CALIFORNIA
INDEPENDENT
ADJUSTER ETHICS
COURSE

4 HOURS

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SUCCESS CONTINUING EDUCATION
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BUSINESS ETHICS

PRINCIPLES OF BUSINESS ETHICS

Business ethics are the principles of conduct governing an individual or group and conforming to accepted professional standards of conduct. In essence, learning what is right and wrong, and then doing what is right. But is there always a right or wrong, rooted in moral principle, or is it ultimately up to the individual depending upon the situation? Philosophers have debated the question for thousands of years.

Moral and ethical principles are based upon values such as integrity, honesty, justice and trustworthiness. How these values are applied is often referred to as moral or ethical principles. However, an ethical guideline can often become a law or regulation, depending upon legal interpretation.

During times of fundamental change in business, previous values can be questioned; therefore, attention to business ethics is critical. Relationships with stakeholders, services and products can be affected dramatically if the concept of knowing the difference between right and wrong, and doing what is right, is ignored. Not having a clear moral path for leaders to follow can lead to multifaceted difficulties.

A SERIOUS MATTER

When most people think of ethics, they think of the golden rule, “Do unto others as you would have done unto you.” However, during critical times, ethical statements such as this can go by the wayside. Therefore, adherence to a strict code of ethics can be a strong deterrent to disaster in business.

The 1960’s proved to be a movement toward social responsibility in the business industry. It became popular to believe that since businesses make a profit off of society, they have a moral obligation to help improve that society. Business leaders realized that only good could come from presenting a more positive image to the general public. As commerce becomes more complicated, moral values must be prioritized to ensure that business dealings are in support of the common welfare of the public and that no one is harmed. Any representative of the business must therefore embrace the same values.
ETHICAL DILEMMAS & THE CODE OF ETHICS

Certain conditions are involved in a significant value conflict between differing interests.

- Real alternatives that are equally justifiable
- Significant consequences on "stakeholders" in the situation

Complex business transactions can’t always be seen as black and white, but may often contain gray areas. A code of ethics is the ethical value system to which an organization or individual aspires. They are normally quite similar to the codes of ethics that most people live their individual lives by. So why write them down and spell them out if they are as common as honesty, truth and fairness? Because a code of ethics is an organic instrument and can often change with the needs of society and the organization.

REGULATING MORALITY

There are no excuses for unethical behavior, yet an individual can often be unethical while remaining within the law. This often times occurs during stressful situations. However, breaking the law often starts with unethical behavior that has gone unnoticed. Small transgressions that do not break any laws can lead to larger acts that do. Therefore, it is imperative that all industry representatives support each other to maintain a high degree of ethics. The focus of ethics in business should include:

- The application of ethics to the corporate community
- A way to determine responsibility in business dealings
- The identification of important business and social issues
- A business critique

INDUSTRY BENEFITS

- Improved society;
- A moral course in difficult times;
- Creates strong teamwork and productivity;
- Supports individual growth;
- Keeping policies legal;
- Assists in avoiding criminal acts of omission and lowering fines;
- Helps manage strategic planning, quality and diversity; and
- Promotes a strong public image.
QUALITIES OF THE HIGHLY ETHICAL INDIVIDUAL

• The "good of the consumer" is part of the individual's own philosophy, in theory and practice;
• The individual's integrity stresses that the other person's interests are as valuable as his own;
• The individual assumes personal responsibility for his actions, and is responsible to himself first and then to his organization; and
• The individual sees his activities in terms of purpose, which ties the individual to the organization, and the organization to the environment.

QUALITIES OF THE HIGHLY ETHICAL INDUSTRY

• There exists a clear vision and picture of integrity throughout the industry;
• The vision is owned and embodied by top management in the industry, over time;
• The reward system is aligned with the vision of integrity;
• Policies and practices of the industry are aligned with the vision; no mixed messages;
• It is understood that every significant decision has ethical value dimensions; and
• Everyone in the industry is expected to work through conflicting value perspectives.

ETHICS IN THE FIELD OF INSURANCE CLAIMS ADJUSTING

A discussion of Ethics lacks the precision of many of the concepts we are familiar with in the financial services industry. There are no hard and fast absolutes where many Ethical concepts are concerned. Nevertheless, the special trust and professionalism that are necessary as a central part of the insurance business make a study of Ethical questions of primary importance. Furthermore, the intangible nature of our products gives rise to an environment where Ethical lapses could not only flourish, but do so undetected. Regulatory efforts by necessity focus on minimum standards of conduct as mandated by law. Ethics could be described as focusing on conduct, commerce, or activity that, while perhaps meeting the letter of the law fails to meet the intent of the law.

MOST ADJUSTERS VIEW THEMSELVES AS PROFESSIONALS
While it is not the position of the author to dispute this view, it would only be reasonable to ask if being a licensed adjuster is sufficient in and of itself to denote a professional.

CHARACTERISTICS OF A PROFESSION

There are five characteristics that all professions exhibit. These would include the following:

- Commonly accepted body of knowledge
- Prior education requirement
- Qualification testing
- Self-regulatory organization
- Enforceable Code of Ethics

Let’s review the five characteristics of a profession as they relate to the adjuster.

COMMONLY ACCEPTED BODY OF KNOWLEDGE

Certainly this criteria is met at least minimally by the licensing process and continuing education requirements. Most professions require a college degree or equivalent type of training and thus a more comprehensive body of knowledge.

PRIOR EDUCATION REQUIREMENT

This criteria is also met minimally in many states by a requirement for applicants to possess a high school diploma, certificate of equivalency or at least demonstrate a certain reading and comprehension level. Once again, however, many professions require a bachelor’s degree prior to undertaking professional studies.

QUALIFICATION TESTING

Adjusters must pass a state licensing exam and all of us will agree this process has become significantly more rigorous over the years. Nevertheless, the state licensing exam could hardly be compared to a bar exam or medical certification.

ENFORCEABLE CODE OF ETHICS

The adjusting industry does have several non-mandatory professional organizations with an enforceable Code of Ethics. As a member of one of these organizations you must adhere to their code or risk losing your professional designation. However you can (and many adjusters do) operate without a professional designation and therefore are not bound by an enforceable Code of Ethics.

SELF REGULATORY ORGANIZATION
There are no mandatory self-regulatory organizations that one must join in order to transact business as an adjuster. Most professions have mandatory organizations that require membership in order to practice in the chosen field (such as American Society of Certified Public Accountants, American Medical Association, American Bar Association, etc). Violation of the rules of these organizations can result in a loss of right to practice in that field.

If you accept the above characteristics as valid for defining a profession, you would have to concede that holding a license as an adjuster in and of itself does not connote a professional. The vast majority of adjusters conduct themselves in a professional manner. The author’s point being that licensure alone does not compel professionalism. Particularly with regard to Ethics, it is only the motivation of the individual which raises his or her conduct to a professional level. In thinking about the recent media concerns about the insurance profession, perhaps we should not be surprised by the misdeeds of the few but rather impressed by the uncompelled professionalism of the many.

THE GENESIS OF PERSONAL ETHICAL STANDARDS

Most experts agree that ethical principles are learned (and thus taught). We are not born knowing right from wrong, but by an early age we have learned a fairly refined sense of right behavior. These basic ethics principles would certainly include all of the following:

PRINCIPLES OF ETHICS

HONESTY

Honesty is certainly telling the truth, but it is more than that. Honesty includes a commitment to the complete truth that adds or omits nothing. It would certainly be dishonest emphasizing the positive features of our service while failing to disclose material exclusions and limitations.

INTEGRITY

Integrity is similar to honesty but adds the additional element of consequences. An adjuster with integrity does the right thing without concern for the cost. If we knew a competitor’s service was better suited for our client, would we be willing to give up a large claims case in order to better serve the client and maintain our integrity?

RESPONSIBILITY/ACCOUNTABILITY

A responsible adjuster is reliable and trustworthy. Our clients depend on us to accurately determine the losses and help covered claims get properly paid. Would it be responsible conduct to conclude a claims adjusting case knowing the client was still unclear on material elements of the claim?

CARING ATTITUDE
We have all heard the old adage that clients don’t care how much you know until they know how much you care. We can never forget our work helps restore people to their former position prior to a loss, but at a cost. We must be able to empathize with them with regard to the impact the loss has had on their life while assuring a fair and just claim settlement. A caring adjuster will be able to answer the client’s objections without losing sight of the validity of their statements.

**COURAGE OF CONVICTION**

Having courage involves being resolute in your convictions to do what is right regardless of how others may view your actions. You must be secure in the knowledge that your actions will inevitably vindicate your convictions even if in the short run you are viewed unfavorably. Courage means being willing to stand on principle knowing it is the right thing to do.

**COMMITMENT TO EXCELLENCE**

A commitment to excellence is the strongest underpinning for ethical behavior. Taking shortcuts or the path of least resistance is antithetical to excellence and high ethical standards. An adjuster’s personal standards should exceed the required minimum standards of any law or regulation. In return, the adjuster builds a reputation for excellence that pays dividends which will compound over a long career.

**THE INSURANCE COMPANY’S ETHICAL RESPONSIBILITY TO THE INSURED**

One of the most important concepts in the business of insurance involves the insurance company's ethical responsibilities to the policy owner. These responsibilities cover the entire spectrum of company operations from the management of field sales agents, to providing day-to-day claims service to policy owners, to maintaining the financial strength of the insurance company.

**CLEARLY WORDED SALES MATERIAL**

As previously mentioned, the insurance company is responsible to the client for the accuracy and completeness of all field sales materials. Since many policyholders do not read their policy these sales material are often the vehicle that sets the insured’s expectation of benefit when a loss occurs. By so doing, the company can assure the prospective policy owner that all sales materials are free of inadvertently misleading terminology and ambiguous statements. These presentation materials, generally designed in the home office marketing department, benefit from a professional appearance and contain well-written, clear, and useful information. These materials are reviewed by a number of proofreaders and editors, as well as the legal department before publication. One of these reviews is to ensure that the materials are legally and ethically appropriate for field use, and are in compliance with company and regulatory standards. Because of this, the client is assured that all information is in the words of the company, and not merely in the words of the agent.
SUPERVISION OF MARKET CONDUCT

Insurance companies have long been in the practice of regularly exercising supervision over agents' sales, administrative, and record-keeping practices. This is in part because of the nature of insurance policies with their necessarily complex language.

Some of these procedures include annual meetings, generally presented by home office personnel, on the subjects of ethics and compliance.

These meetings are designed to educate agents on common types of mistakes made by agents and the consequences of them, sometimes including fines, loss of licenses, and other types of disciplinary actions. Other procedures sometimes include the review of client files and of sales materials in use.

It is also the company's responsibility to assure that agents receive adequate training in the areas of administrative procedure, record keeping, product knowledge and terminology, and company-approved sales methods and materials. The company should also encourage its agents to participate in professional education opportunities within the industry.

WELL TRAINED CLAIMS PERSONNEL

Insurance companies must also provide adequate claims staff to handle claims generated by outstanding policies. The claims personnel must be trained in company products and claims procedures as well as local claims requirements based on law and regulation.

QUALITY COMPANY LEVEL ADMINISTRATION

At the insurance company level there is a large volume of paper and electronic information to be handled on a fast and accurate basis. The policy owner deserves reassurance that this is being done effectively in his or her interests. The company has a responsibility to ensure that every application, beneficiary change, ownership change, etc., is handled correctly because of the damage that could be done to a family's or a business's finances if it is not handled correctly.

The maintenance of records is another major area of responsibility. Often a piece of correspondence, such as a split dollar agreement, from thirty years before may be essential to understanding how the death benefits of a policy are to be paid out. This is true of other documents also, including policy ownership changes, loan requests, optional premium payments, etc. As another example, when a policy cash value is used as a form of retirement supplement, accurate records are necessary to determine how much of each retirement income payment is reportable as taxable income to the recipient. If such records are not accurate and readily available, the policy owner or beneficiary could suffer significant financial loss.
MAINTAINING FINANCIAL STRENGTH

Insurance companies exist to provide benefits to clients and their beneficiaries. They often must do this, even though the premium dollars taken in are only the barest fraction of the substantial claims that could be paid out. Through the expertise of its actuaries, its investment specialists, and its other management decision makers, an insurance company has as one of its pre-eminent ethical responsibilities, the maintenance of its strength as a financial institution. The insurance company must be able to pay the benefits guaranteed to its policy owners and their beneficiaries, in spite of epidemics, large-scale disasters, and fluctuations in the U.S economy.

THE RELATIONSHIP BETWEEN ETHICS AND REGULATION

WHY ADJUSTERS ARE REGULATED

You undoubtedly are aware that one of your responsibilities as an adjuster is to follow and obey insurance laws. In addition to the Code of Professional Ethics, you also need to know why and how insurance is regulated.

PUBLIC INTEREST INDUSTRY

The Insurance industry is a major contributor to the economic and social well being of our society. Due to the availability of insurance for loss of property or injury, it is considered to be a public interest industry.

COMPETITION IS NOT ENOUGH

Companies that prosper are usually the ones whose products and services serve the needs of the client at the best price. Unfortunately, this is not the case in the insurance industry due to the complex nature of this product and its long-term use.

COMPLEX INTANGIBLE PRODUCT

Consumers have a difficult time understanding insurance policies even though these policies have been simplified in recent years. They still contain exclusions, exceptions, conditions and definitions that many people find difficult to interpret.

Unfortunately, this complexity provides opportunities for unscrupulous individuals to take advantage of proposed clients by misrepresenting coverage or pricing their services too high as well as misinforming clients on what they can expect in a claim.

BAD ADJUSTER CONDUCT
An example of bad or unethical conduct for an independent adjuster to engage in would be to disparage the legal profession by telling a claimant that if they retain counsel it will only delay the claims and after paying the attorney the claimant will net less claims proceeds than if they dealt with the adjuster only. Along the same vein for an adjuster to attempt to advise the claimant of their legal rights in a claim would be considered the unlicensed (unauthorized) practice of law.

GOOD ADJUSTER CONDUCT

An independent adjuster should approach each claim with an unbiased attitude, conduct a thorough claims investigation as soon as possible, keep detailed notes, respond promptly and appropriately to the claimant (or their counsel) and recommend a fair and objective settlement if coverage and/or liability apply. The first party claimant has paid their premiums for the contracted coverage and deserves a prompt unbiased assessment of the claim. The adjuster should restrict their comments to facts and not interject personal opinion nor should they attempt to cause anxiety in the mind of the claimant by making any statements that are not grounded in fact.

