

**STATE OF MICHIGAN  
IN THE SUPREME COURT**

SUPREME COURT No. 160242

KEITH BRONNER, an individual  
Plaintiff,

COA Docket No. 340930  
WCCC No.: 15-013452-NF

-v-

CITY OF DETROIT, a Municipal Corporation,  
Defendant and Third-Party Plaintiff/Appellant,

-v-

GFL ENVIRONMENTAL USA INC., f/k/a RIZZO ENVIRONMENTAL SERVICES, INC.,  
Third-Party Defendant/Appellee.

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**CITY OF DETROIT'S SUPPLEMENTAL REPLY BRIEF IN SUPPORT OF  
APPLICATION FOR LEAVE TO APPEAL**

**FILED PURSUANT TO SUPREME COURT ORDER DATED JULY 2, 2020**

**ORAL ARGUMENT REQUESTED**

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September 21, 2020

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**STATUTES**

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GFL's supplemental brief advances several variations of the following argument: The City cannot enforce the indemnity contract because the no-fault act is a comprehensive statute which provides insurers with certain avenues to recover no-fault payments, but those avenues do not include contractual indemnity.

GFL's argument is rejected by all relevant Supreme Court authority. The City's fundamental right to freely contract with its vendor enjoys the utmost protection under Michigan law, and can be negated only if the City's contract rights conflict with the no-fault act. *Cruz v State Farm*, 466 Mich 588 (2002); *Universal Underwriters v Kneeland*, 464 Mich 491 (2001); *c.f. Zahn v Kroger Company*, 483 Mich 34 (2009), (workers compensation). Neither the lower court nor GFL identifies any conflict and, because the City paid Bronner's no-fault benefits as primary and sole insurer, there is none. There was no basis for the lower court to strike down the indemnity contract.

### **RESPONSE TO GFL'S "STATEMENT OF FACTS"**

#### **A. The City of Detroit fulfilled its obligations under the no-fault act.**

The City is acting in two municipal capacities in this case. First, the City operates a bus system for which it acts as self-insurer. Second, the City contracts with GFL for garbage pickup. In its first capacity, the City paid Bronner's no-fault benefits. In its second capacity, the City sued GFL under the indemnity contract for the monetary loss (no-fault benefit payments) caused by GFL's negligence.

GFL argues that the City's separate exercise of its indemnification rights is barred because, as a self-insurer, the City "has all the obligations and rights of an insurer under this chapter." GFL brief pp. 1-2, citing MCL 500.3101(4). That argument fails because the City carried out its "obligations" under the no-fault act by paying Bronner's benefits as primary and sole insurer. That the City also has the "rights as an insurer under this chapter" does not purport to divest the City of its fundamental right to contract with GFL for indemnification.

GFL later repackages this same unsound argument as follows: "one of those obligations of an insurer under Michigan law is to pay PIP benefits with no ability to obtain contractual indemnification." GFL brief p. 6, citing MCL 500.3101(4). But MCL 500.3101(4) imposes no such "obligation" and the City satisfied all of its no-fault obligations. As the lower court acknowledged, nothing in the no-fault act purports to prohibit the City from enforcing the indemnity contract. App 15a.

**B. The City's home rule argument can properly be considered by the Court.**

GFL argues the City's Home Rule City argument is not preserved for appeal because it was not raised before the trial court. Brief, p. 2. However, there is an express exception for arguments implicating Constitutional rights, *People v Grant*, 445 Mich 535, 547 (1994), and the City's home rule powers are embedded in the Michigan Constitution. *Associated Bldrs v Lansing*, 499 Mich 177 (2016).

Further, "[T]his Court may overlook preservation requirements where failure

to consider the issue would result in manifest injustice, if consideration of the issue is necessary to a proper determination of the case, or if the issue involves a question of law and the facts necessary for its resolution have been presented.” *Bisio v City of Village of Clarkston*, 2020 WL 4260397 (Mi Sup Ct, 2020), fn 12. Each of those considerations apply here. Finally, the City’s home rule argument – that the City has the right to seek contractual indemnity from its vendor because there is no express statutory prohibition – is fully consistent with the City’s freedom of contract argument. There is no prejudice to GFL.

**C. The City’s indemnification claim did not improperly delay Bronner’s receipt of no-fault benefits and any such claim is legally irrelevant.**

GFL alleges that the City’s third-party claim against GFL delayed Bronner’s recovery of no-fault benefits. GFL brief, pp. 2-3, 11-12, 15. It is uncontested that Bronner initiated the circuit court litigation after the City had voluntarily paid out tens of thousands of dollars in benefits, and only after a dispute arose as to Bronner’s continued eligibility. GFL offers nothing to show the circuit court litigation – which also involved an intervening provider - was itself prolonged by the indemnity dispute. Indeed, GFL has never before advanced this argument and the court of appeals simply observed that “the City paid no-fault benefits to Bronner.” App 14a.

However, even if there were a delay while the trial court sorted out the legal issues in this case, that is irrelevant to enforceability of the indemnity contract. The circuit court did exactly what this Court has repeatedly demanded. It applied the

contract's plain language and, by doing so, construed the contract in a fashion that was and is fully consistent with the no-fault act. *Cruz, supra* at p. 599 (where contract potentially conflicts with a statute, courts are obliged to construe the contract, where reasonably possible, to harmonize them with the statute).<sup>1</sup>

## ARGUMENT

### I. GFL cannot distinguish this Court's controlling decisions.

***Cruz v State Farm.*** *Cruz, supra*, upheld State Farm's no-fault policy's requirement that insureds submit to examinations under oath. It did so even though the no-fault act provides a specific mechanism for claimants to provide information about a claim. MCL 500.3142(2), (requires claimants to submit "reasonable proof of the fact and of the amount of loss sustained"). GFL attempts to distinguish *Cruz* by quoting the following language from the decision (GFL brief, p. 11; GFL added to the quotation both the bolded and underline emphasis):

"The Court of Appeals, however, while recognizing the utility of EUOs in general, found that EUOs were precluded in the automobile no-fault insurance context because they were not mentioned in the act. In our judgment, the Court was in error. EUOs, or other discovery methods that the parties have contracted to use, are only precluded when they clash with the rules the Legislature has established for such mandatory insurance policies. However, when used to facilitate the goals of the act and when they are harmonious with the Legislature's

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<sup>1</sup>In the circuit court the City's young lawyer improperly argued, in the alternative to indemnity, that the contract made GFL the primary insurer. The trial court properly rejected that argument and the City has expressly disavowed it. City's COA brief, p. 6, fn 1. In any event, a priority dispute does not excuse delay in making timely payment. *Bloemsma v Auto Club*, 174 Mich App 692, 697 (1989).

no-fault insurance regime, EUOs in the no-fault context should be viewed no differently than in other types of policies. **In light of this reasoning, we conclude that an EUO that contravenes the requirements of the no-fault act by imposing some greater obligation upon one or another of the parties is, to that extent, invalid. Thus, a no-fault policy that would allow the insurer to avoid its obligation to make prompt payment upon the mere failure to comply with an EUO would run afoul of the statute and accordingly be invalid.** However, an EUO provision designed only to ensure that the insurer is provided with information relating to proof of the fact and of the amount of the loss sustained—i.e., the statutorily required information on the part of the insured—would not run afoul of the statute.”

The emphasized language provides no support to GFL. GFL correctly argues that even though its garbage truck negligently caused injury to Bronner, GFL could not be held liable under the no-fault act for Bronner’s first party benefits. Brief, p. 11. But GFL erroneously concludes that if the City is entitled to obtain contractual indemnity for its payment of Bronner’s no-fault benefits, GFL would thereby incur a “greater obligation” under the no-fault act than it would otherwise be subject to. GFL brief, pp. 11-12.

GFL’s conclusion is clearly unsound. GFL and the City, unlike the insureds and State Farm in *Cruz*, do not have any no-fault relationship. GFL has no “obligations” under the no-fault arising from the bus accident in which Bronner was injured. Because GFL never had any no-fault obligations, either before or after the accident, no “greater” obligation has been imposed.

**GFL is not being asked to pay first party benefits under the no-fault act.**

GFL is being asked to indemnify the City for the City's monetary loss under the parties' separate and freely negotiated contract. Because the City fulfilled its obligations under the no-fault act, and the contract does not contravene the act, it is enforceable under *Cruz*.

***Universal Underwriters v Kneeland***. GFL next argues that the City "attacked" this Court's *Kneeland* decision. GFL brief, p. 12. The City's supplemental brief (pp. 5-6) did no such thing. *Kneeland* fully supports the City's position and observes: "Nothing in the no-fault system relieves a motor vehicle operator of liability which he may have incurred in contract." *Kneeland, supra* at p. 500.

GFL makes no attempt to respond to the City's arguments. Instead, GFL resorts to its claim that the lower court correctly opined as follows: "If the legislature had desired other cost-shifting procedures, or wants to in the future, it is the legislature's province to create the appropriate statutory mechanism to do so." GFL brief, p. 13, citing App 16a. That argument merely repeats GFL's fundamentally unsound theory of this case, namely, that the City could enforce its indemnity contract only if the no-fault act expressly authorized such a claim. GFL's argument does not improve with repetition including, for example, GFL's citation of "*expressio unius est exclusion alterius*." GFL's brief, p. 19. GFL's argument is exactly backward – the City's fundamental right of freedom of contract and exercise of home rule powers could be abrogated only if the contract actually conflicted with

state law, and it does not.

*Zahn v Kroger Company*. GFL attempts to distinguish *Zahn v Kroger Company*, 483 Mich 34 (2009), on the grounds that it involved workers compensation and not no-fault. GFL brief, pp. 17-19. But *Zahn's* parallels to this case are striking. The Court held:

“Finally, we address whether the exclusive remedy provision of the WCDA precludes enforcement of an indemnification contract when the injured party is the employee of the entity being required to pay the indemnification amount. Cimarron [the employer] suggests that an employer cannot be required to assume liability for a particular type of damages for negligence from which it is otherwise shielded as a matter of law. Although Cimarron cannot be held directly liable for negligence by its own employee by virtue of the WCDA, nothing in contract law precludes an employer from voluntarily assuming liability for negligence through a contractual arrangement. Similarly, nothing in the WCDA precludes parties from entering into such an agreement. Accordingly, we conclude that the contract language controls, and we affirm the judgment of the Court of Appeals.” Id at pp. 41-42.

*Zahn* is very directly on point. GFL could not be held liable for Bronner’s injuries under the no-fault act due to the act’s exclusive remedy provisions. But that does not bar the City from recovering its payments to Bronner under the City-GFL indemnity contract. And Justice Markman’s concurrence reiterates “the fundamental policy of freedom of contract,” id at p. 46, which requires upholding the City’s indemnity contract absent a clear conflict with the no-fault act.

.....

