

Shernoff Bad Faith Insurance Seminar  
April 01, 2001  
By Frank N. Darras and David T. Bamberger

## **Enabling the Disabled: How to Pick, Plead and Win a Disability Bad Faith Case It's finally happened.**

After all these years of fender-bender and collection cases, someone has walked in your door with what appears to be an ironclad bad faith suit. He's told you all about how his disability carrier denied a claim that clearly should have been covered, and he wants you to take on the insurer.

The prospective client hasn't even finished telling you his story, and your head is already dizzy with visions of a seven-figure judgment against a deep-pocket defendant that a jury is sure to despise. But before you spend your share of the recovery, you may want to ask some hard questions about your potential client's case. What kind of plaintiff will he be? How strong are his witnesses? What theories of recovery can be pursued against a disability carrier? Are there any other defendants that should be named in the suit? How will you overcome the insurer's surveillance video and "independent" medical examiner? Will you be able to get the case to a jury, or will it be preempted by ERISA? And even if you're able to keep the case in the courts, can you come up with a trial theme that will inspire a jury to award a substantial verdict?

This syllabus is designed to help you answer these questions and others like them, and to increase the likelihood that your dreams of a substantial jury verdict for your client will become a reality.

### **PRE-SUIT CONSIDERATIONS -SHOULD YOU TAKE THE CASE?**

At the risk of stating the obvious, the first step is to get to know your prospective client. What is your first impression? Do you believe his story? Does he appear to be forthright? Is he honest or evasive? For example, were the representations on his policy application true, complete and accurate? If his answers to medical, occupational or financial questions on the application do not fully comport with the facts, the carrier will argue that he lied to obtain the policy and thus that his claimed injury or sickness cannot be believed either. And the jury may in fact discredit him if he lied or exaggerated when he first dealt with the insurance company.

You also need to evaluate whether your potential client is articulate and likable enough to be an outstanding witness at trial. Even if he is, does he have the emotional stamina to pursue protracted litigation and handle a trial? And does he have the financial wherewithal to litigate and the staying power to survive the appeal process, or is he looking for a quick settlement?

In addition, it is essential that you get to know the other people who will need to corroborate your client's story and confirm his damages. What kind of third-party witnesses (spouse, children, friends, employees, supervisors, co-workers, neighbors) does he have? Will a jury believe them? Are his treating physicians respected in the medical and legal communities, or are they known for providing unnecessary treatment and telling patients - and lawyers - whatever they want to hear?

You also need to evaluate the potential client's damages. How has the insurer's failure to pay benefits affected his life? Has he lost his house? Has his car been repossessed? Did his wife have to sell her wedding ring? Have his children been taken out of private school? Did he have to sell anything in a fire sale? Has he had to cash in an IRA or 401k? Has his credit been ruined? Is he getting dunning letters from credit card companies? Is his family living off cash advances? Has the gas or electricity been turned off? This analysis will give you a better idea of what the case is worth in real damages, before you start thinking about possible

punitive damages.

Next, you need to obtain and review all pertinent documents in the prospective client's possession. These would include:

Advertising and marketing materials (newspaper or magazine ads, trade journals, flyers, brochures, etc.); these will help you understand what the "bait" was, what your potential client's reasonable expectations regarding coverage were, and whether the insurer ultimately delivered what it promised

The policy, including the application and all declarations pages, riders, endorsements and amendments

Payment information - canceled premium checks, receipts, premium lapse notices

Claim notices and proofs of loss

Pertinent photographs, videos and newspaper reports

Previous written or recorded statements by the prospective client

Third party evaluations - investigator reports, witness statements, police reports

Medical records

Correspondence between the potential client and the insurer, insurance agents, and any other key players  
Additionally, have the prospective client provide you with any diaries, logs or journals he has maintained. If he doesn't have any, ask him to prepare a detailed summary of his loss, any medical treatment, and all dealings with the insurance company.

You may be concerned that the potential client will be offended by your extensive inquiries and take his seven-figure case to some other lawyer. But for most prospects, your thoroughness and selectiveness will simply enhance your credibility, and confirm that the real question is whether he is worthy of your representation - not whether you are a good enough attorney for him. And if the potential client balks at your investigation, the odds are that his case isn't as strong as he claims and that you would be better off without investing your reputation, your time, your resources and the emotional penicillin it takes to guide any client through the trial phase.

After the prospective client has left your office, you should conduct the classic 3-step analysis for first-party bad faith cases: (1) Determine the insurer's contractual liability (i.e., whether it was obligated under the terms of the contract to pay the insured's claim for policy benefits), (2) evaluate whether the insurer's failure to pay or delay in paying subjects it to extracontractual liability for compensatory damages over and above whatever is owed under the policy, and (3) analyze whether punitive damages might be recoverable based upon the insurer's conduct (e.g., whether the insurer acted with "oppression, fraud or malice" within the meaning of California Civil Code section 3294(a)).

And if an insurer is on notice that answers in the application are inconsistent or inaccurate but fails to further inquire as to those statements, it waives the right to assert that the information was material. *Anaheim Builders Supply, Inc. v. Lincoln Nat. Life Ins. Co.* (1965) 234 Cal.App.2d 719, 43 Cal.Rptr. 494.

Moreover, the insured's failure to disclose information in response to questions on an application will not justify rescission where he did not know about the non-disclosed medical condition or appreciate its significance, or where that condition related to "minor indispositions" rather than "serious ailments which undermine the general health". *Thompson*, 9 Cal.3d at 915-916, 109 Cal.Rptr. at 480, 513 P.2d 353

Additionally, where the insured did disclose the condition to the insurer's agent but the agent failed to include it in the application or told the insured it was not relevant, the insurer may not rescind the policy. *Boggio v. California-Western States Life Ins. Co.* (1952) 108 Cal.App.2d 597, 599-600, 239 P.2d 144, 146-147; *Byrd v. Mutual Benefit Health & Acc. Ass'n* (1946) 73 Cal.App.2d 457, 463, 166 P.2d 901, 904. And an agent is deemed to be the insurer's agent where the insurer has filed a notice of agency appointment with the Department of Insurance, even if the insured believes the agent to be the insured's own agent. *Loehr v. Great Republic Ins. Co.* (1990) 226 Cal.App.3d 727, 732-734, 276 Cal.Rptr. 667, 670-672.

