

Making an Insurance Claim and Fighting Denials of Coverage

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INTRODUCTION

Insurance is one of many tools used to manage risk. An insurer is paid a premium to assume the risk that certain types of losses will occur. The perfect scenario, for both the insurer and the policyholder, is that the loss never occurs. The insurer gets to keep the premium and any investment income (less expenses), and the policyholder does not have to undergo the disruption and expense of having losses. Everyone knows, however, that the perfect world does not exist.

Losses can disrupt, threaten, and occasionally even destroy organizations. It is at times of loss that policyholders' relations with insurers are put to the test. Denials of coverage can be devastating. Wrongful denials of coverage can be even more so, as the benefits available under the policy have been withheld from the policyholder in a time of crisis.

As discussed below, insurers deny coverage for many reasons. However, a denial of coverage does not necessarily mean that there is no coverage under the policy. Denials can be challenged successfully in four steps:

- Manage the claim properly prior to the potential denial. This may actually avoid a denial, and it can make it easier to challenge the denial at a later stage.
- Do a proper insurance coverage analysis to determine if there is coverage under the policy.
- Determine whether it is appropriate to challenge the denial.
- Determine which method is the best for challenging the denial.

These steps are discussed below.

MANAGING THE CLAIM PRIOR TO THE DENIAL

Management and Storage of Insurance Documents

The first steps must be taken before the loss occurs. Appropriate management, retention, and storage of insurance documents is imperative.

It is obviously important to ensure that the appropriate coverages are in place, that the premiums have been paid, that the necessary endorsements have been issued, and that the complete policy wordings have been delivered. Insurers are notoriously slow to provide complete policy wordings after a loss has occurred. In some cases it will take

months before they are provided. Time is of the essence when dealing with denials of coverage. It is much more advantageous to ensure that the insurance documents are complete prior to the loss.

Once that is done, it is imperative that the documents be stored and archived appropriately. You are not only dealing with your organization's insurance records for the present – you must also be preserving them for the future. We often deal with lost liability insurance policies that could provide coverage for events that happened decades ago. Trying to recreate lost policies from secondary sources is not easy – things are much simpler when complete policy wordings are available. Ask yourself this question – could your organization find your organization's 2009 insurance documents forty years from now? Are the documents complete, properly archived, and indexed? What happens if there is a fire that destroys the records? Are copies stored elsewhere?

Reporting the Loss to the Insurer

It is obviously important to notify the insurer promptly of any losses. The type and method of notice will be set out in the relevant insurance policies. There will be different requirements depending on the type of loss and the type of policy (e.g., a fire or theft loss reported under a property policy, a lawsuit under a CGL policy, an employee theft reported under a crime policy).

Some general comments are set out below. However, it is important to review the policy wordings with respect to notice.

What to Report

The insurer is entitled to prompt notice so that it can properly investigate the loss, assess damages, and determine whether coverage is available. Failure to give prompt notice may prejudice the insurer and may result in a loss of coverage. It is much easier to avoid a denial of coverage by reporting, rather than trying to argue in court that the insurer was not prejudiced by late notice and that the denial of coverage on late notice ought not to be upheld.

What needs to be reported obviously on the type of insurance and the specific policy wording at issue. Under a CGL policy, a statement of claim may have been served. Under a Directors' and Officers' policy, there may have been a threat to sue. A fire loss, an explosion, or a flood will usually have to be reported under a property insurance policy.

Recognizing some of these events is easier than others. A fire is obvious – others are less so.

You should be familiar with the notice provisions in all of the insurance policies held by your organization, in order to preserve coverage. The standard CGL policy, for example, requires not only notice of a claim or an action, but also notice of occurrences which “may result in a claim”.

Many Directors’ and Officers’ and Errors and Omissions (professional liability) policies are written on a claims-made and reported basis. Such policies only cover claims that are first made and reported in the policy period. What constitutes a “claim” under the policy? Depending on the policy wording, it may mean service of a lawsuit, or it may also include a written or oral demand for compensation. If such a demand is not reported during the policy period in accordance with the notice conditions, then there may be no coverage even if the statement of claim is served later. There may also be a duty to report occurrences that may result in a claim.

