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This journal is published by the Insurance and Indemnity Law Section, State Bar of Michigan


Opinions expressed herein are those of the authors or the editor and do not necessarily reflect the opinions of the section council or the membership.
I hope all of you had a wonderful holiday season. I also hope you were able to attend our annual New Year celebration on Thursday, January 11th. Our annual event always has an informative presentation, delicious food, and presents a great opportunity for you to meet and interact with other members of the Section. If you missed this year’s event, I hope to see you at our next one.

As we enter 2018, the Section Council has undertaken several efforts to increase the utility and value of your Section membership. For starters, we have hired Madelyne Lawry as a consultant to coordinate our efforts. Madelyne brings with her vast experience working with other Sections and Bar organizations in a similar manner. Madelyne will be working closely with the Section officers and other members in an effort to enhance the benefits of your membership.

We’re on Facebook!

The Section now has a Facebook page. We will be using the page to share announcements of interest to our members as well as other resources that may be useful to you. I invite you to visit our Facebook page and it would be very helpful if you “liked” it. If you have an announcement you would like to share with other members of the Section, please contact Madelyne (inslaw2017@comcast.net) and she will work with you to get it done!

New postings on our SBM website

We are also in the process of populating our page at the State Bar of Michigan website with articles and other research that will likely be of interest or use to you as you deal with insurance related issues in your practice. Past articles from our Journal as well as other contributions will be posted. If you would like to contribute an article, research or other helpful resource, please let Madelyne know.

Online Seminars

We are also planning on preparing online webinars on insurance related topics. The webinars are created with the assistance of ICLE and are broadcast using ICLE’s online capabilities. The opportunity to participate in or present a webinar is available to all members of the Section so if you have a topic you would like to speak on, let us know.

Our Section’s Growing Presence

The Section's influence and participation in State Bar functions have been steadily increasing.

Our Scholarship

We will be working with Michigan's law schools in conjunction with the granting of a scholarship that will be awarded to a student who wins a competition within each law school on a topic related to insurance.

Michigan Bar Journal Insurance Issue

The Section has also been invited to submit articles to the State Bar of Michigan to be included in an upcoming issue of the Michigan Bar Journal devoted to insurance related topics. We are currently working on the selection of topics and the recruitment of authors. If you have an idea for a topic and would like to be published in the Michigan Bar Journal, please contact me or our coordinator, Hal Carroll at HOC@HalOCarrollEsq.com.

Supreme Court Invitation to File Amicus Brief

The Section has also been invited by the Michigan Supreme Court to file a brief as amicus curiae in the case of Song Yu and Sang Chung v. Farm Bureau General Insurance Company of Michigan, SC 155811, COA 331570.

Tell us how we’re doing

We are working hard to improve what this Section can do for you. We could really benefit from feedback from you as to what more we can do. Please let us know.

Larry Bennett
Siekaly, Stewart & Bennett PC

From the Chair

Invite someone you know to join the fun.

Invite someone to join the section.

Section membership forms can be found at http://www.michbar.org/sections
Editor’s Notes
By Hal O. Carroll
www.HalOCarrollEsq.com

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

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

The Journal is published quarterly in January, April, July and October. Copy for each issue is due on the first of the preceding month (December 1, March 1, June 1 and September 1). Copy should be sent in editable format to the editor at HOC@HalOCarrollEsq.com.

Our 2018 New Year Program took place on January 11 at Steven Lelli’s Inn on the Green. Hors d’oeuvres and libations were provided, and we had a presentation by Raymond Horenstein of the Horenstein Law Office. His topic was Lawyer Liability Insurance Coverage and How to Prevent Malpractice.

Here are some highlights of his presentation:

- Missing a statute of limitation is avoidable if you have a reliable system for logging and tracking the date.
- “Don’t do what you don’t do”: Be cautious about taking on work in an area you are not familiar with.
- Retention letters – Always get one to define the scope of your representation.
- Malpractice Coverage is really “Sleep Insurance.” It allows a lawyer to sleep at night rather than worrying about what mistake might be lurking as a malpractice action.
- Grievance Coverage can be purchased to protect a lawyer from the expensive investigation and disciplinary process that may ensue solely from a client complaint – whether justified or not.
- Cyber liability coverage is an important part of an insurance package to protect against claims that client information has been disclosed. This coverage is extremely reasonable when compared to the cost of remediing the breach. Usually, $1 million in coverage has only a $1,000 premium.
- Malpractice polices are “claims-made,” so you must notify your carrier of any potential claim. If you don’t, there is no coverage.
- But if you do provide notice, there will be coverage even if the actual claim comes after the end of the policy period.
- Every year, every attorney in the firm must disclose anything that might give rise to a claim.
- Policies have a “hammer clause”: if the award is greater than the settlement the carrier was able to negotiate, the attorney pays the excess.
- Don’t forget to buy “tail coverage,” which provides coverage after the firm ceases to renew insurance.
Purchase of a Dwelling by Land Contract Entitles Insureds to “Replacement Cost” Benefits

By Jason J. Liss, Fabian, Sklar, King & Liss, PC

While most homeowners insurance policies cover the cost to repair or replace damage caused by a covered loss, many people do not realize that under most homeowners policies the insured is not entitled to recover replacement cost benefits unless and until the structure is repaired or replaced. Absent repairs or replacement, the insurance company is usually only required by the terms of the policy to pay the actual cash value of the home (ACV), commonly defined as the structure's replacement cost after application of depreciation. This withholding of depreciation until repair or replacement is complete is frequently referred to as the “holdback.”

Some insurers took the position that a land contract purchase did not satisfy the replacement condition because the insured did not receive a deed at closing and, therefore, the replacement was not complete.

Mortgage versus Land Contract Purchase

Insurers have routinely recognized that an insured who finances the purchase of a substitute structure with mortgage financing has met the policy condition to recover payment of the holdback. However, until recently, it remained an unsettled question as to whether an insured's purchase of a substitute dwelling by land contract qualified as replacement under the policy conditions for payment of the holdback. Because insureds frequently needed the payment of the replacement cost holdback to finance the purchase of a substitute dwelling, it became a common practice for insureds to enter into land contracts which made the closing of the sale contingent upon the insurer paying the holdback. Some insurers took the position that a land contract purchase did not satisfy the replacement condition because the insured did not receive a deed at closing and, therefore, the replacement was not complete.

Contingent Land Contracts

In 2016, with its decision in James Glass v Farm Bureau General Insurance Company of Michigan,1 the Michigan Court of Appeals eliminated the practice of making a land contract sale contingent on the insurer's payment of the holdback. In that case, after a fire destroyed his home, the insured notified Farm Bureau of his intent to relocate and purchase a replacement home in a different locale under a land contract. Consistent with common practice, the purchase was contingent on Farm Bureau paying the holdback, which the insured intended to use as the down payment for the transaction. Farm Bureau denied the insured's request for payment of the holdback, asserting that the insured's land contract did not constitute “replacement” of his damaged property. The Court of Appeals agreed, concluding that because the insured's land contract was contingent on Farm Bureau's payment of additional proceeds, replacement was not complete and the land contract property was not an “actual” replacement, as required by the insurance contract, but merely a contract to purchase a “potential” replacement.