Finally, a disability insure's attempt or threat to rescind the policy because of claimed material misrepresentations or concealments by the insured, if found to be unreasonable, may subject the insurer to extracontractual liability. [*Fletcher v. Western Nat'l Life Ins. Co.* (1970) 10 Cal.App.3d 376, 89 Cal.Rptr. 78].

### III. Interplay of Incontestability Clauses, Pre-Existing Condition Provisions and "First Manifest" Restrictions

Even if an insured fails to disclose information on an application, the potential for having the policy rescinded is not open-ended. Disability policies typically contain "incontestability" clauses which provide that once a certain time period (commonly two years) following issuance of the policy has expired, the insurer can no longer "contest" the policy on the grounds that the insured did not fully disclose some bit of medical history or financial information during the application process.

institute declaratory relief or other litigation against its insured only where it has a reasonable basis for doing so;<sup>18</sup>

refrain from construing a disability policy term in a more restrictive manner than the accepted legal definition;<sup>19</sup> and refrain from imposing additional preconditions to coverage beyond those set forth in the policy.<sup>20</sup>

And it is important to consider the possibility of naming defendants other than the insurance company, especially if you are trying to defeat federal diversity jurisdiction. Potential defendants include the agent who procured the policy for the insured,<sup>21</sup> the insurer's claim investigator,<sup>22</sup> the physician retained by the insurer to perform an "independent" medical examination of the insured,<sup>23</sup> and the insurer's claim adjusting agency.<sup>24</sup> The theories of recovery against those defendants may include conspiracy to defraud,<sup>25</sup> intentional infliction of emotional distress,<sup>26</sup> misrepresentation of coverage,<sup>27</sup> and/or professional negligence.<sup>28</sup>

## DISCOVERY IN A DISABILITY ACTION

After filing a detailed, fact-intensive complaint, your first step will be to develop a comprehensive discovery plan. Your discovery should be designed to corroborate your client's story, document the insurer's delay, denial and bad faith, bolster your client's chances of recovering punitive damages, and otherwise prepare the case for trial.

### 1. Requests for production of documents

Generally, the documents you should request from the insurance company include (1) the insurer's complete claim file (local, regional and home office), including all documents regarding the processing, payment and/or denial of your client's claim; (2) medical reports; (3) investigative reports; (4) photographs and videos; (5) underwriting manuals; (6) claim manuals, including additions, deletions and other revisions from previous versions; (7) other materials used to train adjusters; (8) advertising and marketing materials concerning the policy purchased by your client; and (9) training materials and other documents sent to independent agents to teach them how to advertise, promote and sell the policy bought by your client.

It is always a good idea to propound your document request (and other written discovery) as early as possible. But you should resist the temptation to simply notice the deposition of a claim adjuster or company executive and have him produce documents at his deposition. Instead, be sure to obtain, review and prepare questions regarding the documents well before the depositions start.

You also should direct the responding insurer to prepare a privilege log for all withheld documents.<sup>29</sup> Additionally, have the insurer's counsel Bate stamp all produced documents to conform with the order in which they were maintained in the insurer's normal course of business. And of course, if the insurer refuses to produce any documents to which you believe you are entitled, be sure to file a motion to compel further production of documents.

After you have the insurer's documents, you will want to input the documents into your litigation support database system, if any. Also, you will need to do a comprehensive claim file analysis (either in-house or, if necessary, by an outside consultant). As part of that analysis: (1) watch for drafts of letters that differ from what your client ultimately received; (2) look for letters that purport to confirm conversations with third parties but have no corresponding written note in the file; (3) check to see if the insurer promptly and thoroughly followed up on all leads; (4) look for time gaps, delays, and inconsistencies; (5) evaluate whether the insurer looked to the claim with an eye toward paying it or manufacturing grounds to deny it; (6) identify any documents that did not copy well so that you can obtain good copies at a custodian of records deposition; and (7) make a list of all key players by name, title, and place in the insurer hierarchy, and decide whom you need to depose and in what order.

In addition to requesting documents from the insurer, be sure to serve subpoena duces tecums to obtain pertinent documents from third party witnesses. For example, if the insurer has asserted the "advice of counsel" defense in its answer (and thereby waived the attorney-client privilege), serve the insurer's attorney with a subpoena duces tecum seeking a copy of the attorney's file.

Also, be sure to check the court records in your jurisdiction - and, if at all possible, in other jurisdictions as well - to find out about other bad faith actions against the insurer in your case. Then, contact the lawyers representing the plaintiffs in those cases to see if they have any depositions of insurer executives, claim file memos, or other documents that suggest a pattern and practice of treating policyholders in the manner your client was treated (e.g., failing to thoroughly and timely investigate claims, repeatedly relying on the same "independent" medical examiners, imposing preconditions to coverage beyond those set forth in the policy, paying claims then suing for reimbursement, offering policy buyouts for amounts far less than loss reserves, targeting high-exposure claims for denial, or rewarding employees who deny or discontinue the most benefits). These are the types of documents that could spur your jury to award substantial punitive damages to your client.

## 2. Interrogatorie

Like document requests, interrogatories should be propounded early in the litigation. When you do so, be sure to ask for the names (and addresses and telephone numbers, if no longer employed by the insurer) of all individuals involved in the handling of your client's claim. In addition, you should request the dates and amounts of all payments made or denied. Also, have the insurer set forth the specific policy provisions on which it based its payments or denials of benefits. And be certain to propound contention interrogatories asking the insurer to detail all facts, documents and witnesses that it contends support each and all of its affirmative defenses.

You also will want to include interrogatories aimed at confirming that the insurer engaged in acts of the type that harmed your client with such frequency as to indicate a general business practice. In California, these interrogatories are based on *Colonial Life & Acc. Ins. Co. v. Superior Court* (1982) 31 Cal.3d 785, 183 Cal.Rptr. 810. In some instances, this type of discovery will be enough to bring the insurer to the bargaining

table with significant settlement monies in a case with limited damages.

### 3. Depositions of insurer representatives

Consider deposing not only the handling claims adjuster, but also his supervisor, claims managers, and corporate executives. Either start at the top of the corporate ladder and go down, or start at the bottom and work your way up.

You also should consider taking the deposition of the insurer's "persons most knowledgeable" (PMK) regarding areas specified in your deposition notice. For example, you may want to notice PMK depositions concerning the company hierarchy, authentication of documents, training of adjusters, investigation of plaintiff's claim, denial of plaintiff's claim, plaintiff's alleged comparative fault, and/or company-wide practices. The major advantage of PMK depositions is that they keep you from floundering around trying to ascertain which executives in the corporate hierarchy should be deposed.