ADJUSTERS ETHICAL RESPONSIBILITIES

RESPONSIBILITIES TO THE INSURED

The independent adjuster owes an ethical responsibility to the insured or claimant. Following is a short list of some but not all of the ethical responsibilities owed by the independent adjuster to the insured or claimant.

They owe an ethical duty to the claimants (first and third party) to seek only information they believe to be relevant to the matter at hand, they should never seek to misinform or mislead, and remain sensitive to individual rights to privacy. The independent adjuster should not undertake to adjust any loss for which they are not qualified to adjust through technical training and/or experience. The independent adjuster should also never place the interest of their employer above those of the insured.

RESPONSIBILITIES TO THE INSURER

The independent adjuster owes an ethical responsibility to the represented insurer. Following is a short list of some but not all of the ethical responsibilities owed by the independent adjuster to the insurer who has retained their services.

The independent adjuster owes an ethical responsibility to the insurer to judiciously adjust their assigned claims within the local legal requirements and policy provisions and to not undertake any action that would reflect in a negative manner on their employer. The independent adjuster also owes an ethical responsibility to the insurer to remain vigilant for fraudulent claims and inflated or exaggerated costs within otherwise valid claims.
EXAMPLES OF ETHICAL AND UNETHICAL ADJUSTER CONDUCT

KENTUCKY ADJUSTER BAD FAITH

In a 2002 court case in Kentucky a staff adjuster and her insurer were found to have acted in bad faith in an uninsured motorist claim. In her defense the adjuster disclosed adjuster training manuals used by her employer that encouraged adjusters to “plant uncertainty in the minds of the claimants and to seize upon and fear, anxiety, or financial problems” in order to reach a settlement favorable to the insurer.

The jury awarded the policy limits to the plaintiff and 11 times that amount in punitive award.

The insurer appealed the amount of the punitive award by arguing that it violated the Due Process Clause of the US Constitution (in affect that it lacked adequate notice of the potentially severe consequences of it’s misconduct). The Appeals Court ruled against the insurer and the punitive award stood. Part of the summary of the Appeals Court stated “insurers are keenly aware that they risk substantial civil penalties and fines when they engage in unfair claims settlement practices”.

HOW AN ETHICAL ADJUSTER COULD HAVE MADE A DIFFERENCE

How could the adjuster in the above court case have acted differently? She could have refused to engage in the activities espoused in the adjuster training manual. It doesn’t take a finely honed sense of right and wrong to know that the adjuster training manual, and by extension upper management, was telling the adjuster trainees to be deliberately biased and unfair in the claims process. Many decisions in life are difficult to make and occasionally making a decision that is ethical can cost you money in the short run. The adjuster in the above case could have refused to work under those circumstances and looked for other employment. She could also have reported the existence of the adjuster training manual to the Kentucky Department of Insurance and possibly saved numerous insureds from unfair claim settlements.

AN ETHICAL ADJUSTER IN TEXAS

Shortly after hurricane Humberto roared through Beaumont, Texas in September of 2007 a hotel manager offered $20,000 in cash to an adjuster to inflate a claim for $125,000 when actual damages were only $18,000. The adjuster turned the hotel manager in to authorities and the hotel manager was prosecuted.

The adjuster in the above case certainly acted ethically but they also acted legally. To accept the payoff for inflating a claim beyond supportable damages would have been illegal as well as unethical.
CHAPTER REVIEW QUESTIONS
(answers are in the back of the text)

1. All of the following are ethical responsibilities of the insurance company to the insured except:

   A. Supervising market conduct
   B. Providing well trained claims personnel
   C. Coverage of all risks encountered by the public
   D. Clearly worded sales material

2. Being resolute in your determination to do what is right regardless of how others may view your actions is a summary of which principle of ethics?

   A. Integrity
   B. Courage of conviction
   C. Honesty
   D. Responsibility/Accountability
Chapter 2

INDUSTRY CODES OF ETHICS SAMPLES

THE PROCESS OF DEVELOPING A CODE OF ETHICS

- Relevant laws and regulations are reviewed;
- Values which produce the top three or four traits of a highly ethical and successful service or product in the industry are reviewed;
- Values needed to address current issues in the industry are identified—descriptions of major issues in the workplace or industry are collected;
- Evaluate the industry's strengths, weaknesses, opportunities and threats;
- Consider the top ethical values that might be prized by the consumer; and
- The top five to ten ethical values, which are high priorities in the industry, are collected.

Trustworthiness, Respect, Responsibility, Caring, Justice and Fairness, Civic Virtue and Citizenship.

- Behaviors are associated with values;
- Solicit input from members of the industry;
- Review the code regularly; and
- Goals are refined.

GUIDELINES FOR DEVELOPING A CODE OF CONDUCT

- Identify key behaviors needed to adhere to the proclaimed ethical values;
- Declare that all members must conform to the specified behaviors in the code of conduct;
- Obtain review from key members of the organization;
- Announce and distribute the code of conduct; and
- Include examples of topics typically addressed by codes of conduct.
THE AMERICAN SOCIETY OF CLU AND CHFC

The Code is founded upon the crucial ethics of competent advice and service to the client and enrichment of public regard for the CLU and ChFC designations. The purpose of the Code is to provide standards of professional conduct by those involved in providing insurance, financial planning and economic security.

The Code is supported by Guides, which give specificity to the imperatives, with interpretive comment to assist in understanding. A member is in violation of the Code when a member has breached an ethical imperative through failure to adhere to one or more of the Guides. Those who have chosen to enter into membership in the American Society voluntarily bind themselves to the Code of Ethics of their professional organization and any violation would expose a member to sanctions, which range from reprimand to membership revocation.

NATIONAL ASSOCIATION OF PROFESSIONAL INSURANCE ADJUSTERS

RULES OF PROFESSIONAL CONDUCT AND ETHICS

• The members shall conduct themselves in a spirit of fairness and justice to their clients, the Insurance Companies, and the public.

• Members shall refrain from improper solicitation.

• No misrepresentation of any kind shall be made to an assured or to the Insurance Companies.

• Commission rates shall be fair and equitable, and strictly in accordance with the prevailing custom in the locality, and must, where laws or regulations of insurance departments exist, comply fully with such laws or regulations.

• Members shall conduct themselves so as to command respect and confidence. They shall work in harmony with one another, with their clients, and the Insurance Companies' representatives, so as to foster a cordial and harmonious relationship with all branches of the insurance business, and with the general public.

• Members must be fitted, by knowledge and experience, for the work they undertake. They must not endanger the interests of the public adjusting profession, or risk injustice to assureds or to the Insurance Companies, by attempting to handle losses or claims for which they are not qualified, and for which they cannot find competent technical assistance.

• Members shall not engage in the unauthorized practice of law.

• Members shall not acquire any interest in salvaged property or participate in any way, directly or indirectly, in the reconstruction,
repair or restoration of damaged property, except with the knowledge consent and permission of the insured.

- Members shall be cooperative and assist one another in every possible way.
- Members shall not disseminate or use any form of agreement, advertising, or any printed matter that is harmful to the profession of public adjusting, or which does not comply with the rules and regulations of the Insurance Department of the state in which such member is professionally engaged, or which might subject public adjusting and public adjusters to criticism or disrespect.

**AMERICAN INSTITUTE FOR CHARTERED PROPERTY AND CASUALTY UNDERWRITERS CODE OF PROFESSIONAL ETHICS**

**CANONS AND RULES**

**CANON 1**

CPCUs Should Endeavor at All Times to Place the Public Interest Above Their Own.

**Rules of Professional Conduct**

R1.1 A CPCU has a duty to understand and abide by all Rules of Conduct, which are prescribed in the Code of Professional Ethics of the American Institute.

R1.2 A CPCU shall not advocate, sanction, participate in, cause to be accomplished, otherwise carry out through another, or condone any act which the CPCU is prohibited from perform by the Rules of this Code.

**CANON 2**

CPCU’s Should Seek Continually to Maintain and Improve Their Professional Knowledge, Skills and Competence.

**Rules of Professional Conduct**

R2.1 A CPCU shall keep informed on those technical matters that are essential to the maintenance of the CPCU’s professional competence in insurance, risk management or related fields.
CANON 3

CPCU’s Should Obey All Laws and Regulations, and Should Avoid Any Conduct or Activity Which Would Cause Unjust Harm to Others.

**Rules of Professional Conduct**

**R3.1** In the conduct of business or professional activities, a CPCU shall not engage in any act or omission of a dishonest, deceitful or fraudulent nature.

**R3.2** A CPCU shall not allow the pursuit of financial gain or other personal benefit to interfere with the exercise of sound professional judgment and skills.

**R3.3** A CPCU will be subject to disciplinary action for the violation of any law or regulation, to the extent that such violation suggests the likelihood of professional misconduct in the future.

CANON 4

CPCU’s Should be Diligent in the Performance of Their Occupational Duties and Should Continually Strive to Improve the Functioning of the Insurance Mechanism.

**Rules of Professional Conduct**

**R4.1** A CPCU Shall Competently and Consistently Discharge His or Her Occupational Duties.

**R4.2** A CPCU shall support efforts to effect such improvements in claims settlement, contract design, investment, marketing, pricing, reinsurance, safety engineering, underwriting and other insurance operations as will both inure to the benefit of the public and improve the overall efficiency with which the insurance mechanism functions.

CANON 5

CPCU’s Should Assist in Maintaining and Raising Professional Standards in the Insurance Business.

**Rules of Professional Conduct**

**R5.1** A CPCU Shall Support Personnel Policies and Practices Which will Attract Qualified Individuals to the Insurance Business, Provide Them with Ample and Equal Opportunities for Advancement and Encourage Them to Aspire to the Highest Levels of Professional Competence and Achievement.
R5.2 A CPCU Shall Encourage and Assist Qualified Individuals Who Wish to Pursue CPCU or Other Studies, which will Enhance Their Professional Competence.

R5.3 A CPCU Shall Support the Development, Improvement, and Enforcement of Such Laws, Regulations and Codes as will Foster Competence and Ethical Conduct on the Part of all Insurance Practitioners and Inure to the Benefit of the Public.

R5.4 A CPCU shall not withhold information or assistance officially requested by appropriate regulatory authorities who are investigating or prosecuting any alleged violation of the laws or regulations governing the qualifications or conduct of insurance practitioners.

CANON 6

CPCU’s Should Strive to Establish and Maintain Dignified and Honorable Relationships with Those whom they Serve, with Fellow Insurance Practitioners and with Members of Other Professions.

Rules of Professional Conduct

R6.1 A CPCU shall keep informed on the legal limitations imposed upon the scope of his or her professional activities.

R6.2 A CPCU shall not disclose to another persona any confidential information entrusted to, or obtain by, the CPCU in the course of the CPCU’s business or professional activities, unless a disclosure of such information is required by law or is made to a person who necessarily must have the information in order to discharge legitimate occupational or professional duties.

R6.3 In rendering or proposing to render professional services for others, a CPCU shall not knowingly misrepresent or conceal any limitations on the CPCU’s ability to provide the quantity or quality of professional services required by the circumstances.

CANON 7

CPCU’s Should Assist in Improving the Public Understanding of Insurance and Risk Management.

Rules of Professional Conduct

R7.1 A CPCU shall support efforts to provide members of the public with objective information concerning their risk management and insurance needs and the products, services and techniques which are available to meet their needs.
R7.2 A CPCU shall not misrepresent the benefits, costs or limitations of any risk management technique or any product or service of an insurer.

CANON 8

CPCU’s Should Honor the Integrity and Respect the Limitations Placed Upon the Use of the CPCU Designation.

Rules of Professional Conduct

R8.1 A CPCU shall use the PCU designation and the CPCU key only in accordance with the relevant guidelines promulgated by the American Institute.

R8.2 A CPCU shall not attribute to the mere possession of the designation depth or scope of knowledge, skills and professional capabilities greater than those demonstrated by successful completion of the CPCU program.

R8.3 A CPCU shall not make unfair comparisons between a person who holds the CPCU designation and one who does not.

R8.4 A CPCU shall not write, speak, or act in such a way as to lead another reasonably to believe the CPCU is officially representing the American Institute, unless the CPCU has been duly authorized to do so by the American Institute.

CANON 9

CPCU’s Should Assist in Maintaining the Integrity of the Code of Professional Ethics.

Rules of Professional Conduct

R9.1 A CPCU shall not initiate or support the CPCU candidacy of any individual known by the CPCU to engage in business practices which violate the ethical standards prescribed by this Code.

R9.2 A CPCU possessing unprivileged information concerning an alleged violation of this Code shall, upon request, reveal such information to the tribunal or other authority empowered by the American Institute to investigate or act upon the alleged violation.

R9.3 A CPCU shall report promptly to the American Institute any information concerning the use of the CPCU designation by an unauthorized person.
1. The rules of professional conduct and ethics of the National Association of Professional Insurance states that: “Members shall not acquire any interest in salvaged property or participate in any way, directly or indirectly, in the reconstruction, repair or restoration of damaged property _______________.

A. except with the knowledge consent and permission of the insured.
B. unless they pay fair market value determined to the best of their ability.
C. with no exceptions.
D. unless, in an open and public forum, they are the lowest bidder for reconstruction or repair services or the highest bidder for the purchase of salvaged property.

2. All of the following are part of the process of developing a code of ethics except:

A. Reviewing relevant laws and regulations
B. Evaluating industry strengths and weaknesses
C. Soliciting input from industry members
D. Identify key behaviors needed to adhere to the proclaimed ethical values
Chapter 3

THE CLAIMS SETTLEMENT PROCESS

THE ADJUSTERS ROLE

Since the insurance adjuster is a representative of the insurance industry as a whole, their role is vital to public relations. An adjuster should maintain a level of professionalism not only toward their insurance company, but toward competitors as well.

LOFTY GOALS

An adjuster must not only comply with the minimum legal standards established by the state, but adhere to a set of high personal ethical standards as well. Because of the subjective nature of losses and claims, claimants must have trust in the adjuster. If that trust is violated, both parties suffer. Adjusters who are tempted by an individual or a situation to act in an unethical manner must consider the long-term results of those actions, for both the consumer and themselves as well.