GFL repeats several times that “the City of Detroit cannot cite any case law that allows an insurance company to obtain indemnification from a third-party for

its first-party benefit obligation.” GFL brief, pp. 3, 10. Of course not, because this is a case of first impression. More to the point, GFL has not discussed any case where this Court has stricken a contractual indemnity and, as shown above, this Court has repeatedly refused to do so absent a clear conflict between the contract and state law.

## **II. GFL’s policy arguments are unsound and legally irrelevant.**

Because Supreme Court case law emphatically rejects GFL’s position, GFL relies on a variety of policy arguments. But the controlling policy considerations all support the City, namely, (i) “the fundamental policy of freedom of contract,” *Zahn, supra* at p. 46, and (ii) the Michigan Constitution’s broad protection of the City of Detroit’s home rule powers: “home rule cities enjoy not only those powers specifically granted, but they may also exercise all powers not expressly denied.” *Associated Builders v City of Lansing, supra*, fn 29. The City responds to GFL’s policy arguments as follows:

### **A. Arguments concerning commercial no-fault insurers.**

GFL argues “if the City of Detroit is successful in obtaining contractual indemnification, it will only embolden [commercial] insurers to consider whether they, too, may creatively obtain contractual indemnification.” GFL brief, p. 9. GFL cites no legal, factual, or other basis for its alleged concern.

The City is self-insured and has thereby assumed the obligations of a commercial insurer under the no-fault act. But this case arises because the City has

many other responsibilities and obligations including protecting its taxpayers from damages caused by the negligence of a vendor. Commercial insurers have no such obligations. Commercial insurers collect premiums based on actuarial studies of perceived losses, issue policies protecting insureds against those losses, and pay benefits under those policies. GFL does not even suggest how “contractual indemnity” might fit in that business model.

GFL nevertheless insists that “this is not merely a hypothetical concern.” “As just one example, every insurer could write policies that obligate its insureds to indemnify the insurer where it is involved in an accident with another insured for that same insurer and owes PIP benefits.” GFL brief, p. 9. GFL again offers absolutely nothing to support that wild claim. Rather, GFL cites three entirely irrelevant out-of-state cases. *Id.*

**Not one of those cases involved a claim for contractual indemnity or any remotely similar issue.** They involved (i) a dispute over mandatory arbitration (*Hackett v Bonta*, 113 NC App 89 (1993), ex. A); (ii) a dispute over the enforceability of a release (*Heigis v Cepeda*, 71 Wash App 626 (1993), ex. B), and (iii) a tort claim for the insurer’s alleged bad faith delay in paying benefits (*Darlow v Farmers Ins*, 822 P 2d 820 (1991), ex. C). Underlying each case was the conflict that sometimes arises when multiple parties to an auto accident have the same commercial insurer. That issue is entirely irrelevant here.

**B. Other alleged policy issues.**

GFL argues that a ruling in favor of the City “will force first-party benefits to move outside the contained universe of benefits paid/premiums.” GFL brief, p. 8. The City has no concept what GFL’s concern is. The City, as self-insurer, currently pays no-fault benefits without receipt of premiums.

GFL argues that a ruling in the City’s favor will incentivize the City to impose indemnity obligations on bus drivers! Id, p. 8. City bus drivers are heroes who work extremely hard to earn somewhat more than minimum wage. GFL’s argument is ridiculous and insulting.

**III. The City does not mention or rely on its financial condition.**

GFL argues – without citing to any page of the City’s brief - that the City’s financial condition has no relevance to this case. GFL brief, pp. 21-22. The City agrees and its supplemental brief does not mention or rely on the City’s financial condition. The City simply explained its rationale for self-insuring, City brief, pp. 15-16, in response to GFL’s continuing attacks on the City’s decision to self-insure. E.g., GFL brief, p. 5.

Charles N. Raimi (P29746)  
/s/Charles N. Raimi  
Attorney for third-party plaintiff/appellant  
September 21, 2020

**CERTIFICATE OF SERVICE**

The undersigned certifies that on September 21, 2020, he arranged for e-filing

of the foregoing application and exhibits thereby providing service on all counsel of record.

/s/Charles N. Raimi

STATE OF MICHIGAN  
IN THE SUPREME COURT

SUPREME COURT No. 160242

KEITH BRONNER, an individual  
Plaintiff,

COA Docket No. 340930  
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-v-

CITY OF DETROIT, a Municipal Corporation,  
Defendant and Third-Party Plaintiff/Appellant,

-v-

GFL ENVIRONMENTAL USA INC., f/k/a RIZZO ENVIRONMENTAL SERVICES, INC.,  
Third-Party Defendant/Appellee.

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**CITY OF DETROIT'S EXHIBIT LIST IN SUPPORT OF ITS  
SUPPLEMENTAL REPLY BRIEF IN SUPPORT OF APPLICATION FOR  
LEAVE TO APPEAL**

Ex. A - *Hackett v Bonta*, 113 NC App 89 (1993)

Ex. B - *Heigis v Cepeda*, 71 Wash App 626 (1993)

Ex. C - *Darlow v Farmers Ins*, 822 P 2d 820 (1991)

113 N.C.App. 89  
Court of Appeals of North Carolina.

Laura **HACKETT**, Plaintiff,

v.

Theresa J. **BONTA**, Defendant.

No. 924SC1147.

Dec. 21, 1993.

**Synopsis**

Passenger filed negligence action against driver, and insurer of both parties filed appearance as unnamed party for purpose of defending driver. The Superior Court, Onslow County, George R. Greene, J., granted insurer's motion to stay arbitration and denied passenger's motion to compel arbitration. Passenger appealed. The Court of Appeals, Eagles, J., held that passenger did not untimely or unreasonably delay her demand for arbitration of her right to damages under her underinsured motorist policy.

Reversed and remanded.

West Headnotes (2)

[1] **Insurance** ← Demand or notice

Demand for arbitration of her right to damages under her underinsured motorist policy was not untimely or unreasonably delayed by passenger, who filed suit against driver who was insured by same insurer under liability policy and who was defended by insurer as unnamed party; fact that passenger filed suit against driver prior to her written demand for arbitration did not compel finding that passenger nullified effect of her demand to arbitrate, and passenger did not have right to seek payment from her own coverage until insurer offered to pay limits of driver's policy.

2 Cases that cite this headnote

[2] **Insurance** ← Decisions reviewable

Trial court's order denying arbitration in insurance context, although interlocutory, is immediately appealable because it involves substantial right which might be lost if appeal is delayed. G.S. §§ 1-277(a), 7A-27(d)(1).

3 Cases that cite this headnote

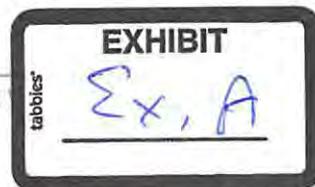
**\*\*688 \*90** Both plaintiff and defendant have automobile liability insurance policies with State Farm Mutual Automobile Insurance Company (hereinafter "State Farm"). State Farm insures defendant Theresa J. Bonta, the driver, pursuant to a personal automobile policy with liability limits of \$25,000.00/\$50,000.00. Plaintiff Laura **Hackett**, a passenger in defendant **Bonta's** vehicle, has \$100,000.00 in uninsured/underinsured (UM/UIM) coverage for each of her two vehicles under a personal automobile policy with State Farm.

On the evening of 17 February 1990, plaintiff was a passenger in defendant's vehicle. While driving near Wilmington, defendant drove across the center line of the highway and struck another vehicle, injuring two of its passengers. As a result of the collision, plaintiff suffered injuries allegedly causing approximately \$20,000.00 in medical expenses and approximately \$388,000.00 in other damages.

By a letter dated 30 March 1990, plaintiff's counsel informed State Farm that "this claim will be worth more than \$25,000," referring to the limits of defendant's liability policy. By a letter dated 6 April 1990, plaintiff's counsel described plaintiff's injuries, stated that these "injuries exceed[ed] the \$25,000.00 insurance available" under defendant's policy, and inquired as to "the extent of the other parties' injuries." By a letter to State Farm dated 15 June 1990, plaintiff's counsel stated that "our client's injuries are well in excess of the \$25,000 and for that reason [we] wish to settle this claim so we may proceed against our client's underinsured coverage." The record does not contain a reply by State Farm. By a letter dated 20 July 1990, plaintiff's counsel again demanded payment in the amount of \$25,000.00 under defendant's policy. Plaintiff also stated that there was \$200,000.00 in coverage under plaintiff's UIM policy and that documentation for that claim **\*91** was being gathered pursuant to State Farm's request. The record reflects that throughout this time, State Farm had assigned one insurance adjuster to negotiate both the claim against defendant's liability policy and the claim against plaintiff's

*Passenger in Bonta's vehicle*

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UIM policy. Plaintiff's counsel informed State Farm *inter alia* in the 20 July 1990 letter that assigning one adjuster for both claims was a conflict of interest impeding the settlement process. By a letter dated 27 July 1990, State Farm, referring to plaintiff's 15 June 1990 and 20 July 1990 demand letters, informed plaintiff's counsel that it needed more information regarding plaintiff's claim and that

[w]e do not feel that we have a conflict since we do not as a company subrogate against our own insureds when we make payments under the underinsured motorist coverages for another State Farm insured. As of July 27, 1990 [State Farm's] Wilmington [office] still does not have the information necessary to evaluate the two \*\*689 claims in that area. If it is necessary for us to exhaust the liability limits under the Bonta policy to conclude the two claims in Wilmington we will do so, and this will obviously increase State Farm's liability to your client under her own underinsured motorist coverage as there will be no offset or the offset will be less than some prorated amount.

On 30 July 1990, State Farm retained attorney Glenn Bailey.

On 29 August 1990, plaintiff filed a complaint against defendant Bonta alleging negligence. Mr. Bailey filed an answer on defendant's behalf denying negligence and demanding a jury trial. Both parties conducted discovery. Trial was scheduled for 16 March 1992.

By a letter dated 17 February 1992, Mr. Bailey forwarded plaintiff's counsel a letter stating as follows:

RE: Laura **Hackett** v. Theresa J. **Bonta** In the Superior Court of Onslow County, Civil File No. 90-CVS-2200

Dear Dick [A. Mu, plaintiff's counsel]:

With this letter we are offering \$75,000.00 in settlement of the above case. If this is rejected, we would welcome a more realistic demand.