Court of Appeals holds that land contract satisfies replacement requirement

Recently, however, in Debra Batton-Jajuga v. Farm Bureau General Insurance Company of Michigan;2 a published decision, the Court of Appeals held that an insured who purchased a dwelling on a land contract without the aforementioned contingency, was entitled to the holdback because the land contract constituted an “actual” and “complete” replacement of the damaged property.

In Batton-Jajuga, following a fire at her home, the insured purchased a replacement dwelling on land contract and made a claim for the holdback. Consistent with common practice, the land contract contained an addendum making the purchase contingent on Farm Bureau's payment of the holdback. When Farm Bureau balked at paying the holdback, the insured removed the addendum, closed on the land contract purchase and again claimed payment of the holdback. Farm Bureau nonetheless refused to pay the holdback on the grounds that replacement was not “complete” because the insured would not obtain a deed transferring legal title until the land contract was paid off. Farm Bureau further argued that the insured had not “actually spent” more than the ACV because the down payment made by the insured did not exceed the ACV payment, even though the land contract itself was for an amount which exceeded the agreed upon replacement cost value (RCV) of the insured’s fire-damaged dwelling.

The Court of Appeals rejected both of Farm Bureau's arguments. Notably, the Court of Appeals held that the land contract vendee, though holding only equitable title, is the owner of the property even though the land contract vendor
An Insured’s Post-Loss Duty to Cooperate in Property Insurance Policies

By Rabih Hamawi, Law Office of Rabih Hamawi, PC

Introduction

Most property insurance policies, such as homeowners, dwelling fires, or commercial property policies, contain many duties and obligations called “conditions” that an insured must first comply with before he or she may 1) recover under the policy; or 2) sue an insurer for a breach of the insurance policy.1

To learn about these conditions, an insured must first read his or her entire policy, not only the declaration page. Generally, policies may have varying conditions regarding the insured’s duties after a loss, but most contain some universal post-loss duties that primarily intend to benefit both the insurer, who needs information from the insured to protect its own interest; and the insured, who needs a claim to be handled expeditiously and appropriately. In examining the insured’s post-loss duty to cooperate, there is a focus on allowing the insurer to timely investigate the loss, and on protecting further damage to the insured property.

This post-loss duty to cooperate is especially important because willful noncooperation of the insured is a valid defense under a policy of noncompulsory insurance, like a homeowners or commercial property policy.2 But generally, noncooperation of the insured is not a valid defense to an insured’s liability to a third party under a compulsory insurance policy, like a no-fault auto or liquor-liability policy.

An insured’s duties after a property loss

After a loss, an insured must cooperate with the insurer during the investigation of the claim, and comply with the remaining policy’s conditions, or risk forfeiture of any available coverage under the policy. Generally, an insured must do the following:3

a. Provide prompt notice of the loss to the insurer or the insurer’s agent;

b. Protect the insured property from further damage;

c. Provide a timely sworn statement in proof of loss; and

d. Appear for an examination under oath.

An insured must provide prompt notice of the loss to the insurer or the insurer’s agent.

Providing prompt notice permits the insurer to a) timely investigate and gather information about the claim before any evidence is lost or destroyed; and 2) protect the insurer from any potential fraudulent, excessive, or invalid claims.4

Unlike other types of policies, like pollution or directors and officers liability policies, which require insureds to provide written notice within a specific period of time or number of days, like 7, 30, or 60 days, most property insurance policies require that insurers are notified promptly, as soon as reason-
When complying with the duty to mitigate the damages after a loss, an insured must act promptly and must not wait on the insurer’s determination of the claim or receiving payment from the insurer. Therefore, an insured must reasonably mitigate the damages even if this means incurring out-of-pocket expenses. Generally, an insured won’t be permitted to recover for any additional damages that could have been avoided if he or she was able to mitigate his or her damages.

Likewise, under Michigan law, an insured must exercise reasonable care to minimize his or her damages. But the insurer has the burden to prove that the insured failed to mitigate the damages, and an insurer can only reduce the insured’s recovery when it shows that the insured has failed to employ every reasonable effort to mitigate damages.

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Under the ISO homeowner’s policy form, late notice doesn’t justify denial of an insured’s claim unless the late notice is prejudicial to the insurer.

Duties After Loss

In case of a loss to covered property, we have no duty to provide coverage if the failure to comply with the following duties is prejudicial to us.

Similarly, in policies that require “prompt,” “as soon as possible,” or other similar notice provisions, under Michigan law, an insurer must prove actual prejudice by late notice before it can escape liability under a property insurance policy. Generally, whether a late notice had prejudiced an insurer is a question of fact for the jury.

An insured must protect the insured property from further damage

Under the ISO property insurance forms, after a loss, an insured has a contractual duty to take all reasonable steps to mitigate his or her damages by protecting the insured property from further damage. An insured must also keep a record of any expenses incurred for emergency and temporary repairs. When mitigating the damages, an insured must only act as a reasonable prudent person; in other words, an insured need not take extraordinary efforts or steps that could create an undue burden on him or her. Whether an insured reasonably mitigated the damages usually depends on the loss’s facts and circumstances.

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When complying with the duty to mitigate the damages after a loss, an insured must act promptly and must not wait on the insurer’s determination of the claim or receiving payment from the insurer.

An insured must provide a sworn statement in proof of loss

Within 30 days of receiving a notice of claim, a property insurer must inform its insured of what information or documents must be submitted to constitute a satisfactory proof of loss. Usually, an insurer will request that the insured submit a “sworn statement in proof of loss” (SSPOL). The SSPOL provides the insurer with the information it needs to determine if the claim is covered and, if so, in what amount, and to prevent fraud by requiring the insured to swear to the truthfulness of the information being submitted.

When responding to the insurer’s request, an insured must timely submit a SSPOL or risk forfeiture of any potential benefits under the policy. But an insurer may not rely on the insured’s failure to submit a document titled SSPOL when an insured substantially complies with the purpose of the SSPOL.

For example, when an insurer receives the functional equivalent of the information included in a SSPOL such as receiving immediate notice of the claim, fully investigating the claim, and examining the insured under oath, the insured is held to have complied with the policy’s conditions, and the insurer may not deny a claim for failure to timely submit a SSPOL.

An insured must also review the policy’s post-loss conditions to determine when the SSPOL is due. Some policies require an insured to submit a SSPOL within 60 days after the date of loss, while others require an insured to submit a SSPOL within 60 days after the insurer’s request.
If an insured cannot timely submit a SSPOL, he or she should attempt to obtain a written extension from the insurer; and if the insurer refuses to approve such extension, the insured should then try to diligently submit any available information within the required time period, and then supplement the SSPOL once additional information becomes available.

Usually, an insurer will request that the insured submit a “sworn statement in proof of loss” (SSPOL). The SSPOL provides the insurer with the information it needs to determine if the claim is covered and, if so, in what amount, and to prevent fraud by requiring the insured to swear to the truthfulness of the information being submitted.

An insured must appear for an Examination Under Oath

The SSPOL usually goes hand-in-hand with another important post-loss condition known as the examination under oath (EUO). Usually, if the insurer has doubts or questions about the facts and circumstances surrounding the loss, the SSPOL, or the insured’s financial condition, it may require the insured to submit to an EUO, during which the SSPOL could be used against the insured. This highlights the importance of providing an accurate and truthful SSPOL to the insurer.