CONDUCT GUIDELINES

- Place the interests of the claimant first;
- Strive for a high level of personal integrity;
- Strive to constantly improve your professional skills and knowledge in the industry;
- Maintain a professional level of conduct with all associates in the insurance industry;
- Make it your personal responsibility to know the laws and rules that regulate the insurance business, and follow them in both spirit and letter of the law;
- Do not make claims you cannot support, or make untrue or exaggerated statements; and
- Be aware of the factors that influence your customers, and provide them with the same service, advice, compassion and skill with which you would serve your own family.
LIABILITY

Just as in one’s personal life, an adjuster must assume responsibility for any mistakes made and make every effort to rectify the situation. Protection from liability exposure may be provided through:

- Awareness and observation of applicable laws and insurance regulations;
- Awareness of company standards and procedures;
- Keeping the lines of communication open between customers and the company, and quickly responding to their needs; and
- Continuously improving knowledge and skill.

AVOID LEGAL REPRESENTATIONS

Adjusters are not attorneys and must therefore refrain from giving legal advice. The following guidelines are suggested for review and clarification.

- Defer to the client’s attorney when presented with questions about how specific legal concepts may affect the client;
- Adjusters must not draft legal documents such as a release, or even make addenda or notes on such documents; and
- Adjusters may gather information about the claim and discuss policy coverage, but avoid trying to apply law to their client’s situation.

MATRIX TO ADDRESS ETHICAL SITUATIONS

METHODODOLOGY – THE ETHICAL CHECKLIST

THE TEN-STEP METHOD

The following ten-step method can be used to improve decision-making abilities in ethical dilemmas.

- What are the facts in the situation?
- Who are the key stakeholders, what do they value and what are their desired outcomes?
- What are the underlying drivers causing the situation?
- In priority order, what ethical principles or operating values should be upheld in this situation?
- Who should have input to, or be involved in, making this decision?
• List any alternative and action plans that would prevent or minimize harm to the stakeholders, uphold the priority values for the situation and be a good solution to the situation.

• Build a worst-case scenario for a preferred alternative to see how it affects the stakeholders. Rethink and revise the preferred alternative, if necessary.

• Add a preventative ethics element to the action plan that deals with the underlying drivers causing the situation listed in Step 3.

• Evaluate the chosen decision and action plan against the Ethics Checklist.

• Decide upon and build an action plan, and implement and monitor it.

KEY QUESTIONS TO ADDRESS ETHICAL SITUATIONS

Use these 12 questions to address ethical dilemmas:

• Has the problem been defined accurately?

• If you were the other party, how would you define the problem?

• What caused this situation?

• As an individual and a member of the corporation, where does your loyalty lie?

• What is your objective in making this decision?

• How does this aim compare with the probable outcome?

• Could your decision or action injure anyone and, if so, whom?

• Prior to making your decision, can you discuss the problem with the affected parties?

• Are you convinced that your position will be as valid over a long period of time as it seems now?

• Could you disclose your decision or action to your boss, CEO, Board of Directors, family and society without trepidation?

• What is the symbolic potential of your action if understood? Misunderstood?

• Would you allow exceptions to your decision and, if so, under what circumstances?
GOOD FAITH VERSUS BAD FAITH

In addition to the actions and performance required by law, insurance adjusters are also held to a high standard of ethical behavior. In all jurisdictions, insurance companies must act in good faith when investigating, evaluating, and settling claims submitted by first-party insureds and third-party claimants. Although not all states recognize a separate cause of action for an insurance company’s bad faith toward its insureds, most states impose substantial penalties for punitive damages when insurers act in bad faith toward third-party claimants, and many impose similar penalties in first-party claims.

Since the business of insurance is based upon a mutual trust between producers and customers, this trust must be founded upon the highest ethical standards. Therefore, it is very important that insurance companies and adjusters avoid any misconduct that could bring about legal action against them for violation of this trust. Adhering to the highest ethical standards is crucial to the integrity of the insurance industry. Through the practice of ethical fitness, insurance professionals will develop a commitment to their profession, and consumers will maintain confidence in their insurance professionals.

The subject of ethics is so important that most states require insurance agents, adjusters, counselors, and similar professionals to complete a specified number of hours of their continuing education requirements on the subject of ethics. This requirement typically may be satisfied by completing courses in the areas of ethical practices, legislative or regulatory changes, current ethical concerns, and similar topics.

An adjuster essentially serves as a liaison between the insurance company and insureds or claimants. The nature of the claim handling process requires various responsibilities during its many stages. While an independent or company adjuster must act in the best interests of his/her principal, the adjuster must also act on behalf of insureds and claimants. When undertaking an insurance claim, a adjuster is confronted with a variety of obligations and must determine which party is owed a particular duty.

An independent or company adjuster traverses a delicate line when handling his/her responsibilities. He/she must respond to the insurance company represented by virtue of the agency or contractual relationship and to the insured or claimant based on the many responsibilities required by law. If the adjuster does not properly carry out these responsibilities, there is a threat of legal action. Therefore, adjusters should be aware of not just their legal responsibilities as called for by the Unfair Claims Settlement Practices Act, but also of the high ethical standards needed to perform their daily affairs.

In order to successfully pursue a claim against an insurance company and/or its agent, the plaintiff must establish the fact that damages were suffered and that the company and/or its agent was the cause of those damages. An insurance producer who is found guilty of an unfair claims practice is generally subject to a civil penalty; that is, a fine for each violation. A pattern of violations may cause its certificate of insurance to be suspended or revoked.
GOOD FAITH

The courts have held that a special relationship exists between the insurer and the insured because of their unequal bargaining position, or the disparity of bargaining power. The disparity of bargaining power is represented by the exclusive control the insurer has over the processing of claims. This special relationship imposes a duty on the insurer to investigate, evaluate, and settle claims thoroughly and in good faith. The core of the duty of good faith and fair dealing is that insurers must act reasonably with respect to the interests of insureds and third-party claimants.

All insurers have the duty of good faith and fair dealing. Typically, the courts have held in dealing with cases involving insurers’ duty of good faith and fair dealing that the plaintiff must prove both of the following:

- The absence of any reasonable basis for denying payment of the benefits under the policy; and

- That the carrier knew there was no reasonable basis for denying the claim or for delaying the payment of the claim.

Of course, insurance companies maintain the right to deny invalid or questionable claims and are not subject to bad faith liability for the mistaken denial of a claim. If a company denies what is later determined to be a valid claim, it must respond under the terms of the policy. As long as there is a reasonable basis to delay or deny payment, even if it is ultimately determined that the delay or denial was made in error, the insurer is not liable for the breach of duty of good faith and fair dealing.

Remember from our earlier discussions that insurers have the common law duty of care. Duty of care encompasses performing with care, skill, reasonable expedience, and faithfulness. Their standard of care is measured by requiring a determination of whether a reasonable insurer under similar circumstances would have delayed or denied a claim. Insurers are held to that degree of care and diligence which a man of ordinary care and prudence would exercise in the management of his/her own business.”

While the duty of good faith and fair dealing requires the parties to deal fairly with one another, it does not imply the burden of requiring one party to place the interests of the other party before its own.

Insurers’ duty to defend arises from the insurance contract. The insurer has the duty to defend any suit against an insured who is seeking damages resulting from bodily injury or property damage. This duty stands, even if the allegations of the suit are ultimately proven to be groundless, false, or fraudulent.

The insurer’s duty to indemnify involves making compensation for the incurred hurt, injury, loss, or damage, and the duty to settle requires insurance companies to settle valid
claims within a reasonable period of time. Every reasonable settlement demand within policy limits should be accepted by the insurer unless the company is willing to take the case to trial.

In Los Angeles, California, 1991, the National General Adjusters Association (NGAA) was created as a learning tool for adjusters. Interaction among general adjusters affords professional advice and experience sharing, specializing in commercial property claims. NGAA is a nationally recognized non-profit organization whose mission is “…to share information and reference materials among professional general adjusters across the United States and internationally to enhance their abilities.” Every approved member is designated as a Registered General Adjuster (RGA); no self-appointed general adjusters are recognized; however, the association does consider all property adjusters who meet the standards and ability of the General Adjuster.

The association provides educational materials through publishing newsletters, holding workshops and conducting seminars to keep adjusters informed on the ever-changing aspects of the insurance industry. Its mission involves “…setting standards to be educational and helpful in pursuing higher ethics in property adjusting above the expected.”

BAD FAITH

The concept of bad faith must be clearly understood and respected. The claims handling field is filled with risks. If claims professionals do not fully understand the influence of their actions or inactions during the claims handling process, a bad faith claim may result.

In addition to the obligations imposed by the duty of good faith and fair dealing, insurers have the obligation to avoid acts of bad faith. In dealing with claims of bad faith, the courts generally distinguish insurance contracts from ordinary commercial contracts on the basis that a special relationship exists between the insured and insurer because of the unique nature of the insurance contract.

The courts have held that insurance contracts are personal in nature, not commercial, and that insurance is purchased in order to protect against accidental risks and not for commercial benefit. Therefore, an insured is purchasing more than financial security; the insured is said to be purchasing peace of mind as well.

The inequity of bargaining power between the parties in an insurance contract is another characteristic of this special relationship. Because insureds are typically in a weak economic position after sustaining a loss and insurance companies are in a superior financial position, some courts believe that the threat of tort action is necessary to prevent insurers from delaying claims or insisting that insureds accept less than the full benefits due under the policy.

In these cases, the courts reason that if the insurance company’s punishment for unfairly refusing to pay a claim were only being forced to pay that which was owed to the insured
under the contract anyway, there would be little or no incentive for the insurer to act in
good faith. For that reason, punitive damages are imposed to punish wrongdoers and to
deter the defendant and others from performing the same or similar acts.

Allegations of bad faith are very common and a part of most insurance claim disputes. At
the same time, the law’s reference to the term “reasonable” can sometimes be difficult to
define, and bad faith allegations are not always easy to prove.

FIRST-PARTY BAD FAITH TORTS

GRUENBERG V AETNA

The beginning for first-party bad faith cases is the landmark decision of the
Supreme Court of California in Gruenberg v. Aetna Insurance Company,
510 P2d 1032 (1973). In deciding whether benefits were owed under a fire
insurance policy, the court cited the principle that there is an implied covenant of
good faith and fair dealing in all contracts of insurance. Explaining its inclination
to recognize a bad faith tort cause of action in the first-party context, the court
stated:

"The insurer has an obligation imposed by law to act fairly and in good faith in
discharging its contractual responsibilities. Where the insurer fails to deal fairly
and in good faith with its insured by refusing, without proper cause, to
compensate its insured for a loss covered by the policy, such conduct may give
rise to a cause of action in tort for breach of the implied covenant of good faith
and fair dealing."

The court noted that the insured had alleged damages for mental distress in
addition to substantial damages for property loss. The court held that a tort
measure of damages should apply and that consequential damages for mental
distress, as well as economic loss in excess of the policy limit, would be available.

THIRD-PARTY BAD FAITH TORTS

Third-party bad faith torts allow an accident victim to bring a claim for punitive
damages against another person’s liability insurer if it is proven that the insurer
engaged in unfair claims settlement practices.

At one time, the courts in all states had held that an insurance policy was a
contract that stated or implied the insurance company’s obligations to its insured.
If an insured believed that the company had failed to meet its obligations under
the terms of the agreement, he/she could bring a claim against the company,
seeking punitive damages for any losses incurred as a result of the company’s
breach of the contract.
However, because other parties injured by the insured were not parties to the contract, the insurance company had no obligation to deal fairly with third-party accident victims. If a third-party accident victim was not satisfied with the insurer’s conduct in settling a claim, he/she could file a complaint with the state insurance department charging that the insurer had violated the state’s insurance code. As we discussed in the previous chapter, the insurance commissioner can investigate such complaints and, when appropriate, impose a fine on an insurer who engages in unfair claim settlement practices.

In the evolution of insurance law, the courts have held that an insurer is obligated to deal in good faith with a claim against one of its insureds; that is, in third-party claims. The courts have generally concluded that a state’s Unfair Trade Practices Act establish a private right of action against insurers that commit the unfair acts or practices defined in the Act. Therefore, a third-party claimant is permitted to bring a separate tort action and seek punitive damages against an insurer for failing to act fairly and in good faith when responding to a claim against its insured.

Because such a claim is separate from the underlying claim between the insured and the insurer and is based on the insurer’s conduct, a third-party claimant may seek compensatory and punitive damages that are not subject to policy limits. This means that an insurer that engages in unfair claims settlement practices is potentially exposed to an unlimited judgment.

STANDARD FOR LIABILITY

ANDERSON V CONTINENTAL

Typically, the most prevailing element of bad faith is intent or willful conduct. In Anderson v. Continental Insurance Company, 271 NW2d 368 (1978), the Wisconsin Supreme Court stated:

“To show a claim for bad faith, a [policy holder] must show the absence of a reasonable basis for denying benefits of the policy and the [insurance company's] knowledge or reckless disregard of the lack of a reasonable basis for denying the claim. It is apparent, then, that the tort of bad faith is an intentional one. [. . .] implicit in that test is our conclusion that the knowledge of the lack of a reasonable basis may be inferred and imputed to an insurance company where there is a reckless [. . .] indifference to facts or to proofs submitted by the [policy holder].”

SPARKS V REPUBLIC

Under the "fairly debatable" standard, an insurer may be liable for bad faith only
when a denial or delay in payment lacked any reasonable basis. When the insurer's position is one on which reasonable minds could differ, the insurer will not be liable simply as a matter of law. In Sparks v. Republic National Life Insurance Company, 132 Ariz. 529, 647 P.2d 1127 (1982), the court held that the fair “debatability” of an insurance claim cannot be created by the insurer's reliance on ambiguity in the policy, otherwise "insurers would be encouraged to write ambiguous insurance contracts.”

The courts seem to agree that while insurance companies owe a duty of good faith and fair dealing to their policy holders, bad faith awards are to be reserved to punish only the most egregious cases of insurance company misconduct where the policy holders suffer extraordinary damages.

The courts have firmly established the existence of an independent bad faith cause of action for nonpayment of claims and have adopted standards by which to measure bad faith claims. Court decisions positioned the ground work for establishing claims handling practices that an insurance company must follow in order to conduct a satisfactory good faith claims process and avoid assertions of bad faith.

