Casualty Co.,[80] the Federal Trade Commission entered cease and desist orders prohibiting the respondent insurance company from carrying on certain insurance advertising practices found by the Commission to be false, misleading and deceptive under the Federal Trade Commission Act. On appeal, the Supreme Court concluded that the existence of applicable state insurance statutes enacted under the McCarran Act prohibited the Federal Trade Commission from regulating such practices. The Court said that "Each State in question has enacted prohibitory legislation which proscribes unfair insurance advertising and authorizes enforcement through a scheme of administrative supervision."[81] The Court emphasized that the state, in this case, had within its boundaries the power to regulate the insurance advertising in question.[82] Thus, the otherwise exclusive jurisdiction of the Federal Trade Commission pursuant to the Federal Trade Commission Act was forced to yield to the relevent state insurance laws, and the Court found that the Commission's action was void.

In the context of this Article, the Board's debtor coercion regulation[83] relates to an area of the business of insurance already fully regulated by the states,[84] and as the *National Casualty* case instructs, any action taken by the Board under such a regulation is void and is superceded by the state regulations pursuant to the express mandate of the McCarran Act.

VII. CONCLUSION

Despite the breadth of the Board's authority underr HOLA to govern associations, acts of debtor coercion by an association are regulated by state insurance law under the debtor coercion laws.[85] The state's regulation of an association's debtor coercion (1) is consistent with the grant of authority to the states in the McCarran Act in that debtor coercion by an association while engaging in the act itself, constitutes doing the business of insurance (2) does not vitiate (a) HOLA nor (b) the supremacy clause of the United States Constitution. As such, any action taken by the Board under its regulations in a state with a debtor coercion provision of its own, is void. Such states are therefore free to exercise their exclusive authority over an association's debtor coercion.

---

80. 357 U.S. 560 (1958).
81. *Id.* at 564.
82. *Id.*
83. 12 C.F.R. § 563.35 (1978).
84. *See* NAIC MODEL ACT.
85. *See* note 7 *supra.*

FIRST PARTY INSURANCE: CLAIMS, PRACTICES AND PROCEDURES IN LIGHT OF EXTRA-CONTRACTUAL DAMAGE ACTIONS

†*Thomas M. Zurek*

I. INTRODUCTION

Insurance has been defined as an arrangement in which one party, called the insurer, contracts with another party, called the insured, to perform a service upon the occurrence of a specified harmful contingency.[1] In its most simplistic form this arrangement is accomplished by an insurer calculating both, the risk of the harmful contingency occurring and the amount of consideration which the insured must provide to compensate the insurer for contractually assuming the risk of occurrence.[2] Insurers seek to accurately predict the liability exposure which results from entering into the insurance contract by underwriting and administering claims. This prediction must be based not only on the mathematical tables which predict the probability of the specified contingency occurring, but also on the law which governs the insured's rights which arise from the contract with the insurer.

Historically, the contract of insurance has been relatively free from acrimonious legal scrutiny.[3] The relationship between insurers and insureds has traditionally been controlled by the narrow terms and conditions found within the four corners of the contract. If there was a cause of action for breach of the terms of the contract, it was brought for the

---

†B.S., Drake University (1970); J.D., Drake University Law School (1973); Currently: Partner in law firm of Mumford, Schrage, Merriman & Zurek, P.C. Law Firm; Counsel for Equitable Life Insurance Company of Iowa; Lecturer in Law (Commercial Law and Trial Advocacy), Drake University Law School. The views are those of the author and not those of Equitable Life Ins. Co. of Iowa.

1. Due to the limited scope of this article all references to the term "insurance" will mean disability income insurance unless otherwise indicated. This article will also pertain only to "first party coverage," i.e., the situation where the insured has actually suffered the injury or economic loss which creates the need for insurance benefits and not to "third party coverage," i.e., where the insured has either been sued as a tortfeasor or where a third party makes a claim against the insured and the insurer must either defend the insured or tender benefits to the third person, respectively. These limitations will apply unless otherwise indicated.

2. R. KEETON, BASIC TEXT OF INSURANCE LAW § 1.2(a) (1971).

3. *See* Hirsch, *Strict Liability: A Response To the Gruenberg-Silberg Conflict Regarding Insurance Awards*, 7 SW. U.L. REV. 310 (1975).

recovery of the benefits promised in the contract. However, the insurance industry can no longer claim that the resolution of conflicts between insurers and insureds should be limited to the recovery of benefits afforded under the contract. Rather, the industry must be prepared to defend against claims arising in the terms of basic tort theory. These actions are referred to as extra-contractual damage actions.[4] Actions such as these are brought when an insurer has refused to pay the insured under the terms of a policy and, in doing so, has engaged in activities which are in bad faith and which cause the insured additional hardship beyond that caused by the denial of the insurance benefit.[5]

The extra-contractual damage cause of action has precipitated a wave of litigation across the United States in which insurers have been called upon to pay massive judgments due to their behavior in the denial of benefit claims under the contract with their insureds. The focus of this Article will be to examine this behavior and to provide an analysis of the legal basis for extra-contractual damage lawsuits. It will also assimilate this legal basis into proposed procedures for the insurer to use in dealing with claims submitted by their insureds. Finally, the Article will provide an analysis of how the insurer can anticipate a dispute seeking extra-contractual damages between itself and the insured.

II. Available Theories of Recovery of Extra-Contractual Damages

A. Recovery Based on Contract Principles Alone

Extra-contractual liability generally does not emanate from breach of contract alone. Rather the vehicle for this type of liability is developed through a combination of tort and contract principles. Approaching the question of what theories are available for recovery of damages from a purely contractual interpretation would apparently leave a plaintiff with a simple contract remedy. An examination of English common law will demonstrate why this is true.

The principle that one cannot recover, for a breach of contract, more than the limits of the contract was established in *Hadley v. Baxendale*.[6]

---

4. The phrase extra-contractual damages can best be defined as compensatory and punitive damages which are in excess of the maximum benefits provided in the insurance agreement. Thorton, *Extra-Contractual and Punitive Damage Liability of Insurers, Primary and Reinsurance Coverages*, 13 Forum 754 (1978).

5. For an in depth discussion of the history of the extra-contractual damage theory of recovery *see* Gage, *Recovery of Unlimited Insurance Proceeds Through Punitive Damages Based Upon Bad Faith and Unfair Dealing*, 5 U.S.F.V.L. Rev. 367 (1977); Hirsch, *supra* note 3; Note, *First Party Torts—Extra-Contractual Liability of Insurers Who Violate The Duty of Good Faith and Fair Dealing*, 25 Drake L. Rev. 900 (1976). [hereinafter cited as *First Party Torts*].

6. 156 Eng. Rep. 145 (Ex. 1854).