An EUO is a process in which an insured verbally answers the insurer’s questions under oath and provide numerous other documents. Although an adjuster may complete an EUO, it is usually conducted by an attorney on the insurer’s behalf, in the presence of a court reporter typing down everything being said, and is usually completed in the presence of the claim’s adjuster or an investigator from the insurer’s special investigation unit. Therefore, when responding to an insurer’s request for an Examination Under Oath, an insured shouldn’t proceed with the Examination Under Oath alone, and should consider retaining a property insurance attorney to assist with the process.

Depending on whether the loss is residential or commercial, the information or documents requested might be very exhaustive and lengthy, which sometimes will prompt insureds to express their frustration with the process, including feeling it is intrusive or overbroad. Nonetheless, an insured must cooperate and submit to an EUO because failure to submit to an EUO suspends the insurer’s duty to provide coverage or payment for the insured’s loss until the EUO is completed.¹⁵

When an insured willfully refuses to submit to an EUO, his or her subsequent suit against the insurer must be dismissed with prejudice.¹⁶ Willful noncompliance is more than an insured’s failure to attend the EUO due to a scheduling conflict. Michigan courts define willful noncompliance as the insured’s “failure or refusal to submit to an [EUO] or otherwise cooperate with an insurer in regard to contractual provisions allowing the insurer to investigate the claim that is part of a deliberate effort to withhold material information or a pattern of noncooperation with the insurer.”¹⁷ The insured has the burden to show that he or she has not deliberately withheld material information.

Some insurers attempt to expand the scope of the duty to cooperate

Although an insured owes the insurer a post-loss duty to cooperate, this duty is not limitless, and it mustn’t create an undue burden on the insured, especially when an insurer requests information that an insured doesn’t have and can’t obtain, or when a non-insured, third-party witness refuses to speak with the insurer.

In recent years, some insurers have frequently attempted to expand the scope of the duty to cooperate, and have requested insureds to provide additional information or documentation, although there is no explicit authority in the policy for requesting these additional documents or information.

For example, a cell-phone forensic download is now a part of most fire-insurance claims. Although a request for cell-phone data might be relevant if it is limited to a day or two before and after the loss, some insurers have attempted to extract all of the information available on a cell-phone since the insured bought it, going back several years; or downloading private irrelevant information, like a photo of the insured’s significant other or the insured’s children.

Similarly, some insurers have requested information from an insured’s social-media accounts, while others have become much more aggressive, requesting the insured’s usernames and passwords to these social-media accounts.

Likewise, some insurers have required an insured to produce friends, neighbors, or other non-insured third parties for a statement under oath, and have wrongfully denied the insured’s claim when those non-insured third parties refuse or fail to respond to the insurer’s request for a statement under oath. It behooves insurers to know that the post-loss duty to cooperate is only a duty of an insured, as defined under the policy. Third parties, which aren’t an insured as defined under the policy, need not cooperate with the insurer, and an insured’s claim shouldn’t be denied for a third-party failure to cooperate with the insurer.

Conclusion

After a property loss, an insured must cooperate with the insurer by 1) providing prompt notice of the loss to the insurer or the insurer’s agent; 2) protecting the insured property
from further damage; 3) providing a timely sworn statement in proof of loss; and 4) appearing for an examination under oath. An insured who doesn't comply with these duties may be barred from recovering under the policy, and generally can't sue an insurer for a breach of the insurance policy until he or she first complies with the policy's terms and conditions.

About the Author

Rabih Hamawi is a principal at Law Office of Rabih Hamawi, P.C. and focuses his practice on representing policyholders in fire, property damage, and insurance-coverage disputes with insurers and in errors-and-omissions cases against insurance agents. He has extensive expertise in insurance coverage and is a licensed property and casualty, life, accident, and health insurance producer and counselor (LIC). He earned the Chartered Property and Casualty Underwriter (CPCU), Certified Insurance Counselor (CIC), and Certified Risk Manager (CRM) designations. His email address is rh@hamawilaw.com.

Endnotes

1 This article discusses the Insurance Services Office, Inc (ISO) policy forms. Some insurers may use their own policy forms, which may include different or additional post-loss duties or conditions.


3 The ISO policy forms contain additional post-loss duties. For example, an insured must notify the police in case of loss by theft and exhibit the damaged property.


6 ISO is an advisory organization providing statistical, actuarial, underwriting, and claims information and analytics; compliance and fraud identification tools; policy language; and other related risk management services to the property and casualty insurance industry.


9 Kliseck v Anderson Sales & Services, Inc, 426 Mich 78, 91; 393 NW2d 356 (1986); see also Lawrence v Will Darrab & Assoc, Inc, 445 Mich 1, 15; 516 NW2d 43 (1994).


11 MCL 500.2006(4).


14 Id.


16 Id.

David Dykhouse, who passed away on September 15, 2017 in Petoskey, Michigan, just shy of his 81st birthday, was a farm boy from the Midwest who came to be intensely interested in the regulation of the insurance industry. He twice served as the Michigan Insurance Commissioner, first during the tumultuous years from 1966 to 1969 and then again in years of marked change from 1991 to 1995. With his passing, Michigan loses a great intellect and a committed public servant. He is of exemplary note today, especially in this era of almost daily questions as to the competency of various public servants and alleged criminal acts by other public servants.

Dykhouse graduated from the University of Michigan law school in 1962. Four years later, at the mere age of 29—and then a deputy in the Department of Commerce—Dykhouse found himself elevated by Governor George Romney to helm the insurance oversight of the seventh largest state in the USA. In July of 1967, he came face to face with the cataclysm of the Detroit riots, during which at least 43 people died. Thousands of storefronts were burned or looted, and hundreds of homes and other buildings suffered severe damage. In his concern for how the city would be rebuilt afterwards, Dykhouse successfully urged President Johnson and Governor Milliken not to declare an insurrection and to take great care in how and under what terms federal troops were deployed, in that, if done incorrectly, it could well have voided property insurance coverages on thousands of structures in the city.

While Commissioner, and in his role as a member of the National Association of Insurance Commissioners, Dykhouse was a draftsmen of the Model Holding Company Act—a law since enacted in every state—which imposes regulation and oversight on not only insurers but also their relationships with affiliate companies. He further authored statutes on financial condition and guaranty associations to assure solvency and protections for consumers in the event of insolvency of insurers. In 1969, he was one of the principal authors of the Michigan Administrative Procedures Act, and served as well on the Administrative Law Commission.

In a first transitory event of his second tour of duty as Michigan’s Commissioner, Dykhouse facilitated, in a complex series of events, the sale of the State Accident Fund to Blue Cross Blue Shield of Michigan. The sale remains among the largest insurance privatizations in history. He represented The Dow Chemical Company and Union Carbide on high profile and controversial insurance coverage matters and, as part of the Shearman & Sterling law firm, was at the center of international insurance disputes as well.

In 1991, the State of Michigan came calling again. Dykhouse’s longtime friend from the days of the Romney administration—Judge William Whitbeck—convinced him to leave his fruitful practice and return to his previous post. He agreed to do so without even knowing what he would be paid as Commissioner. Further, at this juncture, he was faced with several new and trying issues that had gone without address by the prior public servants involved in the regulation of Michigan’s insurance markets.