Generally, when determining bad faith, a two-part analysis is undertaken. First, the plaintiff must prove that the insurer’s conduct was unreasonable. Next, the plaintiff must prove that the insurer intentionally delayed or denied a claim it knew to be valid. Remember, as long as the insurer has a reasonable basis for delaying or denying a claim, bad faith cannot be present.

The most common bad faith assertion is delaying or denying payment of a claim. Suggesting that an insured or claimant not retain legal counsel is also a common bad faith assertion. If an insured or claimant must initiate litigation in order to recover benefits, he/she can probably prove bad faith on the part of the insurer.

**DEGREE OF MISCONDUCT**

The courts have generally held that the duration of an insurer's misconduct, the degree of its awareness of damage, and any concealment of this are elements to be taken into account when assessing the defendant insurer’s culpability for the purpose of awarding punitive damages. For example, an insurer cannot repeatedly attempt to compromise a claim in an amount less than its fair value. The court will recognize evidence of prior similar acts in order to determine if the insurer’s actions are intentional.

Evidence of previous, similar acts speaks to the probability that the conduct in question is unintentional. The more frequently an act occurs, the higher probability that it is intentional. Therefore, whether the defendant intends to injure the plaintiff or consciously disregards the plaintiff’s rights may be suggested by a pattern of similar unfair practices.
REASONABLENESS

The standard established by the courts is really one of reasonableness. However, the term “reasonable” is not always easy to define. The following types of conduct demonstrate unreasonableness on the part of the insurer and have resulted in findings of bad faith:

• An insurer's attempt to withhold payment of an undisputed portion of a claim on the condition of a favorable settlement of a separate, disputed portion;
• An insurer's failure to make prompt payment as coercion of insured into settling for less than full performance;
• An insurer's failure to conduct a reasonably thorough investigation before denying an insured's claim;
• An insurer's unreasonable delay in the handling of a claim;
• An insurer's failure to advise its insured of his/her duty to submit the appropriate forms; and
• An insurer's reliance on a policy provision previously ruled invalid.

It is important to note here that merely a showing of an initial bad faith refusal to pay a claim is cause for a bad faith tort cause of action. The insurer's eventual performance does not release it from liability for bad faith. However, the courts have held that the failure to pay a claim is not the condition for an action for breach of the implied covenant of good faith and fair dealing.

RAWLINGS V APODACA

In Rawlings v. Apodaca, 726 P.2d 565, 572 (Ariz. 1986), the Court remarked that insurance companies cannot be expected to perform perfectly by stating:

“Papers get lost, telephone messages misplaced and claims ignored because paperwork was misfiled or improperly processed. Such isolated mishaps may result in a claim being unpaid or delayed. None of these mistakes will ordinarily constitute a breach of the implied covenant of good faith and fair dealing, even though the company may render itself liable for at least nominal damages for breach of contract in failing to pay the claim.”
QUESTIONABLE CLAIMS

Unfortunately, the concern over punitive damages has become an aspect of evaluating claims, especially dubious claims. Punitive damage claims generally accompany all lawsuits for breach of contract of an insurance policy. As a result, many insurance companies pay questionable claims because of the fear of punitive damage awards.

In some states, the courts impose punitive damage awards when the focus is on the insurer’s deceptive, malicious, oppressive, or fraudulent conduct, and the insurer must be aware that any actions it has taken concerning a policy claim will be judged by the standard of "reasonableness." The question will be whether a reasonable insurer under the circumstances would have denied or delayed payment of the claim.

In applying this standard, it is necessary to determine whether a claim has been properly investigated and whether the results of the investigation were subject to a reasonable evaluation and review. Factors considered here will include whether a thorough investigation was conducted before a determination of the claim was made, whether the adjuster took on a defensive position when determining the validity of the claim, and whether he/she was neutral in disposing of the claim. In order for a plaintiff insured to successfully prevail on a first-party bad faith claim in most states, the insured must prove that the insurer intentionally denied the claim, failed to pay the claim, or delayed payment of the claim without a reasonable basis for its action.

Most insurance policies contain a provision that no action can be brought against the company unless there has been full compliance with all of the terms of the policy. Policies typically require that if all terms of the policy have been met, the action must be started within a specific period of time, for example, two years after the date of loss. In jurisdictions addressing the breach of good faith and fair dealing, the courts have held that the insurer's duty to act reasonably in handling a claim is not excused by the insured's failure to cooperate or comply with the terms of the policy.

However, the duty of good faith and fair dealing is also a mutual undertaking. Therefore, the insurer's liability for unreasonably withholding or denial of policy benefits may be reduced by the insured's failure to cooperate with the company’s investigation or the insured's failure to comply with certain policy provisions.

DEFENSES TO CLAIMS OF BAD FAITH

There are very few accepted defenses to allegations of bad faith. Some of these are discussed below. Remember, state laws vary, and some states’ bad faith tort law may not be as developed as the laws in other states. Therefore, not all of the bad faith defenses discussed here may apply in all states.
In order to justify or excuse its conduct and thereby escape liability that may otherwise result from its delay or refusal to pay policy benefits, insurers may generally assert one of the following defenses:

- **Reasonable Basis for Conduct** — Because an insurer’s lack of consistence with a standard of care that can be considered negligent, the reasonableness of its conduct is a question of fact for a jury. If the insurer can show a reasonable basis for its delay or denial of a claim, there is no breach of the covenant of good faith and fair dealing.

- **Advice of Counsel** — An insurer is entitled to rely on the advice of its counsel and may rely on this advice as a factor in evaluating reasonableness when delaying a claim or when denying a claim. However, the converse is also true. An insurer’s failure to follow the legal advice of its counsel may constitute evidence of the violation of good faith and fair dealing.

- **Compromise and Settlement** — A compromise and settlement agreement stating that the agreement is in settlement of a disputed claim would prevent a bad faith action.

- **Comparative Bad Faith** — If an insured’s conduct contributes to the insurer’s failure to pay a claim on a timely basis or to deny a claim, this comparison of the conduct between the insurer and the insured may be a factor in the insurer’s defense.

- **Statute of Limitations** — The cause of action for a breach of duty of good faith generally begins on the day the insurer wrongfully denies coverage. The state’s statutory limitation period applies, and if this period expires before the claim of bad faith is made, the claim is defensible on this basis.

- **Unsettled Questions of Law** — Insurers are generally not held liable for bad faith for requiring the insured to litigate unsettled questions of law, regardless of the outcome. Remember, insurance companies are prohibited from compelling insureds or claimants to institute litigation in order to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds. However, unsettled questions of law are not grounds for bad faith claims. Therefore, a claim of bad faith would be defensible on this basis.

It should be noted that while promptly filed declaratory judgment actions will not necessarily defeat a finding of bad faith, the filing of a declaratory action does not itself give rise to a finding of bad faith on the part of an insurer.

**BAD FAITH DAMAGES**
Typically, the following types of damages may be recoverable in bad faith cases:

- **Contract Damages** — Prior to the adoption of the tort of bad faith, an insured's only remedy for loss suffered due to the conduct of an insurer was an action for breach of contract. However, such suits can be expensive and time consuming. As a result of a breach of contract action, the insured could only recover that which was already due and consequential damages when appropriate; that is, damages which the parties should have foreseen when they contracted as likely to result from the breach. With the tort of bad faith, insureds are no longer restricted to the damages available under a breach of contract suit.

- **Emotional Distress** — In order to recover damages for emotional distress caused by an insurer's bad faith, the insured must show that the insurer's bad faith resulted in an invasion of property rights. Damages for pain and suffering, humiliation, and inconvenience, as well as pecuniary losses for expenses such as attorney fees, may prompt damages for invasion of protected property rights.

  The tort of intentional infliction of emotional distress requires outrageous conduct. However, damages in a bad faith case may be awarded for emotional distress even though the defendant insurer did not intentionally cause the distress and even though the distress was not severe. The interest in a bad faith case is with emotional distress resulting from a substantial invasion of property interests of the insured and not with the independent tort of intentional infliction of emotional distress.

- **Punitive Damages** — Typically, punitive damages are awarded for the tort of bad faith only when there is proof that the defendant's conduct was aggravated, outrageous, malicious, or fraudulent. Mere negligence is not enough to recover on a claim for punitive damages. Also, while indifference to facts or the failure to investigate is sufficient to establish the tort of bad faith, this conduct does not warrant recovery for punitive damages.

  The courts have generally found that the issue of bad faith may be submitted to a jury on the theory of reckless disregard for the absence of a reasonable basis for the denial of a claim. If the evidence shows only mismanagement and not negligence, punitive damages are not in order. However, the courts do set forth categories of conduct that justify the award of punitive damages in bad faith tort cases.

<table>
<thead>
<tr>
<th>Conduct that will trigger an award of punitive damages includes:</th>
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<tr>
<td>• Fraud on the part of the insurer;</td>
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<tr>
<td>• The insurer concealing the existence of a policy;</td>
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<td>• Deliberate, open, and dishonest dealings with insureds;</td>
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• The willful and knowing failure to process or pay a claim known to be valid;
• Oppressive conduct; and
• Insult and personal abuse.

It is especially important to note that punitive damages are potentially available in tort actions but not in actions for breach of contract. Therefore, punitive damages for bad faith are available only in jurisdictions recognizing a tort cause of action for an insurer's breach of the covenant of good faith and fair dealing.

SUCCESSFUL CLAIMS HANDLING

To complete a claim in a successful manner, the foundation must have been laid correctly and appropriately; preparation is the initial key to successful claims settlement. Most, if not all, of the following should be listed with as much detail as possible in order to begin the settlement process:

• An accurate and comprehensive assessment of all losses;
• Detailed physical inventory of damages;
• Detailed cost appraisal and valuation of loss (complete with depreciation schedules);
• Co-insurance requirements;
• At-fault party;
• Witnesses, etc.

The following are some useful tips that adjusters should employ to assure the professional resolution of insurance claims and to ensure avoiding allegations of bad faith:

• **Be Accommodating** — A professional adjuster will recognize that an insured or claimant has just suffered a loss and will conduct himself/herself in a way that expresses compassion.

• **Be Considerate** — Behavior plays an important role in setting the climate for the entire claims handling process. Showing consideration will establish an adjuster as a professional.

• **Be Objective** — The handling of a claim should never include a preconceived notion of its outcome.

• **Be Practical** — Being practical about a claim and its merits will help to process and settle the claim equitably.

• **Be Direct** — Handling the claim and the insured or the claimant in a straightforward manner will demonstrate professionalism.

• **Be Confident** — Confidence will demonstrate a professional image for the
adjuster as well as for the insurance industry in general.

- **Be Fair** — Bias and prejudice have no place in the claims handling process, and remarks about ethnicity or other arrogant remarks must be avoided.

- **Be Knowledgeable** — The skill and experience of an experienced adjuster can be used to take insureds and claimants through the claims handling process with as little frustration and discontent as possible.

- **Speak Natural** — Adjusters should avoid using legal or industry terminology that insureds or claimants may find daunting.

**CHAPTER REVIEW QUESTIONS**

*(answers are in the back of the text)*

1. It is especially important to note that punitive damages are potentially available in tort actions but not ________________.

   A. For violation of the unfair claims practices act
   B. Breach of the covenant of good faith and fair dealing
   C. In actions for breach of contract
   D. In bad faith torts

2. In order to recover damages for emotional distress caused by an insurer's bad faith, the insured must show that the insurer's bad faith resulted in ________________.

   A. an invasion of property rights
   B. a fraudulent claim
   C. a breach of contract
   D. comparative bad faith
Chapter 4

CALIFORNIA CLAIMS SETTLEMENT REGULATIONS

THE INTERACTION BETWEEN ETHICS AND LAW

Whenever as a society we pass a law we are in essence attempting to manage human behavior. Whether dealing with a civil criminal or tax law there will be various mechanisms employed within the law to discourage conduct, activity or commerce that collectively we deem bad and encourage conduct, activity or commerce that collectively we deem good. Most laws or regulations have penalties that can range from public censor to a financial penalty to incarceration. Many laws also have rewards for engaging in the conduct, activity or commerce that the law is intended to encourage.

If we could ever write a perfect law it would result in a clear, unambiguous delineation (a line in the sand if you will) between good and bad. Enforcing such a perfect law would be easy because any number of the multitude of unique situations that might be judged under the law would clearly fall on one side or the other of this line in the sand. Anyone of fair and sound mind could easily distinguish between good and bad and there would never be disagreement as to which side of the line the conduct, action or commerce fell. We wouldn’t need the courts as they are currently structured because every case judged under the law would result in a unanimous agreement as to good or bad, right or wrong. Justice would be swift, inexpensive, consistent, and within the reach of all regardless of income, education or ability to communicate effectively. We wouldn’t need attorneys to argue points of law because the intent of the law as it applies to the matter at hand would be imminently apparent to anyone who read the law or even heard the law read aloud.

Many factors cause the process of writing and enforcing any law to be a challenging undertaking and diverge from the perfect legal process described above. A few of these reasons are summarized below.

- The English language is somewhat imprecise and not everyone will agree on the exact meaning of the wording used within a law.

- As human beings we are all unique and will interpret the meaning of words in the context of our understanding of their meanings based on our varied perceptions.
• We do not all share the exact same sense of what is right and what is wrong.

• Some among us insist on interpreting and bending the meaning of a law to fit the conduct, activity or commerce that we wish to engage in.

• It is impossible when a law is first written to perceive all of the various situations that might, in the future, be judged under the law.

Almost all laws will be amended after they are initially passed in order to clarify meanings, broaden or lessen the scope and/or applicability, account for unforeseen consequences, and account for conduct, activity or commerce that was not foreseen when the law was originally written. In addition the longer a law has been in existence the more cases have been judged under the law, the more precedent has accumulated to judge future situations and the easier it is to predict how a particular situation might be judged.

If over time there is a sufficient volume of conduct, activity or commerce that is within the law but perceived by many to be unfair, unjust or bad so that public opinion swings to the point that the law is changed to deem the particular conduct, activity or commerce as on the bad side of the law the law will be amended to reflect the current public opinion. This is part of the evolution of the law and is where ethics really lives. It should be noted that often the above scenario is in the other direction where public opinion feels the law is too restrictive or overreaching and prevents conduct, activity or commerce that should be allowed or even encouraged.

As part of this California Independent Adjuster Ethics course we will cover regulations related to unfair claims practices that all adjusters must comply with. In many areas we will quote the California Statute, Regulation or Rule verbatim so as not to lose any meaning in translation. Law tends attempts precise and when one attempts to generalize what a law or rule means much of the spirit and intent of the law falls away.