You will want to ask the insurer representative about his education, employment history, and training (initial classroom training, claim manuals, seminar updates, etc.). In addition, you will need to examine him regarding his duties and responsibilities. For example, have him testify concerning his duties as they were prescribed by his superiors, claim manuals, and/or company memoranda. Also, have the deponent testify regarding his understanding of what key policy terms mean.

At the same time, try to weave in the law (statutes, insurance regulations and cases) regarding insurers' duties. Also, get the deponent to commit to his understanding of an insurer's duties, including the implied duty of good faith and fair dealing. Get him to admit that the implied covenant is part of the insurance contract. If relevant to your case, ask the deponent to agree that the implied covenant of good faith and fair dealing includes the duty to thoroughly and objectively investigate claims, timely respond to inquiries, and promptly settle claims where liability is reasonably clear.

Of course, you also will need to examine the insurer representative regarding the handling of your client's claim. For example, did he follow the insurer's claim manual and other company guidelines, policies and procedures concerning investigation, payment, denial and other claim handling? Was help available, as he felt it necessary? Was he free to consult as needed with a claim committee, a medical advisor, in-house counsel and/or outside counsel? And how did he interact with his superiors? Whom did he report to regarding the file? What was his supervisor's role in the handling of the file? How about the claims manager, Vice-President of claims, and home office? If they were not involved, why not? Also, has he ever been reprimanded concerning his handling of your client's file? Did it ever come up in any annual or semi-annual performance reviews?

During your depositions of the insurer's various adjusters, supervisors and executives, always look for someone who can wear the "black hat" at trial. And in deciding whom that will be, evaluate the witnesses' demeanor and attitude as much as their substantive answers. Are they rude or courteous? Are they responsive or evasive? Do they seem credible and sincere, or calculating and deceptive? Do they make or avoid eye contact? Will a jury trust them or suspect them?

Consider taking the deposition Monday morning, to increase the likelihood that any deposition preparation will be stale (because it was done the previous Friday) or short (because it was done early Monday morning). And try not to let the deponent get too comfortable. Instead of easing into the deposition with background inquiries (education, prior employment, etc.), consider starting off with the tough questions. If you spend the entire morning on easy background material, the deponent's counsel can do further preparation for the meatier inquiries during the lunch break.

Also, try to go to the insurer's home office to take your depositions, especially of senior executives. And be

sure to videotape the depositions. Videotaping will help curb overzealous defense attorneys who interject excessive objections, overly coach the deponents, or take too many breaks. It also tends to reduce the number of "I don't know", "I'm not sure" and "I can't recall" answers given by deponents. And a videotaped deposition can be an effective forum for making the insurer aware of any "smoking gun" documents you may have discovered.

## MOTION PRACTICE IN DISABILITY CASES

It is virtually inevitable that the insurer will file a motion for summary judgment or, at the very least, a motion for summary adjudication seeking dismissal of your claim for punitive damages. In opposing a motion for summary adjudication of a bad faith claim, it should be emphasized that "the reasonableness of an insurer's claims handling conduct is ordinarily a question of fact",<sup>30</sup> and that "[w]hether an insurer's denial of a claim is unreasonable . . . remains a question of fact unless only one inference may be drawn from the evidence".<sup>31</sup> Similarly, punitive damages are an issue "wholly within the control of the jury",<sup>32</sup> and thus are singularly inappropriate for summary adjudication.

Instead of waiting for the insurer's motion, consider filing an offensive motion for summary judgment or summary adjudication. For example, if the insurer is beating the ERISA drum, you may want to file a motion for summary adjudication that the suit is not preempted by ERISA. Or you may want to file a motion for summary adjudication of contractual issues (coverage under policy, amount of benefits owed under policy and/or insurer's breach). If granted, that motion would establish your client's entitlement to benefits, and enable you - and/or the trial judge - to tell the jurors that coverage has been conclusively determined, and that the only remaining issue for them to decide is the unreasonableness, maliciousness or other culpability of the insurer's conduct.

## THE DISABILITY INSURER'S TOP 10 DEFENSES AND HOW TO DEFEAT THEM

Taking on a disability insurer is not for the timid or faint of heart. Your client will be bombarded with a seemingly endless barrage of anti-coverage grenades that share a single target - preventing your client from collecting disability benefits.

As making at his occupation, the insurer will argue that he is pursuing his claim out of choice or for financial gain - not because he is truly disabled. If your client's injury or sickness bears the slightest resemblance to, or shares even one symptom with, a condition he had before his policy inception, the insurer will insist that his injury or sickness is a preexisting condition or first manifested before the policy inception. If the insurer suspects that your client is feigning his disability, the insurer will trot out one of its well-paid "independent" physicians to conduct a medical examination that, inevitably, will find your client in perfect health. And if all else fails, the insurer will have its paparazzi conduct a week-long surveillance of your client that will produce - after careful editing - a 60-minute videotape which suggests that your client could easily qualify for the Olympics (or, at the very least, perform his occupation).

If your client's benefits would pay him more money than he was making at his occupation, the insurer will argue that he is pursuing his claim out of choice or for financial gain - not because he is truly disabled. If your client's injury or sickness bears the slightest resemblance to, or shares even one symptom with, a condition he had before his policy inception, the insurer will insist that his injury or sickness is a preexisting condition or first manifested before the policy inception. If the insurer suspects that your client is feigning his disability, the insurer will trot out one of its well-paid "independent" physicians to conduct a medical examination that, inevitably, will find your client in perfect health. And if all else fails, the insurer will have its paparazzi conduct a week-long surveillance of your client that will produce - after careful editing - a 60-minute videotape which suggests that your client could easily qualify for the Olympics (or, at the very least, perform his occupation).

What can you -- and your client -- do? This section of our syllabus will help you combat the insurer's arsenal of coverage weapons and, in the process, fortify your bad faith action against the insurer.

## 1. Incontestability

Pursuant to Insurance Code § 10350.2, a disability policy is required to contain an incontestability clause in one of two forms. Under Form A, no misstatement on the insured's policy application can be used by the insurer to rescind the policy or deny a claim for a disability commencing more than two years after policy inception, unless the misstatement was fraudulent. Under Form B, if a disability commences after the policy has been in effect for two years, the insurer cannot rescind the policy or deny a claim on the ground that the disease or physical condition giving rise to the disability had existed before the policy began, even if the insured made a fraudulent misstatement on his application regarding the preexisting condition.