This letter did not specify the policy under which State Farm was offering settlement, though the amount offered exceeded the maximum payable to one victim pursuant to defendant's liability \*92 policy. An affidavit submitted by plaintiff's counsel states that this was State Farm's "first offer to settle this matter." On 14 March 1992, plaintiff's counsel transmitted to Mr. Bailey a letter rejecting the offer, offering a covenant not to execute judgment in excess of defendant Bonta's insurance coverage in return for \$25,000.00 (defendant's liability policy limits), complaining of Mr. Bailey's conflict of interest, setting forth a counteroffer

in the amount of "\$165,000.00 as a compromise settlement under the UIM coverage of her [plaintiff's] policy," and stating that "[i]f State Farm is not willing to settle for \$165,000.00 we demand arbitration of all issues of Laura Hackett's [plaintiff's] right to damages pursuant to her policy." In demanding arbitration for the UIM claim, the provision upon which plaintiff relied reads as follows:

PART C—UNINSURED MOTORISTS COVERAGE—  
COVERAGE U

....

ARBITRATION

If we and an *insured* do not agree:

1. Whether that person is legally entitled to recover damages under this Part; or
2. As to the amount of the damages;

the *insured* may make a written demand for arbitration. In this event, arbitration will be conducted in accordance with the Rules of the American Arbitration Association. Judgment on the award decided by the arbitrators may be entered in any court having jurisdiction. Each party agrees the arbitration award is binding.

If an *insured* elects not to arbitrate:

1. Our liability will be determined only in a legal action against us; and
2. We may require the *insured* to join the owner or operator of the vehicle as a party defendant. We may not require this in any action to determine if a vehicle is an *uninsured motor vehicle*.

....

Note: The following endorsement applies when the endorsement number appears in the declarations.

\*93 6273CC.4 UNINSURED/UNDERINSURED  
MOTORISTS COVERAGE—NORTH CAROLINA

(Coverage U1)

....

I. Part C. is amended as follows:

A. The following is added to the first paragraph of the Insuring Agreement:

We will pay under this coverage only after the limits of liability under any applicable liability bonds or policies have been exhausted by payments of judgments or settlements, unless we:

1. Have been given written notice in advance of a settlement between an *insured* and the owner or operator of the *uninsured motor vehicle*, as defined in Section 5 of the definition of *uninsured motor vehicle*; and

**\*\*690** 2. Consent to advance payment to the *insured* in the amount equal to the tentative settlement.

State Farm refused to arbitrate. On 16 March 1992, plaintiff filed a motion to compel arbitration and filed a motion for a continuance of the trial due to defendant's disclosure of "an expert witness during the week prior to trial which surprised plaintiff and did not allow her sufficient time to take a discovery deposition of said witness." A hearing for both motions was scheduled for 30 March 1992. On 30 March 1992, the trial court granted plaintiff's motion for a continuance. Though the record is unclear, Mr. Bailey's affidavit states that on that same date plaintiff withdrew the motion to compel arbitration "without hearing" and subsequently "file[d] suit against the carrier, the prayer of which was only that arbitration be compelled, and later took a voluntary dismissal of that suit." The affidavit of plaintiff's counsel states that "[n]o decision was made [sic] in the motion to compel arbitration, and it was re-calendared for July 27, 1992. Plaintiff filed a separate action to compel arbitration after defendant refused to arbitrate. However, when plaintiff learned that the AAA [American Arbitration Association] would proceed with arbitration without an order to compel, plaintiff dismissed this case ..." Mr. Bailey's affidavit states that plaintiff filed a written demand for arbitration with the AAA and that defendant objected to the scheduling of arbitration.

**\*94** On 15 June 1992, State Farm, through William R. Cherry, Jr., as counsel, filed notice of its "appearance pursuant to the terms and conditions of G.S. 20-279.21(b)(4) as an unnamed party, though not named in the caption of the pleadings, and electing to defend in the name of the named defendant without appearing as a party herein." Plaintiff claims that on that same day "State Farm, as the UIM carrier, also served on plaintiff a motion to stay arbitration with no

reference to affidavits in support of its motion." Plaintiff claims that thirty-five days later State Farm mailed affidavits to plaintiff in support of its motion to stay arbitration and that the affidavits were not received until nine days following their mailing, which was two days after the hearing was held. Plaintiff contends that these affidavits contain allegations which are erroneous and which were prejudicial to her motion to compel arbitration.

On 27 July 1992, the trial court entered an order granting State Farm's motion to stay arbitration and denying plaintiff's motion to compel arbitration. Plaintiff filed a motion to reconsider the 27 July 1992 order, alleging that she had an inadequate opportunity under G.S. 1A-1, Rule 6(d) and (e) to respond to State Farm's affidavits. On 26 August 1992, the trial court denied plaintiff's motion for reconsideration. Plaintiff appeals.

#### Attorneys and Law Firms

Brumbaugh & Mu by [Richard A. Mu](#), Jacksonville, for plaintiff-appellant.

Marshall, Williams & Gorham by [William Robert Cherry, Jr.](#), Wilmington, for defendant-appellee State Farm Mut. Auto. Ins. Co.

Hamilton, Bailey, Way & Brothers by [Glenn S. Bailey](#), Morehead City, for defendant-appellee Theresa J. Bonta.

#### Opinion

[EAGLES](#), Judge.

Plaintiff appeals from the trial court's 27 July 1992 and 26 August 1992 orders. After careful review, we reverse and remand for entry of an order compelling arbitration.

I.

[1] In her first two assignments of error, plaintiff contends that the trial court committed reversible error in denying plaintiff's motion to compel arbitration and in granting defendant's motion to stay arbitration "on the grounds that plaintiff's insurance contract **\*95** with defendant State Farm Mutual Insurance Company grants plaintiff a contractual right to arbitrate." We agree.

[2] This is an interlocutory appeal arising from the denial of plaintiff's motion to stay the proceedings and compel arbitration. Initially, we note that a trial court's "order denying arbitration, although interlocutory, is immediately appealable because it involves a substantial right which might be lost if appeal is delayed." *Bennish v. N.C. Dance Theater*, 108 N.C.App. 42, 44, 422 S.E.2d 335, 336–37 (1992) (quoting *Prime South Homes v. Byrd*, 102 N.C.App. 255, 258, 401 S.E.2d 822, 825 (1991)); *Sims v. Ritter Constr., Inc.*, 62 N.C.App. 52, 302 S.E.2d 293 (1983); G.S. 1–277(a); G.S. 7A–27(d)(1).

Our Supreme Court has held that:

Waiver of a contractual right to arbitration is a question of fact. *E.g.*, *Davis v. Blue Cross of Northern California*, 25 Cal.3d 418, 158 Cal.Rptr. 828, 600 P.2d 1060 (1979); *Doers v. Golden Gate Bridge Etc. Dist.*, 23 Cal.3d 180, 151 Cal.Rptr. 837, 588 P.2d 1261 (1979). Because of the strong public policy in North Carolina favoring arbitration, *see* N.C.Gen.Stat. § 1–567.3 (1983); *Thomas v. Howard*, 51 N.C.App. 350, 355–56, 276 S.E.2d 743, 747 (1981), courts must closely scrutinize any allegation of waiver of such a favored right. *See Keating v. Superior Court*, 31 Cal.3d 584, 183 Cal.Rptr. 360, 645 P.2d 1192 (1982), *dismissed in part and rev'd in part on other issues sub nom. Southland Corp. v. Keating*, 465 U.S. 1 [104 S.Ct. 852] 79 L.Ed.2d 1 (1984); *Doers v. Golden Gate Bridge Etc. Dist.*, 23 Cal.3d 180, 151 Cal.Rptr. 837, 588 P.2d 1261. *See also Moses H. Cone Hospital v. Mercury Constr. Corp.*, 460 U.S. 1, 24–25 [103 S.Ct. 927, 941], 74 L.Ed.2d 765, 785 (1983) ("[A]ny doubts concerning the scope of arbitrable issues should be resolved in favor of arbitration, whether the problem at hand is the construction of the contract language itself or an allegation of waiver, delay, or a like defense to arbitrability."). Because of the reluctance to find waiver, we hold that a party has impliedly waived its contractual right to arbitration if by its delay or by actions it takes which are inconsistent with arbitration, another party to the contract is prejudiced by the order compelling arbitration. *See, e.g., Carolina Throwing Co. v. S & E Novelty Corp.*, 442 F.2d 329, 331 (4th Cir.1971) ("waiver ... may not rest mechanically on some act such as the filing of a complaint or answer but must find a basis in prejudice to the objecting party") (quoting *\*96 Batson Y. & F.M. Gr., Inc. v. Saurer-Allma GmbH-Allgauer M.*, 311 F.Supp. 68, 73 (D.S.C.1970)).

*Cyclone Roofing Co. v. LaFave Co.*, 312 N.C. 224, 229, 321 S.E.2d 872, 876 (1984) (footnote omitted). *See also Servomation Corp. v. Hickory Constr. Co.*, 316 N.C. 543, 544,

342 S.E.2d 853, 854 (1986); *Bennish*, 108 N.C.App. 42, 422 S.E.2d 335. Here, our close scrutiny leads us to conclude that given the terms of plaintiff's policy with State Farm and given State Farm's actions, plaintiff's demand for arbitration of her UIM claim was timely made.

State Farm contends that because plaintiff filed suit against defendant Bonta (another State Farm insured) several months prior to her (plaintiff's) written demand for arbitration, she thus nullified the effect of her demand to arbitrate under the terms of her own UIM policy. We disagree.

We note that plaintiff has two potential claims under two separate State Farm policies: the first is a claim against defendant Bonta's personal automobile liability policy with State Farm, while the second is a claim arising under the UIM coverage of her (plaintiff's) own personal automobile policy with State Farm. We further note that despite the existence of these separate claims brought forward by its own named insured, State Farm initially refused to assign two different adjusters and subsequently refused to assign two different attorneys to handle the respective claims against each policy. The North Carolina State Bar has issued an ethics opinion ruling that "an attorney may not represent the insured, her liability insurer, and the same insurer relative to underinsured motorist coverage carried by the plaintiff." *See* N.C. R.P.C. 154 (proposed 21 October 1992; approved 15 January 1993). State Farm contends that "[i]t should be noted that by letter dated July 27, 1990, the defendant-appellee State Farm had clearly stated to counsel for the plaintiff-appellant that the company did not subrogate against their own insureds when payment was made under the underinsured motorist coverage for another State Farm insured." Nevertheless, we do not find this argument persuasive as to the issue of plaintiff's right to arbitration under the express terms of her UIM policy.

Plaintiff argues that by the express terms of her UIM policy she "did not have a right to seek payment from her State Farm UIM *\*692* coverage (and thus arbitrate) until State Farm, as the liability carrier, offered to pay the limits of the Bonta liability policy. State *\*97* Farm refused to tender the liability limits until 18 months after suit was filed, in spite of demands by plaintiff which provided an objective basis for State Farm to conclude that the value of plaintiff's claim exceeded those liability limits." We agree.

