

1992

# Liberty Mutual Insurance v. Jaren Baxter, Joanne Baxter, Mary Ellen Boulter, Daryl Crape and John Does : Brief of Appellant

Utah Court of Appeals

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## Recommended Citation

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UTAH COURT OF APPEALS  
BRIEF

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DOCKET NO. 92-0301 CA

IN THE SUPREME COURT OF UTAH

LIBERTY MUTUAL INSURANCE  
GROUP,

Plaintiff/Appellee,

vs.

JAREN BAXTER, JOANNE BAXTER,  
MARY ELLEN BOULTER, DARYL  
CRAPE and JOHN DOES,

Defendants/Appellants.

:

:

:

:

:

:

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Case No. 920049  
Subject to Assignment to  
the Court of Appeals

92-0301-<sup>1</sup>

Priority No. 16

BRIEF OF APPELLANT

AN APPEAL FROM THE FINAL ORDER AND JUDGMENT  
GRANTING PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT  
THIRD JUDICIAL DISTRICT COURT OF SALT LAKE COUNTY  
The Honorable James S. Sawaya, Presiding

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Attorney for Appellee

IN THE SUPREME COURT OF UTAH

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LIBERTY MUTUAL INSURANCE	:	
GROUP,	:	
	:	Case No. 920049
Plaintiff/Appellee,	:	Subject to Assignment to
	:	the Court of Appeals
vs.	:	
	:	
JAREN BAXTER, JOANNE BAXTER,	:	
MARY ELLEN BOULTER, DARYL	:	
CRAPE and JOHN DOES,	:	Priority No. 16
Defendants/Appellants.	:	

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vs.	:	
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MARY ELLEN BOULTER, DARYL	:	Civil No. 920049
CRAPE and JOHN DOES,	:	
	:	Priority No. 16
Defendants/Appellants.	:	
	:	

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JURISDICTION

This Court has jurisdiction over this appeal pursuant to §78-2-2(j), U.C.A.

STATEMENT OF THE ISSUE PRESENTED FOR REVIEW

1. Was summary judgment in favor of Liberty Mutual warranted under the facts in this case?
2. Did Baxters and Boulter state a cause of action against Liberty Mutual in their counterclaim which could be the matter of summary judgment proceedings?
3. Does the insured have a first party cause of action against their own carrier, who had written uninsured motorist, for failure to bargain in good faith?

4. Do the Baxters and Boulter have a cause of action entitling them to have the issue of punitive damages decided by the trier of facts?

#### STANDARD OF APPELLANT REVIEW

The trial court granted Liberty Mutual summary judgment as a matter of law on the issue of its breach of duty of good faith and fair dealing. Granting summary judgment on this issue rendered the court's consideration of the other issues moot. Because the trial court granted summary judgment as a matter of law, the appellate court need not give deference to the trial court's legal conclusions and should review the issue de novo. In specifying the standard of review for summary judgment, the court in Pixton v. State Farm, stated: "Because summary judgment is not granted as a matter of fact, but rather as a matter of law, the trial court's legal conclusions are to be reviewed for correctness." 809 P.2d at 748.

#### DETERMINATIVE STATUTES AND ADMINISTRATIVE RULES

Utah Code Ann., §31A-23-219

Utah Code Ann., §31A-26-303(4)

Utah Code Ann., §31A-26-303(5)

Utah Code Ann., §78-18-1(1)(a)

Unfair Claims Settlement Practices Rule, R.540-89

#### STATEMENT OF THE CASE

Jaren and Joanne Baxter ("Baxter") and Mary Ellen

Boulter ("Boulter") defendants and counterclaimants below appeal a summary judgment order granted in favor of Liberty Mutual Insurance Group ("Liberty Mutual"), the plaintiff below. Liberty Mutual sought declaratory relief to determine that one Daryl Crape, an alleged tortfeasor was an insured motorist and to set aside a default judgment that was granted to Baxters and Boulter due to an accident involving Crape as an uninsured motorist. The trial court ruled that the default judgment was binding on Liberty Mutual for purposes of an uninsured motorist provision in it's insurance contract with Baxters and Boulter. Baxters and Boulter in the civil action being the subject of this appeal filed a counterclaim against Liberty Mutual for a breach of its duty to act in good faith and to deal fairly. Liberty Mutual finally paid on the uninsured motorist claim, leaving the issue of the counterclaim in which Liberty Mutual was granted summary judgment. It is this summary judgment that is the subject of this appeal.

#### STATEMENT OF THE FACTS

1. Joanne Baxter as the driver of a vehicle insured by Liberty Mutual and Baxter's mother, Mary Ellen Boulter, who was a passenger, were involved in an automobile accident on April 28, 1989. (R. at 334)

2. Daryl Crape was the driver of the vehicle which collided with Baxter's vehicle. (R. at 334)



3. Jaren Baxter, husband of Joanne Baxter, contacted Liberty Mutual and informed it of the accident on April 28, 1989, (R. at 239) the same day of the accident.

4. After not receiving any information from either Mr. Crape nor Liberty Mutual, Robert M. McRae, counsel for Baxters and Boulter, informed Liberty Mutual, in writing, on July 12, 1989, that a possible uninsured motorist claim existed. (R. at 340)

5. On August 24, 1989, Liberty Mutual sent a letter to McRae stating it would wait for evidence regarding the uninsured motorist situation from McRae's office. (R. at 346)

6. After hearing nothing more from Liberty Mutual, a default judgment was obtained against Crape on October 16, 1989. (R. at 354)

7. On October 30, 1989, McRae sent Liberty Mutual notice of default judgment obtained against Crape and inquired as to whether Liberty Mutual was going to pay on the claim. (R. at 348)

8. After no further contact, on January 4, 1990, Liberty Mutual filed a Declaratory Complaint seeking a declaration as to whether the default judgment against Crape was binding for purposes of the uninsured motorist claim and to also set aside the default judgment. (R. at 02-08)

9. On July 5, 1990, Baxters and Boulter amended their answer and added a counterclaim against Liberty Mutual wherein it argue that Liberty Mutual by its conduct did breach its duty of good faith and fair dealing. (R. at 365-67)

10. Several motions were filed by Liberty Mutual's counsel in this case attempting to obtain partial summary judgment which were denied. (R. at 193, 407)

11. A final order in the Crape case denying said motions was entered on August 13, 1991, denying a motion filed by Liberty Mutual's counsel to set aside the default judgment against Crape. (R. at 407)

12. Liberty Mutual tendered payment of \$20,000.00 to Baxters and \$8,500.00 to Boulter, plus interest, to settle the Crape case, which tender was accepted. (R. at 310)

13. Liberty Mutual filed a Motion for Summary Judgment on November 15, 1991, seeking to have the bad faith claim dismissed. (R. at 422)

14. Summary Judgment was granted in favor of Liberty Mutual on December 23, 1991. (R. at 460)

15. It is this grant of summary judgment in favor of Liberty Mutual that is the subject of this appeal.

#### SUMMARY OF THE ARGUMENT

In granting summary judgment in favor of Liberty Mutual, the trial court relied on the Memorandum in Support of

Summary Judgment provided by Liberty Mutual. The authorities relied on however, are easily distinguishable from this case. The facts in this cases give rise to an action based on Liberty Mutual's breach of its duty to act in good faith and to deal fairly with its insureds, Baxters and Boulter. This breach caused Baxters and Boulter to sustain substantial damages. This Court should remand the case to the district court for a trial on the merits.