California, like most states has adopted a version of the Unfair Claims Practices Act originally promulgated as part of the McCarran Ferguson Act of 1945. In addition to adopting their version of the Unfair Claims Practices Act California has regulations to further clarify examples of what will be consider as unfair claims settlement practices.

You will notice in the preamble to the law below it specifically states that this regulation does not necessarily enumerate all of the unfair claims settlement practices and that there could be other claims settlement practices that are unfair. This leaves room for interpretation of the law in the future.

It is here on the cusp of legal versus illegal that ethics operates. Where conduct that may be technically legal but many individuals reviewing the action, commerce or conduct would say that it is unethical, unfair, unjust, bad or wrong and should be prevented or at least discouraged.
PREAMBLE

2695.1. Preamble.

(a) Section 790.03(h) of the California Insurance Code enumerates sixteen claims settlement practices that, when either knowingly committed on a single occasion, or performed with such frequency as to indicate a general business practice, are considered to be unfair claims settlement practices and are, thus, prohibited by this section of the California Insurance Code. The Insurance Commissioner has promulgated these regulations in order to accomplish the following objectives:

(1) To delineate certain minimum standards for the settlement of claims which, when violated knowingly on a single occasion or performed with such frequency as to indicate a general business practice shall constitute an unfair claims settlement practice within the meaning of Insurance Code Section 790.03(h);

(2) To promote the good faith, prompt, efficient and equitable settlement of claims on a cost effective basis;

(3) To discourage and monitor the presentation to insurers of false or fraudulent claims; and,

(4) To encourage the prompt and thorough investigation of suspected fraudulent claims and ensure the prompt and comprehensive reporting of suspected fraudulent claims as required by Insurance Code Section 1872.4.

SCOPE OF REGULATION

(b) These regulations are not meant to provide the exclusive definition of all unfair claims settlement practices. Other methods, act(s), or practices not specifically delineated in this set of regulations may also be unfair claims settlement practices and subject to California Insurance Code Section 790.03(h) and/or California Insurance Code Section 790.06. These regulations are applicable to the handling or settlement of all claims subject to Article 6.5 of Division 1, Part 2, Chapter 1 of the California Insurance Code, commencing with Section 790, except as specifically provided below:

(1) Workers’ compensation insurance;

(2) Liability insurance for the professional malpractice of health care providers as defined in California Code of Civil Procedure Section 364(f)(1);

(3) Self insured or self funded plans which are bona fide Employee Retirement Income Security Act ("ERISA") plans which are not also multiple employer welfare arrangements, to the extent that these ERISA plans are not covered by insurance;
(4) Any other self funded or self insured plan, to the extent it is not covered by insurance, which is lawfully conducting business in this state.

(c) In recognition of both the unique relationship which exists under a surety bond between the surety, the obligee or beneficiary, and the principal, and the fact that the processing of surety claims is subject to the Unfair Practices Act, beginning with California Insurance Code Section 790, only sections 2695.1 through 2695.6, inclusive, section 2695.10, and sections 2695.12, 2695.13 and 2695.14, inclusive, shall apply to the handling or settlement of claims brought under surety bonds.

(d) These regulations apply to home protection contracts and home protection companies defined in California Insurance Code Section 12740.

(e) All licensees, as defined in these regulations, shall have thorough knowledge of the regulations contained in this subchapter.

(f) 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.

(g) The California Insurance Code provides the commissioner with access to all records of an insurer and the power to examine the affairs of every person engaged in the business of insurance to determine if such person is engaged in any unfair or deceptive act or practice. California Insurance Code Section 790.03(h) requires all persons engaged in the business of insurance to effectuate prompt, fair and equitable settlements of claims and to otherwise process claims in a fair and reasonable manner. The Department considers the use of reliable information to be an essential element of the fair and equitable settlement of claims. The fact that information, data or statistical methods used or relied upon by a licensee to process or establish the value of insurance claims is obtained through a third party source shall not absolve the licensee of its legal responsibility to comply with these regulations or to effectuate prompt, fair and equitable settlements of claims. Failure of a licensee to provide the commissioner with requested information sufficient to examine the licensee's claims handling practices may justify a finding that the licensee was in non-compliance with these regulations or other applicable insurance code provisions. Any and all information received pursuant to the Department's request shall be given confidential treatment, as provided in California Insurance Code section 735.5 and California Government Code Section 11180 et seq. When processing or establishing the value of a claim, a licensee shall not be responsible for the accuracy of information provided by a governmental entity, unless the licensee has discovered or been notified of the inaccuracy and has continued to use the information.

DEFINITIONS

2695.2. Definitions.
As used in these regulations:

(a) "**Beneficiary**" means:

(1) for the purpose of life and disability claims, the party or parties entitled to receive the proceeds or benefits occurring under the policy in lieu of the insured; or,

(2) for the purpose of surety claims, a person who is within the class of persons intended to benefit from the bond;

(b) "**Calendar days**" means each and every day including Saturdays, Sundays, Federal and California State Holidays, but if the last day for performance of any act required by these regulations falls on a Saturday, Sunday, Federal or State Holiday, then the period of time to perform the act is extended to and including the next calendar day which is not a Saturday, Sunday, or Federal or State holiday;

(c) "**Claimant**" means a first or third party claimant as defined in these regulations, any person who asserts a right of recovery under a surety bond, an attorney, any person authorized by operation of law to represent the claimant, or any of the following persons properly designated by the claimant in the manner specified in subsection 2695.5(c): an insurance adjuster, a public adjuster, or any member of the claimant's family.

(d) "**Claims agent**" means any person employed or authorized by an insurer, to conduct an investigation of a claim on behalf of an insurer or a person who is licensed by the Commissioner to conduct investigations of claims on behalf of an insurer. The term "claims agent", however, shall not include the following:

(1) an attorney retained by an insurer to defend a claim brought against an insured; or,

(2) persons hired by an insurer solely to provide valuation as to the subject matter of a claim.

(e) "**Extraordinary circumstances**" means circumstances outside of the control of the licensee which severely and materially affect the licensee's ability to conduct normal business operations;

(f) "**First party claimant**" means any person asserting a right under an insurance policy as a named insured, other insured or beneficiary under the terms of that insurance policy, and including any person seeking recovery of uninsured motorist benefits;

(g) "**Gross settlement amount**" means the amount tendered plus the amount deducted as provided in the policy in the settlement of an automobile total loss claim;

(h) "**Insurance agent**" means:
(1) the term "insurance agent" as used in section 31 of the California Insurance Code; or,
(2) the term "life agent" as used in section 32 of the California Insurance Code; or,
(3) any person who has authority or responsibility to notify an insurer of a claim upon receipt of a notice of claim by a claimant; or,
(4) an underwritten title company.

(i) "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, including reciprocal and interinsurance exchanges, fraternal benefit societies, stock and mutual insurance companies, risk retention groups, California county mutual fire insurance companies, grants and annuities societies, entities holding certificates of exemption, non-profit hospital service plans, multiple employer welfare arrangements holding certificates of compliance pursuant to Article 4.7 of the California Insurance Code, and motor clubs, to the extent that they transact the business of insurance in the State. The term "insurer" for purposes of these regulations includes non-admitted insurers, the California FAIR Plan, the California Earthquake Authority, those persons licensed to issue or that issue an insurance policy pursuant to an assignment by the California Automobile Assigned Risk Plan, home protection companies as defined under California Insurance Code Section 12740, and any other entity subject to California Insurance Code Section 790.03(h). The term "insurer" shall not include insurance agents and brokers, surplus line brokers and special lines surplus line brokers.

(j) "Insurance policy" or "policy" means the written instrument in which any certificate of group insurance, contract of insurance, or non-profit hospital service plan is set forth. For the purposes of these regulations the terms insurance policy or policy do not include "surety bond" or "bond". For the purposes of these regulations the term insurance policy or policy includes a home protection contract or any written instrument in which any certificate of insurance or contract of insurance is set forth that is issued pursuant to the California Automobile Assigned Risk Plan, the California Earthquake Authority, or the California FAIR Plan;

(k) "Investigation" means all activities of an insurer or its claims agent related to the determination of coverage, liabilities, or nature and extent of loss or damage for which benefits are afforded by an insurance policy, obligations or duties under a bond, and other obligations or duties arising from an insurance policy or bond.

(l) "Knowingly committed" means performed with actual, implied or constructive knowledge, including, but not limited to, that which is implied by operation of law.

(m) "Licensee" means any person that holds a license or Certificate of Authority from the Insurance Commissioner, or any other entity for whom the Insurance Commissioner's consent is required before transacting business in the State of California or with California residents. The term "licensee" for purpose of these regulations does not include an underwritten title company if the underwriting agreement between the underwritten title company and the title insurer affirmatively states that the underwritten title company
is not authorized to handle policy claims on behalf of the title insurer.

(n) "Notice of claim" means 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 or bond issued by the insurer and that a condition giving rise to the insurer's obligations under that policy or bond may have arisen. For purposes of these regulations the term "notice of claim" shall not include any written or oral communication provided by an insured or principal solely for informational or incident reporting purposes.

(o) "Notice of legal action" means notice of an action commenced against the insurer with respect to a claim, or notice of action against the insured received by the insurer, or notice of action against the principal under a bond, and includes any arbitration proceeding;

(p) "Obligee" means the person named as obligee in a bond;

(q) "Person" means any individual, association, organization, partnership, business, trust, corporation or other entity;

(r) "Principal" means the person whose debt or other obligation is secured or guaranteed by a bond and who has the primary duty to pay the debt or discharge the obligation;

(s) "Proof of claim" means any evidence or documentation in the possession of the insurer, whether as a result of its having been submitted by the claimant or obtained by the insurer in the course of its investigation, that provides any evidence of the claim and that reasonably supports the magnitude or the amount of the claimed loss.

(t) "Remedial measures" means those actions taken by an insurer to correct or cure any error or omission in the handling of claims on the part of its insurance agent as defined in subsection 2695.2(h), including, but not limited to:

(1) written notice to the insurance agent that he/she is in violation of the regulations contained in this subchapter;

(2) transmission of a copy of the regulations contained in this subchapter and instructions for their implementation;

(3) reporting the error or omission in the handling of claims by the insurance agent to the Department of Insurance;

(u) "Replacement crash part" means a replacement for any of the nonmechanical sheet metal or plastic parts which generally constitute the exterior of a motor vehicle, including inner and outer panels;

(v) "Single act" for the purpose of determining any penalty pursuant to California Insurance Code Section 790.035 is any commission or omission which in and of itself
constitutes a violation of California Insurance Code Section 790.03 or this subchapter;

(w) "Surety bond" or "bond" means the written instrument in which a contract of surety insurance, as defined in California Insurance Code Section 105, is set forth;

(x) "Third party claimant" means any person asserting a claim against any person or the interests insured under an insurance policy;

(y) "Willful" or "Willfully" when applied to the intent with which an act is done or omitted means simply a purpose or willingness to commit the act, or make the omission referred to in the California Insurance Code or this subchapter. It does not require any intent to violate law, or to injure another, or to acquire any advantage;

FILE AND RECORDS DOCUMENTATION

2695.3. File and Record Documentation.

(a) Every licensee's claim files shall be subject to examination by the Commissioner or by his or her duly appointed designees. These files shall contain all documents, notes and work papers (including copies of all correspondence) which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed and the licensee's actions pertaining to the claim can be determined;

INSURER RESPONSIBILITIES

(b) To assist in such examination all insurers shall:

(1) maintain claim data that are accessible, legible and retrievable for examination so that an insurer shall be able to provide the claim number, line of coverage, date of loss and date of payment of the claim, date of acceptance, denial or date closed without payment. This data must be available for all open and closed files for the current year and the four preceding years;

(2) record in the file the date the licensee received, date(s) the licensee processed and date the licensee transmitted or mailed every material and relevant document in the file; and

(3) maintain hard copy files or maintain claim files that are accessible, legible and capable of duplication to hard copy; files shall be maintained for the current year and the preceding four years.

(c) The requirements of this section shall be satisfied where the licensee provides documentation evidencing inability to obtain data, nonexistence of data, or difficulty in obtaining clear documentary support for actions due to catastrophic losses, or other
unusual circumstances providing the licensee establishes to the satisfaction of the Commissioner that the circumstances alleged by the licensee do exist and have materially affected the licensee's ability to comply with this regulation. Any licensee that alleges an inability to comply with this section shall establish and submit to the Commissioner a plan for file and record documentation to be used by such licensee while the circumstances alleged to preclude compliance with this subsection continue to exist.

**REPRESENTATION OF POLICY PROVISIONS AND BENEFITS**

2695.4. Representation of Policy Provisions and Benefits.

(a) Every insurer shall disclose to a first party claimant or beneficiary, all benefits, coverage, time limits or other provisions of any insurance policy issued by that insurer that may apply to the claim presented by the claimant. When additional benefits might reasonably be payable under an insured's policy upon receipt of additional proofs of claim, the insurer shall immediately communicate this fact to the insured and cooperate with and assist the insured in determining the extent of the insurer's additional liability.

(b) No insurer shall misrepresent or conceal benefits, coverages, time limits or other provisions of the bond which may apply to the claim presented under a surety bond.

(c) 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 reasonable demand by the insurer, and unfounded refusal by the claimant, to exhibit property, or (2) of the breach of any policy provision providing for the exhibition of property.

(d) Except where a time limit is specified in the policy, no insurer shall require a first party claimant under a policy to give notification of a claim or proof of claim within a specified time.

**INSURER PROHIBITIONS**

(e) No insurer shall:

(1) request that a claimant sign a release that extends beyond the subject matter which gave rise to the claim payment unless, prior to execution of the release, the legal effect of the release is disclosed and fully explained by the insurer to the claimant in writing. For purposes of this subsection, an insurer shall not be required to provide the above explanation or disclosure to a claimant who is represented by an attorney at the time the release is presented for signature;

(2) be precluded from including in any release a provision requiring the claimant to waive the provisions of California Civil Code Section 1542 provided that, prior to execution of the release, the legal effect of the release is disclosed and fully explained by the insurer to the claimant in writing. For purposes of this subsection, an insurer shall not be required to provide the above explanation or disclosure to a
claimant who is represented by an attorney at the time the release is presented for
signature.