What Policies to Report Under

Ensure that all relevant insurance policies are identified, so that the claim can be reported under the appropriate policies. Your insurance broker can assist in this regard. Issues to consider include:

- Whether successive insurers may have to respond to the loss. For example, all insurers on risk from the commencement of damage to the discovery of the damage may have to defend a claim.
- Whether different classes of insurers may have to respond. For example, a claim may potentially be covered under an auto policy, a CGL policy, and/or an umbrella policy.
- Whether the policyholder is insured as an additional named or unnamed insured under other insurance policies. For example, the policyholder may be named as an additional insured under a contractor’s insurance policy.
- Whether excess insurers need to be notified.

If you are reporting a claim, it is better to err on the side of caution and to report to all insurers that may potentially be on risk.

How to Report

It is obviously prudent and necessary to comply with the policy’s notice conditions, as to timing and the content of the notice. Subject to those terms, some general comments are set out below.

Notice is usually sent to the insurer via the broker. However, it is not sufficient simply to send notice to the broker without comment. Instruct the broker to report the claim to the

insurer so there is no misunderstanding.

From an evidentiary standpoint, it is almost always preferable to give notice in writing. It is usually easier to prove that written notice was given, as opposed to oral notice. For obvious reasons, fax transmissions are often better than notices sent by ordinary mail. Faxes are faster, and the printed confirmation slips are good evidence that the transmission was both sent and received.

If you do have oral conversations with the broker, insurer, or adjuster, always confirm important points in writing: "Further to our conversation this afternoon, I confirm that . . .". It is also a prudent practice to make notes of telephone conversations. You can prepare pre-printed message notes with spaces for the date, time, identity of the person, and whether it was a voicemail message. These can be placed near your telephone for easy access, and they can be kept in a briefcase for when you are out of the office. Once the note is made, it is obviously important that it be filed in the appropriate place.

This type of record keeping is important for dealing with both the purchasing of insurance and the handling of claims.

PROOF OF LOSS

Most property loss claims (*e.g.*, fire, theft, flood, *etc.*) require the insured to file a proof of loss. There will be specific policy provisions in this regard.

Proof of loss is usually made on a standard form which is sworn (or affirmed) before a commissioner of oaths. The form briefly describes the loss, the insurance policy, and the amount of the loss. It is necessary to attach relevant documentation to the form in order to prove quantum.

If the amount of the loss is not immediately known, it is acceptable to file an interim proof (which should be clearly marked as being interim).

It is important to ensure that the proof of loss form is accurate and not inflated. The insurer normally has the right to reject the entire claim if there is fraud in the proof of loss.

Filing a proof is normally a prerequisite to suing the insurer on a property loss claim. The insurance statutes in most of the provinces require proofs to be filed before a lawsuit is commenced.

THE INSURER'S INVESTIGATION

The Role of the Adjuster

Once the insurer receives notice, it will usually investigate the claim. It will want to know more information about the loss. It may do this through its in-house adjusters, or it may hire "independent" adjusting companies.

It is important to understand the role of the adjuster retained by the insurer. While the adjuster will be gathering information to learn about the loss, that is only part of his or her task. The other part is to obtain information relating to coverage under the policy. The adjuster will usually consider whether there has been a breach of condition, or whether an exclusion applies. The adjuster may even make a preliminary recommendation on coverage, or may point out potential coverage defences in the reports to the insurer. To this extent, the adjuster is not truly independent. He or she is working for the insurer to protect the insurer's interests.

The policyholder should not, of course, ignore the adjuster's requests for information or refuse to cooperate. Some policies, including most liability policies, include a condition that requires cooperation with the insurer. That being said, it is important to understand that the adjuster is looking out for the insurer's interests, and not the policyholder's.