#### ARGUMENT

#### POINT I

#### SUMMARY JUDGMENT IN FAVOR OF LIBERTY MUTUAL WAS NOT WARRANTED UNDER THE FACTS OF THIS CASE

In Pixton v. State Farm, 809 P.2d 746, 48 (Utah Ct. App. 1991) the Utah Court of Appeals stated that summary judgment is appropriate only when there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. (Citing Ehlers & Ehlers Architects v. Carbon County, 805 P.2d 789, 791 (Utah Ct. App. 1991); Shire Dev. v. Frontier Inv., 799 P.2d 221, 222-23 [Utah Ct. App. 1990]). The facts and inferences are to be viewed in a light most favorable to the losing party and the judgment is to be affirmed only where there is no genuine dispute as to a material fact or where, viewing the facts as contended by the losing party, the moving party is entitled to judgment as a

matter of law. Id. Because summary judgment is not granted as a matter of fact, but rather as matter of law, the trial court's legal conclusions are to be reviewed for correctness. Id. In this case the District Court below, relying on Liberty Mutual's Memorandum in Support of Summary Judgment, found that Utah case law holds that summary judgment is appropriate in insurance cases where there is an issue of bad faith, even though that issue is disputed. (R. at 312-13, 459-60). Under the facts of this case, however, summary judgment in favor of Liberty Mutual was not appropriate and none of the authority relied on in the court below so holds.

The authority relied upon by the court below on this issue consists primarily of three Utah appellate cases. The first case is Pixton v. State Farm, supra (R. at 312). Pixton involved a third-party claim against an insured's insurer based on a breach of the duty of good faith and fair dealing. 809 P.2d at 747. The trial court granted summary judgment in favor of the insurer, notwithstanding the existence of an affidavit of an expert stating that the insurer had breached its duties of good faith and fair dealing, thereby creating a disputed issue. Id. The Utah Court of Appeals affirmed, holding that there is no duty of good faith and fair dealing running from an insurer to a third-party where there is no privity of contract. Id. at 751. The court stated that the

expert witness' affidavit was simply irrelevant as there was no duty owed by the insurer.

While Pixton is undisputedly the law in Utah as to third-party bad faith claims, the present case involves first-party claimants. There is direct privity of contract between Liberty Mutual and its insureds, Baxters and Boulter. This first-party claimant action based on a breach of the duty of an insurer to deal fairly and act in good faith with its insured was recognized in Beck v. Farmers Ins. Exch., 701 P.2d 795 (Utah 1985). Beck involved an insured who sought damages against his insurer as a first-party claimant due to the insurer's breach of its duty of good faith and fair dealing. Id. at 796,97. Beck will be discussed in greater detail in Point II.

The court below also relied on Amica Mutual Ins. Co. v. Schettler, 768 P.2d 950 (Utah Ct. App. 1989). (R. at 312) Amica involved a claimant who alleged bad faith against his insurance company based on the insurance company assisting a county attorney to prosecute the claimant for insurance fraud. Id. at 958. Similarly, the court below further relied on Callioux v. Progressive Ins. Co., 745 P.2d 838 (Utah Ct. App. 1987). (R. at 312) Callioux also involved allegations of insurance fraud against its insured. Id. at 839. The alleged bad faith consisted of the insurer delaying payment during criminal proceedings for insurance fraud against the

claimant. Id. at 839. It is important to note that immediately following the proceedings, the insured tendered payment to the exonerated claimant. Id. The Court of Appeals held in both cases that summary judgment was appropriate.

The facts of this case are much different than any of the cases relied on by the District Court below. Point II discusses how, even taking Liberty Mutual's version of the facts, its conduct constitutes a clear breach of its duty of good faith and fair dealing that it owed to its insureds, Baxters and Boulter.

#### POINT II

LIBERTY MUTUAL'S CONDUCT CONSTITUTED A BREACH OF ITS DUTY OF GOOD FAITH AND FAIR DEALING THEREBY GIVING BAXTERS AND BOULTER A CAUSE OF ACTION.

Baxters' and Boulter's counterclaim alleged that Liberty Mutual breached its duty of good faith and fair dealing in one or more of the following respects:

- a) Failure to timely and diligently investigate its liability exposure to its insured;
- b) . . .
- c) Failure to act in good faith in performing its implied contractual obligation to a first-party insurance contract claim;
- d) . . .

(R. at 42-45)

It is useful to examine this standard of good faith and fair dealing that was recognized in Beck. Justice Zimmerman, speaking for the Court, stated:

the implied obligation of good faith performance contemplates, at the very least, that the insurer will diligently investigate the facts to enable it to determine whether a claim is valid, will fairly evaluate the claim, and will thereafter act promptly and reasonably in rejecting or settling the claim. The duty of good faith also requires the insurer to deal with laymen as laymen and not as experts in the subtleties of law and underwriting and to refrain from actions that will injure the insured's ability to obtain the benefits of the contract. These performances are the essence of what the insured has bargained and paid for, and the insurer has the obligation to perform them. When an insurer has breached this duty, it is liable for damages suffered in consequence of that breach.

701 P.2d at 801. (Citations omitted)

To further define this standard of good faith and fair dealing, we look to Utah Code Ann. §31A-26-303(4). This section empowers the Insurance Commissioner to define by rule, acts or general business practices which are unfair claim settlement practices. The Commissioner, pursuant to this statute, has promulgated Rule R540-89 entitled Unfair Claims Settlement Practices Rule. The pertinent sections of this rule are:

R540-89-10. FAILURE TO ACKNOWLEDGE PERTINENT COMMUNICATIONS. A. Every insurer, upon receiving notification of a claim shall, within 15 days, acknowledge the receipt of such notice unless payment is made within such period of time, . . .

R540-89-11. STANDARD FOR PROMPT INVESTIGATION OF CLAIMS. Every insurer shall complete investigation of a claim within 45 days after notification of claim,. .

R540-89-12. MINIMUM STANDARDS FOR PROMPT, FAIR AND EQUITABLE SETTLEMENTS APPLICABLE TO ALL INSUREDS.

B. Within 30 days after receipt by the insurer of properly executed notice of loss, the insurer shall complete its investigation of the claim and the first party claimant shall be advised of the acceptance or denial of the claim by the insurer unless the investigation cannot be completed within 30 days the insurer shall so communicate to the claimant and shall continue to communicate every 30 days until the claim is either paid or denied.

Id.

The facts in this case are undisputed. Even looking to Liberty Mutual's version of the facts, Baxters and Boulter can show that Liberty Mutual clearly breached its duty of good faith and fair dealing with them. To examine Liberty Mutual's version of the facts, we turn to its Memorandum in Support of its Motion for Summary Judgment. Again it is important to note that these are the same facts relied on by the District Court in its Order granting Summary Judgment. (R. at 459-60)

The facts state that on July 12, 1989, counsel for Baxters provided Liberty Mutual with a copy of the Summons, Complaint and Return of Service in the lawsuit initiated against Crape by Baxters and Boulter. Baxters and Boulter however claim that notice was given to Liberty Mutual on the same day as the accident. (R. at 239) Also included in this correspondence was a letter from counsel which stated that



there was evidence that Crape was uninsured. On August 24, 1989, some 43 days later, Liberty Mutual wrote to counsel for Baxters and Boulter acknowledging the claim and stating that a file would be opened. In this letter Liberty Mutual stated that it would await evidence regarding the uninsured motorist claim from Baxters' and Boulter's counsel. (Addendum E)

After hearing nothing more from Liberty Mutual, counsel for Baxters and Boulter sent a letter to Liberty Mutual that was received on October 30, 1989. (Addendum F) The letter informed Liberty Mutual that a default judgment had been entered against Crape. The letter also asked whether Liberty Mutual was going to pay on the uninsured motor claim. About 67 days later, on January 4, 1990, and without any further contact with Baxters, Boulter, or their counsel, Liberty Mutual filed this complaint seeking a declaration as to whether the default judgment was binding for the purposes of the uninsured motorist coverage and whether or not Crape was insured.