(f) No insurer shall issue checks or drafts in partial settlement of a loss or claim that
contain or are accompanied by language releasing the insurer, the insured, or the
principal on a surety bond from total liability unless the policy or bond limit has been
paid, or there has been a compromise settlement agreed to by the claimant and the insurer
as to coverage and amount payable under the insurance policy or bond.

(g) No insurer shall require a first party claimant or beneficiary to submit duplicative
proofs of claim where coverage may exist under more than one policy issued by that
insurer.

INSURER DUTIES UPON RECEIPT OF CLAIM

2695.5. Duties upon Receipt of Communications.

INQUIRIES FROM DEPARTMENT OF INSURANCE

(a) Upon receiving any written or oral inquiry from the Department of Insurance
concerning a claim, every licensee shall immediately, but in no event more than twenty-
one (21) calendar days of receipt of that inquiry, furnish the Department of Insurance
with a complete written response based on the facts as then known by the licensee. A
complete written response addresses all issues raised by the Department of Insurance in
its inquiry and includes copies of any documentation and claim files requested. This
section is not intended to permit delay in responding to inquiries by Department
personnel conducting a scheduled examination on the insurer's premises.

COMMUNICATION FROM CLAIMANT

(b) Upon receiving any communication from a claimant, regarding a claim, that
reasonably suggests that a response is expected, every licensee shall immediately, but in
no event more than fifteen (15) calendar days after receipt of that communication, furnish
the claimant with a complete response based on the facts as then known by the licensee.
This subsection shall not apply to require communication with a claimant subsequent to
receipt by the licensee of a notice of legal action by that claimant.

WHEN CLAIMANT DESIGNATES ANOTHER PARTY FOR COMMUNICATIONS

(c) The designation specified in subsection 2695.2(c) shall be in writing, signed and dated
by the claimant, and shall indicate that the designated person is authorized to handle the
claim. All designations shall be transmitted to the insurer and shall be valid from the date
of execution until the claim is settled or the designation is revoked. A designation may be
revoked by a writing transmitted to the insurer, signed and dated by the claimant,
indicating that the designation is to be revoked and the effective date of the revocation.
(d) Upon receiving notice of claim, every licensee or claims agent shall immediately transmit notice of claim to the insurer.

**TIME LIMITS AFTER INSURER RECEIVES NOTICE OF CLAIM**

(e) Upon receiving notice of claim, every insurer shall immediately, but in no event more than fifteen (15) calendar days later, do the following unless the notice of claim received is a notice of legal action:

1. acknowledge receipt of such notice to the claimant unless payment is made within that period of time. If the acknowledgement is not in writing, a notation of acknowledgement shall be made in the insurer's claim file and dated. Failure of an insurance agent or claims agent to promptly transmit notice of claim to the insurer shall be imputed to the insurer except where the subject policy was issued pursuant to the California Automobile Assigned Risk Program.

2. provide to the claimant necessary forms, instructions, and reasonable assistance, including but not limited to, specifying the information the claimant must provide for proof of claim;

3. begin any necessary investigation of the claim.

(f) An insurer may not require that the notice of claim under a policy be provided in writing unless such requirement is specified in the insurance policy or an endorsement thereto.

**TRAINING AND CERTIFICATION OF CLAIMS AGENTS**

2695.6. Training and Certification.

(a) 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 (90) days after the effective date of these regulations or any revisions thereto.

(b) All licensees shall provide thorough and adequate training regarding the regulations to all their claims agents. Licensees shall certify that their claims agents have been trained regarding these regulations and any revisions thereto. However, licensees need not provide such training or certification to duly licensed attorneys.

**ANNUAL TRAINING CERTIFICATION**

A licensee shall demonstrate compliance with this subsection by the following methods:

1. where the licensee is an individual, the licensee shall annually certify in writing under penalty of perjury that he or she has read and understands the regulations and any and all amendments thereto;
(2) where the licensee is an entity, the annual written certification shall be executed, under penalty of perjury, by a principal of the entity as follows:

(A) that the licensee's claims adjusting manual contains a copy of these regulations and all amendments thereto; and,

(B) that clear written instructions regarding the procedures to be followed to effect proper compliance with this subchapter were provided to all its claims agents;

INSURER TRAINING OF ADJUSTERS

(3) where the licensee retains insurance adjusters as defined in California Insurance Code Section 14021, the licensee must provide training to the insurance adjusters regarding these regulations and annually certify, in a declaration executed 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 these regulations and all amendments thereto or has successfully completed a training seminar which explains these regulations;

(4) a copy of the certification required by subsections 2695.6(b)(1), (2) or (3) shall be maintained at all times at the principal place of business of the licensee, to be provided to the Commissioner only upon request.

(5) the annual certification required by this subsection shall be completed on or before September 1 of each calendar year.

CLAIM SETTLEMENT STANDARDS

2695.7. Standards for Prompt, Fair and Equitable Settlements.

NONDISCRIMINATION IN CLAIMS SETTLEMENT

(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.

UPON RECEIPT OF PROOF OF CLAIM

(b) Upon receiving proof of claim, every insurer, except as specified in subsection 2695.7(b)(4) below, shall immediately, but in no event more than forty (40) calendar days later, accept or deny the claim, in whole or in part. The amounts accepted or denied shall be clearly documented in the claim file unless the claim has been denied in its entirety.

(1) Where an insurer denies or rejects a first party claim, in whole or in part, it shall
do so in writing and shall provide to the claimant a statement listing all bases for such rejection or denial and the factual and legal bases for each reason given for such rejection or denial which is then within the insurer's knowledge. Where an insurer's denial of a first party claim, in whole or in part, is based on a specific statute, applicable law or policy provision, condition or exclusion, the written denial shall include reference thereto and provide an explanation of the application of the statute, applicable law or provision, condition or exclusion to the claim. Every insurer that denies or rejects a third party claim, in whole or in part, or disputes liability or damages shall do so in writing.

(2) Subject to the provisions of subsection 2695.7(k), nothing contained in subsection 2695.7(b)(1) shall require an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the subject claim is being investigated as a suspected fraudulent claim.

DISCLOSURE OF RIGHT FOR DEPARTMENT REVIEW

(3) Written notification pursuant to this subsection shall include a statement that, if the 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 shall include the address and telephone number of the unit of the Department which reviews claims practices.

EXCEPTIONS TO TIMELINE

(4) The time frame in subsection 2695.7(b) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the California Insurance Code, disability income insurance subject to Section 10111.2 of the California Insurance Code or mortgage guaranty insurance subject to Section 12640.09(a) of the California Insurance Code, and shall not apply to automobile repair bills arising from policies of automobile collision and comprehensive insurance subject to Section 560 of the California Insurance Code. All other provisions of subsections 2695.7(b)(1), (2), and (3) are applicable.

IF ADDITIONAL INFORMATION OR TIME IS NECESSARY TO SETTLE CLAIM

(c)

(1) If more time is required than is allotted in subsection 2695.7(b) to determine whether a claim should be accepted and/or denied in whole or in part, every insurer shall provide the claimant, within the time frame specified in subsection 2695.7(b), with written notice of the need for additional time. This written notice shall specify any additional information the insurer requires in order to make a determination and state any continuing reasons for the insurer's inability to make a determination. Thereafter, the written notice shall be provided every thirty (30) calendar days until a determination is made or notice of legal action is served. If the determination cannot be made until some future event occurs, then the insurer shall comply with this
continuing notice requirement by advising the claimant of the situation and providing an estimate as to when the determination can be made.

(2) Subject to the provisions of subsection 2695.7(k), nothing contained in subsection 2695.7(c)(1) shall require an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the claim is being investigated as a possible suspected fraudulent claim.

FAIR AND OBJECTIVE INVESTIGATION

(d) 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.

(e) No insurer shall delay or deny settlement of a first party claim on the basis that responsibility for payment should be assumed by others, except as may otherwise be provided by policy provisions, statutes or regulations, including those pertaining to coordination of benefits.

NOTICE OF EXPIRATION OF STATUTE OF LIMITATIONS

(f) Except where a claim has been settled by payment, every insurer shall provide written notice of any statute of limitation or other time period requirement upon which the insurer may rely to deny a claim. Such notice shall be given to the claimant not less than sixty (60) days prior to the expiration date; except, if notice of claim is first received by the insurer within that sixty days, then notice of the expiration date must be given to the claimant immediately. With respect to a first party claimant in a matter involving an uninsured motorist, this notice shall be given at least thirty (30) days prior to the expiration date; except, if notice of claim is first received by the insurer within that thirty days, then notice of the expiration date must be given to the claimant immediately. This subsection shall not apply to a claimant represented by counsel on the claim matter.

UNREASONABLY LOW SETTLEMENT OFFERS

(g) No insurer shall attempt to settle a claim by making a settlement offer that is unreasonably low. The Commissioner shall consider any admissible evidence offered regarding the following factors in determining whether or not a settlement offer is unreasonably low:

(1) the extent to which the insurer considered evidence submitted by the claimant to support the value of the claim;

(2) the extent to which the insurer considered legal authority or evidence made known to it or reasonably available;

(3) the extent to which the insurer considered the advice of its claims adjuster as to
the amount of damages;

(4) 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;

(5) the procedures used by the insurer in determining the dollar amount of property damage;

(6) the extent to which the insurer considered the probable liability of the insured and the likely jury verdict or other final determination of the matter;

(7) any other credible evidence presented to the Commissioner that demonstrates that
   (i) any amount offered by the insurer in settlement of a first-party claim to an insured not represented by counsel, or (ii) the final amount offered in settlement of a first-party claim to an insured who is represented by counsel or (iii) the final amount offered in settlement of a third party claim by the insurer is below the amount that a reasonable person with knowledge of the facts and circumstances would have offered in settlement of the claim.

ACCEPTANCE OF CLAIM AND PAYMENT OF BENEFIT

(h) Upon acceptance of the claim in whole or in part and, when necessary, upon receipt of a properly executed release, every insurer, except as specified in subsection 2695.7(h)(1) and (2) below, shall immediately, but in no event more than thirty (30) calendar days later, tender payment or otherwise take action to perform its claim obligation. The amount of the claim to be tendered is the amount that has been accepted by the insurer as specified in subsection 2695.7(b). In claims where multiple coverage is involved, and where the payee is known, amounts that have been accepted by the insurer shall be paid immediately, but in no event more than thirty (30) calendar days, if payment would terminate the insurer's known liability under that individual coverage, unless impairment of the insured's interests would result. The time frames specified in this subsection shall not apply where the policy provides for a waiting period after acceptance of claim and before payment of benefits.

(1) The time frame specified in subsection 2695.7(h) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the California Insurance Code, disability income insurance subject to Section 10111.2 of the California Insurance Code, or of mortgage guaranty insurance subject to Section 12640.09(a) of the California Insurance Code, and shall not apply to automobile repair bills subject to Section 560 of the California Insurance Code. All other provisions of Section 2695.7(h) are applicable.

(2) Any insurer issuing a title insurance policy shall either tender payment pursuant to subsection 2695.7(h) or take action to resolve the problem which gave rise to the claim immediately upon, but in no event more than thirty (30) calendar days after, acceptance of the claim.
(i) No insurer shall inform a claimant that his or her rights may be impaired if a form or release is not completed within a specified time period unless the information is given for the purpose of notifying the claimant of any applicable statute of limitations or policy provision or the time limitation within which claims are required to be brought against state or local entities.

**NO POLYGRAPH REQUIREMENT**

(j) No insurer shall request or require an insured to submit to a polygraph examination unless authorized under the applicable insurance contract and state law.

(k) Subject to the provisions of subsection 2695.7(c), where there is a reasonable basis, supported by specific information available for review by the California Department of Insurance, for the belief that the claimant has submitted or caused to be submitted to an insurer a suspected false or fraudulent claim as specified in California Penal Code Section 550 or California Insurance Code Section 1871.4(a), the number of calendar days specified in subsection 2695.7(b) shall be:

1. increased to eighty (80) calendar days; or,
2. suspended until otherwise ordered by the Commissioner, provided the insurer has complied with California Insurance Code Section 1872.4 and the insurer can demonstrate to the Commissioner that it has made a diligent attempt to determine whether the subject claim is false or fraudulent within the eighty day period specified by subsection 2695.7(k)(1).

(l) No insurer shall deny a claim based upon information obtained in a telephone conversation or personal interview with any source unless the telephone conversation or personal interview is documented in the claim file pursuant to the provisions of Section 2695.3.

(m) No insurer shall make a payment to a provider, pursuant to a policy provision to pay medical benefits, and thereafter seek recovery or set-off from the insured on the basis that the amount was excessive and/or the services were unnecessary, except in the event of a proven false or fraudulent claim, subject to the provisions of Section 10123.145 of the California Insurance Code.

**INSURER CAN REQUEST MEDICAL EXAM ONLY WHEN REASONABLY NECESSARY**

(n) Every insurer requesting a medical examination for the purpose of determining liability under a policy provision shall do so only when the insurer has a good faith belief that such an examination is reasonably necessary.

(o) No insurer shall require that a claimant withdraw, rescind or refrain from submitting any complaint to the California Department of Insurance regarding the handling of a
claim or any other matter complained of as a condition precedent to the settlement of any claim.

WRITTEN NOTIFICATION WHEN SUBROGATION IS INTENDED

(p) 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. This subsection does not require notification if the deductible is waived, the coverage under which the claim is paid requires no deductible to be paid, the loss sustained does not exceed the applicable deductible, or there is no legal basis for subrogation.

FIRST PARTY DEDUCTIBLE MUST BE PART OF SUBROGATION EFFORT

(q) Every insurer that makes a subrogation demand shall include in every demand the first party claimant's deductible. Every insurer shall share subrogation recoveries on a proportionate basis with the first party claimant, unless the first party claimant has otherwise recovered the whole deductible amount. No insurer shall deduct legal or other expenses from the recovery of the deductible unless the insurer has retained an outside attorney or collection agency to collect that recovery. The deduction may only be for a pro rata share of the allocated loss adjustment expense. This subsection shall not apply when multiple policies have been issued to the insured(s) covering the same loss and the language of these contracts prescribe alternative subrogation rights. Further, this subsection shall not apply to disability and health insurance as defined in California Insurance Code Section 106.

