Friday, November 3, 2017 • 8:45 am – 3:30 pm
Cobb Energy Performing Arts Centre

Swift Currie

ATTORNEYS AT LAW

Scrap the App . . . We Have An Attorney For That!

November 3, 2017

Cobb Energy Performing Arts Centre

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Outlook Calendar and Reminder: New Developments on Time-Limited Demands for Policy Limits

By Stephen M. Schatz

Stephen M. Schatz

Partner

Stephen M. Schatz practices in a wide variety of litigation cases, especially areas related to insurance, construction and general liability. Throughout his career, he has handled a multitude of complex coverage issues under commercial general liability, excess, reinsurance, auto, specialty lines, D&O, disability, pollution, professional liability and first-party insurance policies. He has litigated numerous bad faith, insurance coverage, arson, fraud, theft, damage disputes, agency liability, subrogation and construction defects cases. He has also litigated and tried cases involving general liability, products liability, class actions, multi-district litigation (MDL), environmental liability, employer liability, professional liability and business/contract disputes.

Mr. Schatz is a member of the State Bar of Georgia and practices in all state and federal courts in Georgia. In addition to Georgia, he has litigated matters in jurisdictions pro hac vice, including Alabama, Florida, Mississippi, Missouri, New Jersey, North Carolina, South Carolina, Tennessee and Virginia. Mr. Schatz is a member of the Defense Research Institute, the Claims and Litigation Management Alliance, the Georgia Fire Investigators Association and the Southern Loss Association. He has published an article every year in the *Mercer Law Review* (the "Annual Insurance Survey") since 2002 and the *National Fire and Arson Report*. He is also a frequent speaker on insurance coverage, bad faith and construction litigation issues.

Mr. Schatz graduated with distinction from the University of Virginia in 1985 and earned his J.D. degree from the University of North Carolina School of Law in 1988. He has been a partner with Swift Currie since 1997.

Outlook Calendar and Reminder: New Developments on Time-Limited Demands for Policy Limits

In Georgia, a liability insurer who unreasonably fails to settle a covered claim against its policyholder may be found liable for an amount in excess of its policy limits. With the stakes for insurers so high, claimaints' attorneys are setting complicated traps in order to reap outrageous awards from seemingly innocent conduct by claims professionals. These traps may include, for example, unreasonably short time frames or specific instructions regarding how the payment is to be made. When the insurer fails to accept the demand pursuant to the exact specifications in the demand letter, the claimant cries "gotcha" and demands that the insurer pay all claimed damages, including those in excess of policy limits.

As if the sneaky scenarios devised by claimants' attorneys were not enough, some insurers unfortunately create their own obstacles, fall prey to these set ups by failing to respond at all or provide a limited or incomplete response. With diligence and care, along with an understanding of the consequences of unreasonably failing to accept a settlement offer with a sensitive time constraint, an insurer can better avoid breaching its duty to settle or finding itself liable for an excess judgment. Insurers subjected to "set-up" or "gotcha" demands may also have legal support to challenge liability arising from such.

In response to the insurance industry's cries for a fairer legal process when faced with a time-limited demand for policy limits, the Georgia General Assembly enacted a statute in 2013, O.C.G.A. § 9-11-67.1, which outlines procedures for how such pre-suit settlement demands must be made and, if appropriate, how they are to be accepted. The statute applies only to claims arising from the use of a motor vehicle, though. While the statute has helped limit the "traps" set by claimants somewhat, it did not fix all of the problems. Plaintiffs are still finding ways to trap insurers with time-limited demands, both in motor vehicle accident claims and in non-vehicle claims made under *Southern General Insurance Co. v. Holt*.[1] Moreover, a recent Georgia Supreme Court decision has expanded what a claimant can demand in a pre-suit demand beyond the elements set forth in the statute. The prudent insurer should be aware of the limitations of the protections of O.C.G.A. § 9-11-67.1, as well as the potential pitfalls when faced with non-vehicle claims under *Holt*.

THE INSURER'S DUTY TO SETTLE

The insurer's obligation of good faith requires the insurer to conduct a reasonably thorough and adequate investigation of all claims against its insured.[2] The insurer must also give equal consideration to the interests of its insured when making decisions regarding the litigation or potential settlement of third-party claims.[3] However, the insurer is not required to give greater consideration to the interests of the insured over its own interests.[4]

The insurance company acts in bad faith when it capriciously refuses to entertain an offer or fails to consider the risk to the insured should the case proceed to trial, and then a judgment in excess of the policy limits is rendered.[5] Put another way, if liability is reasonably clear and if the damages are high, the insurer "may not gamble" with the funds of its insured by refusing to settle within the policy limits in the hopes of striking a better deal later, knowing its liability is capped by policy limits if hardball tactics fail.[6]

Two preeminent Georgia cases have shaped the contours of the law on bad faith failure to settle. The first case is *Southern General Insurance Company v. Holt*.[7] In *Holt*, the attorney for the injured party offered to settle the case with the defendant's insurer for an amount within policy limits. This offer, however, stated it was only good for 10 days. The insurer

1 262 Ga. 267, 416 S.E.2d 274 (1992).
2 *Cotton States Mut. Ins. Co. v. Phillips*, 110 Ga. App. 581, 139 S.E.2d 412 (1964).
3 *See Nat'l Svcs. Inds., Inc. v. Hartford Accident & Indemnity Co.*, 661 F.2d 458 (5th Cir. 1981) (applying Georgia law); *Great Am. Ins. Co. v. Exum*, 123 Ga. App. 515, 181 S.E.2d 704 (1971); *U.S. Fid.& Guaranty Co. v. Evans*, 116 Ga. App. 93, 156 S.E.2d 809 (1967).
4 *Id.*
5 *Gov't Employees Ins. Co. v. Gingold*, 249 Ga. 156, 288 S.E.2d 557 (1982); *Cotton States Mut. Ins. Co. v. Fields*, 106 Ga. App. 740, 128 S.E.2d 358 (1962).
6 *McCall v. Allstate Ins. Co.*, 251 Ga. 869, 310 S.E.2d 513 (1984).
7 262 Ga. 267, 416 S.E.2d 274 (1992).

failed to reply within the short deadline, but eventually responded by agreeing to the offer. By that time, the injured party had considered the offer revoked and proceeded to trial, where an excess verdict was reached. The insured then assigned her bad faith claim against her insurer to the injured party, who sued the insurer for bad faith and won.

The case was appealed to the Georgia Supreme Court, which held "an insurance company does not act in bad faith solely because it fails to accept a settlement offer within the deadline set by the injured person's attorney."[8] The court, however, noted an insurer does have a duty to respond to a settlement deadline within policy limits where the insurer has knowledge of clear liability and special damages will exceed the policy limits. The primary thrust of *Holt* is the court's recognition and recitation of the general rule that an insurer's bad faith depends on whether the company acted reasonably in responding to a settlement offer.

Another important case is *Cotton States Mutual Insurance Company v. Brightman*.[9] Brightman, who was seriously injured in the accident, offered in writing on several occasions (including after a non-binding arbitration panel found in Brightman's favor and awarded him $2 million) to settle his claims for payment by Cotton States and State Farm Mutual Automobile Insurance Company of their policy limits. The demand required both insurers to tender their policy limits.

In response to the demand made by Brightman, neither Cotton States nor State Farm tendered their policy limits before the expiration of the 10-day period outlined in the offer. A trial ensued when the jury awarded Brightman damages for personal injury far in excess of the coverage amounts. The driver who was liable for this excess amount then signed over his bad faith claim to Brightman, who brought suit against Cotton States and won the claim for bad faith penalties. This decision was then appealed to the Georgia Supreme Court.

On appeal, Cotton States argued it never had the opportunity to settle because the plaintiff's demand contained a condition beyond its control (the demand that State Farm also tender its policy limits). In response to this argument, the court stated, "an insurance company faced with a demand involving multiple insurers can create a safe harbor from liability for an insured's bad faith claim under *Holt* by meeting the portion of the demand over which it has control, thus doing what it can to effectuate the settlement of the claims against its insured." Essentially, the court found an insurer could be liable for bad faith in not settling even when the settlement required conditions beyond an insurers control.

Brightman does not serve as a mandate that an insurance company must tender its limits. The potential bad faith penalties at issue in *Holt* and *Brightman* applied because the insurer had "knowledge of clear liability and special damages exceeding the policy limits." The rule is that an insurer is negligent in failing to settle if the ordinary prudent insurer would believe choosing to try the case instead of settling it would create an unreasonable risk to the insured and would not adequately take into account the best interests of the insured. An insurer must act unreasonably in not tendering its limits in order to be held liable for bad faith.

HOW TO SPOT ISSUES AND TRAPS WITH THE HOLT DEMAND

An insurer can only be liable for rejecting a reasonable settlement demand. Under Georgia law, a settlement demand is reasonable if the insurer knew or should have known at the time the settlement demand was rejected that liability was clear and the potential judgment was likely to exceed the policy limits based on the claimant's injuries or loss. It is also possible that a settlement demand can be reasonable even if liability is questionable when damages are significant. In other words, it might be reasonable to demand the policy limits when damages are clearly several multiples in excess of policy limits, and the likely allocation of liability against the insured will be a percentage that, when applied to the verdict, likely will exceed the policy limits (even if not 100 percent liable). Whether an offer or settlement demand is reasonable depends upon the information that was available to the insurer when the demand was made. The insurer's conduct is evaluated under the totality of circumstances in which the claim and the settlement demand were presented.

Claimants' lawyers have learned that their primary tool to craft a claim for bad faith is the demand letter. As discussed below, these letters can often be single-sided, ambiguous and unreasonable. Many of these letters seem to be obvious attempts to "set up" the insurance company for bad faith. Such demands place the insurance company in a dilemma. It can

8 *Id.* (citing *Home Ins. Co. v. North River Ins. Co.*, 192 Ga. App. 551, 385 S.E.2d 736 (1989).

9 276 Ga. 683, 580 S.E.2d 519 (2003).

try to meet the terms of the demand and risk failing to meet one of the letter's ambiguous terms. Alternatively, it can try to contact the claimant's counsel for clarification and risk its conversation being deemed a counter offer, which then can be rejected. Although these demand letters take a myriad of forms, some of the commonly encountered issues are set forth below.

Arbitrarily Short Time Limits

The hallmark feature of a set-up demand letter is an arbitrary yet inflexible time period for responding. Offers to settle for policy limits may include short deadlines that pass before there has been adequate time for investigation or discovery, which may be revoked on technicalities. Time-limited demands are also often made without important documents in support of the claim, most notably medical records. This lack of documents prevents the insurer from adequately assessing its liability to make a settlement decision before the time-limited offer expires. If the insurer fails to accept the settlement demand before it expires, then the insurer may find itself defending against a bad faith failure to settle claim. The more unscrupulous claimants' attorneys may send the demand to the wrong department in the insurance company or send the letter when the primary adjuster is scheduled to be out of office.

Although the courts have not provided bright-line rules regarding what time limits are acceptable, the Tenth Circuit Court of Appeals provided instructive guidance in *Wade v. Emasco Insurance Co.*[10] In *Wade,* the court held it was not bad faith for an insurer to reject a settlement limits demand because the time limit set by the plaintiff's attorney was unreasonable.

Indeed, the court found it was reasonable and acceptable for the insurance company to wait to review the relevant medical records before responding to a policy limits demand. The Tenth Circuit reasoned permitting an injured plaintiff's chosen timetable for settlement to govern the bad-faith inquiry would promote the customary manufacturing of bad-faith claims, especially in cases where an insured of meager means is covered by a policy of insurance which could finance only a fraction of the damages in a serious personal injury case. Indeed, insurers would be bombarded with settlement offers imposing arbitrary deadlines and would be encouraged to prematurely settle their insureds' claims at the earliest possible opportunity in contravention of their contractual right and obligation to thoroughly investigate.

In sum, a demand should give the insurer a reasonable time to evaluate both the demand and the claim in order to determine whether it will accept the demand. If an insurer is not given a fair opportunity to evaluate the demand, its failure to accept the demand may be justified and excusable, even if a subsequent verdict exceeds both the demand and the policy limit. That is not to say the deadline should be blithely ignored. The insurance company should respond in writing within the arbitrary deadline to explain why the deadline is unreasonable and what investigation is necessary before the settlement demand can be considered. The response should be drafted with the expectation that, should a bad faith claim result, the letter will be used as an exhibit in the adjuster's deposition and shown to the jury at trial. On the other hand, where the insurer has sufficient information to evaluate a demand, courts have held that deadlines as short as 10 days are reasonable, as demonstrated in the *Holt* decision. Moreover, now that O.C.G.A. § 9-11-67.1 has been enacted, an insurer has at least 30 days to accept a pre-suit demand for policy limits where the claimed injuries arise out of the use of a motor vehicle.

Vague Terms

The settlement demand letter will sometimes contain vague settlement terms requiring clarification. A claimaint's counsel will argue any request to clarify terms or seek information is a counter offer, and is therefore a rejection of the settlement demand within the deadline. They try to place the carrier in a "heads-I-win, tails-you-lose" situation. As a result, the claims representative, wary of this type of set up, is loath to call, even to ask for clarification of intentionally ambiguous demand terms. When they do call, they may be put through to voicemail or given the runaround, in an attempt to stall for time while the days run out on the time-limited demand. When the inevitable bad faith action is brought, such attempts at communication become a mere footnote in the "totality of circumstances" of considerations to which the jury must apply their 20/20 hindsight. Written communication is preferred, with great care given to ensure it is clear the letter seeks only to clarify terms of the demand so that the demand can be considered.

[10] 483 F.3d 657 (10th Cir. 2007).

Conditions Precedent

Offers to settle for policy limits may require an insurer to fulfill various conditions precedent to valid acceptance. Although some conditions are acceptable, certain conditions may render a settlement offer unreasonable, thus precluding an insurer's bad faith liability. For example, a settlement demand in California is not "a settlement demand within policy limits" if it contains conditions beyond simply paying the policy limit.[11] Such conditions include requiring the insured to participate as parties at trial or requiring the insurer to provide a defense for the insured. A settlement offer that includes these conditions may not provide a basis for a bad faith claim. Some claimants' attorneys place as a condition precedent on their demands that the insurer not only accept the policy limits demand within the deadline, but also tender the payment within the deadline. Georgia courts have not had an opportunity to address whether such a condition precedent is appropriate, but the legislature has addressed such in O.C.G.A. § 9-11-67.1, giving the insurer a minimum of 10 days to pay after the written acceptance of the offer to settle.

Absence of a Release

The absence of a release may render a settlement demand unreasonable and invalid as a basis for bad faith. When a settlement demand does not promise a release of all claims against the insured, the insurer should not be obligated to accept the demand. An insurer may also be justified in rejecting a settlement demand that leaves its insured vulnerable against claims by other parties.[12]

For example, in *Coe v. State Farm Mutual Automobile Insurance Co.*, the plaintiff made a policy limits demand with an 11-day deadline for the insurer to respond. State Farm inquired whether the settlement would include a release of a workers' compensation lien and assured the claimant "upon receipt of the very basic information requested, we shall promptly advise you of our position regarding settlement." The plaintiff's attorney did not reply to this inquiry, took the case to trial and obtained a large verdict in excess of the policy limits. The appellate court reversed and ruled State Farm was not responsible for any damages over the policy limits because the demand did not provide the company with a reasonable opportunity to settle all claims, including liens.

That being said, several cases have been decided in Georgia holding an insurer liable for an excess verdict when the insurer's response to a time-limited demand was along the lines of, "We will accept the demand for policy limits, but the plaintiff must agree to satisfy any medical and/or workers' compensation liens." These cases have found that such a response is a counter offer and rejection of the demand. In *Herring v. Dunning*, the defendant's insurer issued an acceptance letter including language requesting a confirmation that no liens existed relevant to the case.[13] The court characterized this language as a mere recommendation — not a "mandatory direction" — especially in light of the acceptance letter's grant of a full and final release. Thus, the letter was "an unequivocal and unconditional acceptance of plaintiff's written offer to settle."

In contrast, in *Frickey v. Jones*,[14] the insurer responded to a policy-limit offer with a letter stating its willingness to pay the policy limit, but only upon receipt of a full release and a resolution of hospital liens and medical insurance liens. The court found this response constituted a counteroffer and thus a rejection of the original offer to settle. The Georgia Supreme Court distinguished this case from *Herring* on the grounds the insurer's acceptance letter did not accept the offer "unequivocally and without variance of any sort," and the requirement to resolve liens rose above the request in *Herring* to confirm the nonexistence of any outstanding liens. The tenuous distinction drawn by the Georgia Supreme Court serves as a warning to insurers to be careful when accepting settlement demands with conditions. This has proven to be very frustrating to insurers, especially in light of the federal government's more aggressive stance recently in enforcing Medicare liens.

Recent decisions, though, should give insurers more comfort. For example, in *Southern General Insurance Co. v. Wellstar Health System*,[15] the court created a "safe harbor" for insurers from liability for bad faith if the sole reason for the parties'

11 *Heredia v. Farmers Ins. Exch.*, 279 Cal. Rptr. 511, 516 (Ct. App. 1991).
12 *See Coe v. State Farm Mut. Auto Ins. Co.*, 136 Cal. Rptr. 331, 337–38 (al App. 2006).
13 213 Ga. App. 695, 699, 446 S.E.2d 199, 203 (1994).
14 280 Ga, 573, 574-577, 630 S.E.2d 374, 376–77 (2006).
15 315 Ga. App. 26, 726 S.E.2d 488 (2012).

failure to reach a settlement within policy limits is the plaintiff's unreasonable refusal to assure that outstanding medical liens will be satisfied. Moreover, when faced with an unreasonable plaintiff, the court gave insurers the option to pay the outstanding liens directly to the creditor and pay the remainder of the limits to the plaintiff.

Again, the overriding concern is for the insurer to demonstrate reasonableness and show the insured's interests are being protected, even if giving at least equal weight to its own interests.

Demands in Excess of Policy Limits

A demand in excess of policy limits is not a reasonable demand that can be accepted by an insurer, and thus "an insurer's settlement duty is not activated until a settlement demand within policy limits is made, and the terms of the demand are such that an ordinarily prudent insurer would accept it."[16] However, keep in mind that in other jurisdictions, the fact that a settlement demand exceeds the policy limits may not absolve the insurer from a duty to settle. In these jurisdictions, the insurer has a duty to make a counter offer for an amount within the policy limit in an effort to resolve the claim against its insured.[17]

Demand Includes Uncovered or Inflated Claims

Sometimes the demand letter will contain unreasonable terms relating to uncovered items or to inflated claims under other coverage. As an example, a plaintiff may reasonably seek policy limits on a bodily injury claim. With that demand, the plaintiff may also seek an overly inflated amount for property damage. The insurance company risks bad faith by contesting the property damage claim, thereby losing the opportunity to settle the bodily injury claim.

Lack of Information

Some settlement demands arrive unsupported by necessary evidence and information. A claimant's failure or refusal to provide key information (e.g., medical records) may significantly affect whether an insurer's rejection of a settlement demand was "reasonable."[18] Other jurisdictions have embraced this reasoning. For example, in *Robins v. Allstate Insurance Co.*, the insurer unsuccessfully attempted to obtain medical records and information from the claimant for two years. The insurer subsequently received a settlement offer for policy limits that included only some past medical bills, but very little documentation of the medical evaluation and diagnosis to explain the medical bills and their relevance to the claim. The court found the insurer's refusal to settle without ascertaining the medical status of the insured was not unreasonable and did not give rise to a bad faith claim.

As a corollary to this principle, an insurer has a right and duty to conduct a reasonable investigation.[19] Hence, an insurer who was not permitted to conduct a sufficient investigation to determine the likelihood of an excess judgment should not be held liable for bad faith.[20] Although plaintiffs or claimants will continue to try setting arbitrary and unreasonable time frames for insurers to respond to policy limit settlement demands, some courts have held such deadlines are not dispositive and insurers have the right to investigate and evaluate the plaintiff's claims.[21]

In *Baker v. Huff*,[22] liability was clear, but Liberty Mutual received medical bills at the time of the policy limit demand that were far less than policy limits and contained notations that the plaintiff's injuries had substantially improved. The plaintiff was not immediately forthcoming with any further medical records showing additional treatment or the current status of injuries. Liberty Mutual refused to accept the demand within the deadline, but later received additional medical records causing it to accept the demand, but the plaintiff rejected the acceptance. The court of appeals denied the fact

16 *See, e.g., Rocor Int'l v. Nat'l Union Fire Ins. Co.*, 77 S.W.3d 253, 262 (Tex. 2002).
17 *See, e.g., Rova Farms Resort, Inc. v. Investors Ins. Co.*, 323 A.2d. 495, 506–7 (N.J. 1974).
18 870 So. 2d 402, 412-13 (La. Ct. App. 2004).
19 *See, e.g., Guebara v. Allstate Ins. Co.,* 237 F.3d 987, 995 (9th Cir. 2001); *Egan v. Mut. of Omaha Ins. Co.*, 620 P.2d 141, 146 (Cal. 1979).
20 *Globe Indem. Co. v. Superior Court,* 8 Cal. Rptr. 2d 251, 255 (Cal. App. 1992); *See also, e.g., Gilderman v. State Farm Ins. Co.*, 649 A.2d 941, 946 (Pa. Super. Ct. 1994); *State Farm Mut. Auto. Ins. Co. v. Hollis*, 554 So. 2d 387, 389–90 (Ala. 1989).
21 *Pavia v. State Farm Mut. Auto. Ins. Co.*, 626 N.E.2d 24, 28–29 (N.Y. 1993).
22 *Baker v. Huff*, 747 S.E.2d 1, 2013 Ga. App. LEXIS 590 (2013).

special damages were less than the limits automatically entitled Liberty Mutual to summary judgment for the bad faith claim, but it granted the insurer summary judgment on the grounds that its failure to accept the demand within the deadline was not unreasonable as a matter of law, because the insurer did not have the information necessary to properly evaluate the demand.

It is important to note that an insurer's lack of information is not an absolute shield to liability for bad faith. If an insurer's lack of sufficient information is due to the insurer's own negligence or lack of diligence, this lack of information will not provide a defense against a bad faith claim. California courts have held insurers liable for bad faith for failing to thoroughly investigate a claim or for unreasonably delaying the commencement of an investigation or coverage decision.[23] Therefore, insurers should document all steps necessary to determine whether a claim is likely to exceed policy limits, inform the insured of the settlement offer, involve the insured when prudent and request specific additional information or additional time to evaluate the claim.

Offer to Settle Only Part of a Bodily Injury Claim

In *Baker v. Huff*, the Court of Appeals of Georgia found that a time-limited demand for the policy limits that was an offer for a partial settlement of pain and suffering damages was not an offer to fully settle a claim within the policy limits under *Holt*.[24] Therefore, the insurer had no duty to engage in negotiations concerning a settlement demand that was in excess of the policy limits.[25]

Defense Counsel's Valuation of the Claim

In some jurisdictions, the insurance company can rely on the advice of counsel in showing its response to a time limited demand was reasonable. Under California law, for example, an insurer may offer proof it acted in good faith reliance on advice of competent counsel to negate allegations it acted in bad faith toward its insured and to negate any claims it acted with the requisite "oppression, fraud or malice" for an award of punitive damages. Along with other relevant evidence, a showing of good faith reliance on advice of counsel may tend to show the insurer was acting "reasonably" in its handling of the claim. Reliance on counsel's advice tends to show the insurer had "proper cause" for its actions and thus tends to negate bad faith.[26]

Applicability of Coverage Defenses

The states are split on whether an insurance company has a duty to settle in the face of a good faith question about coverage under the policy. The California Supreme Court found that where (1) there is a settlement demand within policy limits, and (2) there is a great risk of a judgment in excess of policy limits, an insurer that refuses to accept the settlement demand does so at its own risk.

Importantly, the court clearly stated such risk includes liability for the entire excess judgment and even a reasonable but erroneous belief in non-coverage is no defense.[27] However, in many jurisdictions the insurer has no duty to settle when there is a "fairly debatable" coverage question.[28]

In Georgia, it appears liability can exist for not settling a case even though coverage questions do exist. In *Alexander Underwriters General Agency v. Lovett*, the insurer believed the insurance policy had been cancelled; therefore, it did not defend a liability suit brought against the insured.[29] The lawsuit went into default. Before the trial on damages, the plaintiff wrote to the insurer offering to settle for the $10,000 policy limit. The insurer chose to rely on its position that the policy was cancelled and declined to settle. This final demand was one of 35 items of correspondence directed at the insurer during

23 *See, e.g., Egan*, 620 P.2d at 146; *Love v. Fire Ins. Exch.,* 271 Cal. Rptr. 246, 252 (al App.1990).

24 *Id.* at 365.

25 *Id.*

26 *State Farm Mut. Auto. Ins. Co. v. Superior Court (Johnson Kinsey, Inc.)*, 279 Cal. Rptr. 116, 117–18 (Cal. App.1991) (citations omitted).

27 *Comunale v. Traders & Gen. Ins. Co.*, 328 P.2d 198 (Cal. 1958).

28 *See, e.g., Harman v. Estate of Miller*, 656 N.W.2d 676, 681 (N.D. 2003); *Farmland Mut. Ins. Co. v. Johnson*, 36 S.W.3d 368, 375 (Ky. 2000); *Lasma Corp. v. Monarch Ins. Co.*, 764 P.2d 1118, 1122–23 (Ariz. 1988); *Mowry v. Badger States Mut. Cas. Co.*, 385 N.W.2d 171, 180 (Wis. 1986); *Pham v. State Farm Mut. Ins. Co.*, 70 P.3d 567, 572 (Colo. App. 2003); *Snodgrass v. State Farm Mut. Auto. Ins. Co.*, 804 P.2d 1012, 1022–23 (Kan. Ct. App. 1991).

29 182 Ga. App. 769, 357 S.E.2d 258 (1987).

the case. After an excess judgment was entered, the insured filed a bad faith action against its insurer. The bad faith action went to trial and the insured was awarded the entire amount of the underlying judgment, plus attorney's fees and punitive damages. The insurer appealed, arguing such damages are not proper for the insurer's breach of the duty to defend. The court of appeals, however, held the insurer's liability was predicated not on violating the duty to defend, but instead arose from the fact "there was a timely offer of settlement within the limits of coverage and that the insurer negligently or in bad faith refused to adjust the account or to defend the insured (after the offer of settlement) when the amount of damages . . . was being established."

By holding the insurer liable for failing to settle in *Alexander*, an insurer is effectively required to reexamine its coverage position when confronted with an opportunity to settle, and it must act reasonably in light of all new information. Even if the insurer continues to decline coverage wrongly, but in good faith, it may still be liable for failing to settle.

In *Davis v. Cincinnati Insurance Co.*, the jury absolved the insurer of any bad faith in breaching its duty to defend the insured.[30] Nonetheless, the jury found the insurer acted negligently in failing to settle the claim on behalf of the insured. Implicitly, an insurer can act negligently and be held liable in failing to settle a claim even though it denied coverage. Further, the question of whether the insurer acted negligently in failing to settle is not necessarily tied to considerations of the insurer's good faith in denying coverage.

Based on these decisions, it is questionable whether an insurer can rely on its coverage defenses to determine the reasonableness of a settlement demand. Policyholders can argue that an insurer's "good faith" belief in non-coverage will be no defense to liability flowing from its refusal to accept a reasonable settlement offer. When coverage is dubious, an insurer can protect itself by accepting a settlement demand under a reservation of rights to seek reimbursement of payments for non-covered claims. Indeed, the insurer can make settlement payments over the objections of the insured and then later seek reimbursement when it is determined the underlying claim was not covered under the policy.

Withdrawn Settlement Demands

It is important to remember an insurer cannot necessarily reverse the consequences of an unreasonable settlement demand by subsequently offering to settle for policy limits. When a settlement offer for policy limits is later withdrawn by the claimant, and subsequent offers by the insurer to settle for the same amount are rejected, an insurer may still be found to have acted in bad faith.[31] Therefore, it is prudent to assume the insurer will not be given a "redo" after missing a chance to settle, so it is important to respond properly the first time within the deadline.

Compliance with the Terms of the Offer

A settlement offer may stipulate that acceptance may only be made in a specific manner (e.g. "mailing the lawyer a check for the amount of the policy limits" or providing the policy limits in cash in denominations of $20 and $50 to the lawyer). If such a requirement is present and the insurer accepts in a form that does not comply with the demand, the claimant may have an excuse to reject the acceptance and pursue a bad faith claim. However, courts are trending more toward a reasonable, common-sense approach when looking at whether compliance with a requirement amounts to bad faith.

In *Partain v. Pitts*, the Court of Appeals of Georgia reversed an order denying a claimant's motion to enforce a settlement agreement where the insurer made a minor mistake.[32] In response to a time-limited demand for policy limits, the insurer's settlement draft was made jointly payable to the claimant, the claimant's husband and the claimant's attorney, rather than only to the wife and attorney as instructed in the settlement demand. The insurer inadvertently sent the draft, along with a letter to the claimant's attorney rather than to its own attorney, who was handling the settlement. The insurer corrected its mistake and re-issued the payment to the correct parties within the time frame set forth in the demand. The claimant's attorney argued that the demand was rejected and a counter offer was made. The court of appeals rejected the claimant's argument, finding that no counter offer had been made and noted that the check, along with a letter from the insurer, was a

30 160 Ga. App. 813, 288 S.E.2d 233 (1982).
31 *See, e.g., Berges v. Infinity Ins. Co.* 896 So. 2d 665, 669 (Fla. 2004).
32 338 Ga. App. 298, 787 S.E.2d 354 (2016).

privileged communication meant for the insurer's attorney and not the claimant. As the second check issued by the insurer was delivered within the deadline specified in the settlement demand letter, such delivery constituted acceptance of the offer, and a binding agreement was formed.

GEORGIA'S MOTOR VEHICLE SETTLEMENT DEMAND STATUTE

O.C.G.A. § 9-11-67.1 addresses the procedure to be followed in connection with time-limited policy limits settlement demands for motor vehicle accident cases. Before diving into the outlined procedure, though, it is important to first discuss what the statute does not address:

1. The statute only discusses the procedure for offering and accepting time limit demands. It does not address the merits of such demands. Therefore, the same legal standards discussed above apply in determining whether an insurer has acted in bad faith by rejecting a demand (i.e., whether such rejection was arbitrary or capricious and failed to give equal consideration to the insured's interests).
2. The statute only applies to offers to settle tort claims for injuries "arising from the use of a motor vehicle." This language was part of the compromise. Auto liability insurers who issue minimum required limits in their policies were the most susceptible to getting abused by *Holt* demands. To get the bill to pass, a compromise was reached to limit the law solely to auto claims. Therefore, for tort claims not involving the use of a motor vehicle, the old case law addressing the procedure for time demands will apply. Insurers will need to be very careful not to assume that the protections set forth in O.C.G.A. § 9-11-67.1 apply to non-auto claims.
3. The statute only applies to demand letters written by attorneys. Therefore, *pro se* claimants in auto claims who make *Holt* demands fall under the old procedure.
4. The statute only applies to causes of action arising on or after July 1, 2013.
5. The statute only applies to pre-suit demands.

The following is the new procedure for time limit demand in auto cases:

1. The deadline for acceptance of the demand cannot be less than 30 days from receipt of the demand.
2. The demand must be in writing specifically referencing the statute, sent by certified mail or overnight delivery and set forth the following terms:
    A. amount of monetary payment;
    B. who will be released if the demand is accepted;
    C. the type of release the claimants will provide to each releasee; and
    D. the claims to be released.
3. The demand can require a deadline for payment of the settlement amount (limits), but that deadline cannot be less than 10 days after written acceptance of the demand.
4. If the insurer decides to accept the terms of the demand, such acceptance must be in writing.
5. The insurer has the right to seek clarification of "terms, subrogation claims, standing to release claims, medical bills, medical records, and other relevant facts," and such request for reasonable clarification will not be deemed a counter offer.
6. If the insurer decides to accept the demand, it can elect a variety of payment methods, including cash, money order, wire transfer, cashier's check, insurance company check or draft and electronic payment.

RECENT NOTABLE CASES

Grange Mutual Casualty Co. v. Woodard

In *Grange Mutual Casualty Co. v. Woodard*,[33] a case of first impression, the Supreme Court of Georgia, in response to certified questions from the Eleventh Circuit, held that O.C.G.A. § 9-11-67.1 "permits 'unilateral' contracts, whereby pre-suit offers may demand acceptance in the form of performance . . . before there is a binding enforceable settlement contract" and "does not preclude a pre-suit offer from demanding timely payment as a condition of acceptance."[34]

Woodard arose out of an automobile accident in which Woodard's daughter was killed.[35] In the pre-suit offer to settle for Grange's automobile liability policy limits pursuant to O.C.G.A. § 9-11-67.1, Woodard's attorney conditioned acceptance of a pre-suit offer upon the performance of certain acts, including timely payment within 10 days after Grange's written acceptance of the offer.[36]

Grange's representative accepted the offer in writing in a timely fashion and informed Woodard's counsel that the settlement checks would follow under separate cover within 10 days.[37] When the checks did not arrive within 10 days (due to an administrative error in how they were addressed), Woodard's counsel informed the insurer that Woodard considered the settlement offer to have been rejected.[38] Grange then filed suit to enforce settlement.[39] Both parties filed cross-motions for summary judgment, citing O.C.G.A. § 9-11-67.1.[40] The district court granted summary judgment to Woodard, and Grange appealed to the Court of Appeals for the Eleventh Circuit.[41] The Eleventh Circuit then certified questions to the Supreme Court of Georgia, asking it to interpret O.C.G.A. § 9-11-67.1.[42]

In addressing the certified questions, the Supreme Court relied on common law principles of contract law to determine whether a settlement agreement had been reached.[43] ". . . [T]he common law is well established that (1) the offeror is the master of his or her offer, and (2) agreement requires a meeting of the minds on all material terms."[44] The court concluded that O.C.G.A. § 9-11-67.1 does not contravene common law principles and does not preclude pre-suit offers from requiring terms in addition to the terms set forth in the statute, including requiring payment as a condition of acceptance.[45] While pre-suit offers made pursuant to O.C.G.A. § 9-11-67.1 must contain the five enumerated terms required in subsection (a) of the statute, "additional terms are not prohibited."[46] The court declined to decide the ultimate issues in the case: whether an enforceable settlement was reached based upon the facts of the case and the consequences if the parties had reached an agreement.[47]

Camacho v. Nationwide

In *Camacho v. Nationwide Mutual Insurance Co.*, the District Court for the Northern District of Georgia found that insurer Nationwide acted in bad faith in failing to respond to the estate's settlement demand.[48] The facts and aggressive decision in *Camacho* should be very concerning to insurers.

