."

- *See Jones v. Alfa Mutual Ins. Co.*, 1 So.3d 23, 37(Ala. 2008)(reversing summary judgment for insurer on abnormal bad faith claim). This case involved a claim for roof damage at a home caused by Hurricane Opal. The insurer's engineer did not physically look at the cause of loss that the insured claimed (damage to roof), but instead focused on a policy exclusion (settlement from earth movement). Alfa did not consider any evidence about whether its alleged "settlement" cracks existed before the storm. This evidence included testimony from a real estate agent and an Alfa employee who had seen the property before the hurricane and testified they had seen no cracks.

- *White v. State Farm Fire & Cas. Co.*, 953 So.2d 340, 350-51 (Ala. 2006)(reversing summary judgment for insurer on normal and abnormal bad faith claims without deciding whether the claim was normal or abnormal); involve roof damaged in downtown Bham in commercial bldg in a storm. The insured testified that SF had authorized it to replace the roof on two occasions; SF sent an inexperienced adjuster who left on a family emergency in the middle of the claim; used residential software to determine commercial loss; and did not

properly document the supposed conversation with a builder in which it claimed it had been told roof was an upgrade.



- *National Ins. Ass'n v. Sockwell*, 829 So. 2d 111, 130-32 (Ala. 2002) (affirming jury verdict of $201,000 in mental anguish damages and $600,000 in punitive damages); in a case involving an underinsured motorists claim, insurer died benefits on the based on two exclusions that were void under Alabama law. The Court rejected the insurer's attempt to contrive another reason for denial after denial of the claim. The court also found that the insurer's payment of the available benefits after filing of the lawsuit was evidence of a breach of contract and did not cure the breach for the purposes of bad faith. The insurer made the decision to deny the claim before completing its investigation and did not even apply the facts to its policy language. The court rejected the insurer's attempt to categorize the failure to pay the claim as a "mistake."

- *Aetna Life Ins. Co. v. Lavoie*, 505 So. 2d 1050, 1052-53 (Ala. 1987)(The Court stated, "Clearly, it was Aetna's responsibility to marshal all of the medical facts with regard to Mrs. Lavoie's claim *before* its refusal to pay."). The Court affirmed a bad faith verdict where insurer denied health claim before it had critical sections of file. (nurse's notes and progress notes).

- *Gulf Atlantic Life Ins. Co. v. Barnes*, 405 So. 2d 916, 925-26 (Ala. 1981): The insurer paid $1000 on a $7000 life insurance policy and claimed that the policy should have been issued for $1000 but that coding error caused the accidental issuance of a $7,000 policy. The company originally issued a $7000 check but when the agent received it to deliver it, he told the company it was a mistake and should be reissued for $1000. The company reissued the check and issued a new policy in the amount of $1000. After the suit was filed, the company offered to pay the remaining $6,000. The court affirmed the bad faith verdict finding that the company had no debatable reason to deny the claim and that the jury could have found that the company tried to cover up its error by reissuing policy and trying to settle after the commencement of the suit. "[A]n insured purchases insurance and not an unjustified court battle when he

enters into the insurance contract." *Id.* at 925.

Method Number Two for Proving Bad Faith: Examining the Insurance Company's Own Documents

Another way to prove these special duties is to examine the claims manuals and training materials of the insurance companies themselves. Since handling claims is specialized, insurers commonly have specific training on how it must be done, including standards that must be followed. In addition, insurance companies often have claims manuals that set out these guidelines and rules for handling specific situations. We always look for these types of materials in bad-faith cases.

Method Number Three for Proving Bad Faith: Looking and Industry Guidelines.

Still, another way is to examine the training materials of insurance industry credentialing organizations. Claims representatives will sometimes receive insurance-related designations from these organizations. For instance, "The Institutes" is one of the main insurance credentialing organizations. They offer the Associate in Claims designation or AIC. Many claims representatives have this designation. As a part of the training for this designation, claims people learn about the duty of good faith and practices for conducting thorough investigations. In discovery, we can learn which insurance company employees have these designations and can ask them about their training.

Is Bad Faith the Same as Negligence?

Generally, the answer to this question is no. For instance, the Alabama Supreme Court has said that bad faith imports a dishonest purpose and means a breach of known duty, *i.e.*, good faith and fair dealing, through *some motive of self-interest or ill will. Gulf Atlantic Life Ins. Co. v. Barnes*, 405 So. 2d 916, 924 (Ala. 1981). By contract, negligence is the failure to behave as a reasonable person under similar circumstances would behave. Courts often say that bad faith consists of more than just showing a mistake or a poor investigation. However, evidence that an insurer has conducted a poor investigation and has violated industry standards can be evidence of bad faith when it helps show an intent to favor the insurance company's interests over those of the policyholder.