The adjuster's decisions and reports can result in denials of coverage. For example, we acted for a husband and wife who operated a riding stable. A stable hand was thrown from one of the horses and sued. They reported the claim to the insurer. The adjuster investigated and obtained a statement from the policyholders, who said they "employed" the stable hand. The adjuster then forwarded the statement to the insurer and commented on coverage. The insurer relied on the statement to deny coverage based on an "employee" exclusion. In that case, the insureds did not understand the legal differences between an "employee" and an "independent contractor" when making the statement to the adjuster. We sued the insurer and were successful both before the motions judge and the Ontario Court of Appeal. There was coverage on the basis that the stable hand may have been an independent contractor, and not an employee. The point to take from the policyholders' experience in that case is that the adjuster acts for the insurer, and can have a significant impact on coverage under the policy. While there is usually a duty to cooperate, the policyholder should be careful to ensure that the information provided is both appropriate and correct.

The Non-waiver Agreement

The adjuster may ask the policyholder to sign a non-waiver agreement at the outset of the investigation. This is usually a standard-form agreement which states that the insurer may investigate and defend the claim without prejudice to its rights under the

policy. The purpose of the non-waiver agreement is to protect the insurer from the argument that it has waived its ability to deny coverage, or is estopped from doing so, by its conduct.

There is no obligation to sign a non-waiver agreement. In almost all cases there is no benefit to the policyholder in doing so. It is a document prepared by the insurer to protect the insurer only. In fact, the policyholder may be better off not having signed a non-waiver, as it will have a better chance of preserving waiver and estoppel defences.

One of the few circumstances where it is beneficial to execute a non-waiver is where the insurer is willing to provide coverage immediately, subject to the non-waiver, and where the insured requires immediate coverage for strategic or financial reasons. If a non-waiver is executed, its terms should be carefully reviewed, particularly where it is a customized document instead of the industry's standard form. In particular, the policyholder should reject any terms stating that the policyholder agrees to refund any defence, investigation, or adjusting fees in the event there is no coverage under the policy.

The Reservation of Rights Letter

If the insurer cannot obtain a non-waiver agreement, it may send a reservation of rights letter to the insured. This letter usually identifies the policy, the insured, the claim, and the reasons why the claim might not fall within coverage. The insurer will usually state that coverage for the claim cannot yet be confirmed, and that it is reserving all of its rights under the policy.

The reservation of rights letter should specifically set out the policy defences that the insurer may rely upon. If it does not, write to ask for a clarification, and ask that the defences be spelled out. This is important for a number of reasons. First, you will know what matters are in issue. This helps in determining strategy and an appropriate response. Second, it shows how the insurer initially interpreted the policy. This may be important later if issues of ambiguity arise. If the insurer later changes its position, or if it made an error when interpreting the policy, it will be helpful to have this in writing. Third, it may lead to a waiver by the insurer of a possible policy defence, if it was aware of the possible defence at the time of the reservation of rights, but chose not to rely upon it.

THE DENIAL OF COVERAGE

Receiving and Responding to the Denial

The insurer has a duty to respond promptly to claims. The insurer has a reasonable time in which to make its decision on coverage. What is "reasonable" depends on the

facts in each case. Generally, the insurer will be able to conduct a proper investigation and to obtain a legal opinion if desired, before it is required to give an answer on coverage.

If the insurer has not responded to the claim, you should write to the insurer to ask for its coverage position. If you do not receive a satisfactory answer, follow up in writing. If you are given an oral explanation for the delay, confirm the explanation in writing (“Further to our conversation yesterday, I confirm that you are waiting for a legal opinion and that you anticipate being able to provide a coverage position by next Monday . . .”). If there is any external fact that requires an immediate response, put it in your letter. In a liability insurance claim, for example, a statement of defence may have to be filed. In a property insurance claim, a fire scene may be about to be demolished.

Recording these facts is important for two reasons. First, you want the insurer to be fully informed. This will make it more difficult for the insurer to argue later that there has been a lack of cooperation. Second, it may lead to an estoppel or waiver by the insurer.