On or about March 21, 1990, Baxters and Boulter certified the matter as being ready for trial. Liberty Mutual objected and the Court agreed the matter was not ready for trial. On or About July 5, 1990, Baxters and Boulter added a counterclaim against Liberty Mutual for breaching its duty of good faith and fair dealing with its insureds. On December

28, 1990, Liberty Mutual filed a Motion for Partial Summary Judgment seeking to have the default judgment held to not be binding upon it and to set it aside. This motion was denied on August 13, 1991. Final judgment was also entered on that date. (R. at 407)

On October 28, 1991, Liberty Mutual filed another summary judgment motion seeking to have the bad faith claim dismissed. (R. at 260) Liberty Mutual then tendered payment of the uninsured motorist policy limits to Baxter, and paid Boulter, the judgment amount of \$8,500.00 plus interest, after more than two and one-half years of delay. (R. at 263) (R. at 301-11)

It is the granting of Liberty Mutual's Motion for Summary Judgment on the bad faith claim that is the subject of this appeal.

Liberty Mutual has breached its duty of good faith and fair dealing to its insureds many times throughout the course of the claim maintained by Baxters and Boulter. The first instance of this breach was the 43 days it took Liberty Mutual to acknowledge the receipt of the claim. This was nearly three times as long as the 15 day standard set forth in the insurance rules. Liberty Mutual's next effort to respond to the claim was when it filed a declaratory complaint, 67 days after Baxters' and Boulter's counsel had notified Liberty Mutual regarding the default proceedings and renewing the claim. Although a declaratory complaint was filed 67 days

after contact by Baxters' and Boulter's counsel, over 130 days had lapsed without Liberty Mutual making any attempt to investigate or resolve the matter. Again this is not taking into account that initial notification of the claim was made on the day of the accident.

Liberty Mutual breached its duty of good faith and fair dealing in several other respects as well. It breached its duty by not meeting the 45 day standard to complete its investigation of the claim when it was first made. In fact, Liberty Mutual did not make any attempt to investigate the claim. Further Liberty Mutual breached the 30 day contact standard, as there was only a single instance where it corresponded with its insureds between it receiving notification of the claim on the accident date of April 28, 1989, a letter to Boulter's counsel wanting evidence of Crape's uninsured status dated August 12, 1989 (Addendum F) and the filing of the Declaratory Complaint in January of 1990. There was a total lack of promptness and diligence in the way Liberty Mutual handled this claim. Liberty Mutual having not make any attempt to investigate the claim, it did not provide any assistance to do so.

Liberty Mutual argued in its Motion for Summary Judgment that the insurance rules specifying various time limits within which insurance companies have to act do not create a cause of action for private parties. (R.318) This is true. The statute authorizing these rules states: "This

section does not create any private cause of action." Utah Code Ann. §31A-26-303(5), Baxters and Boulter, however, do not base their counterclaim on these rules. Rather they base their cause of action on the implied duty of good faith and fair dealing that was recognized in Beck. The insurance rules merely reflect standards of and help define the insurer's duty of good faith and fair dealing. As Section R540-89-12 of the Rule states, the purpose of the Rule is to "establish standards of equity and good faith to guide licensees [insurance companies] in the settlement of claims." Id.

Liberty Mutual also argued that its filing of a Declaratory Complaint did not constitute bad faith. (R.at 32) It argued that it has the right to adjudicate its rights and obligations in this situation. While Baxters and Boulter believe the litigation initiated by Liberty Mutual to be a dilatory tactic, they agree that an insurer has the right to delay payment if there is a fairly debatable issue. The thrust, however, of Baxters' and Boulter's argument is that Liberty Mutual's breach of its duty of good faith began from its conduct prior to the filing of the Declaratory Complaint. The failure to timely acknowledge, investigate, and correspond to the claim are what give substance to Baxters' and Boulter's cause of action. There was no fairly debatable issue during this time. Even if there was, Liberty Mutual was obligated

under its duty to act in good faith to notify Baxters and Boulter of this and to correspond regularly, both of which never took place. Liberty Mutual at all times prior to paying its uninsured policy liability to Baxters and Boulter had the right to settle with them at its insureds, take an assignment of their subrogation rights and pursue Crape and/or his liability carrier for reimbursement. Counterclaimants had no right to preclude Liberty Mutual from this contractual or common law right.

### POINT III

BAXTERS AND BOULTER ARE ENTITLED TO DAMAGES AS A RESULT OF LIBERTY MUTUAL'S CONDUCT

A. Baxters And Boulter Are Entitled to Damages Suffered As A Consequence Of Liberty Mutual's Breach of Its Duty Of Good Faith and Fair Dealing

The Beck court held that there is no reason to limit damages recoverable for breach of a duty to investigate, bargain and settle claims in good faith to the amount specified in the insurance policy. 701 P.2d at 801. The court further stated that these damages include both general and consequential damages. Id. Among several classes of damages including attorney's fees (Collier v. Heinz, 182 Utah Adv. Rep. 53, Court of Appeals, 1992) are mental anguish and economic hardship. Beck at 802,03. (Citations omitted). This broad range of damages available to an insured who has

suffered an insurer's breach of its duty of good faith was also confirmed in Crookston v. Fire Exchange, 164 Utah Adv. Rep. 3, 10 (Utah 1991). In this case Baxters and Boulter have incurred substantial attorney fees in pursuing their claim. They have also claimed damages including but not limited to pain and suffering, mental anguish, economic hardship, psychological damage, emotional distress, loss of enjoyment of life, all due to Liberty Mutual's breach of its duty of good faith and fair dealing. Baxters and Boulter have a right to be compensated for the damages resulting from this breach.

B. There Is Sufficient Evidence to Have The Issue of Punitive Damages Decided By The Trier Of Fact.

The standard for punitive damages is spelled out in Utah Code Ann. §78-18-1(1)(a), which states that before any punitive damages can be awarded, the finder of fact must be shown by "clear and convincing evidence that the acts or omissions by the tortfeasor are the result of wilful and malicious or intentionally fraudulent conduct, or conduct that manifests a knowing and reckless indifference toward, and disregard of, the rights of others."

Id.

Beck states that it contemplates something beyond a breach of the duty of good faith and fair dealing for punitive damages. 701 P.2d at 800. Beck distinguishes between an action in tort and one in contract, the former being necessary

for punitive damages. Id. The court, in clarifying this point, said that the acts constituting a breach of contract may also result in breaches of duty that are independent of contract and may give rise to causes of action in tort. Id. at fn 3.

This language in Beck is joined by Crookston which allowed punitive damages on an insurance contract action where a breach of good faith was alleged. 164 Utah Adv. Rep. 3. The court, in Crookston however, remanded the punitive damage award to the trial court on the issue of excessiveness. Id. at 15

Liberty Mutual committed acts which gave rise to punitive damages when it breached its duty of good faith and fair dealing with Baxters and Boulter. A specific example of this disregard for its insureds' rights occurred when Liberty Mutual misrepresented the law on how long it had to decide whether it was going to pay on the claim. A Liberty Mutual representative on numerous occasions told its insured that it had no obligation to act on the claim until the passing of one year. (R. at 432)

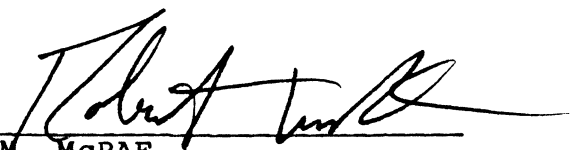
This misrepresentation and acts like it constitutes a "reckless indifference toward, and disregard of, the rights of others" Baxters and Boulter should have their chance to present evidence to the trier of fact on this issue.

