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ETHICAL RULES AND RESPONSIBILITIES FOR CLAIM
ADJUSTERS

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I. Ethics in Claims Handling

The work of adjusting insurance claims engages the public trust. Accordingly, claim adjusters are held to a high ethical standard. Adjusters must put the duty for fair and honest treatment of the claimant above the adjuster’s own interests in every instance. As the Florida Supreme Court eloquently stated:

An insurer, in handling the defense of claims against its insured, has a duty to use the same degree of care and diligence as a person of ordinary care and prudence should exercise in the management of his own business. For when the insured has surrendered to the insurer all control over the handling of the claim, including all decisions with regard to litigation and settlement, then the insurer must assume a duty to exercise such control and make such decisions in good faith and with due regard for the interests of the insured.... The insurer must investigate the facts, give fair consideration to a settlement offer that is not unreasonable under the facts, and settle, if possible, where a reasonably prudent person, faced with the prospect of paying the total recovery, would do so.

II. Code of Ethics

All states have a code of ethics for claim adjusters. Many states’ codes of ethics are based on Florida’s model. For purposes of this paper, we will focus on Florida’s Administrative Code 69B-220.201: Ethical Requirements for All Adjusters and Public Adjuster Apprentices (the “Ethical Requirements”).

The Ethical Requirements are standards of conduct that define ethical behavior, and shall constitute a code of ethics that shall be binding on all adjusters:

(a) An adjuster shall not directly or indirectly refer or steer any claimant needing repairs or other services in connection with a loss to any person with whom the adjuster has an undisclosed financial interest, or who will or is reasonably anticipated to provide the adjuster any direct or indirect compensation for the referral or for any resulting business.

(b) An adjuster shall treat all claimants equally.
1. An adjuster shall not provide favored treatment to any claimant.
2. An adjuster shall adjust all claims strictly in accordance with the insurance contract.

(c) An adjuster shall not approach investigations, adjustments, and settlements in a manner prejudicial to the insured.

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1 Fla. Admin. Code R. 69B-220.201(3).
2 Id.
3 Boston Old Colony Ins. Co. v. Gutierrez, 386 So. 2d 783, 785 (Fla. 1980).
(d) An adjuster shall make truthful and unbiased reports of the facts after making a complete investigation.

(e) An adjuster shall handle every adjustment and settlement with honesty and integrity, and allow a fair adjustment or settlement to all parties without any compensation or remuneration to himself or herself except that to which he or she is legally entitled.

(f) An adjuster, upon undertaking the handling of a claim, shall act with dispatch and due diligence in achieving a proper disposition of the claim.

(g) An adjuster shall not negotiate or effect settlement directly or indirectly with any third-party claimant represented by an attorney, if the adjuster has knowledge of such representation, except with the consent of the attorney. For purposes of this subsection, the term “third-party claimant” does not include the insured or the insured’s resident relatives.

(h) An adjuster shall not advise a claimant to refrain from seeking legal advice, nor advise against the retention of counsel or the employment of a public adjuster to protect the claimant’s interest.

(i) An adjuster shall not attempt to negotiate with or obtain any statement from a claimant or witness at a time that the claimant or witness is, or would reasonably be expected to be, in shock or serious mental or emotional distress as a result of physical, mental, or emotional trauma associated with a loss. The adjuster shall not conclude a settlement when the settlement would be disadvantageous to, or to the detriment of, a claimant who is in the traumatic or distressed state described above.

(j) An adjuster shall not knowingly fail to advise a claimant of the claimant’s claim options in accordance with the terms and conditions of the insurance contract.

(k) An adjuster shall not undertake the adjustment of any claim concerning which the adjuster is not currently competent and knowledgeable as to the terms and conditions of the insurance coverage, or which otherwise exceeds the adjuster’s current expertise.

(l) No person shall, as a company employee adjuster or independent adjuster, represent himself or herself or any insurer or independent adjusting firm against any person or entity that the adjuster previously represented as a public adjuster.