ADDITIONAL STANDARDS APPLICABLE TO AUTOS

2695.8. Additional Standards Applicable to Automobile Insurance.

(a) This section enumerates standards which apply to adjustment and settlement of automobile insurance claims.

(1) the words "automobile" and "vehicle" are used synonymously.

EVALUATING TOTAL LOSS CLAIMS

(b) In evaluating automobile total loss claims the following standards shall apply:

TOTAL LOSS PAYMENT MUST INCLUDE TAXES AND TITLE TRANSFER COSTS

(1) The insurer may elect a cash settlement that shall be based upon the actual cost of a "comparable automobile" less any deductible provided in the policy. This cash settlement amount shall include all applicable taxes and one-time fees incident to transfer of evidence of ownership of a comparable automobile. This amount shall
also include the license fee and other annual fees to be computed based upon the remaining term of the loss vehicle's current registration. This procedure shall apply whether or not a replacement automobile is purchased.

**SALVAGE DISCLOSURES**

(A) If the insured chooses to retain the loss vehicle or if the third party claimant retains the loss vehicle, the cash settlement amount shall include the sales tax associated with the cost of a comparable automobile, discounted by the amount of sales tax attributed to the salvage value of the loss vehicle. The cash settlement amount shall also include all fees incident to transfer of the claimant's vehicle to salvage status. The salvage value may be deducted from the settlement amount and shall be determined by the amount for which a salvage pool or a licensed salvage dealer, wholesale motor vehicle auction or dismantler will purchase the salvage. If requested by the claimant, the insurer shall provide the name, address and telephone number of the salvage dealer, salvage pool, motor vehicle auction or dismantler who will purchase the salvage. The insurer shall disclose in writing to the claimant that notice of the salvage retention by the claimant must be provided to the Department of Motor Vehicles and that this notice may affect the loss vehicle's future resale and/or insured value. The disclosure must also inform the claimant of his or her right to seek a refund of the unused license fees from the Department of Motor Vehicles.

**COMPARABLE AUTO DEFINED**

(2) A "comparable automobile" is one of like kind and quality, made by the same manufacturer, of the same or newer model year, of the same model type, of a similar body type, with options and mileage similar to the insured vehicle. Newer model year automobiles may not be used as comparable automobiles unless there are not sufficient comparable automobiles of the same model year to make a determination as set forth in Section 2695.8(b)(4), below. In determining the cost of a comparable automobile, the insurer may use either the asking price or actual sale price of that automobile. Any differences between the comparable automobile and the insured vehicle shall be permitted only if the insurer fairly adjusts for such differences. Any adjustments from the cost of a comparable automobile must be discernible, measurable, itemized, and specified as well as appropriate in dollar amount and so documented in the claim file. Deductions taken from the cost of a comparable automobile that cannot be supported shall not be used. The actual cost of a comparable automobile shall not include any deduction for the condition of a loss vehicle unless the documented condition of the loss vehicle is below average for that particular year, make and model of vehicle. This subsection shall not preclude deduction for prior and/or unrelated damage to the loss vehicle. A comparable automobile must have been available for retail purchase by the general public in the local market area within ninety (90) calendar days of the final settlement offer. The comparable automobiles used to calculate the cost shall be identified by the vehicle identification number (VIN), the stock or order number of the vehicle from a licensed
dealer, or the license plate number of that comparable vehicle if this information is available. The identification shall also include the telephone number (including area code) or street address of the seller of the comparable automobile.

(3) Notwithstanding subsection (2), above, upon approval by the Department of Insurance, an insurer may use private sales data from the Department of Motor Vehicles, or other approved sources, which does not contain the seller's telephone number or street address. Approval by the Department of Insurance shall be contingent on the Department's determination that reasonable steps have been taken to limit the use of private sales data that may be inaccurately reported to the Department of Motor Vehicles, or other approved sources.

DETERMINING COST OF COMPARABLE AUTO

(4) The insurer shall take reasonable steps to verify that the determination of the cost of a comparable vehicle is accurate and representative of the market value of a comparable automobile in the local market area. Upon its request, the department shall have access to all records, data, computer programs, or any other information used by the insurer or any other source to determine market value. The cost of a comparable automobile shall be determined as follows and, once determined, shall be fully itemized and explained in writing for the claimant at the time the settlement offer is made:

(A) when comparable automobiles are available or were available in the local market area in the last 90 days, the average cost of two or more such comparable automobiles; or,

(B) when comparable automobiles are not available or were not available in the local market area in the last 90 days, the average of two or more quotations from two or more licensed dealers in the local market area; or,

(C) the cost of a comparable automobile as determined by a computerized automobile valuation service that produces statistically valid fair market values within the local market area; or

(D) if it is not possible to determine the cost of a comparable automobile by using one of the methods described in subsections (b)(3)(A), (b)(3)(B) and (b)(3)(C) of this section, the cost of a comparable automobile shall otherwise be supported by documentation and fully explained to the claimant. Any adjustments to the cost of a comparable automobile shall be discernible, measurable, itemized, and specified as well as appropriate in dollar amount and so documented in the claims file. Deductions taken from the cost of a comparable automobile that cannot be supported shall not be used.

IF REPLACEMENT VEHICLE IS OFFERED
(5) In first party automobile total loss claims, the insurer may elect to offer a replacement automobile which is a specified comparable automobile available to the insured with all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile paid by the insurer at no cost other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the insurer's claim file. A replacement automobile must be in as good or better overall condition than the insured vehicle and available for inspection within a reasonable distance of the insured's residence.

(6) Subsection 2695.8(b) applies to the evaluation of third party automobile total loss claims, but does not change existing law with respect to the obligations of an insurer in settling such claims with a third party.

IF INSURED CAN NOT LOCATE A REPLACEMENT VEHICLE FOR THE SETTLEMENT AMOUNT

(c) In first party automobile total loss claims, every insurer shall provide notice to the insured at the time the settlement payment is sent or final settlement offer is made that if notified by the insured within thirty-five (35) calendar days after the insured receives the claim payment or final settlement offer that he or she cannot purchase a comparable automobile for the gross settlement amount, the insurer will reopen its claim file. If subsequently notified by the insured the insurer shall reopen its claim file and utilize the following procedures:

(1) The insurer shall locate a comparable automobile for the gross settlement amount determined by the company at the time of settlement and shall provide the insured with the information required in (c)(4), below, or offer a replacement vehicle in accordance with section 2695.8(b)(4). Any such vehicle must be available in the local market area; or,

(2) The insurer shall either pay the insured the difference between the amount of the gross settlement and the cost of the comparable automobile which the insured has located, or negotiate and purchase this vehicle for the insured; or,

(3) The insurer shall invoke the appraisal provision of the insurance policy.

(4) No insurer is required to take action under this subsection if its documentation to the insured at the time of final settlement offer included written notification of the identity of a specified comparable automobile which was available for purchase at the time of final settlement offer for the gross settlement amount determined by the insurer. The documentation shall include the telephone number (including area code) or street address of the seller of the comparable automobile and:

   (A) the vehicle identification number (VIN) or,
   (B) the stock or order number of the vehicle from a licensed dealer, or
   (C) the license plate number of such comparable vehicle.
(d) No insurer shall, where liability and damages are reasonably clear, recommend that the third party claimant make a claim under his or her own policy to avoid paying the claim under the policy issued by that insurer.

**AUTO REPAIR PROHIBITIONS**

(e) No insurer shall:

1. require that an automobile be repaired at a specific repair shop; or,

2. suggest or recommend that an automobile be repaired at a specific repair shop, unless all of the requirements set forth in California Insurance Code Section 758.5 have been met.

3. require a claimant to travel an unreasonable distance either to inspect a replacement automobile, to conduct an inspection of the vehicle, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.

**IF PARTIAL LOSSES ARE SETTLED BASED ON INSURER ESTIMATES**

(f) If partial losses are settled on the basis of a written estimate prepared by or for the insurer, the insurer shall supply the claimant with a copy of the estimate upon which the settlement is based. The estimate prepared by or for the insurer shall be of an amount which will allow for repairs to be made in a workmanlike manner. 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 the 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 shop that will make the repairs for the amount of the insurer's written estimate. The insurer shall cause the damaged vehicle to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy or as otherwise allowed by law. The insurer shall maintain documentation of all such communications; or,

3. reasonably adjust any written estimates prepared by the repair shop of the claimant's choice and provide a copy of the adjusted estimate to the claimant.

**WHEN NON OEM REPAIR COMPONENTS ARE USED**

(g) No insurer shall require the use of non-original equipment manufacture replacement crash parts in the repair of an automobile unless:
(1) the parts are at least equal to the original equipment manufacturer parts in terms of kind, quality, safety, fit, and performance;

(2) insurers specifying the use of non-original equipment manufacturer replacement crash parts shall pay the cost of any modifications to the parts which may become necessary to effect the repair; and,

(3) insurers specifying the use of non-original equipment manufacturer replacement crash parts warrant that such parts are of like kind, quality, safety, fit, and performance as original equipment manufacturer replacement crash parts; and,

(4) all original and non-original manufacture replacement crash parts, manufactured after the effective date of this subchapter, when supplied by repair shops shall carry sufficient permanent, non-removable identification so as to identify the manufacturer. Such identification shall be accessible to the greatest extent possible after installation; and,

DISCLOSURE OF NON OEM REPLACEMENT CRASH PARTS

(5) the use of non-original equipment manufacturer replacement crash parts is disclosed in accordance with section 9875 of the California Business and Professions Code.

(h) No insurer shall require an insured or claimant to supply parts for replacement.

WHEN SETTLEMENT DEDUCTIONS ARE MADE FOR BETTERMENT

(i) When the amount claimed is adjusted because of betterment or depreciation, all justification shall be contained in the claim file. Any adjustments shall be discernable, measurable, itemized, and specified as to dollar amount, and shall accurately reflect the value of the betterment or depreciation. This subsection shall not preclude deduction for prior and/or unrelated damage to the loss vehicle. The basis for any adjustment shall be fully explained to the claimant in writing and shall:

(1) reflect a measurable difference in market value attributable to the condition and age of the vehicle, and

(2) apply only to parts normally subject to repair and replacement during the useful life of the vehicle such as, but not limited to, tires, batteries, et cetera.

DEPRECIATION OF THE EXPENSE OF LABOR

(j) In a first party partial loss claim, the expense of labor necessary to repair or replace the damage is not subject to depreciation or betterment unless the insurance contract contains a clear and unambiguous provision permitting the depreciation of the expense of labor.
(k) After a covered loss under a policy of automobile collision coverage or automobile physical damage coverage as defined in California Insurance Code Section 660, where towing and storage are reasonably necessary to protect the vehicle from further loss, the insurer shall pay reasonable towing and storage charges incurred by the claimant. The insurer shall provide reasonable notice to the claimant before terminating payment for storage charges, so that the claimant has time to remove the vehicle from storage. This subsection shall also apply to a third party claim filed under automobile liability coverage as defined in California Insurance Code section 660, however, payment to a third party claimant may be prorated based upon the comparative fault of the parties.

AUTO BODY REPAIR BILL OF RIGHTS

2695.85. Auto Body Repair Consumer Bill of Rights.

PROVIDED TO INSURED

(a) Every insurer that issues automobile liability or collision insurance policies shall provide the named insured(s) with an Auto Body Repair Consumer Bill of Rights either at the time of application for an automobile insurance policy, at the time a policy is issued, or following an accident or loss that is reported to the insurer. If the insurer provides the insured with an electronic copy of a policy, the bill of rights may also be transmitted electronically. If the insurer provides the bill of rights following an accident or loss, the insurer shall also provide the bill of rights to the particular insured filing the insurance claim. If the insurer provides the bill of rights at the time of application or policy issuance, all named insureds that have not previously received the bill of rights shall be provided with a copy upon renewal of the policy.

(b) The requirements set forth in subsection 2695.85(a), above, shall apply to all automobile liability and collision insurance policies issued in California including commercial automobile, private passenger automobile, and motorcycle insurance policies.

(c) The Auto Body Repair Consumer Bill of Rights shall be a separate standardized document and plainly printed in no less than ten-point type. An insurer may distribute the form using its own letterhead, but the language of the Auto Body Repair Consumer Bill of Rights shall be developed by the California Department of Insurance and shall read as follows:

AUTO BODY REPAIR CONSUMER BILL OF RIGHTS

A CONSUMER IS ENTITLED TO:

1. SELECT THE AUTO BODY REPAIR SHOP TO REPAIR AUTO BODY DAMAGE COVERED BY THE INSURANCE COMPANY. AN INSURANCE COMPANY SHALL NOT REQUIRE THE REPAIRS TO BE DONE AT A
SPECIFIC AUTO BODY REPAIR SHOP.

2. AN ITEMIZED WRITTEN ESTIMATE FOR AUTO BODY REPAIRS AND, UPON COMPLETION OF REPAIRS, A DETAILED INVOICE. THE ESTIMATE AND THE INVOICE MUST INCLUDE AN ITEMIZED LIST OF PARTS AND LABOR ALONG WITH THE TOTAL PRICE FOR THE WORK PERFORMED. THE ESTIMATE AND INVOICE MUST ALSO IDENTIFY ALL PARTS AS NEW, USED, AFTERMARKET, RECONDITIONED, OR REBUILT.

3. BE INFORMED ABOUT COVERAGE FOR TOWING AND STORAGE SERVICES.

4. BE INFORMED ABOUT THE EXTENT OF COVERAGE, IF ANY, FOR A REPLACEMENT RENTAL VEHICLE WHILE A DAMAGED VEHICLE IS BEING REPAIRED.

5. BE INFORMED OF WHERE TO REPORT SUSPECTED FRAUD OR OTHER COMPLAINTS AND CONCERNS ABOUT AUTO BODY REPAIRS.

COMPLAINTS WITHIN THE JURISDICTION OF THE BUREAU OF AUTOMOTIVE REPAIR

Complaints concerning the repair of a vehicle by an auto body repair shop should be directed to:

Toll Free (800) 952-5210

California Department of Consumer Affairs Bureau of Automotive Repair 10240 Systems Parkway Sacramento, CA 95827 The Bureau of Automotive Repair can also accept complaints over its web site at: www.autorepair.ca.gov

COMPLAINTS WITHIN THE JURISDICTION OF THE CALIFORNIA INSURANCE COMMISSIONER

Any concerns regarding how an auto insurance claim is being handled should be submitted to the California Department of Insurance at:

(800) 927-HELP or (213) 897-8921 California Department of Insurance Consumer Services Division 300 South Spring Street Los Angeles, CA 90013

The California Department of Insurance can also accept complaints over its web site at: www.insurance.ca.gov
FIRST PARTY RESIDENTIAL AND COMMERCIAL PROPERTY CLAIMS


WHEN SETTLEMENT IS BASED ON REPLACEMENT COST

(a) When a residential or commercial property insurance policy provides for the adjustment and settlement of first party losses based on replacement cost, the following standards apply:

DEPRECIATION NOT ALLOWED

(1) When a loss requires repair or replacement of an item or part, any consequential physical damage incurred in making the repair or replacement not otherwise excluded by the policy shall be included in the loss. The insured shall not have to pay for depreciation nor any other cost except for the applicable deductible.