A provision under Coverage U1 of plaintiff's UIM policy, *supra*, specifically stated that "We [State Farm] will pay under this coverage only after the limits of liability under

any applicable liability bonds or policies have been exhausted by payments of judgments or settlements....” Prior to the time plaintiff filed suit against defendant, State Farm had refused plaintiff’s demands for settlement in the amount of \$25,000.00 under defendant’s liability policy. Plaintiff filed suit against only defendant Bonta on 29 August 1990. Thereafter, plaintiff made repeated demands for payment under defendant’s liability policy, all of which were declined by State Farm. Because State Farm assigned one attorney to handle both claims, until the 17 February 1992 offer (of \$75,000.00) plaintiff could not reasonably assume that the limits of defendant’s policy (\$25,000.00) had been exhausted. Accordingly, we conclude that the arbitration rights under plaintiff’s UIM policy were not triggered prior to State Farm’s 17 February 1992 offer. We further note that Part C of plaintiff’s UIM policy specifically states that if State Farm and “an insured do not agree: 1. Whether that person is legally entitled to recover damages *under this Part*; or 2. As to the amount of damages” then the insured is entitled to make a written demand for arbitration. Nothing in plaintiff’s UIM policy states that plaintiff’s filing of a complaint against another State Farm insured for liability arising from the same insured event results in a waiver of plaintiff’s right

to arbitrate under her own UIM policy. By the terms of plaintiff’s UIM policy, plaintiff’s action against defendant was not inconsistent with, and did not prejudice, her right to seek arbitration under the terms of her (plaintiff’s) own policy. In sum, we conclude that plaintiff’s demand for arbitration was not untimely or unreasonably delayed by plaintiff. Because of our disposition of this issue, we need not address the remaining issues raised by plaintiff.

We hold that the trial court erred and that the cause must be submitted to arbitration pursuant to plaintiff’s timely demand under the terms of the insurance contract. Accordingly, the trial court’s 27 July 1992 and 26 August 1992 orders are reversed and the cause is remanded for proceedings not inconsistent with this opinion.

**\*98** Reversed and remanded.

ORR and GREENE, JJ., concur.

#### All Citations

113 N.C.App. 89, 437 S.E.2d 687

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71 Wash.App. 626  
Court of Appeals of Washington, Division 3,  
Panel Two.

Cindy L. **HEIGIS**, Appellant,

v.

Monica Marie **CEPEDA** and  
John Doe Cepeda, husband and  
wife, and the marital community  
comprised thereof, Respondents,

and

State Farm Fire and Casualty  
Company, Defendant.

No. 12131-3-III.

Oct. 5, 1993.

Publication Ordered Nov. 9, 1993.

**Synopsis**

Motorist brought action for personal injuries sustained in automobile accident. Following trial, the Superior Court, Spokane County, **Robert Austin, J.**, dismissed action on basis of release executed by injured motorist, and injured motorist appealed. The Court of Appeals, Thompson, C.J., held that: (1) insurance adjuster dealing in third-party capacity with injured motorist, who was covered by insurer, did not owe enhanced duty of good faith to injured motorist, such that release could be avoided on ground it was obtained by overreaching on part of insurance adjuster; (2) release was not fraudulently obtained; and (3) appeal was not frivolous and did not warrant assessing attorney fees against injured motorist.

Affirmed.

West Headnotes (8)

[1] **Insurance** ← **Fraud or mistake**

Adjuster for insurer that provided automobile coverage both to alleged tort-feasor and to injured motorist owed no enhanced duty of

good faith to injured motorist when dealing with her as third-party claimant and, therefore, had no affirmative obligation to disclose coverage specifics of either motorist's policy or tort-feasor's policy, such that there would be basis for avoiding release executed by injured motorist on ground it was obtained by overreaching on part of adjuster.

3 Cases that cite this headnote

[2] **Insurance** ← **Of Insurers**

Generally, tort-feasor's insurer does not owe third-party claimants enhanced obligations.

1 Cases that cite this headnote

[3] **Evidence** ← **Part of series showing system or habit**

Insurance adjuster's testimony about her routine practice in double-claim situations (i.e., instances when insurer covers both at-fault party and claimant) was admissible as evidence of habit. **ER 406**.

3 Cases that cite this headnote

[4] **Insurance** ← **Actions**

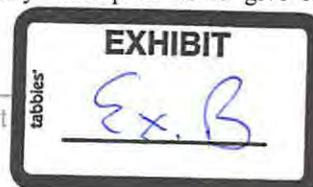
Insurance adjuster's testimony that, in double-claim situations, she always advised claimants that she also represented policy of at-fault party and that claimants could file for their medical expenses under their own policy supported trial court's conclusion that release from injured motorist was not fraudulently obtained, considering additionally corroboration provided by notation referring to alleged tort-feasor's policy on check given to injured motorist.

2 Cases that cite this headnote

[5] **Compromise, Settlement, and Release** ← **Release**

Consideration of \$2,578 given for release of claims arising from automobile accident was not so grossly inadequate as to give rise to

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presumption of fraud, where injured motorist currently alleged special damages of \$4,309.

[6] **Insurance** ← **Fraud or mistake**

Statement by insurance adjuster predicting injured motorist would feel better once she settled was assertion of opinion, not of fact, and it did not support injured motorist's allegation that release was fraudulently obtained.

[7] **Appeal and Error** ← **References to Record**

Injured motorist who signed release failed to establish on appeal that trial court erred in holding that there was no mutual mistake of fact regarding release, where injured motorist did not provide any citations to record to support her assertions, review of record disclosed no such evidence, and insurance adjuster's testimony was to contrary.

[8] **Costs** ← **Nature and form of judgment, action, or proceedings for review**

Appeal from judgment dismissing action for personal injuries sustained in automobile accident, on basis of release executed by injured motorist, was not frivolous, and did not justify award of attorney fees against insured motorist, in that appeal presented debatable issue of whether insurer owed fiduciary duties when dealing with its own insured in third-party context. [RAP 18.9](#).

2 Cases that cite this headnote

**Attorneys and Law Firms**

**\*\*130 \*627** [L. Neil Axtell](#), Axtell, Briggs & Corlett, Spokane, for appellant.

[Stephen C. Haskell](#), Chase, Haskell, Hayes & Kalamon, Spokane, [William R. Hickman](#), [Pamela A. Okano](#), Reed McClure, Seattle, for respondents.

**Opinion**

THOMPSON, Chief Judge.

Cindy L. Heigis brought this action against Monica and John Doe Cepeda for personal injuries she suffered in an automobile accident allegedly caused by Ms. Cepeda's negligence.<sup>1</sup> The Cepedas answered, raising as an affirmative defense a release executed by Ms. Heigis in their favor. Following trial, the Superior Court dismissed Ms. Heigis' action. In this appeal, she contends the court erred when it held the release was not obtained by overreaching, fraud, and/or mutual mistake. We affirm.

On July 8, 1987, Cindy Heigis was involved in a collision with a vehicle driven by Monica Cepeda. Ms. Heigis suffered back and neck injuries, and her two minor children and an adult passenger were also hurt. On September 3, 1987, Ms. Heigis accepted \$2,578 to settle her negligence claim against \*628 the Cepedas. In exchange, she signed a release which discharged the Cepedas

from any and all claims, demands, damages, actions, causes of action or suits of any kind or nature whatsoever, and particularly on account of all injuries, known and unknown, both to person and property, which have resulted or may in the future develop from an accident which occurred on or about the 8th day of July, 1987 at or near Monroe and Walton.

....

Undersigned hereby declares that the terms of this settlement have been completely read and are fully understood and voluntarily accepted for the purpose of making a full and final compromise adjustment and settlement of any and all claims, disputed or otherwise, on account of the injuries and damages above mentioned, and for the express purpose of precluding forever any further or additional claims arising out of the aforesaid accident.

Both Ms. Heigis and the Cepedas were insured by State Farm Fire and Casualty Company. At trial, State Farm adjuster Martha Coulter testified that she secured the release from Ms. Heigis on behalf of the Cepedas. Ms. Coulter met with Ms. Heigis 2 days after the accident and again on July 30 when she paid her for her car, which was totaled. The check for these damages bore a notation that the insured was Jose Cepeda.<sup>2</sup> Ms. Coulter spoke with Ms. Heigis by telephone on

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two or three other occasions prior to obtaining the release. She stated it is her habit to advise claimants in double claim situations (*i.e.*, instances in which State Farm insures both the at-fault party and the claimant) that she is representing the auto policy of the at-fault party and that the claimant can file for any medical expenses under the personal injury protection provision of their own State Farm policy.

**\*\*131** On September 1, 1987, Ms. Coulter telephoned Ms. Heigis with an offer of \$2,850 to settle her and her two children's claims. The next day, Ms. Heigis counteroffered \$5,800. Neither Ms. Coulter nor Ms. Heigis attempted to break their offers down in terms of amounts allocated for damages such as **\*629** pain and suffering or future wage loss. An agreement was reached to settle the claims for \$2,578 for Ms. Heigis and \$806 and \$506 for the two children. Ms. Coulter testified:

A I did not discuss the future ramifications. I explained it was a full and final settlement.

Q But apparently, without going into the elements of what this release means?

A I did not discuss the future ramifications.

Q Well, you did not even discuss what you were paying for her up to that point, did you?

A I said pain and suffering, and wage loss.

Q And that's all you said?

A Yes.

Q Did you—did you attempt to explain the two policies to her?

A I explained that I was handling the auto policy for the other vehicle that struck her vehicle.... And that she had a separate file set up off her own auto policy.

According to Ms. Coulter, she neither stated nor implied that more sums would be paid after the agreed amount was remitted. She had no specific recollection of what she and Ms. Heigis discussed when Ms. Heigis signed the release. Over the objection of Ms. Heigis' counsel, Ms. Coulter was allowed to testify about her routine in such situations. She stated, "I tell them to speak to their own adjuster regarding [medical]", and "this concludes any ... contact you'd have with me."

At the time Ms. Heigis signed the release, she was dealing with other State Farm employees on her first party claims. On July 16, 1987, Tim Donovan sent her a letter asking her to fill out an application for benefits and return it with any medical bills she had received. He observed that her policy provided for medical coverage for "reasonable and necessary treatment" and that State Farm may "ask you to be examined by a doctor of our choice if treatment of your injury appears excessive or inappropriate". By letter dated September 2, 1987, the day before Ms. Heigis signed the release, Beverly Hill, Mr. Donovan's assistant, notified her that State Farm had scheduled an independent medical exam (IME) for her on September 25. As a result, Ms. Heigis said she believed State Farm regarded her injuries as "excessive, and **\*630** inappropriate". She subsequently engaged an attorney and canceled the IME.

Ms. Heigis also testified concerning her contacts with Ms. Coulter:

Q And is it correct that the—one of the phone calls from Ms. Coulter, just before September 3, a day or two before, was one of those calls where she's *saying you should settle, and you will feel a lot better after you get the paperwork behind you?*

A Yes, that's when she called.

Q Did you have any idea, whatsoever, when you signed that release, that you were cutting off your future right to recovery for pain and suffering? Or loss of earning capacity, alteration of life, or any of those items?