CONCLUSION

Baxters and Boulter have shown that Liberty Mutual by its conduct throughout the history of the claim breached its duty to act in good faith and to deal fairly with its insured. The failure to acknowledge, investigate and correspond to the claim all manifest a gross display of indifference on the part of Liberty Mutual. Due to this breach, Baxters and Boulter have incurred substantial damages. This Court must review the facts in a light most favorable to them, and in so doing, it should remand this case back to the trial court for a trial on the merits.

RESPECTFULLY SUBMITTED this 8 day of April, 1992.


McRAE & DeLAND

  
\_\_\_\_\_  
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Baxter and Boulter

CERTIFICATE OF MAILING

I hereby certify that I mailed, postage prepaid, four copies of the foregoing Brief of Appellants to the following on this 1 day of April, 1992.

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ROBERT M. McRAE



## ADDENDUM A

(4) Neither the commissioner nor the state of Utah may be held liable for errors or omissions of the former agent or broker or the trustee. The trustee may not be held liable for errors and omissions which were caused in any material way by the negligence of the former agent or broker. The trustee may be held liable for errors and omissions which arise solely from the trustee's negligence. The trustee's compensation level shall be sufficient to allow the trustee to purchase errors and omissions coverage, if that coverage is not provided the trustee by the former agent or broker or his successor in interest.

(5) It is a breach of the trustee's fiduciary duty to capture the accounts of trustor's clients, either directly or indirectly. The trustee may not purchase the accounts or expiration lists of the former agent or broker, unless the commissioner expressly ratifies the terms of the sale. The commissioner may adopt rules which further define the trustee's fiduciary duties and explain how the trustee is to carry out his responsibilities.

(6) The trust may be terminated by the commissioner or by the person that requested the trust be established. The trust is terminated by written notice being delivered to the trustee and the commissioner.

**History:** C. 1953, 31A-23-218, enacted by  
L. 1985, ch. 242, § 28.

## **31A-23-219. Appointment and listing of insurance agents.**

(1) An insurer may appoint natural persons and organizations that have insurance agent or managing general agent licenses to be insurance agents to do business for the insurer in this state. All insurers shall report to the commissioner, at intervals and in the form he establishes by rule, all new appointments and all terminations of appointments. All insurers shall submit to the commissioner on or before July 1st of each odd-numbered year a list of all agent appointments then in force in this state.

(2) The commissioner may require an insurer to report the cause of termination of an agent's appointment. The information shall remain confidential. No action may be brought against an insurer for anything given in those reports.

(3) If an insurer appoints an organization as its agent, the insurer need not appoint, report, or pay appointment reporting fees for natural person agents listed on the organization's agent's license under Section 31A-23-212.

(4) Each insurer shall maintain with the department, on forms supplied by the department, and signed by the president and secretary of the insurer, a list of natural persons with authority to appoint and remove the company's agents in this state. The insurer shall submit the reports to the commissioner pursuant to Subsection (1).

(5) If an insurer lists a licensee as its agent in reports submitted under Subsection (1), there is a rebuttable presumption that in placing a risk with the insurer the appointed licensee or any of his licensed employees acted as the insurer's agent and not as a broker.

**History:** C. 1953, 31A-23-219, enacted by  
L. 1985, ch. 242, § 28; 1986, ch. 204, § 197.

**Cross-References.** — Insurance agents,  
brokers and adjusters, § 31A-23-102 et seq.

## ADDENDUM B

# Addendum B

31A-26-214

## INSURANCE CODE

(4) A licensee under this chapter whose license is suspended, revoked, or lapsed, but who continues to act as a licensee, is subject to the penalties for conducting an insurance business without a license.

(5) An order revoking a license under Subsection (2) may specify a time not to exceed five years within which the former licensee may not apply for a new license. If no time is specified, the former licensee may not apply for a new license for five years without the express approval of the commissioner.

(6) Any person whose license is suspended or revoked under Subsection (2) shall, when the suspension ends or a new license is issued, pay all fees that would have been payable if the license had not been suspended or revoked, unless the commissioner by order waives the payment of the interim fees. If a new license is issued more than three years after the revocation of a similar license, this subsection applies only to the fees that would have accrued during the three years immediately following the revocation.

**History:** C. 1953, 31A-26-213, enacted by L. 1985, ch. 242, § 31; 1990, ch. 327, § 15.

**Amendment Notes.** — The 1990 amendment, effective April 23, 1990, substituted the present second sentence in Subsection (3) for

the former second sentence, which read "A license which has lapsed under this subsection may be reinstated if the licensee, within 90 days after license lapse, pays twice the usual renewal fee."

### 31A-26-214. Probation.

(1) In any circumstances that would justify a suspension under Section 31A-26-213, the commissioner may instead, after a formal adjudicative proceeding, put the licensee on probation for a specified period no longer than 12 months.

(2) The probation order shall state the conditions for retention of the license, which shall be reasonable.

(3) Violation of the probation is grounds for immediate revocation without a formal adjudicative proceeding, unless one is requested.

**History:** C. 1953, 31A-26-214, enacted by L. 1985, ch. 242, § 31; 1987, ch. 161, § 86.

**Amendment Notes.** — The 1987 amendment, effective January 1, 1988, added the subsection designations, in Subsections (1) and (3),

substituted "formal adjudicative proceeding" for "hearing", and, in Subsection (3), substituted "one is requested" for "a hearing is requested under Subsection 31A-2-301(3)" at the end.

## PART III CLAIM PRACTICES

### 31A-26-301. Timely payment of claims.

(1) Unless otherwise provided by law, an insurer shall timely pay every valid insurance claim made by an insured. By rule the commissioner may prescribe the kinds of notice and proof of loss that will establish validity, the manner in which an insurer may make a bona fide denial of a claim, the periods of time within which payment is required to be made to be timely, and the reasonable interest rates to be charged upon late claim payments.

(2) Notwithstanding Subsection (1), the payment of a claim is not overdue during any period in which the insurer is unable to pay the claim because there is no recipient legally able to give a valid release for the payment, or in

which the insurer is unable to determine who is entitled to receive the payment, provided that the insurer has promptly notified the claimant of the inability and has offered in good faith to pay the claim promptly when the inability is removed.

(3) This section applies only to claims made by claimants in direct privity of contract with the insurer.

History: C. 1953, 31A-26-301, enacted by  
L. 1985, ch. 242, § 31.

#### COLLATERAL REFERENCES

<p><b>A.L.R.</b> — Liability insurance third party's right of action for insurer's bad faith tactics designed to delay payment of claim, 62 A L R 4th 1113</p>	<p>Policy provision limiting time within which action may be brought on the policy as applicable to tort action by insured against insurer, 66 A L R 4th 859.</p>
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### **31A-26-302. Settlement of claims in credit life and disability insurance.**

(1) The creditor shall promptly report all claims to the insurer or its designated claim representative. The insurer shall maintain adequate claims files. All claims shall be settled as soon as possible in accordance with the terms of the insurance contract.

(2) The insurer shall pay all claims either by draft drawn upon the insurer or by check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or upon direction of that claimant to another.

(3) No person other than the insurer or its designated claim representative may settle or adjust claims. The creditor may not be designated as a claims representative.

History: C. 1953, 31A-26-302, enacted by  
L. 1985, ch. 242, § 31.