The injured party in *Hadley* sought the recovery of lost profits which had resulted from the breach of a contract with a fellow merchant. The Exchequer, in denying recovery of lost profits, held that one should only receive compensation for those damages which "may fairly and reasonably be considered either arising naturally . . . from such breach of contract itself"[7] or which at the time of the making of the contract would have been "in the contemplation of both parties . . . as the probable result of the breach of it."[8] The primary importance of this case is that it set a tone with regard to contract damages which continues to prevail throughout our case law today.[9]

An example of the impact which *Hadley* has had on modern legal theories can be seen in the case of *New Hampshire Insurance Co. v. Christy*.[10] The Iowa Supreme Court adopted essentially the same test as set forth in *Hadley*.[11] The essential element for recovery of damages is forseeability, i.e. if it is reasonably contemplated by the parties that the harm will result from the breach of the contract then recovery will be allowed.[12] The court in *Christy*, however, did state that an award of attorney fees would be allowed in a declaratory judgment action brought by the insurer where the insurer had acted in bad faith, fraudulently or was stubbornly litigious.[13] Although *Christy* was a third party action, and as such not directly on point with the subject of this article, it does provide an example of the effect *Hadley* has had where the insured seeks extra-contractual damages but has plead a breach of contract theory alone.

---

7. *Id.* at 151.

8. *Id.*

9. *See* J. CALAMARI & J. PERILLO, THE LAW OF CONTRACTS § 14-5 to 7 (2d ed. 1977) (explaining the rule of *Hadley* in great detail, showing its application in modern situations and setting forth the exceptions which have been created since 1854).

10. 200 N.W.2d 834 (Iowa 1972). In *Christy* the insurer brought a declaratory judgment action in which it sought to avoid paying benefits to which the insured was entitled. The trial court awarded attorney fees to the insured for expenses incurred in defending both the declaratory judgment action and a third party suit brought against the insured involving the same incident which gave rise to the declaratory judgment action. The Iowa Supreme Court affirmed the award of attorney fees for the third party suit and reversed the award regarding the declaratory judgment action. *Id.* at 845. In so doing, the court recognized that the insurer had a duty to defend a third party complaint brought against its insured, but that this duty did not extend to the declaratory judgment action.

11. 156 Eng. Rep. at 151.

12. Christy, 200 N.W.2d at 844 (the forseeability of the harm occurring must have existed at the time of the making of the contract).

13. *Id.* at 844. Therefore, in Iowa, a simple breach of contract coupled with the element of bad faith, fraud or litigious conduct can lead to consideration of damages beyond the terms of the basic contract. It is these theories of recovery which are most troublesome to insurers in regard to litigation with their insureds.

B. Recovery Based on Fraud[14]

To date, three theories of extra-contractual damages have emerged. These theories are linked to the contract theory of recovery since the basic contract is the relationship which must be proved by the insured prior to recovering in an action based on the extra-contractual tort theories.

The first theory discussed is that of fraud. The California courts first set forth the theory of fraud as a vehicle for obtaining extra-contractual damages in *Wetherbee v. United Insurance Company of America*.[15] In so doing, the judiciary set the stage for an extension of damages beyond the traditional concepts of recovery in cases involving breach of contract. Under this concept, an insurer is liable where it knowingly makes either false representations to the insured or fails to disclose a material fact with the intent to deceive the insured. Additionally, the insured must show it relied upon the representation or concealment to its detriment.[16]

In *Wetherbee* the issue of fraud resulted from a letter to the insured inducing her to maintain a present disability policy and to purchase an additional policy.[17] The insurer represented to the insured that if a disability were to befall her, the insurer would not require payment of the future premiums. When the insured became disabled and filed a claim for benefits the insurer, after an investigation, denied her claim.[18] However, the court found that the insurer had conducted an inadequate and inaccurate investigation. Furthermore, from this failure to conduct an adequate investigation, the court inferred a fraudulent intent on the part of the insurer, finding that the insurer never had intended to meet its

---

14. To date, the state of California has the highest incidence of first party extra-contractual lawsuits. As such, those cases will provide the basis of the analysis of the jeopardy in which insurers are currently being placed.

15. 265 Cal. App. 2d 921, 71 Cal. Rptr. 764 (1968).

16. RESTATEMENT (SECOND) OF TORTS § 525 (1977); *see* Grefe v. Ross, 231 N.W.2d 863 (Iowa 1975); Syester v. Banta, 257 Iowa 613, 133 N.W.2d 666 (1965); Phoenix v. Stevens, 256 Iowa 432, 127 N.W.2d 640 (1964).

17. Prior to receiving this letter, the insured attempted to return and cancel this policy because she believed that it could be cancelled by the insurer at any time. The company's response stated, in part, "[y]our policy cannot be terminated nor do you have to send in any further premiums on your policy when you are permanently disabled." 265 Cal. App. 2d at ____ , 71 Cal. Rptr. at 766.

18. The policies contained a provision requiring total confinement to the home before benefits would be awarded for permanent disability. The exception to this provision was that the right to benefits was not to be defeated "because he visits his physician for treatment . . . when such treatment cannot be administered at home." 265 Cal. App. 2d at ____ , 71 Cal. Rptr. at 766. The insured sent a letter to the plaintiff's doctor inquiring about her confinement. The doctor replied that the insured was able to make monthly trips to his office, however, only with the aid of a brace or another person. 265 Cal. App. 2d at ____ , 71 Cal. Rptr. at 767. It was this information on which the insurer based its claim denial.

obligations under the policy and had misrepresented its position with regard to this policy.[19] This determination of fraud gave rise to exemplary damages which were permitted to stand even though the case was based on a contract theory.[20]

Another fraud case in which the insured was awarded extra-contractual damages is *Physicians Mutual Insurance Co. v. Savage*.[21] Whereas *Wetherbee* dealt with a misrepresentation at the time the policy was issued, *Physicians Mutual* was based on a fraudulent act commited at the time of settlement of a claim.[22] In *Physicians Mutual*, the agent in charge of settling the claim with Mr. Savage substituted another contract for the contract which Savage had initially signed. The substituted contract contained a provision which precluded any recovery by Savage.[23] The court found that the insurer and its agent had intentionally defrauded the insured in the course of settlement negotiations. Based on this finding of fraud, the lower court awarded punitive damages against the insurer and the court of appeals affirmed.[24] As such, it is clear that where there is evidence of fraud by the insurer, either at the inception of the contractual relationship or at the settlement stage, that fraud may support an award of extra-contractual damages.

C. Intentional Infliction of Emotional Distress

The second means of obtaining extra-contractual damages was established in 1970 when the courts allowed recovery for intentional

---

19. 265 Cal. App. 2d at ____, 71 Cal. Rptr. at 770. Although the finding of fraud in *Wetherbee* was based on a violation of the concept of awarding punitive or extra-contractual damages as a result of a breach of contract committed in conjunction with the tort of fraud, that same finding of fraud can be based on the common law doctrine of fraud with equal success. *See* Old Southern Life Insurance Co. v. Woodall, 326 So. 2d 726, 729 (Ala. Sup. Ct. 1976).

20. The court upheld the jury award of $1,050 actual damages based on the contract and $200,000 punitive damages based on the fraudulent intent of the insurer. The distinction should be drawn between a breach of contract committed fraudulently and a breach of contract committed in conjunction with fraudulent conduct as was the case in *Wetherbee*, 265 Cal. App. 2d at ____, 71 Cal. Rptr. at 764. The former will not allow recovery of extra-contractual damages. Fletcher v. Western National Life Insurance Co., 10 Cal. App. 2d 376, 401, 89 Cal. Rptr. 78, 92 (1970).