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33 300 Ga. 848, 797 S.E.2d 814 (2017).
34 *Id.* at 858, 797 S.E.2d at 823.
35 *Id.* at 848, 797 S.E.2d at 816.
36 *Id.* at 848-49, 797 S.E.2d at 816-17.
37 *Id.* at 849, 797 S.E.2d at 817.
38 *Id.*
39 *Id.*
40 *Id.* at 850, 797 S.E.2d at 817.
41 *Id.* at 851, 797 S.E.2d at 818.
42 *Id.*; *Grange Mut. Cas. Co. v. Woodard*, 826 F3d 1289 (11th Cir. 2016).
43 *Grange,* 826 F.3d at 853-54, 797 S.E.2d at 819-20.
44 *Id.* at 856, 797 S.E.2d at 821.
45 *Id.* at 854, 797 S.E.2d at 820.
46 *Id.* at 855, 797 S.E.2d at 820.
47 *Id.* at 857, 797 S.E.2d at 822.
48 2016 WL 3069833 (June 23, 2016). Note the case involved a motor vehicle accident before O.C.G.A. § 9-11-67.1 applied. However, the case law is still applicable to non-vehicle cases and to any issues not addressed by the statute.

In *Camacho*, Nationwide was ordered to pay over $8 million in damages for bad faith and negligence after a jury verdict. The jury determined Nationwide had acted negligently and in bad faith after denying a claim arising out of a 2005 automobile accident. Nationwide's insured, Seung Park, ran a red light and struck a car driven by Stacey Camacho, causing her death.

Nationwide was provided with a time-limited settlement demand (a 10-day deadline) for Park's $100,000 policy limit in exchange for a limited liability release that would release Park from all personal liability for any and all claims arising out of the accident, except to the extent other insurance coverage was available from which the Camacho family could seek additional funds. Nationwide rejected the settlement offer after 13 days, insisting on a general release with an indemnification provision related to medical liens. When no settlement was reached, the claimants filed a wrongful death suit in state court. The state court jury awarded $5.83 million.

Following the jury's verdict, Park assigned his right to his bad faith claim against Nationwide to the plaintiffs who filed suit against Nationwide. In the bad faith case, the jury returned a verdict in favor of the plaintiffs, finding that Nationwide acted in bad faith by failing to settle. Nationwide argued that no reasonably prudent insurer would have accepted the demand because it did not clearly offer to resolve the estate claim, and the new attorney who made the demand did not have the apparent authority to make it. The court rejected these arguments, finding that the evidence was sufficient to support the jury's finding that, by failing to respond to Camacho's settlement demand within the 10-day time limit, Nationwide gave no consideration to Park's financial interests. The court found that an insurer may be liable for failing to settle for the policy limits if an ordinarily prudent insurer would consider that choosing to try the case — rather than accepting a reasonable settlement offer to settle within the policy limits on the terms by which the claim could be settled — would constitute an unreasonable risk that the insured would be subjected to a judgment in excess of the policy's limits. The court rejected Nationwide's argument that the failure to settle was not the proximate cause of the excess verdict. Rather, the court found the evidence at trial sufficient for a jury to determine that Nationwide's failure to settle exposed its insured to a $5.83 million excess verdict. The court awarded interest and found the plaintiffs were entitled to an award of reasonable attorneys' fees and expenses.

Camacho was affirmed by the United States Court of Appeals for the Eleventh Circuit with no discussion, other than it reviewed the district court's "thorough and well-reasoned final order."

Linthicum v. Mendakota Insurance Co.

In *Linthicum v. Mendakota Insurance Co.*,[49] the United States Court of Appeals for the Eleventh Circuit found an insurer neither acted negligently nor in bad faith for failing to accept a settlement offer for policy limits when the offer was not to fully settle the entire claim within policy limits.[50] The insurer was not obligated to accept an offer to settle only a wrongful death claim within policy limits where a separate possible claim for pain and suffering still existed.[51]

Linthicum arose out of a drunk driver colliding with and killing the plaintiffs' son.[52] The plaintiffs filed suit, claiming that Mendakota, the insurance provider of the driver, had acted in bad faith and/or negligently for failing to settle the plaintiffs' claim within policy limits.[53] The insurer moved for summary judgment on the grounds it had not acted in bad faith, because the plaintiffs' time-limited demand for policy limits in exchange for settling their claim was only for the wrongful death claim.[54] The offer did not settle a potential claim for the plaintiffs' son's pain and suffering.[55]

"An insurer is not liable for failing to respond to a time-sensitive offer to settle for policy limits when the offer does not resolve fully the claim against its insured."[56] The plaintiffs could sue both for their son's wrongful death (as parents) and for their son's pain and suffering (as administrator of his estate), even though the plaintiffs argued they did not plan to do so.[57] Because the plaintiffs' offer for settlement did not fully settle the claim within policy limits, Mendakota was not obligated "to continue negotiations because the offer would have exceeded policy limits."[58]

49 2017 U.S. App. LEXIS 7840 (May 3, 2017) (unpublished opinion).
50 *Id.* at *9-*10.
51 *Id.*
52 *Id.* at *11-*12.
53 *Id.* at *6.
54 *Id.* at *6-*7.
55 *Id.* at *7.
56 *Id.* at *8, citing *Baker v. Huff*, 323 Ga. App. 357, 747 S.E.2d (2013).
57 *Id.* at *10-*11.
58 *Id.* at *12-*13.

CONCLUSION

The policy limits demand is a tool employed by plaintiffs to transform low-limit insurance policies into open-ended policies of indemnity. Given the increasingly frequent occurrence of insurer set ups, insurers are wise to be attentive to any policy limits demand and to proactively respond to any such demand. By carefully reviewing and investigating claims and being responsive to claimants, insurers can avoid liability and the negative consequences these set ups can bring. The tide is slowly beginning to shift toward decreasing the "gamesmanship" of time-limited demands, by both the courts and the legislature, and focusing on what should be the key issue: whether the insurer acted in bad faith in rejecting the demand. However, claimants' attorneys will continue to push the envelope to explore ways to expose insurers' policy limits. The Supreme Court of Georgia's answers to certified questions in *Grange Mutual Casualty Co. v. Woodard* likely will be used by the claimants' bar to continue to push that envelope.

Denial Letter or Breach Letter: Which App Do I Use?

By Mark T. Dietrichs

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Denial Letter or Breach Letter: Which App Do I Use?

In first-party property coverage claims, the insurer has the right to insist the insured comply with her duties under the policy so long as the insurer has timely exercised its right to demand compliance with those duties. In particular, these duties relate to the submission of a Sworn Statement in Proof of Loss, an itemized personal property inventory, production of relevant documents and records and compliance with the Examination Under Oath provision. Occasionally, there are instances when an insured has prevented insurance company personnel or representatives from entering the premises to conduct an investigation or refused to cooperate in making household members or other key witnesses available for sworn statements. All of these conditions are outlined in the Duties After Loss section in the policy.

In instances when the insured has breached these conditions, the insurer is effectively precluded by the insured's non-cooperation from fully investigating the merits of the claim and determining whether or not exclusions are applicable to the loss or the amount of damage that may be recoverable. The insured's non-cooperation effectively puts the insurer and any named mortgagee in legal limbo. The mortgagee cannot recover its interest in the proceeds independently because no formal decision has been made on the insured's claim. The mortgagee provision allows the insurer to pay the mortgagee independently only when a decision has been made to deny the named insured's claim. An insurer is forced to leave the file open and leave reserves in place while the claim is stalled due to the insured's refusal to cooperate. This delay in providing information frequently prejudices the insurer's ability to identify and preserve critical evidence. Usually this legal impasse remains in effect until the expiration of the suit limitation deadline.

The breach letter outlines the various duties and conditions that have not been performed by the insured despite specific demands by the insurer. The letter should document the dates of the requests or correspondence demanding compliance with the policy conditions. If possible, there should be multiple efforts made to secure the cooperation of the insured before the breach letter is sent, preferably two or three written letters documenting the provisions of the insurance policy and enclosing the necessary forms to allow the insured to comply with the policy provisions.

The breach letter should emphasize the concepts "cooperation," "failure to comply with the policy conditions" and "breach of obligations." The letter should specifically reserve the insurer's right to raise other defenses that might be applicable to the claim. The issuance of a breach letter will allow an insurance company to proceed with resolution of the mortgagee's claim, if the insurer wishes to do so.[1] It is recommended that the insurer put its insured on notice of its intent to communicate directly with the mortgagee and satisfy the mortgagee's claim if it wishes to do so. This intent should be communicated as part of the breach letter so the insured can object if she wishes to do so. Furthermore, the breach letter should reference the suit limitation provision contained in the policy and the date when the insurance company will consider the claim to be time barred.

It is important that the breach letter does not contain the word "deny" or any variation of that term. Georgia courts have repeatedly ruled that once an insurance company communicates to its insured that it has made a decision that the claim is not covered or that there is no duty to defend or indemnify the insured, the parties' rights are effectively fixed. The use of the word "deny," or its variations, communicates the claim is not covered. "Denial" of a claim means the insurer has sufficient knowledge of the facts and it wishes to take a formal position with respect to substantive exclusions or the misrepresentation and fraud defense. Such a "denial" precludes the insurer from thereafter using the provisions of the insurance contract to conduct further investigation that might establish the correctness of its decision.

[1] An argument can be made that the mortgagee can only be independently paid if there has been a formal denial of the insured's claim and a breach letter is insufficient to trigger that option. It is unlikely a court would adopt this position, since it would result in mortgagees having to wait until the expiration of the suit limitation deadline before the mortgagee could be paid. Since the mortgagee is also bound by the suit limitation provision, such a ruling would be patently unfair to all interested parties. Moreover, even the non-cooperating insured is benefitted by the payment to the mortgagee, since the debt is reduced and interest and penalties cease to accrue. The mortgagee may even approve use of the funds to repair the property, despite the insured's non-cooperation.

The Georgia Court of Appeals stated:

> "There can be no doubt that an absolute refusal by the insurer to pay would constitute a sufficient legal excuse, for when that has been done the filing of a proof of loss would be a vain and useless thing."[2]

The same rationale applies to demands for documents, Examinations Under Oath or compliance with the other conditions of the policy.

The viability of the breach letter also depends upon whether the insurance company has timely asserted its right to force the insured to comply with the conditions of the policy. For example, if the insurer does not demand the insured submit a Sworn Statement in Proof of Loss and itemized personal property inventory within three to four months of the date of loss, the insurer may be deemed to have waived its right to demand the Proof of Loss. Similarly, an Examination Under Oath or demand for documentation should be asserted within 15 to 30 days following receipt of the Sworn Statement in Proof of Loss. "A Provision of an insurance policy may be waived by inaction and delay on the part of the insurer."[3] The suit limitation provision contained in the policy requires the insurer be vigilant in communicating its demands for compliance with the provisions of the policy on a timely basis and in following up with these requests.

Unlike the denial letter, the breach letter provides the insured the opportunity to cure the breach by cooperating with the insurance company. "Cooperation" consists of providing the Sworn Statement in Proof of Loss, inventory, Examination Under Oath, access to the property, production of documentation or other action required under the Duties provision of the policy. Once the breach letter is sent, it is not necessary that the insurer initiate further communications with its insured regarding the status of the claim. The burden shifts to the insured to be proactive in curing the breach. If the insured cures the breach and complies with the policy provisions, the insurer should reopen its file and move forward with its investigation of the claim. The goal is to make a decision based upon the merits of the claim, if possible.

However, we recommend against extending the time for the insured to cure the breach beyond the suit limitation deadline contained in the policy or required by Georgia law (one year in some policies, two years in most policies and two years for fire losses). The policy language specifically precludes the insured from filing suit "unless there has been compliance with the policy provisions." By definition, the fact the insured has breached the policy means the insured has not complied with the policy conditions and, therefore, cannot file suit. The purpose behind the suit limitation provision is to allow for prompt investigation and resolution of claims. The longer the claim drags out, the less likely the insurer can identify the necessary information needed to prove the existence of an exclusion under the policy terms. Please note that the burden is on the insurer to establish the necessary facts to justify application of an exclusion. The longer the insurer is delayed from conducting the factual investigation, the less likely these facts can be established, thereby inherently handicapping the insurer's ability to make the correct decision with respect to coverage.

This brings us to the hybrid breach/denial letter. Once the suit limitation deadline has expired, we recommend the insurance company not reopen its file in the event the insured wishes to cure the breach. In the breach letter, the insured should have been notified of the suit limitation deadline. This allows for the normal closure of a file on a timely basis. It also reduces the amount of time an insurer must hold reserves in conjunction with any given claim.

Please note that an insurer is not required to send a breach/denial letter once the suit limitation period expires. If the insured has not initiated any further communication with respect to the claim after the breach letter is sent, the claim file can simply be closed. The only necessary precaution is that the claims professional needs to be alert to the fact the suit limitation deadline has expired, and no further consideration will be given to the claim in the event the insured or an agent/representative of the insured contacts the claims professional regarding the status of the claim. In the event of communication by the insured or a representative of the insured regarding the status of the claim after the suit limitation period has expired, we recommend sending a breach/denial letter. Like the breach letter described above, the breach/denial letter will outline the actions of the insured constituting a breach of the policy conditions and the insurance company's efforts to secure the insured's cooperation on a timely basis. However, the breach/denial letter will not provide another opportunity for the insured to cure the breach. Instead, the insured is told that the claim can no longer be considered or

[2] *Reserve Ins. Co. v. Campbell*, 107 Ga. App. 311, 314, 130 S.E.2d 236, 239 (1963).
[3] *Williams v. So. Gen. Ins. Co.,* 211 Ga. App. 867, 868, 440 S.E.2d 753, 754-55 (1994).

evaluated due to the insured's non-cooperation and failure to file suit and comply with the policy conditions within the prescribed time. Consequently, the claim is denied. The breach/denial letter must include language reserving the right to raise substantive defenses and exclusions that could be applicable to the claim but could not be investigated due to the insured's refusal to cooperate. The letter should express that the insurer has been prejudiced in its ability to investigate and adjust the claim by the insured's conduct.

Allowing the insured to cure the breach and cooperate with the policy provisions after the expiration of the suit limitation provision exposes an insurance company to allegations that it has waived the suit limitation provision. Like the other duties contained in the policy, the suit limitation provision is a condition. This means it can be waived based upon an insurer's conduct if it is not expressly reserved. By agreeing to continue the investigation after the suit limitation provision has expired, an insurer may be exposing itself to a potential lawsuit for up to six years after the date of loss.[4] "An insurer can be held to have waived a limitation period when its investigations, negotiations or assurance up to and past the period of limitation led the insured to believe the limitation would not apply."[5] While an insurance company can take precautions to preserve the suit limitation provision by specifically reserving it and try to adjust the claim on its merits after the expiration of the suit limitation deadline, there are risks associated with this process. Georgia courts have not approved this effort to "have it both ways." Never has a Georgia court enforced the suit limitation provision based solely upon a reservation of rights when an insurer has continued to investigate and negotiate with its insured after the suit limitation deadline has expired. A court may well find that it is a jury question as to whether the insurer's conduct created a waiver or estoppel with respect to the suit limitation provision. Moreover, by continuing to investigate and adjust the claim after the suit limitation deadline, an insurer risks exposure not only to litigation, but bad faith penalties and attorney's fees that would otherwise be legally precluded by the suit limitation deadline. There is also an inherent inconsistency in trying to rely upon a suit limitation provision as a total bar to recovery by the insured after an insurer has allowed the insured to believe the claim would be considered on its merits although the suit limitation deadline has expired. If the insured incurs expenses, such as retaining counsel or a public adjuster, claims of estoppel could also be asserted against the insurer if the insured claims she relied upon the company's willingness to forego the suit limitation deadline and evaluate the claim on its merits. Once a jury issue has been created regarding the potential waiver or estoppel to assert the suit limitation provision, the provision loses its benefit and is difficult to enforce with a jury. Finally, it should be noted that a properly asserted suit limitation defense is the easiest, least expensive path to summary judgment for the insurer.

If an insurance company does not wish to rely upon the suit limitation defense as a total bar after the insured has demonstrated a willingness to cooperate and comply with the conditions in the policy, the carrier could consider tolling the suit limitation period. The tolling process would grant the insured a brief period of time to fully comply with the policy provisions and allow the insurer to make a decision on the merits. The tolling period should only be long enough to complete the investigation on an expedited basis. There should not be adequate time for the insured to perfect a bad faith claim under O.C.G.A. § 33-4-6. Of course, the tolling of the suit limitation provision acts as an extension of the suit limitation deadline, thereby negating the absolute defense of the suit limitation deadline, which existed as of the anniversary date of the loss.

A denial letter is sent once the insurance company has completed its investigation of the claim and determined that coverage does not exist under the policy. The denial letter should identify specific exclusions contained in the policy that preclude coverage. If there are statutory or common law grounds for denying coverage, those grounds should be set forth in the denial letter. The denial letter should outline key facts supporting the decision to deny the claim. However, it is neither necessary nor desirable to set forth every fact upon which the denial is based as some facts may be challenged or altered during the litigation process. The denial letter should reserve the right to raise any other defenses that might be applicable to the claim. In the event the mortgagee will be paid after the denial of the insured's claim, the insured should be notified of this fact in the denial letter.

[4] There is a six-year statute of limitations for actions on contracts that do not contain a contractual suit limitation provision. O.C.G.A. § 9-3-24.

[5] *Appleby v. Merastar Ins. Co.*, 223 Ga. App. 463, 464, 477 S.E.2d 887, 888 (1996); *See Travelers Fire Ins. Co. v. Robertson*, 103 Ga. App, 816, 120 S.E.2d 657 (1961) (insurer's course of conduct waived right to enforce compliance with policy conditions).

All denial letters should be marked "personal and confidential" and sent to the insured. If the insured has retained counsel, the letter should be sent in care of the attorney representing the insured. If the insured's claim is being denied for arson or fraud, the denial letter should not be sent to the public adjuster, agent or any other party besides the insured's attorney. Other parties are not entitled to this information, only notice that the claim has been denied. Notifying others that the insurer has accused the insured of arson or fraud exposes the insurer and the author of the letter to charges of slander and libel.

Breach and denial letters are critical evidence in the event of litigation. In the case of the breach letter, it will serve as a basis for a Motion for Summary Judgment based upon the insured's non-compliance with the policy provisions. The denial letter will be introduced into evidence and shown to the jury. Hopefully, the denial letter is drafted in a way that the jury has a summary of the grounds upon which the claim was denied and the core facts supporting that decision. Consequently, an insurance company may want the assistance of its attorneys in preparing these letters. The letters can be prepared for the signature of the claims professional or for the signature of the attorney so long as the attorney makes it clear that she is sending the letter at the instruction of the insurer. Of course, the claims professional would be responsible for an understanding of the substance of the letter and the reason why it is being sent.

The information set forth herein is not applicable to third-party liability claims. Coverage issues involving liability coverage require sending a reservation of rights and regular supplementation of the reservation of rights as additional information becomes known. In the event an insurer wishes to investigate a claim for application fraud, pursuant to O.C.G.A. § 33-24-7, a formal reservation of rights will be required before the insurance company can demand the insured comply with the conditions of a policy that may subsequently be rescinded for misrepresentations in the application. Rescission of the policy also requires a different type of denial letter (a rescission letter) and a refund of all premiums paid on the policy.

Hopefully, this summary will assist in evaluating the available options with respect to claims in which an insured has refused to cooperate on a timely basis.

Utilities Applications: The Handling of Releases During Settlement

By Melissa A. Segel and Nelofar Agharahimi

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Melissa A. Segel practices commercial litigation and insurance coverage with an emphasis on bad faith and arson and fraud. She has extensive experience defending insurance carriers in Georgia with claims involving homeowners and auto insurance fraud in the context of both first- and third-party property and bodily injury liability losses.

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Ms. Agharahimi was born and raised in the Midwest, growing up in Holland, Michigan. She attended the University of Michigan and received her B.A. in English Literature in 2005 and her J.D. from the University of Toledo in 2008. During law school, she participated in Moot Court and represented Toledo in the Herbert Wechsler National Criminal Moot Court Competition. She spent a summer clerking in Washington, D.C. and stayed through the fall semester to attend American University Washington College of Law, where she was recruited by the Miami-Dade State Attorney's Office. She was admitted to the Florida Bar in 2008 and began her legal career as an Assistant State Attorney in Miami. Ms. Agharahimi is fluent in Farsi and has a working knowledge of Spanish.

Utilities Application: The Handling of Releases During Settlement

Once you have successfully negotiated a demand, time-limited demand and/or offer of settlement and are ready to pay the claim and move on, it is important to ensure the settlement documents are complete. One thing to remember is that any person or entity who has provided benefits to a claimant as a result of her injury may be entitled to a share of the settlement. As a result, settlement documents must identify all of the appropriate parties and the claims to be resolved, as well as address all potential subrogation rights and/or liens. Doing so will aid in developing a smooth transition from negotiation to settlement to the closure of the claim.

MEDICAL PROVIDER LIENS

When there are outstanding medical bills, medical liens can be a big stumbling block. A release, even if it includes language addressing liens, is not enough to protect an insurance carrier from a medical lien. A lien affidavit is also a necessity.

One problem with medical liens is that courts have enforced them even when the medical providers do not follow the statutory requirements of filing a lien. Georgia law allows a medical provider to file a lien against the cause of action to ensure payment from the liability insurance carrier for medical expenses rendered due to an accident or injury.[1] "To ensure payment to the hospital, the statute grants the hospital a lien against a patient's cause of action."[2] The statute identifies a number of requirements the medical provider must complete in order to perfect the lien, including filing written notice within a specific time period.[3] Despite these requirements, Georgia courts have nonetheless still validated liens that did not adhere to the strict statutory requirements. For example, a federal court in Georgia found a hospital lien valid even though the hospital filed the lien affidavit after the expiration of the time period prescribed in the statute.[4] In *Macon-Bibb Hospital Authority*, the court found the lien to be valid and the insurance carrier and defendants jointly and severally liable since they "were not prejudiced in any way by the late filings because they had actual notice of the liens."[5] Citing *Macon-Bibb Hospital Authority*, the Court of Appeals of Georgia also held that "delayed filing [did] not render its lien unenforceable."[6] In *Thomas v. McClure*, the court compared the hospital lien statute with the mechanics lien statute and found the hospital lien statute does not "expressly" require strict compliance with its filing time period, so even a lien filed after expiration of the period is enforceable.[7]

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1 *See* O.C.G.A. § 44-14-470(b), which provides in pertinent part: "Any person, firm, hospital authority, or corporation operating a hospital, nursing home, or physician practice or providing traumatic burn care medical practice in this state shall have a lien for the reasonable charges for hospital, nursing home, physician practice, or traumatic burn care medical practice care and treatment of an injured person, which lien shall be upon any and all causes of action accruing to the person to whom the care was furnished or to the legal representative of such person on account of injuries giving rise to the causes of action and which necessitated the hospital, nursing home, physician practice, or provider of traumatic burn care medical practice care, subject, however, to any attorney's lien. The lien provided for in this subsection is only a lien against such causes of action and shall not be a lien against such injured person, such legal representative, or any other property or assets of such persons and shall not be evidence of such person's failure to pay a debt."

2 *Kight v. MCG Health, Inc.,* 296 Ga. 687, 689, 769 S.E.2d 923, 924 (2015).

3 *See* O.C.G.A. § 44-14-471. For example, O.C.G.A. § 44-14-471(a)(1) requires written notice "to the patient and, to the best of claimant's knowledge, the persons, firms, corporations, and their insurers claimed by the injured person to be liable for damages arising from the injuries" at least 15 days prior to filing the statement required in § 44-14-471(a)(2). O.C.G.A. § 44-14-471(a)(2) requires that a verified statement be filed in the office of the clerk of the superior court of the county where the hospital (or other entity specified in the statute) is located and the county where the patient resides. The verified statement must contain certain identifying information as provided in the statute. The statute provides in O.C.G.A. § 44-14-471(a)(1)(A) that the hospital, nursing home, or provider of traumatic burn care medical practice file the required statement within 75 days after the person has been discharged. Section 44-14-471(a)(1)(A) provides that a statement filed by a physician practice must "be filed within 90 days after the person first sought treatment from the physician practice for the injury."

4 *Macon-Bibb County Hosp. Auth. v. Nat'l Union Fire Ins. Co.,* 793 F. Supp. 321, 323, 1992 U.S. Dist. LEXIS 9350, *1 (M.D. Ga. June 18, 1992).

5 *Id.* at 322, *1.

6 *Id.*

7 *Id.*

After the above two cases, the Georgia legislature amended the statute to clarify that the mere filing of the claim or lien "shall be notice" to those who are liable for the damages, and the failure to perfect the lien by following the statutory requirements:

> "shall invalidate such lien, except as to any person, firm or corporation liable for the damages, which receives, prior to the date of any release, covenant not to bring an action, or settlement, actual notice of a notice and filed statement made under subsection (a) of this Code section, via hand delivery, certified mail, return receipt requested or statutory overnight delivery with confirmation of receipt."[8]

With this statutory language, one would now hope we could rely on the requirement that the lien will be invalidated unless it is sent via hand delivery, certified mail, return receipt requested or statutory overnight delivery with confirmation of receipt. However, the new language has not yet been interpreted by any Georgia courts. Furthermore, a medical lien is not invalidated by a signed release. The statute provides, "No release of the cause or causes of action or of any judgment thereon or any covenant not to bring an action thereon shall be valid or effectual against the lien created by [O.C.G.A. § 44-14-470] unless the holder thereof shall join therein or execute a release of the lien."[9] Therefore, best practices would include an investigation into all potential liens prior to payment being issued and a requirement that the claimant or plaintiff sign an affidavit providing the county of residence of the affiant and affirming that the medical bills were paid.[10]

Other potential liens must be evaluated as well during settlement negotiations, including those asserted under Employee Retirement Income Security Act of 1974 (ERISA) and by Medicare.

MEDICARE

In many of the cases we see, it is common to have a claimant or plaintiff who is either a Medicare beneficiary or is likely to reach the age of eligibility soon after the accident or incident resulting in the claim. In the past, Medicare would bear the cost of treatment to its beneficiaries while claimants pursue their claims with the liable party's insurer. Realizing this loss, Congress enacted the Medicare Secondary Payer Act (MSP), which designated Medicare as a "secondary payer" allowing it to recover payments from other sources, such as liability and no-fault insurance coverage (i.e. primary payer).[11] The MSP was created to ensure that Medicare's interests were being protected by holding the appropriate party responsible for the medical expenses incurred as a result of any accident. Under the MSP, Medicare would make payments to medical providers on the condition that it would be reimbursed by the primary payer (i.e. liability carrier, workers' compensation insurer, etc.). As such, Medicare would either receive reimbursement directly from the primary payer or would be entitled to payment as a term of settlement between the claimant and insurance carrier.[12]

If the primary payer failed to reimburse Medicare for any secondary or conditional payments, the primary payer would be subject to recovery under the beneficiary's right to subrogation for payment of medical bills or by an independent cause of action.[13] If Centers for Medicare & Medicaid Services (CMS) filed suit against a primary payer, the primary payer may be exposed to damages of twice the amount of the payment at issue and accruing interest.[14]

As a result of the MSP, it is imperative to resolve Medicare's interest during settlement negotiations and to address conditional payments in settlement documents to avoid confusion after settlement, as well as to avoid the potential of additional exposure and penalties after settlements proceeds have been issued.[15] Reliance on the claimant's or plaintiff's

8 O.C.G.A. § 44-14-471(b).
9 O.C.G.A. § 44-14-473(a).
10 O.C.G.A. § 44-14-473 notes that "[t]he affidavit shall affirm: (1) That all hospital, nursing home, physician practice or provider of traumatic burn care medical practice bills incurred for treatment for the injuries for which a settlement is made have been fully paid; and (2) The county of residence of such affiant, if a resident of this state; provided, however, the person taking the affidavit shall not be protected thereby where the affidavit alleges the county of the affiant's residence and the lien of the claimant is at such time on file in the office of the clerk of the superior court of the county and is recorded in the name of the patient as it appears in the affidavit." O.C.G.A. § 44-14-473(c).
11 42 U.S.C. § 1395y(b) (2013).
12 42 U.S.C. § 1395y(b)(2)(B)(ii).
13 42 C.F.R. § 411.26 (2013).
14 42 C.F.R. § 411.24(c)(2), (m)(2013).
15 *Haro v. Sebelius*, 747 F.3d 1099, 1116 (9th Cir. 2013) (reasonable interpretation of the MSP for Secretary to demand attorneys withhold settlement proceeds from their clients until after Medicare is reimbursed).

attorney to confirm the claimant's status as a Medicare beneficiary is not recommended. Instead, a better method is to seek information verifying if there have been any payments made under the plan. A condition lien search is an effective way to identify any past payments and to ensure due diligence is performed before entering into any settlement agreements.

The most effective way to ensure Medicare's interests are protected and that the parties have a smooth settlement is to finalize the terms of any settlement after a medical lien is negotiated with CMS by the claimant, plaintiff or attorney. Once the lien is finalized, the primary payer, as a term of the settlement agreement, would issue payment directly to Medicare to resolve the negotiated lien. The remaining proceeds would then be distributed to the claimant, plaintiff and attorney to satisfy the settlement agreement. It is always most effective for parties to work together on resolving the Medicare lien. If there is a failure to satisfy the Medicare lien, the defendant or primary payer may be held responsible to pay the lien within 60 days, even if the insurer has already issued settlement proceeds to the claimant or plaintiff.

MEDICARE SET-ASIDES

One method of incorporating Medicare's interest in negotiations and settlement agreements is through the use of Medicare Set-Asides (MSA). An MSA is just as it sounds: settlement funds that are "set aside," specifically and only for the claimant's future medical treatment to protect Medicare's interest as a secondary payer.

While there are no regulations requiring MSAs in liability settlements, 42 U.S.C. § 1395y(b)(2013) does require parties to protect Medicare's interest with regard to future Medicare-covered treatment. In many lawsuits, plaintiffs have already undergone treatment. However, there are cases where a claimant alleges long-term injuries potentially requiring future treatment well past any settlement discussion occurring during litigation. In those situations, the best method to protect a party from possible liability for future medical expenses is to take into consideration potential future treatment before finalizing any settlement agreements and releases. It is necessary to keep potential future treatment in mind whether or not future care is addressed in the settlement agreement, award, judgment or release. If potential future treatment is addressed in the release, then it is important to identify who is responsible for all future medical costs related to the accident (i.e. whether the settlement for damages includes future damages for medical treatment).

ERISA SUBROGATION LIENS

Health benefit plans provided by employers frequently include a right of subrogation, allowing the plan to recover benefits provided to the employee if the employee has received a settlement or judgment from a third party. Insurance carriers often run into numerous restrictions with these plans, such as prohibiting payment of medical expenses caused by injuries sustained in a motor vehicle accident. Many of the subrogation and reimbursement clauses found in these plans can be inconsistent with state law. However, health carriers claim they are exempt from state laws and allege their subrogation rights are enforceable based ERISA, a federal law governing most employee health plans.[16]

Many ERISA plans rely on preemption principles to assert they are under no obligation to reduce their lien claims and purport they are entitled to their entire reimbursement claim regardless of the circumstances of the case. In fact, federal courts have upheld the rights of ERISA fiduciaries to recover the full amount of medical expenses paid under the plan from beneficiaries.[17]

Nonetheless, there are some exceptions, where ERISA's liens are not enforceable if inconsistent with state law. In 1990, the Supreme Court in *FMC Corp. v. Holliday* interpreted ERISA's preemption provisions and held that group plans funded by insurance, rather than fully funded by the employer, remain subject to state laws.[18] Thus, if a plan is funded through insurance and purchased by the employer, it will be treated as any other group health insurer when it comes time to determine whether a subrogation claim is enforceable. Therefore, when negotiating claims for settlement where a health plan has asserted a right to reimbursement under ERISA, it is crucial to look closely at the terms of the health benefit plan and to identify whether or not the group plan seeking reimbursement or subrogation is self-funded.

16 29 U.S.C. § 1001, et seq.

17 *Sereboff v. Mid Atlantic Medical Services, Inc.,* 547 U.S. 356 (2006) ("Mid Atlantic's action to enforce the 'Acts of Third Parties' provision qualifies as an equitable remedy because it is indistinguishable from an action to enforce an equitable lien established by agreement.").

18 498 U.S. 52 (1990).

The next hurdle to overcome would be to determine if the subrogation provisions of the plan are enforceable or its scope is limited in any way. ERISA itself does not have a provision dealing with subrogation, so we must look to the court's interpretation for guidance. For example, the Eleventh Circuit held in *Cagle v. Bruner* that an injured person must be made whole before a subrogation claim can be made, unless the plan specifically rejects the application of the made-whole doctrine.[19] Without the specific language rejecting the doctrine, plans are able to seek repayment directly from the responsible party or through subrogation. Additionally, a detailed review of the plan may reveal restrictions in the scope of the plan's subrogation rights as well. In some cases, plans have been restricted from claiming reimbursement from uninsured motorist coverage altogether.[20]

BAD FAITH AND WRONGFUL DEATH CLAIMS

Like most states, Georgia allows an insured to make a claim against an insurance carrier for its "bad faith" failure to settle a tort claim within policy limits. Such claims are typically referred to as "*Holt* demands," in light of the Georgia Supreme Court's holding in *Southern General Insurance Co. v. Holt*.[21] In *Holt*, the Georgia Supreme Court outlined the insurer's duty of care in responding to a time-limited demand for policy limits.

When evaluating "bad faith" claims and an insurer's potential liability, it is important to look at "whether the insurance company acted reasonably in responding to the settlement offer."[22] Therefore, the analysis of whether a claimant will be successful in pursuing a bad faith claim does not stop at the simple fact that the insurer did not settle for policy limits within the time frame specified in the demand.

In 2013, the Georgia Legislature enacted a statute that was intended to address some of the abuses associated with time-limited settlement demands in Georgia, including unreasonably short deadlines for a response and unreasonable conditions. Accordingly, O.C.G.A. § 9-11-67.1 states that demands must be in writing and must contain the following material terms:

1. the time period within which such offer must be accepted, which shall be not less than 30 days from receipt of the offer;
2. amount of monetary payment;
3. the party or parties the claimant or claimants will release if such offer is accepted;
4. the type of release, if any, the claimant or claimants will provide to each releasee; and
5. the claims to be released.