In the early 1970s, he left his position as Commissioner to become a legal advisor to the newly elected Governor William Milliken. When Governor Romney became the Secretary of Housing and Urban Development under President Nixon, Dykhouse joined him as special insurance counsel and in other capacities.
In a second tranche of regulatory commitment, Commissioner Dykhouse had to deal with a number of Michigan domiciled insurers and their holding companies that had either a single owner or were closely held. These insurers posed a threat to the orderly market of insurance in Michigan, and upon review by regulatory auditors, he imposed oversight in the form of supervision, seizure, rehabilitation, or liquidation under applicable statutes and initiated the first use of criminal complaints under punitive provisions of the Insurance Code. Commissioner Dykhouse's purpose again being the protection of consumers and creditors against losses arising out of mismanaged and poorly run companies. This included the initiation of liquidation proceedings concerning American Commercial Liability Insurance Company and Confederation Life Insurance Company, as well as the continued oversight and liquidation of Great Lakes American Life Insurance Company, Mid-America Life Assurance Company, Commercial Underwriters Insurance Company, Sovereign Life Insurance Company, Woodland Mutual Insurance Company, and HMO West.

In his statutory role as Liquidator, Dykhouse coordinated services from a multitude of sophisticated vendors employing large workforces seeking to claw back funds improperly diverted by the insurer's owners so as to assure claims were paid as expected and when due. In addition to facing the complexities that come with slowing the descent and dismantling of domiciliary insurers (with national markets in several instances), Dykhouse had to do so while seeking cooperation and satisfaction of many different factions—e.g., guaranty associations, judges, the Attorney General, creditors, policyholders, parent companies, and taxing authorities.

He left the public service of the State of Michigan a second time in 1995 and thereafter dedicated most of his attentions to his new role as the Principal Special Deputy Liquidator for the estate of Confederation Life. Confederation Life was a Canadian company licensed in all fifty states and thus also subject to regulation in Michigan. Despite a long and successful history, the company suddenly collapsed, with liquidation formally filed in 1996. Michigan serves as the “port of entry” for most Canadian life insurers, and so Michigan became the locus of action for the majority of the US claims. The financial collapse of Confederation Life was and remains the largest insurance insolvency in North American history. Dykhouse served as its deputy liquidator for over a decade, marshalling and protecting more than $5 billion in assets and honoring long-term commitments to over 150,000 policyholders in the United States.

Few and likely none have had a fuller insurance life in Michigan (or really anywhere) than David Dykhouse. Thus, Dykhouse was one of the inaugural inductees to the Michigan Insurance Hall of Fame in 1994. He was a true professional as a regulator, attorney, and public servant. He was also a friend to many and an honest broker to all.

A Kaiser Health News article recently called insurance commissioners the “most powerful people you've never heard of.” It correctly surmises that few people comprehend the great scope of powers many states confer on their chief insurance regulators. Nor do people—by and large—appreciate the impact on their daily lives of the decisions made by the person charged with the government’s oversight of risk transfer. There have been many stewards of this crucial industry who have performed their work quietly, professionally, and successfully. We in Michigan were fortunate to have had David Dykhouse at the regulatory helm twice when the state and the industry were in marked need of a strong, sophisticated, and successful public servant.

About the Authors

Joseph Fink is a senior member with Dickinson Wright PLLC and worked for decades on matters with Mr. Dykhouse. Ryan Shannon has recently become a member at Dickinson Wright PLLC and practices in the area of insurance regulation. As a young lawyer, he had the privilege of working with Mr. Dykhouse as well.

Endnotes

1 Published 1974 by the New York State Insurance Department.
Legislative Update

By Patrick D. Crandell, Collins, Einhorn, Farrell PC

Finishing the Year

Following a quiet summer (the House and Senate were out for a two-month recess) the Legislature ramped up its efforts in a final push until the end of the year. Notably, there was another unsuccessful attempt to modify the no-fault insurance system (HB 5103 – referenced below) and the members continued to introduce new bills (1375 in the House and 740 in the Senate).

Since the last update, there are a number of new bills that were referred to and came before the House and Senate Insurance Committees:

- **Accounting firm requirements.** HB 4889 creates a list of requirements that an accounting firm must meet before it may perform “attest or compilation services” for a public body.
- **MCCA disclosure.** HB 4890 requires the Michigan Catastrophic Claims Association (MCCA) to publicly disclose all data, including actuarial computations, it uses to determine rates.
- **Cancellation of life insurance for victims of sexual misconduct.** HB 4903 prohibits a life insurance company from rating, canceling coverage on, or refusing to provide a policy for an individual solely because that person was the victim of criminal sexual conduct.
- **Rate discrimination based on sex.** HB 4904 prohibits insurers from charging different rates based on the insured's sex.
- **No-Fault changes.** HB 5013 makes a number of changes to Michigan’s no-fault insurance system, including: (1) allowing insureds to select one of three PIP coverage levels; (2) permitting insurers to limit the amount of covered attendant care; (3) setting maximum reimbursement rates for medical providers; (4) requiring independent audit of the MCCA; and (5) creating the Michigan Automobile Insurance Fraud Authority and providing for its governance, responsibility and authority. *Reported out of the House Insurance Committee on 10/26/17; Defeated by the House (45-63) on 11/2/17.*
- **No-Fault changes.** HB 5105-5106 create a standard for allowable PIP expenses, details when a charge for a product, service or accommodation is deemed to have been incurred; permits the injured person, their representative and medical providers to commence actions to recover incurred PIP expenses; prohibits voiding of policy due to fraudulent claim, if the claimant did not participate in the fraud

Notably, there was another unsuccessful attempt to modify the no-fault insurance system

- **Insurance coverage of pediatric disorders.** HB 5035 requires health insurance policies to provide coverage for the treatment of pediatric autoimmune neuropsychiatric disorders, including with the use of intravenous immunoglobulin therapy.
- **Breast cancer and occupational causation.** HB 5089 adds breast cancer to the presumed occupational causation list, for fire department employees.
- **Medical examination board.** HB 5101 creates a no-fault independent medical examination board and sets out its composition, responsibilities and authority
- **Mini-tort damage increase.** HB 5102 increases from $1,000 to $5,000 the recoverable damages for mini-tort liability under the no-fault insurance system
- **MCCA adjustment of claims.** HB 5103 prohibits the MCCA from directly or indirectly adjusting or interfering in the adjustment of a claim, unless the it first obtains a court order; prohibits members from adjusting or denying a claim based on whether and to what extent the MCCA will reimburse that member
- **Medical fee schedules for no-fault.** HB 5104 sets fee schedules for medical costs under the no-fault insurance system, implements standards for claims and imposes a duty of fair dealing on insurers
- **Standards for premiums for coordinated benefits.** HB 5107 directs DIFS Director to promulgate standards to determine whether rates filed by an insurer reflect reasonably reduced premiums for coordinated benefits, to apply those standards and to challenge rates that do not comply with standards
- **No-Fault – limit on attendant care.** HB 5108 limits the hourly rate and number of hours of recoverable attendant care provided by a family or household member
• No-Fault – “Serious impairment.” HB 5109 revises the
definition of “serious impairment of body function” to
mean: (1) it is objectively manifested, meaning it is ob-
servable or perceivable from actual symptoms or condi-
tions; (2) it is an impairment of an important body func-
tion, which is a body function or value, significance, or
consequence to the injured person; and (3) it affects the
injured person’s general ability to lead his or her normal life,
meaning it has an influence on some of the injured person’s
capacity to live in his or her normal manner of living.