The Ethical Requirements also outline what is considered a violation of the standards listed above. Not only does a violation of the Ethical Requirements constitute grounds for administrative action against the licensee, but a breach of any of the Ethical Requirements

constitutes an unfair claims settlement practice.6

III. Unfair Claims Settlement Practices Act

Generally, every contract imposes a duty of good faith and fair dealing upon the parties in both the contract’s performance and in its enforcement.7 This tenant of contract law is also true for insurance contracts. The Supreme Court of Alaska has stated that breach of this covenant by the insurer gives the insured a cause of action sounding in tort because of the special relationship between the insured and insurer in the insurance context and because tort liability provides needed incentive to insurers to honor their implied covenant to their insureds.8 Without such a cause of action, insurers can arbitrarily deny coverage and delay payment of a claim with no more penalty than interest on the amount owed.9

The National Association of Insurance Commissioners drafted the model Unfair Claims Settlement Practices Act (“UCSPA”) to set forth standards for the investigation and disposition of claims under policies or certificates of insurance issued to residents of the states that adopt the model act.10 To date, nearly all states have adopted some version of the model UCSPA.11 Specifically, the UCSPA details practices by insurers that are considered to be unfair and can lead to an insured or a third party making a bad faith claim against the insurer.

As we did with the Ethical Requirements in Section II above, we will use Florida’s adoption of the UCSPA as the basis of this discussion.12 As was mentioned above, an implied duty of good faith and fair dealing arises out of Florida’s UCSPA.13 To assert a claim for unfair claims settlement practices, it must first be established that insurance coverage exists, for there can be no unfair settlement if there is no established coverage to be settled.14

7 Restatement (Second) of Contracts § 205 (1981).
11 Iowa, Mississippi, and Nevada have not adopted the Model Unfair Claims Settlement Practices Act.
14 Id. But see Travelers Prop. Cas. Co. of Am. v. Fed. Recover Svcs., 2016 U.S. Dist. LEXIS 4347 (D. Utah, Jan. 12, 2016) (insurer may be liable in bad faith for misconduct toward insured even in the absence of coverage because the covenant of good faith is in addition to the contractual obligations of the policy).
Unfair claims settlement practices in Florida include\textsuperscript{15}:

(1) Attempting to settle claims on the basis of an application or other material document that was altered without notice to, or knowledge or consent of, the insured;

(2) Material representation made to an insured for the purpose and with the intent of effecting settlement of claims, loss, or damage in less favorable terms than those provided in the policy;

(3) Committing or performing with such frequency as to indicate a general business practice any of the following:

(a) Failing to adopt and implement standards for the proper investigation of claims;

(b) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(c) Failing to acknowledge and act promptly upon communications with respect to claims;

(d) Denying claims without conducting reasonable investigations based upon available information;

(e) Failing to affirm or deny full or partial coverage of claims, and, as to partial coverage, the dollar amount or extent of coverage, or failing to provide a written statement that the claim is being investigated, upon the written request of the insured within 30 days after proof-of-loss statements have been completed;

(f) Failing to promptly provide a reasonable explanation in writing to the insured of the basis in the insurance policy, in relation to the facts or applicable law, for denial of a claim or for the offer of a compromise settlement;

(g) Failing to promptly notify the insured of any additional information necessary for the processing of a claim; or

(h) Failing to clearly explain the nature of the requested information and the reasons why such information is necessary.

(i) Failing to pay personal injury protection insurance claims within the time periods required by s. 627.736(4)(b).

(4) Failing to pay undisputed amounts of partial or full benefits owed under first-party property insurance policies within 90 days after an insurer

\textsuperscript{15} See Fla. Stat. § 626.9541(1)(i)(1) – (4).
receives notice of a residential property insurance claim, determines the amounts of partial or full benefits, and agrees to coverage, unless payment of the undisputed benefits is prevented by an act of God, prevented by the impossibility of performance, or due to actions by the insured or claimant that constitute fraud, lack of cooperation, or intentional misrepresentation regarding the claim for which benefits are owed.

The standard for evaluating bad faith claims against insurers for first-party and third-party claims under the UCSPA is whether the insurer acted fairly and honestly toward its insured with due regard for the insured's interests. Florida uses a “totality of the circumstances” test to determine an insurer's liability for unfair claims settlement practices. Specifically, Florida courts will review (1) the insurer’s effort to promptly resolve coverage issues or otherwise limit any potential prejudice to the insured; (2) the substance of coverage disputes or weight of legal authority on the coverage issue; and (3) the insurer's diligence or thoroughness in investigating facts that are specifically pertinent to coverage.