(2) When a loss requires replacement of items and the replaced items do not match in quality, color or size, the insurer shall replace all items in the damaged area so as to conform to a reasonably uniform appearance.

(b) No insurer shall require that the insured have the property repaired by a specific individual or entity.

IF INSURER RECOMMENDS REPAIR ENTITY

(c) No insurer shall suggest or recommend that the insured have the property repaired by a specific individual or entity unless:

(1) the referral is expressly requested by the claimant; or

(2) the claimant has been informed in writing of the right to select a repair individual or entity and, if the claimant accepts the suggestion or recommendation, 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 or as otherwise allowed by these regulations.

WHEN INSURED CONTENTS REPAIR COST WILL EXCEED INSURER ESTIMATE

(d) 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. 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 or entity 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 the claimant other than as stated in the policy or as otherwise allowed by these regulations; or,

(3) reasonably adjust any written estimates prepared by the repair individual or entity of the insured's choice and provide a copy of the adjusted estimate to the claimant.

(e) Once the appraisal provision under an insurance policy is invoked, the appraisal process shall not include any legal proceeding or procedure not specified under California Insurance Code Section 2071. Nothing herein is intended to preclude separate legal proceedings on issues unrelated to the appraisal process.

BETTERMENT OR DEPRECIATION

(f) When the amount claimed is adjusted because of betterment, depreciation, or salvage, all justification for the adjustment shall be contained in the claim file. Any adjustments shall be discernable, measurable, itemized, and specified as to dollar amount, and shall accurately reflect the value of the betterment, depreciation, or salvage. Any adjustments for betterment or depreciation shall reflect a measurable difference in market value attributable to the condition and age of the property and apply only to property normally subject to repair and replacement during the useful life of the property. The basis for any adjustment shall be fully explained to the claimant in writing.

(1) Under a policy, subject to California Insurance Code Section 2071, where the insurer is required to pay the expense of repairing, rebuilding or replacing the property destroyed or damaged with other of like kind and quality, the measure of recovery is determined by the actual cash value of the damaged or destroyed property, as set forth in California Insurance Code Section 2051. Except for the intrinsic labor costs that are included in the cost of manufactured materials or goods, the expense of labor necessary to repair, rebuild or replace covered property is not a component of physical depreciation and shall not be subject to depreciation or
betterment.

ADDITIONAL STANDARDS APPLICABLE TO SURETY INSURANCE

2695.10. Additional Standards Applicable to Surety Insurance.

(a) No insurer shall base or vary its claims settlement practices, or its standard of scrutiny and review, upon the claimant's age, gender, income, religion, language, sexual orientation, ancestry, national origin, or physical disability, or upon the territory of the property or person insured.

UPON RECEIPT OF PROOF OF CLAIM

(b) As soon as possible, but in no event later than forty (40) calendar days after receipt by the insurer of proof of claim, and provided the claim is not in litigation or arbitration, the insurer shall accept or deny the claim, in whole or in part, and affirm or deny liability. Every insurer that denies or rejects a claim in whole or in part, or disputes liability or damages, shall provide to the claimant a written statement listing all bases for such rejection or denial, and the factual and legal bases for each reason given for each rejection or denial, which are within the insurer's knowledge. If an insurer's denial of a claim in whole or in part is based on a specific statute or specific bond provisions, the denial shall include reference thereto and provide an explanation of the application of the statute or bond provision to the claim. Written notification pursuant to this subsection shall also include a notification that the claimant may have the matter reviewed by the California Department of Insurance and shall provide the address and telephone number of the unit of the Department which reviews complaints regarding claims practices.

(1) A principal's absence, non-cooperation, or failure to meet the bonded obligation shall not excuse unreasonable delay by the insurer in determining whether a claim should be accepted or denied.

(2) While an insurer may consider all information provided by a principal, absent reasonable factual and/or legal bases for denying a claim, no insurer shall deny a claim based solely upon a principal's protest of a claim or denial of liability for a claim.

IF ADDITIONAL INFORMATION OR TIME IS NEEDED BY INSURER

(c) In the event an insurer requires more time than is allotted in subsection 2695.10(b) to determine whether a claim should be accepted and/or denied, in whole or in part, the insurer shall provide the claimant with written notice of the need for such additional time within the time specified in subsection 2695.10(b). Such written notice shall specify the
reasons for the need for such additional time, including specification of any additional information the insurer requires in order to make such determination. The insurer shall provide the claimant with written notice as to the continuing reasons for the insurer's inability to make such a determination. Except in cases where extraordinary circumstances are present which materially affect the insurer's ability to comply, such written notice shall be provided within 30 calendar days of the date of the initial notification, and every 30 calendar days thereafter until such determination is made or notice of legal action is received. If the determination cannot be made until some event, process, or third party determination is made, then the insurer shall comply with this requirement by advising the claimant of the situation and provide an estimate as to when the determination can be made.

**DILIGENT PURSUIT OF INVESTIGATION**

(d) No insurer shall fail to pursue diligently an investigation of a claim, or persist in seeking information not reasonably required for or material to resolution of a claim dispute.

(e) No insurer shall deny a claim upon information obtained in a telephone conversation or personal interview with any source unless the telephone conversation or personal interview is documented in the claim file pursuant to the provisions of section 2695.3.

**PAYMENT FOR UNDISPUTED CLAIMS**

(f) Where the claim is to be settled by payment, and where neither the claim nor the amount is in dispute, such payment shall be tendered (1) within 15 calendar days following affirmation of liability where the insurer does not require the claimant to execute a release, or (2) within 15 calendar days following the insurer's receipt of a release properly executed by the claimant, where such release is required by the insurer. Such release shall be provided to the claimant within ten (10) calendar days following affirmation of liability. Where multiple claimants are involved, payment shall be made pursuant to this subsection, provided such payment shall not increase the insurer's liability, or impair the rights of other claimants under the bond.

**REQUIRED NOTICE OF STATUTE OF LIMITATIONS**

(g) Except where a claim has been settled by payment, every insurer shall provide written notice of any statute of limitations or other time period requirement upon which the insurer may rely to deny a claim. Such notice shall be given to the claimant no less than sixty (60) days prior to the expiration date. If notice of claim is first received by the insurer within sixty (60) days of the expiration date and such date is known to the insurer, then notice of the expiration date must be given to the claimant immediately. This subsection shall not apply to a claimant represented by counsel on the claim matter or to a claim already time barred when first received by the insurer.
UNREASONABLY LOW SETTLEMENT OFFERS

(h) No insurer shall attempt to settle a claim by making a settlement offer that is unreasonably low. The Commissioner shall consider any admissible evidence offered regarding the following factors in determining whether or not a settlement offer is unreasonably low:

(1) the extent to which the insurer considered evidence submitted by the claimant to support the value of the claim;

(2) the extent to which the insurer considered legal authority or evidence made known to it or reasonably available;

(3) the procedures used by the insurer in determining the dollar amount of damages;

(4) any other credible evidence presented to the Commissioner that demonstrates that the final amount offered by the insurer in settlement of a claim is below the amount that a reasonable person with knowledge of the facts and circumstances would have offered in settlement of the claim.

ADDITIONAL STANDARDS FOR LIFE AND DISABILITY CLAIMS

2695.11. Additional Standards Applicable to Life and Disability Insurance Claims.

OVERPAYMENTS BY INSURER

(a) No insurer shall seek reimbursement of an overpayment or withhold any portion of any benefit payable as a result of a claim on the basis that the sum withheld or reimbursement sought is an adjustment or correction for an overpayment made under the same policy unless:

(1) the insurer's files contain clear, documented evidence of an overpayment and written authorization from the insured or assignee, if applicable, permitting the reimbursement or withholding procedure, or

(2) the insurer's files contain clear, documented evidence pursuant to section 2695.3 of all of the following:

(A) The overpayment was erroneous under the provisions of the policy.

(B) The error which resulted in the payment is not a mistake of the law.

(C) The insurer notifies the insured within six (6) months of the date of the error, except that in instances of error prompted by representations or nondisclosure of
claimants or third parties, the insurer notifies the insured within fifteen (15) calendar days after the date of discovery of such error. For the purpose of this subsection, the date of the error shall be the day on which the draft for benefits is issued.

(D) Such notice states clearly the cause of the error and states the amount of the overpayment.

(E) The procedure set forth above in (a)(2)(A) through (D) above may not be used if the overpayment is the subject of a reasonable dispute as to facts.

DISCLOSURE OF COMPUTATION OF BENEFITS

(b) With each claim payment, the insurer shall provide to the claimant and assignee, if any, an explanation of benefits which shall include, if applicable, the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits.

PENALTIES UNDER PRECERTIFICATION OF BENEFITS

(c) An insurer may not impose a penalty upon any insured for noncompliance with insurer requirements for precertification of benefits unless such penalties are specifically and clearly set forth in writing in the policy or certificate of insurance.

WHEN INSURER CONTESTS A CLAIM

(d) An insurer that contests a claim under California Insurance Code Section 10123.13 shall subsequently affirm or deny the claim within thirty (30) calendar days from the original notification. In the event an insurer requires additional time to affirm or deny the claim, it shall notify the claimant and assignee in writing. This written notice shall specify any additional information the insurer requires in order to make a determination and shall state any continuing reasons for the insurer's inability to make a determination. This notice shall be given within thirty (30) calendar days of the notice (required under Insurance Code Section 10123.13) that the claim is being contested and every thirty (30) calendar days thereafter until a determination is made or legal action is served. If the determination cannot be made until some future event occurs, the insurer shall comply with this continuing notice requirement by advising the claimant and assignee of the situation and providing an estimate as to when the determination can be made.

PREAUTHORIZATION OF NON-EMERGENCY MEDICAL SERVICES

(e) When a policy requires preauthorization of non-emergency medical services, the preauthorization must be given immediately but in no event more than five (5) calendar days after the request for preauthorization. The preauthorization shall be communicated or confirmed in writing to the insured and the medical service provider, and shall explain the scope of the preauthorization and whether the preauthorization is or is not a guarantee
of acceptance of the claim. In the event the preauthorization is denied, the reason(s) for the denial shall be communicated in writing to the insured and the medical service provider.

**PREAUTHORIZATION FOR EMERGENCY MEDICAL SERVICES NOT ALLOWED**

(f) No preauthorization shall be required by an insurer for emergency medical services.

(g) An insurer shall reimburse the insured or medical service provider for reasonable expenses incurred in copying medical records requested by the insurer.

**PENALTIES FOR VIOLATION**


**FACTORS TO CONSIDER IN PENALTY DETERMINATION**

(a) In determining whether to assess penalties and if so the appropriate amount to be assessed, the Commissioner shall consider admissible evidence on the following:

1. the existence of extraordinary circumstances;

2. whether the licensee has a good faith and reasonable basis to believe that the claim or claims are fraudulent or otherwise in violation of applicable law and the licensee has complied with the provisions of Section 1872.4 of the California Insurance Code;

3. the complexity of the claims involved;

4. gross exaggeration of the value of the property or severity of the injury, or amount of damages incurred;

5. substantial mischaracterization of the circumstances surrounding the loss or the alleged default of the principal;

6. secreting of property which has been claimed as lost or destroyed.

7. the relative number of claims where the noncomplying act(s) are found to exist, the total number of claims handled by the licensee and the total number of claims reviewed by the Department during the relevant time period;

8. whether the licensee has taken remedial measures with respect to the noncomplying act(s);

9. the existence or nonexistence of previous violations by the licensee;
(10) the degree of harm occasioned by the noncompliance;

(11) whether, under the totality of circumstances, the licensee made a good faith attempt to comply with the provisions of this subchapter;

(12) the frequency of occurrence and/or severity of the detriment to the public caused by the violation of a particular subsection of this subchapter;

(13) whether the licensee's management was aware of facts that apprised or should have apprised the licensee of the act(s) and the licensee failed to take any remedial measures; and

(14) the licensee's reasonable mistakes or opinions as to valuation of property, losses or damages.

(b) This section shall not bar, obstruct or restrict any right to administrative due process an insurer may be afforded under California Insurance Code Sections 790.05, 790.06, and 790.07.

CHAPTER REVIEW QUESTIONS
(answers are in the back of the text)

1. For total loss auto claims the insurer may elect a cash settlement that shall be based upon the actual cost of a "comparable automobile" less any deductible provided in the policy. This cash settlement amount shall include all applicable taxes and one-time fees incident to transfer of evidence of ownership of a comparable automobile. This amount shall also include ______________.

A. A waiver of premiums for the period the automobile was not available for the insured’s use due to repair and claim processing.
B. A prorated refund of premiums for the when the automobile was not available for the use of the insured
C. A prorated payment for the road use tax for the period the automobile was not available for the use of the insured
D. License fee and other annual fees to be computed based upon the remaining term of the loss vehicle's current registration.

2. For Surety claims as soon as possible, but in no event later than __________ forty (40) calendar days after receipt by the insurer of proof of claim, and provided the claim is not
in litigation or arbitration, the insurer shall accept or deny the claim, in whole or in part, and affirm or deny liability.

A. 21 calendar days
B. 30 calendar days
C. 40 calendar days
D. 60 calendar days
ANSWERS TO CHAPTER REVIEW QUESTIONS

Chapter 1

1. C is the correct answer (pages 6, 7 and 8)
2. B is the correct answer (page 6)

Chapter 2

1. A is the correct answer (pages 11 and 12)
2. D is the correct answer (page 10)

Chapter 3

1. C is the correct answer (page 20)
2. A is the correct answer (page 29)

Chapter 4

1. D is the correct answer (page 50)
2. C is the correct answer (page 59)