• No-Fault – PIP statute of limitations – three years. HB
5110 extends the statute of limitation for commencing
actions to recover PIP benefits from 1 year to 3 years.

• Auto insurance – prohibited factors. HB 5111 prohib-
its automobile insurers from relying on a number of fac-
tors when determining whether to insure a vehicle and the
amount of the premium.

• No-Fault – PIP Providers right to payment. HB 5115
states that a provider of PIP benefits is entitled to payment
of those benefits on behalf of the injured person.

• No-Fault – waiver of PIP benefits for over-62 insureds.
HB 5124 permits individuals over the age of 62 to waive
certain PIP benefits and to receive a reduced premium
Motion to Discharge from House Insurance Committee
on 11/2/17 – postponed.

• No-Fault – premium rates filing. HB 5125 requiring au-
tomobile insurers to file premium rates that show a corre-
sponding reduction if other changes to the no-fault insur-
ance system also are made.

• Medical transportation services. HB 5217-5219 im-
plement protocols for medical service transportation, in-
cluding requirements to use motor vehicle transportation
in most instances and to notify patients of the costs, and
prescribing certain payments and requirements regarding
air medical transportation Reported out of the House
Insurance Committee on 11/30/17; Passed the House
(96-14) on 12/6/17; Referred to the Senate Insurance
Committee on 12/12/17.

• Unfairly discriminatory rates. HB 5271 amends the
insurance code to state that a rate is unfairly discrimina-
tory as to the premium charged if the rate is established
through or impacted by price optimization; requires the
DIFS Director to report to the Legislature regarding the
use of price optimization in establishing rates.

• DIFS to post comparative rates. HB 5272 requires
DIFS to post on its website comparisons of certain in-
surance rates; imposes fines on insurers that knowingly
submit false or misleading information.

• Disclosure of personal information. HB 5274 requires
insurers to obtain approval to release nonpublic personal
financial information.

• Insurer disclosure of security breaches. HB 5275 re-
quires insurers to annually disclose all security breaches that
require notice to residents under the Identify Theft
Protection Act.

• Worker compensation – part-time firefighters. HB
5296 extends presumption of causation under the Worker’s Compensation Act to part-time, paid on-call and vol-
unteer firefighters.

• Health insurers – cost-sharing for cancer medication.
HB 5367 requires health insurers that provide coverage
for orally, intravenously and/or injected administered an-
ticancer medication to ensure that cost sharing require-
ments and treatment limitations are equal regardless of
the method of administration.

• No-Fault – Short-term prepaid policies. SB 472 –
amends the no-fault insurance system to permit insurers
to issue short-term non-cancelable, nonrefundable pre-
paid policies (for durations of 7-, 14-, 21- or 28-day pe-
riods).

• Health insurance anti-cancer medication. SB 492 sets
financial restrictions on health insurance policies that cov-
er anticancer medication, prohibits disparate treatment
limitations on oral versus intravenous medications, and
sets a process for reviewing the impact of these restrictions and prohibitions Reported out of the Senate Insurance
Committee on 10/12/17; Passed the Senate (36-1) on
10/18/17; Referred to the House Insurance Committee
on 10/18/17.

• Non-profit dental care. SB 631, 673 amend the re-
quirements for and composition of nonprofit dental care
corporation boards; amends the insurance code regard-
ing payment of claims for nonprofit dental care corpo-
ration, prohibits corporation from requiring individuals
to undergo genetic testing and from requiring face-to-
face contact between a health care profession and a pa-
tient: Reported out of the Senate Insurance Committee
on 11/30/17; Passed unanimously by the Senate on
12/6/17; Reported out of the House Insurance Commit-
tee on 12/12/17; Passed the House (107-3) on 12/13/17;
Ordered enrolled with immediate effect.

• Tort liability of insurance agents. SB 638 clarifies the
available tort liability for insurance agents Reported out
of the Senate Insurance Committee on 11/30-17; Passed unanimously in the Senate on 12/6/17; Referred to the
House Insurance Committee on 12/6/17.

• Reinsurance – eligibility for credit. SB 644 modifies the
eligibility for credit for reinsurance.
• **Pet insurance.** SB 648 requires pet insurers to make certain disclosures to its insureds.

• **Auto insurance- rating criteria.** SB 722 prohibits automobile insurers from basing rates on certain non-driving factors, prohibits excessive rates, provides for premium reductions, and makes the MCCA open to the public.

Finally, while the following bill did not go through the insurance committees, it is of note because of the implications for declaratory judgment actions:

**Insurance disputes in Business Courts.** SB 333 modifies the business court statute to, among other things, specify that business courts have jurisdiction over business and commercial disputes seeking equitable or declaratory judgment relief, assuming the matter otherwise meets the jurisdictional requirements. Passed unanimously by the Senate on 5/16/17; Passed unanimously by the House on 6/20/17; Now PA 0101 ’17 with immediate effect

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**Insurance and Indemnity 101**

**Repairing A Policy Clause**

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

Sometimes the drafting attorney is asked to fix a manuscript clause. In the best of all possible worlds, this happens as a result of routine policy review. Often it happens after a coverage dispute has highlighted some problem with a clause.

It’s not unusual for a manuscript form, drafted by or for the insurer, to need some fixing. Many times, it is simply because a situation that was not foreseen when the clause was drafted has raised questions. Sometimes the drafting itself suffers from problems. Broadly speaking, there are two sources of the problems: (1) they weren’t written by attorneys or (2) they were.

A sign of a policy provision not written by an attorney is the awkward use of legal phrases. One policy form, for example, referred to “parole” evidence, rather than parol evidence. A lawyer wouldn’t make that mistake. No, a lawyer would make different mistakes.

When the problem comes from lawyers’ drafting, it’s often because of long circuitous sentences that wind an intricate path through clause after dependent subclause, with a few ponderous phrases and words (“in the event,” “hereinaabove”) thrown in for seasoning. Why lawyers so often abuse the language of Shakespeare is an enduring mystery. Granted, a policy exclusion is as far from the bard as it is possible to imagine, but still, clarity is a virtue. “In the event” is more pretentious than the humble “if,” but it still means the same thing.

Anyway, however a bad clause got that way, there are techniques that can be used to fix it. Herewith an example. A definition of “property damage” reads:

**Property Damage** – The term “Property Damage,” wherever used herein, shall mean damage to or destruction or loss of use of property of others, (excluding, however, damage to property in the care, custody or control of the Named Insured), including property which is purchased by the Named Insured under a contract which provides that the title remains with the sellers until payments have been completed, the liability of the Company being limited to the payments outstanding.

**Remove the chaff**

The first step is to remove unnecessary words.

**Property Damage** – The term “Property Damage,” wherever used herein, shall mean damage to or destruction or loss of use of property of others, (excluding, however, damage to property in the care, custody or control of the Named Insured), including property which is purchased by the Named Insured under a contract which provides that the title remains with the sellers until payments have been completed, the liability of the Company being limited to the payments outstanding.

