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In this Issue

Section News

From the Chair	2
<i>Kathleen A. Lopilato</i>	
Editor's Note	2
<i>Hal O. Carroll</i>	
2015-2016 Officers and Council	28

Columns

Insurance and Indemnity 101	
Insurable Losses: Fortuity, Loss in Progress and Known Risk	11
<i>Hal O. Carroll</i>	
Business Court Report.....	17
<i>Kassem Dakhallallah</i>	
Selected Insurance Decisions.....	18
<i>Deborah A. Hebert</i>	
No Fault Corner	22
<i>Ronald M. Sangster, Jr.</i>	
ERISA Decisions of Interest	27
<i>K. Scott Hamilton and Kimberley J. Ruppel</i>	

Feature Articles

Time to Reconsider Strict Liability Penalty Interest in Coverage Disputes Arising under Third Party Liability Policies	2
<i>Harvey R. Heller, Esq. & Julie C. Mayer, Esq.</i>	
Ordinary and Standard "Loss Payable" Clauses in Property Insurance Policies	9
<i>Jason Liss</i>	
Monkey In The Middle: The Anatomy Of An Insurance Agent Errors & Omissions Claim.....	13
<i>Michael S. Hale, J.D., CPCU, AAI and Melissa L. Him, J.D.</i>	

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Opinions expressed herein are those of the authors or the editor and do not necessarily reflect the opinions of the section council or the membership.

From the Chair



Kathleen A. Lopilato,
Auto-Owners
Insurance Company

It was great to see so many of you at our annual Pre-Holiday event which was held at Cantoro Market on November 23d. A special thank you goes out to Allen Philbrick and Patrick King who spoke to us about real property insurance. Many thanks also to Adam Kutinsky for all of his help in putting on this event.

Please let us know about any ideas you have for future annual events including topics that you would like to see covered.

I am pleased to report that we are now enjoying membership of over 950 attorneys.

With that many people, I was expecting more of a response to the question I posed on our Section website, "What are you

looking to get out of our Section?" I got a whopping single response. From the Chair-Elect. I know that for many people insurance law is not a subject that necessarily inspires excitement. An old friend of mine who sits on the bench used the non-flattering analogy that it was akin to watching paint dry. I am sure however that I am not the only member out there in a Section *devoted to Insurance Law* who has burning questions about the Section or insurance law subjects. Don't we have any diehard insurance geeks out there who have anything to ask or share? My challenge to you this quarter is to check out our website and start a discussion!

Our next council meeting will be on January 26, 2016.

Finally, a hearty welcome is extended to all of our new members!

Thank you for joining! ■

Editor's Notes



By Hal O. Carroll
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The *Journal* – now in its ninth year – is a forum for the exchange of information, analysis and opinions concerning insurance and indemnity law and practice from all perspectives. The *Journal* – like the Section itself – takes no position on any dispute between insurers and insureds. But we welcome all articles of analysis, opinion, or advocacy for either position. All opinions expressed in contributions to the *Journal* are those of the author.

Copies of the *Journal* are mailed to all state circuit court and appellate court judges, all federal district court judges, and the judges of the Sixth Circuit who are from Michigan. Copies are also sent to those legislators who are attorneys.

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Time to Reconsider Strict Liability Penalty Interest in Coverage Disputes Arising under Third Party Liability Policies

By Harvey R. Heller, Esq. & Julie C. Mayer, Esq., *Maddin Hauser*

Introduction

The Michigan Court of Appeals' September 2015 published decision in *Nickola v MIC General Insurance Company*¹ is a significant development in the interpretation of the 12 percent penalty interest provisions of Michigan's Uniform Trade Practices Act ("UTPA"), MCL 500.2006, *et seq.* In *Nickola*, the court refused to assess 12 percent penalty interest

on a *strict liability* basis against an insurer who was found to have incorrectly denied a plaintiff's claim for uninsured motorist benefits.

The decision casts serious doubt on the continued vitality of *Stryker Corp v XL Insurance American*, a 2012 decision of the United States Court of Appeals for the Sixth Circuit.² There, the court upheld an award of 12 percent penalty interest against an insurer in a commercial coverage dispute arising

under a third-party liability policy *without regard to the reasonableness of the insurer's denial decision or its good faith*.

While the Michigan Court of Appeals had previously held that first-party insureds are entitled to penalty interest whether or not the insured's right to coverage was "reasonably in dispute,"³ prior to *Stryker*, no appellate court had ever dispensed with that requirement in cases involving third-party liability policies.

As explained below, *Nickola* should prompt reconsideration of the *Stryker* ruling. Whatever the merits of strict liability penalty interest in first-party cases, in many coverage disputes involving third-party claims, the *Stryker* ruling puts a huge thumb on the scale in favor of the insured. The *Stryker* holding is neither required by the relevant statutory language nor justified by public policy. It imposes a substantial penalty on an insurer – no matter how reasonable its decision to deny coverage or how pure its heart – in commercial litigation over coverage if, in the end, a court decides the insurer got it wrong. In such circumstances, the insurer will pay \$120,000 in penalty interest per year for every \$1,000,000 in coverage at issue.

In American jurisprudence, the imposition of liability without fault is generally reserved for exceptional circumstances.⁴ Despite the absence of such circumstances, the *Stryker* court adopted a rule that penalizes the insurer in a manner that is at odds with Michigan insurance law, interferes with the bargain struck by insurer and insured, chills an insurer's ability to assert its contractual rights, and ignores well-established canons of statutory construction.

Background

The language in paragraphs 1 and 4 of Section 500.2006 has been a source of confusion over the years.⁵ The last sentence of paragraph 1 of Section 500.2006 provides that an insurer's "[f]ailure to pay claims on a timely basis . . . is an unfair trade practice unless the claim is reasonably in dispute." Paragraph 1 imposes this requirement whether or not the claim at issue is a first-party claim or a third-party claim. Paragraph 4, however, treats first-party and third-party claims differently as to this requirement. The first sentence of paragraph 4 provides for 12 percent interest where there is a failure to timely pay benefits "if the claimant is the insured or an individual or entity directly entitled to benefits under the insured's contract of insurance." Emphasis added. The first sentence does not repeat the "reasonably in dispute" standard. However, the second sentence of paragraph 4 provides for 12 percent interest where "the claimant is a *third party tort claimant* . . . if the liability of the insurer for the claim is not reasonably in dispute, the insurer has refused payment in bad faith and the bad faith was determined by a court of law."

For the first 30 years after the statute's enactment in 1977, Michigan courts, with little deviation, stressed the punitive purposes of the statute and read it to require proof that the

insurer's position was *unreasonable* before awarding 12 percent penalty interest. Proof that the claim was not reasonably in dispute was required, without regard to whether the dispute involved a first-party claim or a third-party claim.⁶

While the Michigan Court of Appeals had previously held that first-party insureds are entitled to penalty interest whether or not the insured's right to coverage was "reasonably in dispute," prior to *Stryker*, no appellate court had ever dispensed with that requirement in cases involving third-party liability policies.

In 2007, the Michigan Court of Appeals ruled in *Griswold Properties LLC v Lexington Ins Co*,⁷ that a *first-party* insured is entitled to penalty interest irrespective of the reasonableness of the insurer's position. The court focused on the clear contrast between the treatment of the "reasonably in dispute" requirement in the first sentence of paragraph 4 and second sentence. Relying on basic rules of statutory construction, the *Griswold* court assumed that the legislature intended to omit the "reasonably in dispute" language⁸ from the first sentence of paragraph 4 and, as a consequence, refused to read the phrase into the sentence. Thus, because the claimants were the insureds and/or were "directly entitled to benefits under the insured's contract of insurance," they were entitled to 12 percent penalty interest whether or not their claims were reasonably in dispute.

A few years later, in *Auto-Owners Ins Co v Ferwerda Enterprises, Inc*,⁹ the Michigan Court of Appeals held that the *Griswold* court's reading of the UTPA was *not* applicable to coverage disputes involving third-party tort claimants. In *Ferwerda*, the insurer had denied indemnity coverage for a claim brought by hotel guests who alleged they were injured on the premises. The Court held that where the insured's breach of contract claim is "*specifically tied to the underlying third-party tort claim*," penalty interest could not be recovered if coverage was reasonably in dispute. In finding that the coverage claim at issue was "specifically tied" to the third-party claim, the court reasoned that "the amount of the breach of contract claim exactly matched that of the judgment in the underlying tort claim."¹⁰

The Stryker Case

While the *Ferwerda* court appeared to clarify the law in a salutary way with respect to third-party claims, two years later, the Sixth Circuit decided *Stryker* and chose to read *Ferwerda* narrowly.

In *Stryker, supra*, products liability lawsuits had been filed against Stryker Corporation, who was the insured. The in-

surer denied coverage and Stryker settled the lawsuits and paid the third-party claimants. Parsing the *Ferwerda* decision, the court held that once Stryker had paid the third-party claimants, Stryker's claim for benefits was no longer "tied to" the third-party tort claim and was "converted into a first-party claim." The court reasoned that, at that point, the insured was a party "directly entitled to benefits under the insured's contract of insurance" and, thus, entitled to strict liability penalty interest under the first sentence of MCL 500.2006 (4). Thus, the Sixth Circuit held that up until the time when the insured pays the claims, the insured must prove that the insurer's denial was unreasonable and that it acted in bad faith in order to obtain penalty interest but, after that point, penalty interest is imposed on a strict liability basis. The court further held that an insurer who is party to a third-party liability policy becomes liable on a *strict liability* basis for penalty interest accruing on unpaid *defense expenses* if the insurer is found to have breached its duty to defend.

Thus, in the Sixth Circuit's view, an insured who prevails in a dispute over the duty to defend is always entitled to penalty interest under the first sentence of paragraph 4, whether or not the insurer's duty to defend was reasonably in dispute.

In reaching its conclusion, the court noted that the *Ferwerda* decision had been reversed by the Michigan Supreme Court on other grounds.¹¹ That development, according to the court, left the status of the decision so "uncertain" as to "undercut" the argument that coverage disputes arising from third-party tort actions should not give rise to strict liability penalty interest. Thus, the court stated:

. . . the uncertain status of *Ferwerda* [] does significantly undercut Stryker's argument that all claims stemming ultimately from third-party tort actions are always subject to the "reasonable dispute" rule.¹²

The court further reasoned that this was especially so because, in the court's view, the relevant statutory language concerns the identity of the claimant, not the genesis of the claim. The court stated:

. . . the plain language of the statute focuses on the identity of the claimant who is seeking benefits from the insurer, not the underlying source of the claim. Here, it is undisputed that Stryker is the claimant, because Stryker already paid off the third-party tort claims. *The . . . rule is therefore a logical one and one that is consistent with the statutory language—as long*

*as the "claimant" is a third party, the "reasonable dispute" rule applies; the moment the "claimant" becomes the insured, it ceases to apply.*¹³ Emphasis added.

The court's discussion of the imposition of penalty interest on a strict liability basis when an insurer has breached its duty to defend was short. The court, without elaboration, adopted the district court's reasoning that defense costs "were always 'first party' claims, since they are a benefit due directly to Stryker."¹⁴ Thus, in the Sixth Circuit's view, an insured who prevails in a dispute over the duty to defend is always entitled to penalty interest under the first sentence of paragraph 4, whether or not the insurer's duty to defend was reasonably in dispute.

In 2013, in an unpublished decision, the Michigan Court of Appeals quoted extensively the *Stryker* Court's critique of *Ferwerda* in resolving a penalty interest issue. In *Hastings Mutual Ins Co v Mosher, Dolan, Cataldo & Kelly, Inc.*,¹⁵ the court held that an insured was entitled to penalty interest on accrued defense expenses without regard to the reasonableness of the insurer's decision not to pay them. The dispute, however, concerned only defense expenses and not indemnity coverage. Because the claimants had lost on the merits, indemnity payments were not an issue.

Until *Nickola*, *supra*, *Mosher* suggested that the Michigan Court of Appeals might be sympathetic to the *Stryker* analysis. *Nickola*, however, indicates otherwise.

The *Nickola* Case

In *Nickola*, the personal representative of the deceased husband and wife victims of an auto accident sought underinsured motorist ("UIM") benefits from their no-fault insurer.¹⁶ The defendant insurance company denied the claim on the grounds that the insureds could not establish a threshold injury for noneconomic tort recovery.¹⁷ The plaintiff argued that the decedents were first-party insureds and, thus, entitled to penalty interest under the UTPA whether or not the claim was reasonably in dispute.

The court first considered the plaintiff's argument under *Griswold*. The court noted that *Griswold* involved a consolidation of three cases. In two of the cases, the insureds sought benefits from their insurers for water damage and in the third case, the insured sought benefits for fire damage. "In other words, each of the three consolidated cases involved insureds seeking benefits from their own insurers for losses that were directly covered under the respective policies."¹⁸ The plaintiff argued, that, like the insureds in *Griswold*, he was seeking payment of benefits to which the decedent insureds were directly entitled under their insurance policy.