Form A generally is viewed as being more favorable to the insurer, since it enables the insurer to deny coverage or rescind the policy more than two years after policy inception, as long as the insured's misstatement on the policy application was "fraudulent". However, an insurer may encounter difficulty taking advantage of that perceived benefit. Fraud, of course, requires an intent to deceive. As stated by the California Supreme Court in *Sun 'n Sand, Inc. v. United California Bank* (1978) 21 Cal.3d 671, 703, 148 Cal.Rptr. 329, 351, "an action for fraudulent misrepresentation lies only when the defendant is charged with knowledge of falsity and an intent to deceive"). It may prove problematic, if not impossible, for an insurer to demonstrate that its insured intended to deceive the insurer at the time of the policy application, especially if the insured testifies that he had no such intent or the alleged misstatement was arguably correct.

The incontestability clause can come into conflict with the policy's "preexisting condition" and "first manifest" provisions. As discussed below, the California Supreme Court recently resolved that conflict, in a manner favorable to insureds, in *Galanty v. Paul Revere Life Ins. Co.* (2000) 23 Cal.4th 368, 97 Cal.Rptr.2d 67.

## 2. Preexisting condition

Disability policies typically include a clause that excludes coverage for preexisting conditions that were not disclosed on the policy application. Obviously, should an insurer rely upon this clause, your first line of attack will be to argue that the insured's current injury or sickness is unrelated to the condition that was not disclosed on the application.

But what if the insured's present disability is related to a pre-policy condition and the insured told the insurer's agent about it, but the agent failed to record it on the application? Or what if the agent, during the meeting where he took the application, failed to ask the insured the question that would have disclosed the preexisting condition, or told the insured that the insurer wouldn't care about the non-disclosed condition and the insured relied on that statement?

Fortunately, if the agent is a licensed and appointed agent of the insurer, his knowledge, acts and omissions are imputed to the insurer. *Loehr v. Great Republic Ins. Co.* (1990) 226 Cal.App.3d 727, 734, 276 Cal.Rptr. 667, 671. Thus, the insurer is deemed to have made whatever representations were made by the agent, and to be aware of whatever conditions were disclosed by the insured to the agent.

Moreover, if the insurer rescinds the insured's policy notwithstanding its knowledge, through its agent, of the preexisting condition it claims was not disclosed, it can be liable for bad faith. A disability insurer's unreasonable attempt or threat to rescind a policy based on a claimed misrepresentation by the insured on the policy application may constitute bad faith. *Fletcher v. Western National Life Ins. Co.* (1970) 10 Cal.App.3d 376, 401-402, 89 Cal.Rptr. 78, 93-94; *Imperial Casualty and Indemnity Co. v. Sogomonian* (1988) 198 Cal.App.3d 169, 185, 243 Cal.Rptr. 639.

And if more than two years have passed since the insured's application, the insurer cannot rescind the policy based on the insured's non-disclosure of the preexisting condition even if that condition is related to the insured's current disability. That is because the California Supreme Court determined in *Galanty*, supra, that the statutorily-required incontestability clause (Insurance Code § 10350.2) trumps the policy's preexisting condition clause, such that that an insurer which utilizes a Form B incontestability provision cannot rescind the policy or deny coverage based on the preexisting condition clause (or, as discussed below, the first manifest provision) after the policy has been in effect for two years.

### 3. First manifest

As indicated above, the "first manifest" provision can come into conflict with the statutorily-mandated incontestability clause. For example, what happens if the insured's sickness first manifested before the policy inception but the insured does not file his claim for benefits until more than two years after policy inception? Does the incontestability clause (which bars an insurer from contesting statements on the insured's application after the policy has been in place for two years, unless the insured has a Form A policy and the insurer can demonstrate a fraudulent misstatement on the application) protect the insured, or can the insurer seize upon the "first manifest" clause to deny coverage or rescind the policy?

The California Supreme Court resolved the issue favorably to insureds in *Galanty v. Paul Revere Life Ins. Co.* (2000) 23 Cal.4th 368, 97 Cal.Rptr.2d 67. As indicated above, the Court held that even if the sickness causing the insured's disability first manifested before policy inception, the incontestability clause bars the insurer from denying coverage based on the "first manifest" or "preexisting condition" provision after the policy has been in effect for two years (at least where, as in *Galanty*, the insurer utilized a Form B incontestability clause). The Court reasoned that a statutorily-required incontestability clause takes precedence over policy language, such as a "first manifest" provision, that has been drafted by an insurer.

### 4. ERISA

If the insured's policy was provided by his employer, the insurer will argue that his civil suit is preempted by the Employee Retirement Income Security Act (ERISA). Remedies in connection with an ERISA-preempted insurance policy are limited to the benefits owed and, in the court's discretion, reasonable attorney's fees. Thus, most courts hold that no consequential damages, emotional distress damages or punitive damages can be recovered in an ERISA action.<sup>33</sup>

Here are a few ways to attempt to circumvent ERISA:

An independent contractor is not an "employee" and is therefore not subject to ERISA preemption,<sup>34</sup> unless he obtains insurance benefits through the same group plan that covers employees of the company.<sup>35</sup>

A government employee or the employee of a public agency is exempt from ERISA [29 U.S.C. section 1003(b); 29 U.S.C. section 1002(32)].

Employees of churches or church-operated businesses are exempt from ERISA [29 U.S.C. section 1003(b)].

