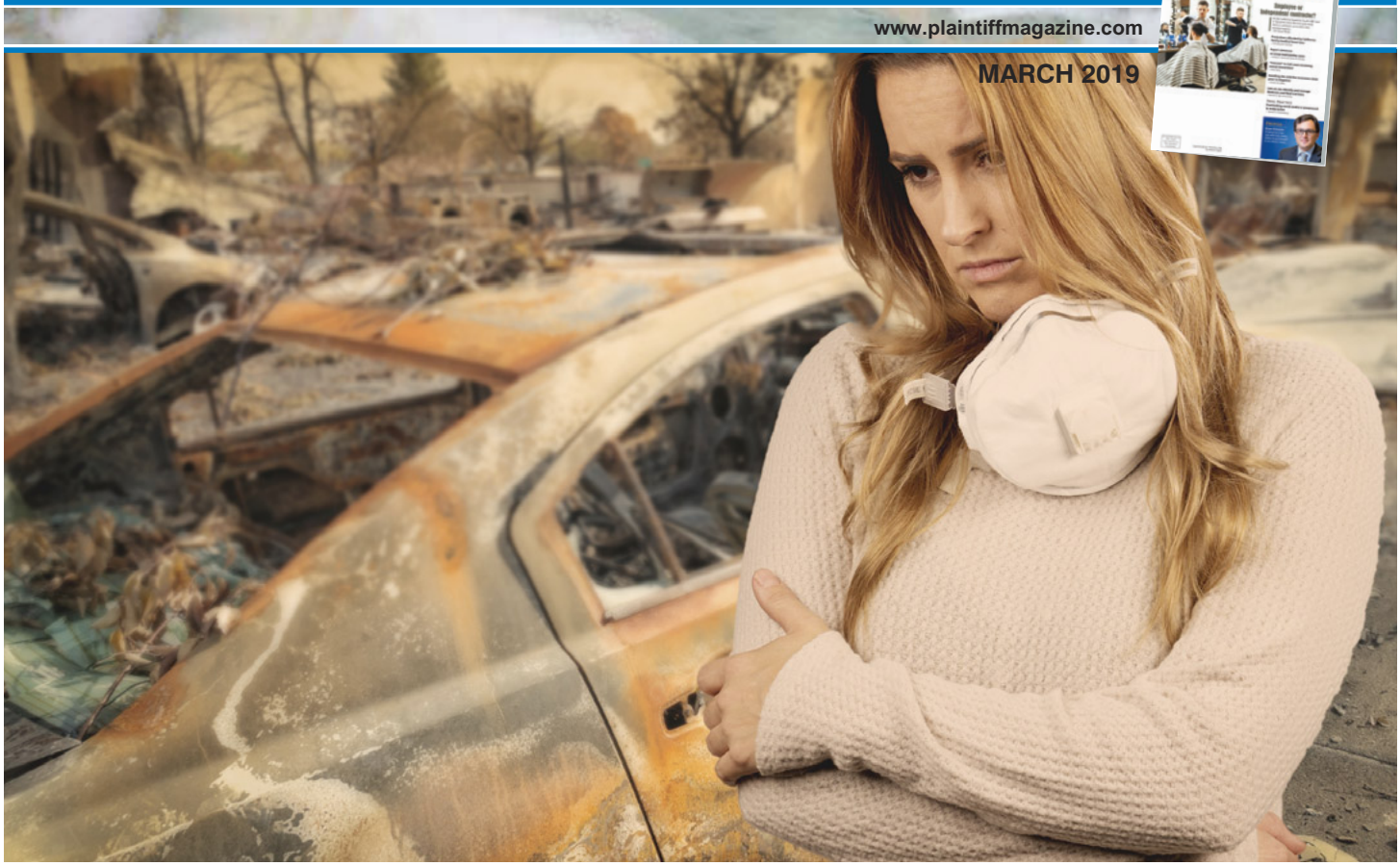

Handling the wild-fire insurance claim prior to litigation

A guide to the process and pitfalls in handling a major fire-damage claim, and using the Insurance Code to your client's advantage

By Charles M. Miller

With the recent devastating fires in both southern and northern California, thousands of California homeowners will present sizeable property-damage claims to their insurers. Many of these same homeowners will be seeking legal advice on the scope of their insurance coverage and how best to present their claims. The proper handling of these pre-litigation claims is critical to both the amount of recovery the homeowner will receive before litigation and the amount of recovery available to a homeowner in the event of litigation with the insurer.