While many pre-suit demands will comply with these statutory specifications, the Georgia Court of Appeals has provided insurers with additional safeguards with respect to responding to time-sensitive offers to settle for policy limits.[23] In *Baker*, the plaintiff sent a time-limited demand to Liberty Mutual for policy limits, but stated that the demand was limited to "pain and suffering only." Because the offer was to settle only pain and suffering damages for the policy limits, the Georgia Court of Appeals explained that the plaintiff's offer "in effect, invited Liberty Mutual to engage in negotiations to fully settle the claim, which included additional damages for medical expenses and lost wages, for an amount in excess of policy limits." Because the insurer had no duty "to engage in negotiations concerning a settlement demand that is in excess of policy limits," it could not be held liable for a "bad faith failure to settle" as a matter of law.[24]

We see similar situations where time-limited demands for policy limits are used in wrongful death actions. In these scenarios, claimants have sought to settle only the wrongful death claim, leaving the potential claim by the estate out of their demands. However, recently the District Court found in *Linthicum v. Mendakota Insurance Co.* — and the Eleventh Circuit agreed — that the insurer had no duty to respond to a time-limited demand and was not liable under *Holt* for its failure

19 112 F3d 1510 (11th Cir. 1997).
20 *Kennedy v. Georgia-Pacific Corp*, 31 F.3d 606 (8th Cir. 1994).
21 262 Ga. 267, 416 S.E.2d 274 (1992).
22 *Id. See Fortner v. Grange Mut. Ins. Co.*, 286 Ga. 189, 190, 686 S.E.2d 93 (2009) ("Whether an insurance company acts in bad faith in refusing to settle depends on whether the insurance company acted reasonably in responding to a settlement offer, bearing in mind that, in deciding whether to settle, the insurer must give the insured's interests the same consideration that it gives its own.").
23 *Baker v. Huff*, 323 Ga. App. 357, 365, 747 S.E.2d 1, 7 (2013).
24 *Id.* (Quoting *Brightman*, 275 Ga. at 687).

to respond, when the settlement demand did not include the potential claim of the estate.[25] Thus, when settling claims, particularly when evaluating demands, it is important to identify what claims are being settled and released by the parties before finalizing negotiations.

CONCLUSION

While one might think negotiating the numbers is difficult, the real obstacles involved in settling claims come in the form of liens (which are sometimes not easily identifiable) and subrogation rights. The above are just a few types of liens that could cause settlement negotiations to go awry. Others include child support liens, workers' compensation liens and attorney fee liens. Parties should communicate about liens very early in the settlement process so both the plaintiff and defendant can properly evaluate the case for potential exposure and take into account possible reimbursement to the lienholder. In many cases, the lienholder may agree to a compromise or reduce the amount of the lien to assist in bringing the case to a resolution.

Before executing any agreements or releases, take proper precaution to ensure the settlement agreement includes language addressing how any liens will be resolved and to include the appropriate language in releases regarding indemnification with respect to known liens and unknown liens that may exist. These steps and precautions will not only protect the insured, but the insurance carrier as well, and will aid in arriving at a favorable resolution of the claim. Keep in mind, however, that a lien affidavit should accompany any settlement agreement or release.

[25] 2017 U.S. App. LEXIS 7840 (11th Cir., May 3, 2017).

Waze(d) and Confused in Alabama: What's Going on Over There?

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Waze(d) and Confused in Alabama: What's Going on Over There?

What Happened in Alabama This Year? Important Decisions Affecting Carriers

The following discusses 2017 court decisions affecting insurers and will help you navigate ethical issues faced while handling insurance coverage, SIU and fraud, property claims and casualty claims in the state next door.

WE HAVE WAZE TO MAKE YOU COOPERATE

Safeway Insurance Company repeatedly asked its insured, Quinzetia Thomas, for documentation and a signed proof of loss and medical authorization form in response to her request for "med pay" benefits. In *Thomas v. Safeway Insurance Co. of Alabama, Inc.*, Thomas and her attorney argued with Safeway about its right to the requested documents instead of providing those documents. Safeway responded by simply not paying the claim; it also did not deny the claim. The trial court reasoned that because Thomas did not satisfy conditions precedent to coverage (i.e., she did not comply with her duties after loss), Safeway did not constructively deny her claim. The Alabama Supreme Court affirmed the decision and found that the policy required the insured to comply with its terms. The "general duties" section of the policy specifically required her to provide Safeway with information that it requests, fill out proof-of-loss forms, provide authorization forms for the release of medical records and make complete disclosures to Safeway of all information it requests. "Our cases have consistently held . . . that the failure of an insured to comply within a reasonable time with such conditions precedent in an insurance policy requiring the insured to give notice of an accident or occurrence releases the insurer from obligations imposed by the insurance contract." Thus, because Thomas failed to meet her obligations and duties under the policy, Safeway did not have an obligation to pay the claim.[1]

MARIO DID NOT LEND YOU HIS CART

An insurer has the right to limit coverage to those using covered vehicles with the express permission of the insured. Where the policy language is clear, implied permission is not enough. An Alfa auto policy defined "covered person" to include any person using the vehicle with the "express permission of the insured or a family member." In *Grimes v. Alfa Mutual Insurance Co.*, the Alabama Supreme Court found Amy Arrington was a noninsured operator of a pickup as she did not have the express permission of Teresa Boop, the insured, to use the pickup. Accordingly, there was no coverage under the Alfa policy. The court rejected the argument that Alabama's financial responsibility statutes required Alfa's policy to provide coverage for individuals operating the vehicle with either express or implied permission of the insured. Instead, it held Alabama's Mandatory Liability Insurance Act does not expressly state that an auto policy must provide coverage for drivers operating a vehicle with the express or implied permission of the insured. Therefore, an insurer is permitted to limit coverage to operators who have the express permission of the insured.[2]

CLICK HERE TO ACCEPT TERMS AND CONDITIONS

In *Johnson v. First Acceptance Insurance Co.*, First Acceptance denied Jimmy Johnson Jr.'s claim, asserting he declined underinsured motorist (UIM) coverage when he applied for his auto policy. The insurer argued he declined UIM coverage with his electronic signature. The trial court entered summary judgment in favor of First Acceptance. Johnson appealed and the Alabama Supreme Court reversed, finding there was a question of fact as to whether Johnson actually e-signed the UIM declination. However, it did not seem impressed with Johnson's argument that the UIM waiver was only effective if he

1 *Thomas v. Safeway Ins. Co. of Ala., Inc.*, 2017 Ala. Civ. App. LEXIS 159 (Aug. 4, 2017).

2 *Grimes v. Alfa Mut. Ins.,* 2017 Ala. LEXIS 7 (Jan. 27, 2017).

physically signed (you know, the old-fashioned way) the declination. Pursuant to Ala. Code 1975, § 32-7-23(a), UIM coverage must be rejected by an applicant "in writing." Alabama's Uniform Electronic Transactions Act (UETA) governs electronic signatures on contracts. UETA provides that, in certain contexts, "if a law requires a record to be in writing, an electronic record satisfies the law." So, had Johnson actually e- signed, he would not have UIM coverage. The problem the Alabama Supreme Court found was the conflicting testimony regarding whether Johnson e-signed the declination.[3]

UIM CARRIER CANNOT OPT OUT WITHOUT ADVANCING THE TORTFEASOR'S POLICY LIMITS

There were three matters that resulted from separate automobile accidents between either an Allstate or GEICO insured with UIM coverage and allegedly underinsured tortfeasors. In each case, the insurer advanced the UIM coverage limits to its insured and opted out of the underlying litigation. In each case, the underinsured tortfeasor sought to enforce a settlement offer and dismissal from the action. The insurers objected. The court addressed the "twilight zone" that an insured is placed in when the UIM carrier does not consent to settle or wants to protect its subrogation rights. The court held that if the UIM carrier wants to protect its subrogation rights, it must, before the tortfeasor is released by the carrier's insured, advance to its insured an amount equal to the tortfeasor's settlement offer. The court further noted the insurer does not need to file a direct action against the tortfeasor to protect its rights of reimbursement, but it may obtain reimbursement from the insured's recovery against the tortfeasor. The court explained that by advancing the tortfeasor's policy limits to its insured, the insurer becomes the beneficial owner of "the case" against the tortfeasor and, as such, has the right to control the prosecution of that case.[4]

COVERAGE EXCLUSION DOES NOT CREATE AN UNINSURED AUTO

Kaysha Bell was killed in a one-vehicle accident. She was a passenger in a Honda she owned jointly with Shandarius Steiner; Steiner was driving at the time of the accident. GEICO denied coverage based on the "household exclusion" stating, "Bodily injury to any insured or any relative of an insured residing in the household is not covered." In *GEICO Indemnity Co. v. Bell*, Bell's estate argued that because the household exclusion precluded coverage for her death, the Honda was converted to an "uninsured auto." Under Alabama law, an "uninsured auto" is a vehicle without liability coverage. Further, the GEICO policy stated an "uninsured auto" does not include "an insured auto." The Alabama Supreme Court held a vehicle that is insured under a policy does not become uninsured because liability coverage may not be available to a particular individual. Therefore, no uninsured motorist (UM) coverage was available.[5]

DOCTOR ON DEMAND. WHO IS RESPONSIBLE?

Hospitals often contract with staffing agencies to provide emergency room physicians. That was done by Helen Keller Hospital (HKH). In *Bain v. Colbert Co. Northwest Alabama Health Care Authority*, a patient's estate sued HKH alleging medical malpractice by one of the contract physicians, Dr. Preston Wigfall. The estate argued the hospital was liable based on the apparent agency relationship between it and the doctor. HKH moved for summary judgment, arguing, among other things, that Dr. Wigfall was an independent contractor, not its employee. Dr. Wigfall was, in fact, working at the hospital through a contract with a staffing agency. He testified HKH did not control his medical decisions and the care and treatment he provided to the deceased was based on his own medical judgment. While the estate conceded Dr. Wigfall was not an actual agent of HKH, it argued HKH was liable on a theory of apparent agency, also known as agency by estoppel. The test for such apparent authority is based on the purported principal's holding of the purported agent out to third parties as having the authority to act. The third party's belief the individual was an agent of the principal must be "objectively reasonable"; what the third party subjectively perceives is immaterial to the analysis. To prevail on her claim, the estate had to prove HKH held out Dr. Wigfall as its agent or that HKH permitted him to hold himself out as its employee or agent. The estate also had

3 *Johnson v. First Acceptance Ins. Co., Inc.*, 2017 Ala. Civ. App. LEXIS 4 (Jan. 6, 2017).
4 *Ex parte Allstate*, 2017 Ala. LEXIS 46 (May 5, 2017).
5 *GEICO Indemnity Co. v. Bell,* 2017 Ala. Civ. App. LEXIS 57 (Mar. 10, 2017).

to prove that because of those acts, the decedent had an objectively reasonable basis for believing Dr. Wigfall was HKH's agent, and it had to prove the decedent actually relied on the appearance that he was an agent or employee of HKH. The estate failed to prove those elements. The Alabama Supreme Court also noted it has specifically rejected the proposition that a patient may presume that a doctor working in a hospital is an employee unless told otherwise.[6]

NANNIES AND OTHERS ARE NOT YOUR GUEST

Alabama has a weird statute that precludes the liability of a driver to her passenger. We call it the Guest Statute. Before you get too excited about something that precludes liability, you need to realize there are a lot of holes in the Guest Statute. Importantly, a passenger is no longer a "guest" if they offer the driver virtually any type of service. Is your babysitter riding with you to help watch your kid? If so, she is not a guest; the statute does not apply to preclude liability if you drive into a tree and injure her. If you bring a friend with you to Walmart to help your elderly aunt get around the store, your friend is not a guest. The Alabama Supreme Court recently affirmed that in *Hurst v. Sneed*. Sherri Hurst rode with her friend Brenda Ray to Walmart to help Ray with her aunt once they got to the store. Ray drove her vehicle to the store and pulled along the front curb to allow her aunt to get out at the entrance. Ray asked Hurst to stand with her aunt on the curb while she parked the car. Hurst then began to get out of the vehicle, but before she had completely exited the vehicle, Ray pulled the vehicle forward, causing Hurst to fall to the ground. Hurst sued Ray (some friend, right?). The defense argued that Hurst's negligence claim was barred by Alabama's Guest Statute; the trial court agreed. However, the Alabama Supreme Court reversed based on its riding finding Hurst was not a guest. A "guest" is not defined in the statute, but it can be anyone who is in the car for any reason that is not "purely social." If the passenger provides any benefit to the driver — even if it is only an anticipated or mutual benefit — the Guest Statute does not apply. The Alabama Supreme Court determined Hurst did not qualify as a guest because she accompanied Ray to Walmart to assist her with her aunt. The act was a benefit to Ray, who was ill and suffering from congestive heart failure, because it relieved her of some of the burden of being the sole caretaker of her elderly aunt on the shopping excursion.[7]

WHERE IS VENUE PROPER?

Forum shopping is a real thing. It always happens when the complaint is filed, and it happens sometimes when a defendant seeks to get the venue changed. Alabama's case law on where venue is proper can be seen as "all over the board," or simply as very liberal. A venue may be "proper" in multiple counties and the trial court has broad discretion in deciding where the case "should be" venued. In 2011, an employee of Alabama Electric was injured while working at Dow Corning's facility in Montgomery County. He sued Dow Corning in Montgomery County. Dow sought to force its subcontractor, Alabama Electric, and its insurer, National Trust, to pay for Dow's defense and its settlement with the injured party. Alabama Electric and National Trust subsequently filed an action in the Houston Circuit Court seeking certain declarations concerning their duties and obligations under the master contract and the National Trust policy regarding the settlement. Dow moved to transfer the declaratory judgment action to Montgomery County. After a hearing, the trial court denied the motions to transfer. The Alabama Supreme Court noted that Houston County, where the plaintiffs elected to file suit, was Alabama Electric's principal place of business, and also where the master contract was negotiated and delivered and where the National Trust policy was issued and delivered. The court further noted that the action was not dependent on evidence to be gathered from the underlying Montgomery action, because it had been settled.[8] In other situations, we saw the courts have required even less of a nexus between the county chosen by the plaintiff and the facts of the claim.

6 *Bain v. Colbert Co. Northwest Ala. Health Care Auth.*, 2017 Ala. LEXIS 9 (Feb. 10, 2017).
7 *Hurst v. Sneed*, 2017 Ala. LEXIS 8 (Feb. 3, 2017).
8 *Ex parte Dow Corning Ala., Inc*. 2017 Ala. LEXIS 83 (Sept. 1, 2017).

ETHICS AND "SUSPICIOUS" CLAIMS

What can you do, ethically, about a suspicious claim? Several things.

Obviously, you can investigate a suspicious claim to determine if it is fraudulent. You have that right and, really, you have that duty. You are also required by Alabama law to warn your insureds that insurance fraud is a crime. Warning them will not be considered an unethical or illegal threat. That warning should be put on insurance applications, claim releases and other claim documents.

You are also required to report insurance fraud. Thus, reporting a suspicious claim is your legal — and ethical — obligation. About five years ago, Alabama enacted the Insurance Fraud Investigation Unit and Crime Prevention Act, Ala. Code § 27-12-1, *et seq*. The provisions most pertinent to your day-to-day work are discussed below.

Insurance fraud is now a felony offense in Alabama. Two types of insurance fraud are:

1. an intentional attempt to defraud by providing false information in connection with an insurance application or claim; and
2. the acceptance of an insurance payment to which the insured is not entitled.

The first type of insurance fraud includes the knowing and intentional attempt to defraud through the concealment of information in presenting to an insurer false information as part of, in support of, or concerning a fact material to:

- an application for the issuance or renewal of an insurance policy;
- a claim for payment or benefit pursuant to an insurance policy; or
- issuance, acceptance, change, endorsement, or continuance of an insurance policy.[9]

The second type of insurance fraud involves the "failure to decline or refusal to return an insurance payment for a loss or a recovery to which the person is not entitled by reason of an insurer's mistake or other facts or circumstances connected with the person's claim or the coverage provided by an applicable insurance policy."[10]

The Alabama Code now requires insurers to provide a written fraud warning on "at least one of the following":

- claim release forms;
- applications;
- reinstatements for insurance;
- participation agreements;
- declaration pages; and/or
- claim documents.

The required fraud warning is:

> Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.[11]

I recommend you put the fraud warning on your initial letter to the claimant and your claim release forms, at a minimum.

9 Ala. Code § 27-12A-2(4)(a), (c) and (m) (2012).
10 Ala. Code § 27-12A-2(5).
11 Ala. Code § 27-12A-20 (2012).

The Insurance Fraud Act also includes mandatory reporting requirements when an insurer has a reasonable belief insurance fraud is being or was committed.[12] The reporting requirement can be satisfied by filing a Uniform Suspected Insurance Fraud Report, directed to Alabama, through the National Association of Insurance Commissioners (NAIC) Online Fraud Reporting System (OFRS), which is available on the NAIC website.

The Alabama Code provides immunity from civil liability for reporting suspected insurance fraud unless the report contains false statements made with actual malice.[13] Furthermore, all information and documents reported to the Department of Insurance are confidential, not part of the public record and not subject to discovery or subpoena in a civil or criminal action.[14]

The insurer is required to keep copies of all documents, materials and information furnished to the Department of Insurance with regard to suspected insurance fraud.

Do the ethical thing when presented with a suspicious claim. Investigate it fairly. Warn the insured of Alabama's Insurance Fraud Act. Report the claim if you believe it constitutes insurance fraud.

12 Ala. Code § 27-12A-21 (2012).
13 Ala. Code § 27-12A-22 (2012).
14 Ala. Code § 27-12A-23(a) (2012).

The Race to the Bottom in the Worlds of Reptilian Tactics and Contingent Fee Damage Consultants

By Frederick O. Ferrand, Thomas B. Ward and Rebecca E. Strickland

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Partner

Frederick O. Ferrand specializes in complex litigation claims relating to commercial and insurance disputes, property damage claims, products liability actions and negligence causes of action, both from plaintiff and defense perspectives. Having gained his experience in trial and appellate courts throughout the U.S., the Caribbean and Europe, Mr. Ferrand has successfully litigated and arbitrated cases around the world. Mr. Ferrand is fluent in French and Spanish. He is admitted to practice in state, territorial and federal courts in Georgia, Pennsylvania and the Virgin Islands. He is also admitted in the Supreme Court of the United States and in the United States Courts of Appeals for the Third and Eleventh Circuits. As a member of the Georgia, Pennsylvania and Virgin Islands Bar Associations, Mr. Ferrand participates in their insurance, litigation and products liability committees.

After receiving his undergraduate and law degrees from the University of Virginia in 1981 and University of Pittsburgh in 1984, respectively, Mr. Ferrand started his practice of law in the Virgin Islands. Within his first five years of practice, his appellate work there, which helped lower then-existing high jury awards, was published in the *American Bar Association Journal*. During that same period, Mr. Ferrand was included in the *Who's Who in American Law* listings as a result of his litigation experience, his position as Treasurer of the Virgin Islands Bar Association and his being the creator of their Attorney Referral Program. Mr. Ferrand has also been named a Georgia Super Lawyer by *Atlanta Magazine*, a listing of the top attorneys in Georgia as voted by his peers. Additionally, Mr. Ferrand has spoken on litigation matters in many national forums.

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Mr. Ward joined Swift Currie in 2008 after gaining experience at another Atlanta firm in a broad range of litigated matters, including those involving construction law, environmental law, premises liability, ERISA and insurance coverage disputes. He practices in the property insurance litigation section of the firm. Mr. Ward graduated from the Walter F. George School of Law at Mercer University, where he served as the articles editor for the *Mercer Law Review*. Mr. Ward graduated, *magna cum laude*, from Georgia State University with a B.B.A. in Finance.

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Before beginning her law practice, Ms. Strickland was a consultant at Accenture, designing payroll and financial systems for U.S. and Canadian companies and managing a team that was based in the U.S. and the Philippines.

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The Race to the Bottom in the Worlds of Reptilian Tactics and Contingent Fee Damage Consultants

REPTILIAN TACTICS

What are Reptilian Tactics and Why Do They Matter?

Reptilian tactics are intended to manipulate jurors into finding in favor of a plaintiff or increasing the award because the juror herself feels threatened by the defendant's allegedly unsafe conduct. Instead of using logic to guide jurors to a reasoned conclusion, attorneys using reptilian tactics appeal to emotion by crafting a prism through which all other case evidence seemingly must be viewed. Witnesses and jurors then feel as though they must accord with the prismatic netting in which they have been snared. Their pressure to heel stems from the cognitive fretfulness described below.[1]

Reptilian tactics may be used to accomplish high value settlements by manipulating defendant-witnesses into providing damaging deposition testimony. For example, in a premises liability case, the plaintiff's attorney may cajole the witness into agreeing that multiple safety rules exist, are reasonable and should be complied with. Once these admissions are on the record — often on videotape — the plaintiff argues that the defendant has admitted liability and must either settle the case for an amount over its likely value or go to trial with dangerous impeachment vulnerabilities that can severely damage the defendant's credibility.[2] Of course, in some situations, a hazard may exist notwithstanding compliance with safety procedures. Nevertheless, if the case proceeds to trial, the plaintiff may choose to argue safety and security issues in order to play upon the emotions of the jury instead and to distract the jury from the legal issues of whether the defendant breached the applicable standard of care or other elements of the cause of action.

When effective, this warped guidance causes juries to return high verdicts, ostensibly so as to prevent danger to their families and communities at large. Jurors become captive to the plaintiff's crafting of a safety rule, which has assuredly been violated. An attorney using reptilian tactics might assert that any violation of the safety rule, by any community member, places the jury and their families in danger.[3] This admonition compels the jurors to return a high verdict, in order to thwart the warned-of danger.

So, how did these shady practices come to be associated with lizards? The "Reptile Mind" was first developed as part of Triune Brain Theory, which was elucidated by the neuroscientist Paul MacLean. Dr. MacLean labeled the R-complex in the human brain "reptilian" because it is identical in function to the brain of a reptile.[4] Reptilian theory focuses on the awakening of thoughts of safety and security within this reptilian complex, which in turn controls other thoughts.[5] The theory has since been discredited, but while the science undergirding the theory may be dead, reptilian tactics themselves — and the rate at which they are effective — remain deadly.

Take for example, a recent case out of DeKalb County, Georgia, in which a jury returned a $3.5 million verdict to two women who were shot outside of a Stone Mountain nightclub. The club itself was held liable for $2.4 million of that award, post-apportionment. The women had been patrons of the club on the evening the incident occurred, but, along with all other patrons, were forced outside after a fight involving two other patrons broke out inside. As the women made their way back inside, they were shot randomly in a drive-by shooting. The jury was nudged to find the club largely at fault by the plaintiffs' attorneys, who argued that the women were shot due to the club's violation of its own security protocol. In forcing patrons outside, the argument went, the club "did not follow its own policies, and because of that, a shooting occurred."[6] Thus, despite serious questions of proximate cause and foreseeability, the jury felt compelled to hold the club more responsible than the shooter-perpetrator for the women's injuries, because it could not dissociate the scary act that occurred outside the club from the preferred — yet unrealistic — ideal of 100 percent safety at all times on and around the club's premises.

1 *See generally* Ryan A. Malphurs and Bill Kanasky, Jr., "Derailing the Reptile Safety Rule Attack," *Georgia Defense Lawyer*, pp. 15-37 (Spring 2015).
2 *Id.*
3 *Id.*
4 *Id.*
5 Tyler J. Derr, *Recognizing and Defeating the Reptile: A Step-by-Step Guide*, 3 Stetson J. Advoc. & L. 29 (2016).
6 Greg Land, "Jury Awards $2.4M to Women Shot at Dekalb Bar," Daily Report (August 20, 2017), *available at* www.dailyreportonline.com.

Defendants must be prepared to anticipate when reptilian tactics may be deployed and, most importantly, how to dispel their creeping effectiveness.

How Plaintiffs' Attorneys Use Reptilian Tactics to Confuse and Derail Defendant-Witnesses at Deposition

Reptilian tactics involve psychological weaponry that is used not simply to influence the defendant-witnesses, but to completely control them. This arsenal of "weapons" consists of confirmation bias, anchoring bias, cognitive dissonance and the hypocrisy paradigm. An attorney using reptilian tactics employs four primary "rule" questions to lure the defendant-witness into the psychological trap, with each rule question corresponding, respectively, with each of the above-noted weapons. The four types of rule questions are classified as follows:[7]

1. General Safety Rules (Broad Safety Promotion)
2. General Danger Rules (Broad Danger/Risk Avoidance)
3. Specific Safety Rules (Safe Conduct, Decisions and Interpretations)
4. Specific Danger Rules (Dangerous/Risky Conduct, Decisions and Interpretations)

A typical line of reptilian questioning, and the consequential trapping of the unsuspecting defendant-witness, might begin with the plaintiff's attorney presenting the witness with a series of general safety or danger rule questions. Instinctually, the defendant-witness affirmatively agrees with any safety or danger rule question because doing so supports their highly reinforced belief that safety is always paramount and danger should always be avoided. The witness continues to agree to additional safety or danger rule questions that link safety or danger to specific conduct, given that doing so aligns with their previous agreement to the general safety or danger rule.[8] Then, unknowingly and inadvertently, the defendant-witness begins entrenching himself into an inflexible position in which relevant circumstances and ordinary judgment are minimized. The plaintiff's attorney proceeds to present facts from the case at hand to the witness, creating internal discomfort for the witness, as those facts do not neatly align with the previous safety or danger rule agreements. The plaintiff's attorney further illuminates that the aforementioned safety or danger rule, which, by now has been repeatedly agreed to under oath, was obviously violated in the circumstances of the case and harm was done as a result of such violation.[9] Feeling hypocritical, the defendant-witness regretfully admits to being negligent or causing harm, and worst of all, the emotionally battered witness further admits that had they followed the safety or danger rule, all harm certainly would have been prevented.

Manipulating defendant-witnesses into agreeing with these four types of questions is the linchpin of the plaintiff's attorney's cross examination methodology, since the witness's agreement goads their internal psychological pressure during each subsequent round of questioning. The reptile attack so easily succeeds through the construction and ordering of deposition questions in a manner that fully capitalizes on the natural biases and flaws inherent in the minds of vulnerable defendant-witnesses.

Reptile That Shows its Head in Pleadings

A plaintiff may even hint at the intent to use reptilian tactics in the initial complaint. While pleadings that reference "violations of safety rules" or "unnecessarily endangering the public or community" are sometimes appropriate, defendants should be alert to whether these phrases are being used in an improper context. In instances where such references are not part and parcel to a cause of action, these allegations should be denied. These are clues that defense counsel should prepare its defendant-witnesses for the likely reptilian tactics to be used in depositions.[10]

7 Malphurs & Kanasky, *supra*, at 15.
8 *Id.*
9 *Id.*
10 Derr, *supra*, at 3.

Claims, such as negligent hiring, retention, training, supervision or entrustment are sometimes only incidental to more central claims in a plaintiff's action. When this is the case — i.e., when the aforementioned claims are not the crux of the suit — such claims ought to be attacked through motions to dismiss or motions to strike because they often render evidence of prior accidents discoverable and admissible. This is undesirable, given that jurors' sense of fear and threat is activated by events that may be perceived as demonstrating a systematic violation of a safety rule (particularly when so spun at trial). Success can be had here because corporate negligence claims often "lack factual support and simply recast boilerplate elements and legal conclusions,"[11] and thus are ripe for dismissal under the *Twombly/Iqubal* [12] standard for Rule 12(b)(6).[13] Once these claims have been dismissed, other incidents and accidents become far less likely to be relevant to the claims at hand and therefore, less likely to be admitted as evidence.[14]

Ways to Combat Reptilian Tactics

Rebuilding Cognitive Schemas Prior to Deposition

Traditional preparation techniques are not sufficient for the emotional and psychological manipulation defendant-witnesses endure during reptile-style questioning at deposition. Witnesses' vulnerable cognitive schemas are the product of years of conditioning and reinforcement regarding workplace safety rules that have fostered powerful and inflexible preconceptions absent circumstance and judgment. Again, the reptile attack preys upon this commonplace vulnerability. The good news is that witnesses can be properly trained to identify safety and danger rule questions, or at least to avoid absolute agreement, so that the powerful effect of cognitive dissonance is mostly neutralized.

Properly training a defendant-witness to withstand reptilian tactics requires a sophisticated reconstruction of the witness's preexisting cognitive schema, followed by the rebuilding of a new adjusted schema. The foundation of this new schema will be the witness's awareness of the role of circumstance and judgment in every case. Once the new schema is firmly in place with no signs of regression, the defendant-witness will largely be immune from the plaintiff's attorney's safety and danger rule attacks. While a complete reconstruction of a witness's cognitive schema is no easy task and, to be fully accomplished, would require advanced training in neuroscience, communication and personality theory, there are some steps that can be taken by the defense attorney to at least generally ameliorate reptilian tactic effects. These steps involve candid communication with the witness prior to the deposition.

To begin educating the defendant-witness, define cognitive schemas and how they work, identifying and discussing the witness's personal safety and risk schemas along the way. Cognitive flaws regarding safety and danger may be demonstrated in conversation or through auditory or visual media, such as articles or videos. Define "confirmation bias," "anchoring bias," "cognitive dissonance" and the "hypocrisy paradigm," being careful to explain the science behind each doctrine. Then, orchestrate a simulation for the witness. This can be done by creating cognitive dissonance and forcing failure through the asking of the types of questions that the witness will be peppered with in deposition. The witness will fail repeatedly, but such failure is desirable, because it proves to the witness that their cognitive schema is flawed, which in turn ingrains more successful communication habits. Correct answers should be positively reinforced, while incorrect agreements should be criticized. This whole simulation should be repeated by attempting to force cognitive dissonance and agreement from varying angles. Repetition of the simulation can solidify the witness's good habits — their new cognitive schema — until cognitive regression is minimal to none.[15]

Motions in Limine to Exclude Reptilian Tactics

When used properly, motions in limine can cut the reptile down to size.[16] Even if the motion is denied, the court will be alerted to the possibility that the plaintiff will use reptilian tactics and may be more receptive to objections made later when

11 *Id.*
12 *See generally Ashcroft v. Iqbal*, 556 U.S. 662 (2009); *Bell Atl. Corp. v. Twombly*, 550 U.S. 544 (2007).
13 Fed. R. Civ. Proc. 12(b)(6).
14 Derr, *supra*, at 3.
15 Malphurs & Kanasky, *supra*, at 36.
16 Derr, *supra*, at 6.

evidence is being presented. A strong motion will explain what reptilian tactics are, state with specificity the questions or testimony that is anticipated and cite controlling case law to support the exclusion.[17] Failure to adequately identify the specific evidence a movant is seeking to exclude can be fatal.[18] Thus, it is paramount to the success of the motion that the questions or testimonies that are anticipated or desired for exclusion are stated in the motion forthright.[19]

To educate the court in the introduction, discuss the psychology behind reptile theory and the creation of safety rules through the use of hypothetical questions. While the science should not overwhelm the judge, it is very important she properly understands the theory and how it is employed. Next, discuss the impermissible use of reptilian tactics to ask jurors to place themselves in the plaintiff's shoes or to act as the conscience of the community or to engage in character assassination of the defendant. Perhaps most importantly, any anticipated circumventing of the Golden Rule should be discussed, especially including ways in which impermissible Golden Rule arguments may be disguised. Substance can be added to the motion through the identification of specific *voir dire* questions and closing argument statements that are expected.[20] Additionally, a motion's citation of prior deposition questions establishes the plaintiff's strategy and intent to use reptilian tactics at trial.

PASSING OFF ON ACCOUNTING STANDARDS IN CONTINGENT FEE DAMAGE CONSULTANTING

The potential for skirting rules and gray areas also arises in the context of damage claim adjusting. Insurers can confidently rely on the records produced by their own associated forensic accountants; however, due to those records' attestation, the same cannot be assured for records produced by the subsidiaries hired by certain public adjusters and damage consultants. Due to the lack of attestation, caution is merited when viewing or putting faith in these calculations. No attestation means these records may or may not comply with professional accountant consulting standards. Simply put, these damage consultants may have done nothing to verify their support records. If the records that the public adjuster or damages expert utilizes are not accurate, then the preparer's calculations have no value to you. In fact, any certified public accountant (CPA) hired by a public adjuster through a third party may face risk in their own right under those standards.

The American Institute of Certified Public Accountants issues the Standards for Consulting Services, which govern the activities of CPAs outside of typical services like tax return preparation, personal financial planning or bookkeeping. The Introduction to the Standards is laid out as follows:

> Consulting services differ fundamentally from the CPA's function of attesting to the assertions of other parties. In an attest service, the practitioner expresses a conclusion about the reliability of a written assertion that is the responsibility of another party, the asserter. In a consulting service, the practitioner develops the findings, conclusions, and recommendations presented. The nature and scope of work is determined solely by the agreement between the practitioner and the client. Generally, the work is performed only for the use and benefit of the client.[21]

Thus, in a bit of contrast with traditional auditing work, consulting work done by accountants is largely concerned with client objectives. The concern is that practitioners working for third parties may essentially serve as proxies for the party who hired them. These practitioners and their hiring adjusters may violate a variety of the promulgated standards in the absence of strong enforcement mechanisms. First, they are confronted with the general standards of the accounting profession. These include the admonition to always "obtain sufficient relevant data to afford a reasonable basis for conclusions or recommendations in relation to any professional services performed."[22] Records produced for an adjuster may therefore be attacked by inquiring whether the consulting individual contemplated all manners of accounting for the particular circumstances and if they contemplated all items to be accounted.

17 *Id.* at 7.
18 *Id.*
19 *Id.*
20 *Id.* at 6.
21 AICPA *Standards for Consulting Services*,. 02 (effective Jan. 1992).
22 *Id.* at n.6.

Paragraph .07 of the standards reminds that a balance must be struck between "seeking to accomplish the objectives established by the understanding with the client . . . [and the] maintain[ance] . . . [of] integrity and objectivity." So, records may not be reliable if questions exist regarding the balance struck. The standards elaborate on integrity as defined therein, noting that "[s]ervice and the public trust should not be subordinated to personal gain or advantage," and that even relationships that appear to impair a member's objectivity in rendering attestation services are precluded here.[23] Relatedly, the principle of objectivity imposes "the obligation to be impartial, intellectually honest, and free of conflicts of interest."[24] The objectivity standards apply to all services rendered by any CPA.

Finally, the standards are preoccupied with conflicts of interest, which may occur when a practitioner "has a relationship with another person, entity, product, or service, that, in the . . . [practitioner's] professional judgment, the client or other appropriate parties may view as impairing the member's objectivity."[25] This is especially relevant to public adjusting firms that also hire their own accounting experts as part of their adjustment service who are paid from the public adjuster's contingency fee. This is because these contingency fee relationships represent direct conflicts for those CPAs, especially in the eyes of other "appropriate parties," such as insurance companies.

In sum, adjusters need to know whether the damage preparers verified the accuracy of the damage support documents that they utilized in their calculations. If these support records were not verified or tested for accuracy, then their use must be questioned. Similarly, those damage loss preparers or public adjusters who are paid on contingency fees for their work have inherent conflicts of interest, warranting close scrutiny of their work.

23 *Id.* at n.2.
24 *Id.*
25 *Id.* at n.3.

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Third-Party Liability Coverage News(feed)

By Christy M. Maple

Christy M. Maple

Associate

Christy M. Maple practices in the areas of insurance coverage and commercial litigation. Ms. Maple has represented insurers in connection with commercial first-party property disputes and litigation arising from catastrophic and other large value losses. Her first-party practice also involves representing insurers with respect to high value claims arising out of fidelity bonds, financial institution bonds and commercial crime policies. In addition to her first-party practice, Ms. Maple has significant experience in representing insurers in coverage disputes involving various types of liability policies, including commercial general liability and directors and officers liability policies. Ms. Maple also routinely defends insurers against alleged statutory and common law bad faith claims and extra-contractual damages.