A No. At the time I had no idea what those items meant.

....

Q ... No one from the insurance carrier had ever explained them to you?

A Right.

(Italics ours.) She further testified that as of the date of trial, October 1991, her back still hurt, she had not returned to her part-time job as a cocktail waitress, and she had incurred \$4,309.34 in medical expenses to treat injuries caused by the accident.

Ms. Heigis assigns error to the following findings and conclusions entered by the trial court: (1) Ms. Coulter explained to Ms. Heigis her role as a representative for the Cepeda policy. (2) Ms. Heigis consented to **\*\*132** settle her

claim, even though she had not fully recovered, believing she would do so in the near future. (3) Ms. Heigis assumed any ongoing medical expenses or wage loss would be covered by her insurance. In fact, coverage for these items existed under the personal injury protection provision of her policy. And, (4) the release was not obtained by fraud or overreaching and, therefore, was binding upon Ms. Heigis.

[1] First, Ms. Heigis seeks to avoid the release on the ground it was obtained by overreaching on the part of Martha Coulter, the State Farm agent who represented the Cepedas' policy. See *Pepper v. Evanson*, 70 Wash.2d 309, 313, 422 P.2d 817 (1967) (a release is voidable if it is the result of fraud, \*631 overreaching, misrepresentation, or mutual mistake). She cites the enhanced obligations an insurer owes its insureds as part of its duty of good faith. See *Tank v. State Farm Fire & Cas. Co.*, 105 Wash.2d 381, 386, 715 P.2d 1133 (1986), and authorities therein. Ms. Heigis argues Ms. Coulter had a duty to advise her of the coverages for pain and suffering and loss of earning capacity she was giving up by agreeing to the settlement.

[2] Although this action against the Cepedas is separate from Ms. Heigis' bad faith action against State Farm, the issues in the two actions overlap insofar as Ms. Heigis seeks to avoid the release based upon the conduct of State Farm Agent Coulter. Generally, the tortfeasor's insurer does not owe third party claimants enhanced obligations. *Tank*, at 395, 715 P.2d 1133. Does this general rule apply here, in a situation in which the third party claimant, Ms. Heigis, is insured by the same insurer as the tortfeasor?

We could not find any Washington case addressing this issue. The majority of jurisdictions which have considered it hold there is *no* enhanced duty of good faith owed by an insurer when dealing with its own insured as a third party claimant. *Clinton v. State Farm Mut. Auto. Ins. Co.*, 110 Ga.App. 417, 138 S.E.2d 687 (1964) (plaintiff dealt "at arm's length" with State Farm with respect to his personal injury claim even though he was also insured by State Farm); *Chavez v. Chenoweth*, 89 N.M. 423, 553 P.2d 703 (Ct.App.1976) (representations were made in arm's length dealings on the basis of plaintiff's claim against State Farm as the insurer of Chenoweth; nevertheless, the court found the allegations sufficient to state a claim of fraud); *Pixton v. State Farm Mut. Auto. Ins. Co.*, 809 P.2d 746 (Utah App.1991) (there is no duty of good faith and fair dealing imposed upon an insurer running to a third party claimant, such as Pixton, seeking to recover against the company's insured). See also Annot.,

*Liability Insurer's Rights and Duties as to Defense and Settlement as Affected by its Having Issued Policies Covering Parties Who Have Conflicting Interests*, 18 A.L.R.3d 482, § 2, at 485 (1968).

\*632 Ms. Heigis relies upon *State Farm Mut. Auto. Ins. Co. v. Ling*, 348 So.2d 472 (Ala.1977). There, the court found the plaintiff "was repeatedly assured by State Farm [which insured both the plaintiff and the at-fault party] that he had nothing to worry about, the accident was entirely the fault of [the other insured] and his expenses would be paid; State Farm would settle his claim." *Ling*, 348 So.2d at 474. Thus, State Farm acted fraudulently when it required a doctor's report as a condition of settling the claim, knowing that the statute of limitation would run before such a report could be filed. *Ling*, 348 So.2d at 474, 476. In contrast, Ms. Coulter told Ms. Heigis she would probably feel better after she settled and "got the paperwork behind her", but there is no testimony she led Ms. Heigis to believe she was watching out for her interests.

We hold Ms. Coulter had no affirmative obligation to disclose the coverage specifics of either Ms. Heigis' own policy or that of the Cepedas. They dealt at arm's length. Consequently, the trial court correctly determined the release was not void for overreaching.

[3] [4] Second, Ms. Heigis attacks the court's conclusion that the release was not fraudulently obtained. See *Pepper*, 70 Wash.2d at 313, 422 P.2d 817. In this \*\*133 regard, she assigns error to the court's permitting Ms. Coulter to testify that it is her habit to advise claimants in double claim situations that she represents the adverse party. According to Ms. Heigis, without this testimony, there is nothing to support the court's finding.

ER 406 provides:

Evidence of the habit of a person or of the routine practice of an organization, whether corroborated or not and regardless of the presence of eyewitnesses, is relevant to prove that the conduct of the person or organization on a particular occasion was in conformity with the habit or routine practice.

The habit in question must be just that: "[O]ne's regular response to a repeated specific situation so that doing the habitual act becomes semi-automatic." See Comment, ER 406. "As with most evidentiary questions, the determination \*633 of admissibility is within the trial court's discretion." *Norris v. State*, 46 Wash.App. 822, 826, 733 P.2d 231 (1987).

Ms. Coulter's testimony about her routine practice in double claim situations qualifies as evidence of habit. As an adjuster, she deals with double claims on a repeated basis. She testified she "always" advises such claimants that she represents the policy of the at-fault party and that they can file for their medical expenses under their own policy. Although corroboration is not required, *see* ER 406, the fact the checks she gave Ms. Heigis bore the notation "Cepeda policy" lends credence to her testimony.

Accordingly, the trial court did not abuse its discretion when it admitted Ms. Coulter's testimony on this issue. That testimony supports the court's holding that Ms. Coulter did not mislead Ms. Heigis as to her role when she negotiated the settlement.

[5] Ms. Heigis also contends the release was procured by fraud, based upon "the gross inadequacy" of the consideration and upon Ms. Coulter telling her she would feel better after she got the paperwork behind her. " 'When the inadequacy of consideration is very gross, fraud will be presumed ...' " *Hicks v. Jenkins*, 68 Wash. 401, 406, 123 P. 526 (1912) (quoting 6 *American Engineering Encyclopedia Law* 701 (2d ed.)). In *Hicks*, the plaintiff released the defendant for \$152.50, even though his injury caused episodes of mental impairment so severe he could not function normally. Here, Ms. Heigis settled for \$2,578 and now alleges special damages of \$4,309. The alleged inadequacy of the consideration in this case is not so gross as to presume fraud.

[6] Finally, the statement by Ms. Coulter predicting Ms. Heigis would feel better once she settled is the assertion of an opinion, not a fact. It does not support Ms. Heigis' allegation the release was fraudulently obtained. *Cf. In re*

*Washington Public Power Supply Sys. Sec. Litigation*, 650 F.Supp. 1346, 1350 (W.D.Wash.1986) (opinions are generally not actionable as they are not misstatements of fact). The trial court correctly determined the release was not void for fraud or misrepresentation.

\*634 [7] Third, Ms. Heigis disputes the trial court's holding, as found in its oral opinion, that there was no mutual mistake of fact. *See Pepper*, 70 Wash.2d at 313, 422 P.2d 817. She contends even Ms. Coulter did not know what coverages the release concerned, and she was also mistaken as to the extent of coverage under Ms. Heigis' own policy. But Ms. Heigis does not provide any citations to the record to support her assertions. We saw no such evidence in our own review of the record. As State Farm points out, Ms. Coulter's testimony is to the contrary.

[8] Fourth, we address the Cepedas' request for attorney fees under RAP 18.9. RAP 18.9 provides for such an award when the appeal is frivolous, *i.e.*, it presents no issue upon which reasonable minds can differ. *Boyles v. Department of Retirement Sys.*, 105 Wash.2d 499, 506-07, 716 P.2d 869 (1986). Whether an insurer owes fiduciary duties when dealing with its insured in a third party context presents a debatable \*\*134 issue; therefore, we refuse to award fees.

Affirmed.

MUNSON and SWEENEY, JJ., concur.

#### All Citations

71 Wash.App. 626, 862 P.2d 129

#### Footnotes

- 1 In the same complaint, Ms. Heigis also sued State Farm Fire and Casualty Company, which insured both her and the Cepedas. She alleged State Farm breached the Consumer Protection Act and its obligation to deal with her in good faith. Prior to trial, the court ordered Ms. Heigis to file all claims against State Farm in a separate amended complaint. The court also granted the Cepedas' motion to bifurcate their trial from that of State Farm. That case is not involved in this appeal.
- 2 Jose Cepeda is Ms. Cepeda's father. He was the named insured on the State Farm policy.

822 P.2d 820  
Supreme Court of Wyoming.

Candelaria V. **DARLOW** and Daniel  
L. **Darlow**, Appellants (Plaintiffs),  
v.  
FARMERS INSURANCE  
EXCHANGE, a California  
corporation, Appellee (Defendant).

No. 91-76.  
|  
Dec. 9, 1991.

**Synopsis**

Insured who was injured in automobile accident brought bad faith tort suit against insurer, which also provided coverage for other party involved in accident. Insurer's motion for summary judgment was granted by the District Court, Albany County, Arthur T. Hanscum, J., and insured appealed. The Supreme Court, Urbigkit, C.J., held that: (1) insurer's failure to give insured first party medical payment benefits for ten weeks after accident was reported to local agent was not bad faith; (2) insurer's duty of good faith and fair dealing included informing insured as to coverage and policy requirements when it is apparent to insurer that there is a strong likelihood that its insured only can be compensated fully under her own policy; and (3) insurer did not violate duty of informing insureds as to coverage and policy requirements, as claims representative clearly stated that until settlement was reached, insured's medical bills would be paid under terms of insured's policy.

Affirmed.

West Headnotes (10)

[1] **Insurance** ← Insurer's Settlement Duties in General

**Insurance** ← Duty to Settle or Pay

Insurance company owes duty of good faith to its insureds not to unreasonably deny claim for benefits under policy, and breach of duty of good

faith and fair dealing give rise to independent tort action for bad faith.

5 Cases that cite this headnote

[2] **Insurance** ← Reasonableness of Insurer's Conduct in General

Appropriate standard of care to determine bad faith of insurer in denying benefits is the objective standard of whether validity of denied claim was fairly debatable.

6 Cases that cite this headnote

[3] **Insurance** ← Absence of Coverage; Coverage Disputes in General

To show bad-faith denial of coverage, insured must show absence of reasonable basis for insurer to deny benefits, or that reasonable insurer under circumstances would not have acted as insurer did by denying or delaying payment of claim, and, second, knowledge or reckless disregard of lack of reasonable basis for denying claim must be proven.