Sole proprietors, partners, and their spouses are exempt, so long as the business does not provide benefits under the policy to a common-law employee [29 C.F.R. sections 2510.3-3(b) and (c)].<sup>36</sup>

Some courts have suggested that a plan is not "established or maintained" by an employer [29 U.S.C. section 1002(1)] unless the employer intended to create an ERISA plan.<sup>37</sup> Other courts have indicated that an employer has "established or maintained" an ERISA plan only if it actively participated in the design and operation of the plan, directly controlled the day-to-day operation of the plan, exercised substantial discretion over the plan, and/or established a separate administrative scheme to manage the plan.<sup>38</sup> Still others have

found that the "established or maintained" requirement may not be met even if the employer was significantly involved in the administration of the plan.<sup>39</sup> Certain others have indicated that an ERISA plan has not been "established" where the insurer failed to comply with ERISA's reporting and disclosure requirements and failed to mention ERISA in policy documents, brochures and letters.<sup>40</sup> And a few others have held that the "is maintained" requirement implies that the plan must be in current operation, and thus that ERISA does not apply where the former employer has sold his business and stopped contributing to the plan<sup>42</sup> or has gone bankrupt and ceased any involvement in the plan.<sup>43</sup>

Plans that fall under the Department of Labor's "safe harbor" regulations [29 C.F.R. section 2510.3-1(j)] are exempt from ERISA. The regulations generally state that ERISA is inapplicable where (1) the employer does not "endorse" the program;<sup>44</sup> (2) employee participation is completely voluntary; (3) premiums are paid entirely by the employee;<sup>45</sup> (4) the employer's sole functions are to permit the insurer to publicize the program, collect the premiums through payroll deductions, and remit the premiums to the insurer; and (5) the employer receives no consideration, except reasonable compensation for collecting and remitting the premiums. Significantly, however, some courts have found the "safe harbor" regulations applicable despite employer activities far beyond those permitted by the regulations.<sup>46</sup>

An insurer sometimes concedes that the insured is a partner or other non-employee and that the disability policy covers only him, but argues that his claims are nevertheless subject to ERISA because his policy is part of an overall company benefit plan that included other policies which did cover employees. This argument has been made -- and soundly rejected -- in several recent opinions.<sup>47</sup> In addition to the cases discussed above, there is a recent indication by the United States Supreme Court that it will be receptive to arguments against ERISA preemption. In *UNUM Life Ins. Co. of America v. Ward* (1999) 526 U.S. 358, 119 S.Ct. 1380, 1390, n. 7, the Court noted that the Solicitor General of the United States -- on whose brief the Court had based its ruling in *Pilot Life*<sup>48</sup> that ERISA is the exclusive remedy for state law causes of action for bad faith -- had changed its position on that issue. Although the Court concluded in *Ward* that it "need not address the Solicitor General's current argument" because *Ward* was suing under ERISA (for benefits due) rather than trying to circumvent it, the case at least suggests that the Court may be open to reconsidering its decision in *Pilot Life*.

And the federal district courts concur. During the past year, district court judges in Colorado,<sup>49</sup> Oklahoma<sup>50</sup> and Alabama<sup>51</sup> have relied on *Ward* in ruling that ERISA does not preempt a bad faith cause of action by an insured under a group insurance policy. In so holding, those courts distinguished *Pilot Life Ins. Co. v. Dedeaux* (1987) 481 U.S. 41, 107 S.Ct. 1549, wherein the U.S. Supreme Court had held that Mississippi's bad faith law was preempted by ERISA because it imposed liability against both insurance and non-insurance entities (and therefore did not "regulate insurance" within the meaning of ERISA's "savings clause" [29 U.S.C. § 1144(B)(2)(A)] so as to avoid preemption). Conversely, Colorado, Oklahoma and Alabama limit the cause of action to the insurance industry<sup>52</sup> -- and so does California.

More specifically, the California Supreme Court has repeatedly held that claims for tortious breach of the implied covenant of good faith and fair dealing (i.e., bad faith) can only be brought in cases involving insurance contracts. For example, the Court held in *Foley v. Interactive Data Corp.* (1988) 47 Cal.3d 654, 684, 254 Cal.Rptr. 211, 228 that it is only "in the context of insurance contracts where . . . breach of the implied covenant will provide the basis for an action in tort". And the Court recently reiterated that "compensation for [breach of the implied covenant] has almost always been limited to contract rather than tort remedies" and that "at present, this court recognizes only one exception to that general rule: tort remedies are available for a breach of the covenant in cases involving insurance policies [*Cates Construction Inc. v. Talbot Partners* (1999) 21 Cal.4th 28, 43, 86 Cal.Rptr.2d 855].

Thus, unlike the Mississippi law construed in *Pilot Life* (which allowed tortious bad faith claims in a variety of contexts and therefore did not "regulate insurance"), California's bad faith tort is only available in the insurance arena. For that reason, California's bad faith law should be found to "regulate insurance" and therefore be "saved" from ERISA preemption.

## 5. Legal Disability

Another fertile area being plowed by disability insurers is the concept of "legal disability". This denial of benefits occurs where the insured is unable to engage in his profession due to legal impediments (e.g., revocation of a license necessary to practice), irrespective of whether he also happens to be physically disabled.

The primary published decision on this issue is *Massachusetts Mutual Life Ins. Co. v. Ouellette* (1992) 159 Vt. 187, 617 A.2d 132. In *Ouellette*, an optometrist was found guilty of lewd and lascivious conduct, resulting in the revocation of his license to practice optometry and his imprisonment. As a result, he applied for benefits under his disability policy. The Court held that the insured's pedophilia, while causing his license revocation and incarceration, was not a sickness that rendered him physically unable to practice his profession. In other words, but for the license revocation and the incarceration, he was physically able to practice and thus was not "factually" disabled.<sup>53</sup>

In a similar context, some courts have held that a person afflicted with a disease but not otherwise disabled is not entitled to benefits where he is precluded from engaging in his profession because he is a carrier of the disease [*Dang v. Northwestern Mutual Life Ins.* (D. Neb. 1997) 960 F.Supp. 215; *Gates v. Prudential Ins. Co.* (1934) 270 N.Y.S. 282].

Those holdings, of course, should have no application where the insured's physical or mental illness or disability occurred first, even if the condition subsequently led to the revocation of his license or other "legal" disability. Indeed, that is the conclusion reached in at least two published opinions. In *Ohio National Life Assurance Corp. v. Crampton* (E.D. Va. 1993) 822 F.Supp. 1230, *aff'd*, 53 F.3d 328 (4th Cir. 1995) and *Paul Revere Life Ins. Co. v. Bavaro* (S.D.N.Y. 1997) 957 F.Supp. 444, the courts reasoned that if the insured was in fact disabled, a later legal disability did not preclude recovery of benefits.

Thus, the key to addressing these cases is clarifying for the court the fact that the disability -- be it mental or physical -- existed first and that even if the legal disability vanished, the factual disability would preclude the insured from engaging in his occupation in any event.

## 6. Dual occupations at onset

Disability policies generally provide that an insured is totally disabled (and thus entitled to benefits) if he is unable to perform the substantial and material duties of his occupation due to an injury or sickness. The insured's occupation is usually defined as the occupation in which he was regularly engaged at the time he became disabled.