Nonetheless, the court rejected the plaintiff's argument. The court reasoned that the case was more complicated than *Griswold* because the plaintiff was not making a simple, first-party claim as in *Griswold*. Rather, to prevail, the plaintiff was

required, effectively, to prove a third-party claim against the decedent's own insurer, with the insured seeking benefits that arose from the alleged tortfeasor's liability. The court stated:

. . . the instant case is not as simple as *Griswold*. As noted, *Griswold* involved a consolidation of cases in which each of the insurers was directly liable to their first-party insureds for covered losses. Here, while plaintiff is seeking UIM benefits that are provided in the policy, he is doing more than merely making a simple, first-party claim as was involved in *Griswold*. In order for plaintiff to succeed on his UIM claim, he has to essentially allege a *third-party tort claim* against his own insurer or, in this case, against the insurer of George and Thelma, of whom plaintiff is the personal representative. Defendant, the insurer, stands in the shoes of the alleged tortfeasor and plaintiff seeks benefits from defendant that arose from the alleged tortfeasor's liability.¹⁹

The *Nickola* court further reasoned that a third-party UIM tort claim was "different in nature from a typical claim for first-party benefits" because it often required proof of "the extent and nature of the injured person's injuries, [and] the injured person's prognosis over time . . ." "In addition, such a third-party tort claim is designed to compensate 'for past and future pain and suffering and other economic and non-economic losses rather than compensation for immediate expenses' that are generally associated with a first-party claim."²⁰

The court concluded that, "[i]n other words, plaintiff's UIM claim is *tied to* a third-party tort claim for damages that, in many respects, is 'fundamentally different' than a typical first-party claim."²¹

The court explained that the case was controlled by *Ferwerda*, *supra*, which recognized that not all penalty interest claims fit neatly into the *Griswold* analysis.²² The court held that, like the claim in *Ferwerda*, the claim for benefits under UIM coverage was "specifically tied to the underlying third party tort claim" and presented a "wholly different situation than found in the cases in *Griswold*."²³ The court stated:

. . . in the UIM context, defendant was standing in the shoes of the alleged tortfeasor. The fact that the claim for UIM benefits was specifically tied to the underlying third-party tort claim warrants applicability of the "reasonably in dispute" language found in the second sentence of MCL 500.2006 (4).²⁴

Stryker Should Be Revisited

The decision in *Stryker* is sharply at odds with *Nickola*. While the *Stryker* court regarded *Ferwerda* as weak precedent because the Supreme Court reversed the ruling on other grounds, the Court of Appeals in *Nickola* embraced *Ferwerda*.

Indeed, the *Nickola* court expanded the ruling by applying it to an insurance claim under a first-party policy.

The fact that the *Nickola* court applied the *Ferwerda* analysis to a coverage dispute over uninsured motorist benefits leaves little question that the focus of the Michigan Court of Appeals in interpreting paragraph 4 is the nature of the underlying claim. In *Nickola*, despite that the insureds were individuals "directly entitled to benefits under" the policy, the court held that the insureds' estate was not entitled to strict liability penalty interest. The court reasoned that the claim for coverage was "specifically tied to the underlying third-party tort claim."²⁵ Thus, the *Nickola* court implicitly rejected the *Stryker* court's contention that the focus of the analysis should be on the identity of the claimant seeking benefits from the insurer and not the underlying source of the claim. In short, the *Stryker* court's construct of shifting claimants and claims that become "untied" to the original third-party claim is inconsistent with *Nickola*.

In fact, the *Stryker* court's "shifting" or "morphing" claimant formulation is at odds with the common understanding and usage of the term "claimant" in the insurance industry. In the *Stryker* court's view, an insured, under a third-party liability policy, becomes the "claimant" once it settles the case. The third-party tort claimant ceases to exist for purposes of MCL 500.2006 (4). However, in the insurance industry, "claimant" is a term of art. It is the person or entity who brings the "claim" against the insured, and the term "claim" is defined in the policy and/or case law. In the typical coverage case, the claim that is made by the third-party claimant remains the focus of the case throughout the pendency of the litigation for purposes of determining coverage, whether or not the coverage litigation continues after the insured has paid the claimant. This "shifting claimants" theory is contrary to the everyday experience of claims adjusters and defense counsel. Where coverage under third-party liability policies is concerned, such industry professionals do not re-conceptualize the "claimant" if and when the insured pays the claim.

In reality, the "claimant" continues to be "a third-party tort claimant" under the second sentence of paragraph 4, irrespective of whether the claim has been paid by the insured. And therefore, as the *Ferwerda* court reasoned, the coverage dispute continues to be "tied to" the third-party claims and, setting aside defense expenses, the "amount of the breach of contract claim" will match "that of the [judgments and settlements] in the underlying tort claim."²⁶

This analysis is no less applicable to defense expenses. An insured's duty to defend typically turns on the language of the third-party claimant's complaint.²⁷ For purposes of determining an insurer's duty to defend, and thus its duty to pay defense expenses, "the claimant" is almost always "the third-party tort claimant."²⁸ Thus, a dispute over the insurer's obligation to pay defense expenses falls squarely within the plain language

of the second sentence of paragraph 4. Further, under *Ferwerda* and *Nickola*, the insured's demand for payment of defense costs is closely tied to the underlying third-party claim.

At best, the *Stryker* decision points up the ambiguities in the penalty interest statute. The court's "shifting claimant" ruling and its defense costs ruling are not compelled by the language of the paragraph 4. Indeed, the many difficulties the appellate courts have had interpreting the statute over the years attests to its ambiguity.

The *Nickola* court further reasoned that a third-party UIM tort claim was "different in nature from a typical claim for first-party benefits" because it often required proof of "the extent and nature of the injured person's injuries, [and] the injured person's prognosis over time . . ." "In addition, such a third-party tort claim is designed to compensate 'for past and future pain and suffering and other economic and noneconomic losses rather than compensation for immediate expenses' that are generally associated with a first-party claim."

The language of the statute does not require a court to ignore the fact that the case was brought by a third-party tort claimant if the claimant is paid by the insured before the coverage dispute is resolved. By the same token, the statute does not compel the conclusion that defense expenses are a first-party benefit where the coverage dispute concerns a third-party liability policy. Significantly, the second sentence of paragraph 4 is written in the passive voice. It states, "[i]f the claimant is a third party tort claimant, then [12 percent penalty interest is due] if the liability of the insurer is not reasonably in dispute" and the insurer refused payment in bad faith. As indicated, in coverage disputes over the duty to defend, "the claimant" is a third party, not the insured, even assuming defense costs "are a benefit directly due to" the insured (as the *Stryker* court reasoned). Without overstating the point, even that premise is open to question. Typically, defense costs are "due directly" to defense counsel and the experts and vendors used in the litigation. Just like an indemnity payment made to a third-party tort claimant, defense expenses are paid on behalf of the insured.

The *Stryker* court, however, chose to subordinate the language in the second sentence of paragraph 4 that plainly applied to the facts at hand to language in the first sentence of paragraph 2. In particular, the court determined that the phrase "if the claimant is the insured or an individual or entity

directly entitled to benefits" in the first sentence should control the questions before it.

To the extent that MCL 500.2006 is ambiguous,²⁹ the fact that it is a penalty statute resolves any question as to its construction. Under well-established canons of statutory construction, a statute imposing a penalty, MCL 500.2006 must "be strictly construed in favor of the party subject to the penalty."³⁰

There can be no serious question as to MCL 600.2006's status as a penalty statute. Shortly after enactment, the Court of Appeals declared that the law was "intended as a penalty to be assessed against insurers who procrastinate in paying meritorious claims in 'bad faith.'"³¹ Consistent with that, over a period of thirty years, courts have repeatedly recognized that the legislative purpose behind MCL 500.2006 is "to punish the insurance company" when it "is dilatory in making timely payments to the insured."³²

Despite a legislative intent to punish dilatory insurers, the *Stryker* rule extends the reach of the statute to impose penalty interest liability on insurers who deny coverage for third-party claims without proof that the insurer acted unreasonably or in bad faith. With respect to third-party insurance, there is no public policy justification for burdening an insurer's coverage decisions, its right to litigate and even its right to appeal with 12 percent penalty interest in this fashion.

As a general proposition, absent a strong public policy justification, the imposition of liability without fault is extraordinary and inconsistent with our jurisprudence. In the insurance context, this is particularly so in light of the commitment of the Michigan Supreme Court to the interpretation of insurance policies in the same manner as every other contract.³³

As a matter of public policy, there is reasonable support for the conclusion that the legislature in MCL 500.2006 chose to treat first-party insurance and third-party insurance differently. In the case of a first-party insured, it is the insured who has suffered the flood, the fire or the disability and who suffers the hardship until the claim is paid. See *Griswold, supra*. However, under the typical third-party liability policy, the coverage dispute is commercial in nature and the insured is the accused tortfeasor and not the allegedly injured party.

Further, under a first-party policy, proof of loss requirements and the fact that the insured is the injured party incentivize the insured to act promptly to report a loss. Contractual limitations provisions in first-party policies often provide that an insured must bring an action against a carrier within 12 months of the inception of the loss.³⁴ Such provisions impose a check on the runaway accrual of penalty interest. On the other hand, 12 percent interest incentivizes the insurer to resolve claims promptly.

Extending strict liability penalty interest to the third-party liability setting, however, tends to reward delay. For example, consider an insured with a liability in excess of limits of \$5,000,000 who does not sue until the end of the six-year

limitations period. If the insurer loses, the insured will be entitled to \$3,600,000 in pre-complaint interest, no matter how complicated and fairly debatable the coverage decision at issue. If the case is in litigation for another five years, the insurer would be required to pay \$6,600,000 in interest in addition to the \$5,000,000 due under the policy.

The *Stryker* court's rule also leads to anomalous results.³⁵ Under *Stryker*, the statute treats the wealthy insured better than the penurious one. Thus, while an insured who is in a position to pay a settlement or judgment in favor of its third-party claimants is entitled to strict liability penalty interest, an insured who cannot pay and who suffers an adverse judgment must satisfy the no reasonable dispute and bad faith standards before obtaining penalty interest.

Indeed, it is fair to assume that in the great majority of instances where the insured is in a position to pay a substantial judgment or a settlement, rather than wait for the resolution of the coverage litigation, the insured is large corporate entity, such as *Stryker*. Typically, such disputes are purely commercial, where the equities that support the imposition of strict liability penalty interest in the usual first-party case are nowhere to be found.

Notably, the *Stryker* decision runs afoul of the Sixth Circuit's commitment to restraint when treating novel questions arising in diversity cases. The court has recognized that "federal courts sitting in a diversity case are in 'a particularly poor position . . . to endorse a fundamental policy innovation.'" ³⁶ Therefore, "[w]hen given a choice between an interpretation of [state] law which reasonably restricts liability, and one which greatly expands liability, we should choose the narrower and more reasonable path." ³⁷

Conclusion

In sum, the *Stryker* ruling should no longer be regarded as binding or even persuasive precedent in the wake of *Nickola*. That is a good thing. As a matter of statutory construction and public policy, 12 percent penalty interest should not be imposed without fault where coverage under a third-party liability policy is at issue. ■

About the Authors

Harvey R. Heller is a shareholder, Managing Director and Chairman of Maddin Hauser's Defense and Insurance Coverage Practice Group. Harvey is the creator of the Result Focused Case Management System. He is an honors graduate of Michigan State University, as well as a cum laude graduate of Detroit College of Law. Mr. Heller has been continuously selected by his peers for inclusion in the Michigan edition of *Super Lawyers*® from 2006-2015 and *Best Lawyers in America*® since 2003 in the areas of insurance law and legal malpractice law-defendants. He also has the added distinction of being recognized as the 2015 "Detroit Lawyer of the Year" for insurance law.

Julie Chenot Mayer is a shareholder of the Maddin Hauser. She who received her undergraduate degree from the University of Michigan. In 1986, she obtained her Juris Doctor, cum laude, from the Detroit College of Law, where she was a member of the Law Review. Ms. Mayer concentrates her practice in the area of litigation with an emphasis on insurance coverage and professional liability defense.

Endnotes

1 __ Mich App __ (2015) (Docket No. 322565).

2 735 F3d 349 (6th Cir 2012).

3 *Griswold Properties, LLC v Lexington Ins Co*, 276 Mich App 551 (2007).

4 Thus, for example, it has been observed:

For a court to extend the exceptional doctrine of liability without fault into a new field of commercial enterprise involving no recognizable probability of danger, there must be an unusual case and one amenable to no other solution as a matter of public policy.

74 Am Jur 2d Torts, Section 14.

5 Subparagraphs 1 and 4 of MCL 500.2006 are the provisions that are relevant to the imposition of penalty interest. They state:

Sec. 2006. (1) A person must pay on a timely basis to its insured, an individual or entity directly entitled to benefits under its insured's contract of insurance, or a third party tort claimant the benefits provided under the terms of its policy, or, in the alternative, the person must pay to its insured, an individual or entity directly entitled to benefits under its insured's contract of insurance, or a third party tort claimant 12% interest, as provided in subsection (4), on claims not paid on a timely basis. **Failure to pay claims on a timely basis or to pay interest on claims as provided in subsection (4) is an unfair trade practice unless the claim is reasonably in dispute.**

(4) If benefits are not paid on a timely basis the benefits paid shall bear simple interest from a date 60 days after satisfactory proof of loss was received by the insurer at the rate of 12% per annum, if the claimant is the insured or an individual or entity directly entitled to benefits under the insured's contract of insurance. **If the claimant is a third party tort claimant, then the benefits paid shall bear interest from a date 60 days after satisfactory proof of loss was received by the insurer at the rate of 12% per annum if the liability of the insurer for the claim is not reasonably in dispute, the insurer has refused payment in bad faith and the bad faith was determined by a court of law.**

Emphasis added.