Ultimately, the insurer will have to make its decision on coverage. If it is an oral decision that there is coverage, ask for written confirmation. If the insurer declines to put its position in writing, send a letter to the insurer confirming the oral advice that the claim is covered. A written record makes it easier to prove the insurer’s position. If the insurer has advised that there is coverage and it extends coverage (either by making a payment or defending), it may later be precluded from denying coverage.

If it is a denial of coverage, it will usually be in writing. If the insurer’s denial letter is properly written, it should state the grounds for the denial and it should refer to the clauses in the policy that are being relied upon for the denial. If the insurer has denied coverage orally, or if the letter does not set out the grounds for the denial, you should write to the insurer to ask that the grounds be set out, for the reasons discussed above concerning reservation of rights letters.

Establishing a written record in the ways discussed above can be very helpful in contesting a denial of coverage.

Why Did the Insurer Deny Coverage?

It is important to understand the reasons why insurers deny coverage in order to challenge a denial of coverage effectively. Possible reasons for denial include the following:

- There is actually no coverage under the policy.
- There is coverage under the policy, but the denial resulted from one or more of the following:

- The claims adjuster was too busy to devote the proper amount of time to investigation and analysis.
- The claims adjuster was inexperienced and did a figurative coin toss.
- It was a questionable claim. The adjuster decided to deny coverage to see if the policyholder would challenge the denial.
- It was a very large claim. The insurer would rather deny and gamble that it will prevail in coverage litigation, rather than admit it is liable to pay hundreds of thousands or millions of dollars.
- The insurer received bad advice in a coverage opinion from its lawyers.
- The insurer believes that the loss was not intended to be covered by the policy, regardless of what the policy says.

This list is obviously not exhaustive. The point to take from it is this: *a denial does not necessarily mean there is no coverage under the policy.*

DETERMINING IF THERE IS COVERAGE UNDER THE POLICY

Once the denial is made, you will have to consider whether it ought to be challenged, and, if so, how. Before that can be done, however, you will need to know whether there is coverage under the policy.

The Insurance Broker

As a first step, ask your broker for assistance. The broker is obviously familiar with the insurance it sells. The broker may have a dedicated claims department that helps policyholders with claims under their policies. There is usually no extra cost for this service, as the broker is paid through commissions on the premium.

The broker will often be able to advise whether the claim is covered, and whether it is worthwhile to obtain a legal opinion.

The Coverage Lawyer

At this point, it is usually appropriate to bring in the lawyers, although some policyholders involve lawyers at earlier stages in particularly large or contentious claims.

Choosing the right lawyer is perhaps the most important task. It is important that the

matter be referred to a lawyer whose practice focuses on insurance coverage analysis and litigation. Too frequently the matter is referred to the organization's usual corporate counsel or commercial litigators, who have little experience in insurance matters. Obtaining a coverage opinion on a complex matter from such lawyers is usually more expensive (because you are paying to educate the lawyer about something he or she knows nothing about) and less effective (because the lawyer does not know the intricacies of insurance coverage law).

Regardless who you retain to act for your organization, you must ensure it is someone who is knowledgeable about insurance coverage analysis, strategy, and litigation.

The Coverage Opinion

Once you have retained an insurance coverage lawyer, you will need an opinion on coverage. This is the first step in deciding whether to challenge the denial. If the denial was proper, then you need to know that. If the denial was improper, you will want to know that as well. You will have many questions: What are the chances of success? How much will it cost to challenge the denial? How much will it cost *not* to challenge the denial? What will happen if the denial is not challenged? These are all issues you will need to consider when facing a denial of coverage.

A good coverage opinion will outline the facts, state the issues, and review all of the known and potential coverage issues. It will then state the chance of succeeding in a coverage denial, and, most importantly, it will comment on options and strategies for challenging a denial if it is warranted.