### **31A-26-303. Unfair claim settlement practices.**

(1) No insurer or person representing an insurer may engage in any unfair claim settlement practice under Subsections (2), (3), and (4).

(2) Each of the following acts is an unfair claim settlement practice:

(a) knowingly misrepresenting material facts or the contents of insurance policy provisions at issue in connection with a claim under an insurance contract; however, this provision does not include the failure to disclose information;

(b) attempting to use a policy application which was altered by the insurer without notice to, or knowledge, or consent of, the insured as the basis for settling or refusing to settle a claim; or

(c) failing to settle a claim promptly under one portion of the insurance policy coverage, where liability and the amount of loss are reasonably clear, in order to influence settlements under other portions of the insurance policy coverage, but this Subsection (2)(c) applies only to claims made by persons in direct privity of contract with the insurer.

(3) Each of the following is an unfair claim settlement practice if committed or performed with such frequency as to indicate a general business practice by an insurer or persons representing an insurer:

(a) failing to acknowledge and act promptly upon communications about claims under insurance policies;

(b) failing to adopt and implement reasonable standards for the prompt investigation and processing of claims under insurance policies;

(c) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by those insureds when the amounts claimed were reasonably near to the amounts recovered;

(d) failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment was made;

(e) failing to promptly provide to the insured a reasonable explanation of the basis for denial of a claim or for the offer of a compromise settlement;

(f) appealing from substantially all arbitration awards in favor of insureds for the purpose of compelling them to accept settlements or compromises for less than the amount awarded in arbitration;

(g) delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms which contain substantially the same information; or

(h) not attempting in good faith to effectuate a prompt, fair, and equitable settlement of claims in which liability is reasonably clear.

(4) The commissioner may define by rule, acts or general business practices which are unfair claim settlement practices, after a finding that those practices are misleading, deceptive, unfairly discriminatory, overreaching, or an unreasonable restraint on competition.

(5) This section does not create any private cause of action.

**History:** C. 1953, 31A-26-303, enacted by L. 1985, ch. 242, § 31; 1986, ch. 204, § 218; 1987, ch. 91, § 61.

**Amendment Notes.** — The 1987 amendment, in Subsection (2)(c), substituted "this Subsection (2)(c)" for "this Subsection (1)(c)."

#### COLLATERAL REFERENCES

**A.L.R.** — Liability of independent or public insurance adjuster to insured for conduct in adjusting claim, 50 A.L.R.4th 900.

Duty of insurer to pay for independent counsel when conflict of interest exists between insured and insurer, 50 A.L.R.4th 932.

Liability insurer's post-loss conduct as

waiver of, or estoppel to assert, "no-action" clause, 68 A.L.R.4th 389.

Pre-emption by Longshore and Harbor Workers' Compensation Act (33 USCS §§ 901 et seq.) of state law claims for bad-faith dealing by insurer or agent of insurer, 90 A.L.R. Fed 723

## ADDENDUM C

## CHAPTER 18

### PUNITIVE DAMAGES AWARDS

Section 78-18-1	Basis for punitive damages awards — Section inapplicable to DUI cases — Division of award with state	Section 78-18-2	Drug exception
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#### **78-18-1. Basis for punitive damages awards — Section inapplicable to DUI cases — Division of award with state.**

(1) (a) Except as otherwise provided by statute, punitive damages may be awarded only if compensatory or general damages are awarded and it is established by clear and convincing evidence that the acts or omissions of the tortfeasor are the result of willful and malicious or intentionally fraudulent conduct, or conduct that manifests a knowing and reckless indifference toward, and a disregard of, the rights of others

(b) The limitations, standards of evidence, and standards of conduct of Subsection (1)(a) do not apply to any claim for punitive damages arising out of the tortfeasor's operation of a motor vehicle while voluntarily intoxicated or under the influence of any drug or combination of alcohol and drugs as prohibited by Section 41-6-44

(c) The award of a penalty under Section 78-11-15 or 78-11-16 regarding shoplifting is not subject to the prior award of compensatory or general damages under Subsection (1)(a) whether or not restitution has been paid to the merchant prior to or as a part of a civil action under Section 78-11-15 or 78-11-16.

(2) Evidence of a party's wealth or financial condition shall be admissible only after a finding of liability for punitive damages has been made.

(3) In any judgment where punitive damages are awarded and paid, 50% of the amount of the punitive damages in excess of \$20,000 shall, after payment of attorneys' fees and costs, be remitted to the state treasurer for deposit into the General Fund

**History:** C. 1953, 78-18-1, enacted by L. 1989, ch. 237, § 1; 1991, ch. 6, § 4.

**Amendment Notes.** — The 1991 amendment, effective April 29, 1991, made a stylistic change in Subsection (1)(b) and added Subsection (1)(c)

**Applicability.** — Laws 1989, ch. 237, § 4 provides that the act applies to all claims for punitive damages that arise on or after May 1, 1989

**Effective Dates.** — Laws 1989, ch. 237, § 4 makes the act effective on May 1, 1989

#### COLLATERAL REFERENCES

**Utah Law Review.** — Recent Developments in Utah Law — Legislative Enactments — Tort Law, 1990 Utah L Rev 269

**A.L.R.** — Punitive damages relationship to defendant's wealth as factor in determining propriety of award, 87 A L R 4th 141



## ADDENDUM D

**Rule R540-89**

**UNFAIR CLAIMS SETTLEMENT PRACTICES RULE**

Section	
R540-89-1.	Authority.
R540-89-2.	Purpose.
R540-89-3.	Scope.
R540-89-4.	Definitions.
R540-89-5.	Notice of loss.
R540-89-6.	Proof of loss.
R540-89-7.	Unfair methods, deceptive acts and practices defined.
R540-89-8.	File and record documentation.
R540-89-9.	Misrepresentation of policy provisions: Prohibited acts applicable to all insurers.
R540-89-10.	Failure to acknowledge pertinent communications.
R540-89-11.	Standards for prompt investigation of claims.
R540-89-12.	Minimum standards for prompt, fair and equitable settlements applicable to all insurers.
R540-89-13.	Standards for prompt, fair and equitable settlements applicable to automobile insurance.
R540-89-14.	Unfair claims settlement practices applicable to automobile insurance.
R540-89-15.	Penalties.
R540-89-16.	Severability.
R540-89-17.	Effective date.

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**R540-89-1. Authority**

This rule is promulgated pursuant to Section 31A-201(1) and 31A-2-201(3)(a) in which the Commissioner is empowered to administer and enforce this title and to make rules to implement the provisions of this title. Further authority to provide for timely payment of claims is provided by Section 31A-26-301(1). Matters relating to proof and notice of loss are promulgated pursuant to sections 31A-26-301 and 31A-21-312(5). Authority to promulgate rules defining unfair claims settlement practices or acts is provided in Section 31A-26-303(4). Section 31A-2-308(1)(a) provides for penalties for any person who violates any insurance statute or rule.

**History.** — Effective December 1, 1982; formerly Regulation 82-3; effective September 14, 1989.

**R540-89-2. Purpose**

The business of insurance continues to be one of public trust assumed by persons accepting licenses to operate in this State and inherently

includes a duty to treat claimants fairly, equitably and in good faith. The breach of such duty is considered to be an unfair or deceptive business practice and injurious to the insuring public. The purpose of this rule is to respond to the volume of complaints arising from claims settlement practices by affirmatively establishing standards of equity and good faith to guide licensees in the settlement of claims. Furthermore, as the standards are properly followed by all licensees, it should encourage future self-regulation of the insurance industry. It is intended that this rule will help to establish parity between the public and professional insurance licensees and facilitate the prompt and fair settlement of insurance claims.