6 See e.g., *Fletcher v Aetna Casualty & Surety Co*, 80 Mich App 439 (1978); and *OJ Enterprises, Inc v Insurance Company of North America*, 96 Mich App 271 (1980); *Griswold Properties, LLC, supra*; but see *Yaldo v North Pointe Ins Co*, 457 Mich 341 (1998); and *Acme Roll Forming Co v Home Ins Co*, 31 Fed Appx 866 (6th Cir 2002).

7 *Griswold Properties, LLC, supra*.

- 8 *Id.* at 565-566.
- 9 287 Mich App 248 (2010), *vacated in part on other grounds*, 488 Mich 917 (2010).
- 10 *Ferwerda*, 287 Mich App at 260.
- 11 735 F3d at 360-361.
- 12 *Id.*
- 13 *Id.*
- 14 *Id.*
- 15 Unpublished opinion per curiam of the Court of Appeals, issued February 14, 2013 (Dkt No 296791), *vacated in part*, 495 Mich 888 (2013).
- 16 *Nickola, supra*.
- 17 As the Court noted, the deaths of the accident victims was unrelated to the motor vehicle accident that precipitated the litigation.
- 18 ___ Mich App ___, slip op at 6, fn 4.
- 19 *Id.*, slip op at 4 (emphasis added).
- 20 *Id.*, quoting *Adam v Bell*, ___ Mich ___ (2015) (Docket No 319778).
- 21 *Id.* (emphasis added)
- 22 *Id.*, slip op at 4.
- 23 *Id.* at 5.
- 24 *Id.*
- 25 *Nickola, supra*, slip op at 5.
- 26 *Ferwerda*, 287 Mich App at 259.
- 27 “The duty of the insurer to defend the insured depends upon the allegations in the complaint of the third party in his or her action against the insured.” *Detroit Edison Co v Mich Mut Ins Co*, 102 Mich App 136, 141–142 (1980).
- 28 The authors acknowledge that many third-party liability policies provide coverage for claims that are not, strictly speaking, tort claims. For example, many employment claims alleging statutory violations are not classic tort claims. Nevertheless, as a practical matter, in Michigan, employment “discrimination claims have always been characterized as a species of statutory tort.” *Mack v City of Detroit*, 467 Mich 186, 194 (2002), citing *Donajkowski v Alpena Power Co.*, 460 Mich 243, 247 (1999).
- 29 When a statutory provision is ambiguous, statutory construction is necessary to determine the intent of the legislature. *Kinder Morgan Michigan, LLC v City of Jackson*, 277 Mich App 159, 163-164 (2007). In construing a statute, “a court must look to the object of the statute in light of the harm it is designed to remedy, and strive to apply a reasonable construction that will best accomplish the Legislature’s purpose.” *Marquis v Hartford Accident & Indemnity* (after remand), 444 Mich 638, 644 (1994). In this endeavor, a court should not abandon the canons of common sense. *Id.*
- 30 *McCabill v Commercial Union Ins Co*, 179 Mich App 761, 779 (1989); *Medley v Canady*, 126 Mich App 739, 744 (1983). See also *Tew v Hillsdale Tool & Mfg. Co*, 268 Mich App 399, 407-408 (2005) (narrowly construing statute imposing a penalty for late workers compensation medical payments in light of the principle that “a penalty provision is to be strictly construed in favor of the party subject to the penalty”); *Goetz v Black*, 256 Mich 564, 572-573 (1932) (stating, “a statute awarding a penalty is to be strictly construed and, before a recovery can be had, the case must be brought clearly within its terms”); *Washburn v Michailoff*, 240 Mich App. 669, 677 (narrowly construing statute imposing penalty for usury and stating, “[b]ecause the statute provides a penalty, it must be strictly construed in favor of the person being penalized”); *Ellison v City of Detroit*, 196 Mich App 722, 723 (1992) leave denied, 442 Mich 899 (1993) (construing statute imposing penalty for late payment of wage loss benefits narrowly because “[p]enalty provisions are strictly construed in favor of the person being penalized”).
- 31 *Fletcher v Aetna Casualty & Surety Co*, 80 Mich App 439 (1978); *OJ Enterprises, Inc v Ins Co of North America*, 96 Mich App 271, 274 (1980).
- 32 *Yaldo v North Pointe Ins Co*, 457 Mich 341, 348 (1998); See also *McCabill, supra* (“[t]he statute is intended to provide a penalty to be assessed against recalcitrant insurers who procrastinate or are dilatory in paying meritorious claims in bad faith . . . [it] evinces no intent to compensate a plaintiff for the delay in recovering funds rightfully his”); *Commercial Union Ins v Liberty Mutual Ins Co*, 426 Mich 127, 136 fn. 5 (1986) (noting that “Section 6 of the Uniform Trade Practices Act is a statutory penalty, intended to penalize recalcitrant insurers who, in bad faith, are dilatory in paying claims”); See also *Dept. of Transp v Initial Transport, Inc*. 276 Mich App 318 (2007), reversed in part on other grounds, 481 Mich 862 (2008); *Federal Ins Co v Hartford Steam Boiler Co*, 415 F3d 487, 499 (6th Cir. 2005); *Society of St. Vincent DePaul v Mt Hawley Insurance Co.*, 49 F Supp 2d 1011, 1020 (ED Mich 1999).
- 33 *Stryker*, 735 F3d at 355, citing *Wilkie v Auto-Owners Ins Co*, 469 Mich 41 (2003).
- 34 See e.g. *Montrose Chemical Corp. v Admiral Ins. Co.*, 10 Cal. 4th 645, 664-665; 913 P.2d 878, 887 (1995) (noting that an important difference between first and third party policies is that first party insurance policies require the insured to bring any action against the insurer within 12 months after “inception of the loss”); and see e.g. MCL 500.2833q (requiring that that actions for fire loss be brought within one year after the loss).
- 35 “Statutes should be construed to avoid absurd consequences, injustice, or prejudice to the public interest.” *McAuley v Gen. Motors Corp.*, 457 Mich. 513, 518, (1998), overruled in part on other grounds; *Rafferty v Markovitz*, 461 Mich. 265 (1999).
- 36 *Combs v Int’l Ins Co*, 354 F3d 568, 577–78 (6th Cir 2004) (quoting *Dayton v Peck, Stow & Wilcox Co. (Pexto)*, 739 F2d 690, 694 (1st Cir 1984)) (alteration omitted).
- 37 *Id.* at 577 (quoting *Todd v Societe Bic, SA*, 21 F3d 1402, 1412 (7th Cir 1994) (en banc)) (alterations in original).



Ordinary and Standard “Loss Payable” Clauses in Property Insurance Policies

By Jason Liss, *Fabian, Sklar & King, PC*

It is common to protect a creditor’s financial interest in an insured’s property by naming the creditor as a loss payee or mortgagee in the declarations of the insured’s property insurance policy. The extent to which the creditor’s financial interest is protected depends, however, on the nature of the policy’s loss payable clause. While they may be given different labels, depending on the type of property covered, the two most common loss payable clauses are the ordinary mortgage clause and the standard mortgage clause. Of the two, the standard mortgage clause affords the creditor far greater protection.¹

The “Ordinary” Mortgage Clause

Under an ordinary mortgage clause, the mortgagee is no more than an appointee to receive the insurance proceeds up to the amount of its financial interest in the insured property.² Common language in an ordinary mortgage clause states that the insurer will pay the mortgagee for a covered loss “as interests may appear” in the policy declarations. Under this type of mortgage clause, the mortgagee’s right to receive payment is wholly dependent on the Insured’s ability to recover under the policy. Therefore, under an “ordinary” mortgage clause, an insured’s acts, omissions and misrepresentations, over which the mortgagee has no control, may result in a forfeiture of the mortgagee’s right to recover for an otherwise covered loss.

The “Standard” Mortgage Clause

In contrast, the standard mortgage clause insulates the mortgagee from the effects of any of the insured’s conduct which violates a policy condition or triggers an exclusion to coverage. Land Contract vendors have the same status as mortgagees under a standard mortgage clause.³ Though contained entirely within the insured’s policy, the standard mortgage clause is considered to establish a separate and independent contract between the insurer and the mortgageholder,⁴ and has its own conditions specifically applicable to the mortgagee in the event of any default by the insured. The following language excerpted from the mortgage clause of an ISO Commercial Property Building and Personal Property Coverage Form (CP 00 10 04 02) contains all of the hallmarks of a typical standard mortgage clause:⁵

We will pay for covered loss of or damage to buildings or structures to each mortgageholder shown in the Declarations in their order of precedence, as interests may appear.

If we deny your claim because of your acts or because you have failed to comply with the terms of this Coverage Part, the mortgageholder will still have the right to receive loss payment if the mortgageholder:

- (1) Pays any premium due under this Coverage Part at our request if you have failed to do so;
- (2) Submits a signed, sworn proof of loss within 60 days after receiving notice from us of your failure to do so; and
- (3) Has notified us of any change in ownership, occupancy or substantial change in risk known to the mortgageholder.

All of the terms of this Coverage Part will then apply directly to the mortgageholder.

Despite the clear language of a standard mortgage clause, some insurers have denied payment to mortgagees on the theory that the insured’s acts or omissions take the cause of loss, and even the insured property itself, outside of the scope of coverage.

In a case where the cause of loss argument was raised, the standard mortgage clause stated that “loss or damage, if any, under the policy shall be payable as interests may appear... and this insurance as to the interest of the ... Mortgagee ... shall not be invalidated by any act or neglect of the [insured].” Since the policy defined the term “loss” as “direct and accidental loss,” the court rejected the insurer’s argument that the arson committed by the insured was not accidental and the “cause of loss” was therefore outside the definition of the perils covered by the policy.⁶

The argument that the property itself was not covered was made in a case involving residential property. The policy covered damage and loss to the “residence premises.” The policy defined the term “residence premises” as “the place where you reside.” It was undisputed that the insured had not resided at the insured dwelling for the four years preceding the loss. The court rejected the insurer’s argument that the insured’s failure to reside at the home took the dwelling outside of the policy’s definition of “covered property.”⁷

Insurers taking these positions have achieved little success invalidating the mortgagee’s coverage because they so irrevocably conflict with the plain language of the mortgagee’s

independent contract, stating the insured's acts or failure to comply with policy conditions will not invalidate the mortgagee's coverage.⁸ The standard mortgage clause so thoroughly insulates a mortgagee from an insured's conduct that even an insured's material misrepresentations in the application for insurance, which permit an insurer to rescind the policy *ab initio*, will not void a mortgagee's coverage for a loss.⁹

Mortgagee Must Comply with Coverage Conditions

While it is clear that an insured's acts, omissions and misrepresentations cannot compromise a mortgagee's right to payment for a covered loss under a standard mortgage clause, a mortgagee must still comply with the conditions of the clause itself. The language emphasized in the excerpted clause quoted above identifies three conditions commonly found in most standard mortgage clauses. These include: (1) payment of any unpaid premiums; (2) submission of a sworn proof of loss upon request if the policyholder had not previously done so; and, (3) notification to the insurer of any changes in title, occupancy or increase in hazard known to the mortgagee.

The obligations to pay unpaid premiums or to timely submit a sworn proof of loss at the insurer's request are usually self-explanatory and not the subject of legal controversy. A mortgagee's obligation to notify the insurer of any change in ownership, occupancy or increase in hazard, however, has been the subject of much litigation.

One common scenario involves the mortgagee's foreclosure of the insured property. A foreclosure clearly affects title to the property, but it is well established in Michigan that a mortgagee's initiation of foreclosure proceedings and subsequent purchase of the insured property is not considered a "change in ownership" and does not require notification to the insurer, even after the expiration of the redemption period.¹⁰ While an exhaustive search has failed to identify any Michigan cases directly addressing the issue, a mortgagee who fails to notify the insurer of a foreclosure risks having the insurer take the position that coverage was forfeited if the insured vacated the property, since that may constitute a change in occupancy or an increase in hazard.¹¹

Conclusion

Because insurance policies do not label their mortgage clauses as "ordinary" or "standard," it is their substance that determines their characterization. A mortgage clause that only promises to pay a loss "as interests may appear" in the declarations may be considered an ordinary mortgage clause by the insurer and the mortgagee remains subject to all the defenses the insurer may assert against the insured. The hallmark of a standard mortgage clause is language which states that the conduct of the Insured will not invalidate the mortgagee's coverage. While a mortgagee can expect that no act, omission or representation of the Insured will compromise its coverage, the mortgagee still needs to be cognizant of and comply with its own duties and obligations under the insurance policy. ■

About the Author

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Endnotes

- 1 In the context of movable property, the policy may instead contain a lender's loss payable endorsement, rather than a mortgage clause. The substance of a lender's loss payable endorsement is equivalent to the substance of a standard mortgage clause and affords a creditor the same protection.
- 2 *Foremost Ins Co v Allstate Ins Co*, 439 Mich 378, 383; 486 NW2d 600, 602 (1992).
- 3 *Cole v Michigan Mut Ins Co*, 116 Mich App 51, 55; 321 NW2d 839, 841 (1982).
- 4 *Singer v Am States Ins*, 245 Mich App 370, 379; 631 NW2d 34, 40 (2001).
- 5 ISO stands for Insurance Services Office, Inc.
- 6 *Foremost Ins. Co.*, 439 Mich. 378
- 7 *Wells Fargo Bank, NA v Null*, 304 Mich App 508; 847 NW2d 657 (2014).
- 8 In *Boyd v Gen Motors Acceptance Corp*, 162 Mich App 446; 413 NW2d 683 (1987) *Foremost Ins Co v Allstate Ins Co*, 439 Mich 378; 486 NW2d 600 (1992), Auto Club Insurance Association succeeded in persuading the Court of Appeals that the insured's act of arson took the loss outside the scope of coverage under a standard mortgage clause. *Boyd* was later overruled by the Supreme Court in *Foremost Ins. Co.*, 439 Mich. 378. However, more recently, in *Waterstone Bank, SSB v Am Family Mut Ins Co*, 348 Wis 2d 213; 832 NW2d 152 (2013), an insurer persuaded the Wisconsin Court of Appeals that the lender was not entitled to payment where the insured failed to occupy the insured premises for 60 consecutive days before the loss. This case appears to be an outlier and nationally, courts have rejected its reasoning. See, e.g., *Old Second Nat Bank v Indiana Ins Co*, 29 NE3d 1168 (Ill App Ct 2015).
- 9 *Citizens State Bank of Clare v State Mut Rodded Fire Ins Co of Michigan*, 276 Mich 62; 267 NW 785 (1936).
- 10 *Citizens Mortg Corp v Michigan Basic Prop Ins Ass'n*, 111 Mich App 393; 314 NW2d 635 (1981).
- 11 In *Perry State Bank v Farmers All. Mut Ins Co*, 953 SW2d 155 (Mo Ct App 1997), the Missouri Court of Appeals upheld an insurer's denial of coverage under a standard mortgage clause to a mortgagee which knew the insured property had been unoccupied for a substantial period of time.