21. 296 N.E.2d 165 (Ind. Ct. App. 1973).

22. *Id.* at 169.

23. The policy under which the claim arose was an accidental death benefit policy under which there was no exclusion for death while intoxicated. The policy which Savage was shown during settlement negotiations excluded benefits where the decedent's injuries occurred while intoxicated. Since the decedent's death resulted from a motor vehicle accident which occurred while her blood alcohol content was .21%, the insurer denied benefits. *Id.* at 167.

24. The trial court awarded $10,108 in compensatory damages and $50,000 in punitive damages. The court of appeals affirmed both the assessment of punitive damages and the amount. *Id.* at 170.

infliction of emotional distress in cases dealing with the breach of an insurance contract.[25] In the landmark decision of *Fletcher v. Western National Life Insurance Co.*[26] the court adopted the Restatement (Second) of Torts[27] criteria for establishing a prima facie case of intentional infliction of emotional distress.[28]

In *Fletcher* the insured was suffering from a back injury which the company claimed was a non-disclosed pre-existing condition and therefore, a sickness as opposed to an injury. The company conducted no investigation other than interpreting a rather questionable medical report.[29] The insurer through its claims department attempted to settle the claim with the insured and, in so doing, resorted to the use of oppressive tactics.[30] The trial court found that the insurer's conduct was the type of conduct contemplated by the Restatement (Second) of Torts[31] and therefore, an award of punitive damages for intentional infliction of emotional distress was warranted.[32]

This method of obtaining extra-contractual damages has been used successfully in many jurisdictions.[33] However, as the next section will

---

25. *First Party Torts, supra* note 5, at 903 n. 22, 23.

26. 10 Cal. App. 3d 376, 89 Cal. Rptr. 78 (Ct. App. 1970).

27. RESTATEMENT (SECOND) OF TORTS § 46 (1966).

28. The elements as set forth by the *Fletcher* court were:
    1) Outrageous conduct by the defendant;
    2) Defendant's intention of causing or reckless disregard of the probability of causing emotional distress;
    3) Plaintiff's suffering severe or extreme emotional distress; and
    4) Actual and proximate causation of the emotional distress by the defendant's outrageous conduct.

10 Cal. App. 3d at 394, 89 Cal. Rptr. at 88.

29. The insured was covered by a disability income policy which provided for a maximum of two years benefits where the insured was sick and a maximum of 30 years benefits where the insured was injured. In an attempt to save the company money, the claims supervisor terminated injury related benefits based on a questionable medical report which stated that the insured was ill and not injured. *Id.* at 389, 89 Cal. Rptr. at 84.

30. The insurer threatened to sue the insured if he did not return a portion of the benefits already paid. During this time period the insurer was aware of the poor financial condition of the insured which had resulted from the denial of benefits and the insured's inability to work. *Id.* at 390-91, 89 Cal. Rptr. at 85.

31. RESTATEMENT (SECOND) OF TORTS § 46 (1966). The trial court was not called upon to define "outrageous conduct" because the insurer admitted that its conduct had been outrageous. *Id.* at 394, 89 Cal. Rptr. at 88.

32. The trial court awarded the plaintiff $60,000 in compensatory damages and $640,000 in punitive damages. The court of appeals reduced the punitive damages award by remittiter to $180,000. *Id.* at 98, 89 Cal. Rptr. at 409.

33. *See, e.g.*, Eckenrode v. Life of America Insurance Co., 470 F.2d 1 (7th Cir. 1972); World Insurance Co. v. Wright, 308 So. 2d 612 (Fla. 1975); Ledingham v. Blue Cross Plan for Hospital Care of Hospital Service Corp., 29 Ill. App. 3d 339, 330 N.E.2d 540 (1975); Amsden v. Grinnell Mutual Reinsurance Co., 203 N.W.2d 252 (Iowa 1972) (even though there was no showing of outrageous conduct in the case at hand, the Iowa Supreme Court recognized the existence of a cause of action for intentional infliction of emotional distress).

demonstrate, there now exists a cause of action which provides for extra-contractual damages, in which the burden of proof for the insured is much easier than establishing the presense of "outrageous conduct" which is necessary when proving intentional infliction of emotional distress.[34]

D. Bad Faith

The most recent judicially established cause of action for recovery of extra-contractual damages has its foundation in *Gruenberg v. Aetna Insurance Co.*[35] This decision resulted in the creation of a new tort: the tort of bad faith.

It has long been held that an insurer owes an implied duty of good faith and fair dealing to its insured.[36] Breach of this duty allows contractual recovery limited to the amount of the insurance contract. The decision in *Gruenberg* goes one step further, finding that the insured's failure to live up to this duty gives rise to a cause of action based on the tort of bad faith[37] in addition to the cause of action based on breach of contract.

The facts of *Gruenberg* are as follows: Gruenberg brought suit against a number of insurance companies, investigators and attorneys seeking both compensatory and punitive damages arising out of their bad faith and outrageous conduct which took place during negotiations in which the insurer refused to pay benefits owed pursuant to certain fire insurance policies. An additional act of bad faith arose when the defendants provided police authorities with false information which implied that the insured had committed arson.[38] The court held that an insurer can be found to have breached the implied duty of good faith and fair dealing when it unreasonably and without justification fails to pay the insured the benefits owed under the insurance contract. Under these cir-

---

34. An additional element which the plaintiff must prove when seeking recovery for intentional infliction of emotional distress is that the distress caused was of substantial quantity and enduring quality. This element arises from the *Fletcher* court's interpretation of Restatement (Second) of Torts section 46, Comment j (1966). 10 Cal. App. 3d at 378, 89 Cal. Rptr. at 90. *See* Richardson v. Employees Liability Assurance Corp., 25 Cal. App. 3d 232, 102 Cal. Rptr. 547 (1972) (remanded on damage issue due to lack of proof of substantial and enduring distress).

35. 9 Cal. 3d 566, 510 P.2d 1032, 108 Cal. Rptr. 480 (1973).

36. *See* Henke v. Iowa Home Mutual Casualty Co., 250 Iowa 1123, 97 N.W.2d 168 (1959); Communate v. Traders & General Insurance Co., 50 Cal. 2d 654, 328 P.2d 198 (1958).

37. 9 Cal. 3d at 581, 510 P.2d at 1042, 108 Cal. Rptr. at 490.