This article will address several of the immediate issues likely to arise for any attorney representing a homeowner making a wild-fire claim. The issues discussed are certainly not exhaustive. Many difficult issues arise in any fire loss, from debris removal to the amount of replacement-cost coverage and whether the client is underinsured. The aspiration here is to provide counsel with guidance on some of the most important issues.

Counsel's initial request for documents

By the time counsel becomes involved in an insurance claim it is likely that the insurer has already inspected the client's property and possibly created an estimate for the amount of the loss. In addition, the insurer may have done additional investigation, such as interviewed the client before the client hired an attorney and obtained fire-department reports or other information regarding the fire.

It is therefore critical that counsel, upon taking a case, immediately request

the insurer's claim documents. California Insurance Code section 2071 provides the mechanism for accomplishing that by requiring insurers to notify their policyholders of the right to obtain all "claim-related documents." The statute defines these documents to include bids, estimates, scopes, appraisals, etc. The insurer must provide the documents within 15 days after they are requested.

The foregoing provision should be cited in counsel's first letter to the insurer along with a demand for all "claim related documents." Although statements taken of the client are not included in the definition of "claim related documents," a request for transcriptions of any recordings should also be made.

In addition, a request must be made for a certified copy of the insurance policy. Policyholders who have just lost their homes may not have complete and accurate copies of the policy. Section 2071 of the Insurance Code requires insurers to provide policyholders, free of charge, a current, complete copy of the policy.

The insurer's request for documents

The policy provision

Section 2070 of the Insurance Code requires all fire-insurance policies to be on the "standard form," which is set forth at Insurance Code section 2071. The standard form requires the policyholder to produce certain documents upon the insurer's request. It says:

> The insured, as often as may be reasonably required and subject to the provisions of Section 2071.1, shall exhibit to any person designated by this company all that remains of any property herein described, and submit to examinations under oath by any person named by this company, and subscribe the same; and, as often as may be reasonably required, shall produce for examinations all books of account, bills, invoices, and other vouchers, or certified copies thereof if the originals be lost, at any reasonable time and place as may be designated by this company or its representative, and shall permit extracts and copies thereof to be made. The insurer shall inform the insured that tax returns are privileged against disclosure under applicable law but may be necessary to process or determine the claim.

(Ins. Code, § 2071.)

Addressing the insurer's requests for documents

Insurers commonly request a long list of documents after a loss. It is critically important to timely respond to and comply with these requests for documents or other information as soon as possible. The failure to provide requested documents may give the insurer a basis to claim that the policyholder has breached the duty to cooperate. (*Othman v. Globe Indem. Co.* (9th Cir. 1985) 759 F.2d 1458, 1465 (applying Calif. law) [overruled on other grounds in *Bryant v. Ford Motor Co.* (1987) 844 F.2d 602].)

When responding, always ask if the insurer needs anything further, and if so, to let you know immediately so the claim can be timely processed. If the insurer does not reply but then asks for additional documents much later, this request can evidence the insurer's delay in handling the claim.

There are several documents that may be provided to the insurer upon the insurer's request, or even before the request. These include contractor's estimates, the client's list of damaged or destroyed personal property, receipts and invoices documenting additional living expenses and repairs to the property following the loss, photographs taken by the client, engineering or other expert reports on the scope of loss and estimated cost of rebuilding or repairs, and title documents if needed.

By providing the foregoing categories of documents to the insurer, even where not requested, counsel will be "populating" the claim file with documents that support the client's claim that the insurer may not otherwise seek to obtain. This may make it more difficult for the insurer to later deny the claim or limit the amount of its payment and provide further evidence of the insurer's bad faith.

"But we didn't get the insured's documents"

Insurers may use the pretext that the insured has not provided all the requested documents as a justification for not completing their investigation and/or timely paying the claim. This is a fairly common tactic. The insurer may also contend that the insured's failure to timely provide the requested documents is a breach of the cooperation clause of the policy.

Nonetheless, any breach of the cooperation clause must be material to the claim. (See *Collin v. American Empire Ins. Co.* (1994) 21 Cal.App.4th 787, 819.) A breach is likely not material where the request itself does not seek material documents. (See 10 C.C.R. ¶2695.7(d) "Every insurer shall conduct and diligently pursue a thorough, fair and objective investigation and shall not persist in seeking information not reasonably required for or material to the resolution of a claim dispute.") For example, the failure to provide a marriage license where ownership of the property is not at issue may not be material to the claim. Accordingly, any response to the insurer's requests should point out, when appropriate, where the requests are not material to the claim and invite the insurer to explain why the request is material.