Ms. Maple earned her B.S. in Mathematics and German from Vanderbilt University, graduating, *summa cum laude,* in 2004. She earned her J.D. from the University of North Carolina School of Law in 2008. In Germany, Ms. Maple studied at the University of Regensburg and taught English at the University of Erfurt.

Third-Party Liability Coverage News(feed)

This paper provides an overview of cases from Georgia state and federal courts over the last year dealing with issues that are important to liability insurers. In particular, we address the following issues:

- Georgia's approach to when coverage is triggered;
- an insured's obligation to comply with policy conditions after a claim has been denied;
- how to determine when work is completed for purposes of an exclusion; and
- an insurer's ability to recoup defense costs.

TRIGGER

One of the most vexing issues for liability insurers is determining when, exactly, coverage is triggered. The insuring agreement in liability policies typically contains language that requires the property damage occurs during the policy period and is caused by an "occurrence," where "occurrence" is typically defined as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions." Thus, when coverage is triggered depends not on when the negligent act occurred, but when the resulting damages occurred.[1]

In the context of latent damages — i.e., damages occuring undetected over time, such as claims for property damage caused by pollution or construction defects — determining when the damage occurred and, therefore, when coverage is triggered, can be tricky. The United States District Court for the Northern District of Georgia previously explained the various trigger theories:[2]

- Exposure: Coverage is triggered when the injury-producing agent first makes contact with the property.
- Injury in fact: Coverage is triggered at the point in time when actual injury first occurs.
- Manifestation: Coverage is triggered only when damage occurs and is discovered — that is, "manifests" itself as readily obvious — within the policy period.
- Continuous: All liability policies in effect from the exposure to manifestation provide coverage and are responsible for the loss.

Georgia courts have not addressed the question of what policies are "triggered" in the context of latent damages occurring over time.[3] The Georgia Court of Appeals faced this question in August 2016.[4] In *Columbia Casualty Co. v. Plantation Pipe Line Co.*, Plantation employees discovered in 1976 that turbine fuel had leaked from an underground pipeline. Within 24 hours, Plantation repaired the pipeline and cleaned up the leak. Without resorting to insurance, it compensated the only affected landowner $50. More than 30 years later, in 2007, one of Plantation's workers found contaminated soil during maintenance of Plantation's pipeline, and the contamination was traced to the 1976 leak.

At the time of the 1976 leak, Plantation had an excess policy issued by Columbia. Plantation filed suit against Columbia in 2012, seeking to recover amounts it had spent to settle third-party claims, amounts expended for remediation and projected costs to complete remediation. The trial court allocated all of Plantation's losses to the policies in place at the time of the fuel leak, rather than allocating Plantation's losses pro rata among the multiple, successive policies issued to Plantation over the 30-year period, during which the environmental contamination continued to accrue. On appeal, Columbia urged the court to adopt the "continuous" trigger theory, arguing that Plantation's total financial loss from the latent, continuous and progressive property damage taking place over three decades should be allocated pro rata among each successive policy period from 1976 to 2007, when the contamination was discovered and became "manifest."

1 *See, e.g., Prescott's Altama Datsun v. Monarch Ins. Co. of Ohio*, 170 Ga. App. 545, 317 S.E.2d 845 (1984) (no coverage was owed for damages to a motor vehicle when the damages occurred after the policy expired, even though the repair work that led to the damage occurred during the policy period).

2 *Arrow Exterminators, Inc. v. Zurich Am. Ins. Co.*, 136 F. Supp. 2d 1340, 1345-46 (N.D. Ga. 2001).

3 *See Boardman, Inc. v. Federated Mut. Ins. Co.*, 926 F. Supp. 1566 (S.D. Ga. 1995) (the district court held that the most rational interpretation of the contract language suggested an "exposure" trigger; on appeal, the Eleventh Circuit certified the question of which trigger applied to the Georgia Supreme Court, which declined to address the issue and decided the case on other grounds).

4 *See Columbia Cas. Co. v. Plantation Pipe Line Co.*, 338 Ga. App. 556, 790 S.E.2d 645 (2016).

The court of appeals refused to adopt the "continuous" trigger, explaining that the language of the Columbia policy provided that it applied to occurrences taking place during the policy period and the definition of occurrence included continuous or repeated exposure to substantially the same general harmful conditions. The court of appeals therefore affirmed the trial court's grant of summary judgment in favor of Plantation. Thus, under *Plantation Pipe Line*, in Georgia, unlike in many states, all losses can be allocated to the policy in effect at the time of the occurrence.

Accordingly, while no Georgia state court has made an affirmative ruling adopting one of the trigger theories set forth above, the decision in *Plantation Pipe Line* makes it look increasingly likely that Georgia courts will ultimately adopt the "exposure" trigger. In fact, several federal courts applying Georgia law previously reached the same conclusion and applied the "exposure" trigger.[5] While not controlling, these federal cases will likely be persuasive. In any event, *Plantation Pipe Line* made clear that, in the case of latent damages occurring over time, the policy in effect at the time of the occurrence can provide coverage for the totality of the damages, even if those damages manifested after the policy period expired.

NOTICE/COMPLIANCE WITH POLICY CONDITIONS

Notice is typically a more straightforward issue than trigger. Liability policies generally require that policyholders provide notice of a claim and forward any suit papers to the insurer "as soon as practicable" or other similar language. Georgia federal courts recently faced the issue of whether a policyholder was required to provide notice of a second, identical suit after the insurer had already denied coverage for the first suit.[6]

In *G.M. Sign, Inc. v. St. Paul Fire and Marine Insurance Co.*, the claimant filed a class action lawsuit against the policyholder in November 2008, alleging the policyholder violated the Telephone Consumer Protection Act (TCPA) by sending out numerous unsolicited faxes without giving the recipient the ability to opt out. The policyholder notified its insurer of the lawsuit and demanded a defense and coverage, but the insurer denied coverage. Thereafter, the claimant and the policyholder stipulated to the dismissal of the lawsuit without prejudice in July 2009. The next day, the claimant filed a new class action complaint against the policyholder alleging the same claims on behalf of the same class of plaintiffs as the first suit. The policyholder did not tender the second suit to its insurer. The policyholder and the claimant eventually settled the second suit. As part of the settlement, the policyholder assigned its right to payment under the policies to the claimant, who then filed suit against the insurer seeking a declaratory judgment that the insurer owed the policyholder coverage under the policies for the settled claims and damages for bad faith. The insurer counterclaimed, contending that it owed no coverage under the policies because the policyholder failed to satisfy the notice requirement with respect to the second suit, which was a condition precedent to coverage.

At the trial court level, the Northern District of Georgia granted summary judgment in favor of the insurer, reasoning that the claimant's second complaint initiated a lawsuit separate from the suit initiated by the first complaint. The policyholder did not give the insurer notice of the second complaint; therefore, the policyholder failed to satisfy a condition precedent to coverage for liability arising from the claims asserted in the second lawsuit. Reversing on appeal, the Eleventh Circuit explained that, under Georgia law, "an insurer's denial of coverage under a policy waives the notice requirements under that policy." Thus, the insurer's denial of coverage waived the notice requirement, and the policyholder was no longer obliged to provide the insurer with notice of the second suit. The fact that the claims in the first suit were dismissed was immaterial, because the re-filed claims were exactly the same as the claims asserted in the first suit. In holding that the insurer waived its right to notice, the Eleventh Circuit also rejected the insurer's purported reservation in its denial letter of "the right to rely on any other policy provision or defense that may be subsequently found to limit or preclude coverage."[7]

The Eleventh Circuit's decision in *G.M. Sign* shows that Georgia courts will interpret the notice provisions of a liability policy broadly in favor of policyholders,[8] and that an insurer cannot rely on a previous denial, even if the new claims are identical to those previously asserted.

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5 *See Plantation Pipe Line Co. v. Continental Cas. Co.*, 2006 WL 6106248 (N.D. Ga. 2006); *Arrow Exterminators, Inc. v. Zurich Am. Ins. Co. and TIG Ins. Co.*, 136 F. Supp. 2d 1340 (N.D. Ga. 2001).

6 677 Fed. Appx. 639 (11th Cir. 2016).

7 *Id.* at n.1 (citing *Hoover v. Maxum Indem. Co.*, 291 Ga. 402, 402, 730 S.E.2d 413, 415 (2012)).

8 *Hoover*, 291 Ga. at 407, 730 S.E.2d at 418.

COMPLETED OPERATIONS

An issue that often arises in the context of construction defect claims is whether work has been completed, which is important for determining whether certain "business risk" exclusions apply. The Eleventh Circuit recently addressed this issue, albeit in a different context.[9] In *Liberty Surplus Insurance Corp. v. Norfolk Southern Railway Co.*, a motorist sustained severe injuries when she was struck by an incoming train at a crossing owned by a subsidiary of the insured railway company. The motorist filed suit against the insured, Norfolk Southern, alleging that overgrown and improperly maintained vegetation at the railroad crossing impaired her ability to see an approaching train. The motorist later added NaturChem as a defendant to the litigation. The insured had entered into a contract with NaturChem, which provided that NaturChem would apply herbicide to each of the insured's crossings in Georgia at least twice per year and monitor the crossings and perform required maintenance as necessary. NaturChem and the insured alerted the insurer to the lawsuit, and the insurer agreed to provide a defense.

The insurer subsequently filed a declaratory judgment action and requested that the court determine its obligations under the policy. The policy at issue contained a "completed work" exclusion, which precluded coverage for property damage occurring after the "work" (as defined in the policy) is completed. The exclusion further provided that the work will be deemed completed at the earliest of the following times:

1. when all the "work" called for in the "contractor's" contract has been completed;
2. when all the "work" to be done at the "job location" has been completed; or
3. when that part of the "work" done at the "job location" has been put to its intended use by you, the governmental authority or other contracting party.

The insurer argued NaturChem completed its herbicide application at the crossing 90 days prior to the motorist's accident. Thus, NaturChem's "work" at the "job location" (the crossing) had been returned to its intended use, and subsection (2) or (3) of the Completed Work exclusion applied. The district court rejected the insurer's argument on the basis that the term "work" referred not just to the herbicide application, but also to NaturChem's ongoing maintenance and monitoring obligations, which NaturChem had not completed at the time of the motorist's accident. The Eleventh Circuit agreed, explaining that because NaturChem had an ongoing duty to maintain the vegetation at the crossing, the "work" had not been completed or returned to its intended use.

The *Norfolk Railway* decision is a cautionary tale for insurers that do not wish to provide coverage for completed work or operations. Where a contract provides for services, work or operations to be supplied over a period of time, exclusions for completed work or completed operations must be clear and unambiguous as to when the services, work or operations are deemed to be complete.

RECOUPMENT OF DEFENSE COSTS

When a liability insurer undertakes the defense of its insured pursuant to a reservation of rights, the insurer often includes language in the reservation of rights letter reserving its right to recoup defense costs in the event it is determined that the insurer had no duty to defend. However, one recent decision makes clear that such language must be clear and unambiguous.

In *Evanston Insurance Co. v. Sandersville Railroad Co.*,[10] the insurer sent a reservation of rights letter to its insured, stating its position that the policy did not cover the underlying claim against the insured (which was not yet in litigation) because of the pollution exclusion. In the letter, the insurer reserved its rights "as to whether the pollution exclusion applies to bar coverage for this claim," and "with respect to the investigation, settlement, and defense of the claim." If litigation ensued, the insurer agreed to pay the reasonable costs of defense for the insured's chosen defense counsel, upon the exhaustion of the insured's self-insured retention (SIR), subject to a reservation of rights to withdraw from providing the defense upon a determination that there is no coverage and a reservation of "the right to reimbursement of costs paid if it establishes that it owes no coverage to [the insured]." The insurer also reserved the right to file a declaratory judgment action. The letter concluded by stating that neither the insurer nor the insured waived any rights under the policy or the law.

9 684 Fed. Appx. 788 (11th 2017).

10 No. 5:15-CV-247 (MTT), 2017 U.S. Dist. LEXIS 115686 (M.D. Ga. July 25, 2017).

After the third-party claimant filed suit against the insured, the insurer did not supplement its reservation of rights letter. at that time Once the insured exhausted its SIR, it tendered its defense to the insurer. The insurer then issued a second reservation of rights letter that was virtually identical to the first. The second letter made no mention of the claimant's complaint or the allegations contained therein. The insurer subsequently filed a declaratory judgment action, and the court ruled the insurer had no duty to indemnify and no further duty to defend. As to the insurer's attempt to recoup the defense costs it had already paid, the court explained it could not say, as a matter of law, that the allegations of the claimant's complaint established that the insurer never had a duty to defend.

The court went on to explain that, even assuming the insurer never had a duty to defend, it did not show that it was entitled to recoup defense costs. The court noted that through its dealings with the insured, the insurer had muddled the distinction between the duty to defend and the duty to indemnify. In its reservation of rights letters, the insurer stated it "reserves the right to reimbursement of defense costs paid if it establishes that it *owes no coverage* to the insured," (emphasis added). However, as the court explained, the duty to defend is broader than the duty to indemnify and there are, accordingly, many situations where the insurer has no coverage for the claim but nonetheless owes a duty to defend. Here, the insurer established, based on evidence well outside of the complaint, that it had no coverage for the claimant's claim. But that did not establish that the insurer was entitled to reimbursement of defense costs paid. Rather, such costs can be recovered only if there was no duty to defend.

Here, however, the insurer failed to established that it had no duty to defend from the outset of the litigation. The insurer's second reservation of rights letter, issued after the complaint was filed against the insured, was the insurer's opportunity to explain that it did not believe it had a duty to defend because the allegations of the claimant's complaint, taken as true, unambiguously fell within the pollution exclusion and accordingly excluded coverage. But the second letter did not even mention the complaint. The court explained that the insurer's reservation of rights letters never stated a position that the insurer did not owe a defense, let alone why. It was incumbent upon the insurer to fairly inform the insured that the insurer would have the right to reimbursement of defense costs paid if it established the allegations of the complaint unambiguously excluded coverage because the allegations, taken as true, necessarily fell within the pollution exclusion. The insurer did not do so, and its reservation of rights letters were therefore insufficient to support any right to recoup the defense costs.

Sanderson Railroad is an important reminder to liability insurers to distinguish between the duty to defend and the duty to indemnify in their reservation of rights letters, to specifically address the allegations of the underlying complaint in reservation of rights letters and explicitly reserve the right to recoup defense costs where the allegations of the complaint demonstrate the insurer had no duty to defend. Facts later revealed establishing the insurer has no further duty to defend will not suffice to establish the insurer's right to recoup defense costs already paid.

SKIMMing Through: All the Property News and Info You Need in 20 Minutes or Less

By Jessica M. Phillips

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Associate

Jessica M. Phillips is a member of the firm's coverage and commercial litigation team. Since 2010, Ms. Phillips has assisted her clients in evaluating a variety of coverage issues ranging from policy exclusions and sources of loss to arson, application fraud and claim fraud. She is well-versed on Georgia law regarding contractual defenses, mortgagee rights, suit limitation defenses, non-cooperation defenses and first-party bad faith claims.

Ms. Phillips evaluates coverage issues under a variety of policies including traditional homeowners policies, inland marine policies, builders risk policies, renters policies and valuable articles policies. She has taken numerous examinations under oath and depositions and defends her clients in litigation relating to a variety of policy provisions, including appraisal provisions and "suit against us" provisions. In conjunction with her defense of these matters, Ms. Phillips has prepared and successfully defended dispositive motions, including motions to dismiss and motions for summary judgment. She also assists her clients in evaluating the value of losses including replacement cost value, actual cash value and additional living expenses. Ms. Phillips also defends numerous third-party claims including auto accidents, dog bite claims and First Amendment claims.

Ms. Phillips graduated, *cum laude*, from Mercer University Walter F. George School of Law (J.D., 2010). While in law school, she was an active member of the *Mercer Law Review* where she was published on two separate occasions. She was also an active member of the Mercer Advocacy Board and was inducted into the Order of the Barristers. Ms. Phillips graduated, *cum laude*, from the College of Charleston in 2004 with a degree in Psychology and minor in Biology.

SKIMMing Through: All the Property News and Info You Need in 20 Minutes or Less

In 2016 and 2017, Georgia courts clarified several issues in the law governing first-party insurance coverage disputes including non-cooperation, misrepresentation, insurable interest and judicial estoppel. We have provided snippet summaries of several important cases below.

FURTHER EVALUATION OF THE NON-COOPERATION DEFENSE

In 2016 and 2017, both the Eleventh Circuit and the Northern District of Georgia further evaluated the consequences when an insured fails to cooperate with its insurer's investigation by failing to provide the information and documents requested by the insurer. First, in *Hsu v. Safeco Insurance Co. of Ind.,*[1] the Eleventh Circuit considered whether an insurer may deny coverage to insureds who failed to provide their income tax returns as requested by their insurer and as required by their policy.[2] As part of its claims investigation, the insurer specifically requested financial records of the insured, including yearly tax returns from all years since 2009.[3] The policy contained provisions requiring the insureds to cooperate with the insurer's investigation full compliance with the policy provisions as a precondition to filing suit.[4] The insureds never provided the tax records, but did provide the insurer with an authorization to obtain these records directly from the Internal Revenue Service (IRS).[5] The insurer attempted to obtain the tax records directly from the IRS, but the documents were mailed by the IRS to the insured instead.[6] Despite multiple attempts to obtain these records from the insureds, the insurers never received the tax records.[7] However, the insureds sued their insurer for coverage under the policy. The insurer claimed that the insureds were barred from recovery because they failed to comply with the policy's preconditions for filing suit, to wit, providing the requested tax documents.[8]

On appeal, the insureds argued that a question of fact existed as to whether the insurer had exercised "due diligence" in obtaining the outstanding tax records on its own.[9] In so arguing, the insureds relied upon *Diamonds & Denims v. First of Georgia Insurance Co.*[10] In *Diamonds & Denims*, the court denied the insurer's motion for summary judgment because the insured cooperated to some degree and provided an explanation for its noncompliance.[11] In addition, the insurer failed to act with diligence and good faith in obtaining the outstanding information since it did not attempt to follow up on alternative methods offered by the insureds to obtain the outstanding documents.[12] Specifically, in *Diamonds & Denims* a fire destroyed the insured's warehouse and the insurer requested certain documents in conjunction with its investigation of the claim.[13] The insured attempted to comply with the insurer's broad request for "books and records," though most were destroyed.[14] Since most of the books and records were burned in the fire, the insured offered to provide the requested information in an alternate way and offered an authorization for the insurer to obtain these records.[15] The insurer, however, never followed up on its request.[16] The court in *Diamonds & Denims* concluded that a question of fact existed as to whether the insurer exercised "due diligence" to obtain these records.[17]

1 654 Fed. Appx. 979 (11th Cir. 2016).
2 *Id.* at 980.
3 *Id.* at 980-81.
4 *Id.* at 980.
5 *Id.*
6 *Id.* at 981.
7 *Id.*
8 *Id.*
9 *Id.*
10 203 Ga. App. 681, 683, 417 S.E.2d 440, 441 (1992) ("An insurer is entitled to require its insured to abide by the policy terms, and the insured is required to cooperate with the insurer in investigation and resolution of the claim.").
11 *Id.*
12 *Id.*
13 *Id.*
14 *Id.* at 682, 417 S.E.2d at 441.
15 *Id.*
16 *Id.* at 683, 417 S.E.2d at 442.
17 *Id.*

The *Hsu* Court found the case's facts were akin to *Allstate Insurance Co. v. Hamler*, not *Diamonds & Denims*.[18] In *Hamler*, the insured sued when the insurer refused to provide coverage for items the insured claimed were stolen from her home.[19] The insured refused to provide federal income tax returns after the insurer sent a "lengthy and detailed request" for them.[20] Thus, the insured failed to abide by her duties under the policy.[21] In *Hsu,* the Eleventh Circuit concluded the insurer, similarly to the insurer in *Hamler*, requested specific documents and "diligently pursued the matter," but "the insureds refused to cooperate."[22] Thus, the insureds failed to satisfy their duties under the policy and the insurer was entitled to judgment in its favor as a matter of law.

Second, in *Durden v. State Farm Fire & Casualty Co.,*[23] the Northern District of Georgia affirmed that an insured's failure to provide financial information, including income and credit information, which was material to an insurer's fraud investigation, barred legal action as a matter of law.[24] In *Durden*, the insureds' renters insurance policy provided coverage for "accidental direct physical loss" to personal property. However, the insureds were not entitled to coverage if they "cause[d] or procure[d] a loss to property" or "intentionally conceal[ed] or misrepresent[ed] any material factor or circumstance relating to th[e] insurance."[25] The policy also contained provisions requiring an insured submit to examinations under oath and provide requested documents and a provision making satisfaction of these duties a precondition to filing suit.[26] After the insureds were evicted, they filed a claim for lost or stolen property that was considerably higher than the amount that they originally reported to police.[27] However, they refused to provide information and documents requested by the insurer, including financial records, tax returns and social media records, because they contended such items were irrelevant.[28] The court found evidence of possible fraud by the insureds; therefore, the insureds "breached the terms of the Policy by failing to provide 'material information'" requested by the insurer.[29] Their claim was barred because they did not comply with this condition precedent, and summary judgment in the insurer's favor was granted.[30]

APPLICATION MISREPRESENTATION

When an insurer discovers an insured materially misrepresented the size of his property on his insurance application, the insurer may rescind the policy.[31] In *Great Lakes Insurance SE v. Queen*, the insured made a claim under his insurance policy to recover for fire damage to an outbuilding on his property.[32] Although the insured indicated on his insurance application that his property was not more than five acres, the insurer discovered that the property was eight acres during investigation of the claim.[33] The insurer submitted an affidavit stating it would not have issued the policy if the true size of the property was known.[34] In finding the insurance application contained a material misrepresentation, the Middle District of Georgia allowed the insurer to rescind the policy, even though the insured denied intent to defraud. The insured believed he was only insuring his house and the outbuilding, which sat on a tract less than five acres.[35] The court did not consider the insured's intent and allowed the insurer to rescind the policy. However, the court noted it did not find credible the affidavit from the underwriter stating that the insurer would not have issued the policy had the appropriate size of land been indicated. An affidavit from a "qualified person" contradicting the underwriter's affidavit would, according to the court, create a question of fact that would have precluded summary judgment.[36]

18 *Hsu*, 654 Fed. Appx. at 981.
19 *Allstate Ins. Co. v. Hamler*, 247 Ga. App. 574, 574, 545 S.E.2d 12, 12 (2001).
20 *Id.* at 578, 545 S.E.2d at 15.
21 *Id.*
22 *Hsu*, 654 Fed. Appx. at 981.
23 2017 U.S. Dist. LEXIS 26567 (N.D. Ga. Feb. 27, 2017). We also note that Swift Currie partner Melissa Segel won summary judgment in this case.
24 *Id*. at *1.
25 *Id.*
26 *Id.*
27 *Id.* at *3-5.
28 *Id.* at *13.
29 *Id.* at *23, 25.
30 *Id.* at *25.
31 *Great Lakes Ins. SE v. Queen*, 2017 U.S. Dist. LEXIS 8491, at *1 (M.D. Ga. Jan. 23, 2017).
32 *Id.*
33 *Id.* at *2.
34 *Id.* at *1.
35 *Id.* at *2.
36 *Id.* at *11.

AN INSURER'S OPTION TO REPAIR AND PAY TO REPAIR

The court of appeals held that an insurer may choose between repairing and paying to repair even if it had already commenced to repair the property.[37] In *Clary v. Allstate Fire & Casualty Insurance Co.*, the insureds' home was damaged after a lightning strike caused severe fire and water damage.[38] After initially choosing the option in the policy to repair the damages, the insurer decided to exercise its option of demanding appraisal and then to issue checks to the insureds after the amount of damages was decided by appraisal.[39] The insureds returned the checks, demanding that the insurer complete the home's restoration.[40] When the insurer refused, the insured sued, alleging that the insurer breached its contract and arguing that once an insurer begins repairs and restoration, it cannot change its election to the option of paying for the loss.[41] The court disagreed, holding that the insurer did not breach its "contract by abandoning the restoration and electing to pay the [insureds] the amount of the loss."[42]

DIMINUTION IN VALUE UNDER HOMEOWNERS POLICIES

In *Anderson v. American Family Insurance Co.*,[43] the insured repaired his home after it incurred water damage.[44] The insured sued when the insurer who issued his homeowners policy refused to "assess and pay damages for diminished value" of his home after he repaired the water damage.[45] The Middle District of Georgia found that the insured's policy did cover for diminished value to the structure due to a covered loss based on prior precedent.[46] In *State Farm Mutual Automobile Insurance Co. v. Mabry*, the Georgia Supreme Court determined that an insurer's physical damage provision in an automobile insurance policy afforded coverage for diminution in value to the automobile.[47] In *Royal Capital Dev. LLC v. Md. Casualty Co.*, the Supreme Court extended this holding beyond automobile policies.[48] Using the same rationale as in *Mabry* and *Royal Capital*, the *Anderson* Court concluded the insurer's homeowners insurance policy provided diminution in value coverage and explained that, "[a]lthough [the insured] may not realize the full *consequences* of that diminution in value until he sells his home, his home nevertheless allegedly experienced a diminution in value as a result of the water damage."[49] The court rejected the carrier's argument that diminution in value did not constitute a "direct accidental physical loss" as required by the policy.[50]

JUDICIAL ESTOPPEL

On September 18, 2017, the United States Court of Appeals reconsidered its judicial estoppel precedent in circumstances where an individual has failed to disclose a civil claim in their bankruptcy petition and action.[51] In *Slater v. U.S. Steel*, the court indicated that judicial estoppel should only be applied to bar a plaintiff's civil claim if the court finds that "the plaintiff intended to make a mockery of the judicial system."[52] According to the court, all facts and circumstances of the failure to disclose the claim should be considered — including a party's level of sophistication and whether the party understood the disclosure obligations.[53] According to the court, it will no longer automatically infer an intent to misuse the courts simply by virtue of the failure to disclose, instead requiring a fact-intensive inquiry to determine if the failure was done with intent to

37 *Clary v. Allstate Fire & Cas. Ins. Co.*, 340 Ga. App. 351, 351, 795 S.E.2d 757, 759 (2017).
38 *Id.* at 353, 795 S.E.2d at 760.
39 *Id.* at 354, 795 S.E.2d at 761.
40 *Id.*
41 *Id.*
42 *Id.* at 355, 795 S.E.2d at 762.
43 2016 U.S. Dist. LEXIS 84186 (M.D. Ga. June 29, 2016).
44 *Id.* at *2.
45 *Id.*
46 *Id.* at *11.
47 274 Ga. 498, 498, 556 S.E.2d 114, 116 (2001).
48 291 Ga. 262, 263, 728 S.E.2d 234, 235 (2012) (finding that *Mabry* was not limited by the type of property insured, but rather speaks generally to the measure of damages an insurer is obligated to pay).
49 *Anderson*, 2016 U.S. Dist. LEXIS 84186, at *11 (emphasis in original).
50 *Id.*
51 *See Slater v. U.S. Steel*, D.C. Docket No. 2:09-cv-01732-KOB (11th Cir September 18, 2017).
52 *Id.* at p.2.
53 *Id.* at pp.3, 25.

make a mockery of the judicial system.[54] In *Slater*, the insured successfully argued that "her omission of the civil claims in the bankruptcy proceeding was inadvertent and that she never intended to thwart the judicial process."[55] The district court failed to consider Slater's actual intent, since it relied on prior precedent that motive is automatically inferred because Slater knew about her 2009 action when she filed her 2011 bankruptcy and did not disclose the 2009 claim in her 2011 bankruptcy petition. The district court was acting in accordance with prior precedent, which stated: "we treated the fact that the plaintiff could potentially benefit from the nondisclosure as sufficient to establish that the plaintiff, in fact, intended to deceive the court and manipulate the proceedings."[56] Nonetheless, the Eleventh Circuit Court of Appeals overturned this precedent and deemed the prior inconsistent position as something that should require more review instead of an automatic application. According to the court, "[a]s an equitable doctrine, judicial estoppel should apply only when the plaintiff's conduct is egregious enough that the situation 'demand[s] equitable intervention' . . . [w]hen a plaintiff intended no deception, judicial estoppel may not be applied.[57]

Although *Slater* did not specifically address the prior Georgia precedent of *Battle v. Liberty Mutual Insurance Co.*,[58] which previously set forth the guidelines for the applications of judicial estoppel, this new court decision set forth another layer of analysis that should be considered when applying judicial estoppel in insurance claims. Furthermore, the court's opinion in *Slater* may be limited to instances where an insured has wholly failed to identify a pending civil action or insurance claim in his or her bankruptcy petition. However, insureds will likely refer to *Slater* to encourage courts to consider other circumstances such as lack of education, sophistication, understanding of disclosure obligations and familiarity with the legal process when determining whether to apply judicial estoppel.

INSURABLE INTEREST

The Northern District of Georgia recently offered more clarity regarding how to evaluate insurable interest in the subject of an insurance policy. In *Baumgartner v. State Farm Fire & Casualty Co.*,[59] the court granted summary judgment to State Farm on the basis that its insured, Ms. Baumgartner, did not maintain any insurable interest in the property as required by the policy and applicable Georgia law.[60] Ms. Baumgartner did not own the property — the property was owned by the "Hugh Lee Baumgartner Trust," of which she was not a trustee.[61] The trust handled maintenance for the property and major repairs for the property.[62] Ms. Baumgartner was the named insured on the policy, but she did not bear the financial cost of replacing or fixing damages to the property and had no pecuniary interest in the property's continued preservation. Ms. Baumgartner contended that she maintained an equitable interest in the property as a beneficiary of the trust and since she was permitted to live there.[63] The court rejected Ms. Baumgartner's argument and held that, even if she held an equitable interest in the property, it was not sufficient to create an insurable interest in the property's physical structure.[64] Thus, summary judgment in favor of State Farm was appropriate.

54 *Id.*
55 *Id*. at p.7.
56 *Id.* at p.17 (citing *Barger v. City of Cartersville*, 348 F.3d 1289 (11th Cir. 2003)). *See Burnes v. Pemco Aeroplex, Inc.,* 291 F.3d 1282 (11th Cir. 2002) for precedent involving Chapter 7 bankruptcies *and Robinson v. Tyson Foods, Inc.,* 595 F.3d 1269, 1275-76 (11th Cir. 2010) and *De Leon v. Comcar Indus., Inc.,* 321 F.3d 1289, 1291-92 (11th Cir. 2003) for precedent involving Chapter 13 bankruptcies.
57 *Slater v. U.S. Steel,* D.C. Docket No. 2:09-cv-01732-KOB, p.29 (11th Cir. Sept. 18, 2017) (citing *Hazel-Atlas Glass Co. v. Hartford-Empire Co.*, 322 U.S. 238, 248 (1944)).
58 276 Ga. App. 434, 623 S.E.2d 541 (2005).
59 2017 U.S. Dist. LEXIS 40136 (N.D. Ga. Mar. 21, 2017). We also note that this case was handled by Swift Currie attorneys Mark Dietrichs and Marcus Dean.
60 *Id.* at *9.
61 *Id.* at *2.
62 *Id.*
63 *Id.* at *9.
64 *Id.*

Interpreting Additional Insured Clauses and Indemnification Clauses: There's No App for That

By Brian C. Richardson

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Associate

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Mr. Richardson is an Alabama native and attended Auburn University where he received a Bachelor of Science in Building Science. While there, he successfully completed the professional requirements for the Cooperative Education program and was awarded the Comer Foundation Scholarship. After graduating, Mr. Richardson worked as an estimator and project manager for a large regional general contractor. During his time in this line of work, he helped manage the construction of a multi-million dollar healthcare facility and participated in several successful bids and estimates related to schools, banks, healthcare facilities and wastewater treatment plants. He was also a member of the Associated General Contractors of Alabama and earned a LEED Accredited Professional certification from the Green Building Certification Institute.

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Interpreting Additional Insured Clauses and Indemnification Clauses: There's No App for That

Your insured just filed a claim involving work on a construction project and coverage has been confirmed — now what? As of September 2017, there were no apps for this. By the time you read this, one may exist. Until then, this paper is the next best thing to guide you when faced with this scenario. The first thing you should do is identify all those involved on the project or incident and analyze relevant insurance documents and contractual agreements to determine whether you can shift the ultimate liability for the claim, or at least some of it, to other parties and carriers. This paper will explore two particular risk shifting tools: additional insured clauses and indemnification clauses and how Georgia and Alabama courts enforce them.

Your insured may be an additional insured on another entity's policy or may avail itself of an indemnification clause contained in a contractual agreement with another entity. Applicable insurance policy language often extends coverage to an additional insured for claims "arising out of" acts or omissions of the named insured. This language may extend additional insured coverage to any and all claims that have any relationship to the business transaction between the named insured and the additional insured, and such business transaction alone may suffice to satisfy the requirement between the alleged injury and the alleged negligence of the named insured.

With respect to indemnification clauses, some contracts purport to indemnify one party for "any and all" acts or omissions of another party to the contract. These clauses — though appearing to encompass the indemnification one seeks — may be void as a matter of public policy within the construction context. However, this determination depends largely on the applicable law and contractual language.

WHO IS AN ADDITIONAL INSURED

Construction subcontracts generally always require the subcontractor to procure additional insured coverage for the general contractor and others on a project.[1] This coverage is often added to the subcontractor's existing liability policy in endorsements.[2] The general contractor's commercial general liability (CGL) policy is one of the most common commercial risk shifting policies used for construction projects. Generally speaking, most insurers use the Insurance Services Office (ISO) CGL forms for primary layers of coverage, including either CG 00 01 (occurrence) form or CG 00 02 (claims made) form.[3] Many CGL policies, in either the "Who Is An Insured" section or in a specific additional insured endorsement, contain language which provides that any person for whom the named insured agrees in a "work contract" or written agreement that such person or organization be made an insured or named as an additional insured on the policy, does in fact qualify as an additional insured.[4] Most contractors require verification from subcontractors through certificates of insurance indicating the additional insured endorsement. Those same provisions typically contain a limitation, which restricts additional insured coverage to liability "arising out of" or "resulting from" the named insured's (often a subcontractor's) work or operations performed for that additional insured (typically a general contractor, developer, or owner).

1 Sistrunk, Jeff, *A General Contractor's Guide to Additional Insured Coverage*, Law360 (Aug. 8, 2017), https://www.law360.com/articles/949709/a-general-contractor-s-guide-to-additional-insured-coverage.

2 *Id.*

3 Wilshun, Fred, et. al., Construction Checklists: A Guide to Frequently Encountered Construction Issues(2008).

4 The ISO form CG 20 10 Additional Insured-Owners, Lessees or Contractors-Scheduled Person or Organization is an additional insured endorsement that covers the primary named insured's acts or omissions or the acts or omissions of those acting on its behalf "in performance of its ongoing operations for the additional insured." If the contract requires both operations exposure and completed operations coverage to the additional insured, both forms 20 33 and 20 37 must be issued. Form CG 20 33 is entitled Additional Insured-Owners, Lessees or Contractors-Automatic Status When Required in Construction Agreement with You and CG 20 37 is entitled Additional Insured-Owners, Lessees or Contractors-Completed Operations (scheduled entity).