**History.** — Effective December 1, 1982; formerly Regulation 82-3; effective September 14, 1989.

#### R540-89-3. Scope

This rule defines certain minimum standards which, if violated, may constitute unfair claims settlement practices. All agency actions will be conducted pursuant to the Utah Administrative Procedures Act. Penalties for violation of this rule shall be in accordance with Section 31A-2-308, Utah Code. This rule applies to all persons and to all insurance policies, contracts and transactions. Individual agents, brokers, consultants, and adjusters are subject to these standards, as well as other persons herein defined. This rule is not exclusive, and other acts, not herein specified, may also be considered to be violations of the insurance code or other rules. This rule is regulatory in nature and is not intended to create a private right of action.

**History.** — Effective December 1, 1982; formerly Regulation 82-3; effective September 14, 1989.

#### R540-89-4. Definitions

A. "Agent" means any individual, corporation, association, organization, partnership or other legal entity authorized to represent an insurer with respect to a claim, whether or not licensed within the State of Utah to do so.

B. "Claim" means, for the purpose of this Rule, a request or a demand on an insurer, whether by a first party or a third party, for payment of benefits according to the terms of an insurance policy.

C. "Claimant" means either a first party claimant, a third party

claimant, or both and includes such claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant;

D. "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such policy or contract. For the purposes of this Rule, certificate holders of group disability policies are considered to be first party claimants;

E. "General business practice" means a pattern of conduct.

F. "Insurance policy" or "insurance contract" shall mean any contract of insurance, indemnity, medical or hospital service, suretyship, or annuity issued, proposed for issuance, or intended for issuance by any person;

G. "Insurer" means a person who may issue or who does issue any insurance policy or insurance contract within this state, whether or not licensed to do so.

H. "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract;

I. "Notice of Loss" shall be that notice which is in accordance with policy provisions and insurer practices. "Notice of Loss" shall include "Special Notice of Loss" as defined herein. Notice of loss shall also include a Notice of Default or Notice of Delinquency to mortgage insurers.

J. "Notification of claim" means any notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim;

K. "Person" shall mean any individual, corporation, association, partnership, reciprocal exchange, self-insurer, interinsurer, Lloyds insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including agents, brokers, consultants and adjusters.

L. "Proof of Loss" shall mean, reasonable documentation by the insured as to the facts of the loss and the amount of the claim.

M. "Special Notice of Loss" shall mean Notice of Loss required to be given by means other than first class mail, such as by telephone or facsimile, or at times which could be other than during normal business hours.

N. "Specific Disclosure" shall mean notice to the insured by means of policy provisions in boldface type or a separate written notice mailed or delivered to the insured.

O. "Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer.

**History.**— Effective December 1, 1982, formerly Regulation 82-3; effective September 14, 1989

#### **R540-89-5. Notice of loss**

A. Notice of loss to an insurer, if required, shall be considered timely if made according to the terms of the policy, subject to the definitions and provisions of this rule.

B. Notice of Loss may be given by an insured to any appointed agent, authorized adjuster, or other authorized representative of an insurer unless the insurer clearly directs otherwise by means of Specific Disclosure as defined herein.

C. Subject to policy provisions a requirement of written or Special Notice of Loss may be waived by any appointed agent, authorized adjuster, or other authorized representative of the insurer.

D. If Special Notice of Loss is required, the insured shall be advised by Specific Disclosure, as defined herein.

E. Insurance policies shall not require Notice of Loss to be given in a manner which is inconsistent with the actual practice of the insurer. An insurer shall not generally conduct business on the basis of waivers of right, enforcing the terms of the contract only in exceptional circumstances. For example, if the general practice of the insurer is to accept Notice of Loss by telephone, the policy shall reflect that practice, and not require that the insured furnish "immediate written notice" of loss.

**History.**— Effective September 14, 1989

**R540-89-6. Proof of loss**

A. Proof of loss to an insurer, if required, shall be considered timely if made according to the terms of the policy, subject to the definitions and provisions of this rule.

B. The requirements of Section 31A-21-312(1)(a) and (b) may be satisfied in practice and do not require that the actual language of the above-noted sections be recited in the policy.

**History.**—Effective September 14, 1989.

**R540-89-7. Unfair methods, deceptive acts and practices defined**

The following are hereby defined as unfair methods of competition and unfair or deceptive acts and practices in the business of insurance, and the commission of which are violations of this rule:

A. Denying or threatening the denial of the payment of claims or rescinding, cancelling or threatening the rescission or cancellation of coverage under a policy for any reason which is not clearly described in the policy as a reason for such denial, cancellation or rescission.

B. Failing to provide the insured or beneficiary with a written explanation of the evidence of any investigation or file materials giving rise to the denial of a claim based on misrepresentation or fraud on an insurance application, when such misrepresentation is the basis for the denial.

C. Compensation by an insurer of its employees, agents or contractors of any amounts which are based on savings to the insurer as a result of denying the payment of claims.

D. Failing to delivery a copy of standards for prompt investigation of claims to the Insurance Department when requested to do so.

E. Refusing to pay claims without conducting a reasonable investigation.

F. Offering first party claimants substantially less than the reasonable value of the claim. Such value may be established by one or more independent sources.

G. Making claim payments to insureds or beneficiaries not accompanied by a statement or explanation of benefits setting forth the coverage under which the payments are being made and how the payment amount was calculated.

H. Failing to pay claims within 30 days of properly executed proof of loss when liability is reasonably clear under one coverage in order to influence settlements under other portions of the insurance policy coverage or under other policies of insurance.

I. Refusing payment of a claim solely on the basis of an insured's request to do so unless:

1. the insured claims sovereign, eleemosynary, diplomatic, military service, or other immunity from suit or liability with respect to such claim; or

2. the insured is granted the right under the policy of insurance to consent to settlement of claims.

J. Advising a claimant not to obtain the services of an attorney or suggesting the claimant will receive less money if an attorney is used to pursue or advise on the merits of a claim.

K. Misleading a claimant as to the applicable statute of limitations.

L. Requiring an insured to sign a release that extends beyond the occurrence or cause of action that gave rise to the claims payment.

M. Deducting from a loss or claims payment made under one policy those premiums owed by the insured on another policy unless the insured consents.

N. Failing to settle a first party claim on the basis that responsibility for payment of the claim should be assumed by others, except as may otherwise be provided by policy provisions.

O. Issuing checks or drafts in partial settlement of a loss or a claim under a specified coverage when such check or draft contains language which purports to release the insurer or its insured from total liability.

P. Refusing to provide a written basis for the denial of a claim upon demand of the insured.

Q. Denial of a claim for medical treatment after preauthorization has been given, except in cases where the insurer obtains and provides to the claimant documentation of the pre-existence of the condition for which the preauthorization has been given or if the claimant is not eligible for coverage.

R. Refusal to pay reasonably incurred expenses to an insured when

such expenses resulted from a delay, as prohibited by these rules, in claims settlement or claims payment.

S. When an automobile insurer represents both a tort feisor and a claimant:

a. failing to advise a claimant under any coverage that the same insurance company represents both the tort feisor and the claimant as soon as such information becomes known to the insurer;

b. allocating medical payments to the tort feisor's liability coverage before exhausting a claimant's personal injury protection coverage.

T. Failure to pay interest at the legal rate, as provided in Title 15, Utah Code, upon amounts that are overdue under these rules.

**History.** — Effective December 1, 1982; formerly Regulation 82-3; effective September 14, 1989.

#### **R540-89-8. File and record documentation**

The insurer's claim files shall be subject to examination by the Commissioner or by his duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed.