The coverage opinion forms the backbone of the claim, should it be advanced. It outlines strategy and options. It forms the basis for the evidence and law that will be heard in court. It is important to get it right at the outset.

SHOULD THE DENIAL BE CHALLENGED?

Lawyers who do not focus on insurance coverage often advise their clients to sue the insurer automatically following a denial of coverage. That is often an overly simplistic recommendation that can lead to trouble down the road. The decision of whether to sue involves a balancing of a number of factors.

First, the policyholder must consider the effect of challenging the denial. Will the claim adversely affect the organization's claims history? Will it result in significantly increased premiums? Will the insurer cancel or decline to renew? Will it be difficult or impossible to obtain coverage in the future because of the claim? Is it a hard or soft insurance market?

Next, the policyholder must consider the consequences of not challenging the denial. Is it a significant claim in monetary terms? The policyholder may decide, for a variety of reasons, not to challenge the denial of a small loss and to swallow the cost of the claim. This may not be possible where the claim is particularly large or important from a precedential standpoint.

It ultimately comes down to a balancing of these factors. Is it worth pursuing the claim for monetary or strategic reasons? Many claims will be worth it; some will not. The important point is that these factors must be considered before deciding whether, and how, to challenge the denial.

CHALLENGING THE DENIAL

There are many different ways to challenge a denial of coverage. The options discussed below are a progression from less confrontational to more confrontational.

The Broker

Your insurance broker is an excellent resource for assisting with claims. It is in the broker's interests to help clients resolve claims amicably with the insurer. The broker also wants to keep your business.

Further, brokers send insurers business. Insurers therefore need to keep the brokers happy, as the broker may send business elsewhere in response to an insurer with a poor claims handling reputation.

Meeting With the Insurer

The next option is to meet with the insurer to discuss the claim. Depending on the circumstances, it may be appropriate to meet with the adjuster, or with a claims manager that is higher up the chain. Facts and issues can be discussed and analyzed. The insurer can be asked to reconsider its position based on new information.

External factors can be brought into effect during a meeting with the insurer. Is your organization's insurance account significantly large that the insurer would not want to lose the business and premium revenue if the policies were renewed with a different insurer?

Are there any other external factors that can be brought to bear on the insurer? For example, in one case we were representing a policyholder in a particular business. The insurer issued policies almost exclusively to members of that business. As it turned out,

the policyholder was hosting the annual convention for that business at the time of the claim, and the insurer was planning on having sales representatives attend at the convention. The denial was questionable, and the insurer knew it could lose a lot of business at the convention if the claim was not resolved. We obtained a favourable settlement for our client. One factor was that the insurer was not prepared to lose future business by having the claim outstanding at the convention.

Have Your Coverage Lawyer write to the Insurer

It is often helpful to have your coverage lawyer write to the insurer. The insurer will occasionally reverse its decision after receiving a letter from a well-known insurance coverage firm. In one case we were acting for a landlord who was being sued. The insurer had retained its own lawyer to provide an opinion, and it denied coverage. The landlord retained us after the denial. We wrote one concise letter to the insurer and pointed out why its coverage analysis was wrong. We then advised in the letter that we would be commencing court proceedings within the next week. The insurer immediately reversed its decision and extended coverage.

Arbitration

If the insurer still maintains its denial, one option is arbitration. Some policies require coverage disputes to be arbitrated, but that is relatively rare for most insureds. In most cases, the parties must agree to arbitrate.

In an arbitration, the insurer and policyholder choose an arbitrator (or a panel of three arbitrators) to decide the issue. The arbitrator(s) essentially takes the place of the judge and decides the matter.

Arbitration has a number of potential benefits:

- *Privacy:* The parties can agree on a confidentiality clause, which will prevent the case from becoming a precedent for or against the insurer or policyholder. This may also be important if the policyholder has similar pending claims against other insurers.
- *Ability to choose the decision-maker:* The parties can choose an arbitrator with an insurance background and who understands insurance principles. By contrast, you cannot choose your judge when proceeding in a court. You may have a judge who practiced criminal or family law, and who knows nothing about insurance.
- *Speed:* Arbitrations can often be scheduled more quickly than court hearings.