Insurable Losses: Fortuity, Loss in Progress and Known Risk

Hal O. Carroll, *Law Office of Hal O. Carroll*

Introduction

Perhaps the most fundamental issue when insurance comes into dispute is whether the loss is insurable at all. Even before analyzing whether “Section I – Coverages” grants coverage or “Section II – Exclusions” takes it away, the risk itself must be one that the law will allow to be insured. This question is expressed in the related doctrines of “fortuity,” “loss-in-progress” and “known-risk.”

These complementary doctrines address the fundamental question whether a particular loss can be insured against. When they come into play they are “policy defenses,” because they do not depend on the language of any policy, but are based on the fundamental nature of insurance and what kinds of losses are insurable. These doctrines are “based on the rationale that insurance policies cover fortuitous events or risks of loss, not losses that are certain to occur. Once a loss has happened, or once it is in progress, the event is no longer fortuitous and the risk has already been realized.”¹

“Fortuity” is a common term in the area of insurance law. In the real world, the word carries the meaning “lucky or fortunate.”² In insurance, “fortuity” means that the insured event is either uncertain to occur or (in life insurance, for example), certain to occur but at an uncertain time.

The common expression of the loss in progress and known risk rules is that no one can insure a sinking ship, and as it happens the first case in Michigan to apply the rule did involve a ship. In *Gauntlett v Sea Insurance*,³ a ship sank near Mackinac Island. Notice of the loss was telegraphed at 6:30 a.m. to the insured. The insured had already been in the process of negotiating for insurance before the ship sank, but had not yet obtained it. At 8:00 a.m., the insured sent a telegram requesting insurance. The Supreme Court held that because the ship had sunk, the policyholder could not recover.⁴ The court acknowledged that “[v]essels and cargoes upon the seas may be insured when both parties are in ignorance of the condition of the property,” but concluded that the insured knew of the loss before any policies were issued.

The next case to apply the rule is *Harper v Tornado v Michigan Mutual Tornado Ins Co*,⁵ in which the plaintiff sought to collect insurance on a building that had burned down. The building had been insured by the previous owner with a mutual company, but the rules of the company required that the company approve any new insured when property was transferred. The building burned down before the successor owner

was approved as an insured, and the court held that there was no insurance.⁶

In insurance, “fortuity” means that the insured event is either uncertain to occur or (in life insurance, for example), certain to occur but at an uncertain time.

The Supreme Court more recently applied the rule in *American Bumper v Hartford Fire Ins Co*.⁷ The court acknowledged that Michigan “recognizes that a completed loss is not covered under an after-acquired insurance policy.”⁸ The phrase “completed loss” is accurate, but the rule is broader. If the unfortunate ship owner in *Gauntlett* had bought insurance between the time when the ship started to sink and the time when it settled beneath the waves, the result would have been the same. The reference to a “completed loss” must be read in the context of the Supreme Court’s more general statement of the rule:

Under the loss-in progress doctrine, an insurer is not liable if the loss was already in progress before the policy’s coverage took effect. The doctrine is based on the rationale that insurance policies cover fortuitous events or risk of loss, not losses that are certain to occur. Once a loss has happened, or once it is in progress, the event is no longer fortuitous and the risk has already been realized.⁹

These principles are not based on or limited by the terms of the policy. Fortuity and the loss in progress and known risk doctrines are related to two other insurance concepts – “adverse selection” and “moral hazard.” “Adverse selection” is the tendency of a person who knows he or she is more likely to suffer a loss to buy insurance. Young and healthy people, known in the trade as “invincibles,” are less likely to buy health insurance. “Moral hazard” is the problem that one who has insurance will engage in riskier behavior – or intentional conduct – precisely because he or she knows the insurance will make good the loss.

Adverse selection and moral hazard by applicants or policyholders provide perhaps the greatest threat to fortuitous underwriting by insurers. Adverse

selection is the tendency of persons who are more likely to suffer a loss to purchase insurance on such risks. At its worst, adverse selection can mean an insurance applicant's seeking a policy that will cover a loss he knows is certain to occur.¹⁰

Fortuity and the loss in progress and known risk doctrines are related to two other insurance concepts – “adverse selection” and “moral hazard.”

Michigan has applied the moral hazard rule in several cases. Addressing the issue in the context of the insured's failure to disclose a material fact, the Supreme Court said:

“It cannot be presumed that a breach of a condition which increases the moral hazard does the insurer no injury. Quite the contrary. Courts have uniformly avoided the policy upon breach of such conditions, upon the ground that an essential and material change of the contract was thus effected and the insurer prejudiced.”¹¹

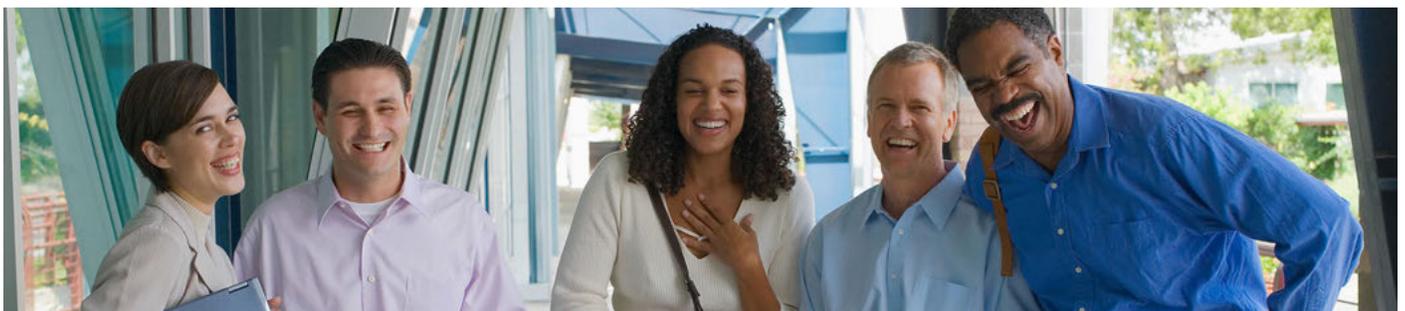
Policies may address the moral hazard problem in several ways. One is to draft the insuring language carefully to confine it to the type of risks the insurer is willing to accept. And many of a policy's exclusions are aimed at that problem. The exclusion that most directly reflects the concept of fortuity, in a liability insurance policy, is the “expected or intended injury” exclusion (a/k/a the “intentional act exclusion”). A property insurance policy will usually contain a provision that requires the insured to take steps to prevent certain types of loss. Also, a policy may contain a provision, usually in the Conditions section, that prevents coverage when the insured fails to disclose a material fact in the application. ■

About the Author

Hal Carroll is a co-founder and first chairperson of the Insurance and Indemnity Law Section. His practice includes civil appeals and indemnity and insurance coverage disputes, where he represents insureds as well as insurers. Mr. Carroll is a chapter author in ICLE's Michigan Insurance Law and Practice and has been designated a Super Lawyer® again in 2015. His email address is HOC@HalOCarrollEsq.com.

Endnotes

- 1 *American Bumper v Hartford Fire Ins Co*, 452 Mich 440, 459; 550 NW2d 475 (1996).
- 2 *American Heritage Dictionary*, Third Ed., p 716.
- 3 *Gauntlett v Sea Insurance*, 127 Mich 504; 86 NW 1047 (1901).
- 4 127 Mich at 511.
- 5 *Harper v Tornado v Michigan Mutual Tornado Ins Co*, 173 Mich 459; 139 NW 27 (1912).
- 6 173 Mich at 463.
- 7 *American Bumper v Hartford Fire Ins Co*, 452 Mich 440; 550 NW2d 475 (1996).
- 8 *American Bumper* at 459, citing *Gauntlett*.
- 9 *American Bumper* at 459.
- 10 Stempel, *Law of Insurance Contract Disputes*, Chapter 1, Core Insurance Concepts, § 1.05[b], page 1-65.
- 11 *Lagden v Concordia Mutual Fire Insurance Co*, 188 Mich 689, 697; 154 NW 87 (1915).



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Monkey In The Middle: The Anatomy Of An Insurance Agent Errors & Omissions Claim

By Michael S. Hale, J.D., CPCU, AAI and Melissa L. Hirn, J.D.

Key Principles from this Article

- Many duties owed by Michigan insurance agents hinge on whether they are independent or captive / exclusive agents.
- The failure of the policyholder to read the policy goes to the defense of comparative negligence as opposed to proximate cause, but could defeat a misrepresentation cause of action against an insurance agent.
- Duties of insurance agents have been recently extended by the Sixth Circuit Court of Appeals to include additional insureds, but not injured third parties.
- The failure to place or procure coverage must be distinguished from the duty to advise in assessing a potential cause of action against an insurance agent.
- It is now settled that the negligence statute of limitations is three years, not two, for insurance agent professional liability.

The typical licensed insurance agent is sandwiched between duties owed to the insurer and the insured. Yet who is the agent's master? Is the insurer liable for the acts of the agent? Is the agent responsible for the acts of the insurer? What duties does the Michigan agent owe to the insured to procure coverage or to advise of a policy's adequacy?

When an insurer denies an insurance claim, many insureds are quick to blame the insurance agent. These errors and omissions claims are more common than the practitioner might think, particularly in that many insureds do not read their policies, and if they do, it is questionable whether they understand the intricacies of the coverages, exclusions and conditions. Although the agent did not write the policy, he or she is often perceived by the insured to be the culpable party when a claim is not covered by the insurer. After all, the agent sold the policy to them.

Michigan law is somewhat in a state of flux on the issue of the duties owed by an independent agent versus that of a captive agent. The trend of the decisions out of the Michigan Court of Appeals seems to be that where the agent is the agent for the insured, a heightened duty is owed to that insured. However, in the 1999 seminal case regarding agent liability, *Harts v Fire Insurance Exchange*,¹ the Michigan Supreme Court did not draw a particular distinction between types of agents and who they represent, leaving many to wonder what the law is.

New causes of action against insurance agents have recently been recognized by the Michigan Court of Appeals in the area of negligent appraisal in determining values for buildings and contents.

This article examines the roles and legal responsibilities of the independent agent, the captive or exclusive agent, and the insured.

Michigan Insurance Agent Causes of Action

Michigan case law recognizes two broad categories of professional liability claims – failure to procure and failure to advise of coverage adequacy. It is important to distinguish the two as they involve different standards. As to either, however, the Michigan Court of Appeals recently determined that a three-year statute of limitations applies, rather than the two-year statute in professional liability cases.²

The cause of action for failure to procure coverage invokes common law negligence theories and defenses.³ For example, if an agent forgets to bind coverage and a loss occurs, this does not trigger an analysis of whether coverage was adequate as coverage was never procured in the first place.

The more common negligence cause of action involves the agent placing coverage which is later determined to be inadequate. Despite being the seminal case on agent liability, *Harts, supra*, leaves something to be desired in the scope of determining whether a duty exists, with numerous appellate courts analyzing such lawsuits in various ways.

Harts, however, does make it clear that a distinction exists between insurance *counselors* and insurance *agents*, each of which require a separate state license in Michigan. By statute, only licensed counselors are permitted to advise on coverage benefits, make comparisons between policies, and perform other tasks that involve more than simply explaining a proposal or policy being sold.⁴ Counselors certainly owe different duties than do agents.

The *Harts* case imposes a four-prong analysis as to whether an insurance agent owes a duty to the insured to advise of the adequacy of coverage, holding that there is such a duty if one of the following exists:

- (1) the agent misrepresents the nature or extent of the coverage offered or provided,
- (2) an ambiguous request is made that requires a clarification,
- (3) an inquiry is made that may require advice and the agent, though he need not, gives advice that is inac-

curate, or (4) the agent assumes an additional duty by either express agreement with or promise to the insured.⁵

Some of these four factors tend to bleed over into the others, sometimes making it difficult to determine whether a duty is owed. However, some courts appear to be looking through a conservative lens in analyzing whether the pending claim meets any of these factors. For example, at least one Michigan court has determined that the failure to advise the insured of a notice of cancellation was not a breach of duty under *Harts*.⁶

The trend over the last few years is for courts to look at the legal relationship between the parties to determine duty and liability. In the published decision of *Genesee Foods Services, Inc v. Meadowbrook, Inc*⁷ the Michigan Court of Appeals put an emphasis on the insurance agency's status as an independent agency, meaning that it represented numerous insurance companies in placing accounts. *Genesee Foods* distinguished *Harts* and its four-prong test in holding that *Harts* only applied to captive or exclusive agents where the agent is typically the agent for the insurer. This often involves situations where the agent is an employed salesperson for the insurer.