38. The insured owned several buildings which were destroyed by fire. The insurance investigation produced information which was forwarded to the arson investigators; on the basis of that information, the insured was charged with arson. While the charges were pending the insurer asked Gruenberg to take an examination, under oath, regarding the fire. The insured refused to attend the examination, after first requesting a delay, and the insurer denied coverage on the grounds that Gruenberg had failed to live up to the cooperation clause of the policy. *Id.* at 572, 510 P.2d at 1035, 108 Cal. Rptr. at 483.

cumstances, the court found that the breach of this duty resulted in liability from an independent tort of bad faith giving rise to compensatory and punitive damages, in addition to the damages available under the contract.[39] Therefore, this cause of action allows recovery for the same types of damages as does the cause of action based on the tort of intentional infliction of emotional distress.[40] However, unlike the tort of intentional infliction of emotional distress, under the tort of bad faith the insured does not have to establish that the insurer's conduct was outrageous and intentional, or that the distress suffered was of substantial quantity and enduring quality.[41]

One year later the California Supreme Court reviewed the availability of punitive damages in bad faith tort suits. In *Silberg v. California Life Insurance Co.*,[42] the company refused to make benefit payments until it had determined whether or not workers' compensation benefits were available.[43] The court held that a delay in payment under these circumstances was bad faith as a matter of law and sustained the lower court's award of extra-contractual compensatory damages.[44] However the court found that the mere breach of the duty of good faith and fair dealing was insufficient to support a punitive damage award.[45] In order to obtain punitive damages under the *Silberg* test, the insured must show that the insurance company acted oppressively, fraudulently or maliciously with the "intent to vex, injure or annoy, or with a conscious disregard of the plaintiff's right."[46] Thus, *Silberg* has added an additional element

---

39. *Id.* at 580, 510 P.2d at 1041, 108 Cal. Rptr. at 489. Therefore, under this doctrine, an insurance company which is found to have committed the tort of bad faith will be liable for all of the damages incurred by the insured which were proximately caused by the company's bad faith conduct. This would include an award for pain and suffering, attorney fees, appeal costs, etc. *See* Hirsch, *supra* note 3, at 322.

40. *See* notes 32, 33 *supra.*

41. *See First Party Torts, supra* note 5, at 910.

42. 11 Cal. 3d 452, 521 P.2d 1103, 113 Cal. Rptr. 711 (1974). In *Silberg* the insured was covered by a medical and hospital policy designed to pay medical bills up to $5,000; however, the policy excluded coverage if the injury was compensable under workers' compensation. The plaintiff injured himself under circumstances giving rise to possible workers' compensation benefits.

43. During this time period the plaintiff incurred substantial medical bills. Due to his inability to pay them he was forced to go to three different hospitals to obtain the required treatment. He was also evicted from five different residences for failure to pay his rent and his utilities were repeatedly shut off. *Id.* at 457, 521 P.2d at 1107, 113 Cal. Rptr. at 715.

44. The California Supreme Court upheld an award of $4,900 due under the contract and $75,000 compensatory damages. The insurance company raised as a defense the fact that they had followed the customary practice of the industry in claims such as this. The court held that the implied duty of good faith and fair dealing could not be eroded by industry custom. *Id.* at 462, 521 P.2d at 1109, 113 Cal. Rptr. at 717.

45. *Id.* at 462, 521 P.2d at 1110, 113 Cal. Rptr. at 718.

46. *Id.*

which the plaintiff must establish before recovering punitive damages in bad faith tort suits.[47]

The final chapter in the extra-contractual damage cases in the first-party type litigation has not yet been written. The California cases are continuing to have an impact on the area of insurance litigation. Two recent California cases indicate what might be coming. These cases are *Johanson v. California State Auto Association Inter—Insurance Bureau*[48] and *Neal v. Farmers Insurance Exchange*.[49] *Johanson* was a third party excess liability case[50] in which the insurance company believed in good faith it had a justifiable reason for failing to settle the claim within policy limits.[51] The Supreme Court stated that:

> an insurer who denies coverage does so at its own risk, and, although its position may not have been entirely groundless, if the denial is found to be wrongful it is liable for the full amount which will compensate the insured for all the detriment caused by the insurer's breach of the express and implied obligations of the contract.[52]

As the result of *Johanson*, an insurer who refuses to accept a reasonable offer of settlement based on a "good faith" belief that coverage does not exist can not use its "good faith" conduct as a defense if the refusal to settle is found to be erroneous.

Thus it may be argued that the California Supreme Court has adopted a standard of strict liability in third party cases when the insurer was wrong in its decision to deny coverage of its insured even

---

47. *See* Gage, *supra* note 5, at 378; *First Party Torts*, *supra* note 5, at 911.

48. 15 Cal. 3d 9, 538 P.2d 744, 123 Cal. Rptr. 288 (1975).

49. 64 Cal. App. 3d 966, 135 Cal. Rptr. 105, vacated 68 Cal. App. 3d 422, 137 Cal. Rptr. 660 (1977).

50. A third party excess liability case is a case in which the insured is sued as a tortfeasor for an amount exceeding the policy limits and where the insurance company must assume the insured's defense under the terms of the policy. In the present case, Ms. Johanson was injured in an automobile accident caused by Gary Dearing, the insured of the defendant. Dearing was insured for $10,000 for bodily injury and $5,000 for property damage. Johanson sued Dearing at which time Dearing's insurance company denied coverage. *See* note 52, *infra*. Johanson obtained a judgment in the amount of $33,889.30, $19.692.19 of which Dearing's insurance company subsequently paid after a declaratory judgment held that Dearing was covered by his policy. Prior to obtaining judgment Johanson offered to settle with the insurance company within the limits of the policy. Based on the company's refusal to settle, Johanson obtained an assignment of Dearing's rights against his insurer for the balance of the judgment. She then brought this action against Dearing's insurance company based on refusal to settle. 15 Cal. 3d at 11-12, 538 P.2d at 746-47, 123 Cal. Rptr. at 290-91.

51. The defendant contended that the car driven by Dearing, at the time of the accident, had been purchased more than thirty days prior to the accident and that Dearing had not reported the purchase to the insurance company. Based on the terms of the policy, these facts would have excluded coverage had the defendant been able to prove them. 15 Cal. 3d at 12 n.z., 538 P.2d at 747 n.z., 123 Cal. Rptr. at 291 n.z.

52. *Id.* at 13, 538 P.2d at 748, 123 Cal. Rptr. at 292 (quoting Communale v. Traders & General Insurance Co., 50 Cal. 2d 654, 660, 328 P.2d 198, 202 (1958)).

though the decision was made in complete good faith. Cases such as *Johanson* may lead to the inability of an insurance company to contest claims without being held strictly liable for all the detriment which befalls the insured as a result of the insurance company's failure to settle. The industry is being pushed to the point where it must be nearly 100% certain of its right to contest a particular claim or else face the consequences of acrimonious litigation involving the possibility of extra-contractual damage awards.

The question of first party coverage was more recently dealt with in *Neal v. Farmers Insurance Exchange*.[53] In this case Farmers had provided automobile insurance for the Neals.[54] The Neals were struck by an uninsured motorist and Mrs. Neal was seriously injured. The company disputed liability contending that the uninsured driver was not negligent and that even if he was negligent, Mr. Neal was also negligent and that his contributory negligence was imputable to Mrs. Neal.[55] The case proceeded to arbitration where the arbitrator held the company liable for the $15,000 uninsured motorist benefits and additionally held that the company was not entitled to offset the $5,000 previously paid pursuant to the medical payment coverage. The Neals brought an action against Farmers based upon Farmers' breach of the implied covenant of good faith and fair dealing. Judgment was entered against Farmers and they appealed.[56] The California Court of Appeals reiterated its earlier findings concerning the covenant of good faith and fair dealing.[57] The court found the jury had sufficient facts to determine the company had no colorable defense at the time it was denying coverage.[58] The court concluded that this in and of itself was bad faith and would support an award of extra-contractual compensatory damages.