With increasing frequency, disability insurers are trying to argue that their insureds have dual occupations, and that even if they are unable to perform one of those occupations they are not totally disabled under the policy because they can perform the other. For example, an insurer may argue that a self-employed physician is not only a physician but also an "owner-manager". The insurer goes on to argue that even if the insured cannot perform his medical duties (e.g., perform surgeries), he still can run his medical business and thus is not totally disabled.

However, disability policies provide coverage for the insured's "real occupation" [*Dixon v. Pacific Mutual Life Ins. Co.* (2nd Cir. 1959) 268 F.2d 812, 815; *Continental Cas. Co. v. Novy* (1982) 437 N.E.2d 1338, 1349], "chosen profession" [*Continental, supra*, 437 N.E.2d at 1350], or "regular job" [*Vanderklok v. Provident Life and Accident Ins. Co., Inc.* (6th Cir. 1992) 956 F.2d 610, 614] - i.e., "his particular occupation for which he seeks protection by insurance" [*Dixon, supra*, 268 F.2d at 815; *Continental, supra*, 437 N.E.2d at 1351]. And

the fact that the insured, although unable to perform his particular occupation, might be able to perform some other occupation, is "immaterial" [Pistorious v. Prudential Ins. Co. of America (1981) 123 Cal.App.3d 541, 546, 176 Cal.Rptr. 660, 663, n. 4] and "beside the point" [Warren v. Commercial Travelers Mutual Accident Assoc. of America (1951) 199 Misc. 864, 865, 107 N.Y.S.2d 325, 326].

Based thereon, an insured physician (to continue the example) can argue that (1) he has a single "real occupation" or "chosen profession"; (2) that occupation or profession is physician; (3) the insurer knew, based on the insured's policy application, that the "particular occupation for which he [sought] protection by insurance" was physician, and it insured him as such; (4) the substantial and material duties of that occupation are performing surgeries (or whatever the case may be) -- not being an administrator or otherwise running a business; and (5) his inability to perform those duties renders him disabled.

Significantly, the California Supreme Court rejected an insurer's "dual occupations at onset" argument (although it was not stated as such) in *Erreca v. Western States Life Ins. Co.* (1942) 19 Cal.2d 388, 121 P.2d 689. In *Erreca*, the Court found that an injured owner of multiple ranches was totally disabled from his occupation even though he could still buy livestock and supplies, sell farm products, arrange crop financing, negotiate leases, and determine what crops to plant and the time and price for selling them -- i.e., administer the farming business. The Court reasoned that before his injury, the insured's duties had included manual labor (including plowing, driving tractors, and repairing fences and machinery) and personally supervising his employees' farm work (via walking, horseback and automobile), and that he could not perform those tasks -- i.e., the tasks of an active farmer -- as he had before his injury.

## 7. Choice

Disability insurers frequently argue that an insured has stopped working -- and made a claim for disability benefits -- out of choice, not because he is genuinely disabled. For example, the insurer may argue that the insured has chosen to leave his job because he has grown weary of long hours and declining pay, or because he is tired of dealing with clients or patients, or because he is going through a mid-life crisis, or because he is wealthy and doesn't need the income from his occupation (or, as discussed below, because his tax-free disability benefits provide him with more money than working full-time at his occupation).

At the risk of stating the obvious, the best way to counter the "choice" argument is to deny it. For example, the insured can testify that he is not suffering from burnout or some kind of mid-life crisis, that he loves his work, that he derives great fulfillment from his profession (helping clients, saving lives, working with the public, etc.), that he takes enormous pride in providing for his family, that he hates being a burden to his wife and children, and that he would work if he were able.

And it is imperative that the insured's work ethic and occupational satisfaction be corroborated by third-party witnesses, including his spouse, children, friends, employees, supervisors, co-workers, neighbors, patients and clients. They must confirm that the insured is unable, not unwilling, to work.

Finally, beware of the insurer that attempts to manufacture a "choice" argument by offering to retrain or rehabilitate the insured. If the insured declines the offer, the insurer will argue that the insured has chosen to remain disabled and therefore is not entitled to benefits. However, an insured is not required to make any attempt to retrain himself for an occupation which he would be physically able to pursue. And the fact that through rehabilitation or retraining the insured might be able to perform a job is not relevant to the issue of whether he is totally disabled. *Pistorious v. Prudential Ins. Co. of America* (1981) 123 Cal.App.3d 541, 546, 176 Cal.Rptr. 660, n. 4.

## 8. Financial gain

As a variation on the "choice" theme, a disability carrier may argue that the insured has filed its disability

claim for financial gain -- not because he is truly disabled. This argument is especially likely if the insured's benefits (which typically are tax-free) would provide him with more money than he was making at his occupation.

Generally, this argument should be countered in the same fashion as the insurer's "choice" argument. For example, the insured -- again, supported by friends, family and co-workers -- can testify that he finds his occupation highly fulfilling, that he garners great satisfaction out of providing for his family, and that he would much rather be working than collecting disability benefits. And of course, if the insured made, or had the potential to make, more money working than he receives in disability benefits, that fact needs to be emphasized -- and, if possible, verified by balance sheets, financial projections, or similar documents.

#### 9. Activities inconsistent with disability

Many disability insurers are cynical by nature. They believe that most claimants (especially those with long-standing claims or particularly high benefits) are not truly disabled -- or, at the very least, are not as disabled as they contend. And even if they suspect that their claimants may in fact be disabled, the insurers -- who want to hold onto premiums, earn interest on those premiums, and turn their claim departments into profit centers -- are constantly looking for ways to avoid paying claims.

Toward that end, some disability carriers conduct field visits. These visits are usually unannounced, and are designed to catch the insured performing activities that are inconsistent with his claimed disability. Additionally, the field representative often will try to take a recorded statement from the insured, hoping to lure the insured into making a devastating admission that will support the choice defense ("yeah, I'm tired; yeah, I'm burned out"), the financial gain defense ("yeah, my industry has dried up; yeah, managed care has made it impossible for me to make a decent living"), or some other coverage shield.

So how can you keep your client's claim from being sabotaged by a field visit? Most importantly, you need to tell your client to assume that he is being watched by a representative of the insurer (either a field visitor or, as discussed below, a videographer) at all times and to refrain from engaging in activities that could be misinterpreted by the insurer or, ultimately, a jury. In addition, you must instruct your client to speak with no one affiliated with the insurer (especially if the conversation is being recorded) unless you are present as well.