Independent Agent as Fiduciary to the Insured

Citing long-established Michigan case law that such an independent agent is the agent for the insured rather than the insurer,⁸ the court in *Genesee Foods* applied a fiduciary duty standard, holding that the "agent has the obligation to obtain the most comprehensive coverage available for the insured."⁹ The fiduciary duty standard exposes the independent insurance agent to major risk given the court's reference to "the primary fiduciary duty of loyalty" and "the most comprehensive coverage available."

In looking to basic principles of fiduciary law in Michigan, a fiduciary duty arises when the relationship between the two parties is "of such character that each must repose trust and confidence in the other and must exercise a corresponding degree of fairness and good faith."¹⁰ This fiduciary relationship factor has been a consideration weighed by numerous recent courts in analyzing insurance agent duties.

Since *Genesee Foods*, a number of unpublished cases have attempted to further refine the standard.

In the 2011 case of *Nokielski v Colton*¹¹ the Michigan Court of Appeals expressly held that the *Harts* standard applies equally to the independent agent and to the captive agent. Another panel reached the same conclusion in the 2014 case of *Richardson v Grimes*.¹²

Other courts have stressed that independent agents owe fiduciary duties as enunciated in *Genesee Foods* but that such a duties are not unlimited. For example, in *Deremo v TWC & Associates, Inc.*,¹³ the court determined that although such a broad sweeping duty of fiduciary care was owed by the agency,

it satisfied that duty by asking the insured for additional information which was never provided.

In a November 3, 2015 opinion, *John Hohensee v Nas-sar Insurance Agency, Inc.*,¹⁴ the Michigan Court of Appeals considered a claim that an insurance agent misrepresented the scope of coverage resulting in a substantially lesser payment from the insurer than should have been made following a fire. In that case, the limit of insurance for the building was \$500,000 yet the reconstruction costs were determined to be \$842,948. After the insured decided not to rebuild, the insurer paid \$236,148 which was less than it would have paid had the insured rebuilt. The insured sued the agent claiming that the terms of the policy had been misrepresented in that "agreed value" ultimately did not mean he would get the full \$500,000 policy limit.

The court held that a negligence cause of action was not viable because no duty was owed nor was the loss the proximate cause of any negligence by the agent. Although the defendant was an independent agent, the court applied the *Harts* standards and determined that there was no duty to advise of coverage adequacy as there was no special relationship.¹⁵

In addition to applying *Harts*, the court also looked to whether there was a fiduciary duty owed, *i.e.* did the agent use "reasonable diligence and care to procure insurance as requested by the insured."¹⁶ The court did not reference in its opinion the principle of *Genesee Foods*¹⁷ that the fiduciary duty required the agent to obtain the most comprehensive insurance available for the insured.¹⁸

Extending the Duty to an Additional Insured

Insurance agents may also owe duties to parties which are not their clients. In a vigorously defended case that was ultimately decided by the Sixth Circuit Court of Appeals, it was held that an insurance agent could also owe a duty to an additional insured listed on the policy.¹⁹ Recently, however, the Sixth Circuit Court of Appeals declined to extend this rationale to a duty of an insurance agent to an injured third party claimant.²⁰

Should the Insurer Be Included as a Defendant?

In cases involving errors or omissions of independent insurance agents, the insurer is usually not a viable defendant absent an independent theory for breach of contract or in unusual circumstances, for an independent tort. The reason for this is the principle previously discussed that the independent agent is the agent for the insured. This means that acts or omissions of the agent are generally not binding upon the insurer, even though there is a separate contract between the insurer and the agent.

The acts of omissions of exclusive or captive agents are generally binding upon the principal insurer and, in such cases, the insurer should be included as a defendant.

Types of Causes of Action

Negligence. The typical underinsured loss analysis of captive agent liability will invoke the four-prong *Harts*²¹ test as to whether a duty exists to advise of coverage adequacy. As noted above, this may also be part of the analysis when an independent agent is involved but this has not been settled to date. It is advisable to plead such factually supported claims specifically in the negligence count.

Fiduciary Duty. Pleading in the alternative, it is advisable to consider a separate claim for fiduciary duty where the defendant is an independent insurance agent. This is consistent with *Genesee Foods*.²² One potential advantage of a fiduciary cause of action is that it may not be subject to a defense of comparative negligence, although the authors are aware of no appellate decisions which have squarely addressed this. It is noted, however, that some Michigan courts analyzing the fiduciary duty of independent insurance agents have done so in the context of “duty” and “negligence,” implying that there would be the potential for a comparative negligence defense.

Breach of Contract. Michigan courts have held that a claim for an insurance agent’s failure to advise is in tort rather than for breach of contract.²³ Furthermore, when a contracting party is sued by a non-contracting third-party for negligence, the inquiry is whether defendant owed any independent legal duty to the plaintiff.²⁴ Thus, the breach of contract cause of action will usually be superfluous.

Misrepresentation. Something of a misnomer in the context of an agent case, the misrepresentation count tends to be a weaker theory in the scope of causes of action. Already included as an element in the *Harts*²⁵ analysis, it typically has fewer teeth given its element of reasonable reliance²⁶ which can often be derailed to the extent of an admitted failure of the plaintiff to read the policy.

Defenses

No duty. The issue of duty is typically the primary defense asserted by insurance agents and *Harts*²⁷ is often the basis for the defense.

However, courts have also looked to whether an insurance agent has a duty in more remote situations. For example, in *Therault v Al Bourdeau Insurance Service, Inc.*²⁸ the Michigan Court of Appeals addressed a fact pattern where the insurance agent for a bar owner did not advise the insured to file a claim with another agency which wrote a separate policy, holding: “It would be inconsistent with that limited duty to hold an insurance agent such as defendant liable in connection with an insurance policy it did not write and an insurance company with which it had no relationship.”²⁹

No Third Party Beneficiary. Generally, insurance agents owe no contractual duty to an injured third party claimant and, for this reason, the third party lacks standing to sue the agent. However, courts have not applied this no duty rule

to cases involving automobile accidents, finding that such injured victims *are* third-party intended beneficiaries of an auto-insurance policy.³⁰

Proximate Cause. Michigan courts have determined that where a plaintiff fails to show that coverage was available to address the coverage gap at issue, causation is lacking, defeating the negligence theory.³¹ Expert testimony may be needed to establish the availability of coverage.

At least one other court has held that where an insured elected not to rebuild and received a lesser sum from the insurer, causation was also lacking.³²

A key defense usually interposed by agents is that the insured should have read the policy and raised any questions within a reasonable period of time. Along these lines, agents have argued that where the insured does not read the policy, it, not the agent, is the proximate cause of any loss. However, the published opinion of *Zaremba Equipment, Inc v Harco National Insurance Company*³³ held that failure to read the policy is not dispositive on the issue of negligence and instead goes to comparative negligence.

Misrepresentation. The insured, being bound to the knowledge of the terms and conditions of the insurance policy,³⁴ usually fails to prevail on a misrepresentation claim given that there can be no reasonable reliance where the insured failed to read the policy.³⁵ This analysis likely also applies to cases where the insurer rescinds the policy for a misrepresentation on the application that the insured signed but did not complete or read.

Other Litigation Considerations

Discovery. Discovery in an agent errors and omissions case follows general procedures, subject to a few nuances.

Agents often maintain detailed computerized activity logs which should be requested by name (an expert can assist you with this). These logs may contain vital information on what transpired in a particular case. The underwriting and claims files of the insurer provide relevant documentary discovery as they usually include correspondence from the agent, applications, etc.

Experts. Whether an expert is needed to support an insurance agent errors and omissions claim typically involves determining if something more than an interpretation of the policy language is required. Instead, a case usually warrants an expert where the fact finder requires additional assistance in the explaining of the standard of care of a reasonably prudent insurance agent.

However, even where the practitioner chooses not to retain a testifying expert, a retained advisory expert can provide valuable assistance with formulating causes of action or defenses, seeking appropriate discovery and explaining the availability of coverage.

Conclusion

Whether independent or captive, the insurance agent in Michigan is often the monkey in the middle, appearing to have to please two masters while primarily owing duties to represent the interests of only one.

While the case law is somewhat in a state of flux, it is anticipated that the issue of who the insurance agent represents will ultimately play a key role in the case law governing such errors and omissions cases. Depending on the nature of the relationship and the interaction on coverages, the current state of the law can assign to the agent, and in particular the independent agent, considerable liability exposure. The intricacies and options regarding coverages make the process of purchasing insurance a complicated one to say the least. ■

About the Authors

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Endnotes

- 1 *Harts v Fire Ins Exchange*, 461 Mich 1, 6; 597 NW2d 47 (1999).
- 2 *Stephens v Worden Ins Agency, LLC*, 307 Mich App 220; 859 NW2d 723 (2014); MCL 600.5805(10).
- 3 *Haji v. Prevention Ins Agency, Inc.*, 196 Mich App 84; 492 NW2d 460 (1992). 3 Couch, Insurance, 3d, cited by *Micheau v. Hughes & Havinga Ins Agency*, unpublished opinion per curiam of the Court of Appeals, issued May 21, 2013 (Docket No. 307914).
- 4 MCL 500.1201(a); MCL 500.1232; MCL 500.1234; MCL 500.1236; *Harts*, 461 Mich 1.
- 5 *Harts*, 461 Mich at 6-7.
- 6 *Triangle Business Center, Inc v Hartford Casualty Ins Co*, unpublished opinion per curiam of the Court of Appeals, issued November 29, 2012 (Docket No. 305504).
- 7 *Genesee Foods Services, Inc v Meadowbrook, Inc*, 279 Mich App 649; 760 NW2d 259 (2008).
- 8 *West American Ins Co v. Meridian Mut Ins Co*, 230 Mich App 305; 583 NW2d 548 (1998).
- 9 *Genesee Foods*, 279 Mich App 649.
- 10 *Portage Aluminum Co v Kentwood Nat'l Bank*, 106 Mich App 290; 307 NW2d 761 (1981); see also *Meyer & Anna Prentis Foundation, Inc v Barbara Ann Karmanos Cancer Institute*, 266 Mich App 39, 43; 698 NW2d 900 (2005); lv den 474 Mich 871 (2005).
- 11 *Nokielski v. Colton*, unpublished opinion per curiam of the Court of Appeals, issued January 4, 2011 (Docket No 294143).
- 12 *Richardson v. Grimes*, unpublished opinion per curiam of the Court of Appeals, issued January 21, 2014 (Docket No. 312782).
- 13 *Deremo v TWC & Assoc, Inc*, unpublished opinion per curiam, issued August 30, 2012 (Docket No. 305810).
- 14 *Hohensee v Nasser Ins Agency, Inc*, unpublished opinion per curiam of the Court of Appeals, issued November 3, 2015 (Docket No. 321434).
- 15 *Bruner v. League General Ins Co*, 164 Mich App 28; 416 NW2d 318 (1987) has long been cited in agent cases for its proposition that in order to create a duty there must be an interaction on a question of coverage i.e. a special relationship.
- 16 *Hohensee*, unpub op Citing *Zaremba Equipment, Inc v Harco Nat'l Ins Co*, 280 Mich App 16; 761 NW2d 151 (2008).
- 17 *Genesee Foods*, 279 Mich App 649.
- 18 *Id.*
- 19 *Cleveland Indians Baseball Co, LP v. New Hampshire Ins Co*, 727 F3d 633 (CA 6, 2013).
- 20 *Johnson v. Doodson Ins Brokerage, LLC*, 793 F3d 674 (CA 6, 2015).
- 21 *Harts*, 461 Mich 1.
- 22 *Genesee Foods*, 279 Mich App 649.
- 23 *Holten v. A+ Ins Assoc, Inc*, 255 Mich App 318; 661 NW2d 248 (2003). See also *Zaremba*, 280 Mich App 16.
- 24 *Loweke v. Ann Arbor Ceiling & Partition Co*, 489 Mich 157; 809 NW 2d 553 (2011).
- 25 *Harts*, 461 Mich 1.
- 26 *Novak v. Nationwide Mut Ins Co*, 235 Mich App 675, 688; 599 NW2d 546 (1999).
- 27 *Harts*, 461 Mich 1.
- 28 *Therault v. Al Bourdeau Insurance Service, Inc*, unpublished opinion per curiam of the Court of Appeals, issued October 14, 2008 (Docket No. 278643).
- 29 *Id.*
- 30 *Auto-Owners Ins Co v Michigan Mut Ins Co*, 223 Mich App 205; 565 NW 2d 907 (1997).
- 31 *Micheau*, unpub op.
- 32 *Hohensee*, unpub op.
- 33 *Zaremba*, 280 Mich App 16.
- 34 *Casey v. Auto Owners Ins Co*, 273 Mich App 388; 729 NW2d 277 (2006).
- 35 *Hohensee*, unpub op, citing *Zaremba*, 280 Mich App 16.