**History.** — Effective December 1, 1982; formerly Regulation 82-3; effective September 14, 1989.

#### **R540-89-9. Misrepresentation of policy provisions: Prohibited acts applicable to all insurers**

A. No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented, including loss of use and household services.

B. No agent shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.



C. No insurer shall deny a claim for failure to exhibit the property without proof of demand and unfounded refusal by a claimant to do so.

**History.**— Effective December 1, 1982; formerly Regulation 82-3; effective September 14, 1989.

**R540-89-10. Failure to acknowledge pertinent communications**

A. Every insurer, upon receiving notification of a claim shall, within 15 days, acknowledge the receipt of such notice unless payment is made within such period of time, or unless the insurer has a reason acceptable to the Insurance Department as to why such acknowledgement cannot be made within the time specified.

B. Every insurer, upon receipt of an inquiry from the Insurance Department respecting a claim shall, within fifteen days of receipt of such inquiry, furnish the Department with a substantive response to the inquiry.

C. A substantive response shall be made within 15 days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.

D. Every insurer, upon receiving notification of claim shall promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements.

**History.**— Effective December 1, 1982; formerly Regulation 82-3; effective September 14, 1989.

**R540-89-11. Standards for prompt investigation of claims**

Every insurer shall complete investigation of a claim within 45 days after notification of claim, unless such investigation cannot reasonably be completed within such time. It shall be the burden of the insurer to establish, by adequate records, that the investigation could not be completed within 45 days of its notification of such claim.

**History.**— Effective December 1, 1982; formerly Regulation 82-3; effective September 14, 1989.

**R540-89-12. Minimum standards for prompt, fair and equitable settlements applicable to all insurers**

A. The insurer shall provide to the claimant a statement of the time

and manner in which any claim must be made and the type of proof of loss required by the insurer.

B. Within 30 days after receipt by the insurer of properly executed notice of loss, the insurer shall complete its investigation of the claim and the first party claimant shall be advised of the acceptance or denial of the claim by the insurer unless the investigation cannot reasonably be completed within that time. If the investigation cannot be completed within 30 days the insurer shall so communicate to the claimant and shall continue to so communicate at least every 30 days until the claim is either paid or denied. No insurer shall deny a claim on the grounds of a specific provision, condition, or exclusion unless reference to such provision, condition or exclusion is included in the denial. Any basis for the denial of a claim shall be noted in the insurer's claim file and must be communicated promptly and in writing to the claimant.

C. Unless otherwise provided by law, an insurer shall promptly pay every valid insurance claim. A claim shall be overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of the loss. Payment shall mean actual delivery or mailing of the amount owed. If such written notice is not furnished to the insurer as to the entire claim, any partial amount supported by written notice or investigation is overdue if not paid within 30 days. Any payment shall not be deemed overdue when the insurer has reasonable proof to establish that the insurer is not responsible for the payment, notwithstanding that written notice has been furnished to the insurer.

D. If negotiations are continuing for settlement of a claim with a claimant, notice of expiration of statute of limitation or contract time limit shall be given to the claimant at least 60 days before the date on which such time limit may expire.

E. No insurer shall make statements which indicate that the rights of a third party claimant may be impaired if a form of release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations.

F. Proof of loss requirements may not be unreasonable and should consider all of the circumstances surrounding a given claim.

**History.** — Effective December 1, 1982; formerly Regulation 82-3; effective September 14, 1989.

**R540-89-13. Standards for prompt, fair and equitable settlements applicable to automobile insurance**

A. When the insurance policy provides for the adjustments and settlement of first party automobile total losses on the basis of actual cash value or replacement with another of like kind and quality, one of the following methods must apply:

(1) The insurer may elect to offer a replacement automobile which is a specific comparable automobile available to the insured, with all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile paid, at no cost other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the claim file.

(2) The insurer may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile including all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of a comparable automobile. Such cost may be determined by:

(a) The cost of a comparable automobile in the local market area when a comparable automobile is available in the local market area; or

(b) One of two or more quotations obtained by the insurer from two or more qualified dealers located within the local market area when a comparable automobile is not available in the local market area.

(3) When a first party automobile total loss is settled on a basis which deviates from the methods described in subsections A(1) and A(2) of this section, the deviation must be supported by documentation giving particulars of the automobile condition. Any deductions from such cost, including deductions for salvage, must be measurable, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for such settlement shall be fully explained to the first party claimant.

B. Total loss settlements with a third party claimant shall be on the basis of the market value or actual cost of a comparable automobile at the time of loss. Settlement procedures shall be in accordance with paragraphs (2) and (3) of subsection A.

C. Where liability and damages are reasonably clear, insurers shall not recommend that third party claimants make a claim under their

own policies solely to avoid paying claims under such insurer's insurance policy or insurance contract.

D. Insurers shall not require a claimant to travel an unreasonable distance to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.

E. Insurers shall, upon the claimant's request, include the first party claimant's deductible, if any, in subrogation demands initiated by the insurer. Subrogation recoveries may be shared on a proportionate basis with the first party claimant when an agreement is reached for less than the full amount of the loss, unless the deductible amount has been otherwise recovered. The recovery shall be applied first to reimburse the first party claimant for the amount or share of the deductible when the full amount or share of the deductible has been recovered. No deduction for expenses can be made from the deductible recovery unless an outside attorney is retained to collect such recovery. The deduction may then be for only a pro rata share of the allocated loss adjustment expense. If subrogation is initiated but discontinued, the insured shall be advised.

F. If an insurer prepares or approves an estimate of the cost of automobile repairs, such estimate shall be in an amount for which it may be reasonably expected the damage can be satisfactorily repaired. If the insurer prepares an estimate, it shall give a copy of the estimate to the claimant and may furnish to the claimant the names of one or more conveniently located repair shops.

G. When the amount claimed is reduced because of betterment or depreciation, all information for such reduction shall be contained in the claim file. Such deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.

H. When the insurer elects to repair and designates a specific repair shop for automobile repairs, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.

I. Where coverage exists, loss of use payment shall be made to a claimant for the reasonably incurred cost of transportation, or for the reasonably incurred rental cost of a substitute vehicle, including collision damage waiver, during the period the automobile is necessarily withdrawn from service to obtain parts or effect repair, or, in the event

the automobile is a total loss and the claim has been timely made, during the period from the date of loss until a reasonable settlement offer has been made by the insurer. The insurer may not refuse to pay for loss of use for the period that the insurer is examining the claim or making other determinations as to the payability of the loss, unless such delay reveals that the insurer is not liable to pay the claim. Loss of use payments shall be an amount in addition to the payment for the value of the automobile.

J. Subject to subsection A and B, an insurer shall fairly and equitably and in good faith attempt to compensate a claimant for all losses incurred under collision or comprehensive coverage. Such compensation shall be based at least, but not exclusively, upon the following standards:

1. An offer of settlement shall not be made exclusively on the basis of useful life of the part or vehicle damaged.

2. An estimate of the amount of compensation for the claimant shall include the actual wear and tear, or lack thereof, of the damaged part or vehicle.

3. Actual cash value shall take into account the cost of replacement of the vehicle and/or the part for which compensation is claimed.

4. An actual estimate of the true useful life remaining in the part or vehicle shall be taken into account in establishing the amount of compensation of a claim.

5. Actual cash value shall include taxes and other fees which shall be incurred by a claimant in replacing the part or vehicle or in compensating the claimant for the loss incurred.

K. An insurer may not demand reimbursement of Personal Injury Protection payments from a first-party insured of payments received by that party from a settlement or judgement against a third party.