And you also must warn your client about the insurer using an outside investigator to conduct covert surveillance of his activities. The surveillance will be videotaped, will span a week or more, and will follow the insured virtually wherever he goes. The goal, of course, is to obtain videotape that shows the insured engaging in activities (e.g., bending, twisting, lifting) that are inconsistent with the restrictions and limitations claimed by the insured and corroborated by his treating physicians.

So what can you do if the insurer's paparazzi videotapes your client performing activities that, at least arguably, are inconsistent with his disability claim? The key is to remember that, in California, "'total disability' does not signify an absolute state of helplessness" [Erreca v. Western States Life Ins. Co. (1942) 19 Cal.2d 388, 396, 121 P.2d 689, 685]. Rather, it is "a disability that renders one unable to perform with reasonable continuity the substantial and material duties necessary to pursue his usual occupation in the usual or customary way" [Moore v. American United Life Ins. Co. (1984) 150 Cal.App.3d 610, 632, 197 Cal.Rptr. 878, 892].<sup>54</sup> Thus, an insured is totally disabled as long as he cannot perform the essential duties of his profession in the customary way and with reasonable continuity -- even if he can perform some of those duties to some extent and/or on some occasions (on a videotape or otherwise).

Accordingly, in Erreca, supra, the California Supreme Court found that a farm owner who could not perform manual labor or supervise farm operations as he had before his injury was totally disabled even though he could still buy livestock and supplies, sell farm products, negotiate leases, arrange financing, determine what

crops to plant, and set the price of crops and the time for selling them. Similarly, in *Austero v. Nat. Cas. Co. of Detroit, Mich.* (1978) 84 Cal.App.3d 20, 148 Cal.Rptr. 653, the Court held that an attorney suffering from memory loss and impaired judgment was totally disabled despite the fact that he appeared at 251 court hearings (an average of 20.9 per month), had 689 scheduled office appointments with clients (57.3 per month), and took 16 depositions -- and thus was "obviously able to perform at least some of the functions of his profession". 84 Cal.App.3d at 23, 148 Cal.Rptr. at 668. Based thereon, you must argue that the videotape does not show that your client can perform his occupational duties in the manner he did before his injury or sickness, or that he can do so on a continuous basis.

Other arguments to consider include the following:

The videotape is tainted, slanted and otherwise biased. The tape reflects the insurer's carefully calculated effort to "investigate" the claim with an eye toward denying benefits rather than an eye toward paying them -- in flagrant violation of its duty of good faith. For example, the insurer's investigator -- who was recommended by the insured's lawyer and paid by the insurer's adjuster -- stalked plaintiff for 12 hours a day for 7 days, yet reduced its surveillance to a mere 1 hour tape. The other 83 hours of surveillance are conspicuously omitted from the tape. Predictably, all of the videotaping that was done (or at least all of the videotaping that was included in the selectively spliced video) was of activities deemed by the investigator to be inconsistent with plaintiff's disability, and the investigator failed to videotape any activities (or inactivity) to the contrary. In fact, the videotape never shows plaintiff doing nothing.

The surveillance tape is distorted. The tape was deceptively created through the use of telephoto lenses, misleading camera angles, and careful omission of footage favorable to the insured.

The videotape was obtained through deceptive means. The videographer set up the activities the insured unwittingly performed, induced the insured to perform those activities, or otherwise manipulated events to entrap the insured.]

The insurer offered plaintiff no opportunity to explain his activities on the surveillance tape. The insurer never wrote to plaintiff to ask if he had any explanation for his taped activities. Thus, plaintiff never had the chance to tell the insurer that he had no choice but to perform the activities on the videotape because groceries had to be bought and children had to be lifted, and there was nobody else to do it. Also, plaintiff had no opportunity to explain that he was only able to perform the tasks depicted on the tape because he was having an unusually good day or was wearing a back support and was under heavy medication (a medication that, if taken at work, would prevent him from performing his job). Moreover, plaintiff had no chance to tell the insurer how many rest periods (all untaped) he had to take during the depicted activities or how infrequently he performed them because of the pain they produced. Further, plaintiff had no opportunity to explain that performing the activities on the tape caused him to suffer excruciating pain for many hours after the activities shown on the tape, and so exhausted him that he had to rest in bed for several days. And plaintiff never had the chance to have his treating physician explain that the depicted activities were not inconsistent with plaintiff's complaints or the physician's own findings, or that the videotape showed that plaintiff had to guard himself in his movements to avoid painful extremes of motion or was otherwise restricted in ways that insurers -- and jurors -- might not observe.

Reliance upon the videotape to deny coverage meant that the insurer had to ignore MRIs, X-rays, physical capacity evaluations, monthly progress statements, treating physicians' notes, and other objective evidence confirming his disability, in violation of the insurer's duty to evaluate the insured's claim objectively, and to consider the totality of the evidence produced.

And what if the insurer's paparazzi films the insured at his office or other place of work? Significantly, an insured who attempts to return to work is still disabled if he cannot perform his duties as he did before his injury. In *McMackin v. Great American Reserve Ins. Co.* (1971) 22 Cal.App.3d 428, 99 Cal.Rptr.227, the Court found that an injured C.H.P. officer remained totally disabled even though he returned to work for eight

months and received his regular compensation because he was "unable to perform his duties fully" and "worked slowly" as compared to his efficiency before his injury. *Id.* at 434-435. As stated by the Court, "an insured should not be penalized for a desire to resume his job, and a futile effort to return to work, notwithstanding the existence of disability, will not preclude recovery of benefits." *Id.* at 438.

Thus, you must demonstrate that although the insured tried to return to work, his effort was unsuccessful. Perhaps the insured could not "work . . . with reasonable continuity" [*Erreca v. Western States Life Ins. Co.* (1942) 19 Cal.2d 388, 394-395; 121 P.2d 689, 694] or was only "able to perform sporadic tasks" [*Id.*, 19 Cal.2d at 396, 121 P.2d at 695]. Or maybe he was unable to perform his work tasks in his "usual or customary way" [*Moore v. American United Life Ins. Co.* (1984) 150 Cal.App.3d 610, 632, 197 Cal.Rptr. 878, 892]. One or more of these arguments should be aggressively advanced.