Bad faith claims put the insurer’s actions under a microscope. There is a body of case law outlining claims for breach of the implied covenant of good faith and fair dealing that can be used as guidance for adjusters and insurers who seek to avoid bad faith claims. An insurer may not treat its own insured in the manner in which an insurer may treat third-party claimants to whom no duty of good faith and fair dealing is owed. In dealing with third parties, the insured's interest must be given faithful consideration and the insurer must treat a claim being made by a third party against its insured's liability policy as if the insurer alone were liable for the entire amount of the claim. Another way, the insurer is required to approach settlement as if the policy limits do not exist and to ignore the policy limits during settlement negotiations.

Florida courts have even held that if an insured’s liability is clear and the injuries of a claimant are so severe that a judgment in excess of policy limits is likely, the insurer has an affirmative duty to initiate settlement negotiations. The reason for the rule is that an insurance

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18 Id.
19 Newport v. USAA, 11 P.3d 190, 196 (Okla. 2000).
21 Badillo, 121 P.3d at 1093; see also Berglund v. State Farm Mut. Auto. Ins. Co., 121 F.3d 1225, 1227-1228 (8th Cir. 1997).
22 Powell v. Prudential Prop. & Cas. Ins. Co., 584 So. 2d 12, 14 (Fla. App. 3d DCA 1991), review denied, 598 So. 2d 77 (Fla. 1992). See also Gohegan v. Am. Vehicle Ins. Co., 107 So. 2d 433, 438-439 (Fla. 2012), citing Powell; see also Farmers Ins. Exch. v. Schropp, 567 P.2d 1359 (Kan. 1977) (duty to initiate settlement negotiations arises if carrier would initiate settlement negotiations on its own behalf were its potential liability equal to that of its insured); Rova Farms Resort, Inc. v. Investors Ins. Co., 323 A.2d 495 (N.J. 1974) (where substantial injuries and potential liability of insured are obvious, failure to offer policy limits constitutes bad faith even where there is no assurance that action can be settled); Alt v. Amer. Family Mut. Ins. Co., 237 N.W.2d 706 (Wis. 1976) (insurer has
company, in dealing with a third-party claim against its insured, is acting in a fiduciary capacity toward its insured by virtue of the terms of the insurance policy, which give the insurer the authority to determine whether an offer of compromise or settlement should be accepted or rejected. A central issue in any analysis to determine whether breach of the duty of good faith and fair dealing has occurred is gauging whether the insurer had a good faith belief in some justifiable reason for the actions it took or omitted to take that are claimed violative of that duty. Breach by an insurer of the implied duty to deal fairly and to act in good faith with the insured gives rise to an action in tort for which consequential and, if proper, punitive, damages may be sought.

Moreover, bad faith may be inferred from a delay in settlement negotiations which is willful and without reasonable cause. An insurer's decisions regarding settlement must be made based on a thorough investigation of the underlying circumstances of the claim and on informed interaction with the insured. The insurer's duty includes the duty to timely and adequately inform the insured of the progress of settlement negotiations. An insurer's duty of good faith and fair dealing includes the duty to act in a diligent manner in relation to investigation, negotiation, defense and settlement of claims being made against the insured. The duty to inform the insured of settlement opportunities is one of the duties subsumed within the duty of good faith owed by an insurer to an insured.

IV. Case Studies

Courts across the country have examined issues related to whether insurers have breached the duty of good faith and fair dealing owed to their insured:

A. Lockwood v. Geico General Insurance Company

In Lockwood v. Geico General Insurance Company, the Supreme Court of Alaska held that there was a material issue of fact as to whether the insurer (1) had a reasonable basis to affirmative duty to investigate possibilities of settlement); Eastham v. Oregon Auto Ins. Co., 540 P.2d 364 (Or. 1975) (insurer may be found to have acted in bad faith for delaying an offer to settle). See generally 14 COUCH ON INSURANCE 2d § 51:17 (Rev. ed. 1982); J. Appleman, INSURANCE LAW AND PRACTICE § 4711 at 383 (Rev. ed. 1979).

23 Badillo, 121 P.3d at 1093; see also Am. Fid. & Cas. Co. v. G.A. Nichols Co., 173 F.2d 830, 832 (10th Cir. 1949), Am. Fid. & Cas. Co. v. L.C. Jones Trucking, 321 P.2d at 687.