11 Cases that cite this headnote

[4] **Insurance** ← Duty to Settle or Pay

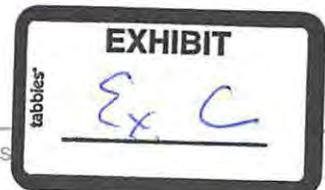
Automobile insurer's failure to give insured first party medical payment benefits for ten weeks after accident was reported to local agent was not bad faith, where insured made no claims for medical payments in her initial report, and, when form was completed and returned, insurer took only 24 days to make initial payment. W.S.1977, § 26-15-124(a).

1 Cases that cite this headnote

[5] **Insurance** ← Time of Payment

Statutory 45-day period for automobile insurer to make first party insurance benefit payments begins when insurer receives proof of loss and supporting evidence. W.S.1977, § 26-15-124(a).

1 Cases that cite this headnote



**[6] Insurance** ← Duty to Settle or Pay

Insured's suspension of chiropractic treatment following automobile accident when chiropractor demanded payment did not demonstrate unreasonableness on automobile insurer's part, for purposes of insured's bad-faith tort claim against insurer, as no claim for chiropractic bill had been submitted to insurer at time insured elected to suspend treatment, although other claims were being processed.

1 Cases that cite this headnote

**[7] Insurance** ← Weight and Sufficiency

Claim by insured, who was injured in automobile accident, that her insurer, which also represented driver of other vehicle, used offer of medical payment benefits as negotiation tool in settlement of third-party claim against other driver's policy was not supported by evidence; during initial report of accident, insured never inquired of rights under policy and made no requests for payment of medical bills, and agent discouraged premature bodily injury claim settlement and advised insured that medical claims would be paid by insured's policy.

2 Cases that cite this headnote

**[8] Insurance** ← Insurer's Settlement Duties in General**Insurance** ← Duty to Settle or Pay

Subsequent payment of denied or unreasonably delayed insurance claim does not absolve insurer from liability for bad-faith denial or delay in paying claim.

11 Cases that cite this headnote

**[9] Insurance** ← Good Faith and Fair Dealing

Insurer's duty of good faith and fair dealing includes informing insured as to coverage and policy requirements when it is apparent to insurer that there is a strong likelihood that its insured only can be compensated fully under her own policy and insured has no basis to believe that she must rely upon her policy for coverage, in

cases where both parties to incident are insured by same insurer.

7 Cases that cite this headnote

**[10] Insurance** ← Good Faith and Fair Dealing

Insurer, which provided coverage to both parties involved in automobile accident, did not violate duty of informing insureds as to coverage and policy requirements, as claims representative clearly stated that until settlement was reached, insured's medical bills would be paid under terms of insured's policy and no evidence indicated that insured did not understand concept of first-party medical payment benefit coverage which she had acquired in full coverage policy.

5 Cases that cite this headnote

**Attorneys and Law Firms**

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Before URBIGKIT, C.J., and THOMAS, CARDINE, MACY and GOLDEN, JJ.

**Opinion**

URBIGKIT, Chief Justice.

The issue to be decided by this appeal is whether the conduct of an insurer with its insured constituted bad faith under the rule this court announced in *McCullough v. Golden Rule Ins. Co.*, 789 P.2d 855 (Wyo.1990). The policyholders, appellants Candelaria V. Darlow and Daniel L. Darlow, appeal from a summary judgment entered in favor of appellee, Farmers Insurance Exchange. Appellants claim appellee acted in bad faith by unreasonably delaying or denying auto insurance policy medical payment benefits owed following a two-car collision where both vehicles were insured by the same insurance carrier.

We affirm.

I.

## ISSUES

Appellants present three issues for review:

- [1.] Whether the insurer's delay in payment of first-party medical-payment benefits was unreasonable.
- [2.] Whether the trial court erred in holding that insurer bad faith in a first-party case is cured by later payment of the claim.
- [3.] In a double-insured auto accident case—that is, the same company insures both drivers—whether an insurer acts in bad faith when it negotiates the insured's third-party claim without informing her of the rights to which she is entitled under her own policy, and without clearly disclosing that the insurer is acting not on behalf of the insured but instead on behalf of the other driver.

Appellee's formulation of the relevant issues on appeal differs:

- [1.] In an action for bad faith under *McCullough v. Golden Rule Insurance Company*, can an insurance company be liable where it has paid its insured's claim promptly and in full?
- [2.] Is a claimant seeking recovery under a liability policy entitled to special treatment simply because she is also insured by the same company under a separate policy of insurance?

II.

## FACTS

The innocuous beginning of this litigation occurred on October 1, 1988. Misty \*822 Jackson, a juvenile, drove a 1979 Mustang out of a parking lot in Laramie, Wyoming and struck broadside Candelaria Darlow's 1977 Buick. Jackson accepted liability for the accident. Mrs. Darlow's whiplash injuries required emergency room treatment and subsequent physical therapy.<sup>1</sup>

Candelaria Darlow and her husband Daniel Darlow (Darlows) purchased their automobile insurance policy from Farmers Insurance Exchange (Farmers) in Ogden, Utah. The Darlows had moved to Wyoming only two months before the accident so Mr. Darlow could begin law school. Their Wyoming E-Z-Reader Car Policy, in effect at the time of the accident, was actually issued October 28, 1988, but effective on September 23, 1988. The policy was signed by the Laramie agent of Farmers, T.F. Thone. This policy included first-party medical claims coverage. "We will pay reasonable costs for necessary *medical services* furnished within two years from the date of the *accident*, because of *bodily injury* sustained by an *insured person*." (Emphasis in original.)

The Mustang driven by Jackson was also insured by Farmers. The policyholders were Ms. Jackson's parents, Marvin and Kathryn Browning of Laramie. Thone had sold the Brownings their policy. This policy provided liability coverage for third-party property damage and bodily injury claims.

Mr. Darlow reported the accident to Thone on Monday, October 3, 1988, after obtaining his name from Jackson's mother. Mr. Darlow completed a form titled "Statement of Facts of Accidents" at Thone's office. This insurance form identified the parties to the accident and indicated that both parties were insured by "FIG" or Farmers Insurance Group. The form reported damage to the Darlows' Buick and the injury to Mrs. Darlow. Farmers processed this form as a third-party liability claim by the Darlows against the Browning policy.

During the meeting, Mr. Darlow did not ask Thone any questions about coverage under the Darlows' policy and no requests for payment of medical bills were made. Thone said that Jackson had admitted liability and that Charles Robert Inman, a Farmers claims representative from Cheyenne, Wyoming, would be the adjuster for their claim. Thone clearly indicated that he was the agent for both parties in this accident, since both were covered by the same company, and his job would be to forward the paperwork. Mr. Darlow informed Thone that his policy was "full coverage" including comprehensive, collision, medical and liability coverage.

Farmers opened a property damage claim file on October 4 and a bodily injury claim file on October 5, 1988. Inman, the claims representative, contacted the Darlows on October 5 by telephone and scheduled an appointment to meet with the Darlows at their home on October 12, 1988.

At the October 12 meeting, Inman informed the **Darlows** that he represented Jackson and the Brownings in reaching a settlement. The **Darlows** do not recall such a specific statement. However, the **Darlows** acknowledge that Inman immediately settled the property damage claim on their vehicle by paying \$470.

During the meeting, Inman offered, after discussing Mrs. **Darlow's** condition, to settle the bodily injury claim for a total of \$3,000. However, Inman discouraged the **Darlows** from settling their claim so soon after the accident. Inman informed the **Darlows** that until they settled, any medical bills would be paid by their insurance policy. Mr. **Darlow** acknowledged he had medical coverage since he had reviewed the terms of his insurance policy prior to the meeting.

Inman's next meeting with the **Darlows** occurred on November 4, 1988. Inman offered the **Darlows** a revised settlement of \$3,500 which the **Darlows** rejected. The **Darlows** requested a \$5,000 to \$10,000 settlement.

\*823 At the November meeting, the **Darlows** gave Inman medical bills to be paid from the **Darlows'** medical payments coverage. After this meeting, Farmers opened a first-party medical claim file under the **Darlows'** policy. On November 8, 1988, Farmers requested a proof of loss form be completed by Mrs. **Darlow**. She completed the form on November 17, 1988 and Farmers received it on November 22. The initial payment of \$770.55 for medical bills was made by Farmers on December 16, 1988. Subsequent installment payments were made to total the sum for all medical bills submitted by the **Darlows**.

Mrs. **Darlow** sought legal assistance on December 2, 1988 which resulted in a negligence lawsuit against Jackson filed on December 21, 1988. Mrs. **Darlow** accepted, on May 30, 1989, an offer of judgment under W.R.C.P. 68. On June 12, 1989, Mrs. **Darlow** filed a satisfaction of judgment acknowledging receipt of \$15,035 for settlement of her claims against Jackson. As a result, no third-party claims are at issue in the present action.

The **Darlows** filed this action on November 21, 1989 alleging bad faith, deceit and duress, and intentional infliction of emotional distress in Farmers' handling of the first-party claims. After more than one year of discovery, Farmers filed a motion in the district court for summary judgment on all claims. The **Darlows** responded with a cross motion for partial summary judgment on the bad faith claim. The district

court granted Farmers' motion and denied the **Darlows'** motion. The **Darlows** appeal only from the portion of the summary judgment which denied their bad faith claim. Consequently, we now consider the duty of the insurer under its first-party automobile insurance medical payment benefit coverage when that carrier also had the liability coverage on the other driver involved in the two-car accident.

III.

#### DISCUSSION

A.

This appeal contemplates a grant of summary judgment in favor of Farmers which is only proper if there are no genuine issues of material fact and the insurer as the prevailing party is entitled to judgment as a matter of law. *St. Paul Fire and Marine Ins. Co. v. Albany County School Dist. No. 1*, 763 P.2d 1255 (Wyo.1988); *Teton Plumbing and Heating, Inc. v. Board of Trustees, Laramie County School Dist. No. One*, 763 P.2d 843 (Wyo.1988). Where, as in this case, the facts are not in dispute and the questions presented are strictly ones of law, the appellate court accords no special deference to and is not bound by the district court's decision. *Albany County School Dist. No. 1*, 763 P.2d at 1257-58; *Teton Plumbing and Heating, Inc.*, 763 P.2d at 847.

"[W]e review the judgment in the same light as the district court, using the same information. A party moving for summary judgment has the burden of proving the nonexistence of a genuine issue of material fact. Material fact has been defined as one which, if proved, would have the effect of establishing or refuting an essential element of the cause of action or defense asserted by the parties. Upon examination of a summary judgment, we view the record from the vantage point most favorable to the party opposing the motion, giving him all favorable inferences which may be drawn from the facts."