Many insurers have taken the position that if the named insured was not liable or responsible for the bodily injury or property damage alleged by the claimant against the additional insured, then the additional insured is not entitled to coverage under the policy. However, decisions over the last 10 years have continued to underscore the fact that insurers should not take that position absent more specific policy language.

Alabama

Alabama courts interpret the "arising out of" language very broadly and comprehensively, to mean "origination from," "having its origin in," "growing out" or "flowing from."[5] In other words, this broad interpretation "simply requires that the additional insured's negligent acts are connected to the named insured's operations performed for the additional insured."[6] However, even with a liberal construction of an additional insured endorsement covering "liability arising out of the named insured's operations," an additional insured (general contractor), for example, has no coverage where the damages did not arise out of the named insured's (subcontractor) work if the additional insured endorsement states:

> "Who Is An Insured is amended to include . . . the person or organization shown in the SCHEDULE as an insured but only with respect to liability arising out of the Named Insured's operations . . . [t]he insurance afforded by this endorsement . . . shall not apply to damages arising out of the negligence of the person(s) or organization(s) added by this endorsement."[7]

In *Regency Club*, the insurer filed a declaratory judgment action arising from a lawsuit brought by a homeowners' association against the developer, general contractor and subcontractors. The facts were undisputed that the subcontractor did not perform any work for the general contractor — the putative additional insured — on the subcontractor's policy on the development. The federal district court held the above additional insured provision clearly limited additional insured coverage to "liability arising out of the Named Insured's operations . . . . " The court held the general contractor's vicarious liability did not arise out of the work actually performed by the named insured. Therefore, the general contractor was not entitled to coverage under the express language of the policy.

Alabama appellate courts have not interpreted an additional insured endorsement similar to CGL 088 (07 10). Thus, we do not know how broadly or narrowly the Alabama courts would interpret the provision limiting the additional insured coverage to "'bodily injury' . . . which is caused, in whole or in part, by 'your work'" or similar provisions. This very question is currently on appeal in the Supreme Court of Alabama.[8] There, the trial court granted summary judgment in favor of the putative additional insured, granting that status for claims apparently based on its sole negligence.

There are a wide variety of additional insured endorsements, so the specific language must be taken into account. For example, where the additional insured endorsement states it applies to "liability arising out of the named insured's operations," Alabama courts have liberally construed the endorsement.

Furthermore, endorsements such as CGL026 (11 08) (providing additional insured coverage "with respect to your negligent actions, which cause liability to be imposed on such person . . . without fault on the part of said person . . . , caused by 'your work' performed for that insured") and CGL055 (12 05) (providing additional insured coverage "with respect to (1) your negligent actions . . . which cause liability to be imposed on such person . . . without fault on the part of said person . . . and (2) the partial negligence of the additional insured which combines with your partial negligence . . . in causing the accident . . . . This insurance does not cover the sole negligence of the additional insured . . . . ") may be interpreted differently.

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5 *See Twin City Fire Ins. Co., Inc. et al., v. Ohio Cas. Ins. Co., Inc.*, 480 F.3d 1254 (11th Cir. 2007) (citing *Davis Constructors & Eng'rs, Inc. v. Hartford Acc. & Indem. Co.*, 308 F. Supp. 792, 795 (M.D. Ala. 1968)) (where indemnity provision applied to claims "arising out of work," the subcontractor is obligated to indemnify contractor even though the subcontractor's employees were injured only because their work for [the subcontractor] happened to put them in the path of an accident that was him solely by the contractor's negligence); *See also e.g. Taliaferro v. Progressive Specialty Inc. Co.*, 821 So. 2d 976 (Ala. 2001); *State Farm Fire & Cas. Co. v. Erwin*, 393 So. 2d 996 (Ala. 1981) ("arising out of the ownership, maintenance, or use of the owned automobile" is about as general and broad as could be written); *Pacific Indem. Co. v. Run-A-Ford Co.*, 161 So. 2d 789 (Ala. 1964) (noting the words "arising out of" are broad, general and comprehensive, effecting broad coverage).

6 *Int'l Paper Co., Inc. v. QBE Ins. Corp.*, 2010 U.S. Dist. LEXIS 44048, *15-16 (M.D. Ala. 2010).

7 *Canal Indem. Co. v. Regency Club Owners Ass'n*, 924 F. Supp. 2d 1304 (M.D. Ala. 2013).

8 *See Am. Res. Ins. Co. v. Int'l Paper Co.*, Appeal Nos. 1140230, 1140272, 1140359.

Georgia

Interpretation of Georgia courts' application of additional insured language suggests that so long as there is a "business transaction" between the putative additional insured and the named insured, which can be formed via contract, then any injuries necessarily "arose out of" the named insured's work.

In *BBL-McCarthy, LLC v. Baldwin Paving Co.*, the general contractor subcontracted with Baldwin Paving and Magnum Development (the subcontractors), separately, to construct a traffic "deceleration lane" leading from the project.[9] Magnum performed the grading work and Baldwin completed the paving. Both subcontracts contained an indemnification clause and insurance clause. The indemnification clause required the subcontractors to defend, indemnify and hold the general contractor harmless for all claims arising out of the performance of the subcontractors' work. The insurance clause required the subcontractors to obtain liability insurance to cover claims arising out of the subcontractors' work and for which the general contractor may be liable. The subcontractors obtained CGL policies naming the general contractor as an additional insured, but the policies contained language limiting coverage to the general contractor for liability "arising out of" the subcontractors' work or operations.[10] Following an auto collision near the construction project, claimants brought lawsuits alleging their injuries resulted from the general contractor's negligent management of the project, as well as the general contractor's and the subcontractors' negligent construction of the road.

The trial court held that the general contractor qualified as an additional insured under the subcontractors' policies, regardless of whether the injuries were attributable to the general contractor or subcontractors.[11] The court broadly construed the phrase "arising out of" the subcontractors' work or operations as meaning arising out of a business transaction with or work performed for the general contractor.[12] Because the alleged injuries were related to the subcontractors' work, the general contractor qualified as an additional insured, regardless of whether actual liability for the injuries was attributable to the general contractor or the subcontractors.[13]

Similarly, in *Ryder Integrated Logistics v. Bellsouth Telecommunications, Inc.*, reversed on other grounds that the putative additional insured did not dispute that it was solely negligent for the injuries to the named insured's employee, nor contend that the named insured did anything to contribute to the injuries in a premises liability claim.[14] The named insured, Ryder, agreed in its contract with Bellsouth to provide additional insured coverage to Bellsouth.[15] Ryder's CGL policy provided that Bellsouth would be an additional insured, "but only with respect to liability arising out of [Ryder's] operations."[16] The court held that because the claimant was a Ryder employee performing work at the Bellsouth facility pursuant to Ryder's "business transaction" — that is, pursuant to the contract with Bellsouth — Bellsouth qualified as an additional insured under the policy, even though it was *solely* liable for the injuries.[17] "The fact that the defect [that caused the injury] was attributable to [the additional insured's] negligence is irrelevant, since the policy language does not purport to allocate coverage according to fault."[18]

The decisions in *BBL* and *Ryder* initially shocked a lot of insurers in Georgia because the rulings all but eliminated the requirement of any causal connection between the plaintiff's injury and the work performed by the named insured. In fact, the courts suggested that as long as there is a "business transaction" between the named insured and purported additional insured, which can be evidenced by a contract between them, then the injuries necessarily "arose out of" the named insured's work. In *Ryder*, the fact the injured person was a Ryder employee and a contract existed between Bellsouth and Ryder was sufficient for the court to find a connection, even though Ryder's operations did not contribute to the alleged injury — other than the employee's mere presence in doing his job at the project site pursuant to the contract.

9 285 Ga. App. 494., 646 S.E.2d 682 (cert. denied) (2007).
10 *Id.* at 495-96.
11 *Id.* at 499.
12 *Id.* at 498 (The court noted that it had similarly construed "arising out of" as meaning "had its origins in," "grew out of" or "flowed from," and, therefore, "almost any causal connection or relationship will do" in satisfying the "arising out of" requirement.).
13 *See Video Warehouse Inc. v. So. Trust Ins. Co.*, 2009 Ga. App. LEXIS 396 (Mar. 30, 2009) (citing *BBL-McCarthy, LLC v. Baldwin Paving Co.*, 285 Ga. App. 494, 646 S.E.2d 682 (2007)) (noting that the Georgia Supreme Court has interpreted the same "arising out of" language as excluding all claims for injuries caused by the excluded acts, regardless of the theory of tort liability).
14 277 Ga. App. 679, 627 S.E.2d 358 (2006). *See Ryder Integrated Logistics, Inc. v. Bellsouth Telecomms., Inc.,* 281 Ga. 736, 242 S.E.2d 695 (2007).
15 *Ryder,* 627 S.E.2d 358.
16 *Id.* at 363.
17 *Id.* at 364-65.
18 *Id.* at 364 (citing *Acceptance Ins. Co. v. Syufy Enter.*, 69 Cal. App. 4th 321, 81 Cal Rptr. 2d 557 (1999)).

Insurers whose additional insured provision uses the language "liability resulting from" the named insured's work, may be tempted to argue that such language requires a much more direct, causal connection between the named insured's work and the claimant's alleged injuries or damages than is required by an additional insured provision containing the phrase "liability arising out of" the named insured's operations. However, Georgia law has found no material distinction between the phrases "arose out of" and "caused by."[19]

While Georgia courts have shown a propensity to interpret additional insured provisions in CGL policies very broadly to find that an entity qualifies as an additional insured, courts are beginning to narrowly interpret the extent of coverage provided to the additional insured. In *Auto-Owners Insurance Co. v. Gay Construction Co.*, Gay Construction, a general contractor, qualified as an additional insured under a CGL policy issued by Auto-Owners to named insured Dai-Cole Waterproofing Company, Inc., the waterproofing subcontractor on a project.[20] After completion of the project, the owner complained that water was leaking into the space below the terrace when it rained. Gay Construction investigated the complaint and determined the waterproofing membrane and drainage mat were improperly installed. Dai-Cole either failed, and/or refused, to properly repair the work and, as a result, Gay Construction was forced to make the repairs and replace damaged materials and fixtures.

As a prerequisite to performing work on the project, the project and contract documents required Dai-Cole to obtain a CGL policy, which it obtained from Auto-Owners. The policy provided, in part, that:

> A person or organization is an Additional Insured only with respect to liability arising out of "your work" for that Additional Insured by or for you (1) [i]f required in a written contract or agreement; or (2) [i]f required by an oral contract or agreement only if a Certificate of Insurance was issued prior to the loss indicating that the person or organization was an Additional Insured.

And that Auto-Owners would:

> Pay those sums that the insured becomes legally obligated to pay as damages because of "bodily injury" or "property damage" to which this insurance applies.... This insurance applies to "bodily injury" and "property damage" only if . . . [such] is caused by an "occurrence" that takes place in the "coverage territory."[21]

Following Gay Construction's completion of the repairs and replacement work, Gay Construction sought coverage under the Auto-Owners Policy as an additional insured.[22] Auto-Owners denied the claim, and Gay Construction sued.[23] Auto-Owners filed a motion for summary judgment arguing that Gay Construction's claim did not seek damages resulting from property damage as defined by the policy, and that the damages sought were barred by the policy's business risk exclusion.[24] The trial court denied Auto-Owner's motion and permitted an interlocutory appeal.[25]

On appeal, the Georgia Court of Appeals confirmed that Gay Construction did qualify as an additional insured and determined that the policy's business risk exclusion applied to Dai-Cole's faulty workmanship.[26] Had Dai-Cole made a request for coverage under the CGL policy, Auto-Owners would have denied the request because of the business risk exclusion. This left the court with a question of first impression as to "which party's scope of work should be considered when determining whether a business risk exclusion applies to a general contractor's claim for first-party coverage as an additional insured under its subcontractor's CGL policy."[27]

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19 *See Jefferson Ins. Co. of N.Y. v. Adrian*, 269 Ga. 213, 496 S.E.2d 696 (1998) (both phrases required the same causal connection between the alleged injuries and the insured's conduct). An additional insured's coverage may be limited to instances where the additional insured is vicariously liable for the wrongs of the named insured. *BP Chemicals, Inc. v. First State Ins. Co.*, 226 F. 3d 420, 423 (6th Cir. 2000) (finding that additional insured under CGL policy was not provided with coverage for its own negligence . . . neither an indemnity agreement nor the additional insured endorsements expressly stated an intention to indemnify the additional insured against its own negligence). Such language must be specifically and unambiguously stated in the policy.

20 332 Ga. App. 757, 774 S.E.2d 798 (2015).

21 *Id.* at 799.

22 *Id.* at 799-800.

23 *Id.* at 800.

24 *Id.*

25 *Id.*

26 *Id.* at 800-01.

27 *Id.*

The court reasoned that Auto-Owners did not contract to guarantee Dai-Cole's scope of work and the business risk exclusion removed Dai-Cole's defective workmanship that caused damage to the project from coverage under the policy.[28] Gay Construction was responsible for all work performed within the scope of its contract with the owner.[29] If the business risk exclusion were interpreted so narrowly as to only apply to work performed by Dai-Cole, then it would permit the additional insured, Gay Construction, to enjoy broader coverage than was granted to the policy holder. In essence, requiring Auto-Owners to guarantee Dai-Cole's work.[30]

INDEMNIFICATION CLAUSES

Indemnification clauses present another opportunity to shift risk in the construction context. Many construction contracts contain an indemnification clause requiring one of the parties, typically the subcontractor, to defend, hold harmless and indemnify the other party for claims, injuries and damage that arise out of the work on the project.

While the breadth of indemnification clauses vary, there are certain restrictions at play based on the applicable law. In Georgia, it is against public policy to contract away liability to an indemnitor for damages arising from the sole negligence of an indemnitee in construction contracts.[31] Alabama has no such statutory limitation. Alabama law allows parties to enter into "indemnity agreements that allow an indemnitee to recover from the indemnitor even for claims resulting solely from the negligence of the indemnitee," so long as the indemnity contract clearly and unequivocally indicates an intention to indemnify for the indemnitee's own negligence.[32]

Alabama

Generally, Alabama law prohibits contribution or indemnity between joint tortfeasors.[33] Broad indemnification agreements are not looked upon favorably in Alabama. Agreements that purport to indemnify another for the others intentional conduct is void as a matter of strong public policy.[34]

Alabama law allows parties to enter into "indemnity agreements that allow an indemnitee to recover from the indemnitor even for claims resulting solely from the negligence of the indemnitee."[35] Strict construction against the indemnitee is appropriate where it seeks indemnification for its own negligence.[36] Furthermore, the burden of proof is on the indemnitee to establish its right to indemnification under such an agreement.[37]

Whether an indemnity agreement applies will depend on the contract language and the facts surrounding the claim. That the injured party did not sue the indemnitor is not controlling. A duty to indemnify may be triggered even when the plaintiff in the underlying action avoided directly naming the indemnitor as a party. Alabama courts have recognized that "the fact that a complaint names one possible tortfeasor alone does not resolve whether any resulting damages in that case relate solely to the named tortfeasor's own fault or conduct, because that tortfeasor may be held liable for the entire loss, which may be also attributable to other joint tortfeasors."[38] Thus, "under Alabama law, when determining liability under an indemnity provision, a court may look beyond the complaint in the underlying action to the underlying facts shown by admissible evidence."[39]

The controlling question is usually what is "clear and unequivocal" language. The following indemnity agreements did not provide for indemnity as to the owner's negligence (i.e., the indemnitee):

28 *Id.*
29 *Id.*
30 *Id.* at 801-02.
31 O.C.G.A. § 13-8-2 (b) (2007).
32 *Holcim (US), Inc. v. Ohio Cas. Ins. Co.*, 38 So. 3d 722, 728 (Ala. 2009); *Indus. Tile, Inc. v. Stewart*, 388 So. 2d 171, 175 (Ala. 1980).
33 *See, e.g., Humana Med. Corp. v. Bagby Elevator Co.*, 653 So. 2d 972, 974 (Ala. 1995).
34 *City of Montgomery v. JYD Int'l, Inc.*, 534 So. 2d 592, 594 (Ala. 1988).
35 *Holcim,* 38 So. 3d at 728; *Industrial Tile, Inc. v. Stewart*, 388 So. 2d 171, 175 (Ala. 1980) (noting that an indemnity contract must "clearly indicate" an intention to indemnify for the indemnitee's own negligence; that intent must be expressed in "clear and unequivocal language").
36 *Craig Constr. Co. v. Hendrix*, 568 So. 2d 752, 757 (Ala. 1990).
37 *Royal Ins. Co. v. Whitaker Contracting Corp.*, 824 So. 2d 747, 752 (Ala. 2002).
38 *Holcim,* 38 So. 3d at 729-30 (citing *FabArc Steel Supply, Inc. v. Composite Constr. Sys., Inc.*, 914 So. 2d 344, 361 (Ala. 2005)).
39 *Holcim*, 38 So. 3d at 730.

"[Indemnify/defend claims] . . . arising out of the work undertaken by the Subcontractor . . . and arising out of any other operation no matter by whom performed for and on behalf of the Subcontractor, whether or not due in whole or in part to conditions, acts or omissions done or permitted by the Contractor or Owner."[40]

Owner agrees to save agent harmless from all damage suits and claims arising in connection with said property and from all liability for injuries to persons or property while in, on, or about the premises. *Nationwide Mut. Ins. Co. v. Hall*, 643 So. 2d 551, 555 (Ala. 1994) (indemnity for the consequences of indemnitee's own negligence is enforceable only when contract language specifically refers to the negligence of the indemnitee).

"[Indemnify/defend claims] . . . arising out of or occasioned by [indemnitor], or anyone for whose acts [indemnitor] is or may be liable, provided that such claim . . . is attributable to bodily injury . . . to the extent caused or alleged to be caused in whole or in any part by any act . . . by [indemnitor] . . . ."[41]

"[Indemnify/defend claims] . . . arising out of or in any manner connected with the performance of this Agreement, whether such injury, loss or damage shall be caused by the negligence of the Contractor, his subcontractor, or any other party for whom the Contractor is responsible . . . ."[42]

Whereas these indemnity clauses did require indemnification even for the Owner's own negligence:

"[Indemnify/defend claims] . . . attributable to bodily injury . . . alleged to be caused in whole or in any part by any negligent act or omission of the Subcontractor . . . , regardless of whether it is caused in part by a party indemnified hereunder.[43]

"[Indemnify/defend claims] . . . arising out of or in any way related to the performance of the Work by [West] . . . , in whatever manner the same may be caused, and whether or not the same may be caused, occasioned or contributed to by the negligence, sole or concurrent, of ARP . . . ."[44]

"To the fullest extent permitted by law, [Marathon] shall defend and indemnify . . . 'Indemnitees'[] against . . . all liabilities, [etc.] . . . that arise in any way, directly or indirectly, out of a failure by [Marathon] . . . to . . . : (a) carry out the Work in a safe manner; (b) strictly comply with any applicable laws, regulations, building codes, rules, or industry standards; (c) exercise reasonable care in the performance of the Work or to execute the Work in a non-negligent manner; or (d) strictly comply with the requirements of this Subcontract. [Marathon's] obligation to defend and indemnify the Indemnitees shall not be diminished or excused merely because the negligence or other breach of a legal duty on the part of any Indemnitee also contributed to the Indemnified Loss . . . ."[45]

"[Indemnify/defend claims] . . . arising out of or resulting from the performance of the work, provided that any such claim . . . (1) is attributable to bodily injury . . . and (2) is caused in whole or in part by any negligent act . . . of the contractor, any subcontractor, anyone directly or indirectly employed by any of them or anyone for whose acts any of them may be liable, regardless of whether or not it is caused in part by a party indemnified hereunder."[46]

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40 *See Craig Const. Co.*, 568 So. 2d at 754 (Ala. 1990); *see also Brown Mech. Contractors, Inc. v. Centennial Ins. Co.*, 431 So. 2d 932, 946 (Ala. 1983) ("This provision was insufficient as a matter of law for [the Contractor] to be indemnified for its own negligence."); *U.S. Fid. & Guar. Co. v. Mason & Dulion Co.*, 274 Ala. 202, 145 So. 2d 711 (1962).

41 *McInnis Corp. v. Nichols Concrete Constr., Inc.*, 733 So. 2d 418 (Ala. Civ. App. 1998).

42 *Amerisure Mut. Ins. Co. v. QBE Ins. Corp.*, 2012 WL 3854402 (N.D. Ala. 2012).

43 *FabArc Steel Supply, Inc. v. Composite Constr. Syss., Inc.*, 914 So.2d 344 (Ala. 2005) (emphasis added).

44 *Twin City Fire Ins. Co. v. Ohio Cas. Ins. Co.*, 480 F.3d 1254 (11th Cir. 2007) (emphasis added).

45 *Doster Const. Co. v. Marathon Elec. Contractors, Inc.*, 32 So. 3d 1277, 1283 (Ala. 2009).

46 *McBro, Inc. v. M & M Glass Co.*, 611 So. 2d 283, 284 (Ala. 1992).

In *Montgomery v. JYD, International, Inc.*, JYD employee Lillian Farris was injured when she slipped and fell in the Montgomery Civic Center.[47] At the time of Farris's injury, JYD leased the "River Room" in the Montgomery Civic Center.[48] The facts surrounding her injury were as follows:

> On the day of the accident, Mrs. Farris entered the civic center, not from the two primary entrances, but from a service entrance at the rear of the civic center. She took a "short-cut" through the grand ballroom, and, as she crossed in front of the stage there, she slipped on an oily substance and fell, fracturing her arm.[49]

Montgomery cross-claimed against JYD, demanding indemnification pursuant to the terms of the indemnity clause.[50] JYD filed a motion for summary judgment as to Montgomery's third-party claims, which was granted.[51] Montgomery appealed.[52] The lease between Montgomery and JYD described "the premises leased [to JYD] as the 'River Room,' to be used for the purpose of rug sale," and it contained the following indemnity language:

> G. THE LESSEE HEREBY PROMISES AND AGREES:
>
> 7. To save the City of Montgomery and the Civic Center harmless and to indemnify them against any claims or liability arising or resulting from any injury to any visitor, spectator or participant in any activity in any part or portion of the Civic Center, regardless of entrance gained to said Civic Center -- by paid admissions, by pass issued by Lessee or Lessor or by any unlawful admission gained without knowledge of Lessor or Lessee.
>
> I. IT IS FURTHER MUTUALLY AGREED BY AND BETWEEN THE PARTIES HERETO:
>
> 3. That the Lessor shall not be responsible for any damages or injury that may happen to Lessee, or the Lessee's agents, servants, employees or property from any cause whatsoever, prior, during or subsequent to the period covered by this lease; and the said Lessee hereby expressly releases said Lessor from, and agrees to indemnify it against any and all claims for such loss, damage or injury.[53]

At issue on appeal was "whether JYD must indemnify [Montgomery] pursuant to the agreement for [Montgomery's] negligence in connection with an accident that took place not within the leased area."[54] A critical factor in the Alabama Supreme Court's analysis was whether, as a matter of public policy, such an agreement was enforceable "with respect to injuries that occur outside of the immediate area of the leased premises." The Alabama Supreme Court assumed, "without deciding, that the language employed unequivocally and unambiguously expressed the intent to indemnify Montgomery against its own negligence."[55] The court ultimately held that the agreement was void as against public policy:

> [T]he degree of control retained by the indemnitee over the activity or property giving rise to liability is a relevant consideration. This is true because the smaller the degree of control retained by the indemnitee, the more reasonable it is for the indemnitor, who has control, to bear the full burden of responsibility for injuries that occur in that area. However, the opposite is also true: The more control the indemnitee retains over the area, the less reasonable it is for the indemnitor to bear the responsibility for injuries that occur in that area. In this case, the mishap took place in an area not within the actual leased area and, for all that appears from the record, an area in which the lessee (the

47 534 So. 2d 592, 593 (Ala. 1988)
48 *Id.*
49 *Id.*
50 *Id.*
51 *Id.*
52 *Id.*
53 *Id.*
54 *Id.*
55 *Id.* at 595.

> indemnitor) had no right of control. To allow the indemnitee to transfer financial responsibility to the indemnitor under such circumstances would be totally at odds with the tort system's incentives to encourage safety measures. Any argument that the agreement simply shifts the burden to the indemnitor to take such measures is untenable if the indemnitor has no right to exercise control over the potentially hazardous area or activity. Taken to its extreme, the agreement in this case could cast upon the lessee the responsibility for accidents that occur due to defects in sidewalks or parking lots at the civic center. Arguably, the language in paragraph E is so broad as to encompass injuries resulting from Montgomery's failure to properly maintain the streets by which people traveled to the civic center.[56]

This case often serves as a benchmark in situations where a subcontractor was working in a relatively small work area on a large development and one of its employees was injured in an area outside the work area, not due to the subcontractor's negligence, in an area controlled by another party (such as the contractor) and arising from the other party's negligence.

Georgia

Generally, Georgia law allows a party to contract away liability to another party for consequences of its own negligence without contravening public policy except when such an agreement is prohibited by statute.[57] However, in the construction context, such an agreement is specifically prohibited by statute. O.C.G.A. § 13-8-2 provides in part:

> B. A covenant, promise, agreement, or understanding in or in connection with or collateral to a contract or agreement relative to the construction, alteration, repair, or maintenance of a building structure, appurtenances, and appliances, including moving, demolition, and excavating connected therewith, purporting to require that one party to such contract or agreement shall indemnify, hold harmless, insure, or defend the other party to the contract or other named indemnitee, including its, his, or her officers, agents, or employees, against liability or claims for damages, losses, or expenses, including attorney fees, arising out of bodily injury to persons, death, or damage to property caused by or resulting from the sole negligence of the indemnitee, or its, his, or her officers, agents, or employees, is against public policy and void and unenforceable. This subsection shall not affect any obligation under workers' compensation or coverage or insurance specifically relating to workers' compensation, nor shall this subsection apply to any requirement that one party to the contract purchase a project specific insurance policy, including an owner's or contractor's protective insurance, builder's risk insurance, installation coverage, project management protective liability insurance, an owner controlled insurance policy, or a contractor controlled insurance policy.[58]

"The apparent purpose of O.C.G.A. § 13-8-2(b) is to prevent a building contractor, subcontractor, or owner from contracting away liability for accidents caused solely by his negligence, whether during the construction of the building or after the structure is completed and occupied.... [I]t would seem that construction contracts were singled out because of the possibility of hidden, or latent, defects of an extremely dangerous nature and not ordinarily detectable by a lay person."[59]

The Supreme Court of Georgia has imposed even stricter requirements for indemnification/limitation of liability clauses in design and construction contracts. In *Lanier At McEver, L.P. v. Planners And Engineers Collaborative, Inc.*, Lanier, a construction developer, hired Planners, a civil engineering firm, to design the storm-water drainage system for an apartment complex.[60] In the contract, the parties agreed:

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56 *Id.* ("The indemnity agreement by which the indemnitee attempts to obtain indemnity for its own negligence, under these circumstances, is void as a matter of public policy.").

57 *See, e.g., Smith v. Seaboard Coast Line R. Co.*, 639 F 2d 1235, 1239 (5th Cir. 1981).

58 O.C.G.A. § 13-8-2 (2007).

59 *Federated Dep't Stores et al. v. Superior Drywall & Acoustical, Inc.*, 264 Ga. App. 857, 862, 592 S.E.2d 485 (2003) (citing *Borg-Warner Ins. Fin. Corp. v. Exec. Park Ventures*, 198 Ga. App. 70, 74, 400 S.E.2d 340 (1990)).

60 284 Ga. 204, 663 S.E.2d 240 (Ga. 2008).

> In recognition of the relative risks and benefits of the project both to [Lanier] and [Planners], the risks have been allocated such that [Lanier] agrees, to the fullest extent permitted by law, to limit the liability of [Planners] and its sub-consultants to [Lanier] and to all construction contractors and subcontractors on the project or any third parties for any and all claims, losses, costs, damages of any nature whatsoever[,] or claims expenses from any cause or causes, including attorneys' fees and costs and expert witness fees and costs, so that the total aggregate liability of [Planners] and its subconsultants to all those named shall not exceed [Planners'] total fee for services rendered on this project. It is intended that this limitation apply to any and all liability or cause of action however alleged or arising, unless otherwise prohibited by law.[61]

Following completion of the apartment complex and drainage system, Lanier discovered erosion, which an expert attributed to the negligent design of the drainage system.[62] Lanier repaired and sued Planners for negligent construction, breach of contractual warranty and litigation expenses.[63] During litigation, Planners filed a partial motion for summary judgment, arguing the parties' agreement applied and limited Planners' liability to its total fee for services.[64] The trial court granted Planners' motion and the court of appeals affirmed. Lanier filed a petition for certiorari to determine whether the construction contract violates Georgia's public policy under O.C.G.A. § 13-8-2(b).

The Georgia Supreme Court reversed the lower courts' decision because the clause violated public policy. The court reasoned that the contract violated public policy, as prohibited by O.C.G.A. § 13-8-2(b), particularly regarding claims for which Planners may be solely negligent for injuries to a third party. For instance, the clause applies to "any and all claims" by third parties and, in essence, shifts all liability above Planners' fees for services to the developer, Lanier, no matter who was at fault.[65] In other words, while the clause does not prevent a third party from suing Planners, the clause permits all liability above its fees for services to be shifted to Lanier — even for damages arising from Planners' sole negligence.[66]

The *Lanier* Court indicated that the limitation of liability clause might have been valid had it restricted damages to only those between the contracting parties, opining that removal of third party language may remove the problem all together.[67] Moreover, parties may avoid violating O.C.G.A. § 13-8-2 if the agreement includes an insurance clause, which shifts the risk of loss to an insurer no matter who is at fault.[68]

In *Federated Department Stores v. Superior Drywall and Acoustical, Inc.*, the Georgia Court of Appeals held that, absent an insurance clause showing the parties' mutual intent for the subcontractor's insurance to supply coverage for loss or damages incurred by both parties, the indemnity clause at issue in that case was void and unenforceable pursuant to O.C.G.A. § 13-8-2(b).[69] That indemnity clause provided that the subcontractor must indemnify the contractor and owner for "all damage or injury of any kind . . . 'resulting from' or 'arising out of' the Work. Injuries or damages that may arise out of the sole negligence of the contractor or owner that were included in the definition of the 'Work' would be included in the blanket and general indemnity clause in the Contract."[70]

The requirement that insurance be purchased was not automatically a cure-all for the dangers proscribed by the enactment of O.C.G.A. § 13-8-2.[71] The subcontractor purchased CGL insurance to cover only its own negligence and the insurance satisfied the owner before the work began.[72] Thus, the owner could not credibly assert that the intent of the parties was for the insurance to cover the negligent acts of the owner or contractor. An indemnity clause within the terms

61 *Id.* at 241-42.
62 *Id.*
63 *Id.*
64 Lanier spent approximately $250,000 in repairs to the system and expected to spend $500,000 in total. Planner's total fee for services was approximately $80,000.
65 *Lanier at McEver,* 663 S.E.2d at 243.
66 *Id.*
67 *See id.* at 243-44 (citing *1800 Ocotillo, LLC v. WLB Group, Inc.*, 217 Ariz. 465, 176 P 3d 33 (2008)) (limitation of liability clause did not reference third party claims or allow for reimbursement by developer for third-party negligence claims for which the subcontractor was solely liable).
68 *Lanier at McEver,* 663 S.E.2d 240 (citing *ESI, Inc. of Tn. v. Westpoint Stevens, Inc.*, 254 Ga. App. 332, 562 S.E.2d 198 (2002)).
69 264 Ga. App. 857, 592 S.E.2d 485 (2003).
70 *Id.* at 860-61.
71 *Id.*
72 *Id.*

of a contract must "unequivocally express the intent of the parties to shift the risk of loss and look solely to an insurance policy obtained in order to cover loss or damages incurred by both parties . . . the type of insurance and the intent of the parties in mandating the purchase of insurance must play a part in the analysis."[73]

Moreover, simply naming one party to an insurance policy as an additional insured does not create an independent basis that would require the named insured to defend and indemnify the additional insured for the additional insured's own negligence or gross negligence.[74] The court will look to the policy itself, along with the applicable endorsements, to determine the obligation of the insurer (by virtue of its contract with the insured).

Thus, it appears that the only way an indemnification clause may be upheld in a construction defect claim is if the clause is specific in its application only to claims between the contracting parties or shifts liability only as a result of partial fault of the contracting party (and not its sole liability), or shifts the responsibility to an insurance carrier or carriers (waiver of subrogation clause). Therefore, upon receipt of a construction defect claim, the insurer should obtain a copy of all contracts between its insured and other parties. If the contract contains an indemnification clause, the insurer should analyze its validity. If the clause does not attempt to shift the insured's sole negligence or liability to the other party, then the carrier should tender a defense and indemnification to the other party. As long as the indemnification clause is valid, and as long as the other party is at least one percent negligent (i.e., the insured is not solely negligent), then many indemnification clauses will require the other party to provide the insured with 100 percent of the defense and indemnification.

Once the indemnification clause is found to be valid and enforceable, the court of appeals has shown a similar propensity to uphold the language as it has done with respect to additional insured language. For example, in *JNJ Foundation Specialists, Inc. v. D.R. Horton, Inc.*, the indemnification clause in the contract between D.R. Horton and JNJ provided that JNJ had a duty to defend and indemnify D.R. Horton for any claims "in any way occurring, incident to, arising out of or in connection with . . . the work performed or to be performed by contractor [JNJ] or contractor's personnel, agents, suppliers or permitted subcontractors."[75] In upholding and enforcing this language, the court of appeals undertook the same analysis as it did in finding additional insured coverage under *BBL-McCarthy*:

> Under Georgia law pertaining to indemnity provisions, "arising out of [means] 'had its origins in,' 'grew out of,' or 'followed from.'" Importantly, the term "arising out of" does not mean proximate cause in the strict legal sense, nor [does it] require a finding that the injury was directly and proximately caused by the insured's actions. Almost any causal connection or relationship will do.[76]

POINTERS AND TAKEAWAYS

Alabama and Georgia courts continue to broadly interpret the "arising out of" or "resulting from" language in additional insured clauses, which should provide a caveat to insurers who refuse to defend a purported additional insured entity without first examining the contractual relationship between that entity and the named insured. The expansive application of these terms may broaden the policy coverage applicable to the insured on another contracting party's policy, or vice versa, may broaden the availability of coverage to an additional insured under the insured's policy. Based on the recent case law, no more than a slight causal connection between the injuries alleged and the contractual scope of work is required to find additional insured coverage. Only where no relationship whatsoever exists between the scope of the work and the alleged injuries can an insurer have any confidence that no additional insured coverage exists. As a result of this application, many insurers now include special additional insured endorsements to restrict the circumstances under which additional insured coverage will be triggered. Those endorsements specifically state that an entity qualifies as an additional insured only for damages or injury in which the named insured is found at fault or negligent.