24 Badillo, 121 P.3d at 1093-1094; see also Buzzard v. McDanel, 736 P.2d 157, 159 (Okla. 1987).

25 Christian, 577 P.2d at 904.


29 Badillo, 121 P.3d at 1096; see also State Auto. Ins. Co. v. Rowland, 427 S.W.2d 30, 33 (Tenn. 1968).

deny payment to the insured under her policy and (2) breached its duty of good faith and fair dealing. An uninsured, intoxicated motorist rear-ended another car while it was stopped at a red light.\textsuperscript{31} The driver who was rear-ended, Lockwood, suffered neck and back injuries in the accident.\textsuperscript{32} Lockwood received medical treatment for her injuries, including extended chiropractic treatment.\textsuperscript{33} Lockwood had an automobile policy with Geico that provided medical payments coverage and uninsured motorist coverage.\textsuperscript{34} Lockwood eventually exhausted her medical payments coverage and sought payment under her uninsured motorist coverage.\textsuperscript{35} Geico never paid Lockwood’s medical bills under the uninsured motorist policy.\textsuperscript{36} Eventually, Lockwood’s medical care was too cost prohibitive (over $6,000), so she stopped treatment despite continued pain.\textsuperscript{37}

Lockwood attempted to settle with Geico over the next two years. Geico first offered to settle Lockwood’s uninsured motorist claim for $750, based on Lockwood’s request for the cost of childcare while she was receiving treatment.\textsuperscript{38} Lockwood refused the offer and retained an attorney to pursue medical payments from Geico.\textsuperscript{39} Later, Geico advised Lockwood that it would not consider paying her medical bills outside of a total settlement and that her medical bills seemed high.\textsuperscript{40} Lockwood offered to settle for the policy limit of $50,000, and a month later, Geico responded with a counteroffer of $12,000, which Lockwood refused.\textsuperscript{41}

Lockwood sued Geico, alleging a breach of contract claim under her uninsured motorist coverage and a tort claim for Geico’s breach of the covenant of good faith and fair dealing.\textsuperscript{42} Faced with a lawsuit, Geico requested for the first time, nearly three years after the accident, that a doctor perform an independent medical evaluation of Lockwood.\textsuperscript{43} The doctor’s report stated that he could find no objective evidence to support Lockwood’s contention that she hurt her lower back in the accident.\textsuperscript{44} Geico increased its settlement offer to $25,000, which

\begin{itemize}
  \item \textsuperscript{31} \textit{Lockwood}, 323 P.3d at 693.
  \item \textsuperscript{32} Id.
  \item \textsuperscript{33} Id. at 693-694.
  \item \textsuperscript{34} Id. at 693.
  \item \textsuperscript{35} Id. at 694.
  \item \textsuperscript{36} Id.
  \item \textsuperscript{37} Id.
  \item \textsuperscript{38} Id.
  \item \textsuperscript{39} Id.
  \item \textsuperscript{40} Id.
  \item \textsuperscript{41} Id.
  \item \textsuperscript{42} Id. at 694-695.
  \item \textsuperscript{43} Id. at 695.
  \item \textsuperscript{44} Id.
\end{itemize}
Lockwood accepted, although she preserved her claims for extracontractual/bad faith damages against Geico. Geico filed a motion for summary judgment on Lockwood’s extracontractual/bad faith claims, which the lower court granted, finding that none of the evidence presented raised a factual question as to whether Geico lacked a reasonable basis in failing to pay the demanded settlement amount. Specifically, the lower court found that Geico had ample reason to delay further payments to Lockwood pending further investigation into the medical necessity for further treatment and a determination regarding the causation and extent of her injuries.

Lockwood appealed, arguing that there were genuine issues of material fact as to whether Geico unreasonably delayed payment. The Supreme Court of Alaska agreed with Lockwood. First, the court stated that there was an issue of fact as to whether an offer of $750 was unreasonable behavior on the part of Geico, who is subject to the duty of good faith and fair dealing. Specifically, Geico’s initial settlement offer was solely based on Lockwood’s childcare expenses and not on her medical condition, the connection of that condition to the car accident, her medical bills, general damages, or lost wages. Lockwood continued to incur medical expenses, lost wages, and other non-economic general damages after the exhaustion of her medical payments coverage.

Second, the court stated that there was an issue of fact as to whether Geico’s decision to condition additional medical payments on a global settlement actually was connected to Lockwood’s medical condition and the accident. The court reasoned that if Geico had legitimate concerns about the extent of Lockwood’s injuries after she exhausted her medical payments coverage, an inference can be drawn that a reasonable insurer would have advised Lockwood of those concerns with specificity and either asked Lockwood for more medical information or requested an independent medical exam. Geico took no such action when it demanded a global settlement.