**History.**— Effective December 1, 1982; formerly Regulation 82-3; effective September 14, 1989.

#### **R540-89-14. Unfair claims settlement practices applicable to automobile insurance**

The following acts or practices are defined as unfair claims settlement practices pertaining to automobile insurance:

- A. Using as a basis for cash settlement with a claimant an amount

which is less than the amount which the insurer would be charged if repairs were made, unless such amount is agreed to by the claimant or provided for by the insurance policy.

B. Refusing to settle a claim based solely upon the issuance or failure to issue a traffic citation by a policy agency.

C. If an application for benefits is required by the insurer, failing to provide a section for each coverage under the policy under which the claimant can make a claim.

D. Failing to, in good faith, disclose all coverages, including loss of use, household services, and any other coverages available to the claimant.

E. Requiring a claimant to use only the insurer's claim service in order to perfect a claim.

F. If the insurer makes a deduction for the salvage value of a total loss retained by the claimant, failing to furnish the claimant with the name and address of the salvage dealer who will purchase the salvage for the amount deducted if so requested by the claimant.

G. Refusing to disclose policy limits when requested to do so by a claimant or claimant's attorney.

H. Using a release on the back of a check or draft which requires a claimant to release the company from obligation on further claims in order to process a current claim when the company knows or reasonably should know that there will be future liability on the part of the insurer.

I. Refusing to use a separate release of claims document rather than one on the back of a check or draft when requested to do so by a claimant.

J. Intentionally offering less money to a first party claimant than the claim is reasonably worth, a practice referred to as "low-balling."

K. Refusing to offer to pay claims based upon the Doctrine of Comparative Negligence without a reasonable basis for doing so.

L. In a bailment situation, imputing the negligence of a permissive user of a vehicle to the owner of the vehicle.

**History.**—Effective September 14, 1989.

**R540-89-15. Penalties**

Subject to the provisions of the Utah Administrative Procedures Act, violators of this rule shall be subject to fine, suspension, or revocation of their insurance license or Certificate of Authority, and/or any other penalties or measures as are determined by the commissioner in accordance with law. Any penalty imposed under this rule shall be commensurate with the violation committed and subject to the following provisions and limitations:

A. Separate and disparate penalties may be assessed insurer, organization and individual persons;

B. Frequency of occurrence and severity of detriment to the public shall be considered in determining a penalty;

C. No license or Certificate of Authority shall be suspended on the basis of a single violation; and

D. No revocation of license or Certificate of Authority shall occur except upon a finding of improper conduct as a general business practice.

**History.** — Effective December 1, 1982; formerly Regulation 82-3; Effective September 14, 1989.

**R540-89-16. Severability**

If any provision or clause of this rule or the application thereof to any person or situation is held invalid, such invalidity shall not affect any other provision or application of the regulation which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

**History.** — Effective December 1, 1982; formerly Regulation 82-3; effective September 14, 1989.

**R540-89-17. Effective date**

This rule shall take effect on September 14, 1989.

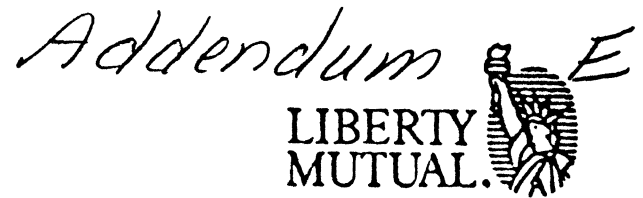
**History.** — Effective September 14, 1989.

[Page 287 follows]

## ADDENDUM E



127 South 500 East  
Suite 510, P O Box 45440  
Salt Lake City, Utah 84145-0440  
Telephone: (801) 363-3057  
Utah Toll Free: 1-800-634-4201



August 24, 1989

McRae & DeLand, Attys. at Law  
209 East 100 North  
Vernal, UT 84078

Attn: Robert M. McRae

**RE: JOANNE E. BAXTER AND MARY ELLEN BOULTER - JAREN BAXTER**  
**OUR CLAIM #'s: AL 667-010979-01 H, 02 H**  
**DATE OF ACCIDENT: 04/28/89**

Dear Mr. McRae:

This will acknowledge our belated receipt of your letter dated July 12, 1989 and its enclosures. When you called to discuss it on August 8th, I advised you that we never received the original letter and enclosures and you, therefore, FAXed copies to me.

We are handling No-Fault and Medical Payment files in the names of both of your clients as named above. I understand that you are attempting to pursue a liability claim against the parties who were responsible in this accident, and you served them with a Summons and Complaint in order to protect your client's interest. You have advised me that the defendant is in the process of moving to the state of Oregon and voiced to me your concern regarding that complication.

So far, we have paid only No-Fault coverage out on both of your clients. On Joanne Baxter's claim, we have paid out a total of \$3,356.10 in No-Fault benefits, \$1,278.70 of which was for medical bills and the remainder of which was wage reimbursement. On Mary Ellen Boulter's claim, we have paid a total of \$542.24 in No-Fault medical benefits to date. Each of these claimants has an additional \$1,000 in Medical Payments coverage available under the terms of this policy, once the No-Fault benefits are exhausted.

If I understand your intentions, you are interested in placing an Uninsured Motorist claim on the behalf of each of these two claimants, with regard to the above-captioned accident. Provided you can show reasonable evidence that the responsible party is not insured, I don't have a problem with honoring such a claim, assuming that the injured parties are shown to have crossed the Utah No-Fault threshold, which would make them eligible to place a liability claim in this state.

As the medical bills which I have paid show that your clients have not crossed the No-Fault threshold by virtue of the amount of medical bills incurred to date, perhaps you are able to provide me with medical reports which shows that they have crossed the threshold in one of the other possible ways.

00345

Mr. McRae  
August 24, 1989  
Page 2

In the meantime, I am having Uninsured Motorist claim files set up for each of your clients, which will be separate from their No-Fault and Medical Payment claim files. By the time I hear back from you on this, I will have the new claim file numbers and be able to provide you with those for your records and future correspondence.

If you have any questions or comments regarding this matter in the meantime, please do not hesitate to contact me. Otherwise, I will await the evidence regarding the Uninsured Motorist situation and the eligibility to place the liability claims from your office.

Very truly yours,  
LIBERTY MUTUAL INSURANCE COMPANY

Tracy Birdsong  
Technical Claims Specialist

TB/kl/026

00346

## ADDENDUM F

Addendum F

McRAE & DeLAND  
ATTORNEYS AT LAW

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VERNAL, UTAH 84078  
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ROBERT M. McRAE  
HARRY H. SOUVALL

THE WHITLEY MANSION  
32 SOUTH 600 EAST  
SALT LAKE CITY, UTAH 84102  
TELEPHONE (801) 364-1333

LONI F. DeLAND

October 30, 1989

Mr. Tracy Birdsong, Technical Claims Specialist  
Liberty Mutual Insurance Company  
P.O. Box 45440  
Salt Lake City, UT 84145-0440

AL 10979 05  
06

Re: Joann E. Baxter and Mary Ellen Boulter - Jaren  
Baxter, Your claims #'s: AL 667-010979999-01 H, 02 H  
Date of Accident: 4/28/89

Dear Ms. Birdsong:

In as much as you decline to participate in the investigation of whether or not Daryl Crape was insured at the time of the subject accident as evidenced with your letter of August 25, 1989, I went ahead and had the plaintiffs testify in support of a default judgment, a copy of which is enclosed. Please advise as to what your attitude is going to be about paying the same.

Sincerely,



Robert M. McRae

RMM:p

Enclosure

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