In addition, the insured's failure to comply with the requests must substantively prejudice the insurer in order for the insurer to contend that the cooperation clause has been breached. Therefore, where there is a material breach the insurer cannot argue breach of contract when it has not been prejudiced. (See *Pruyn v. Agricultural Ins. Co.* (1995) 36 Cal.App.4th 500, 516 [insurer has the burden of proving that it has been prejudiced by the insured's breach of the cooperation clause].)

It is also suggested that the following approach be taken in order to minimize, if not defeat, any claim by the insurer that the insured has delayed providing requested documents:

(1) Respond timely to the insurer's requests, pointing out that the requested documents are being assembled and will be provided by a certain date.

(2) Keep a list of all documents provided and the date they were provided, and cross-compare that list with a list of the requested documents so that you can keep up-to-date on any outstanding request.

(3) Point out, where appropriate, that certain documents no longer exist or never have existed. This is particularly the case where many documents are likely to have been destroyed in the fire.

(4) Because insurers often ask for documents in one letter, and then in a second or third letter ask for additional documents, and so forth, make sure that in every letter to the insurer regarding the requested documents, you point out that you assume the current list of requested documents is all that the insurer needs to adjust the claim, but if there are any other documents which the insurer needs, that they should please advise you immediately so the claim can be timely handled.

Always seek to put the burden of the claim handling back on the insurer.

The insured is required to protect the property from further damage

The Standard Form policy requires the policyholder to give notice of the loss "without unnecessary delay," and to "protect the property from further damage." It also requires the policyholder to separate the damaged personal property from the undamaged property, and to "furnish a complete inventory of the destroyed, damaged and undamaged property, showing in detail quantities, costs, actual cash value and amount of loss claimed." (Ins. Code, § 2071.)

Where the dwelling is still standing, even if only partially, it may be necessary to arrange for protection of the property from vandalism or theft. Protection of the property may also sometimes require the insured to board up a building, hire guards or demolish part of a structure to prevent further damage. There also may be other structures on the property which have not been destroyed or are only partially damaged, which may require protection. Further, if such steps are taken, the insurer should be advised immediately what has been (or will be) done and what costs have been (or will be) incurred. Indeed, the Standard Insurance Services Office ("ISO" Homeowners 3 Policy provides:

> a. We will pay the reasonable cost incurred by you for the necessary measures taken solely to protect covered property that is damaged by a Peril Insured Against from further damage.
> b. If the measures taken involve repair to other damaged property, we will only pay if that property is covered under this policy and the damage is caused by a Peril Insured Against. This coverage does not:
> (1) Increase the limit of liability that applies to the covered property; or
> (2) Relieve you of your duties, in case of a loss to covered property, described in B.4. under Section I – Conditions.

(ISO Form HO 00 03 10 00, pp. 5-6)

The foregoing provision should always be read along with the policy requirement that the insured protect the property from further damage. Indeed, it is a violation of the California Unfair Claims Settlement Practices Regulations for an insurer not to disclose this coverage where it may apply to the insured's claim. This is because 10 CCR 2695.4(a), requires insurers to disclose to the policyholder "all benefits, coverages, time limits or other provisions of any insurance policy issued by the insurer that may apply to the claim presented by the claimant."

Where the insured has incurred (or will incur) such costs, a demand should be made on the insurer for their payment, along with supporting documentation of the costs and payment. This should be done each time such costs are or will be incurred. This action will document the insurer's claim file that the insured is complying with the policy requirement, that the insured is mitigating the loss and that the insured has incurred such costs.

Advances to the insured

Although the Standard Form policy does not provide for advance payments, it is a practice in the insurance industry to make such advances, particularly in cases where a home has been destroyed by fire. (See Popow, Donna J. [Ed.], *Property Claim Practices* [The Institutes, 1st ed., 2011] § 3.35.) In that circumstance, the insured has likely lost all their personal property and needs immediate funds to buy clothing, personal articles, and other items simply to maintain their daily life. While additional living expenses are only payable as they are incurred, insurers will advance such costs by making the advances under the personal property coverage.