45 Id.
46 Id. at 696.
47 Id.
48 Id.
49 Id. at 697.
50 Id, at 698.
51 Id.
52 Id.
53 Id.
54 Id.
55 Id.
Third, the court stated that there was an issue of fact as to whether Geico had a reasonable basis for delaying payment of Lockwood’s uninsured motorist benefits and whether Geico breached its duty of good faith and fair dealing. The court reasoned that Geico denied further payment under the uninsured motorist policy and declined to make any further attempts to reach a settlement based solely on its unsubstantiated doubts about the necessity of medical care for injuries sustained in the accident. Other than asserting these doubts, Geico did nothing to reduce the alleged medical uncertainty about the cause of Lockwood’s pain or to clarify the necessity of further treatment from her chiropractor. Geico did not request a second medical opinion or an independent medical exam until three years after it stopped paying Lockwood’s medical bills, nor did it cite a medical basis to call the chiropractor’s treatment into question. Additionally, Geico did not seek to use the voluntary-arbitration clause in the insurance contract to resolve the medical uncertainty, nor did it advise Lockwood of the action she would have to take to resolve the medical uncertainty to Geico’s satisfaction.

Ultimately, the Supreme Court of Alaska remanded to the lower court for a determination on the questions presented above.

B. Gohegan v. American Vehicle Insurance Company

In Gohegan v. American Vehicle Insurance Company, the District Court of Appeal of Florida, Fourth District, held that there was a question of fact as to whether (1) the Personal Representative’s retention of an attorney was an impediment to settlement communications and (2) the victim’s coma prevented any possible settlement. The Personal Representative of Molly Swaby’s estate filed a bad faith claim against an insurer which arose as a result of a motor vehicle accident where the insured was traveling at a high rate of speed and was intoxicated. Swaby sustained catastrophic injuries and remained in a coma for nearly three months after the accident before she died.

The insured reported the accident to the insurer two days later, and a claim adjuster was assigned. The adjuster immediately notified the insured of the policy limits for bodily

56 Id. at 699.
57 Id. at 698.
58 Id.
59 Id.
60 Id. at 698-699.

61 The Personal Representative of the estate was Swaby’s mother. For purposes of this discussion, she will be referred to as the Personal Representative, regardless of the fact that Swaby was alive for a period of time while negotiations were ongoing.

62 Gohegan, 107 So. 3d at 434-435.
63 Id. at 435.
64 Id.
injury claims ($10,000 per person; $20,000 per accident) and advised the insured that she would make every attempt to settle all claims for bodily injury in accordance with the policy limits.65 Days later, the adjuster concluded that the insured was the sole cause of the accident, Swaby’s injuries were far in excess of the policy limits, and the claim should be settled.66 Four days after the accident, the adjuster called and spoke with Swaby’s stepfather who told her that the Personal Representative had retained an attorney and that the adjuster would have to speak to the Personal Representative to obtain the attorney’s name.67 That same day, the adjuster called a different number for the Personal Representative and spoke to a person identified as a friend and was advised that the Personal Representative was not available.68 Six days after the accident, the adjuster called the Personal Representative and left a voice mail message with her contact information.69

The adjuster waited three weeks to contact the Personal Representative again, at which time she spoke with her and asked for the name of her attorney.70 The Personal Representative asked the adjuster to call back at a later time.71 The adjuster called the Personal Representative about a week later, and the Personal Representative advised the adjuster that she was not in a position to discuss matters at that time.72 About three weeks later, the adjuster called the Personal Representative, who informed the adjuster that it was not a convenient time to talk.73 Three days later, the adjuster learned that the Personal Representative sued the insured.74 The adjuster attempted to tender the policy limits, which the Personal Representative rejected.75 The wrongful death claim was not resolved, and an approximately $2.8 million judgment was entered against the insured in favor of the Personal Representative.76 In addition, the lower court granted summary judgment in favor of the insurer on the issue of bad faith.