*Doud v. First Interstate Bank of Gillette*, 769 P.2d 927, 928 (Wyo.1989) (quoting *Garner v. Hickman*, 709 P.2d 407, 410 (Wyo.1985)).

[1] [2] Wyoming announced the rule that an insurance company owes a duty of good faith to its policyholders not to unreasonably deny a claim for benefits under the policy in *McCullough*, 789 P.2d 855. The breach of the duty of good

faith and fair dealing gives rise to an independent tort action for bad faith. *Id.* at 858. The appropriate standard of care to determine bad faith is the objective standard of whether or not the validity of the denied claim was fairly debatable. *Id.* at 860.

“To show a claim for bad faith, a plaintiff must show the absence of a reasonable \*824 basis for denying benefits of the policy and the defendant’s knowledge or reckless disregard of the lack of a reasonable basis for denying the claim. It is apparent, then, that the tort of bad faith is an intentional one.”

*Id.* at 860 (quoting *Anderson v. Continental Ins. Co.*, 85 Wis.2d 675, 271 N.W.2d 368, 376–77 (1978)).

[3] The test announced in *McCullough*, as adopted from *Anderson*, contains two essential components. *Reuter v. State Farm Mut. Auto. Ins. Co., Inc.*, 469 N.W.2d 250 (Iowa 1991); *Fehring v. Republic Ins. Co.*, 118 Wis.2d 299, 347 N.W.2d 595 (1984). First, the insured must show the absence of a reasonable basis for the insurer to deny the benefits of the policy. Stated another way, the insured must show that a reasonable insurer under the circumstances would not have acted as they did by denying or delaying payment of the claim. *McCullough*, 789 P.2d at 860; *Anderson*, 271 N.W.2d at 377. Second, knowledge or reckless disregard of the lack of a reasonable basis for denying the claim must be proven. The *Anderson* court recognized that:

[T]he knowledge of the lack of a reasonable basis may be inferred and imputed to an insurance company where there is a reckless disregard of a lack of a reasonable basis for denial or a reckless indifference to facts or to proofs submitted by the insured.

*Anderson*, 271 N.W.2d at 377.

The **Darlows**’ foundational premise asserts that Farmers’ delay in payment of the first-party medical payment benefits was unreasonable. The principal support the **Darlows** provide for the premise comes from three contentions. First, the **Darlows** were denied medical payment benefits for ten weeks after reporting the accident to the local Farmers agent. Second, the lack of payment allegedly caused Mrs. **Darlow** to decline medical treatment. Third, Farmers used the offer of medical payment benefits as a negotiation tool in settlement of the **Darlows**’ third-party claim against the Browning policy.

[4] The first contention fails since no medical payments were in fact denied for a period of ten weeks. It is undisputed that the **Darlows** made no claim for medical payments in

their initial report to Farmers on October 3, 1988. At the October 12, 1988 meeting, Mr. **Darlow** claimed he gave Inman medical bills to “get them taken care of” from the ambulance service, hospital, and X-ray technician. Inman did not recall receiving medical bills during this meeting. The submitted hospital statement contained in the record for \$432.55 was dated November 3, 1988.

[5] The November 4, 1988 meeting marked the first time the **Darlows** sought to make a claim for benefits under terms of their first-party medical payments coverage. Inman accepted the medical bills and provided them to the Cheyenne office of Farmers to process. Four days later, November 8, Farmers requested a proof of loss form be completed by Mrs. **Darlow**. The form carries a stamped notation that “[n]o medical bills can be paid until this form is completed, signed & returned.” After Mrs. **Darlow** completed the form on November 17, 1988, it arrived in Cheyenne on November 22, 1988. Farmers then took twenty-four days after receiving the completed proof of loss form and the associated medical bills to process the claim and make an initial payment on December 16, 1988. This twenty-four day period is just over one-half of the statutory forty-five day period established under Wyoming law. “Claims for benefits under a life, accident or health insurance policy shall be rejected or accepted and paid by the insurer or its agent designated to receive the claims within forty-five (45) days after receipt of the proofs of loss and supporting evidence.” W.S. 26–15–124(a) (1991). The statutory period for the first-party insurance benefit payments begins when the insurer receives the proofs of loss and the supporting evidence. *Hart v. Allstate Ins. Co.*, 437 So.2d 823 (La.1983).

[6] The contention that Mrs. **Darlow** declined necessary medical treatment also fails to demonstrate unreasonableness on Farmers’ part. Mrs. **Darlow** sought treatment \*825 from Dr. W.F. Hankins, III on October 20, 1988. The doctor’s records indicate Mrs. **Darlow** was examined and had six additional office visits for chiropractic adjustments during the period from October 20, 1988 through November 23, 1988. In deposition testimony, Mrs. **Darlow** stated she suspended these visits after the doctor demanded payment. Mr. **Darlow** admitted that at the time his wife elected to suspend treatment, no claim for the \$190 medical bill had been submitted to Farmers, although other claims were being processed. In fact, the doctor’s statement establishes that when Mrs. **Darlow** suspended treatment on November 23, no balance was owed since the **Darlows** had paid for the visits. Farmers cannot reasonably be expected to anticipate the need for payment of

a chiropractic treatment billing that has not been presented to them. Farmers did reimburse the **Darlows** for the money they paid to Dr. Hankins after a claim was made.<sup>2</sup> Mrs. **Darlow** resumed treatment with the doctor on December 30, 1988.

[7] The third argument advanced by the **Darlows** in support of their unreasonable delay theory is that Farmers used the offer of medical payment benefits as a negotiation tool in settlement of their third-party claim against the Browning policy. This contention is unsupported by the record. During the initial report of the accident, the **Darlows** never inquired of the rights under their policy and made no requests for payment of medical bills. During the October 12 meeting, Inman discouraged a premature bodily injury claim settlement and advised the **Darlows** that medical claims would be paid by their insurance policy. After rejecting a second settlement offer at the November 4, 1988 meeting, the **Darlows** presented Inman with medical bills for payment as a first-party claim under the **Darlows'** policy. These bills were paid without unreasonable delay. At no time did Farmers withhold medical payments with the intent to coerce a settlement of the third-party liability claims.

The **Darlows'** argument fails to satisfy even the first portion of the *McCullough* test requiring proof of the absence of a reasonable basis to deny the benefits under the policy. The **Darlows** receive no support for their position from other authority. Our attention is directed to *Chavez v. Chenoweth*, 89 N.M. 423, 553 P.2d 703 (App. 1976), where the court merely found that allegations of delay in paying first-party medical expenses under an insurance contract were sufficiently pleaded to state a claim for relief. The plaintiff contended that the bad faith dealings had occurred from April until December of 1972, a period of nine months. *Id.*, 553 P.2d at 709. In *Neal v. Farmers Ins. Exchange*, 21 Cal.3d 910, 148 Cal.Rptr. 389, 389–95, 582 P.2d 980, 983–86, (1978), the California Supreme Court determined that a delay of two-years and eight-months for payment of an uninsured motorist claim was sufficient support for a jury finding of a breach of good faith and fair dealing. Delays in claims payments of nine or more months created a breach of good faith and fair dealing in *Kanne v. Connecticut General Life Ins. Co.*, 607 F.Supp. 899 (D.Cal.1985), *aff'd in part, rev'd in part*, 819 F.2d 204, *withdrawn*, 823 F.2d 284 (9th Cir.1987), *reh'g*, 859 F.2d 96, *superseded*, 867 F.2d 489 (9th Cir.1988), *cert. denied*, 492 U.S. 906, 109 S.Ct. 3216, 106 L.Ed.2d 566 (1989). Unreasonable attempts to “starve out” an insured were found in *Chester v. State Farm Ins. Co.*, 117 Idaho 538, 789 P.2d 534 (App. 1990) when the court found claim forms had been

repeatedly rejected by the insurer in a prolonged and confused seven-month-long process.

In the present case, Farmers received an initial claim for third-party liability coverage by the **Darlows** against the Browning policy. Farmers reacted properly by investigating the accident, determining liability and offering property and bodily injury settlements. The **Darlows** accepted the property settlement, but refused the bodily injury settlement, partly on the well-considered advice of the Farmers' claims representative. \*826 Later, the same claims representative instituted the processing of first-party medical claims at the **Darlows'** request. The fact the **Darlows** declined two Farmers settlement offers and eventually received a larger sum after instituting proceedings on the third-party claim is immaterial. We hold Farmers did not act unreasonably, in a fashion calculated to achieve delay for delay's sake, in paying the first-party medical claims. *Greene v. Truck Ins. Exchange*, 114 Idaho 63, 753 P.2d 274 (1988). Once submitted, the medical claims were fully and promptly paid.

B.

[8] The **Darlows** also contend, in essence, that Farmers had a duty to deal in good faith, and, if it did not do so, it is not absolved as a matter of law by eventual payment of the first-party medical claims. Farmers counters that its duty was fulfilled as there was absolutely no denial or delay of benefits under the terms of the **Darlow** policy. Farmers argues absent denial or unreasonable delay that bad faith cannot exist as a matter of law. The difficulty with both arguments originates with the failure to comprehend that bad faith requires objective review of whether or not the validity of the denied claim was fairly debatable. *McCullough*, 789 P.2d at 860.

The **Darlows** rely primarily upon the Arizona Supreme Court's decision in *Rawlings v. Apodaca*, 151 Ariz. 149, 726 P.2d 565 (1986) for support. That court determined that the implied covenant of good faith and fair dealing in an insurance contract can be breached, even if a company performs its express covenants under the insurance contract by paying the claim demanded. *Id.*, 726 P.2d at 573. The express covenant was a \$10,000 coverage provision in a homeowners policy for the loss by fire of a hay barn valued at \$40,000. *Id.* 726 P.2d at 568, 576. Farmers Insurance Company of Arizona (Farmers of Arizona) paid the claim a month after the fire. *Id.*, 726 P.2d at 568. The first-party bad

faith arose when the insurer failed to disclose to the insured an investigator's report that determined the fire was started negligently by a neighbor, who carried a \$100,000 liability policy also with Farmers of Arizona. *Id.* The court found that Farmers of Arizona had acted improperly to impede its insured's recovery of the uninsured portion of the loss. *Id.*, 726 P.2d at 569, 579.

What the **Darlows** conveniently ignored was the *Rawlings* court rationale. First, the court determined that the insurer's conduct was unreasonable by delaying the insured's claim against the tort-feasor. *Id.*, 726 P.2d at 573. The court then determined that the insurer acted intentionally without fairly debatable grounds using deceit, nondisclosure, renegeing on promises, violation of industry custom and deliberate attempts to obfuscate. *Id.*, 726 P.2d at 576–77. *Rawlings* clearly followed the two-step test outlined in *McCullough* and *Anderson* for first-party liability. *Clearwater v. State Farm Mut. Auto. Ins. Co.*, 164 Ariz. 256, 792 P.2d 719 (1990); accord, *White v. Unigard Mut. Ins. Co.*, 112 Idaho 94, 730 P.2d 1014 (1986).