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73 *Id.* 861-62.
74 *See Serv. Merch. Co. v. Hunter Fan Co.*, 274 Ga. App. 290, 297, 617 S.E.2d 235 (2005).
75 311 Ga. App. 269, 717 S.E.2d 219 (2011).
76 *Id.* at 270, 717 S.E.2d at 222.

Whether an indemnity agreement applies depends on the contract language, the facts surrounding the claim and the applicable law. Refusing to defend and/or indemnify an insured based on contractual liability shifting provisions is a risky proposition if the contract is drafted incorrectly. Determining whether other entities may owe indemnification at an early stage is critical to ensure timely notice may be provided to those parties' insurers. Moreover, in construction defect claims involving latent defects, all policies in effect from the date of the alleged improper construction and the date of discovery of the defects may be triggered.

So what should you do? Taking the application of the law to these clauses and policy language, an insurer's main questions when looking to applicable contracts, an insurer's own policy, and those of others, are as follows: (1) does the contract specify insurance to be procured; (2) how expansive is the language in the insured's own policy; (3) how expansive is the language in the endorsements purporting to include the insured as an additional insured on other contracting parties policies; (4) what is the damage asserted; (5) who does the complaint assert caused the damage; and (6) what is the date of construction and the date of discovery of a latent defect? If another policy is arguably applicable to the loss, whether through contract or insurance policy language, the insured should give notice of the claim or suit as soon as practicable and tender its defense for same. The same applies to any tender of a defense and indemnification to the indemnitee under a construction contract.

Trolling for Coverage: Insurable Interest is Key

By Steven DeFrank and Gillian Crowl

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After graduation, Ms. Crowl worked for a boutique civil litigation firm in Dayton, Ohio. She then spent five years in a Charlotte, North Carolina firm, where her practice was focused on insurance coverage, healthcare, ERISA, transportation and general personal injury defense. She is admitted to practice in Georgia and North Carolina and has represented clients in matters before state and federal courts.

Trolling for Coverage: Insurable Interest is Key

WHAT IS AN INSURABLE INTEREST?

An "insurable interest" is "a legal interest in . . . the protection of property from injury, loss, destruction, or pecuniary damage."[1] Absent an insurable interest in the insured property, a person cannot enforce an insurance policy covering that property.[2] Georgia statute defines an insurable interest as follows:

> Insurable interest – Property insurance
>
> A. As used in this Code section, "insurable interest" means any actual, lawful, and substantial economic interest in the safety or preservation of the subject of the insurance free from loss, destruction, or pecuniary damage or impairment.
>
> B. No insurance contract on property or of any interest therein or arising therefrom shall be enforceable except for the benefit of persons having, at the time of the loss, an insurable interest in the things insured.
>
> C. The measure of an insurable interest in property is the extent to which the insured might be damnified by loss, injury, or impairment of such interest in such property.[3]

A person has an insurable interest when they have "such a right, title, or interest therein, or relation thereto, that he will be benefited by [the property's] preservation and continued existence, or suffer a direct pecuniary loss from its destruction or injury."[4] "The insured must have some *lawful* interest in property before he can have an insurable interest in the property, although that interest may be slight or contingent, legal or equitable."[5] However, mere ownership or title is not the only conclusive factor in determining whether a person has an interest in property.[6] Rather, Georgia courts have generally found that "[i]f the holder of an interest in property will suffer loss by its destruction, he may indemnify himself therefrom by a contract of insurance."[7]

HOW DO YOU DETERMINE IF SOMEONE HAS A LAWFUL INTEREST?

Since title is not conclusive, Georgia courts look at the insured's relationship with the property to determine whether and to what extent a person has an insurable interest in the preservation of property. Key issues in determining whether a person has an insurable interest include:

1. Current interest in the property.

The insured must have a current interest in the property at the time of the loss. A party who divests his interest in property no longer has an insurable interest on the property.[8] "Either transfer of title to property or transfer of the policy of insurance without the consent of the insurer voids the policy."[9]

2. Financial obligations related to the property.

If the insured has a financial obligation for the property, he has an insurable interest, even if he no longer owns or possesses the property. In *Brown v. Ohio Casualty Insurance Co.*, the Georgia Court of Appeals held that an insured who executed a quitclaim deed in connection with a separation agreement with his estranged wife still had an insurable interest in the marital home.[10] As a part of the separation agreement, the insured's wife agreed to assume all indebtedness for the home.[11] However,

1 *Conex Freight Systems, Inc. v. Georgia Ins. Insolvency Pool*, 254 Ga. App. 92, 96, 561 S.E.2d 221, 224 (2002).
2 *See Ga. Farm Bur. Mut. Ins. Co. v. Smith,* 179 Ga. App. 399, 400, 346 S.E.2d 848, 849 (1986).
3 O.C.G.A. § 33-24-4.
4 *Conex Freight Systems*, 254 Ga. App. at 97, 561 S.E.2d at 225.
5 *Id.*
6 *Id.*
7 *Pike v. Am. Alliance Ins. Co.*, 160 Ga. 755, 761, 129 S.E. 53, 56 (1925).
8 *Curtis v. Girard Fire & Marine Ins. Co.*, 190 Ga. 854, 856-857, 11 S.E.2d 3, 5 (1940).
9 *Langley v. Pacific Indem. Co.*, 135 Ga. App. 29, 31, 217 S.E.2d 369, 371 (1975).
10 *Brown v. Ohio Cas. Ins. Co.*, 239 Ga. App. 251, 251, 519 S.E.2d 726, 727 (1999).
11 *Id.*

the insured remained a signatory on the loan for the home.[12] As a result, the court held, that "[d]espite relinquishing title to the property, . . . [the insured] retained an insurable interest in the property. At the time of the loss, . . . [the insured], a grantee on the warranty deed, was liable under the mortgage assumption agreement and the security deed. Consequently, he had an insurable interest in the property as of the date of the loss."[13]

3. Investments in the property.

If the insured neither owns a property, bears no financial costs related to the property and makes no investments into the property, then he does not have an insurable interest in the property. In *Baumgartner v. State Farm Fire & Casualty Co.*, the plaintiff sought recovery for wind and hail loss in a breach of contract and bad faith action against the insurer.[14] During the litigation, it was discovered that the property was owned by a trust and not the insured.[15] The insured made no mortgage or rental payments to the trust and the trust handled all repairs on the property.[16] The insurer moved for summary judgment on the grounds the insured did not have an insurable interest in the property. The United States District Court for the Northern District of Georgia held as follows:

> All of [the] rights and obligations [for the property] lie instead in the Trust. [The plaintiff's] sole right to the Property, conferred by the Trust, is the right of possession. So while she may have an equitable interest in maintaining possession of the Property, her equitable interest extends no further. And here, [the plaintiff] is attempting to enforce the Policy to recover for alleged damage to the Property's physical structure. Had [the plaintiff] suffered loss of possession of the Property, she may have some form of claim under the Policy to compensate her for that loss. Such a claim could not, however, be for compensation of the loss to the Property's physical structure. Because her equitable interest does not extend to the Property's physical structure, any insurable interest she may have in the Property cannot either. And without an insurable interest, [the plaintiff] cannot enforce the Policy.[17]

4. Legal and authorized possession or ownership.

The legality of the ownership and/or possession of the property is of paramount importance. If the insured does not have legal ownership or possession of the property or has not obtained possession of the property in a lawful matter, he does not have an insurable interest in the property.

In the case of rental property, if the insured/lessor is not authorized to lease the property, he does not have an insurable interest. In *Splish Splash Waterslides, Inc. v. Cherokee Insurance Co.*, the Georgia Court of Appeals held the renter of the unit via an improper assignment did not have an insurable interest in the property.[18] The property was leased by Fostin Securities, Inc. to L. W. Cleveland Company, and L. W. Cleveland Company then leased the property to Lonnie E. Watson.[19] On the day Watson's lease with Cleveland was executed, Watson assigned all of his interest in the lease to Splish Splash.[20] Splish Splash obtained a policy of insurance covering the property.[21] The building was then destroyed by fire.[22] The Cleveland-Watson lease contained no clause permitting Watson to transfer or assign his interest. Cleveland was unaware of the assignment to Splish Splash, and Cleveland did not acquiesce in the assignment.[23]

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12 *Id.*

13 *Id.* at 253-54, 728. *See Cherokee Ins. Co. v. Gravitt*, 187 Ga. App. 179, 184, 369 S.E.2d 779, 783 (1988) (holding the vendor had a "substantial economic interest in the safety or preservation of the insured property," as he remained liable on his promissory note to the bank, and he and the buyer both had a "slight or contingent, legal or equitable" interest in the insured property which would have been enforceable either in law or equity had the fire not occurred and the debts paid); *Farmers Mut. Fire Ins. Co. v. Pollock*, 52 Ga. App. 603, 607, 184 S.E. 383, 386 (1936) ("A mortgagee or one succeeding to the interest or rights of a mortgagee in the mortgaged property has an insurable interest therein.").

14 *Baumgartner v. State Farm Fire & Cas. Co.*, 2017 U.S. Dist. LEXIS 40136, *1, 2017 WL 1062370 (N.D. Ga. Mar. 21, 2017).

15 *Id.* at *2-3.

16 *Id.*

17 *Id.* at *10.

18 *Splish Splash Waterslides, Inc. v. Cherokee Ins. Co.*, 167 Ga. App. 589, 591, 307 S.E.2d 107, 110 (1983).

19 *Id.* at 589, 108.

20 *Id.*

21 *Id.*

22 *Id.*

23 *Id.* at 589-90, 108.

Accordingly, the court held:

> Without a valid assignment, [Splish Splash] 'would be a mere intruder subject to be summarily ousted by the landlord.' . . . As such, [Splish Splash]'s legal status vis-a-vis this putatively insured property would be similar to that of a possessor of stolen property, . . . and would be clearly distinguishable from that of a person without title possessing property under a legal right . . . . [W]e hold that a mere intruder or trespasser on the land of another has no insurable interest in that real estate or the buildings thereon . . . . Consequently, [Splish Splash] can claim no insurable interest in the realty buildings involved in this case unless Watson's lease was effectively assigned.[24]

Similarly, in *Gordon v. Gulf American Fire & Casualty Co.*, the Georgia Court of Appeals held that an insured did not have an insurable interest in stolen property that was later purchased by the insured, even though the insured was a bona fide purchaser of the property.[25] The Georgia Court of Appeals held that "mere possession of property, although giving the possessor certain rights against a trespasser, is in and of itself not sufficient to constitute an insurable interest [and w]hile title may not always be the determinative factor, . . . the insured must have some lawful interest in property before he can have an insurable interest in the property."[26]

Therefore, when evaluating whether an insured has an insurable interest in the property, the analysis cannot end with the issues of ownership or possession. Rather, the analysis must also address issues related to the insured's relationship with the property, i.e., the nature of the insured's interest in the property, how the insured came to own or possess the property and what contribution, if any, does the insured make to the property.

HOW TO DEAL WITH MULTIPLE OWNERS WITH VARIOUS INTERESTS IN THE PROPERTY

Once an insurable interest is shown to exist, it is the policy at issue that determines the amount the insured is entitled to recover.[27] Georgia courts also look to external documents to determine the extent of an insured's interest, such as deeds, divorce decrees and mortgages, to determine the extent of the insured's insurable interest. In *Huckaby v. Georgia Farm Bureau Mutual Insurance Co.*, the Georgia Court of Appeals found that although the insured had an insurable interest because of indebtedness on the property, he did not have a right to recover because he had received full payment under the security deed as those payments became due and no longer had any obligation under the note.[28] Accordingly, the insured had not suffered a loss.[29]

Recently, in *Georgia Farm Buraeu Mutual Insurance Co. v. Franks*, the Georgia Court of Appeals addressed and clarified the amount of insured interest when there is an undivided interest in the property. The court found that as joint tenants, the homeowner and his partner shared "one and the same interest, accruing by one and the same conveyance, commencing at one and the same time, and held by one and the same undivided possession." The court reasoned that, "although ownership is shared, the title and interest are not divided into fractional shares" and the homeowners' interests in the insured property were undivided.[30] As such, the insured's interest in the property was 100 percent.[31] In reaching this conclusion, the court noted it disapproved of a formula applied in prior cases related to joint tenancy, wherein the prior court found that "the insured is entitled to recover one-half of the difference of the policy limits less 'expenses,' in that case, the outstanding debt secured by the property."[32]

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24 *Id.* at 591-92, 110.
25 *Gordon v. Gulf Am. Fire & Cas. Co.*, 113 Ga. App. 755, 757, 149 S.E.2d 725, 727 (1966).
26 *Splish Splash*, 167 Ga. App. at 591, 307 S.E.2d at 109.
27 *Ga. Farm Bur. Mut. Ins. Co. v. Franks*, 320 Ga. App. 131, 135, 739 S.E.2d 427, 431 (2013).
28 *Huckaby v. Ga. Farm Bur. Mut. Ins. Co.*, 140 Ga. App. 493, 493-94, 231 S.E.2d 378, 379 (1976).
29 *Id.*
30 *Ga. Farm Bur. Mut. Ins. Co. v. Franks*, 320 Ga. App. at 432.
31 *Id.*
32 *Id.* at 433 (citing *Allstate Ins. Co. v. Thompson*, 164 Ga. App. 508, 510, 297 S.E.2d 520, 522 (1982)); *Allstate Ins. Co. v. Ammons*, 163 Ga. App. 385, 386, 294 S.E.2d 610, 611 (1982) ("*Ammons II*"); *Allstate Ins. Co. v. Ammons*, 160 Ga. App. 257, 259, 286 S.E.2d 765, 767 (1981) ("*Ammons I*").

FINAL NOTE

It is important to note the distinction between an insurable interest in damage to property versus an insurable interest due to liability related to property. Georgia courts have held that a person can have an insurable interest in property for a liability policy based on the potential liability exposure stemming from said property even if they have no ownership interest in the property.

In *Stephens v. Conyers Apostolic Church*, the Georgia Court of Appeals determined a church minister could insure, in his name, a vehicle titled in the church's name because the minister had "primary custody of the vehicle . . . [and] . . . had a sufficient insurable interest in the vehicle through his potential legal liability to authorize his decision to insure the vehicle under his personal liability policy, notwithstanding his lack of ownership."[33] In *Auto-Owners Insurance. Co. v. Smith*, the Georgia Court of Appeals held a father had an insurable interest in his teenage son's vehicle — despite the fact the vehicle was driven by his son, titled in his son's name and purchased with the son's own money — because the father may have had an interest in protecting himself from liability if his son was involved in an accident.[34]

This premise also permits a motor carrier to insure cargo despite its lack of ownership in the property.[35] In *Certain Underwriters at Lloyds, London v. DTI Logistics, Inc.*, the Georgia Court of Appeals held that "'[t]he Carmack Amendment to the Interstate Commerce Act makes common carriers liable for actual loss of or damage to shipments in interstate commerce . . . . As a result of this liability, carriers have an insurable interest in the cargo . . . .'"[36]

[33] *Stephens v. Conyers Apostolic Church*, 243 Ga. App. 170, 172, 532 S.E.2d 728, 731 (2000).
[34] *Auto-Owners Ins. Co. v. Smith*, 178 Ga. App. 420, 421, 343 S.E.2d 129, 130 (1986).
[35] *Certain Underwriters at Lloyds, London v. DTI Logistics, Inc.*, 300 Ga. App. 715, 717, 686 S.E.2d 333, 335-36 (2009).
[36] *Id.*

Death — There's No App for That Either

By Thomas D. Martin

Thomas D. Martin

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Death — There's No App for That Either

Smart phones and the "apps" they use provide us with instant access to information, people and resources. They also can be the bane of our existence — a daily reminder of all the things we are not getting done. Mostly, however, smart phones are one tool among many these days designed to facilitate our productivity, our efficiency and our access to one another, raising expectations of instant connectivity and immediate gratification. Increasingly, the phrase "there's an app for that" becomes an expectation for addressing virtually every problem.

However, some issues require a bit of old school patience and analysis. This is particularly true when dealing with property insurance claims that involve the death of the insured property owner or the death of a named insured. From a claims standpoint, the death of a property owner or of an insured can introduce a myriad of complications to the normal claims investigation that, if overlooked, can result in overpayments, underpayments or even voluntary payments. These complications often occur because many policyholders, property owners and heirs often try to do their own estate planning through creative deed conveyances and verbal agreements. Claims personnel, overwhelmed these days by too many claims and not enough time to investigate them all, sometimes may be tempted to make snap judgments or assumptions about the interests in the property or who is entitled to payment. The consequences can be disastrous. The following illustrates some of the common complications surrounding death in the claims process.

HIGDON V. FARM BUREAU

Most policies address the death of a named insured. The "Death" provisions of many policies generally provide that, if a named insured dies, then the company will insure any person "having temporary custody" of the insured property, "but only until appointment of a legal representative." After that, the company will insure the legal representative. One might note that these provisions seem to emphasize the personal nature of insurance. They may or may not insure certain property at a particular location, depending upon the policy limits, exclusions and conditions but, at the end of the day, the policies follow people, not necessarily property. Thus, the death provisions authorize others to become insureds under the policy following the death of the named insured but only those with temporary custody or qualified as a legal representative.

The importance of this personal nature is best illustrated by one of the few cases in Georgia dealing with the death of a named insured. The case is *Higdon v. Georgia Farm Bureau Insurance Co.,*[1] and it addresses situations involving a pre-loss death of an insured. In *Higdon*, the court addressed the issue of whether three sons could sue under their deceased father's homeowner's policy where the father died with a will just four months before the date of loss.

The father died on August 8, 1989, naming one son as executor and leaving the estate equally to his three sons. Instead of probating the will, the sons agreed to distribute the estate equally. Part of this agreement included the proceeds from the sale of a house that was insured by Farm Bureau under a policy issued to the father. According to the sons' agreement, one of the three was to move into the house, renovate it and then sell it. The other two sons conveyed their interest to the son living in the house on October 11, 1989. The deed was recorded. The son then moved in without having the Farm Bureau policy assigned to him or without having the policy reissued in his name.

In his deposition, the son who occupied the house testified that he called a Farm Bureau agent and informed her that he was in the process of going to the bank to borrow money to remodel the house before selling it. The son did not inform the agent that he had title to the property. The insurance agent informed him that if he decided to keep the house or if the insurance ran out, she would be glad to help him in any way she could with respect to the insurance on the house. The agent denied any such conversation.

The house was destroyed by fire on December 23, 1989. Farm Bureau denied the claim, alleging that none of the three qualified for coverage under the policy. None was a "temporary" custodian and none was a legal representative of the father's estate. All three sons sued to collect on the policy, claiming that the term "legal representative" did not require a judicial appointment and "could well mean legal heirs who have taken over custody of" the property while a policy was in effect. The court, however, rejected the plaintiffs' arguments.

[1] 204 Ga. App. 192, 419 S.E.2d 80 (1992).

First, although one of the sons had been living with his father and was therefore insured at the time of his father's death pursuant to the terms of the contract, his status as an insured terminated when he moved out of the house. According to the court, when the insured died, another could become an insured under the policy only if that person was in proper, temporary custody of the property until appointment and qualification of a legal representative.[2] In *Higdon*, however, title to the property had been transferred, placing the property in the "permanent custody" of the son living in the house.[3]

Furthermore, the court found that even if a telephone conversation occurred between the agent and the son, the conversation would not impute coverage, because the son failed to tell the agent that title to the house had been conveyed. Instead, the conversation indicated that the son was living in the house merely on a temporary basis. Such a temporary interest would be covered under the terms and conditions of the policy.

Finally, the court concluded that the son could not be an insured because he never obtained written consent to have the policy issued to him. As the court explained, a person other than the person to whom a policy of insurance is issued cannot, in his own name, maintain an action unless the policy has been duly assigned to him in writing.[4] According to the court, the insured could unilaterally substitute another party to become an insured without the insurer's consent. Insurance policies are personal contracts. The insurer is selective of those risks, which revolve around the character, integrity and personal characteristics of those whom they will insure.[5]

In other words, *Higdon* concluded that when title vested permanently in one of the three sons of the decedent, none could qualify as an insured under the terms of the policy absent a valid assignment from the insurance company. Thus, the court found in favor of Farm Bureau on all of the theories espoused by the sons. The court acknowledged that its approach might be somewhat harsh, but noted it was bound to be just before it was generous, holding that [the] " . . . courts have no more right by strained construction to make the policy more beneficial by extending the coverage contracted for than they would have to increase the amount of insurance."[6]

There are no Georgia cases directly addressing what happens if the loss occurs after the insured's death but before permanent ownership or title has passed to the heirs. In *Higdon*, title vested before the date of loss. Therefore, none of the heirs qualified as an insured under the death provisions of the Farm Bureau policy. Other jurisdictions have examined the effect of this language following the death of an insured but before final disposition of the property. In *Gray v. Holyoke Mutual Farm Insurance Co.*,[7] the Alabama Supreme Court held that an insurance policy on a building is a chose in action and is personal property that passes to the personal representative of the insured. The Kentucky Supreme Court also reached the same conclusion. In *Oldham's Trustee v. Boston Insurance Co.*,[8] the court held that the personal representative is the proper person to sue for proceeds regardless of who may be entitled to the property after collection. Therefore, in some jurisdictions, it would appear that insurance remains with the person having proper legal custody of the property until appointment of a legal representative, and then to the legal representative. Coverage ends, however, when the property is finally transferred to the heirs or legatees.

STATUTORY PROVISIONS

The issue addressed by the court in *Higdon* was the effect of the permanent transfer of title to the named insured's son, indicating that, when considering a claim involving the pre-loss death of an insured, coverage will extend to temporary custodians and legal representatives pending permanent resolution of the estate. Notably, however, the court in *Higdon* did not examine several statutes in Georgia that govern the administration of wills, trusts and estates under Title 53 of the Official Code of Georgia. By statute, with or without a will, title to property vests instantly upon death.

2 *Id.* at 195.
3 *Id.*
4 *Id.* at 194.
5 *Id.*
6 *Id.* (citing *Republic Ins. Co. v. Chapman*, 146 Ga. App. 719, 247 S.E.2d 156 (1978)).
7 293 Ala. 291, 302 S.2d 104 (1974).
8 189 Ky. 844, 226 S.W.106 (1920).

Under O.C.G.A. § 53-2-7, which governs property of a decedent without a will, title to real property vests instantly in the heirs and title to all other property vests instantly in the administrator.

A. Upon the death of an intestate decedent who is the owner of any interest in real property, the title to any such interest which survives the intestate decedent shall vest immediately in the decedent's heirs at law, subject to divestment by the appointment of an administrator of the estate.

B. The title to all other property owned by an intestate decedent shall vest in the administrator of the estate for the benefit of the decedent's heirs and creditors.

Similarly, where a will is involved, O.C.G.A. § 53-4-2 provides that a "will shall take effect instantly upon the death of the testator," however long the probate may be postponed. However, probating the will is necessary to fix the rights in property retrospectively based upon the applicable law and factual circumstances existing at the time of the testator's death.[9] It is therefore necessary to probate a will before the will can be recognized as an instrument affecting rights in property.

While the will is awaiting the probate process, title rests with the legal representative of the estate.[10] O.C.G.A. § 53-8-15(a) states that title to all property of the estate rests with the personal representative of the estate for purposes of paying debts and other purposes of administration. Actual title " . . . does not pass to the heirs or beneficiaries until the personal representative assents thereto in evidence of the distribution of the property to them, except as otherwise provided in Code Section 53-2-7."[11] Such assent may be express or presumed from the conduct of the personal representative.[12] Absent assent, the discharge of the estate representative shall be conclusive evidence of assent.[13]

Though not specifically relying upon these provisions, the court in *Higdon* acknowledged these principles, noting "it is well settled that agreements among the heirs at law to distribute or divide property devised under a will, in lieu of that manner provided by the will, are valid and enforceable."[14] Thus, title would relate back to the death of the testator once the actual title transferred to the heir. Title could be transferred by the completion of the probate proceedings or by agreement of the parties.

DEATH OF THE NAMED INSURED

So why does this matter? There are numerous policy provisions that can be affected by the death of a named insured. They include owner-occupancy, residency, vacancy, insurable interests and payment, to name but a few. Below are some examples of how the death of an insured can affect the application of these provisions.

Residency and Covered Property

Consider a recent example where an insured died several years before the loss. By the time of her death, title already passed to the insured's heirs. By the time of the loss, the insured was still named in the policy, though only one of her heirs was living in the insured home, dutifully paying the premiums when they came due. The sole occupant in the home was but one of four heirs that shared in the ownership of the home. The insured's estate was never probated. Title passed by deed from the insured (before her death) to one child. After her mother's death, the one heir deeded partial interests to her siblings, all before the loss occurred. The sole occupant in the home at the time of the loss never resided with the named insured but instead assumed occupancy following her mother's death.

Under these circumstances, the home and the personal property may no longer qualify as covered property. Many homeowner policies only cover the home if the home qualifies as the residence premises. "Residence premises" is frequently defined as the home identified in the policy declarations " . . . where you reside" (where "you" is defined as the named

9 *See Oliver v. Irvin*, 219 Ga. 647, 135 S.E.2d 376 (1984); *Williams v. Williams*, 236 Ga. 133, 223 S.E.2d 109 (1976); *Woodall v. Pharr*, 119 Ga. App. 692, 168 S.E.2d 645 (1969), *aff'd*, 226 Ga. 1 (1970).

10 O.C.G.A. § 53-8-15.

11 O.C.G.A. § 53-8-15(a).

12 O.C.G.A. § 53-8-15(b).

13 O.C.G.A. § 53-8-15(c).

14 *Higdon* v. *Ga. Farm Bureau Ins. Co.*, 204 Ga. App. 192, 193, 419 S.E.2d 80 (1992) (quoting *McGhee v. Craig*, 230 Ga. 553, 198 S.E.2d 165 (1973)).

insured or spouse). Since the insured died many years before the loss, the home may no longer qualify as covered property under the policy. Several courts in Georgia have upheld residency of the named in insured as a property and reasonable condition of coverage.[15] Other Georgia cases address policies similar to the one in *DeMoonie* but where residence premises is defined as the family dwelling where "you" or "the insured" resides.[16] In our example, since the insured died and the occupant never resided with her mother, the home would no longer qualify as covered property.

With respect to personal property, many policies define covered property as property owned or used by "you" (again referring to the named insured or spouse) or an "insured" (meaning a relative residing with the named insured). In our example, the insured died long before the loss, and none of the family members resided with her before her death. Moreover, title to the insured's personal property passed to the other family members long before the date of the loss and much of it was moved out, being replaced by items owned and used exclusively by someone who was not named in the policy and did not qualify as an insured by definition. Thus, at the time of the loss, much of the property in the home did not qualify as covered property and probably was not the named insured's personal property.

Payment

In our example, the named insured cannot endorse a payment check, since she passed away long before the loss occurred. No "estate" was set up so there is no legal representative of the named insured to endorse a payment check. Even if other interests in the home could be identified, none of the persons with a potential interest in the insured property (real or personal) qualified as an insured by definition. None qualified as a potential payee under the policy terms. Many policies contain a "loss payment" provision that would require the insurer to pay only the named insured " . . . unless someone else is legally entitled to receive payment." As was noted by the court in *Higdon*, however, nothing in the law qualifies as person with title or an interest in the property as " . . . legally entitled to receive payment" where that person was not named in the policy and did not otherwise qualify as an insured.

Insurable Interest

Insurable interest arguably is one of the most important conditions in a policy of insurance. Often, the insurable interest condition appears as the first condition listed under a policy's general conditions. It is so important that the requirement is codified under Georgia law. O.C.G.A. § 33-24-4(b) requires that an insured have an insurable interest in covered property in order to enforce a contract of insurance. Insurable interest, by definition, means "any actual, lawful and substantial economic interest in the safety or preservation of the subject of the insurance from loss, destruction, or pecuniary damage or impairment."[17] The test of insurable interest is "whether the insured has such a right, title or interest therein, or relation thereto, that he will be benefited by its preservation and continued existence, or suffer a direct pecuniary loss from its destruction or injury by the peril insured against."[18]

In other words, a party has an insurable interest in property when the party has a financial interest in the property — when the party will be financially injured if the property is damaged or destroyed. Insurable interest and financial interest are "two sides of the same coin." This principle is not only recognized under Georgia law, but is also a time-honored principle of insurance. For example, the textbook for property loss adjusting in the Associate In Claims designation (AIC 35), provides as follows:

> An insurable interest exists when the insured derives a monetary benefit or advantage by the preservation and continued existence of property or would suffer a monetary loss from its destruction. In other words, if a person will be financially harmed if a piece of property is damaged or destroyed, that person has an insurable interest in that property.[19]

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15 *See Grange Mut. Cas. Co. v. DeMoonie*, 227 Ga. App. 812, 490 S.E.2d 451(1997); *Epps v. Nicholson*, 187 Ga. App. 246, 370 S.E.2d 13 (1988).

16 *See Hill v. Nationwide Mut. Fire Ins. Co.*, 214 Ga. App. 715, 448 S.E.2d 747 (1994); *Ga. Farm Bur. Ins. Co. v. Kephart*, 211 Ga. App. 423, 439 S.E.2d 682 (1993).

17 O.C.G.A. § 33-24-4(a). *See Splish-Splash Waterslides v. Cherokee Ins. Co.*, 167 Ga. App. 589, 307 S.E.2d 107 (1983).

18 *Splish-Splash,* 167 Ga. App. at 591.

19 James J. Markham, *Property Loss Adjusting*, Ch. 1 *in* 1 Persons and Property Insured (2d 1995).

At least two significant purposes are served by this connection between financial interest and insurable interest. First, the proper people are indemnified for the proper amount. In other words, the insured is restored to her pre-loss financial condition. Second, the insurable interest requirement prevents people from wagering on losses: those who have an interest can recover no more than the value of their interest and those without an interest cannot recover at all.[20]

These principles are mirrored in many insurance policies. Thus, policies of insurance generally provide that even if more than one person has an insurable interest in the covered property, the insurer shall not be liable to the insured for an amount greater than that insured's interest.

Returning to our example, even if the occupant of the home (one of four heirs of the insured's property) was deemed an insured, she would only be able to recover to the extent of her interest: she would be entitled to receive only 25 percent of the value of the property (her one-quarter share of the insured's property).

Moreover, altering the policy may still be necessary in order to change the named insured from the decedent to the decedent's daughter so as to permit payment and negotiation of any payment checks. Generally speaking, the law permits such changes to the policy through the process of reformation. Reformation can occur where the parties agree to reform a contract or where there is a mutual mistake as to the contract terms.[21] The purpose of reformation is to "'do equity' among the interested parties by changing completed transactions to reflect true intentions."[22] In this connection, however, it should be noted that in our example, there was not any mutual mistake in the formation of the policy. At the time it was formed, the named insured was alive, possessed an interest in the property and intended that only she would be the named insured. The insurer intended the same. There was no mutual mistake. The "mistake," if any, arose later on, when the policy was renewed following the insured's death.

Vacancy

Some homeowner policies exclude vandalism or malicious mischief (v/mm) if the "residence premises" have been vacant or unoccupied for more than 30 or 60 consecutive days immediately before a loss. The use of the phrase "residence premises" in this context again connotes owner-occupancy by the person named in the policy. Once again, the policy emphasizes the personal nature of the insurance, removing from coverage the risk of loss due to crimes against the property if the policy becomes vacant or if the property is no longer owner-occupied by the named insured.

Moreover, just as the vacancy provision removes coverage for property crimes (v/mm and breakage of glass) during extended periods of owner absence, other provisions require monitoring and care for the home by the named insured. These other provisions can require timeliness in discovering, reporting and presenting a claim; the need for vigilance in protecting the property from loss; and the need to maintain the property to avoid a loss or to avoid exacerbating a loss that already has occurred. Many of these provisions specifically require that "you" (the named insured) see that the conditions are performed which, in the case of death, can be a tall order.

HARSH RESULTS

The consequence of the insured's death can be the loss of coverage all together or, in our example, a significant reduction in the liability to the person who ended up occupying the property. As was noted by the court in *Higdon*, such a harsh result can be troubling. Still, such divestiture has been upheld in other contexts. For example, in *Cotton States Mutual Insurance Co. v. Haire*,[23] the court of appeals held that a husband who received title to the marital home pursuant to a divorce agreement could not recover on a policy for casualty loss to the home because the policy was issued in the name of the wife only.[24] The court reasoned that the husband, after the divorce, was no longer a relative or the spouse and, therefore, not entitled to recover on a policy issued only to the wife.[25]

20 *Id.*
21 *Cherokee Nat'l Life Ins. Co. v. Coastal Bank of Ga.*, 239 Ga. 800, 803, 238 S.E.2d 866 (1977) (noting that reformation is available to the parties to an insurance contract if there was a mutual mistake in the formation of the contract).
22 *Id.*
23 214 Ga. App. 799, 449 S.E.2d 161 (1994).
24 *Id.*
25 *Id.*

In addition to the remedy of reformation, the courts in Georgia have sought ways to remedy such harsh results through other principles of equity. The most comprehensive is the Implied Trust Doctrine. The doctrine was first recognized by the court of appeals in *Georgia Farm Bureau Mutual Insurance Co. v. Smith*.[26] In *Smith*, two brothers, Thomas and James, filed a lawsuit against Farm Bureau arising out of a fire loss to a home. After a trial, James, who was the named insured on the Farm Bureau policy, received a verdict of some $23,000. Farm Bureau appealed.

The ownership history of the Smith property was convoluted. James received complete title to the property in 1972 via a deed from a third brother, Robert. Likewise, James held title in 1974 when construction began on the house that would eventually burn. James transferred title by warranty deed to his brother, Thomas, on April 13, 1983. About one month before the transfer, James obtained a policy of insurance. James continued to pay the premiums on the policy even after he transferred title to Thomas. The policy was renewed in James's name in March of 1984, approximately one month before the fire. Neither James nor Thomas notified Farm Bureau of the change in title after the policy was issued in March of 1983 or before the fire occurred in April of 1984. James resided in the home up to the time of the fire. Thomas never lived there.

As a result of the title transfer from James to Thomas, Farm Bureau contended that James divested himself of any insurable interest in the property. James argued, however, that he retained an insurable interest because the property was impressed with an implied trust in his favor, notwithstanding the title transfer. The brothers alleged they jointly purchased the property from their brother Robert. The deed was made only in the name of James because Thomas allegedly was "having trouble with [his] wife back then."

Furthermore, the brothers testified that each expended approximately $20,000 in time and labor building the house that burned. It was agreed that James would live in the house during his lifetime; that he would pay the taxes and insurance. Thomas's ex-wife and her children also resided in the house from the time of its completion until the fire. James deeded the property to Thomas only because James believed, at that time, that he (James) was going to die and wanted everything settled. No consideration was actually paid by Thomas to James, although the deed recited $10 as consideration. James and Thomas's ex-wife continued to reside in the house up to the time of the fire.

In accepting the implied trust theory proposed by the brothers, the court in *Smith* cited with approval some general principles governing implied trusts.