#### 10. "Independent" medical examination

Disability insurers frequently require their claimants to undergo independent medical examinations. In reality, though, they should be called "defense medical examinations", as the doctor is retained and paid by the insurer with one goal in mind: finding the insured not disabled. Indeed, it is virtually a foregone conclusion that the carrier's "independent" medical examiner will conclude that your client is not disabled. When the inevitable happens, there are numerous arguments you can make to attack the doctor and his findings. Here are a few examples:

The doctor has a bias in favor of insurers generally. If you're lucky, the vast majority of his practice is devoted to performing "independent" medical examinations for which he is paid by insurers. And those insurers typically get what they paid for, as the doctor finds that the claimant is not disabled virtually every time.

The doctor is biased in favor of this particular insurer. Your client's insurer paid the doctor thousands of dollars to perform the "independent" medical examination, with the obvious expectation that he would come back with a finding of non-disability. And the doctor has performed many "independent" medical examinations for this insurer in the past (to his considerable profit), and certainly hopes that the insurer will continue to retain him in the future. The easiest way to ensure referrals in the future is to give the insurer an opinion that will save it money now.

The doctor performs "independent" medical examinations, including your client's, for his financial gain. Due to the restrictions of managed care, the doctor is earning far less money in his practice than he once did. It is much more lucrative for him to perform IMEs, at about \$5,000 per exam, than to actually practice medicine, especially if he has a volume IME practice. (This can be a particularly effective counterattack if the insurer has taken the position that your client is pursuing his claim for his financial gain.)

It isn't the insured who has made a choice to stop working and collect disability benefits. Rather, it's the doctor who has made a choice -- the choice to sell out to high-paying insurance companies (by discrediting claimants with genuine disabilities) instead of helping patients. (This can be a particularly effective counterattack if the insurer is asserting that the insured made the choice to abandon his career.)

The doctor isn't qualified to render an opinion regarding the insured's condition. He is hardly seeing patients anymore, and does not keep current on the practice of medicine. Instead, the bulk of his time is devoted to performing "independent" medical examinations for insurance companies. And on those occasions when he does practice medicine, it is outside the medical area relevant to the insured's condition.

The doctor ignored objective evidence of the insured's disability, including X-rays, MRIs, CT scans, discograms, and attending physicians' statements.

In fact, you may want to hire your own investigator to help you neutralize the insurer's "independent" doctor and his findings. Your investigator can look for prior malpractice actions against the doctor, Medical Board or license problems, or even disability claims filed by the doctor. The investigator can also search for other

cases in which the doctor has testified, during depositions and/or trial, and thereby help you establish that the doctor is biased in favor of insurance companies or has taken a position in other cases that is inconsistent with the one he is advocating in your client's suit.

And while you're attacking the doctor, don't forget the insurer that retained him. For example, if your client's treating doctors found him disabled but the "independent" medical examiner did not, you should emphasize that an insurer has the duty to give more weight to treating physicians' opinions than those of non-treating physicians [Lester v. Chater (9th Cir. 1996) 81 F.3d 821, 830; Pitzer v. Sullivan (9th Cir. 1990) 908 F.2d 502, 506, n. 4; Gallant v. Heckler (9th Cir. 1984) 753 F.2d 1450, 1454; Monroe v. Pacific Telesis Group Comprehensive Disability Benefits Plan (C.D. CA 1997) 971 F.Supp. 1310, 1315]. Further, if the insurer breached its duty to provide the policy definition of "disability" to the independent medical examiner it utilized to review the insured's claim [Moore, supra, 150 Cal.App.3d at 618 and 637-638, 197 Cal.Rptr. at 882-883 and 895-896], that failure should be highlighted as well. And if the insurer denied your client's claim without even having him undergo an independent medical examination, you should argue that an insurer has a duty to conduct such an examination before deciding whether its insured is entitled to disability benefits [Monroe, supra, 971 F.Supp. at 1316; Russell v. UNUM Life Insurance Co. of America (D.C. S.C. 1999) 40 F.Supp.2d 747, 751].

#### BRINGING IT HOME -- TRIAL THEMES THAT SING

Of course, all of the above -- the careful screening of potential clients, the skillful pleading, the tenacious discovery, the aggressive motion practice -- will have been for naught if the jury isn't excited about your case. From voir dire to opening statement to witness examination to closing argument, you must have a consistent, inspiring theme that will continue to resonate in the jurors' minds while they are deliberating -- and hopefully, calculating damages -- in the jury room. Only if you have raised and reinforced a powerful theme will the jury be compelled to award a substantial verdict to your client.

Here are some possible themes for you to consider:

A deal is a deal. An insurer, like any person, should keep the promises it made. Here, instead of accepting responsibility and owning up to its commitments, the insurer welched on its word.

This is a story of betrayal. The insured paid hard-earned money for what he trusted would be protection, peace of mind and security. The insurance company betrayed that trust by delaying, then denying, the insured's claim.

The insurance company went trolling, and the plaintiff took the bait. Through newspapers, radio, television, mailings, and agents' presentations, the insurer touted its age-old experience ("been around since the midnight ride of Paul Revere") and dependability, extolled the features, advantages and benefits of its policy, and promised that it would be there if the plaintiff ever needed help -- and the plaintiff was hooked. But when the plaintiff became injured or sick, the insurer tossed him back into the ocean and let him fall to the very bottom of his life -- and, in the process, wholly disregarded its sales promises. It was advertising and marketing fraud, plain and simple.

This is a classic example of the two faces of Eve. On the sales side, the insurer is all warm, fuzzy and reassuring, promising peace of mind and security. But when an insured, after faithfully paying premiums for years, has the audacity to actually make a claim, the dark side of Eve rears her ugly head. In the claim zone, it's cold, the insured is swimming upstream, and the water is plenty deep. The insured has moved from the asset side of the insurer's ledger to the liability side, and that's where the promise made becomes the promise broken.

This insurance company added insult to the insured's injury or sickness. It spat on the insured while he was

down and out. Just when the insured needed a helping hand out of his hole, the carrier kicked dirt down that hole.

This lawsuit was unnecessary. It could have been prevented if the insurance company had just kept its word, honored what it sold and followed the rules of the road: Don't lie, don't cheat, don't chisel, don't lowball, and don't delay. Just do the right thing: Be honest, pay what you owe, pay it on time, and do it every time.

Buying an insurance policy is not like buying a car. You don't get a chance to try it out before you buy it and take it home. So you have to know that it's going to work when you need it. And if it doesn't perform like the seller assured you it would, that seller should be held fully accountable.

You can't change an agreement after it's been made (unless both sides want to change it). So, for example, if a policy doesn't specifically say that the i