An insurer may make an advance while preserving any coverage defenses by having the insured sign an advance payment receipt, which is widely used in the insurance industry.

Similarly, the insured will need to seek alternative living arrangements which are paid for under the policy additional living expense coverage. Although additional living expenses, per the policy, are not owed until they are incurred, a request for an advance of such payments should be made as insurers will consider such advances. In addition, the California Insurance Code requires:

> In the event of a loss under a homeowners' insurance policy for which the insured has made a claim for additional living expenses, the insurer shall provide the insured with a list of items that the insurer believes may be covered under the policy as additional living expenses. The list may include a statement that the list is not intended to include all items covered under the policy, but only those that are commonly claimed, if this is the case. If the department develops a list for use by insurers, the insurer may use that list.

(Ins. Code § 2060).

Where the insured is seeking additional living expenses, a demand should be sent to the insurer requesting the list of items the insured believes are covered.

The adjuster's site inspection

It is generally held that where the adjuster requests to inspect the property, whether totally or only partially destroyed,

the insured should not make any changes to the property until the inspection(s) has taken place.

The insured should arrange to have a representative present during the insurer's inspection. The insured's representative can:

(1) Observe the insurer's inspection and take photographs of areas photographed by the insurer's representative.

(2) Point out, as needed, the damages that have been incurred. The insured's representative should be familiar with all the damages so that the representative can point them out to make sure that the insurer does not overlook or miss any element of damage.

(3) Provide copies of any invoices or damage estimates.

(4) Agree on a time frame for follow-up on any requests for additional information.

(5) Agree on a time frame for receipt of the insurer's position on coverage and payment.

The follow up to the inspection

Following the inspection, the insured representative should follow up with a letter, which, (1) Confirms the scope of the inspection; (2) Sets forth the damages that were presented to the insurer representative; (3) Requests a copy of the insurer's photographs; (4) Requests a copy of any diagrams or other notes made by the insurer's representative; (5) Confirms future dates; and (6) Provides any follow-up documents or information or provides a date by which they will be provided.

Documenting conversations

It is critical to document conversations that take place during the inspection. Insurance claims representatives frequently fail to include in their reports significant conversations or information obtained during the inspection(s). When providing the insurer with the documentation of these conversations, also write that if the claims handler disagrees with anything in the recitation of the conversation, they should advise the insured as soon as possible so that any corrections, if necessary, can be timely made.

Making the insured available during the inspection

In some situations, it may be advisable to tell the insurer that you will make the insured available at the inspection, so that the claims handler can ask any questions of the insured that she or he may have. This again shows the insured's cooperation and effort to assist in the claim investigation. This offer may be made where there are circumstances of the loss that may give rise to coverage issues that the insured has direct knowledge of.

Insurer's inspection with contractor and/or expert

The insurer may also seek an inspection of the property by a contractor and/or expert, such as a civil engineer. In arranging this inspection, it is advisable to have the insured's contractor or expert also in attendance. The purpose of this meeting is not to have the insured's and insurer's contractor/experts exchange opinions, but rather to have the insured's contractor or expert observe their insurer counterparts and document what the counterparts have done. This would include photographing the insurer's contractor/expert's inspection, where that contractor/expert took photographs, what measurements were made at the loss site, and other observations taken by the insurer's contractor/expert.

When the insurer seeks to have the property inspected by an expert, it is recommended that, before the inspection takes place, the following steps be taken:

1. Request a copy of the expert's CV. You may also want to have your own corresponding expert provide any background information they have on the insurer's expert or contractor. Online background research may also be useful.

2. Obtain a detailed explanation of what the expert will do – what is to be inspected and what the purpose of the inspection will be. In other words, come to an agreed-upon inspection protocol.

3. Determine if the expert will conduct any destructive testing (or take samples), and if so, what will be done and with what equipment. If destructive testing is agreed to, then it is particularly important that the insured's contractor or expert also be present to document the testing.

4. Insurers frequently use the same engineering consultants to investigate claims. Firms such as Rimkus and Haag are commonly used by insurers. Research into the insurers' use of the same engineering consultants may be advisable to develop an argument that they are biased (See "Bad Faith, genuine dispute, and the "expert safe-harbor" How insurance Companies Use Biased Experts To Deny and Underpay Claims, And What To Do About It," Advocate magazine, Sept. 2017 by Evangeline-Fisher Grossman and Christopher Dion. www.advocatemagazine.com)

As with the adjuster's inspection of the property, it may be advisable to follow up the inspection with a letter to the insurer similar to the follow-up letter used for the adjuster's inspection.