---

53. 64 Cal. App. 3d 966, 135 Cal. Rptr. 105, *vacated*, 68 Cal. App. 3d 422, 137 Cal. Rptr. 660 (1977).

54. Pursuant to this coverage, there were medical payments protection, up to $5,000 maximum, and uninsured motorist coverage, up to $15,000 maximum. The policy provided that payments under the medical payments coverage would be offset against any payments made under the uninsured motorist provision. *Id.* at 429, 137 Cal. Rptr. at 663.

55. The company paid $5,000 under the medical payment portion of the policy. In addition to denying coverage under the uninsured motorist section, the company also took the position that any possible payments which might be made pursuant to the uninsured motorist section would have to be off-set by the $5,000 already paid. *Id.* at 431, 137 Cal. Rptr. at 664.

56. The initial judgment was for $1,548,211. This amount was reduced by remittance to $749,011, $9,573 of which were compensatory damages. *Id.* at 431, 435, 137 Cal. Rptr. at 664, 667.

57. *See* Silberg v. California Life Insurance Co., 11 Cal. 3d 452, 521 P.2d 1103, 113 Cal. Rptr. 711 (1974); Gruenberg v. Aetna Life Insurance Co., 9 Cal. 3d 566, 510 P.2d 1032, 108 Cal. Rptr. 480 (1973).

58. The fact that substantial evidence existed to support the jury determination could be seen in the fact "that defendant asserted defenses known to be invalid in an effort to take advantage of the Neals' desperate situation and effect a settlement at a bargain price." Neal v. Farmers Insurance Exchange, 68 Cal. App. 3d 422, 433, 137 Cal. Rptr. 660, 665 (1973).

The court then addressed the punitive damages issue, noting that to award punitive damages the motive and intent of the insurer must be considered. The court provided that punitive damages could be awarded where there is evidence, upon which the jury might rely, that the insurer acted maliciously, oppressively or fraudulently with the "intent to vex, injure or annoy, with a conscious disregard for the plaintiff's rights."[59] The court found that, in the case at hand, there was substantial evidence upon which the trier of fact could find the necessary motive. However, the court held that the jury's award was not justified by the defendant's conduct and therefore the award must have been based on passion and prejudice. For these reasons the judgment was reversed.[60]

The importance of this case is in the court's treatment of the insurance company's use of a "reasonable defense" in justifying a claim denial. The *Neal* case leads to the conclusion that the question of whether the insurer had available a reasonable defense will utimately become a question of fact to be determined by the jury.[61] Additionally, the court attempted to provide the trier of fact with guidelines upon which to base its determination regarding the amount of punitive damages, if any, which are to be awarded. In so doing, however, the court failed to address the two most pressing issues in this area: is an award of punitive damages in these circumstances constitutional and does such an award actually produce the desired effect of deterring future acts of this nature?[62]

The California cases, in liberalizing the recovery of extra-contractual damages, have affected judicial decisions on similar issues in other states. The Iowa Supreme Court's decision in *Kooyman v. Farm Bureau Mutual Insurance Co.*[63] is an example of the influence which the California cases have had. In *Kooyman*, an action was brought against an insurer for negligently failing to settle a claim within the policy limits. This was a third party action in which the plaintiff, injured by Farm Bureau's insured, obtained a verdict against the defendant insured.[64] Subsequently,

---

59. *Id.* at 433, 137 Cal. Rptr. 666 (quoting Silberg v. California Life Insurance Co., 11 Cal. 3d 452, ____, 521 P.2d 1103, 1110, 113 Cal. Rptr. 711, 718 (1974)).

60. In addition to the passion and prejudice of the jury, the court found that the plaintiff's counsel pursued an incorrect legal theory regarding the potential liability of the insurance company. The court decided that this erroneous legal theory affected not only the amount of the award, but, also the question of defendant's bad faith conduct and therefore, the only reasonable solution was "outright reversal" of the lower court. *Id.* at 440, 137 Cal. Rptr. at 670.

61. *Id.* at 433, 137 Cal. Rptr. at 665.

62. *See* Egan v. Mutual of Omaha Ins. Co., 63 Cal. App. 3d 659, 133 Cal. Rptr. 899 (1976). Defendant's Appellate Briefs to the California Supreme Court set forth the argument that the punitive damage actions as are being espoused today are unconstitutional.

63. 267 N.W.2d 403 (Iowa 1978).

64. *Id.*

the defendant insured assigned to the plaintiff all of the potential claims against the defendant insurer, Farm Bureau, which the defendant insured might have had. The Iowa Supreme Court indicated in *Kooyman* that an insurance company may be liable in excess of the limits of the policy where it is established that the company acted in bad faith.[65] Further, the court provided that an insurer may be held liable *only* for bad faith in its handling of an insured's defense.[66] However, the court made it clear that this bad faith requirement requires a showing of more than mere negligence before liability will be assessed against the insurance company: "[O]nly acts of negligence that show or permit an inference of indifference to or disregard of the interest of the insured" will support a charge of bad faith.[67] Thus, the Iowa Supreme Court seems to be moving in the direction of the California decisions in its analysis of bad faith as a ground for damages beyond the scope anticipated by the terms of the contract.

III. Suggested Methods for Avoiding Extra-Contractual Damage Litigation

The above discussion has provided examples of insurance company practices and procedures which have been found to be unacceptable and therefore, have supported an award of extra-contractual damages. While it is clear that California is the jurisdiction most amenable to extra-contractual insurance damages, it should be equally clear that the first party insurer, in any jurisdiction, should conduct itself as if the California precedents were enforceable nationwide. However, this is not to say that insurers should deny claims only at their own peril, or that insurers should settle all claims without asserting their legitimate legal defense. The following discussion will attempt to set forth some standards and procedures which will help protect insurance companies from the burden of extra-contractual damages awards.

It appears that the standards for claim practices will be scrutinized by the courts in terms of the insurer's "good faith" and "fair dealing."[68] However, these concepts have not been thoroughly defined by the courts, and as such, insurance companies are unclear as to what procedures should be utilized for handling claims. The simplistic way for companies to deal with the lack of predictability as to potential extra-contractual liability in claims handling is to only contest claims which can be denied for legitimate reasons. This seems to be an irrefutable statement. However,

---

65. *Id.* at 406.
66. *Id.*
67. *Id.* at 407.
68. Langdon & Systma, *The Duty of Good Faith and Fair Dealing and The Pre-Adjudicatory Role of The Insurance Company Advocate*, 45 Ins. Counsel J. 309, 312 (1978).

the inherent problem is that in denying a claim for legitimate reasons, the insurer must be cognizant of what a jury's determination of the "legitimacy" of an insurer's behavior will be. Since the definition of "good faith" and "fair dealing" is unclear, an insurer can only speculate as to what acceptable behavior may be.