- *Finality*: The parties can agree that any decision may not be subject to appeal. (Alternatively, the parties can agree that it is subject to appeal to a panel of three arbitrators.)

These advantages can also be disadvantages. It may be beneficial to have a precedential decision in a court, or at least the threat of such a decision. That may force an insurer to settle the claim rather than face a decision which will lead to similar claims by others. Alternatively, the policyholder may wish to keep open the option of appealing. Another potential disadvantage is price. While arbitrations are intended to be more efficient than court hearings, it is necessary to pay the arbitrator(s). Arbitrations are not appropriate for all cases, but they can be useful. In one case, we acted for one of Canada's largest corporations to contest a coverage denial. We entered into an arbitration agreement with the insurer, we chose an excellent arbitrator, and we executed an agreed statement of facts. We succeeded before the arbitrator, and the decision was upheld by an appellate arbitrator. We obtained a decision in excess of \$8 million for the client.

LITIGATION

Another option is litigating the coverage denial in the courts. There are two basic types of court proceedings: an action and an application.

The Action

An action is what is familiarly known as a lawsuit. The plaintiff issues a statement of claim. The parties exchange documents and have the opportunity to examine each other under oath. The matter will eventually proceed to trial before a judge alone or before a judge and jury. Some cases must proceed by way of an action, due to their complexity or disputed facts.

Actions are usually costly and lengthy. It may take years before the trial takes place.

Some coverage issues in an action can be resolved by what is known as a motion. This is a court hearing that is based on affidavit evidence or an agreed statement of facts. A motion may last an hour or a couple of days. At the end of the motion, it is possible for all issues in the litigation to be resolved. In some cases, a motion is a way to shorten the length of the action and to obtain a decision prior to trial.

The rules for motions are fairly complex. Motions are only appropriate in certain circumstances. For example, the duty to defend under a liability insurance policy is often determined by way of a motion.

The Application

An application can be used instead of an action to determine the interpretation of an insurance contract, or where the facts are not in dispute. It is similar to a motion, in that it is based on affidavit evidence. Like a motion, the application may take an hour or a few days.

Where an application is an appropriate way to proceed, it is an excellent option. It is usually much faster and cheaper than a full trial in an action. It is particularly good for resolving duty to defend issues.

Appeals

The unsuccessful party can appeal most actions, motions, and applications as of right to the Ontario Court of Appeal. In some limited circumstances it is necessary to obtain permission from the court to bring an appeal – this is known as an application for leave to appeal.

Appeals from motions and applications to the Court of Appeal can often be heard within eight months after the judge's decision is released. Appeals from trials take longer to schedule because it is usually necessary to have the testimony typed and transcribed.

In about 95% of the cases, the Court of Appeal is the court of last resort for litigants in Ontario. Parties wishing to appeal further must seek permission from the Supreme Court of Canada. They must demonstrate that there is an issue with national importance. The Supreme Court hears relatively few cases each year, and it rarely grants leave to appeal.

Limitation Periods

Most insurance policies contain limitation periods. If legal proceedings are not commenced against the insurer before the expiry of the specified limitation period, then the policyholder's right to sue will be lost.

Many property policies contain a one-year limitation period which runs from the date of the loss (although legislation may impose a two-year limitation period in certain cases instead). Liability policies often contain a one-year limitation period which runs from the date of settlement or judgment. It is important, however, to review the policy wording and the appropriate provincial legislation carefully to ensure that the limitation period is not missed.

CONCLUSIONS

An insurer's denial of coverage does not necessarily mean that there is no coverage under the insurance policy. It is important to assess the denial carefully. If there is coverage, it is important to determine whether it is appropriate to challenge the denial.

If challenging a denial, it is usually best to start with the less confrontational (and less expensive) approaches first before suing (assuming there are no imminent limitation deadlines).