Business Court Report



By Kassem Dakhllallah, AT Law Group PLLC

Liquidated Damages Awarded Under Escrow Agreement that was Silent on When Buyer Would be Entitled to Escrowed Funds

Court: Kent County, Hon. Christopher P. Yates

Case: The Shoppes Plaza LLC v. NHS Retail One LLC et al, No. 13-08223-CKB

Date: July 9, 2015

Issue: Who is entitled to escrowed funds – the buyer or the seller - under an escrow agreement executed after closing of the sale of real property where the seller did not satisfy a condition of closing that it obtain a permanent easement?

Ruling: The original purchase agreement made it a condition to closing that the seller obtain a permanent easement to allow access to the subject real estate (a strip mall) from 28th Street. Buyer closed without this condition being satisfied, thus waiving this condition. However, the parties entered into a subsequent escrow agreement whereby seller placed \$75,000 in escrow to go towards obtaining the permanent easement. Under the escrow agreement, the escrowed funds would be released to the seller when it obtained the permanent easement. Seller never was able to obtain the easement. The escrow agreement was silent on what would happen to the funds if seller was unable to procure the easement. The court determined that since the parties fixed \$75,000 in their escrow agreement as the amount of money that would be necessary to obtain the permanent easement, that amounted to an agreement on liquidated damages if the easement was not obtained. Accordingly, the court denied the seller's request that it was entitled to any portion of the \$75,000, and simultaneously refused to award the purchaser any additional amount above the escrowed funds (although buyer argued that the actual amount to obtain the easement was about \$250,000). Therefore, the court entered judgment in favor of buyer for the full \$75,000 in escrow.

Note: The court also rejected seller's argument that buyer should be denied any relief due to buyer's alleged unclean hands. In so doing, the court relied on *New Products Corp v Harbor Shores BHBT Land Development LLC*, 308 Mich App 638 (2014), which held that equitable defenses like unclean hands cannot defeat an action at law.

Customer Lists may be Subject to Protection as Trade Secrets

Court: Macomb County, Hon. Kathryn A. Viviano

Case: Rocket Enterprise Inc v Jerry A. Bowers et al, Case No. 2014-4890-CB

Date: October 13, 2015

Issue: Whether customer lists are entitled to protection as trade secrets.

Ruling: Defendants argued that customer lists are not entitled to protection as trade secrets under the Michigan Uniform Trade Secrets Act, and therefore, plaintiff's MUTSA claim should be dismissed under MCR 2.116(C)(8). In denying the defendant's motion for summary disposition, the Court relied on *Kubik Inc v Hull*, 56 Mich App 335 (1974), which held that customer lists are entitled to trade secret protection where they are not easily ascertainable and are "developed and nurtured from much investigation." Accordingly, customer lists are entitled to trade secret protection in some circumstances. Therefore, the court could not dismiss plaintiff's claim as a matter of law. ■

About the Author

Kassem Dakhllallah is a founding partner with Hammoud & Dakhllallah Law Group in Dearborn. Kassem is a Wayne County Circuit Court Business Court case evaluator and mediator. Kassem is also a board member of the Detroit Metropolitan Bar Association Barristers. Kassem is a Super Lawyer – Rising Star for 2014 and 2015 in the Business Litigation category. Kassem's practice focuses on business and commercial litigation, including commercial insurance litigation. His email address is kd@hbdalawgroup.com.

**Insurance
Case
Summary**


Selected Insurance Decisions

By Deborah A. Hebert, *Collins, Einhorn, Farrell*; Deborah.hebert@ceflawyers.com

Michigan Supreme Court Decisions

Remand to Consider whether MCCA is a “Public Body”
Under FOIA

*Coalition Protecting Auto No-Fault Brain Injury Assc of Mich
v MCCA*

Supreme Court No. 150001

October 16, 2015

In this Freedom of Information Act request for claims information from the Michigan Catastrophic Claims Association, the Supreme Court has vacated part of the Court of Appeals opinion and remanded for further consideration of whether the MCCA is a “public body” within the meaning of the Freedom of Information Act, and to then further address the constitutionality of MCL 500.134(4) in light of its resolution of that issue. For the Court of Appeals opinion, see 305 Mich App 301 (2014).

Michigan Court of Appeals – Published Decisions

Insurer Misconduct Can Support a
Consumer Protection Act Claim

Dell v Citizens Ins Co of America

___ Mich App ___ (2015), lv app pending

Docket No. 322654

Released October 20, 2015

An insurer’s misconduct during the claims handling and adjusting process can support a cause of action under the Michigan Consumer Protection Act, assuming such a claim is otherwise supported by the evidence. The case involves a PIP claim which is summarized more thoroughly elsewhere in this *Journal*.

No PPI Coverage for Stored Auto

MEEMIC Ins Co v Michigan Millers Mut Ins

___ Mich App ___ (2015), lv app pending

Docket No. 322072

Released October 27, 2015

Plaintiff homeowners insurer cannot recover in subrogation against auto insurer for amounts paid to compensate the loss of personal property destroyed by a fire inside a storage facility. The fire occurred as a result of maintenance work on a 1966 Corvette stored in the same facility. Because no-fault property protection coverage is required only for motor vehicles driven or moved upon a highway, and because this

vehicle had not been driven for several years, the comprehensive policy issued for that vehicle was not required to afford PPI coverage.

Michigan Court of Appeals - Unpublished
No Cause of Action Against Agent

Hohensee v Nasser Ins Agency, Inc

Docket No. 321434

Released November 3, 2015

The insured owners of a bowling alley have no viable cause of action against their insurance agent for the conditional coverage provided by their replacement cost policy. After the insured building was destroyed by fire, the insureds expected to recoup policy limits of \$500,000 because the cost of replacing that building exceeded the limit. But the policy’s replacement cost limit applied only if the structure was actually replaced. Otherwise, recovery was limited to the actual cash value of the property which was under \$250,000. This misunderstanding on the part of the insureds did not support a cause of action against their agent. The insureds did not read their policy, which plainly identified the requirement of replacement for full limits, and there was no evidence of any misrepresentation. Nor did the insureds produce evidence of a special relationship with their agent or evidence of any breach of the duties accompanying that relationship if it existed.

Statements in the Application Not Part of the Policy

Bailey v Great Lakes Mut Ins Co

Docket No. 321655, lv app pending

Released November 17, 2015

Statements made by the insured in her policy application were not expressly incorporated into the insurance contract and thus cannot be enforced as conditions of coverage. Defendant issued a policy to this owner of a rental home. In her application, the insured stated that the property was occupied and that if it became unoccupied for more than 60 days, she would notify the insurer and her policy would automatically revert to “Form 1” coverage for vacated premises. During the second policy year, the property was damaged by a water leak inside the house after it had been vacant for several months. Defendant denied coverage and the insured sued. The court found coverage because the policy did not incorporate the insured’s statement of occupancy and did not otherwise provide for a reduction of coverage in the event of a vacancy.

[t]he policy’s replacement cost limit applied only if the structure was actually replaced. Otherwise, recovery was limited to the actual cash value of the property which was under \$250,000. This misunderstanding on the part of the insureds did not support a cause of action against their agent.

No Coverage for Insured Auto Used to Deliver Pizzas

Farm Bureau Mut Ins v Wagner
 Docket No. 322738
 Released November 17, 2015

The Court of Appeals again upholds the standard auto policy exclusion for liability coverage where the covered vehicle is “being used to carry persons or property for a fee.” This exclusion is permitted by MCL 500.2118(2)(f) and applies to the use of a privately owned vehicle used to deliver pizzas. The insured was paid an hourly wage plus \$1.50 toward mileage and fuel for each delivery made in the course of his employment with Pizza Hut. His personal auto policy with Farm Bureau did not cover the insured for liability claims arising out his use of the vehicle in that business capacity.

Penalty Interest Under the UTPA Not Available

The Cincinnati Ins Co v V.K. Vemulapalli
 Docket No. 322840, lv app pending
 Released November 17, 2015

After sustaining major flood damage to a commercial building, the owner submitted a claim to his commercial

property insurer captioned “Sworn Statement in Proof of Loss,” but provided no documentation of the losses claimed. The insurer wrote back asking for documentation but none was provided until arbitration, which resulted in an award for the insured. This appeal addresses the insured’s request for penalty interest on the judgment entered on the arbitration award, per the Uniform Trade Practices Act, MCL 500.2001 *et seq.* The court affirmed the lower court finding that the insurer’s letter asking for proof of loss satisfied the terms of MCL 500.2006(3) and thus required the insured to respond with satisfactory proof of loss. Because the insured never produced satisfactory documentation of her property loss prior to arbitration, penalty interest was not applicable.

Um Coverage Denied to Daughter Who Did Not Reside with Insureds

Johnson v Auto-Owners
 Docket No. 323394
 Released November 19, 2015

The named insureds’ daughter sought UM coverage under her parents’ policy after she was injured in a hit-and-run accident while a passenger in a taxi cab. The parents’ UM policy afforded coverage for a relative of the named insureds if that relative resided with the insureds and was injured in a non-owned vehicle. Plaintiff-daughter acknowledged in response to requests to admit that she resided with her fiancée and not with her parents. Her subsequent deposition testimony explaining that she was transitioning between the two households and spent two to three nights a week at her parent’s house did not overcome the formal judicial admission of residency elsewhere.

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Because the insured never produced satisfactory documentation of her property loss prior to arbitration, penalty interest was not applicable.

Auto Policy Rescinded for Fraud

Secura Ins v Thomas

Docket No. 322240

Released December 1, 2015

Auto policy was rescinded where the named insured and her daughter, the permissive user, lied about the circumstances of the covered auto being operated in the State of Georgia. The named insured testified that she was visiting her daughter in that state at the time of the accident and her daughter was using the car to run an errand when she was involved in an accident. In a separate proceeding involving injuries to the named insured in two prior accidents, the named insured testified that her injuries prevented her from driving at the time she claimed to have driven to Georgia. Her medical records further established that she was being treated in Michigan when she claimed to be visiting her daughter in that state. Because the auto policy contained a provision providing coverage in the event *any* insured (including a permissive user) made false statements about a claim, Secura was allowed to rescind the policy and also had the right to recover amounts paid.

One-year Limitations Period for Property Claim

Thill v State Farm Fire & Cas Ins Co

Docket No. 323339

Released December 15, 2015

Plaintiff's homeowners insurance claim for damage caused by an "ice dam" was not covered because plaintiff failed to file suit within the statutory period of limitations provided by MCL 500.2833(1)(g). The limitations period set forth in the policy was void.

Federal District Court Decisions - Published

Auto Policy Exception for Permissive Users Unenforceable

Maher v Federated Ins Co

___ F. Supp 3d ___ (ED Mich 2015)

Case No. 15-cv-10790

Released October 26, 2015

In this dispute between two commercial auto insurers, the trial court followed Michigan state courts in determining as a matter of law that an exception in commercial auto policies withholding coverage for permissive users engaged in auto sales is unenforceable under the Michigan No-Fault Act. The driver in this case was transporting a vehicle to the auction house for sale.

Abstention in DJ Action

Chelsea Hearth & Fireplaces, Inc v Scottsdale Ins Co

___ F. Supp 3d ___ (ED Mich 2015)

Case No. 15-cv-12240

Released November 9, 2015

Upon review of the parties' cross motions for summary judgment and for dismissal, the court issued an order directing plaintiff to show cause why the court should not decline to exercise jurisdiction, and then issued this opinion applying the factors first announced in *Grand Trunk W.R. Co. v Consol. Rail Corp.*, 746 F.2d 323 (6th Cir. 1984) to decline to decide the matter. The court noted in particular that because the underlying plaintiff was not a party to the DJ action, the court's decision would not finally resolve the coverage controversy. In addition, the state court offered an alternative resolution mechanism and the state had a significant interest in determining questions of insurance.

Plaintiff was judicially estopped from recovering under her homeowner's policy because she denied ownership of the property in her bankruptcy proceeding, and the bankruptcy court relied on that representations in issuing its relief.

Professional Services Exclusion Bars Additional Insured Coverage for Project Engineer

Orchard, Hiltz & McCliment, Inc v Phoenix Ins Co

___ F. Supp 3d ___ (ED Mich 2015)

Case No. 14-cv-11902

Released November 19, 2015

In this first impression case, the court first concluded that the blanket additional insured (AI) endorsements in two commercial general liability policies covered more than the AI's vicarious liability for the named insured. But the AI endorsement did not cover the liability of the project engineer as an AI because coverage was excluded for liability arising out of professional services, which is broadly defined under Michigan law. An engineer's supervisory responsibilities at a construction site are professional services.

Federal District Court Decisions - Unpublished

Question Of Fact Relapse In Coverage For Non-Payment

Greer v State Farm Ins Co

E.D. Case No. 14-cv-13639

Released October 19, 2015

The insured purchased a homeowners insurance policy from defendant and signed up for automatic payments. But the payments withdrawn from her account differed from

month to month and were inconsistent with the quoted premium, leading to a certain amount of confusion regarding the up-to-date status of her account. The trial court found a question of fact as to whether the insurer properly denied coverage for damage to the home based on lapse of coverage due to non-payment of premiums.

No Diversity Jurisdiction In Dj Action

Conifer Ins Co v Continental Inc

E.D. Case No. 15-cv-11650

Released November 12, 2015

The insurer's naming of the claimants from the underlying liability case in its declaratory judgment action was appropriate and effectively destroyed federal diversity jurisdiction.