The issue on appeal was whether the insurer acted in bad faith resulting in a judgment against the insured in the amount of $2.8 million.77 When the insurer moved for summary


65 Id.
66 Id.
67 Id.
68 Id.
69 Id.
70 Id.
71 Id.
72 Id.
73 Id.
74 Id.
75 Id.
76 Id.
77 Id.
judgment in the lower court, it asserted that it had acted fairly and honestly toward its insured with due regard for his interest but was prevented from entering into settlement negotiation or consummating a settlement for two reasons: (1) Swaby was in a coma and there was no one to make the offer to; and (2) because the insurer had been made aware that there was an attorney involved, Florida Administrative Code 69 and 69B-220.201 prohibited it from communicating or negotiating a settlement with Swaby or the Personal Representative.\(^78\)

The District Court of Appeal held that the trial court erred in granting summary judgment to the insurer based on the assumption that there could be no bad faith because Swaby was in a coma and therefore there was no one to whom to make a settlement offer.\(^79\) The District Court of Appeal also reasoned that the insurer could have made a written offer and/or tender to Swaby through her Personal Representative.\(^80\) The court also noted that if the Personal Representative had retained an attorney, the assistance of the attorney may have been necessary to finalize a settlement but would not have precluded an offer.\(^81\) The court further reasoned that with catastrophic injuries, clear liability, and the limited available liability limits of $10,000, a jury could decide that there was not much to negotiate and that representation by an attorney would not have been an impediment to at least make an offer to settle.\(^82\)

The District Court of Appeal did not hold as a matter of law that the insurer was guilty of bad faith, and in fact noted that the jury might conclude that the insurer acted reasonably and prudently in attempting to protect its insured.\(^83\) It did note, however, that the financial exposure to the insured was a ticking financial time bomb where a lawsuit could be filed at any time.\(^84\) The court reasoned that any delay in making an offer under the circumstances, even where there was no assurance that the claim could be settled, could be viewed by a fact finder as evidence of bad faith. The case was remanded to the lower court for further proceedings.\(^85\)

**C. Badillo v. Mid Century Insurance Company**

In *Badillo v. Mid Century Insurance Company*, the Supreme Court of Oklahoma held that the lower court did not err in submitting the issue of breach of the implied duty of good faith and fair dealing to the jury and that no reversible error was demonstrated at trial that would warrant overturning the $2.2 million judgment in favor of the insured. The insured struck a pedestrian while driving his truck, seriously injuring the pedestrian.\(^86\) The pedestrian incurred

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\(^{78}\) Id. at 436.

\(^{79}\) Id. at 439.

\(^{80}\) Id.

\(^{81}\) Id.

\(^{82}\) Id.

\(^{83}\) Id.

\(^{84}\) Id.

\(^{85}\) Id.

\(^{86}\) *Badillo*, 121 P.3d at 1088.
hundreds of thousands of dollars in medical bills as a result of the collision. The insured had a $10,000 automobile liability policy. The policy gave the insurer authority to settle any claim made for the liability coverage as it deemed appropriate.

After the insured notified the insurer of the accident, the insurer’s adjuster told the insured not to discuss the case with anyone except the insurer. The adjuster later informed the insured that the value of the pedestrian’s claim might exceed the policy limits, but the adjuster never had an in-person meeting with the insured. The adjuster reviewed the police report of the accident, but he never spoke directly with the officer who worked on the accident, something that was required by the insurer’s procedure manual for a serious injury case.

The pedestrian retained an attorney shortly after the accident, who then notified the adjuster of the retention. The adjuster spoke with the attorney on the telephone, but the matter was not settled. The adjuster sent a check for the $10,000 policy limits and a release to the attorney. After receiving the check and the release, the attorney determined that it would be a mistake to recommend settlement to the pedestrian without conducting further investigation into whether there might be an employer or some other person or entity to pursue in the matter, in addition to the insured. Accordingly, the attorney requested that she be allowed to take the insured’s statement. The adjuster, after conferring with a supervisor but not the insured, refused the request.

After receiving the refusal letter, the pedestrian hired a litigation attorney. The litigation attorney again attempted to persuade the adjuster to produce the insured for a statement, but was unable to do so and a negligence action against the insured was filed later that day.