The overriding concept pervading all insurance contract relationships and claim practices is "reasonableness."[69] The test of what behavior is reasonable must not be based on what the insurer considers reasonable, given the terms of the contract and the acts undertaken pursuant to that contract, but, rather, on what a reasonable person in the position of the insured would have understood the contract to mean.[70] Evaluation of all contracts, statements, documents and speculations regarding contracts must not be strained, forced, arbitrary or strictly technical. The evaluation must be fair, natural, logical and practical regarding the original intent of the parties considering the contract in question and the expectation of the insured at the time the contract was entered into.[71]

The only way to guarantee "reasonableness" in claim practices is to properly educate company personnel regarding the standard to which the insurance company will be held in "bad faith" cases. Education will help to control improvident, ill-advised and perhaps illegal claim practices. For example, all claims personnal should be knowledgeable regarding the Unfair Settlement Practices Act[72] a piece of model legislation which has been adopted in some form by most states.[73] The act should be a starting point for claim personnel education. Insurance companies should internally provide personnel with guidelines and acceptable behavior and procedure concerning investigation of claims, policy analysis, documentation of claims and evaluation of the entire scope of claims handling.

The claim file is the tangible evidence which reflects the insurer's attitude concerning the factors listed above.[74] Careful construction of the file is a necessity. It should be developed with a view towards litigation and contain all pertinent information.[75] This information is critical as a tool both in litigation and as a tool in assisting trial counsel in preparation for litigation.[76] A typical claim file which contains the necessary information should include the following:

---

69. IOWA CODE § 507B.4(9) (1977).

70. *See* Shain v. Mutual Benefit, Health & Accident Ass'n., 232 Iowa 1143, 7 N.W.2d 806 (1943). *See generally* Hein v. American Family Mut. Ins. Co., 166 N.W.2d 363 (Iowa 1969).

71. 1 G. COUCH, *Cyclopedia of Insurance Law* § 15.16 (2d ed. 1959 & Supp. 1977).

72. IOWA CODE § 507B.4(9) (1977).

73. *See, e.g.*, IOWA CODE Ch.507B (1977).

74. J. MCCARTHY, PUNITIVE DAMAGES IN BAD FAITH CASES 233 (1976).

75. Kornblum & Wilson, *The Role of Insurer's Corporate Counsel in Defending First-Party Extra-Contract Litigation*, 1978 INS. L.J. 255, 259.

76. *Id.*

(1) insured's application;
(2) policy as issued plus endorsements;
(3) agent information, i.e., name, agency, years with the company;
(4) premium payment information;
(5) local laws which affect the claim;
(6) claim form submitted by insured;
(7) claim correspondence with insurance company's attorney;
(8) claim correspondence with the insured;
(9) documentation concerning claim:
    a) insured's job description, education, specialized training and experience;
    b) insured's medically defined disability;
    c) insured's physician reports regarding disability;
    d) medical data (medical reports);
    e) independent medical examination report;
    f) evaluation of medical evidence by company medical director;
    g) evidence of other insurance;
    h) company attorney or retained attorney opinion concerning policy coverage questions.

Although the scope of the information we have been discussing emphasizes disability income claim handling, it should be pointed out that proper claim practices can be universally applied. However, no amount of file documentation, investigation or evaluation will aid an insurer in any type of extra-contractual insurance case where a claim is denied without proper cause. In light of the *Johanson*[77] and *Neal*[78] decisions, insurers should have, at a minimum, a sound definable position for denying a claim. This position should be grounded in a legal defense and on substantial medical evidence.

Perhaps the most difficult decision to be made by an insurer in the disability income area is defining whether an insured is disabled under the terms of a policy.[79] The primary consideration in the disability income area incorporates the questions of legal defenses and medical evidence.

Disability insurance policies generally provide benefits which are a replacement for earnings when the insured cannot secure employment as a result of some disease or injury.[80] The question of disability is generally a medical determination. This determination can be made by evaluating

---

77. Johanson v. California State Auto Ass'n. Inter-Ins. Bureau, 15 Cal. 3d 9, 538 P.2d 744, 123 Cal. Rptr. 288 (1975). *See* notes 48-52 *supra* and accompanying text.

78. Neal v. Farmers Exchange Insurance, 64 Cal. App. 3d 966, 135 Cal. Rptr. 105, *vacated*, 68 Cal. App. 3d 422, 137 Cal. Rptr. 660 (1977). *See* notes 53-62 *supra* and accompanying text.

79. 15 G. COUCH, CYCLOPEDIA OF INSURANCE LAW § 53.41 (2d ed. 1959 & Supp. 1977).

80. *Id.* at § 53.40.

factors concerning the insured and his disability, such as age, physical limitations, mental limitations, lifestyle to which the insured has become accustomed and education and experience. To gather the necessary documents and properly evaluate them, the following procedures can be followed to be implemented along with the claim file:

1. The insurance company should approach all claims from the standpoint of the insured's expectation that he purchased disability insurance for the purpose of satisfying his fears of being unable to earn a living and support his family. This is an argument which will have to be overcome in defending any lawsuit which results from the denial of disability income benefits;[81]

2. A declaration of the insured's disability should be obtained from the insured's medical practitioner. This declaration is critical as it is the basis for any inquiry into the actual medical condition of the insured. The medical practitioner's statement should include the following:

   a. A statement of the insured's physical condition (including all medical data available to the physician);
   b. The relationship between the insured's physical condition and the insured's capacity to work;
   c. A statement as to whether or not the insured is disabled from performing any job, a specific job, and the estimated length of such disability; and
   d. A statement by the practitioner indicating what he feels the disability is.

If the claim evaluator does not reasonably feel that the insured's medical practitioner has provided the information as set out above, the practitioner should be contacted and the necessary information requested. Without a complete medical file no determination as to disability can be made;

3. Upon preliminary analysis of the medical information the claims evaluator should consult the company medical staff about claims that give rise to any question concerning disability and its relation to medical data. The medical staff can evaluate such claims in terms of the medical facts and at this point, the necessity of additional medical evaluation may be deemed to be appropriate. If the medical staff determines that there is a question regarding medical information, further inquiry can be made of the insured's medical practitioner or an evaluation may be requested by a medical practitioner chosen by the insurer. The information sought from this medical practitioner should be the same as that requested from the insured's practitioner. If upon receipt of information from the insurer's chosen medical practitioner the results support disability, obviously payment should be made immediately. If, however, there is a divergence of

---

81. *See* J. McCarthy, Punitive Damages in Bad Faith Cases 50 (2d ed. 1978).

medical opinion regarding the disability, the claim evaluator will have to determine if additional medical opinion should be sought. If that is required, an independent medical examiner should be consulted and given the opportunity to evaluate the decision of the insured's practitioner and the insurer's practitioner. This independent medical examiner's opinion is critical at this stage of conflict between the insurer and the insured; therefore, this individual should be mutually acceptable to the parties. Using the independent medical examiner decreases the possibility of speculation on the part of claims personnel, and is necessary to avoid the appearance of arbitrariness regarding its claim practices;

4. After gathering all documentation concerning the medical evidence it may be necessary to have an independent investigation done regarding the insured. This evaluation and investigation may be necessary to determine the following information:

a. The family, social and educational background of the claimant;
b. The financial condition of the claimant;
c. The work history of the claimant; and
d. The reputation of the claimant;