Loss of Coverage Based on Judicial Estoppel

Rizka v State Farm Fire and Cas Co

E.D. Case No. 13-cv-14870

Released December 23, 2015

Plaintiff was judicially estopped from recovering under her homeowner's policy because she denied ownership of the property in her bankruptcy proceeding, and the bankruptcy court relied on that representations in issuing its relief. The opinion offers a full discussion of the circumstances warranting judicial estoppel. ■

About the Author

Deborah A. Hebert is a shareholder in the firm of Collins Einhorn Farrell PC, where she specializes in civil appeals, and insurance coverage law. She has been recognized by Best Lawyers as the 2016 Insurance "Lawyer of the Year." Her email address is deborah.hebert@ceflawyers.com

Nominations Open for Major State Bar Awards; Deadline is Feb. 19

Nominations are now open for major State Bar of Michigan awards that will be presented at the September 2016 Annual Meeting in Grand Rapids.

The **Roberts P. Hudson Award** goes to a person whose career has exemplified the highest ideals of the profession. This award is presented periodically to commend one or more lawyers for their unselfish rendering of outstanding and unique service to and on behalf of the State Bar, given generously, ungrudgingly, and in a spirit of self-sacrifice. It is awarded to that member of the State Bar of Michigan who best exemplifies that which brings honor, esteem and respect to the legal profession. The Hudson Award is the highest award conferred by the Bar.

The Frank J. Kelley Distinguished Public Service Award recognizes extraordinary governmental service by a Michigan attorney holding elected or appointed office. Created by the Board of Commissioners in 1998, it was first awarded to Frank J. Kelley for his record-setting tenure as Michigan's chief lawyer.

The **Champion of Justice Award** is given for extraordinary individual accomplishments or for devotion to a cause. No more than five awards are given each year to practicing lawyers and judges who have made a significant contribution to their community, state, and/or the nation.

The **Kimberly M. Cahill Bar Leadership Award** was established in memory of the 2006-07 SBM president, who passed away in January 2008. This award will be presented to a recognized local or affinity bar association, program or leader for excellence in promoting the ideal of professionalism or equal justice for all, or in responding to a compelling legal need within the community during the past year or on an ongoing basis.

The **John W. Cummiskey Pro Bono Award**, named after a Grand Rapids attorney who was dedicated to making legal services available to all, recognizes a member of the

State Bar who excels in commitment to pro bono issues. This award carries with it a cash stipend to be donated to the charity of the recipient's choice.

The **John W. Reed Michigan Lawyer Legacy Award** was introduced in 2011 and is named for a longtime and beloved University of Michigan Law School professor and Wayne State University dean. This award will be presented periodically to a professor from a Michigan law school whose influence on Michigan lawyers has elevated the quality of legal practice in the state.

All SBM award nominations are due by 5 p.m. Friday, Feb. 19, 2016.

The **Liberty Bell Award** recipient is selected from nominations made by local and special-purpose bar associations. The award is presented to a non-lawyer who has made a significant contribution to the justice system. The deadline for this award is Monday, May 13, 2016.

An awards committee co-chaired by Brian D. Figot and SBM Vice President Donald G. Rockwell reviews nominations for the Roberts P. Hudson, John W. Reed, Champion of Justice, Frank J. Kelley, Kimberly M. Cahill, and Liberty Bell awards. The SBM Pro Bono Initiative Committee reviews nominations for the Cummiskey Pro Bono award. These recommendations are then voted on by the full Board of Commissioners at its April meeting.

Last year's non-winning nominations will automatically carry over for consideration this year. Nominations should include sufficient details about the accomplishments of the nominee to allow the committees to make a judgment.

Any SBM member can nominate candidates for awards. To apply online or download application forms visit www.michbar.org/programs/eventsawards. Cummiskey Award nominations can be directed to Robert Mathis at rmathis@mail.michbar.org; all other nominations can be submitted to Joyce Nordeen at jnordeen@mail.michbar.org

No-Fault Corner



Ronald M. Sangster, Jr.
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As we begin 2016, the amount of no-fault cases being decided at the Appellate Court level continues unabated. Issues that were not even thought about years ago have now become “hot topics,” which impact on claimants, their medical providers and no-fault insurers. In fact, we have two published Court of Appeals decision that directly impact on a medical provider’s right to pursue payment of medical expenses, in situations where (1) the injured claimant has failed to cooperate with the insurer, with regard to appearing at Examinations Under Oath and Independent Medical Evaluations, and (2) where the injured claimant has actually signed a release discharging the insurer from any liability for a particular medical expense. What follows is an analysis of these two published Court of Appeals’ decisions.

We also have an interesting published Court of Appeals case regarding property protection claims and coverage, and some of the more interesting unpublished decisions that have been released over the past summer, many of which deal with policies issued to individuals who do not own the vehicles that are being insured under the policy.

Court Of Appeals Action

Insurer Faces “Double Jeopardy” After Settling with Its Insured, Where No-Fault Insurer had Written Notice of a Medical Provider’s Claim in Its File at the Time It Negotiated the Settlement Directly with Its Insured

Covenant Med Ctr v State Farm
_ Mich App _, _ NW2d _

Court of Appeals’ docket no. 322108, rel’d 10/22/2015

In *Covenant*, the Court of Appeals sent shockwaves throughout the no-fault world when it reversed a lower court’s ruling, and allowed a medical provider to pursue a no-fault insurer for payment of its medical expenses, even though the patient himself had signed a release, specifically discharging the no-fault insurer from any obligation to pay the disputed medical expenses. Thus, the no-fault insurer must now pay twice for the same medical expense.

In *Covenant*, its patient, Jack Stockford, had incurred medical expenses totaling just under \$44,000.00. His no-fault insurer, State Farm, had denied the claim due to causation. Stockford had filed his own separate lawsuit against State Farm, and eventually agreed to settle his claim against State Farm for \$59,000.00. The release contained an agreement that Stockford would “indemnify, defend and hold harmless”

Because State Farm had written notice of the claim presented by Covenant, the release signed by its insured, Covenant’s patient, was not binding on the medical expense claims presented by Covenant Medical Center.

State Farm from “any liens or demands made by any provider . . . including . . . Covenant Medical . . . for payments made or services rendered.” Covenant Medical Center subsequently filed its own lawsuit against State Farm, seeking to recover payment of the disputed medical expenses. State Farm filed a motion for summary disposition, arguing that the provider’s claim was barred by the release entered into between its patient, Stockford, and State Farm. The lower court agreed.

However, on appeal, the Court of Appeals reversed. Relying on MCL 500.3112, the Court of Appeals observed that because State Farm had Stockford’s medical and billing records in its file at the time it negotiated the settlement directly with Stockford, it had run afoul of MCL 500.3112, which provides:

“Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer’s liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person.”

Because State Farm had written notice of the claim presented by Covenant, the release signed by its insured, Covenant’s patient, was not binding on the medical expense claims presented by Covenant Medical Center. State Farm did file a timely Application for Leave to Appeal with the Michigan Supreme Court, which remains pending as of the date this article is being prepared.

This case has been the subject of much commentary. See e.g., Sevanthinathan and Burkhart, “Covenant: Enemy of the PIP Settlement,” *Michigan Lawyers Weekly*, January 4, 2016, as well as an article submitted by this author that will appear in an upcoming edition of *Michigan Defense Quarterly* magazine. Suffice it to state that this decision has generated much controversy as the no-fault world grapples with how to handle PIP settlements.

Medical Providers Allowed to Pursue Payment for Their Medical Expenses, Even Though Their Patients Failed to Comply with Policy Provisions Requiring Attendance at EUOs and IMEs

Chiropractors Rehab Group PC v State Farm

_ Mich App _, _ NW2d _

Court of Appeals docket no. 320288 rel'd 10/29/2015

In *Chiropractors Rehab*, the injured claimants in these consolidated cases were injured under suspicious circumstances. Both injured claimants were requested to appear for Examinations Under Oath and Independent Medical Evaluations by their insurer, State Farm. Both claimants refused to appear and cooperate with the insurer in its investigation into the claims. Their medical providers subsequently filed suit in the District Court, seeking to obtain payment for the medical expenses incurred by the injured claimants. State Farm filed a motion for summary disposition, arguing that the providers' claims were barred based upon the claimants' failure to comply with the policy provisions regarding appearance at Examinations Under Oath and Independent Medical Evaluations. The District Court denied State Farm's motions, and the Circuit Courts refused to hear the Interlocutory Appeals.

The Court of Appeals granted State Farm's application for leave to appeal. State Farm argued that the providers' ability to recover benefits is dependent on whether the injured claimant would be eligible to receive PIP benefits. State Farm contended that both claimants were ineligible to recover benefits due to their failure to comply with the policy provisions. The Court of Appeals disagreed and noted that the injured claimants' ability to recover benefits had only been suspended, based upon their failure to cooperate. A suspension of benefits was simply not the same a declaration of ineligibility to recover benefits. Furthermore, in one of the consolidated cases, the Court of Appeals reversed the lower court's decision and allowed State Farm to amend its Affirmative Defenses, to plead that an underlying claimant's ineligibility for benefits precludes the provider's cause of action.

State Farm has filed an application for leave to appeal with the Michigan Supreme Court.

Court of Appeals Rules That No-Fault Insured is not Liable for Payment of Property Protection Insurance Benefits, Even Though Insurer was Undoubtedly the "Insurer of the Owner of the Motor Vehicle" Involved in the Incident Under MCL 500.3125.

MEEMIC Ins Co v Michigan Miller's Mut'l Ins Co

_ Mich App _, _ NW2d _

Court of Appeals docket no. 322072, rel'd 10/27/2015

In *MEEMIC*, MEEMIC Insurance Company, a homeowners insurance carrier, filed suit against two No-fault insurance carriers, seeking to recover reimbursement for property losses

paid by MEEMIC as a result of a fire that occurred in a commercial storage facility while a motor vehicle was being maintained. The specific motor vehicle involved in the incident, a 1966 Corvette, was insured for comprehensive coverage through State Farm, as permitted under MCL 500.3101(1). The owner of the Corvette owned other motor vehicles insured by Home-Owners Insurance Company. Therefore, MEEMIC amended the Complaint to add Home-Owners Insurance Company as a party defendant, arguing that it was the "insurer of the owner or registrant of the motor vehicle" involved in the property damage claim, even though Home-Owners Insurance Company did not insure the actual vehicle.

In its opinion, the Court of Appeals conceded that with regard to a claim for PIP benefits, the Court of Appeals had construed similar language contained in the priority section to render a no-fault insurer responsible for payment of no-fault benefits, even though it did not insure the particular motor vehicle involved in the accident. See e.g., *Titan Ins Co v American Country Ins Co*, _ Mich App _, _ NW2d _ (11/15) (docket nos. 319342 and 321598); *Farmers Ins Exch v Farm Bureau*, 272 Mich App 106, 724 NW2d 485 (2006); *Pioneer State v Titan Ins Co*, 252 Mich App 330, 652 NW2d 469 (2002). However, the Court of Appeals noted that Property Protection Insurance coverage, along with the other mandatory coverages, "shall only be required to be in effect during the period the motor vehicle is driven or moved upon a highway." See MCL 500.3101(1). Therefore, because the 1966 Corvette was not being "driven or moved upon a highway" at the time it caught fire, during the maintenance activities, and because the vehicle was insured by State Farm with comprehensive coverage, Home-Owners Insurance Company could lawfully exclude the Corvette from coverage under the no-fault policy that it issued to the owner of the Corvette, covering the other motor vehicles.

Injured Claimant's Medical Records, Describing How an Injury Occurred, were Admissible as Substantive Evidence, Even Where the Injured Claimant Himself Could not be Located to Testify

Hurley Med Ctr v Michigan Assigned Claims Plan,

Court of Appeals docket no. 320936

unpublished decision rel'd 6/18/2015

In *Hurley Med Ctr*, one Craig Makela, a homeless individual, was injured after jumping from a moving vehicle to avoid being robbed. After being discharged from plaintiff's facility, Mr. Makela could not be located again, and there was no way to determine whether or not there were any other insurers available to pay the medical expenses at issue. Hurley Medical Center subsequently filed a claim with the Michigan Assigned Claims Plan, which denied coverage as there was insufficient evidence to show that Makela was entitled to no-fault benefits. Hurley subsequently filed suit.

The court also noted that the boards that fell out of the trailer and stuck Plaintiff were not “property” which was being lifted onto or lowered from the vehicle in the loading or unloading process. At best, plaintiff was injured while engaged in acts preparatory to the eventual loading or unloading of the property. It was undisputed that the boards were not going to be unloaded at the driver’s destination.

Efforts to depose Makela, during the pendency of the Circuit Court litigation, proved fruitless. The MACP then filed a motion for summary disposition, arguing that the statements contained in the medical records, regarding the etiology of Makela’s injuries, were inadmissible. Furthermore, the MACP argued that even if the medical records and statements were admissible, they were insufficient to show that the injuries were accidental, and not intentional. The Circuit Court granted summary disposition in favor of the MACP, and the provider appealed.

In a 2-1 decision, the Court of Appeals reversed the decision of the trial court. In doing so, the Court of Appeals held that Makela’s statement regarding the “cause or external source” of his injuries were admissible under MRE 803(4). Furthermore, the medical records themselves were admissible as a business record, pursuant to MRE 803(6). With regard to the “intentional act” exclusion found in MCL 500.3105(4), the Court of Appeals determined that there was sufficient evidence for a reasonable juror to conclude that Makela jumped from the moving vehicle to avoid being robbed, and his injuries were therefore the “unintended result of an intentional act,” relying on *Frechen v DAIIE*, 119 Mich App 578, 326 NW2d 566 (1982). Therefore, the issue should be submitted to the jury for resolution.