\[\text{\textsuperscript{87}}\text{Id. at 1089.}\]
\[\text{\textsuperscript{88}}\text{Id.}\]
\[\text{\textsuperscript{89}}\text{Id.}\]
\[\text{\textsuperscript{90}}\text{Id.}\]
\[\text{\textsuperscript{91}}\text{Id.}\]
\[\text{\textsuperscript{92}}\text{Id.}\]
\[\text{\textsuperscript{93}}\text{Id.}\]
\[\text{\textsuperscript{94}}\text{Id.}\]
\[\text{\textsuperscript{95}}\text{Id.}\]
\[\text{\textsuperscript{96}}\text{Id.}\]
\[\text{\textsuperscript{97}}\text{Id.}\]
\[\text{\textsuperscript{98}}\text{Id. at 1090.}\]
\[\text{\textsuperscript{99}}\text{Id. at 1091.}\]
\[\text{\textsuperscript{100}}\text{Id.}\]
jury awarded the pedestrian about $630,000 in damages against the insured.\textsuperscript{101} The insurer tendered the $10,000 policy limit to the pedestrian, which she accepted.\textsuperscript{102} The insured could not satisfy the judgment, so he reached an agreement with the pedestrian to stay any attempt to collect on the judgment pending the outcome of his bad faith lawsuit against the insurer.\textsuperscript{103} The insured agreed to use funds from any judgment he obtained against the insurer to satisfy the judgment he owed to the pedestrian.\textsuperscript{104} The lawsuit between the insured and the insurer went to a jury.\textsuperscript{105} The jury returned a verdict in favor of the insured in the amount of $2.2 million for his financial losses, embarrassment, and mental pain and suffering.\textsuperscript{106}

The insurer’s issue on appeal was whether the trial court erred in not directing a verdict on the insured’s breach of good faith and fair dealing claim.\textsuperscript{107} The essential elements the insured was required to show to prove a prima facie case were: (1) insured was covered under the policy issued by the insurer and that the insurer was required to take reasonable actions in handling the pedestrian’s claim; (2) the actions of the insurers were unreasonable under the circumstances; (3) the insurers failed to deal fairly and act in good faith toward the insured in its handling of the pedestrian’s claim; and (4) the breach or violation of the duty of good faith and fair dealing was the direct cause of any damages sustained by the insured.\textsuperscript{108} Based on the facts outlined above, the Supreme Court of Oklahoma held that the trial court correctly decided that the proof presented as to each element was sufficient to warrant submission to the jury for its consideration.\textsuperscript{109}

Specifically, the court reasoned that the insurer did little, if anything, to work out an alternative to the pedestrian’s request for a personal statement from the insured.\textsuperscript{110} This inaction implicated the extent to which the insurer ignored its requirement to communicate/consult with the insured when his assets and financial well-being were on the line.\textsuperscript{111} In addition, the court noted that the pedestrian’s request for a personal statement from the insured was reasonable, especially when the insured, who did not know about the request until after he was sued by the pedestrian, would have given such a statement.\textsuperscript{112}

\textsuperscript{101} Id.
\textsuperscript{102} Id. at 1091-1092.
\textsuperscript{103} Id. at 1092.
\textsuperscript{104} Id.
\textsuperscript{105} Id.
\textsuperscript{106} Id.
\textsuperscript{107} Id.
\textsuperscript{108} Id. at 1093.
\textsuperscript{109} Id.
\textsuperscript{110} Id. at 1094-1095.
\textsuperscript{111} Id.
\textsuperscript{112} Id. at 1095-1096.
V. Addressing Ethical Issues

Every claim on which an adjuster works has the potential to raise ethical questions and concerns. By following the standard of care outlined below and upholding the Ethical Requirements, adjusters can avoid many of the ethical pitfalls that lead to bad faith claims against insurers.

Generally, claim adjusters assume specific roles throughout the duration of a claim. The adjuster must identify policy coverage, examine the property, prepare claim documentation, engage experts as needed, advise and update the policyholder, determine property values, negotiate claim settlement, and conclude the claim. At all times while performing these roles, claim adjusters must uphold the ethical requirements imposed upon them, which can be considered a standard of care in claim handling. There must be adequate communication between the insurer and insured or claimant. The insurer must be accurate and truthful in the information it gives to the insured or claimant. The insurer must adequately investigate the claim. The insurer cannot cause any undue delay in paying a claim that is covered under the policy.

At each step in the claim process, the adjuster has to ask him- or herself, in the broadest sense, whether he or she is doing the right thing. To a certain extent, when an adjuster takes into consideration the Ethical Requirements and the standard of care, this question comes down to a gut-feeling assessment. If the action does not feel right to the adjuster, in all likelihood, the action is not ethical and should not be taken.

113 The Claim Function & Professional Ethics, American Institute for Chartered Property Casualty Underwriters, 2012, at 1.5.


115 Id.

116 Id.

117 Id.
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