How is a Bad Faith Case Handled Differently Than Other Cases?

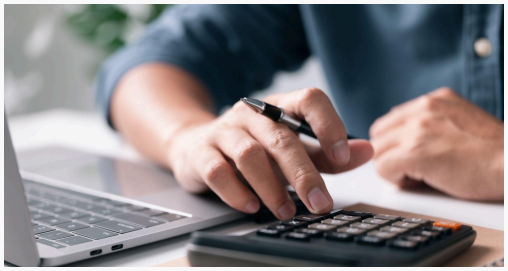
Because of the differences between bad faith and other types of cases, bad faith cases do have to be handled differently than many other cases. For

instance, because the insurance industry can be outside of the understanding of many jurors and judges, we may need to hire a claims-handling expert to explain how the insurance company violated industry standards.

Bad faith cases will also require extensive discovery and investigation. While a car wreck case may require only two or three depositions, I have taken as many as seventeen in a bad faith case because it can be important to talk to all of the claims handlers and decision-makers involved in a claim. These days more and more individuals can be involved in a claim due to high turnover and because insurance companies are outsourcing more and more of their claims investigations.

In addition, bad faith cases require a thorough review of the claims file, any underwriting file, any claims manuals, compensation of claims employees and other information designed to show that the insurance company was deliberately trying to game the system and put its interests ahead of its policyholders. We frequently have to review thousands of documents to understand the case and to uncover any smoking guns.

What types of damages may I recover in a bad faith case?



Policy benefits

It is well established that an insured can recover the policy benefits that should have been paid as part of a bad faith claim. You can also recover these damages under a breach of contract claim and we usually will assert a breach of contract claim along with a bad faith claim.

Mental Anguish

Mental anguish consists of states of mind like worry, anxiety, depression, loss of sleep, anger, and bitterness. Mental anguish is commonly available for insurance bad faith.

Possibly Prejudgment Interest

Prejudgment interest is available in some states for insurance claims, including bad faith, especially where the amount owed by the company for the claim is a specific amount.

Possibly consequential damages

Consequential damages are damages that flow from the breach of the insurance policy that would have been reasonably foreseeable to result from

the denial of the claim. These could include items like late fees and interest.

Attorney's Fees

Some states allow for the recovery of attorney fees for the commission of bad faith or other unjustified denials. For instance, Texas and Washington State both provide for attorney's fees by statute and case law under situations giving rise to bad faith. However, some states, like Alabama, do not allow for the recovery of attorney fees generally.

Treble Damages

Treble damages or additional damages of three times the amount of actual damages are available by statute in some states, including Texas and Washington. They are not available currently in Alabama.

Punitive Damages

Punitive damages are additional damages designed to punish and deter wrongful conduct. They are available in some but not all states for insurance bad faith. However, typically they require more than just bad faith by itself. For instance, in Alabama, they are available when an insurer commits bad faith "with malice, willfulness, or wanton and reckless disregard of the rights of others." In Texa,s they are only available "when an insurer was actually aware that its actions involved an extreme risk" to the policyholder. In Washington, they are not available for bad faith at all.

What should I look for in a bad-faith lawyer?

Examine a lawyer's website, blog and other written publications. Have they written a book or articles? Have they presented at seminars? Do they consistently blog on insurance topics? Also, pay attention to the detail of the information provided. Is it specific or helpful? Or on the other hand, does it just seem like a big sales pitch or generic information thrown together by AI. This book is 100% AI free!

Don't be afraid to interview your potential attorney and ask questions like: How many bad faith cases have you handled? Have you handled cases like mine? If you haven't handled one like mine, what do you intend to do to prepare? What are my potential damages? What are our state's requirements for proving bad faith? How long will this process last? What are the steps in the process? Don't be afraid to be an informed consumer.

Websites like Martindale.com, Avvo, and Super Lawyers contain attorney rating information and are reliable sources of information. The highest available rating on Martindale is AV and is awarded by an attorney's peers. Attorneys are also chosen for selection in Super Lawyers by other attorneys. Of course, reading Google reviews can be helpful. Finally, you can ask other lawyers who the best insurance lawyers representing policyholders are or ask them about an attorney you might be considering.

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