Judge Gadola dissented, arguing that the statements made by Makela “were not sufficiently reliable to warrant admission under MRE 803(4).” Judge Gadola further observed that the statements Makela made to the psychologist, regarding the mechanism of his injuries, “were not reasonably necessary for his medical treatment or diagnosis.”

Provider’s Claim is Barred Where an Earlier Action had Determined that the Claimant had Fully Recovered from Any Injuries He Suffered in a Motor Vehicle Accident, Prior to Commencement of Treatment with the Provider

Garden City Rehab LLC v State Farm
Court of Appeals docket no. 320543
unpublished decision rel’d 6/18/2015

In *Garden City Rehab*, the provider filed suit against State Farm to recover payment of medical expenses incurred by its

patient, Ali Elchami, from February 24, 2012, through April 5, 2012, allegedly stemming from a motor vehicle accident that occurred in 2009. Its patient, Elchami, had previously filed a lawsuit against State Farm, which eventually went to a bench trial. In the bench trial, the Court specifically found that Elchami had recovered from whatever injuries he may have suffered in the 2009 motor vehicle accident, and was not entitled to any no-fault benefits after October 5, 2010. Based on this earlier determination, which had not been appealed, the Court of Appeals ruled that the provider’s claim for payment of medical expenses incurred two years after the date of its patient’s recovery was barred by collateral estoppel and *res judicata*. In support of its decision, the Court of Appeals relied heavily on its earlier, published decision in *TBCI PC v State Farm*, 289 Mich App 39, 795 NW2d 229 (2010).

Mosby specifically argued that she should be deemed a “named insured” under the policy, because she was listed as a “driver” under the policy. The Court of Appeals rejected this argument, noting that the terms “named insured” and “other drivers” are not synonymous . . .

Plaintiff Who was Injured After Being Struck by Boards, Which had Fallen out of a Trailer Door, Found not to be Entitled to Recover No-Fault Benefits

Gallagher v Northland Farms LLC
Court of Appeals docket no. 321976
unpublished decision rel’d 7/14/2015

In *Gallagher*, Plaintiff was transporting some plants to a florist. After arriving at the destination, he discovered that no employees were present as of yet. He decided to open the trailer doors and, in doing so, he was struck by some boards that had apparently been stacked against the trailer wall by the individuals who had loaded the plants on the trailer. Plaintiff filed a claim for no-fault benefits against the truck’s insurer and his personal motor vehicle insurer. Both insurers denied the claims, based upon the “Parked Vehicle Exclusion” set forth in MCL 500.3106. The Circuit Court granted summary disposition in favor of the insurers.

On appeal, the Court of Appeals affirmed the decision of the lower court and found that plaintiff’s injuries were not compensable. Specifically, the Court of Appeals noted that plaintiff was not injured as a “direct result of physical contact with equipment permanently mounted on the vehicle,” because the door to the trailer was actually an integral part of the trailer, relying on the Michigan Supreme Court’s decision in *Frazier v Allstate Ins Co*, 490 Mich 381, 808 NW2d 450 (2011). The court also noted that the boards that fell out of

the trailer and stuck Plaintiff were not “property” which was being lifted onto or lowered from the vehicle in the loading or unloading process. At best, plaintiff was injured while engaged in acts preparatory to the eventual loading or unloading of the property. It was undisputed that the boards were not going to be unloaded at the driver’s destination. Therefore, Plaintiff was not entitled to recover no-fault benefits.

Even Though Insurer Undoubtedly Insured the Motor Vehicle Occupied by Plaintiff, No-Fault Insurer not Obligated to Pay No-Fault Benefits Pursuant to the Terms of the Insurance Contract

Culbert v Starr Indemnity & Liability Co
Court of Appeals docket no. 320784
unpublished decision rel’d 7/16/2015

In *Culbert*, three individuals, Mosby, Culbert and Williams were involved in a motor vehicle accident while Mosby was driving a 2007 Chrysler PT Cruiser. The vehicle was insured by Starr Indemnity under a policy that had been purchased by Mosby’s boyfriend, Fudge. However, only Fudge was listed as a named insured on the policy. Both Mosby and Fudge were listed as drivers in the insurance application. In the application, Fudge had falsely represented that he owned all of the vehicles listed in the application, even though he was not the owner of the PT Cruiser involved in the accident. Mosby and the other occupants filed a claim for no-fault benefits against Starr Indemnity Company, which was denied.

Plaintiffs argued that they were entitled to benefits from Starr Indemnity pursuant to MCL 500.3114(1). Mosby specifically argued that she should be deemed a “named insured” under the policy, because she was listed as a “driver” under the policy. The Court of Appeals rejected this argument, noting that the terms “named insured” and “other drivers” are not synonymous, relying on *Stone v Auto-Owners Ins Co*, 309 Mich App 169, 858 NW2d 765 (2014). Only Fudge was the named insured. Because none of the occupants were related to Fudge, they were not entitled to claim benefits under this section.

The three injured Plaintiffs then argued that they were entitled to benefits under MCL 500.3114(4), noting that Starr Indemnity Company was the insurer of the owner or registrant of the motor vehicle they were occupying at the time of the accident. The Court of Appeals undertook an exhaustive, step-by-step analysis of the applicable policy language, and noted that none of the occupants qualified as an “insured” under the policy. The Court of Appeals likewise noted that the PT Cruiser was not even considered “Your Covered Auto,” as that term was used in the policy, because its named insured, Fudge, was not required to insure the vehicle because he simply did not own it. The court likewise concluded that Starr Indemnity was not obligated to pay uninsured motorist benefits, either. Accordingly, the Court of Appeals reversed the Circuit Court’s

decision to the contrary and remanded the matter back to the Circuit Court for entry of judgment in favor of the insurer.

Daughter Who was Injured in a Motor Vehicle Accident Occurring Eight Months After She Moved Out of Parents’ Home not Entitled to Recover No-Fault Benefits, Even Though Parents Continued to Insure the Involved Motor Vehicle

Hoskins v Miller

Court of Appeals docket no. 320150
unpublished decision rel’d 7/16/2015

This case, like the previous case, graphically illustrates the problems with insuring vehicles that the named insured does not own. In *Hoskins*, Plaintiff’s parents had purchased a 2003 Ford Focus for their daughter’s use. Plaintiff’s father was the titled owner of the Focus and Plaintiff’s parents obtained insurance on the Focus through Home-Owners Insurance Company. Although Plaintiff was not named as an insured, she was designated as a principal operator of the Ford Focus.

Plaintiff moved out of her parents’ home and reimbursed her father for the loan that he had taken out to pay for the car. Her father subsequently transferred title to the Plaintiff on April 18, 2011. Plaintiff did not obtain an insurance policy of her own to cover the vehicle, but her parents continued to insure the vehicle under their policy. In January 2012, Plaintiff was injured while driving the Ford Focus. Defendant denied coverage for this loss and Plaintiff filed suit. The Circuit Court determined that there were genuine issues of material fact as to whether Plaintiff was entitled to recover no-fault benefits, thereby denying the insurer’s Motion for Summary Disposition. The insurer then filed an Application for Leave to Appeal with the Michigan Court of Appeals, which was granted.

On appeal, the Court of Appeals again held that simply being designated as a “driver” or “principal operator” on a policy does not elevate that individual to the status of a “named insured,” again relying on its earlier decision in *Stone v Auto-Owners Ins Co*, 307 Mich App 169, 858 NW2d 765 (2014). Furthermore, the Court observed that Plaintiff was not a “relative . . . domiciled in the same household” as her parents, at the time of the accident. Therefore, she was not eligible for benefits under MCL 500.3114(1).

Similarly, the Court of Appeals rejected Plaintiff’s argument that she was entitled to benefits under MCL 500.3114(4). This statute provides that occupants of a motor vehicle shall secure payment of no-fault benefits from

“The insurer of the owner or registrant of the vehicle occupied.”

Under the terms of the policy, her parents were simply not the owner or registrant of the involved vehicle – she was.

The court likewise rejected plaintiff’s arguments that the policy should be reformed, because there was no indication

that the Auto-Owners Insurance policy at issue violated public policy or contravened the legislative intent of the No-Fault Act. The court also rejected plaintiff's arguments that she should be entitled to benefits because she was an "innocent third party" to the insurance transactions between her parents and Auto-Owners Insurance Company.

Again, the lesson here is that red flags must be raised whenever one is dealing with an injury arising out of the use of a motor vehicle that one owns, but is insured by someone else. Courts are taking a much closer look at these cases and almost invariably are concluding that no coverage is warranted, even though the vehicle itself is undoubtedly insured by the insurer.

[t]he Court of Appeals again held that simply being designated as a "driver" or "principal operator" on a policy does not elevate that individual to the status of a "named insured," . . .

In a Priority Dispute, Insurer Found not to be Liable for Injuries Suffered by Injured Motorcyclist Where Owner and Operator of the Motor Vehicle were Determined not to be "Insureds" Under Their Respective Parents' Policies

Wolverine Mut'l Ins Co v State Farm
Court of Appeals docket no. 322318
unpublished decision rel'd 7/21/2015

In this case, Wolverine Mutual was the motor vehicle insurer of an injured motorcyclist and his wife. Wolverine Mutual paid benefits under MCL 500.3114(5)(c) and sought recoupment from State Farm, arguing that State Farm occupied a higher order of priority under MCL 500.3114(5)(a) as the insurer of the owner or registrant of the motor vehicle

under a policy issued to the owner's parents, or under MCL 500.3114(5)(b), as the insurer of the operator of the motor vehicle, under a policy issued by State Farm to his parents. Shawnah-May's parents and Jonathan's parents were both insured under State Farm policies.

The lower court apparently determined that Shawnah-May and Jonathan were domiciled in Jonathan's parents' household, and ordered State Farm to reimburse Wolverine for the benefits that Wolverine Mutual had paid. State Farm appealed. After examining the facts that had developed regarding Shawnah-May and Jonathan's domicile, at the time of the motor vehicle-motorcycle accident, the Court of Appeals concluded, as a matter of law, that Shawnah-May and Jonathan were not domiciled with her parents at the time of the accident. Shawnah-May testified that she intended the move from her parents' home in November 2011 to be permanent and she never intended to return there. In fact, the evidence presented showed that as long as Shawnah-May and Jonathan continued to live together, and not get married, she would not be permitted to live in her parents' home. Therefore, State Farm would not be considered the insurer of the owner or registrant of the motor vehicle involved in the accident pursuant to MCL 500.3114(5)(a), under the policy issued to her parents.

With regard to whether or not State Farm occupied the next highest order of priority, as the insurer of the operator of the motor vehicle, the Court of Appeals noted that there was nothing in the record that would have allowed the lower court to find that State Farm was Jonathan's insurer. Therefore, the Court of Appeals vacated the lower court's ruling and remanded the matter back to the lower court to allow Plaintiff an opportunity to amend its Complaint to specifically allege that Jonathan's parents' policy with State Farm provided coverage at the time of the occurrence. ■

**ERISA
Case
Summary**


ERISA Decisions of Interest

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Sixth Circuit Court of Appeals Update

Denial Of Ltd Claim was Arbitrary and Capricious Where the Claimant's Mental Illness Prevented Her From Meeting a Reporting Deadline

Waskiewicz v Unicare Life and Health Ins. Co., 802 F.3d 851 (6th Cir., Dec. 7, 2015)

The Ford Motor Company Salaried Disability Plan (the "Plan") at issue provided that in order to be eligible to receive disability benefits, a claimant must be an active employee with a disability, provide proof of the disability and medical treatment, and be unable to engage in regular employment with the company. This type of language is common in many disability plans.

The Plan also provided that, if an employee was absent from work for more than five consecutive work days, the employee was required to notify both the company and the disability claim administrator. Failure to provide medical evidence or other authorization supporting an absence lasting longer than five days could result in termination. After being notified of termination, an employee was no longer eligible for disability benefits after the date of notification.

This case presented the unique confluence of those Plan provisions in a situation where the claimant, who suffered a mental breakdown, was unable to notify her employer that she was unable to return to work due to her disability.

A few weeks after the plaintiff last appeared for work, her employer sent a letter terminating her employment for failure to report to work or to justify her absence, effective the day after she last reported for work. According to the administrative record, the plaintiff's parents checked on her after no contact for several weeks and found her barricaded inside her home, in a catatonic state. The plaintiff's parents filed a claim

for disability benefits on her behalf a few weeks later. Because the claim was filed approximately six weeks after the effective date of termination from employment, her claim was denied. The district court agreed with the claim administrator that she was not eligible for benefits because she was not an "active" or "covered" employee at the time of her claim as defined by the Plan, due to her retroactive termination.

The Sixth Circuit reversed, despite a discretionary standard of review which typically results in deference to the claim fiduciary's determination. The opinion noted that the plaintiff's failure to comply with the Plan's absence notification requirements appeared to be the direct result of severe mental illness which was the basis for her claim. The court found that the claim fiduciary's application of Plan terms was contrary to the spirit of ERISA, which is designed to protect employee benefits, and contrary to other language of the Plan at issue, which protected an employee from reduction or termination of ongoing benefits upon leaving the company for another reason if the employee was disabled at that time.

Accordingly, the case was remanded for the plaintiff to be allowed to provide proof that her alleged failure to provide notice of the reason for her absence from work was due to the very disability for which she sought benefits. ■

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