In clean form, it now reads:

**Property Damage** means damage to or destruction or loss of use of property of others, (excluding, however, property in the care, custody or control of the Named Insured), including property which is purchased by the Named Insured under a contract which provides that the title remains with the sellers until payments have been completed, the liability of
the Company being limited to the payments outstanding.

Fix the core definition

The next step is to look for specific terms that can be improved.

Saying “Property Damage means damage . . .” is using the defined term to define itself, a circular definition and a per se drafting faux pas. If we replace “damage” with “physical injury” it avoids circularity. Inserting “physical” makes clear that we are talking about tangible property, not the many kinds of intangible property interests. Just to be sure, we can insert the word “tangible” in front of “property.”

Also, the parenthetical phrase is unclear because it is intended to remove from coverage property of “others” that is in the custody of the insured, but there is no reference to “others” in the parenthetical phrase.

Both of these can be fixed this way:

**Property Damage** means physical damage to or destruction or loss of use of the tangible property of others, (excluding, however, but not any property of others that is in the care, custody or control of the Named Insured), including property which is purchased by the Named Insured under a contract which provides that the title remains with the sellers until payments have been completed, the liability of the Company being limited to the payments outstanding.

In clean form, it now reads:

**Property Damage** means physical damage to or destruction or loss of use of the tangible property of others, but not any property of others that is in the care, custody or control of the Named Insured, including property which is purchased by the Named Insured under a contract which provides that the title remains with the sellers until payments have been completed, the liability of the Company being limited to the payments outstanding.

Up to the word “including,” it’s easier to read. Note that replacing “excluding, however” with “but not” also avoids the confusion of using “excluding” in one phrase and then following it immediately with “including.”

Separate the separate coverages

The next target is the second half of the sentence, which begins with “including.” This says the amount of coverage is limited when the damaged property is being purchased by the insured under a “title-retaining contract.” That text now reads:

including property which is purchased by the Named Insured under a contract which provides that the title remains with the sellers until payments have been completed, the liability of the Company being limited to the payments outstanding.

The purpose of this clause is to limit coverage where the insured is buying property “on time” and still owes something on it. The idea is to limit coverage to the amount still owed to the seller. Fair enough, but the language needs a lot of work. It’s a real mess.

First the clause uses the phrase “title remains with the sellers,” but a “title-retaining contract” is only one kind of security interest and by far the least common. The insured could well find itself without coverage depending on the formal structure of the purchase. We need reference to security interests in general. Before that, we need to drop the beginning phrase “including property.” This is a separate kind of coverage.

The first sentence covers damage to the property of others, but this part covers damage where the insured owes money on property that it is buying, so that the seller sues for the loss to its interest. This part also contains a limit in the amount of coverage. Splicing the different concepts together in one sentence is a bad idea.

It should be a whole new sentence, not tacked onto the previous one. Rewriting the whole second part thing, we come up with this:

For property that is subject to a security interest, the coverage provided by this policy shall not exceed the amount remaining to be paid to the seller, under a contract which provides that the title remains with the sellers until payments have been completed, the liability of the Company being limited to the payments outstanding.

There is a side benefit to this new text as well. Under the existing language, the seller (who is not the insured) could argue that it is entitled to add up all the remaining “payments outstanding” and get that sum. But the remaining payments would likely include interest, so that the actual balance owed is less than the sum of the remaining payments. The insurer has good reason to be generous with its insureds, but none to be generous with the seller of goods.

In clean form, then, we have:

For property that is subject to a security interest, the coverage provided by this policy shall not exceed the amount remaining to be paid to the seller.

After all of these repairs are made, this is what we end up with.

**Property Damage** means physical damage to or destruction or loss of use of the tangible property of others, but not any property of others that is in the care, custody or control of the Named Insured.
For property purchased by the Named Insured and which is subject to a security interest, the coverage provided by this policy shall not exceed the amount remaining to be paid to the seller.

This clause is shorter, more direct, easier to understand and more “user-friendly” than the existing version. This is not necessarily the only way to write the clause. For example, maybe the reference to “seller” should be a reference to the holder of the security interest, to cover the situation where the purchase is financed by a bank. But the technique of fixing a bad clause is still valid: drop the unnecessary words, look closely at the definitions, watch out for conjunctions, and give different coverage different sentences.

Benefit to insurer and insured

It is a good marketing point for an insurer to be able to show an insured that the policy is clear and easy to follow. Insureds probably assume they will not understand the policy language, and are often both surprised and pleased when they actually can understand it. Clarity benefits everyone. The insured likes it because it knows what is covered, the claims department benefits because coverage is easier to analyze, and the underwriting department benefits because the policy is easier to sell. ■

About the Author

Hal Carroll is a co-founder and first chairperson of the Insurance and Indemnity Law Section. Mr. Carroll practices extensively in the area of insurance coverage and indemnity law, and was designated a “Super Lawyer®” again in 2017. He also consults with businesses and insurers on the drafting of contracts, represents insureds and insurers in declaratory actions, and is a frequent author of articles in the areas of insurance coverage and indemnity contracts. His email address is HOC@HalOCarrollEsq.com.

Selected Insurance Decisions

By Deborah A. Hebert and Amy Felder
Collins, Einhorn, Farrell PC

Michigan Supreme Court

The ruling of Barnes v Farmers Ins Exchange to be reviewed

Dye v Esurance Property & Cas Ins Co
___ Mich ___ (2017) (Docket No. 155784)
Order of December 27, 2017

The Supreme Court has granted leave to consider “whether an owner or registrant of a motor vehicle involved in an accident may be entitled to personal protection insurance benefits for accidental injury where no owner or registrant of the motor vehicle maintains security for payment of benefits under personal protection insurance.” The order expressly refers to Barnes v Farmers Ins Exchange, 308 Mich App 1 (2014), which held that an owner or registrant of a motor vehicle who lists that vehicle on another person’s policy is barred from recovering PIP benefits under MCL 500.3113(b).

Michigan Court Of Appeals – Published Decisions

UM policy allows recovery despite late notice

Wagner v Farm Bureau Mut Ins Co of Mich
___ Mich App ____ (2017) (Docket No. 332400), lv app pending
Released September 12, 2017

Both the injured person and the at-fault driver were insured under policies with Farm Bureau, but the liability coverage for the at-fault driver was disputed because he was delivering pizzas at the time of the accident. Coverage was ultimately decided by way of a declaratory judgment ruling issued four years after the accident. At that point, plaintiff made a claim for UM benefits under her own policy but Farm Bureau denied it due to late notice. The policy stated that a “written notice of a claim for Uninsured Motorist Coverage” had to be made “within three years after the accident occurs” and that no suit could be filed “later than three years after the accident that caused the injuries being claimed.”