These evaluations can be done by national investigation agencies, private company investigators and local law firms; and

5. If all information points to the fact that the insured is actually not disabled under the terms of the policy, the decision to deny should be abated until it is determined that all medical information is available and has been viewed, the personal investigation of the claimant has been made available and has been reviewed and the medical and personal information relied upon for denial is not effectively refuted by contrary medical or personal facts.[82]

In considering the steps of claim analysis set out herein from a medical and individual viewpoint, one should be aware that this information should not be gathered with an appearance of arbitrarily attempting to create medical or personal evidence upon which to refute a claim. Instead, an attempt should be made to create medical evidence which corroborates the insured's claim for disability and provides a "reasonable" basis for paying or denying a claim. This factor is absolutely necessary to avoid claims against the insurer for bad faith.[83]

Prior to making the final decision to pay or decline a disability claim, the legal implication of the contract between the insurer and insured must be considered. It has been held that an insured may be found to be

82. The rule approaching Strict Liability for a good faith, though erroneous defense espoused by an insurer as set out in *Johanson v. California State Auto Ass'n. Inter-Ins. Bureau*, should be kept in mind when deciding if accumulated information is sufficient to support a denial of benefits in first party cases. If the denial is based on insufficient facts there could be a strong argument created for recovery.

83. *See* the cases cited in note 70 *supra*.

disabled within the meaning of a disability policy if he is found to be unable to perform a substantial and material part of some gainful work or occupation with reasonable continuity.[84]

This definition of disability is critical in that it must be applied to the facts as determined by the medical practitioner. This legal definition will be the standard against which the insurer will have to analyze the medical data and personal data. If the criteria set out herein supports a conclusion of disability, the claim must be paid. If, however, the criteria supports a conclusion of no disability, and the company has investigated thoroughly and in good faith, the claim should be denied. This conclusion accepts the fact that extra-contractual lawsuits are becoming more apparent but it presumes that the insurer operates in good faith and is entitled to rely on the terms of the contract.

In avoiding bad faith lawsuits, perhaps the most important function that should be implemented by an insurer, next to proper claims handling, is educating claims personnel to recognize burgeoning bad faith claims. The initial point at which time the claims personnel should recognize the possibility of a bad faith suit developing is not when a lawsuit is filed by way of service of process on the insurer. Rather it is when a claim is opened and there is an apparent conflict between the parties. All claims practices and procedures must be considered to be complete since they will instantly be opened to scrutiny by the discovery process available in the various jurisdictions from which the disgruntled policyholder may choose.[85] At this point it will be difficult to rehabilitate past mistakes and claim practices.

In addition, a more subtle approach by the insured other than a lawsuit may also alert the insurer of potential bad faith suits. The company may receive a communication from the insured, a relative of the insured or the insured's attorney. This letter will generally contain the following information to put the company on notice of an impending bad faith claim:

1. Information concerning the coverage in question (this can take the form of an actual reference to a policy, a general description of coverage or even a simple statement that the claimant is insured by the company);

2. A statement concerning the peril which the claimant has suffered which activates the company's alleged liability under its contract of insurance;

3. A declaration that the company has refused to pay benefits pursuant to the terms of coverage in the original contract of insurance;

---

84. Culley v. New York Life Ins. Co., 27 Cal. 2d 187, 163 P.2d 698 (1945). In *Culley* the court stated, " '[a]ccording to overwhelming authority, the term 'total disability' does not signify an absolute state of helplessness. . . .' " 27 Cal. 2d at 189, 163 P.2d at 700 (quoting Erreca v. Western States Life Ins. Co., 19 Cal. 2d 388, 396, 121 P.2d 689, 695 (1942)).

85. *See* FED. R. CIV. P. 26; IOWA R. CIV. P. 121-34.

4. A request for information concerning the status of insured's claim, including all documentation upon which the decision not to pay was based and an explanation of the insurer's position concerning its denial of the claim;

5. A statement concerning the hardship that has befallen the insured as a result of the insurer's failure to pay benefits;

6. A demand for benefits to be paid; and

7. A time deadline for response to the communication or payment of benefit.[86]

The letter can take many different forms but it will always state that the claimant has suffered the "insured-against" injury and that the failure to pay benefits has caused the claimant hardship. The tone of the letter will most probably be one which is non-combative and which contains no hint of recrimination or threat. It is for this reason that insurers should be aware of such communications.[87] These letters are created for the purpose of forcing insurers into mistakes which can demonstrate bad faith. To avoid this, the insurer should respond as follows;

1. It should communicate immediately with the claimant or claimant's attorney. Delay in response is arguably bad faith, especially in light of claimant's representation that the company's failure to pay is causing continuing hardship:

   a. This communication should speak to all issues raised in claimant's communication; and
   b. Point out the basis for decisions made to deny benefits;

2. If all of the reasons for denial are not yet compiled, inform the claimant that the investigation is continuing and generally outline the steps being taken to gather additional information;

3. The insurer should request information from the insured which the insured feels may be important to the consideration of his claim;

4. It should avoid placing time deadlines on the investigation; and

5. Most important of all, the insurer should be reasonable.

In responding to a claimant letter described above, an important element to consider is the defference paid to the claimant by the insurer. The insurer must realize that it is in a position of jeopardy when dealing with an insured after a demand letter has been received. Therefore, all claims practices and procedures must be tuned to protect the interests of the insurance company as they may appear.

A primary consideration at this point is whether an insurer should be paying benefits to an insured while it is investigating a questionable claim. The *Johanson* case has indicated that where there is a potential

---

86. *See* McCarthy, *supra* note 81, at 204.

87. *See Appendix* I *infra.*

question as to coverage under the terms of an insurance policy, it may be most appropriate for the insurer to pay benfits while a determination is being made as to the coverage under the terms of the policy.[88] Although the *Johanson* case is a third party excess situation, the first party coverage defenses can be easily applied. When an insurer is continuing an investigation into a first party insurance claim, the investigation is proceeding at a slow pace and the insured is not being compensated under the terms of the policy, it is arguable that such non-payment constitutes bad faith. The insured can be said to be suffering economic distress as a result of the insurer's investigative delay. To avoid this, it may be wise to begin paying benefits to an insured pursuant to a non-waiver agreement or a reservation of rights. The non-waiver agreement is most generally a bilateral agreement whereby the parties agree that payment of benefits or required acts pursuant to the contract of insurance shall commence, and that the insurer reserves the rights it has under the terms of the contract.[89] The insurer does not waive or is not estopped from asserting any of its rights. Included in this package of "non-waived" rights is the right to cease payment and the right to seek reimbursements of the amounts paid. If a bilateral agreement is not available, the insurer may choose to begin payment pursuant to a reservation of rights. This reservation of rights is merely a notice to the insured that the insurer is making payment or performing acts pursuant to the terms of a contract, but that it is reserving all rights based on non-coverage or other stated grounds.[90] The critical element necessary for non-waiver agreements or a reservation of rights notice is that the agreement or notice must fairly inform the insured of the insurer's position by setting out why the insurer is reserving its rights.