The insurer's estimate of loss

Requesting the insurer's estimates

The insurer must be asked to provide copies of all estimates of the loss, whether prepared by an adjuster, contractor, or both. Where the insurer states that no estimate was prepared, it is suggested that a letter be sent to the insurer asking why none was prepared, given that the insurer has the obligation to investigate and evaluate the amount of the loss.

Evaluating the insurer's estimate

Insurers' estimates of the loss can be evaluated by a local contractor to determine if they accurately reflect local pricing and whether they encompass the full scope of loss. Insurers commonly use various software programs to prepare their estimate, with Xactimate being the most commonly used.

Xactimate estimates are updated periodically to supposedly reflect local materials and labor costs. In a disaster situation, however, those costs may rise dramatically in a short period of time and not be immediately reflected in the Xactimate program.

Further, the Xactimate software may not be particularly useful in estimating full replacement of a dwelling, as the program may be considered primarily useful for repair, rather than full replacement. The Xactimate program may also not be suitable for estimating damage to high end properties. (See "Xactimate Demystified," United Policyholders, 2008, "If your property is unique to the extent it is custom built, Victorian styled, era-built home, or located in a high value area, then Xactimate software will likely not be sufficient to reimburse you properly for your loss"). An expert on Xactimate use may be helpful in examining these and other possible limitations of a Xactimate estimate.

Insurers are required to investigate the accuracy of their estimates. California Code of Regulations, title 10, section § 2695.9(d) requires estimates to conform to applicable policy provisions, and to provide an amount that will restore the damaged property to no less than its condition prior to the loss and that will allow for repairs to be made in a manner meeting accepted trade standards for good and workmanlike construction. The insurer shall take reasonable steps to verify that the repair or rebuilding costs utilized by the insurer or its claims agents are accurate and representative of costs in the local market area.

Counsel should also keep in mind that insurers can change the unit prices for labor and materials in the Xactimate program. When this is done, it is not uncommon to learn that the unit prices have been lowered. In that event it may be particularly difficult for the insured to find a contractor who can do the work for the Xactimate estimate.

The proof of loss

The Policy provides:

> Send to us, within 60 days after our request, your signed, sworn proof of loss which sets forth, to the best of your knowledge and belief:
>
> a. The time and cause of loss;
> b. The interests of all "insured's" and all others in the property involved and all liens on the property;
> c. Other insurance which may cover the loss;
> d. Changes in title or occupancy of the property during the term of the policy;
> e. Specifications of damaged buildings and detailed repair estimates;
> f. The inventory of damaged personal property described in 6. above;
> g. Receipts for additional living expenses incurred and records that support the fair rental value loss; and
> h. Evidence or affidavit that supports a claim under E.6. Credit Card, Electronic Fund Transfer Card Or Access Device, Forgery And Counterfeit Money under Section 1 – Property Coverages, stating the amount and cause of loss.

(Policy, p. 13)

Complying with Request for Proof of Loss

It is particularly important to comply with any request for a proof of loss. Additional time to comply may be requested as needed. Failure to comply may be viewed as a breach of contract. (See *Abdelhamid v. Fire Ins. Exch.* (2010) 182 Cal.App.4th 990, 999-1001.) The insured may also submit its own proof of loss, along with supporting documentation, without the insurer's request.

When the insured/client does not know the full amount of their claim, and where an insurer provides the insured with a proof of loss which includes what the insurer contends is the full amount of the loss, the insured may sign the proof of loss and modify it by writing on it, "Partial Proof of Loss."

Insurers will frequently use an insured's failure to comply with all the requirements for a proof of loss as a reason to delay the handling of the claim and/or contend that the insured has breached the policy. It is, however, widely recognized that "[a]ll that is required is a reasonable and substantial compliance with the policy requirements" for submission of proofs of loss (See *1231 Euclid Homeowners Ass'n v. State Farm Fire & Cas. Co.* (2006) 135 Cal.App.4th 1008, 1018).

Where an insurer rejects a proof of loss, the insured/client should respond by inquiring why the proof of loss was rejected (where that is not provided) and, if necessary, request additional time to comply with the proof of loss requirement. Further, an insurer cannot reject a proof of loss simply because it disagrees with the amount sought in the proof of loss. There is no provision in the Policy which permits the insurer to do this.