But another provision in the policy stated that “[f]ailure to perform any duty or to give any notice required does not invalidate [plaintiffs’] claim if [plaintiffs] show that it was not reasonably possible to perform such duty or give such notice promptly or within such time otherwise specified in this policy, and that [plaintiffs] performed the duty or submitted the notice as soon as reasonably possible.” The court held that it would have been impossible to prove injuries sustained by an uninsured vehicle until a determination of the tortfeasor’s access to liability coverage. Because plaintiffs claimed UM benefits soon after the declaratory ruling, they were not barred from coverage.
UIM insurer not liable for actual damages beyond policy limits

*Andreson v Progressive Michigan Ins Co*

___ Mich App ___ (Docket No. 334157)

Released November 21, 2017

Plaintiff husband and wife had UIM coverage with defendant up to limits of $250,000/500,000. After sustaining injuries in an accident, they settled with the tortfeasor for policy limits of $50,000/100,000. Each insured recovered $50,000 from the tortfeasor and then claimed $200,000 under their UIM coverage. Defendant denied the claims based on the lack of threshold injuries, so the claims proceeded to trial and resulted in verdicts exceeding $1,000,000. The trial court entered judgments in the amounts awarded by the jury, and declined to remit the verdicts to policy limits, finding that the jury’s verdicts were not excessive based on the injury evidence presented. That decision was reversed. The Court of Appeals held that defendant’s liability was controlled by the terms of the contract and the jury’s assessment of damages could not alter those terms. To hold otherwise would nullify the contract and create insurance by estoppel, a path to insurance coverage not available in this state.

Leasing clause in bobtail business-use exclusion does not apply

*Estate of Hunt v Drielick*

___ Mich App ___ (2017) (Docket No. 333630)

(motion for reconsideration pending)

Released December 14, 2017

In its second trip to the Court of Appeals, this case asks whether defendant’s “bobtail” policy with Empire Fire and Marine Insurance Company excludes coverage under the second leasing clause of the policy’s business-use exclusion. The owner of the insured semi-tractor truck was on his way to pick up a trailer at a business called GLC when he was involved in an accident that injured three people, one fatally. The business use exclusion in his policy barred liability coverage if he was carrying property, or alternatively, if the tractor was being operated under a lease or rental agreement. In a prior proceeding culminating in *Hunt v Drielick*, 496 Mich 366 (2014), the Supreme Court held that the first clause of the business-use exclusion did not apply because the truck was not attached to a trailer at the time of the accident, so the insured was not carrying any property. It remanded the case for further proceedings on the second clause, to determine whether the insured had “entered into a leasing agreement as contemplated by the terms of the insurance policy.”

Further evidence was presented and both the trial court and the Court of Appeals concluded that the second clause likewise did not apply because the tractor was not under lease with GLC at the time of the accident. The insured’s practice was to keep his tractor at home, sometimes driving it on personal business. When he received an assignment from GLC, he would drive to the yard where GLC maintained its trailers and obtain the paperwork. The Court of Appeals found no basis to conclude that the truck was under lease when it was involved in the accident. “At most, the evidence supported a finding that a lease would be formed as of the time that Drielick Trucking arrived at the GLC yard to accept an assignment. Accordingly, we conclude that a lease as contemplated by the insurance policy did not exist at the time of the accident and that the leasing clause in the business-use exclusion does not apply.”

Land contract satisfies the “actual and complete” replacement requirement under policy

*Batton-Jajuga v Farm Bureau Gen Ins Co of Michigan*

Plaintiff had replacement-cost coverage with Farm Bureau for real property she owned. The property was destroyed in a fire. Farm Bureau paid the actual cash value of the property and withheld the remaining agreed-upon replacement cost value until Plaintiff could locate replacement property. Plaintiff replaced the destroyed property with other property purchased through a land contract. Farm Bureau argued that Plaintiff “spent nothing to repair or replace the damaged building” and that “acquisition of another property under a land contract does not constitute “replacement” of the damaged building within the meaning of its policy. The Court of Appeals found that the sale of real property operates as an equitable conversion of the entire property at the time of the sale. Because the final land contract was unconditional and effective upon execution, Plaintiff was the equitable owner of the replacement property and had “actually spent” the $200,000 in purchase money. Plaintiff satisfied the complete replacement requirement when she became the owner of new property under the land contract.

Michigan Court of Appeals –Unpublished Decisions

Policy’s “personal profit or advantage” exclusion bars coverage

*Employers Mut Cas Co v Helicon Associates, Inc, et al*

Docket No. 322215

Released September 7, 2017, lv pending

A charter school operated by defendant Helicon issued approximately $7 million in bonds it was not authorized to issue. The various “Funds” purchasing the bonds sued for recovery and the parties reached a consent judgment involving, among other things, an acknowledgement that the insureds violated a section of the Connecticut Uniform Securities Act. After defending the insureds in that lawsuit, Employers Mutual filed
a declaratory judgment lawsuit seeking a declaration that it was not obligated to indemnify the insureds based on four separate exclusions in the policy, one being the personal profit or advantage exclusion, which barred coverage for “Wrongful Acts” based upon or attributable to an “insured(s)” gaining any personal profit or advantage to which an “insured(s)” is not legally entitled. The Court of Appeals held that the exclusion applied even if the profit the insureds gained was not itself an illegal act because the exclusion only required a gain to which the insured was “not legally entitled.” There was no dispute that the insureds were not legally entitled to the personal profit or advantage gained by issuing the bonds to the Funds.

Plaintiff’s statements insufficient to support physical contact with another vehicle

Parker v Doe and Progressive Marathon Insurance Co
Docket No. 332461
Released September 12, 2017, lv pending

Plaintiff claims she was sideswiped by another car as it merged into her lane, causing her to lose control of her car and hit a pole. The police report states that at the time, plaintiff was unsure whether contact was made with the other vehicle and photographs of plaintiff’s vehicle fail to show any physical damage caused by such contact. The parties also deposed the responding officer, who mostly relied on his report, but also had a vague recollection of the event. He confirmed that he observed no physical damage to plaintiff’s vehicle caused by contact with another vehicle and he described the event as a single-car accident. Progressive successfully moved for summary disposition because its UM coverage required contact with the hit-and-run vehicle. Progressive supported its motion with evidence of the police report, the photographs and the officer’s testimony. Plaintiff opposed the motion with her statements insufficient to support physical contact with another vehicle. The Court of Appeals agreed that her statements were too vague and equivocal to create a question of fact sufficient to warrant a trial.

Listing of business owner in policy declarations makes him a named insured for UM, PIP

Fezzani v Grange Ins Co of Michigan
Docket No. 331580
Released October 10, 2017, lv pending

Plaintiff Riadh Fezzani’s truck was insured under an auto policy with Grange Insurance. He used the truck in the course of his business, described as “truck-driving services.” He sustained injuries in an accident with an uninsured vehicle and made a claim for both UM and PIP benefits. Grange believed coverage was owed by Cherokee Insurance Company, who insured the company for which Fezzani was providing services at the time of the accident. The Court of Appeals agreed with the trial court that Grange owed both coverages because (1) both Fezzani and his business were listed in the policy declarations, which meant that Fezzani was “an insured” for purposes of UM coverage, and (2) Grange was an independent contractor, not an employee, of Cherokee’s insured so the employee exception did not override the priority of coverage owed by Fezzani’s own insurer.