IV. Conclusion

Since the initial extra-contractual damage decisions, the insurance industry has had to reevaluate its behavior in terms of what the fact finder would deem acceptable when subjected to judicial scrutiny. This analysis had endeavored to indicate areas of jeopardy for insurers with suggestions of how to cope with the problems created by extra-contractual damage lawsuits. The future monetary and societal effects of these causes of action can be devastating to the insurance industry unless reasonable, good faith behavior becomes the rule of all dealings between insurers and insureds. It is hoped that these practical guidelines will help achieve that desired behavior.

---

88. *See* notes 48-52 *supra* and accompanying text.
89. *See Appendix* II *infra.*
90. *See Appendix* III *infra.*

Appendix I

Example (a):

Dear Agent:

This office has been retained to represent Joe Doe relative to his claim for damages as a result of matters surrounding the death of John Roe, his business partner.

You, as an agent of Insurance Company and Insurance Company, we contend, violated Doe's rights in that you represented to Mr. Doe that the insurance you were in the process of selling to him and Mr. Roe, reciprocal life insurance policies relative to their business partnership, had been provided, and coverage was bound, until shortly before Mr. Roe's death on December 25, 1977. In fact, this was a representation that the subject of a transaction had been supplied when in fact it had not. Your insurance binder issued in January 1977 had expired 60 days from its issuance, although you misrepresented to Mr. Doe that there was coverage beyond the 60 days, when in fact there was not. Had the parties known the facts previous, application could have been made and coverage could have possibly been gotten through another carrier, or through Good Co., the existing carrier. In addition, you falsely represented that a replacement insurance policy was needed, when in fact it was not, because the existing Good Co. coverage was satisfactory on all counts, at the time you made the representation, in first attempting to sell the parties your replacement policy. Since you are an agent of Insurance Co., your actions are those of Insurance Co. in doing the things above-mentioned.

Demand is hereby made that you and Insurance Co. honor the terms of the coverage on Mr. Roe's life, which was contemplated by the parties, and if the above defects are cured in this manner within 30 days, i.e. by payment of $150,000.00, no further action will be taken. However, after the expiration of 30 days, Mr. Doe will be entitled to seek his action and remedies at law.

I will be looking forward to hearing from your or your representative at your earliest possible convenience relative to this matter.

Very truly yours,

Example (b):

Dear Claim Manager:

Mr. Claimant has referred to me your letter of August 11, along with his policy with Insurance Co. I have reviewed the policy and letter with Mr. Claimant and have discussed with him his usual activities while operating his business. I have also reviewed with him his medical condi-

tion and medical reports of Doctor. Based upon this review, I have advised Mr. Claimant that in my opinion your company should continue to make payments under his policy.

It is my understanding that Mr. Claimant's condition had essentially remained unchanged from the time he first initiated his claim for benefits. In light of this, I see no reason for your company to now take the position that benefits should terminate. I further question your interpretation of the policy which would appear to require that Mr. Claimant be totally incapacitated and literally unable to function before he would qualify for benefits. I don't believe that this is the intent of the policy or that it would be interpreted this way in court. A high percentage of Mr. Claimant's activity that was required in the running of his business involved lifting, carrying and moving of furniture. The fact that he might have been able to perform some sedentary work since his injury and claim, does not mean that he was able to engage in his regular business.

For these reasons, I have advised Mr. Claimant that there is no basis for your company terminating payments.

This letter is formal notice of Mr. Claimant's position and if payments are not reinstated, we will initiate formal claim against your company. Please advise.

Very truly yours,

Appendix II

NON-WAIVER AGREEMENT

It is mutually agreed between insured and Insurance Co., pursuant to the terms of Insurance Policy No. ____ and claim submitted pursuant to said Insurance Policy by insured that Insurance Co. will investigate all facts pertinent to the claim submitted, and while such investigation is taking place Insurance Co. shall pay benefits pursuant to said policy and claim and that said investigation and payment shall not be considered to be a waiver of any right which Insurance Co. may have under the terms of the said insurance policy nor shall this agreement be considered as a waiver of any right of insured under the said insurance policy.

_____

INSURED

_____

COMPANY

Appendix III

RESERVATION OF RIGHTS

To: Insured

You are hereby notified that pursuant to Insurance Policy No. ____ and your claim for benefits submitted pursuant to said policy, Insurance Co. will investigate all facts pertinent to the claim submitted, and while such investigation is taking place Insurance Co. shall pay benefits pursuant to said policy and claim and that said investigation and payments shall not be considered to be a waiver of any right which Insurance Company may have under the terms of the said insurance policy.

_____

COMPANY

Note

WORKERS' COMPENSATION IN IOWA—THE GOING AND COMING RULE AND ITS EXCEPTIONS.

I. INTRODUCTION

Workers' compensation laws were originally enacted to provide benefits to employees victimized by work-related injuries. This social purpose is achieved by placing a "liability without fault" burden upon the employer of the injured employee for injuries incurred while the employee is acting within the scope of his employment.[1] To avoid thwarting the social purpose underlying these laws, most jurisdictions, including Iowa, have liberally construed workers' compensation statutes in favor of the employee.[2] However, this policy of liberal construction is not intended to make employers absolutely liable for all injuries suffered by an employee.[3] Certain requirements under present workers' compensation laws must be satisfied before an employee may be compensated for injuries. For example, in Iowa, two main requirements must be satisfied before an employee's injury is deemed to be compensable: it must both arise out of and in the course of the injured party's employment.[4] The circumstances in which an injury "arises out of and in the course of" employment is defined as follows:

> The words "*personal injury arising out of and in the course of the employment*" shall include injuries to employees whose services are being per-

---

1. Larson, *The Nature and Origins of Workmen's Compensation*, 37 CORNELL L.Q. 206 (1952); 1 A. LARSON, THE LAW OF WORKMEN'S COMPENSATION §§ 2.00-.10 (1978).

2. *See* Alm v. Morris Barick Cattle Co., 240 Iowa 1174, 1175, 38 N.W.2d 161, 162 (1949) (claimant, who was employed to feed cattle, was in the course of employment when injured unloading cattle at the direction of the employer's local representative); Pohler v. T. W. Snow Constr. Co., 239 Iowa 1018, 1027-28, 33 N.W.2d 416, 421 (1948).

3. Bulman v. Sanitary Farm Dairies, 247 Iowa 488, 73 N.W.2d 27 (1955). The court in *Bulman* qualified the liberal construction doctrine by requiring that workmen's compensation laws be administered by logical rules, not by the sympathies and sentiments of any particular judge. *Id.* at 494, 73 N.W.2d at 30.

4. Lindahl v. L. O. Boggs, Co., 236 Iowa 296, 307, 18 N.W.2d 607, 613 (1945). In *Lindahl* the court stated that "[u]nder the Iowa act, to justify an award, three things must be shown by the evidence, direct or circumstantial. . . . These are: (1) That the employee suffered the injury; (2) that the injury was sustained in the course of employment; and (3) that the injury arose out of the employment." *Id.* at 308, 18 N.W.2d at 613-14.