Request for an examination under oath

Property Policies commonly provides that the insured "[s]ubmit to examination under oath, while not in the presence of another "insured," and sign the same." (ISO HO 3 Form, HO 00 03 10 00, p. 13 of 22).

The most common reason for an insurer to request an examination under oath is because the insurer suspects insurance fraud. Other reasons include seeking additional information on the insured's real and personal property loss. However, it may be bad faith for an insurer to seek an examination under oath to investigate fraud where the insurer has no evidence of fraud. (See *Tomaselli v. Transamerica Ins. Co.,* 25 Cal.App.4th 1269, 1281 [allowing a bad-faith claim to go to the jury where an insurance company without any evidence of fraud forced an insured to submit to an examination under oath, dissuaded the insured from having an attorney present, and misled the insured about the purpose of the examination].)

Cases have confirmed that an insurer may contractually require, as a condition of coverage, that an insured submit to an examination under oath and answer all proper questions as part of the insurer's investigation of the insured's claim. (See *Globe Indemnity Co. v. Superior Court* (1992) 6 Cal.App.4th 725, 730-73.)

Before responding to any request for an examination under oath counsel should review and be familiar with Section 2071.1 of the Insurance Code.

Insurer requests burdensome documentation

An insurer's request for an examination under oath is often accompanied by an extensive request for documents. The request may seek documents that are not relevant to the insured's claim, that may not exist, or that are burdensome to produce. A recent addition to the insurance code may limit the scope of such requests. Section 2071.1 provides that, "[a]n insurer may conduct an examination under oath only to obtain information that is relevant and reasonably necessary to process or investigate the claim." Pursuant to this provision an insured may contend that the insurer's requests for documents are not relevant or reasonably necessary. Caution, however, should be observed in asserting this position so as not to create a basis for the insurer to deny coverage for the insured's failure to comply with this policy condition.

Another approach is to provide the insurer with a time-limited release to obtain certain types of documents, so that the insured is not "saddled" with the responsibility to provide them. This avoids the later claim that the insured has failed to provide the documents.

Insurer's failure to timely respond to correspondence

Whenever you write the insurer a letter in which you request a response, remind the insurer, by quoting the Unfair Claims Settlement Practices Act section regarding timely response to correspondence, that the insurer is obligated to respond timely. Indeed, it is an unfair claims settlement practice to fail to respond timely to the insured's correspondence. (See Cal Ins. Code § 790.03(h)(2) [it is an unfair claims settlement practice act to fail "to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies] and 10 CCR § 2695.5(d) ["Upon receiving any communications from a claimant, that reasonably suggests that a response is expected, every licensee shall immediately, but in no event more than fifteen (15) calendar days after receipt of that communications, furnish the claimant with a complete response based on the facts as then known by the licensee"].) By pointing this out you are making a record in the insured's claim file that they are not acting in good faith.

Payment of the claim (including the undisputed amount)

The standards for prompt payment of claims are clearly set forth in the California Unfair Claims Practices Act and should be used where the insurer is failing to timely pay the claim (See Ins. Code, § 790.03(h)(5) Unfair claim settlement practice to not "attempt[ ] in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.). Elsewhere, it has been noted that "[a]n insurer must make payment to its insured within a reasonable time after demand is made." The insurer is required to timely pay the undisputed amount of the claim, which is the amount determined by the insurer that is owed under the policy. (See 10 C.C.R. 2695.7(h).

Your correspondence with adjuster

In correspondence with the adjuster, don't engage in threats of litigation or make allegations of bad faith. Your letters will be exhibits at trial, and you will want them to show that you cooperated with the insurer at all times and did not engage in allegations regarding the insurer's conduct.

In correspondence with the claims adjuster:

- Confirm conversations and agreements.
- Confirm discussions at inspections.
- Confirm what was found at inspections.
- Avoid allegations of bad faith and citation to case law.
- Request assistance from the insurer.

A concluding comment

The handling of a first-party insurance property claim, such as a fire loss, can be complicated and loaded with traps for the unwary. The foregoing is only a sample, and hopefully a helpful one, of the many issues that may likely arise in such cases. Wherever possible, such claims should be handled by or in association with counsel who are experienced in such claims.

And finally, make sure that you are aware of all of the California Department of Insurance Bulletins concerning the adjustment of insurance claims arising from the recent fires. These Bulletins are published on the California Department of Insurance website.


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