- "A trust is an equitable obligation, either express or implied, resting upon a person by reason of a confidence reposed in him, to apply or deal with property for the benefit of some other person, or for the benefit of himself and another or others, according to such confidence."[27]
- "Implied trusts are those trusts which are inferred by law from the nature of the transaction or the conduct of the parties."[28]
- "A trust is implied: (1) Whenever the legal title is in one person but the beneficial interest, either from the payment of the purchase money or from other circumstances, is either wholly or partially in another . . . ."[29]

In applying these principles, the court concluded that an implied trust could be inferred that resulted in favor of Thomas when the plaintiffs jointly purchased the subject property, but the deed named only James as the grantee. The court also concluded that, when James transferred title to Thomas in 1983, an implied trust resulted in favor of James as well: "A deed absolute in form may be shown by parol evidence to have been made in trust for the benefit of the grantor, where the maker remains in possession of the land."[30] In that case, however, it is unclear why the court upheld the dwelling verdict of $20,000 to James where the policy limit was $30,000. If an implied trust existed as to both interests and their combined contributions to the property were $20,000 each, then it would seem as though James should have been awarded the policy limit of $30,000. Presumably, the court relied upon the doctrine to re-instate James's divested interest. However, since James could only recover to the extent of his interest, $20,000, the jury's verdict was upheld. James could not recover for Thomas, despite the available coverage.

26 179 Ga. App. 399, 346 S.E.2d 848 (1986).
27 *Id.* at 401 (citing *Smith v. Francis*, 221 Ga. 260, 267, 144 S.E. 2d 439 (1965); O.C.G.A. § 53-12-20; O.C.G.A. § 53-12-21.)
28 *Id.* (citing O.C.G.A. § 53-12-22).
29 *Id. (*citing O.C.G.A. § 53-12-26).
30 *Id.*

This case is instructive because it illustrates the lengths to which a court will go to protect parties who have an interest in property and obtain insurance only to discover later that the insurance protection is limited due to the complicated rules surrounding the probate of wills or the transfer of real property interests. Where the parties to the transactions are not lawyers and do not strictly follow the rules regarding the transfer of property rights, Georgia courts might use the Implied Trust Doctrine to aid the family in obtaining a favorable ruling on coverage.

CONCLUSION

Each year, we receive numerous referrals for claims involving the death of a named insured or title and interest problems related to the death of an owner of insured property. These claims are often complicated by circumstances where the insured or the owners of property make changes in title to property through deeds or verbal agreements without making any corresponding changes to the policies that insure their property. These changes and agreements are innocent enough, often intended to simplify the passing of title at death and to avoid the lengthy process of probate. However, the unintended consequence can be a series of significant coverage questions, particularly for those insurers who take seriously the notion that insurance is strictly personal. For those insurers that reserve the right to refuse coverage to persons other than the named insured or those persons specifically authorized by the policy, failure to recognize these coverage questions can result in coverage or payment mistakes. There is no app for analyzing and resolving these issues. They often require thorough evaluation, investigation and consideration before they can be adequately resolved.

TAB

4

Is Sharing Really Caring? The Sharing Economy's Coverage and Liability Issues

By Kelly G. Chartash

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Is Sharing Really Caring? The Sharing Economy's Coverage and Liability Issues

In the modern world of mobile phone apps, "hailing a cab" has come to have a new meaning. One simply has to open their ridesharing app, input their destination and a nearby driver will be on the way. Need a place to stay, but do not want to stay at a hotel? What about a couch to crash on? There are apps for that too! With the new technology of today's sharing economy, legal questions regarding liability and insurance coverage are bound to arise.

THE SHARING ECONOMY

After the financial crisis around 2008, the sharing economy sprung up.[1] The sharing of personal goods for personal gain through the Internet or use of mobile phone apps came to be known as the "sharing economy."[2] Airbnb allows users to share their homes and now has more than 200 million guests and home rental locations in more than 65,000 cities and 191 countries.[3] Couchsurfing advertises it is a global community of 12 million people in more than 200,000 cities, allowing travelers to couchsurf and stay with locals.[4]

Ridesharing companies such as Uber and Lyft have introduced the sharing economy into the transportation world. Uber now has more than a billion drivers and riders in 632 cities worldwide.[5] Lyft is in more than 300 cities nationwide and completes 28 million rides per month.[6]

RIDESHARING ISSUES

When Uber first started, its insurance strategy was to have drivers pursue claims under their personal automobile insurance in the event of an accident.[7] Things changed in 2014 when an Uber driver struck a child in a San Francisco crosswalk in a fatal accident.[8] Uber denied coverage, stating the tragic accident did not include a driver making a trip on the Uber system because the driver was out looking for rides with the app on, but did not have any passengers.[9] As a result, California introduced legislation requiring ride-sharing companies to have proper commercial insurance in place from the time the drivers turn on their apps until the time of customer drop off.[10] Other states, including Georgia, also enacted similar legislation.

GEORGIA'S RIDESHARE STATUTE

In 2015, Georgia enacted O.C.G.A. § 33-1-24 (the "rideshare statute") prescribing specific amounts of liability coverage the "transportation network company" must maintain depending on whether or not a passenger is in the vehicle.[11] The rideshare statute defines "transportation network company" as "a corporation, partnership, sole proprietorship, or other entity that uses a digital network or other means to connect customers to transportation network company drivers for the purposes of

1 Riebana Sachs, *The Common Carrier Barrier: An Analysis of Standard of Care Requirements, Insurance Policies, and Liability Regulations for Ride-Sharing Companies*, 65 DePaul Law Review 873, 876 (2016).
2 Claire Cain Miller, *Is Owning Overrated – The Rental Economy*, N.Y. Times (Aug. 29, 2014), *available at* https://www.nytimes.com/2014/08/30/upshot/is-owning-overrated-the-rental-economy-rises.html?mcubz=0.
3 *About Us*, Airbnb, https://www.airbnb.com/about/about-us (last visited Sept. 18, 2017).
4 *About Us*, Couchsurfing, http://www.couchsurfing.com/about/about-us/ (last visited Sept. 19, 2017).
5 *Our Story*, Uber, https://uber.com/our-story/ (last visited Sept. 16, 2017).
6 *Business*, Lyft, https://www.lyft.com/business (last visited Sept. 18, 2017).
7 Ron Lieber, *The Question of Coverage for Ride Service Drivers*, N.Y. Times (Sept. 5, 2014), *available at* https://mobile.nytimes.com/2014/09/06/your-money/auto-insurance/offloading-the-risk-in-renting-a-car-ride.html.
8 Josh Constine, *Uber's Denial Of Liability In Girl's Death Raises Accident Accountability Questions*, TechCrunch (Jan. 2, 2014), *available at* https://techcrunch.com/2014/01/02/should-car-services-provide-insurance-whenever-their-driver-app-is-open/).
9 *Id.*
10 Lieber, *supra*, at n.7.
11 O.C.G.A. § 33-1-24.

providing transportation for compensation, including, but not limited to, payment, donation, or other item of value."[12] It specifically excludes emergency or nonemergency medical transports.[13]

Importantly, the rideshare statute divides "transportation network company services" into two phases.[14] First, phase "A" includes the entire period of time a rideshare driver is logged onto the transportation network's company's digital network and available to accept a ride request until the driver logs off.[15] In contrast, phase "B" is the period of time the rideshare driver accepts a ride request from the transportation network digital network until the driver completes the transaction or the ride is completed, which is later.[16] This "app on, but no passenger in the vehicle" distinction is critical. During phase "A," the transportation network company must provide a minimum of liability coverage of $50,000 per person and $100,000 per accident for bodily injury coverage and $50,000 for property damage (excluding cargo) coverage.[17] During phase "B," the transportation network company must provide a minimum of $1 million in liability insurance for bodily and property damage per occurrence and at least $1 million in uninsured motorist coverage per incident.[18]

As a result of the legislative action, ride-sharing companies' websites dedicate specific pages describing their insurance coverage. For instance, Lyft's website explains that it offers "contingent liability" insurance coverage of $50,000 per person and $100,000 per accident in bodily injury liability insurance and $25,000 in property damage liability insurance only "when the app is in driver mode before you've received a ride request in the event your personal insurance does not respond."[19] Lyft's website further states that its policy may be modified to comply with specific city or state insurance requirements.[20] Lyft offers primary liability insurance "from the time you accept a ride request until the time the ride has ended in the app."[21] Lyft's app also allows for its users to view the automobile insurance under the driver's vehicle information.[22] Similarly, Uber's website sets forth its insurance policy based on whether the driver has the app on and is waiting for a request, on the way to pick up a rider or while a rider is on a trip in the driver's vehicle.[23]

RIDESHARING EXCLUSIONARY POLICY LANGUAGE

In addition to state legislatures, insurance carriers have also responded to the ridesharing insurance questions. Personal automobile policies often include language that would exclude ridesharing as driving "for compensation or a fee," "driving for hire" or "business use." Some carriers have added in special endorsements to address ridesharing. For instance, some vehicle owners have the option of purchasing a "ride for hire" endorsement. Some carriers also offer ridesharing hybrid policies that replace existing personal automobile policies, which are less than a typical commercial automobile policy.

PROPERTY SHARING ISSUES

Property sharing in today's sharing economy also presents some coverage and liability issues. For example, a family renting a cottage in Texas through Airbnb suffered tragedy when the father, testing a rope swing before his children used it, was killed when the tree limb supporting the swing snapped.[24] In such a situation, is there coverage under the homeowner's policy? What is Airbnb's liability, if any? In this instance, the owner's insurance policy included coverage for commercial activity and the insurer reached a settlement with the family.[25] However, that outcome is likely the exception rather than the rule.

12 O.C.G.A. § 33-1-24(a)(2).
13 *Id.*
14 O.C.G.A. § 33-1-24(a)(5).
15 O.C.G.A. § 33-1-24(a)(5)(a).
16 O.C.G.A. § 33-1-24(a)(5)(b).
17 O.C.G.A. § 33-1-24(b)(2).
18 O.C.G.A. § 33-1-24(b)(3).
19 *Insurance Policy*, Lyft, https://help.lyft.com/hc/en-us/articles/213584308-Insurance-Policy (last visited September 18, 2017).
20 *Id.*
21 *Id.*
22 *Id.*
23 *Insurance*, Uber, https://www.uber.com/drive/insurance/ (last visited Sept. 18, 2017).
24 Zak Stone, *Living and Dying on Airbnb,* Medium (Nov. 8, 2015), *available at* https://medium.com/matter/living-and-dying-on-airbnb-6bff8d600c04#.3tqu3udgb.
25 Ron Lieber, *Death in Airbnb Raises Liability Questions,* N.Y. Times (Nov. 13, 2015), *available at* http://www.nytimes.com/2015/11/14/your-money/death-in-airbnb-rental-raises-liability-questions.html?_r=0.

With respect to Airbnb, a homeowner's liability coverage typically excludes claims arising from the renting of any part of the insured premises, and the property coverage usually excludes losses to business property.[26] However, those exclusions can be different from policy to policy. Some insurers allow homeowners to rent out a room occasionally, but not for business purposes.[27] Other insurers let homeowners occasionally rent out their residence while maintaining liability coverage for a few weeks a year.[28] Another insurer will maintain coverage if their insured does not take in more than $15,000 in rental income.[29] In each of those scenarios, if a claim is asserted, an analysis of the specific policy terms would likely be required on a case-by-case basis to determine coverage.

The amount of coverage, if any, may be further complicated by the existence of Airbnb's "Host Protection Insurance."[30] Hoping to keep existing users, as well as attract new ones, Airbnb announced that the secondary insurance coverage it provides to hosts, which allows up to $1 million in liability coverage, has been upgraded to primary coverage.[31] As such, in situations where a homeowners policy actually provides coverage to an Airbnb host, and Airbnb's Host Protection Insurance also provides coverage, each insurer's liability for a claim will require a comparison of both policy's "other insurance" clauses.

SO, WHAT'S NEXT?

The sharing economy looks like it is here to stay in Atlanta. In 2017, the Georgia Supreme Court upheld a state law regulating and allowing ridesharing services, marking a victory to Uber and Lyft against Atlanta tax drivers.[32] The ridesharing world continues to grow and evolve. For instance, Uber now even offers delivery from local restaurants through Uber Eats.[33] Coverage and liability questions will continue to arise with the evolving technology. As a new statute, Georgia's rideshare statute has yet to be really tested by Georgia courts. Dare we ask what the future holds for liability and coverage questions involving a self-driving, ridesharing car? What about a robot-maintained property share? Until next time!

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26 Ron Lieber, *The Insurance Market Mystifies an Airbnb Host,* N.Y. Times (Dec. 19, 2014), *available at* http://www.nytimes.com/2014/12/20/your-money/the-insurance-market-mystifies-an-airbnb-host.html.

27 Ron Lieber, *A Liability Risk for Airbnb Hosts,* N.Y. Times (Dec. 5, 2014), *available at* https://www.nytimes.com/2014/12/06/your-money/airbnb-offers-homeowner-liability-coverage-but-hosts-still-have-risks.html.

28 *Id.*

29 *Id.*

30 *Host Protection Coverage*, Airbnb, https://www.airbnb.com/host-protection-insurance (last visited March 15, 2016).

31 *Id. See* Steven Musil, *Airbnb beefs up liability insurance offering for hosts,* cnet (Oct. 22, 2015), *available at* http://www.cnet.com/news/airbnb-beefs-up-liability-insurance-offering-for-hosts/.

32 *Georgia Supreme Court Upholds Ridesharing Law*, Insurance Journal, http://www.insurancejournal.com/news/southeast/2017/05/17/451322.htm) (last visited Sept. 18, 2017).

33 Uber Eats, https://www.ubereats.com/san_francisco/ (last visited Sept. 18, 2017).

Venmo: Yours, Mine and Ours

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Venmo: Yours, Mine and Ours

No one wants to pay for something they did not do or cause. Often in life, we encounter situations that force us to do just that. Accepting fault for your actions is a fundamental principle of apportioned liability. A shift in Georgia law has now made fault sharing a reality.

In life, we see examples in which fault sharing would be extremely beneficial. One notable example is a group dinner with friends. At the end of the meal, someone yells out, "Just bring the check and we will split it evenly." Even splitting works out well for the person who got the $70 steak, who now only has to pay $50. The splitting does not tend to go over well with the person who ordered a $30 garden salad, who now must pay $50. Parents are another good example. Parents are often forced to assume full responsibility for the acts of their children, simply based on their parental status and regardless of their lack of involvement with incurring the so called "cost."

Parties are often faced with similar issues as those described above in tort lawsuits. In the past, parties had to assume full financial responsibility for an action they did not commit, or, if they were involved, they certainly were not the party primarily responsible for the issue. While they could seek contribution from the other defendants, they were often left without recourse when the other defendants were insolvent.

PRE-2005: JOINT AND SEVERAL LIABILITY

Prior to 2005, Georgia law was the quintessential example of the aforementioned fault-sharing issue.Specifically, pre-2005 Georgia law, in pertinent part, stated the following:

> Except as provided in Code Section 51-12-33, where an action is brought jointly against several trespassers, the plaintiff may recover damage for the greatest injury done by any of the defendants against all of them. In its verdict, the jury may specify the particular damages to be recovered of each defendant. Judgment in such a case must be entered severally.[1]

As you can see, pre-2005 Georgia law provided for joint and several liability. Simply stated, a plaintiff could seek to recover the full verdict amount from any of the defendants. Often, the party with the "big pocket" was left with a large bill. While that party could seek contribution from the other defendants, the plaintiff was entitled to seek full payment of the verdict from any of the named defendants regardless of that defendant's percentage of fault.

TURING OF THE TIDE: APPORTIONMENT (2005)

In 2005, Georgia apportionment law was overhauled. The Georgia Legislature enacted a new section on apportionment. The statute provides the following:

> O.C.G.A § 51-12-33. Reduction and apportionment of award or bar of recovery according to percentage of fault of parties and nonparties.
>
> (a) Where an action is brought against one or more persons for injury to person or property and the plaintiff is to some degree responsible for the injury or damages claimed, the trier of fact, in its determination of the total amount of damages to be awarded, if any, shall determine the percentage of fault of the plaintiff and the judge shall reduce the amount of damages otherwise awarded to the plaintiff in proportion to his or her percentage of fault.
>
> (b) Where an action is brought against more than one person for injury to person or property, the trier of fact, in its determination of the total amount of damages to be awarded, if any, shall after a reduction of damages pursuant to subsection (a) of this Code section, if any, apportion its award

[1] O.C.G.A. § 51-12-33 (1987), amended by S.B. 3 (2005).

of damages among the persons who are liable according to the percentage of fault of each person. Damages apportioned by the trier of fact as provided in this Code section shall be the liability of each person against whom they are awarded, shall not be a joint liability among the persons liable, and shall not be subject to any right of contribution.

(c) In assessing percentages of fault, the trier of fact shall consider the fault of all persons or entities who contributed to the alleged injury or damages, regardless of whether the person or entity was, or could have been, named as a party to the suit.

(d)(1) Negligence or fault of a nonparty shall be considered if the plaintiff entered into a settlement agreement with the nonparty or if a defending party gives notice not later than 120 days prior to the date of trial that a nonparty was wholly or partially at fault.

(d)(2) The notice shall be given by filing a pleading in the action designating the nonparty and setting forth the nonparty's name and last known address, or the best identification of the nonparty which is possible under the circumstances, together with a brief statement of the basis for believing the nonparty to be at fault.

(e) Nothing in this Code section shall eliminate or diminish any defenses or immunities which currently exist, except as expressly stated in this Code section.

(f)(1) Assessments of percentages of fault of nonparties shall be used only in the determination of the percentage of fault of named parties.

(f)(2) Where fault is assessed against nonparties pursuant to this Code section, findings of fault shall not subject any nonparty to liability in any action or be introduced as evidence of liability in any action.

(g) Notwithstanding the provisions of this Code section or any other provisions of law which might be construed to the contrary, the plaintiff shall not be entitled to receive any damages if the plaintiff is 50 percent or more responsible for the injury or damages claimed.

ASSIGNED PERCENTAGES

The 2005 apportionment statute ended joint and several liability among defendants in tort cases and fostered a new era of equity in jury verdicts. The law allows juries to apportion percentages of fault amongst the parties (or non-parties) responsible for the injuries or damage. The assigned percentages specifically identify the amount of responsibility of each party. Once a verdict is reached, the judge then uses the percentages to calculate the amounts owed by each defendant.

As explained in subsection (a), the plaintiff's fault in causing her own injuries or damage is also considered by the jury. The plaintiff's award is reduced by the amount of her negligence. However, as provided for in subsection (g), if the plaintiff is more than 50 percent responsible for causing the injury or damages, then the plaintiff will be barred from recovering.

NON-PARTY APPORTIONMENT

Often, plaintiffs will intentionally avoid suing certain individuals and companies. The named defendants are then left to bear the brunt of the verdict alone. As discussed in subsection (c), the apportionment statute now allows the jury to apportion fault to non-parties. While fault can be apportioned to a non-party, the non-party will not be forced to pay the plaintiff for amounts associated with any assigned percentage of fault (as discussed in subsections (f)(1) and (f)(2)). Information regarding the apportioned percentages is also inadmissible in any subsequent action against the non-party.

There are several good case examples of when apportioning fault to a non-party is helpful. For example, in negligent security cases involving criminal assailants, plaintiffs often avoid naming the criminal assailant in the lawsuit. It is undisputed that the assailant who perpetrated the attack is somewhat responsible (if not completely) for the plaintiff's injuries and damages. Georgia courts have made it abundantly clear that defendants can seek to apportion fault against non-party

criminal assailants.[2] Apportioning fault to the non-party assailant may greatly reduce the percentage of fault assigned to the owner/occupier of the property.

Another good example is apportioning fault to a non-party employer.[3] The Georgia Worker's Compensation Act does not allow a person to sue their employer for on-the-job injuries. However, that employer may have caused and/or contributed to the plaintiff's injury. Consider this: a plaintiff injures his knee after stepping in a hole in his employer's parking lot. The plaintiff's employer does not own the parking lot, but was informed of the large hole before the incident and failed to inform the plaintiff. The plaintiff may sue the owner of the parking lot, but cannot sue his employer. The apportionment statute allows the defendant property owner to apportion fault to the plaintiff's employer for its failure to warn the plaintiff of the hazard. Such apportionment may greatly limit the property owner's potential exposure at trial.

REQUIRED NOTICE FOR APPORTIONMENT

In subsection (d), the apportionment statute provides very specific requirements for apportioning fault to a non-party. First, and most importantly, the defending party must give notice at least 120 days prior to trial. While discovery is fluid and often changing, notice identifying the party should be given as soon as possible. Georgia courts have strictly enforced the 120-day notice requirement. In *Monitronics International, Incorporated v. Veasley*, the Georgia Court of Appeals held that a notice filed on July 12, 2011, was untimely as trial started on November 7, 2011.[4] As you can see, the Georgia courts strictly enforce the notice requirements identified in subsection (d).

Second, the notice should provide information identifying the non-party, along with the non-party's contact information. Moreover, the statute requires a brief recitation of the factual reasons for believing the non-party is responsible for the claimed damages/injuries.

PRACTICAL APPLICATION

Apportionment is a strong tool for defendants to use to potentially minimize exposure at trial. In some cases — like the negligent security case previously noted — it appears readily apparent that a non-party (or the named criminal assailant) is at least partially responsible for the plaintiff's injuries. Surprisingly, juries have reluctantly apportioned fault to criminal assailants.

Martin v. Six Flags Over Georgia II, L.P., provides a great example of this issue.[5] In *Martin*, on July 3, 2007, the plaintiff was severely beaten by a mob of individuals, four of whom were seasonal employees of Six Flags.[6] When the case was tried in 2013, a Cobb County jury found in favor of the plaintiff and awarded him $35 million in damages.[7] The jury apportioned 92 percent of the fault to Six Flags.[8] The jury apportioned two percent fault to each of the four named criminal assailants.[9] Six Flags was left to pay $32.2 million in damages to the plaintiff.[10] This case is a great example of how juries often avoid apportioning much, if any, of the fault to criminal assailants. Some of the assailants were known and identified in *Six Flags*, and yet still only received two percent of the assigned fault each.

On August 30, 2017, a DeKalb County jury awarded two women over $3.5 million after they were shot outside of a restaurant.[11] The women were innocent bystanders. The shooting stemmed from a disagreement between some individuals

2 *See generally Couch v. Red Roof Inns., Inc.*, 291 Ga. 359, 729 S.E.2d 378 (2012).

3 *See generally Zaldivar v. Prickett*, 297 Ga. 589, 774 S.E.2d 688 (2015) (holding that apportioning fault to a non-party employer is allowed); *see also Walker v. Tensor Mach., Ltd.*, 298 Ga. 297, 779 S.E.2d 651 (2015).

4 323 Ga. App. 126, 137, 746 S.E.2d 793, 804 (2013).

5 301 Ga. 323, 801 S.E.2d 24 (2017).

6 *Id.* at 324.

7 *Id.*

8 *Id.*

9 *Id.*

10 Since that time, the Georgia Supreme Court has determined that the lower court erred in failing to allow the jury to apportion fault to all of the criminal assailants (only the named criminal assailants were included initially).

11 *Canady v. Jay's Place Sports Bar and Lounge, Inc.*, In the State Court of DeKalb County, Georgia, Case No. 13-A-47164-3; *Temika Jemila Johnson v. Jay's Place Sports Bar & Lounge, Inc.* In the State Court of DeKalb County, Georgia, Case No. 13-A-47165-3.

inside the restaurant. The men involved in the altercation were removed from the bar. The men returned and opened fire in what was described as a drive-by shooting. The jury apportioned 30 percent of the liability to the unknown criminal assailants and 70 percent to the restaurant.[12] Again, the jury was hesitant to place a large percentage of fault on the criminal assailant. As you can see, apportionment may assist in reducing the fault, but juries have time and time again refused to place a majority of the blame on the criminal assailants.

While apportioning fault to non-parties is viable with the 2005 apportionment reform, the cases referenced show that juries often apportion little to no fault to criminal assailants. Juries are much more informed in today's society and likely know that a plaintiff will be unable to recover from a criminal who is not a party to the case.

CONCLUSION

All things considered, the 2005 apportionment statute was a great improvement from the days of joint and several liability. As in life, we should only be responsible for the things that we cause and/or do. As we continue to defend cases, we must use this statute in our favor to limit liability at trial.

[12] *Id.*

Spot(ify) the Lie: How Electronic Data Can be Used to Fight Claim Fraud

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Prior to joining Swift Currie, Mr. Mikhalevsky gained experience while working as an extern with the Supreme Court of Georgia and with the Gwinnett County Solicitor's office where he tried numerous criminal cases.

Spot(ify) the Lie: How Electronic Data Can be Used to Fight Claim Fraud

The last two decades have brought rapid expansion and increased integration of technology into our daily lives. Smart phones can now be found in the pockets of over three quarters of Americans, and almost 100 percent of adults aged 18 to 29.[1] You can find a wearable device, such as the Apple Watch or Fitbit activity band, on the wrists of one in six adults. It has been suggested that by 2019, one in three adults will use a wearable device.[2] Smart devices have drastically changed how we interact with each other and the world and also opened the door for new claim investigation tactics, in light of the fact that these smart devices collect extensive information about the lives and activities of their users.

The amount and extent of data compiled through the use of a smart device is staggering and, in many cases, unknown to the average smart device user. Do you have the Google Maps application installed on your cell phone? If so, and if you have not disabled the "location history" option in your Google privacy settings, you may find Google's Timeline feature a bit shocking.[3] Through Google's Timeline feature, you can see the exact second-by-second location of your phone on any day since you installed the Google Maps application.

Google's Timeline feature represents just one of thousands of technological tools insurance companies can use in evaluating a claim. This article is not meant to provide an exhaustive list or discussion of the various tools available to insurance companies. Instead, this article focuses on three valuable tools that can be used in the investigation of a claim without a significant expenditure of time or resources. More specifically, this article addresses how to compile and analyze metadata stored in electronic photographs and videos, cellular tower information and activity data from wearable devices such as the Fitbit. Finally, the article closes with a brief discussion regarding the use of electronic data at trial.

METADATA IN ELECTRONIC PHOTOGRAPHS AND VIDEOS

What is Metadata?

Metadata is "data that provides information about other data."[4] In the context of electronic files, metadata is simply data about the file itself. For example, when you type a document on your computer in Microsoft Word, the program will embed within the file certain information about the file, including the date and time the file was created, the author of the file and the file size. This information is part of the "metadata" for the file. Metadata is automatically populated and embedded in every electronic file, including photographs and videos.

Metadata Stored in Image and Video Files

The metadata embedded in photographs and videos is particularly useful in insurance claim investigations. Nowadays, when an insured takes a photograph or video, it is likely they will do so on their smart phone. When a picture or video is taken on a smart phone, the phone will automatically generate and embed metadata about the photo or video into the image file. The specific information that is stored and embedded into the file will depend on the particular device used and the user's settings on that device. Typically, however, the metadata embedded in a photograph or video taken on a smart phone will include data about the type of camera used to take the photo or video (i.e. Apple iPhone 6), the date and time the photograph/video was taken (i.e. 11/03/2017 at 14:02:46) and the GPS coordinates for the location where the photograph was taken (i.e. - 33°53'04.1"N 84°27'29.2"W).

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1 Aaron Smith, *Record shares of Americans now own smartphones, have home broadband*, Pew Reasearch Center (Jan. 12, 2017), http://www.pewresearch.org/fact-tank/2017/01/12/evolution-of-technology/.

2 https://www.forbes.com/sites/bernardmarr/2016/03/18/15-mind-boggling-facts-about-wearables-in-2016/#3e9e89772732.

3 Bernard Marr, *15 Noteworthy Facts About Wearables in 2016,* Forbes (Mar. 18, 2016, 2:16 AM), *Timeline*, Google Maps, https://www.google.com/maps/timeline.

4 "Metadata." Merriam-Webster.com. Merrian-Webster, n.d. Web. Oct. 12, 2017.

Having objective information about the device used, the time the photograph was taken and the location of the photograph can be particularly useful in claim investigations. To illustrate a potential use of metadata in a claim investigation, take the following personal property theft claim I handled as an example.

The insured claimed that on February 6, 2016, her property was broken into and that various electronics were stolen, including her son's video game system, a number of televisions and her cell phone. Pursuant to the terms of her insurance policy and on behalf of the insurer, I requested documents from the insured that would show her ownership of the allegedly stolen items, including electronic copies of any photographs of the stolen property. The insured submitted a number of photographs to me via email depicting the electronics she claimed were stolen. During her examination under oath, I verified that each of the photographs showed an item that was stolen during the loss and the photos were all taken prior to the loss using the cell phone that was stolen. Notably, the metadata revealed that the photos submitted by the insured were taken over a month after the loss (and a week after I requested the proof of ownership documents from her), using the cell phone that the insured claimed was stolen during the loss. The photos were taken both at her sister's house, as well as in a store that sells electronics. Based on the foregoing, I recommended the client issue a denial of the insured's claim.

Extracting Metadata

Extracting metadata from an image or video file is a simple process. Generally, electronic photographs are saved as a .jpeg file when downloaded or exported to a computer. To extract metadata from a .jpeg or other image file on a PC, all a user has to do is right click the file and scroll down to "Properties."[5] In the alternative, various websites provide free services where a user can upload an image file or batches of image files and receive metadata with a click of the mouse.[6]

Obtaining Original Image and Video Files

The means of obtaining an original electronic image or video file will depend on the type of claim being investigated. In a first-party claim investigation, original electronic copies of images can be obtained directly from the insured via document requests made pursuant to the terms of the policy. In making such a request, the insurer should specifically request the insured email original image files to the adjuster or save them to a disc or USB drive that will be provided to the adjuster. In liability claims, such as personal injury claims, an insurer can request electronic image files from an injured party or their attorney, but they are under no obligation to provide those files prior to litigation. However, once litigation ensues, original electronic media files can be obtained through the discovery process via requests for production to the opposing party.

CELLULAR TOWER RECORDS

What are Tower Records?

Obtaining cell phone records as part of a claim investigation is not a novel idea. However, the records that are typically requested and provided by an insured or claimant are limited to usage records. These usage records typically only provide a list of incoming and outgoing calls and messages with corresponding dates and times. While usage records are valuable in evaluating who the insured or claimant is communicating with and when, their value is limited in that they do not provide any information regarding the location of the phone, which can prove critical when evaluating a fraudulent claim.

Cell tower records are maintained and kept by each cellular service provider and contain a wealth of information beyond that contained in usage records. Most importantly, the tower records allow an investigator to determine information about the location of a cell phone when it receives or makes calls or messages.

Understanding cell phone tower data and how it can be used requires a bit of background about how cell phones work. To keep it simple, cell phones are constantly connected to a cellular tower. Generally, the cell phone will be connected to the closest cellular tower. Once a call is made or received, the call is routed through the cell phone tower and data about the call is tracked. The specific data tracked depends on the cellular service provider, but, in general, the following pertinent information is logged: the number making the call, the number receiving the call, the length of the call and the cell towers

[5] On a Mac, rather than clicking "Properties," the user will select "Get Info."

[6] For example, www.metapicz.com and www.imageforensic.org provide a free service allowing users to extract metadata from media files.

used to transmit the call or message. With respect to the specific cell tower conducting the transmission, if a caller is stationary or sending a text message, it is likely the call/message will be connected to only one tower throughout the duration of the transmission. If a caller is moving, it is possible the call will be transferred to multiple towers to ensure the caller has the best possible service. While a call may be routed through multiple towers, typically only the starting and ending towers are logged by the provider. The data kept regarding the specific cell towers used for each transmission comprises what is referred to as the cell tower records.

How are Tower Records Used?

Like regular cellular usage records, tower records list all incoming and outgoing calls, the time the call occurred and the duration of the call. However, tower records have the added benefit of listing the cellular towers used in the transmission. Tower records will list the tower used at both the beginning and end of a call and the GPS coordinates for that tower. Notably, tower records also show the general angle from which the call transmission came into the tower at the time the call began, as well as the general angle between the phone and the tower at the time the call ended. By knowing the specific towers used, the GPS coordinates of the tower(s) and the angle between the phone and the tower at the time the call begins and ends, an investigator can determine the general location and direction of travel of the caller. To do so, the investigator has to plot the GPS coordinates of the towers and the angle of the call on a map for each call or message transmission. While the process of plotting GPS coordinates sounds complicated, it is fairly simple as GPS coordinates can be copied directly from the tower records and pasted into Google Maps to determine the location of the cell tower.[7] Obviously, the more calls or messages sent or received from the phone, the more data an investigator has about the location and direction of travel for the user.

The particular uses for cellular tower data will depend on the claim at issue. As a general matter, the location of a cell phone at the time it makes or receives a call or message can prove critical in evaluating an insured or claimant's version of events and alibi. For example, where an insured claims to be out of town on the date of loss, cell phone tower records can be used to show whether the insured was in the area where the loss occurred at the time of the loss.

Analyzing tower records is a fairly complex and technical task. With some basic knowledge, an investigator or adjuster may be able to map the general location of a phone during each call, but without training and experience, an expert should be consulted. To that end, if an investigator's initial evaluation of tower records and GPS coordinates suggests the insured or claimant may not have been in a location where she claimed to be, it may be prudent to retain an expert to more fully evaluate the records prior to making a decision on the claim.

In addition, it should be noted that tower records provide information about the location of the phone itself, not necessarily the owner of the phone. If an insurer wants to rely on tower records to show the location of the insured or claimant, it is necessary to confirm with the insured or claimant that they had their cell phone on their person during the times in question and that no one else borrowed or used the phone at those times.

Obtaining Tower Records

Tower records are not typically available to a customer, so obtaining them can prove difficult. To that end, it is unlikely that an insurer will be able to get tower records during the investigative stage of a claim. In some cases, a properly worded authorization from the insured or claimant may be sufficient, but in the past, cellular service providers have been reluctant to provide tower records to an insurer absent a court order or a subpoena.

Notably, some states have statutes that allow a court to issue an order or subpoena prior to litigation when time is of the essence. Swift Currie is currently exploring the possibility of obtaining tower records prior to litigation in Georgia, as Georgia has a statute that allows for pre-litigation discovery. If we are successful in obtaining these records, it could provide a valuable tool to investigators in evaluating claims prior to litigation.

[7] Google Maps, http://www.maps.google.com.

While obtaining tower records prior to litigation can prove difficult, the process becomes much easier once litigation has ensued. Once a file is in litigation, a non-party request or subpoena for the records can be issued to the cellular service provider during the discovery process. It is important to request the tower records as soon as possible in light of the document retention policies of many cellular service providers, which mandate that the records be disposed of on a periodic basis. For example, Verizon typically disposes of tower records after one year. On the other hand, AT&T typically keeps records for seven years.

WEARABLE DEVICE AND ACTIVITY BAND DATA

What is a Wearable Device?