A number of courts have found, as the *Rawlings* court determined, that “only a showing of an initial bad faith refusal to pay a claim—not a showing of its ultimate nonpayment—is a required element of a bad faith tort cause of action.” 1 J. McCarthy, *Recovery of Damages for Bad Faith* § 1.11 (5th ed. 1990). See *Robinson v. North Carolina Farm Bureau Ins. Co.*, 86 N.C.App. 44, 356 S.E.2d 392 (1987). The Eleventh Circuit Court of Appeals concluded that refusal to pay a valid insurance claim is a tortious act that cannot be erased by subsequent payment. *Berry v. United of Omaha*, 719 F.2d 1127 (11th Cir.1983). See also *Schlauch v. Hartford Acc. and Indem. Co.*, 146 Cal.App.3d 926, 194 Cal.Rptr. 658 (1983). The affirmative act of nonpayment, rather than the condition of nonpayment, is the focus of the courts' inquiries. *Berry*, 719 F.2d at 1129.

For the **Darlows**, the case law reveals no hidden treasure. We agree that subsequent payment of a denied or unreasonably delayed claim does not absolve a tort-feasor; however, no claims of the **Darlows** for medical payments were denied after submission. No claims for medical payments \*827 were unreasonably delayed after submission. No affirmative act of nonpayment sufficient to constitute a tort occurred. Therefore, the payment of the medical claims could not absolve Farmers of tort liability since, as a matter of law, none existed. *Coleman v. Gulf Life Ins. Co.*, 514 So.2d 944 (Ala.1987).

C.

[9] The **Darlows** argue Farmers acted with knowledge or reckless disregard of the lack of a reasonable basis for denying the claim in one of two alternatives. First, it is claimed that Farmers violated its duty of good faith and fair dealing by intentional failure to inform the insured of available policy benefits, and second, Farmers violated its duty of good faith and fair dealing by intentional misrepresentations concerning the insured's rights under the policy. The **Darlows'** argument is prefaced upon the nature of the legal duty owed to an insured particularly in a situation in which both parties to an incident are insured by the same company, the so called double-insured situation. Farmers defends its actions by saying that the **Darlows** never asked for an explanation of coverage or benefits and no misrepresentations occurred.

The duty owed to an insured is often characterized by the nature of the claim. When the benefit derives from the insurer's duty to defend the insured against third-party actions, that relationship is characterized as a third-party claim. *Farmers Group, Inc. v. Williams*, 805 P.2d 419 (Colo.1991). A first-party claim results when the insured makes a claim against his insurer for benefits accruing directly from the insurance contract. *Id.* In *Western Casualty and Surety Co. v. Fowler*, 390 P.2d 602 (Wyo.1964), this court previously defined the duty of an insurer to an insured in a third-party claim. The insurer's duty is to “exercise intelligence, good faith, and honest and conscientious fidelity to the common interest” of the insured as well as the insurer and give at least equal consideration to the interest of the insured, and, if it fails to do so, the insurer acts in bad faith. *Id.* at 606.

The duty of good faith and fair dealing announced in *McCullough* applies to first-party claims. *McCullough*, 789 P.2d at 855. In an issue of first impression in Wyoming, the **Darlows** argue that inherent in this duty is the requirement that the insurer inform the insured of the extent of the coverage afforded under their policy before negotiating a settlement, especially when it is apparent that the insured did not know the coverage. *MFA Mut. Ins. Co. v. Flint*, 574 S.W.2d 718 (Tenn.1978). In *Flint*, the court specifically found it was apparent to the adjuster that the insured did not know the extent of their coverage. *Id.* The adjuster took advantage of the insured's ignorance to negotiate a settlement that was grossly inadequate. *Id.*

While *Flint* specifically dealt with uninsured motorist provisions of a first-party claim, the Tennessee Supreme Court applied the duty to inform to similar policy provisions involved in a double-insured situation. *Gatlin v. Tennessee Farmers Mut. Ins. Co.*, 741 S.W.2d 324 (Tenn.1987). The court reasoned the duty of good faith and fair dealing includes “informing an insured as to coverage and policy requirements when (1) it is apparent to the insurer that there is a strong likelihood that its insured only can be compensated fully under her own policy and (2) that the insured has no basis to believe that she must rely upon her policy for coverage” (hereinafter “Tennessee Rule”). *Id.* at 326. *Gatlin* involved a two-car accident in which both parties had liability coverage with the same insurer. *Id.* at 325. The driver who was clearly at fault had only minimum coverage. *Id.* at 326. The insurer failed to disclose the restricted coverage of the party at fault and failed to disclose that the injured party would have greater coverage under her own policy. *Id.*

The court in *Dercoli v. Pennsylvania Nat. Mut. Ins. Co.*, 520 Pa. 471, 554 A.2d 906 (1989) gave the most expansive reading to the Tennessee Rule. The duty to deal fairly and in good faith includes the duty of full and complete disclosure as to all of the \*828 benefits and every coverage that is provided by the applicable policy or policies along with all requirements, including any time limitations for making a claim, when the insurer's agents undertake to provide assistance and advice and advise against retaining independent legal counsel. *Id.* A more restrictive reading came from the Utah Supreme Court which adopted the philosophy of the Tennessee Rule, in explaining the duty of good faith, without expressly adopting the entire statement. *Beck v. Farmers Ins. Exchange*, 701 P.2d 795 (Utah 1985). One commentator expresses the view that there must be some bounds on the insurer's duty to inform; otherwise, the claims adjustment process would grind to a halt if the insured could avoid the force of any provision of his choosing simply by alleging that the insurer did not explain it to him. S. Ashley, *Bad Faith Actions* § 5:15 (1984–1990).

California's Supreme Court also recognized the benefit of an obligation to inform an insured of policy provisions. In *Davis v. Blue Cross of Northern California*, 25 Cal.3d 418, 158 Cal.Rptr. 828, 600 P.2d 1060 (1979), the court reasoned that the implied duty of good faith and fair dealing requires the insurer to give at least as much consideration to the insured's interest as it does to its own. See *Egan v. Mutual Of Omaha Ins. Co.*, 24 Cal.3d 809, 169 Cal.Rptr. 691, 620 P.2d 141 (1979). The *Davis* court determined the insurer has a duty

reasonably to inform an insured of the insured's rights and obligations under the insurance policy. *Davis*, 158 Cal.Rptr. at 833, 600 P.2d at 1065. The court found a particular need for information existed when the insured's lack of knowledge may potentially result in a loss of benefits or a forfeiture of rights. *Id.*, 158 Cal.Rptr. at 833–34, 600 P.2d at 1065–66.

Farmers offers no alternative construction for the duty of good faith and fair dealing. Instead, Farmers views the situation as a double-insured in which the insured party was automatically treated as a third-party claimant to be dealt with at arm's length. See *Chavez*, 553 P.2d at 708–09, bad faith claim allowed for unreasonable delay in first-party medical payments; however, the bad faith claim not allowed when alleged misrepresentations concerned third-party claims; *Pixton v. State Farm Mut. Auto. Ins. Co. of Bloomington, Ill.*, 809 P.2d 746 (Utah App.1991), insurance company did not owe insured a duty to deal fairly and in good faith in her capacity as a third-party claimant. However, third-party issues are not in dispute in this case—the **Darlows** finitely settled those issues in separate litigation. The law has clearly advanced beyond arm's length dealings when considering first-party obligations such as medical payment provisions. To this date, neither party directs this court's attention to any existing Wyoming cases on point.

We believe the Tennessee Rule appropriately states the obligations of the insurer. Under this formulation, the duty of good faith and fair dealing includes informing an insured as to coverage and policy requirements when it is apparent to the insurer that (1) there is a strong likelihood that its insured only can be compensated fully under her own policy and (2) the insured has no basis to believe that they must rely upon their policy for coverage. *Gatlin*, 741 S.W.2d at 326.

[10] Measured against this standard, Farmers' handling of the **Darlows'** claim, as a matter of law, did not demonstrate knowledge or reckless disregard of the lack of a reasonable basis for denying the claim. The Farmers' claims representative clearly stated at both the October 12 and November 4, 1988 meetings that until a settlement was reached, Mrs. **Darlow's** medical bills would be paid under the terms of the **Darlows'** insurance policy. The insured was placed on notice that she could secure payment from her own policy. Such payment would probably have been made earlier than when third-party negligence litigation would have been resolved. The adjuster did not act in a manner calculated to take advantage of the insured's ignorance. *Flint*, 574 S.W.2d at 722.

In sharp contrast to the case precedents upon which the **Darlows** depend, they knew and understood the terms of their policy, \*829 fulfilling their duty to read. *Security Ins. Co. of Hartford v. Wilson*, 800 F.2d 232 (10th Cir.1986). In making the accident report, Mr. **Darlow** informed Farmers' agent that his policy was "full coverage" which he understood to include medical payments. Mr. **Darlow** also reviewed the policy prior to the October 12, 1988 meeting with the Farmers' claims representative. The **Darlows** contend that Farmers remained obligated to explain the medical payment benefits of the **Darlows'** policy. The **Darlows** never requested this explanation. Therefore, there was no occasion to advise the **Darlows** of their rights under the policy and no violation of any obligation to inform them. *Twaite v. Allstate Ins. Co.*, 216 Cal.App.3d 239, 264 Cal.Rptr. 598 (1989). Nothing is provided as evidence by this record to reveal first to the trial court or now to this court that the **Darlows** as the insured did not understand the concept of first-party medical payment benefit coverage which they had acquired in their automobile insurance as provided with the full coverage policy. Certainly it is unquestioned that they knew the coverage existed.

No violation of the Tennessee Rule was demonstrable by documentation submitted which would justify the trial court's denial of the insurer's motion for summary judgment.

IV.

#### CONCLUSION

No disputed extrinsic facts exist in the present case, so the issue before this court is whether the conduct of Farmers constituted first-party bad faith as defined by Wyoming law. The **Darlows** have failed to show that Farmers denied or unreasonably delayed payment of their claim. The decision of the district court in granting summary judgment in favor of Farmers is affirmed.

#### All Citations

822 P.2d 820

#### Footnotes

- 1 The medical expenses incurred by Mrs. **Darlow** apparently totalled \$1,540.55, including Iverson Memorial Hospital emergency room—\$279.55, ambulance—\$153, radiology—\$40, physical therapy—\$240, medical doctor—\$173 and the balance of \$655 for chiropractic treatments.
- 2 The district court may have viewed with some suspicion any suggestion that the chiropractic treatment provider refused to treat when the insured was well aware and could have advised that first-party medical payment benefit insurance of a sufficient amount was in effect.

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