Wearable technology devices or "wearables" are simply technological devices that are worn by the user. The wearables market is comprised largely of devices worn on the wrist or head of the user to provide or track information for the user. Some of the most popular wearable devices include the Apple Watch, Google Glass, Fitbit activity bands and watches (which comprised more than 50 percent of the wearables market in 2014 and 2015)[8] and Beats wireless headphones.

Data Tracked by Wearables

In the context of claim investigations and personal injury litigation, wearables that provide information about the user's activities and health are particularly useful. The latest Fitbit activity tracker, for example, tracks the number of steps taken by the user, distance traveled, calories burned, active minutes, stairs climbed, hourly activity, sleep patterns, stationary time, heart rate, breathing patterns, location, elevation gained and other activity and health information about the user. Once compiled, this information is then stored in "the cloud" and can be accessed via the user's activity band itself, the user's smartphone or through the Internet.[9]

Use of Electronic Data from Wearables

Over the last few years, evidence obtained from wearable devices like the Fitbit have become more prevalent in the legal system. The first known case activity data from a wearable was admitted occurred in Canada in 2014 when a plaintiff used the data from her Fitbit to show decreased activity levels after her injury.[10] Since then, activity data from wearable devices has been used in various criminal and civil cases,[11] including to support a defense of comparative negligence based on a deceased defendant's speed at the time of a collision,[12] to discredit an allegation of rape based on the victim's lack of activity at the time of the alleged rape[13] and in support of charges for murder based on the suspect's increased activity prior to the victim's death.[14]

As you might expect, data obtained from wearable devices is particularly useful in evaluating personal injury claims. In the personal injury context, activity data can be used to show decreased, increased or maintained activity levels after an accident, which may be inconsistent with injuries claimed by an injured party.

In addition to personal injury claims, wearable data could also prove valuable in first-party claim investigations. In the first-part context, wearable device data can be used to evaluate an insured or claimant's potential alibi. For example, if an insured claims to have been sleeping when a loss occurred, data from an activity band might show they were moving or active prior to or when the loss occurred. In an arson case, data from an activity band may show an elevated heart rate for the insured prior to the fire starting, suggesting the insured may have been preparing to set the fire or that she may have known the fire was about to occur. Again, the potential uses for the data obtained from wearable devices is only limited by the creativity of the claim investigator.

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8 Mikel Delgado, *How Fit is that Fitbit?*, Berkeley Science Review (Oct. 7, 2014).

9 Kate Crawford, *When Fitbit Is the Expert Witness*, The Atlantic (Nov. 19, 2014); *See* Fitbit Charge 2, https://www.fitbit.com/charge2.

10 Samuel Gibbs, *Court Sets Legal Precedent With Evidence From Fitbit Health Tracker*, The Guardian (Nov. 18, 2014, 11:03 EST), https://www.theguardian.com/technology/2014/nov/18/court-accepts-data-fitbit-health-tracker.

11 *Id. See* Alexander Howard, *How Data From Wearable Tech Can Be Used Against You In A Court Of Law*, Huff. Post, http://www.huffingtonpost.com/alexander-howard/how-data-from-wearable-te_b_7698764.html.

12 *Flint v. Strava*, Case No. CGC 12 521659 (San Franciso Cty., Ca.); John G. Browning, *Legally Speaking: When All Else Fails, Blame Social Media*, Se. Tex. Rec. (July 6, 2012, 8:37 AM), http://bit.ly/25iuilK.

13 *Commonwealth v. Risley*, Criminal Docket: CP-36-CR-0002937-2015 (Lancaster Cty., Pa.).

14 *State v. Dabate*, Case No. TTD -CR17-0110576-T (Tolland Cty., Ct.).

Obtaining Activity Band Data

The process of obtaining wearable device data will depend on the type and status of the claim being investigated. In the first party context, prior to litigation, wearable device data can be obtained through a request to the insured pursuant to the terms of the insured's policy or directly from the device manufacturer, with a properly executed authorization form. In the liability context, while an insurer or defense counsel can request the data from the claimant prior to litigation, it is unlikely the claimant will provide the information if it would be detrimental to their case. In such a case, it may be prudent to send a preservation letter to the claimant demanding they preserve the wearable device data and warn that their failure to do so will be considered spoliation of evidence.

Prior to litigation, it may also be worth searching a claimant's social media history. Many devices allow users to connect their device directly to their social media account, so that activity results are automatically posted whenever a workout is completed or an "achievement" is reached.

If litigation ensues in either a first- or third-party claim, activity band data can be requested through the discovery process. Notably, requests can be sent directly to the insured or claimant, but also to the device manufacturer, as the manufacturer typical maintains the activity data on its servers. As this is a relatively new and unfamiliar area for many wearable device manufacturers, requests to obtain these records from a manufacturer without the authorization of its user will likely be met with resistance. However, the privacy policies for companies like Fitbit suggest that they have the right to provide personal user information in response to proper legal requests for the same.[15]

CONSIDERATIONS REGARDING THE USE OF ELECTRONIC DATA AT TRIAL

Use of electronic data in the courtroom is still a relatively new and evolving area of the law. Attempts to use such data at trial will likely be met with resistance from opposing counsel, especially when the data is detrimental to their client's case. It should be noted that the proponent of computerized evidence has the burden of laying a proper foundation for its admission.[16] To be admissible, the evidence has to be relevant, reliable and properly authenticated.[17] Expert testimony will likely prove critical in establishing the reliability and admissibility of such evidence.[18] Proper certifications from the source of the data will be necessary to properly authenticate the data.[19]

CONCLUSION

Smartphones and other technological devices are now commonplace in the lives of the average insured and claimant. These "smart" devices track and compile significant amounts of data about the user's life, much of which is compiled without the knowledge of the average user. In the hands of a claim investigator, the objective data compiled by smart devices can provide critical information necessary for proper evaluation of a claim. The uses for this data are practically endless and limited only by the ingenuity of the investigator.

While the particular circumstances of a claim will dictate the type and extent of investigation necessary, the tools discussed in this article, including metadata, cell tower records and wearable device data, provide a means of obtaining objective information about a claim and/or a claimant without significant expenditure of time and effort.

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15 *See Privacy Policy*, Fitbit, http://fitbit.link/25itdKy (last visited Sept. 27, 2017) (stating that Fitbit may share personal information in response to valid legal process or order, including a subpoena for records).

16 *Lorraine v. Markel Am. Ins. Co.*, 241 F.R.D. 534, 557, 2007 U.S. Dist. LEXIS 33020 (D. Md. 2007) (citing Manual for Complex Litigation at § 11.447).

17 O.C.G.A. §§ 24-4-401, 24-4-403, 24-9-901, 24-9-902, and 24-9-923.

18 *See United States v. Brown*, 579 F.3d 672, 683-684, 2009 U.S. App. LEXIS 19189 (6th Cir. Ohio 2009) ("Testimony from qualified experts about the metadata underlying digital images could be helpful in ascertaining when photographs were taken and whether photographs were taken in sequence.").

19 Under the Federal Rules of Evidence, the methods of authentication include: (1) a witness with personal knowledge; (2) expert testimony; (3) distinctive characteristics; and (4) system or process capable of producing a reliable result. Fed. R. Evid. 901(b)(1-9).

Heads Up!
Beating the Buzzer on UM Coverage

By Kori E. Eskridge

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Heads Up! Beating the Buzzer on UM Coverage

WHAT IS UNINSURED MOTORIST COVERAGE?

Uninsured motorist (UM) coverage compensates an insured who is injured by an at-fault uninsured or underinsured motorist. More eloquently, it exists "to facilitate indemnification for injuries to a person who is legally entitled to recover damages from an uninsured motorist, and thereby to protect innocent victims from an uninsured motorist . . . and to protect innocent victims from the negligence of irresponsible drivers."[1]

Georgia drivers are required to be insured for at least the minimum limits of liability set out by Georgia law in order to drive on public roads and highways in the state.[2] Accordingly, to the extent that an at-fault driver is not properly insured, the UM coverage in an injured insured's policy provides a method of recovery for their injuries and other costs incurred. Notably, however, UM coverage does not cover punitive damages.[3]

Additionally, UM coverage also applies in situations where the at-fault driver is "underinsured." This tends to be more common in automobile liability claims and occurs when the insured's proven damages exceeds the at-fault driver's available liability coverage. In these instances, the insured's uninsured motorist coverage serves to fill the gap between the amount of coverage available from the at-fault driver's liability policy and the total amount of the insured's injuries.

O.C.G.A. § 33-7-11 is the Georgia Uninsured Motorist Act, which provides, in pertinent part, as follows:

> (a)(1) No automobile liability policy or motor vehicle liability policy shall be issued or delivered in this state to the owner of such vehicle or shall be issued or delivered by any insurer licensed in this state upon any motor vehicle then principally garaged or principally used in this state unless it contains an endorsement or provisions undertaking to pay the insured damages for bodily injury, loss of consortium or death of an insured, or for injury to or destruction of property of an insured under the named insured's policy sustained from the owner or operator of an uninsured motor vehicle, within limits exclusive of interests and costs which at the option of the insured shall be:
>
> (A) Not less than $25,000.00 because of bodily injury to or death of one person in any one accident, and, subject to such limit for one person, $50,000.00 because of bodily injury to or death of two or more persons in any one accident, and $25,000.00 because of injury to or destruction of property; or
>
> (B) Equal to the limits of liability because of bodily injury to or death of one person in any one accident and of two or more persons in any one accident, and because of injury to or destruction of property of the insured which is contained in the insured's personal coverage in the automobile liability policy or motor vehicle liability policy issued by the insurer to the insured if those limits of liability exceed the limits of liability set forth in subparagraph (A) of this paragraph. In any event, the insured may affirmatively choose uninsured motorist limits in an amount less than the limits of liability.
>
> * * *
>
> The coverage required under paragraph (1) of this subsection shall not be applicable where any

[1] *Smith v. Commercial Union Assur. Co.*, 246 Ga. 50, 268 S.E.2d 632 (1980) (quoting 7 Am.Jur.2d "Automobile Insurance" § 293, pp. 934, 935).
[2] *Automobile Insurance*, Office of Insurance and Safety Fire Commissioner (Sept. 18, 2017, 4:49 PM), www.oci.ga.gov/consumerservice/autoinsurance.aspx.
[3] *Bonamico v. Kisella*, 290 Ga. App. 211, 213, 659 S.E.2d 261 (2014).

(3) insured named in the policy shall reject the coverage in writing. The coverage required under paragraph (1) of this subsection excludes umbrella or excess liability policies unless affirmatively provided for in such policies or in a policy endorsement. The coverage need not be provided in or supplemental to a renewal policy where the named insured had rejected the coverage in connection with a policy previously issued to said insured by the same insurer. The amount of coverage need not be increased in a renewal policy from the amount shown on the declarations page for coverage existing prior to July 1, 2001. The amount of coverage need not be increased from the amounts shown on the declarations page on renewal once coverage is issued.

* * *

As used in this Code section, the term:

(b)(1)

* * *

(B) "Insured" means the named insured and, while resident of the same household, the spouse of any such named insured and relatives of either, while in a motor vehicle or otherwise; any person who uses, with the expressed or implied consent of the named insured, the motor vehicle to which the policy applies; a guest in such motor vehicle to which the policy applies; or the personal representatives of any of the above . . . .

* * *

(D) "Uninsured motor vehicle" means a motor vehicle, other than a motor vehicle owned by or furnished for the regular use of the named insured, the spouse of the named insured, and, while residents of the same household, the relative of either, as to which there is:

(i) No bodily injury liability insurance and property damage liability insurance;

(ii) Bodily injury liability insurance and property damage liability insurance and the insured has uninsured motorist coverage provided under the insured's motor vehicle insurance policy; the motor vehicle shall be considered uninsured . . . .[4]

WHO IS AN INSURED?

The Uninsured Motorist Act identifies different classes of persons who are considered "insured." These individuals include the named insured, the resident spouse of the named insured and the resident relatives of either the named insured or the spouse. These individuals are covered under the statute "while in a motor vehicle or otherwise." Although not specifically stated in the statute, Georgia courts have held that these individuals are insured under the statute "regardless of location and such insureds need not be in the insured automobile."[5]

The second class of "insureds" under the statute includes "any person who uses, with the expressed or implied consent of the named insured, the motor vehicle to which the policy applies."[6] To be considered an insured, the individual must have permission of the named insured to operate the vehicle, and the accident giving rise to coverage must have involved the motor vehicle that is insured under the applicable policy.[7]

4 O.C.G.A. § 33-7-11.
5 *Dunn-Craft v. State Farm Mut. Auto. Ins. Co.*, 314 Ga. App. 620, 621, 724 S.E.2d 903, 906 (2012).
6 *Id.* at 622.
7 *Beard v. Nunes*, 269 Ga. App. 214, 215, 603 S.E.2d 735, 737 (2004).

REJECTING UM COVERAGE

O.C.G.A. § 33-7-11 provides strict requirements for allowing a policyholder to reject UM coverage. Specifically, "any insured named in the policy shall reject the coverage in writing," although there are no requirements as to the form of the rejection, other than it must be in writing.[8] However, once an insured gives a proper rejection of coverage to its insurer, that insurer is not obligated to provide the coverage in a renewal policy issued to the same insured.[9] Notably, this is an all-or-nothing endeavor; while an insured can reject this coverage, the statute does not permit an insured to substitute an amount of lesser coverage.[10]

RECENT CASES IN UM COVERAGE

Coker v. American Guarantee and Liability Insurance Company[11]

Mr. Coker, the plaintiff, was severely injured in a motor vehicle accident in which he was struck by another driver who crossed the center line of the road and struck the plaintiff head on. At the time of the accident, the plaintiff was acting in the course of his employment and driving a truck owned by his employer, Ansco & Associates (Ansco). The plaintiff sued the other driver and obtained a $5.5 million consent judgment against the other driver. The other driver had automobile liability insurance of $25,000, which was paid to the plaintiff in exchange for a limited liability release.

As the other driver's policy limits were not sufficient to satisfy the amount of the consent judgment, the plaintiff attempted to recover additional monies from Ansco's liability insurance policies, which included policies with Liberty Mutual Insurance Company (a business automobile policy), Westchester Fire Insurance Company (an umbrella policy), Great American Insurance Company (an excess liability policy), American Guarantee & Liability Insurance Company (an excess liability policy) and Endurance American Specialty Insurance Company (a surplus lines policy).[12] It was undisputed that the plaintiff was insured under Ansco's multiple policies at the time of the accident.

The plaintiff eventually settled with both Liberty Mutual and Westchester, but a substantial portion of the consent judgment he obtained remained unpaid. Accordingly, the plaintiff filed a lawsuit against Ansco's three remaining excess insurers. The main question the court had to determine was whether the plaintiff's failure to exhaust the limits of the first two policies prevented his ability to recover from the excess insurers.

The court first determined that Georgia's UM statute applied to the excess liability policies. Since Ansco had not rejected UM coverage in writing as specifically required by the statute, any umbrella or excess liability policy providing coverage for bodily injury sustained by the insured due to a motor vehicle access was required by law to provide UM coverage equal to the policy's overall liability limits.

Next, the court determined that excess or secondary coverage, "by their very nature," contain an exhaustion requirement, which is not triggered until the limit of liability of the primary policy is exhausted. When an excess policy clearly sets a threshold starting point for payment, the contract is unambiguous and enforceable.[13]

Finally, the court held the UM statute did not supersede the vertical exhaustion requirements contained in the excess liability policies. While the statute may void "other insurance" provisions where there are multiple cases that are horizontally aligned, applying the same reasoning to void vertical exhaustion requirements would "alter the nature and fundamental purpose of the agreement itself — that is, to provide excess coverage."[14]

Accordingly, the court found the excess insurance policies had not been triggered, due to the fact the limits of the primary and secondary insurance policies had not been exhausted.

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8 O.C.G.A. § 33-7-11(a)(3).
9 *Nat'l Union Fire Ins. Co. v. Johnson*, 183 Ga. App. 38, 357 S.E.2d 859 (1987).
10 *Doe v. Rampley*, 256 Ga. 575, 577, 351 S.E.2d 205 (1987).
11 *Coker v. Am. Guar. & Liab. Ins. Co.*, 825 F.3d 1287 (11th Cir. 2016).
12 These policies are listed in order of priority.
13 *Coker*, 825 F.3d at 1294.
14 *Id. See U.S. Fire Ins. Co. v. Capital Ford Truck Sales, Inc.* 257 Ga. 77, 355 S.E.2d 428, 431 (1987).

GEICO v. Morgan[15]

Plaintiff Wanda Morgan was involved in a motor vehicle accident with Dwain Mims, in which she sustained injuries and damages totaling over $100,000. The plaintiff's husband, Victor Morgan, also made a claim for loss of consortium. Prior to litigation, the plaintiffs sent a demand to Mr. Mims and his insurer tendered his liability limits of $25,000. At the time of the accident, the plaintiffs were covered under an automobile insurance policy issued by GEICO that had a liability limit of $100,000 and also included UM coverage. However, there was a dispute as to the amount of UM coverage available under the policy.

The plaintiffs sent a pre-litigation demand to GEICO for $100,000, which is what they believed to be the limits of UM coverage under their policy. GEICO tendered a check for $25,000, which is what it believed to be the per-person limit of UM coverage under the policy. The plaintiffs filed a lawsuit against Dwain Mims and served GEICO with a copy of the complaint. GEICO answered and counterclaimed for a declaratory judgment regarding the amount of UM coverage.

According to GEICO, the plaintiffs added UM coverage to their automobile policy in 1991. The next year, however, they discontinued that coverage and completed a selection form indicating they rejected UM coverage "entirely." This was echoed in forms completed in 2000 and 2003. In August 2003, the plaintiffs made changes to their policy, which included adding UM coverage back to the policy. Based on the evidence presented, these changes were not made in writing. Further, the plaintiffs submitted affidavits stating that GEICO did not explain to them that they could select coverage in an amount equal to their policy limits. The policy continued to renew every six months, but no additional selection forms were completed. At the time of the accident, the plaintiffs' declarations page indicated that the policy provided UM coverage with a limit of $25,000 per person.

The court found that subsection (a)(3) of the UM statute, which provides that an insurer does not have a duty or obligation to offer UM coverage once it has been rejected by the insured, does not apply in instances where the insured makes a request to add the coverage back to the policy. Once the insured elects to obtain UM coverage, the insured has the option to obtain either the statutory minimum of $25,000 or an amount equal to the policy's liability coverage limits.[16] Notably, however, an insured must affirmatively choose lesser coverage.[17]

The court of appeals affirmed the trial court's decision that the plaintiffs were entitled to UM coverage in an amount equal to their policy's bodily injury liability coverage, which was $100,000. The court stressed the absent evidence that the plaintiffs affirmatively chose a lesser amount of coverage, the default amount (policy limits of liability) applied.

Massey v. Allstate Insurance Company[18]

Plaintiff Jody Massey was injured in a motor vehicle accident after her vehicle was struck by a truck driven by Brett Pruitt. She filed a lawsuit against Mr. Pruitt and eventually settled with his insurer for the limits of his liability insurance policy, which was $100,000. After this, she amended her complaint to add a claim for declaratory judgment regarding her automobile and umbrella insurance policies, both of which were with Allstate, to determine the amount of UM coverage available. She later settled with Allstate for the limits of her underinsured motorist policy in the amount of $100,000.

Allstate filed a motion for summary judgment as to coverage under the umbrella policy. It contended that the plaintiff's umbrella policy ceased to include UM coverage as of June 2010. The motion was granted by the trial court and the plaintiff appealed.

The evidence showed that in June 2009, the plaintiff's umbrella policy included both excess liability coverage and UM coverage, each providing $5 million in coverage. Separate premiums were assessed for each. When Massey received her policy renewal documents in May 2010, the documents indicated the policy no longer included UM coverage. Additionally, a separate premium for UM coverage was not assessed. A subsequent notice was sent to the plaintiff on June 2, 2010, advising that her excess liability policy limits had been reduced and that UM coverage was not included. This was echoed in the 2011 umbrella policy renewal documents.

15 *Gov't Emples. Ins. Co. v. Morgan*, 341 Ga. App. 396, 800 S.E.2d 612 (2017).
16 O.C.G.A. § 33-7-11 (a)(1).
17 *Gov't Emples. Ins. Co.,* 341 Ga. App. at 399 (quoting *McGraw v. IDS Property & Cas. Ins. Co.*, 323 Ga. App., 408, 410-411, 744 S.E.2d 891 (2013)).
18 *Massey v. Allstate Ins. Co.*, 341 Ga. App. 462, 800 S.E.2d 629 (2017).

After determining that O.C.G.A. § 33-24-45 — which contains the requirements an insurer must comply with to effectively cancel or refuse to renew automobile policy coverages — applies to umbrella policies, the court looked to see whether Allstate's cancellation of UM coverage under the umbrella policy was proper. The court found that because Allstate could not show that it either delivered the notice to the insured personally or via first-class mail, the cancellation was ineffective.[19] Absent strict compliance with O.C.G.A. § 33-24-45's notice requirements, a policy is renewed automatically by operation of law. Accordingly, the court determined that the plaintiff's umbrella policy continued to include UM coverage in 2010 and 2011.

ETHICAL CONSIDERATIONS REGARDING UM COVERAGE

There are many ethical issues that can arise in the course of a UM case. The very nature of a UM case, specifically one in which the primary liability limits of the defendant have been exhausted, puts the insurer and its insured in adverse positions. Accordingly, it is important to remember to exercise "good faith" in reviewing and responding to all demands for payment from the insured, since failing to do so could expose the insurer to a potential bad faith claim.[20]

Additionally, it is important to consider the implications of subrogation and apportionment in UM cases. There are times where it is advantageous to agree to waive the company's right to subrogation in order to gain the cooperation of the defendant, especially in cases that are expected to proceed to trial. In cases involving apportionment, the manner in which apportionment is ultimately assigned can serve to reduce the obligation of the insurer, but can also reduce the potential recovery for the insured.

It is important to consider these issues and potential conflicts of interest when adjusting UM claims and participating in UM litigation. As the insurance landscape evolves, new ethical issues arise at a rapid pace. Additionally, timing is often an integral and strategic part of the decision-making process, especially when considering demands or requests to waive subrogation. It is important to keep your *Heads Up!* and be on the lookout for potential issues before they arise.

19 O.C.G.A. § 33-24-45 (e)(1).
20 *See* O.C.G.A. § 33-7-11 (j).

TAB

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Attorney Bios

Michael H. Schroder

Partner

For more than 30 years, Michael H. Schroder has maintained a broad defense litigation practice, handling numerous trials and appeals. He advises insurance clients on a wide range of insurance coverage issues, including both first- and third-party coverage matters, the defense of premises and transportation cases, professional liability and intellectual property matters. Mr. Schroder is a member of the Federation of Defense and Corporate Counsel, the Atlanta Bar Association and the Defense Research Institute. He participates as a speaker, a discussion leader and a panelist for litigation seminars on numerous subjects. He serves as one of the Deans of the Litigation Management College presented each year at Emory University. Mr. Schroder continues to be named a Georgia Super Lawyer by *Atlanta Magazine*.

As a 1972 graduate of Princeton University, *magna cum laude*, with a degree in History, Mr. Schroder obtained his Juris Doctor in 1976 from the University of Georgia, graduating with honors. He is a past chairman of the Aviation Section of the State Bar of Georgia.

Mike O. Crawford, IV

Partner

Mike O. Crawford, IV litigates commercial general liability, premises liability, trucking/transportation, excess coverage, automobile, fire, explosion, contract, toxic tort and construction defect claims, as well as a variety of subrogation claims. Throughout his career, Mr. Crawford has represented insurance carriers and their insureds including trucking companies, transportation companies, hotels and restaurants, in addition to various other corporations and individuals. He has extensive experience in the resolution of claims through negotiations, mediations, jury trials and bench trials, personally appearing as lead counsel in 139 of the 159 counties within the State of Georgia.

Mr. Crawford attended Georgia State University, College of Law. While there, he served as an intern for the Honorable Marion Pope at the Georgia Court of Appeals. Mike graduated with Honors in 2000.

Melissa K. Kahren

Senior Attorney

Melissa K. Kahren joined Swift Currie n 1999. Her practice is focused in the areas of property, first-party coverage and construction litigation.

Ms. Kahren was admitted to the Georgia Bar in 1996. She is also admitted to practice before the United States District Court for the Northern District of Georgia, the United States District Court for the Middle District of Georgia and the Eleventh Circuit Court of Appeals.

Ms. Kahren graduated, *summa cum laude,* with a degree in English literature from Vanderbilt University in 1992 where she was a member of Phi Beta Kappa. Ms. Kahren received her J.D. from Emory University School of Law in 1995, where she was a managing editor of the *Emory International Law Review*.

Bright Kinnett Wright

Senior Attorney

Bright Kinnett Wright originally joined Swift Currie in 1981, practicing in the area of first-party insurance litigation, property law, bad faith, insurance coverage, arson and fraudulent insurance claims. She has worked for Swift Currie for 14 years, returning in May 2007. She also practiced for six years at other Atlanta law firms in the area of asbestos litigation and pharmaceutical defense. Ms. Wright currently practices in the area of property insurance law. She has significant experience in handling jury trials in both state and federal courts, as well as experience with worker's compensation hearings.

Ms. Wright has been a member of the State Bar of Georgia since 1980 and is a member of the Litigation Section. She is admitted to practice in the U.S. Courts of Appeal for the Eleventh Circuit and the United States District Courts for the Northern, Southern and Middle Districts of Georgia. Ms. Wright formerly served on the Law Council of the Emory University School of Law and she is a Fellow of the State Bar of Georgia Lawyers Foundation. She has participated as a judge on several occasions for the Emory University Law School Trial Techniques program and as a judge for law school trial team competitions. She is also a member of the International Association of Arson Investigators and the Georgia Fire Investigators Association.

Ms. Wright obtained her B.A. in Psychology from the University of North Carolina at Chapel Hill in 1974 and received her Paralegal Certificate in Civil Litigation from the National Center for Paralegal Training in 1980. In 1980, Ms. Wright obtained her J.D. degree from the Emory University School of Law, where she was a teaching assistant for two years in research, writing and advocacy.

R. Brady Herman

Associate

Robert Brady Herman is an associate in the firm's coverage and commercial litigation practice area.

Mr. Herman received his J.D., *cum laude*, from the Walter F. George School of Law Mercer University. While in law school, Mr. Herman served as a member on the *Mercer Law Review*. He also served on the Mercer Advocacy Council as the Student Writing Editor for Moot Court. During his time with the Mercer Advocacy Council, he competed in the John J. Gibbons National Moot Court competition in Newark, New Jersey. In addition, he served on the Student Bar Association as both his class representative as well as the chair of community service. During his final semester of law school, Mr. Herman gained valuable experience working as a judicial extern for the Honorable Chief Justice Hugh P. Thompson of the Supreme Court of Georgia.

Prior to law school, Mr. Herman received his B.B.A. in Real Estate with a minor in Legal Studies from the Terry College of Business at the University of Georgia. Mr. Herman was a summer associate with Swift Currie in 2015 before joining the firm as an associate.

Kathleen B. Hicks

Associate

Kathleen "Kate" B. Hicks is an associate in the firm's coverage and commercial litigation section. She received her B.A. in English and Political Science from Colgate University, and her J.D., *cum laude*, from the University of Georgia School of Law. While in law school, Ms. Hicks served as the Executive Notes Editor for the *Journal of Intellectual Property Law.* She also competed for the school's moot court team, finishing as Best Oralist and Team Semifinalist at the Georgia Intrastate Moot Court Competition, as well as Regional Champion, National Quarter-Finalist and National Best Brief at the ABA National Appellate Advocacy Competition.

As part of Georgia Law's appellate litigation clinic, Ms. Hicks appeared before the Federal Circuit Court of Appeals for the District of Columbia in a whistle-blower retaliation case. Ms. Hicks was a summer associate with Swift Currie and prior to attending law school, spent two years working as a political journalist in Washington, D.C.

Emily B. Marshall

Associate

Emily Ballard Marshall practices in the areas of insurance coverage and commercial litigation. Ms. Marshall graduated from Brigham Young University with a Bachelor of Science degree in Economics and minor in Political Science. Ms. Marshall graduated from Ave Maria School of Law in 2013. While in law school, Ms. Marshall was a member and editor of the *Ave Maria Law Review*. Ms. Marshall had the privilege of clerking for the Honorable Richard L. Sippel, Chief Administrative Law Judge of the Federal Communications Commission. Prior to joining Swift Currie, Ms. Marshall practiced at a Florida defense firm in the Bonita Springs office.

Janelle E. Zabresky

Associate

Janelle Zabresky practices in the areas of insurance coverage and commercial litigation. Janelle has represented clients at the state and federal level in a variety of matters including contracts and breach of contract, insurance coverage, warranty claims, premise liability, personal injury, trucking liability and general civil litigation. Prior to joining Swift Currie, Ms. Zabresky gained experience in insurance defense at another Atlanta law firm. Before moving to Atlanta in 2014, she represented homeowners in insurance disputes in St. Petersburg, Florida.

Ms. Zabresky graduated, *magna cum laude*, from Clarion University in 2010, with a Bachelor of Science degree in Political Science. While at Clarion, she was a member of the Clarion Women's Basketball team and was named PSAC Player of the Week in 2007. She earned her law degree, *cum laude*, from the Florida State University College of Law in 2013. She was a member of the *Florida State University Law Review* and had her article titled "Creating a Safe Harbor for Florida's Children: An Overview of Florida's Legislative Evolution in Domestic Minor Sex Trafficking" published in the Winter 2013 issue.

During law school, Janelle gained valuable experience as an intern for Justice Ricky Polston at the Florida Supreme Court. She also interned with the Public Interest Law Center's Healthcare Access Clinic where she represented fragile and developmentally delayed children in healthcare eligibility decisions for Medicaid Waiver and other related services. Originally from Pennsylvania, Janelle interned at the Luzerne County District Attorney's Office in Wilkes-Barre, Pennsylvania during her senior year of college.

Brandon J. Clapp
Associate

Brandon J. Clapp is an associate in the firm's coverage and commercial litigation section. He has experience in a broad variety of litigation matters representing businesses and individuals in insurance coverage, construction, employment, premises liability, products liability, transportation and wrongful death litigation.

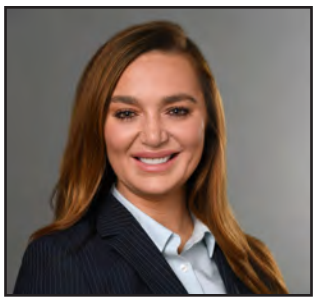
Mr. Clapp is admitted to practice law in the state of Alabama and in the U.S. District Court for the Northern, Middle and Southern Districts of Alabama. He attended Hampden-Sydney College in Virginia where he played on the varsity golf team. Mr. Clapp graduated, *cum laude*, with a Bachelor of Arts Degree in Political Science and a minor in Public Service in 2009. He then attended Cumberland School of Law at Samford University and graduated in 2012. During law school, Mr. Clapp served as the Associate Chief Justice of the Honor Court and received Scholar of Merit Awards in Constitutional Law and State and Local Tax Law.

Clayton O. Knowles
Associate

Clayton "Clay" O. Knowles practices in the areas of insurance coverage, commercial litigation, property insurance, automobile liability, arson and fraud and premises liability. He has defended some of Georgia's most prominent insurance companies and their insureds in litigation involving automobile policies, homeowners policies and commercial general liability policies.

Mr. Knowles has effectively litigated complex matters through trial and defended coverage disputes around Georgia. He has gained trial and deposition experience with first- and third-party automobile insurance litigation. He has also drafted and argued dispositive motions, evaluated coverage issues and defenses and negotiated settlements across all areas of his practice. He achieves success in the courtroom by combining his skill in evaluating claims with an aggressive approach in defending his clients.

Mr. Knowles graduated, *cum laude*, from the University of Georgia with a B.B.A. in Economics in 2011. He returned to Athens to obtain his J.D. from the University of Georgia School of Law in 2014. While in law school, Mr. Knowles won the award for Best Oralist at the Georgia Intrastate Moot Court Competition. He also served as the Executive Chairman of UGA Law's Moot Court program and as a pupil in the Lumpkin Inn of Court.



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Brycen D. Maenza is a member of the firm's coverage and commercial litigation practice group. Ms. Maenza's areas of practice are insurance coverage, personal injury, catastrophic injury and wrongful death litigation, premises liability and commercial litigation. Her practice includes defending individuals, insurance carriers, corporations, hotels, retailers, convenience stores, general contractors and subcontractors. Ms. Maenza has conducted numerous examinations under oath, depositions and mediations to obtain favorable results for her clients. In conjunction with her defense of these matters, Ms. Maenza has prepared and successfully argued several dispositive motions, including motions to dismiss and motions for summary judgment. She has also provided coverage advice, drafted reservation of rights and coverage disclaimer letters for several insurance companies with respect to pending litigation.

Ms. Maenza received her J.D. from the New England School of Law in Boston, Massachusetts in 2014. While in law school, Ms. Maenza clerked for the Honorable A. Gregory Poole of the Superior Court of Cobb County. In 2010, she graduated from University of South Carolina with a Bachelor of Science degree in Sports and Entertainment Management.

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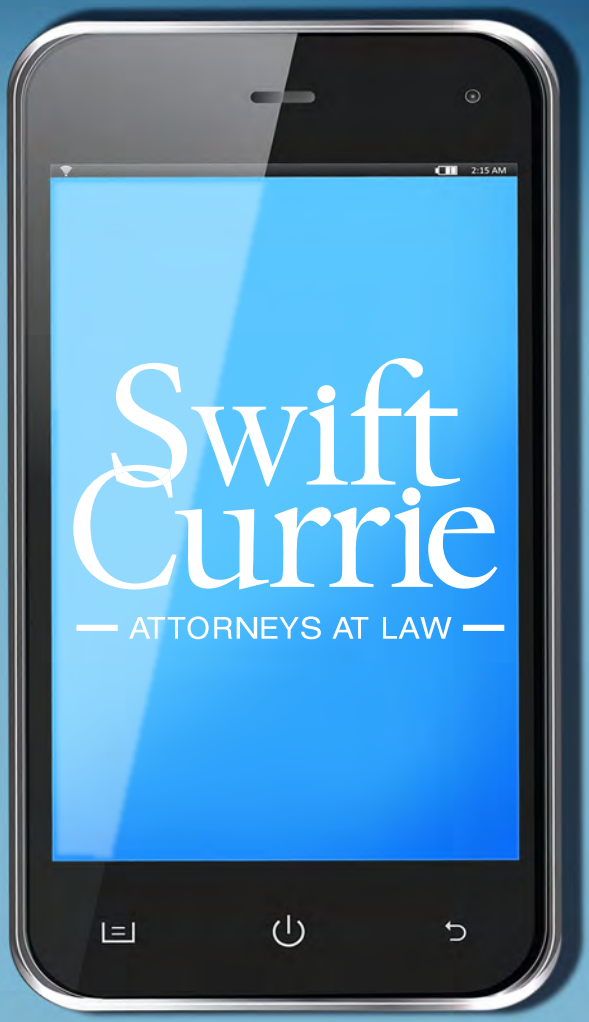

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