Vehicle owner insuring his vehicle under ex-wife’s business policy is statutorily barred from PIP and tort recoveries

Salmo v Oliverio and Auto-Owners Ins Co
Docket No. 333214
Released October 17, 2017

Plaintiff owned a vehicle that he insured under a policy issued to his ex-wife’s business. He did not have any ownership interest in that business and was not employed by it. “Because Salmo was the vehicle’s only ‘owner,’ he was required to secure statutorily required no-fault insurance. As he failed to do so, the circuit court summarily dismissed his tort claim against a third-party who injured Salmo in a motor vehicle accident and his claim for underinsured motorist benefits against the vehicle’s owner. This result is mandated by Barnes v Farmers Ins Exchange, 308 Mich App 1; 862 NW2d 681 (2014),” as well as by MCL 500.3113(b) and MCL 500.3135(2)(c).

Unilateral mistake or mistake in law is not a basis for reformation

Pantos Investment Co v Peerless Indem Ins Co, et al
Docket No. 334108
Released October 17, 2017

Plaintiff owned a strip mall damaged by a fire. Plaintiff’s insurance application indicated that the strip mall was equipped with a centrally monitored fire alarm. Based on this representation, the Peerless policy included a protective safeguard endorsement, which required plaintiff to maintain the fire alarm while the policy was in effect. The strip mall never had a fire alarm at any point in time. Peerless denied Plaintiff’s claim for damage from the fire after an inspection determined that the strip mall lacked the automatic fire alarm required by the protective safeguard endorsement. Plaintiff filed suit seeking reformation of the policy because of mutual mistake. The Court of Appeals held that Plaintiff’s complaint only alleged a unilateral mistake and unilateral mistakes are not a basis for reformation. Plaintiff also argued that both parties intended for the policy to cover property damage. The Court of Appeals held that this presented a mistake of law with regard to the policy’s coverage and a mistake in law is similarly not a basis for reformation.
Sixth Circuit Update

No Magic Words Necessary To “Clearly Specify” Alternate Payee Information In a QDRO

Sun Life Assurance Company of Canada v. Jackson, 877 F.3d 698 (6th Cir. 2017)

In general, ERISA preempts “any and all State laws insofar as they . . . relate to any employment benefit plan.” 29 U.S.C. § 1144(a). One exception to preemption is for a qualified domestic relations order (“QDRO”). 29 U.S.C. § 1144(b)(7). A QDRO includes any state “judgment, decree, or order” relating to the provision of “child support, alimony payments, or marital property rights” that recognize an “alternate payee’s right to . . . benefits”. 29 U.S.C. § 1056(d)(3)(B). A QDRO must “clearly specify” the following: (1) name and address of the participant and alternate payee; (2) amount or percentage to be paid to the alternate payee; (3) number of payments or period to which the order applies; and (4) the plan to which the order applies. 29 U.S.C. § 1056(d)(3)(C).

The Sixth Circuit in this case analyzed whether a divorce judgment which incorporated a separation agreement and shared parenting plan as a whole satisfied the foregoing criteria. The plan participant designated his brother as his beneficiary of his employer provided life insurance policy. When the participant and his wife divorced, the separation agreement provided both of them would maintain all employer provided life insurance for their child. However, the husband did not change the beneficiary designation. After the husband passed away, the carrier paid the benefits to the brother, claiming the divorce documents did not “clearly specify” the necessary criteria to be considered a QDRO.
Rather than looking for “magic words” or a formulaic statement identifying the requisite criteria in one provision, the court applied a commonsense approach and analyzed the three divorce documents together to determine whether the QDRO requirements were satisfied. The court found that the separation agreement identified the husband as the plan participant, the child as the alternate payee, included an address for both, indicated that the child was to be named as beneficiary for “all employer provided life insurance” until the child reached the age of 18 or graduated from high school, whichever occurred last. Accordingly, the court found that each of the statutory requirements were “clearly specified” and affirmed the award of benefits to the child of the plan participant rather than his brother.

The Sixth Circuit confirmed in a published decision, holding “that ‘use of alcohol’ most naturally refers to the act of consuming alcohol, and not post-consumption conduct.”

Claimant’s Injuries From Motorcycle Accident While Playing “Chicken” In Farm Field At Night With Blood Alcohol Level Twice the Legal Limit Were Not “Incurred As A Result of . . . Illegal Use of Alcohol”


The plaintiff drank enough alcohol to have a blood alcohol level twice the limit for operating an off-road vehicle. He and his friends played “chicken” in a dark farm on their motorcycles and the plaintiff was severely injured when he collided, head-on, with another motorcycle, and incurred about $200,000 in medical expenses.

The insurer denied his claim for benefits under a plan exclusion that disallowed coverage for “[s]ervices, supplies, care or treatment of any injury or sickness which occurred as a result of [the insured’s] illegal use of alcohol.” Reviewing de novo, the district court disagreed and reversed the administrative decision, noting “that there is a difference between the illegal use of alcohol – such as drinking while under 21 or drinking in defiance of a court order – and illegal post-consumption conduct, such as the illegal use of a motor vehicle.” According to the district court, “what was illegal about [the insured’s] behavior was his use of a motor vehicle, not of alcohol.”

The Sixth Circuit confirmed in a published decision, holding “that ‘use of alcohol’ most naturally refers to the act of consuming alcohol, and not post-consumption conduct.” The plan did not define “use,” but dictionaries define it as the “action of consuming something such as food, drink, or drug, etc.,” and “to consume or take (as liquor or drugs) regularly.”

The Court concluded that “[r]ead this way, [the insured’s] conduct was not an ‘illegal use of alcohol’; [he] was over the legal age to drink, and no other law ‘prohibited [him] from consuming alcohol.”

The court also noted that elsewhere in the plan, the insurer used specific language to exclude coverage for injuries sustained “while under the influence of any controlled substance . . . not administered by a physician,” and if the insured intended the “illegal use of alcohol” exclusion to exclude injuries sustained while the insured was under the influence of alcohol, it could have (and should have) used the same phraseology. Thus, the court concluded, under “the plan ‘use’ and ‘under the influence’ are different.”

Lastly, the court rejected the several cases across the country that supported the insurer’s position, saying that “those cases elided the distinction between ‘use of alcohol’ and post-use conduct.”

Cash Value of Death Benefit Only Policy Was Properly Interpreted as The Surrender Value at Death


The plan participant here was eligible for a “death benefit only” type of life insurance plan sponsored by his employer. As his beneficiary, his wife was eligible for payment of no less than the cash value of the policy upon his husband’s death, to be paid out over ten years. While the participant was still alive but fighting terminal cancer, the employer estimated the amount of the cash value of the policy. After the participant’s death, the estimate dropped two more times before a payment was made of even a lower figure, a calculation which was challenged by the widow in this suit.

After determining the plan at issue was governed by ERISA and thus federal jurisdiction was proper, the court then considered the widow’s argument that she was entitled to payment of the entire death benefit of the policy, or the “face amount” of the policy, rather than the value of the policy if surrendered on the date of her husband’s death as the employer argued. The court found the employer’s interpretation of the plan language “cash value of the policy” was reasonable.

The widow also argued the employer’s process of estimating different payment amounts was arbitrary and capricious. The court agreed those changes unnecessarily added to her confusion. However, the court found the plan provided the employer with discretion to determine a benefit of “no less than the cash value of the policy” such that the different calculations were due to inclusion of a surplus amount the employer at one time planned to add to the minimum benefits to which the widow was entitled. Since the ultimate payment was not less than the cash surrender value, the employer complied with plan terms.
The widow also raised arguments that the employer breached its fiduciary duties by acting in self-interest which led to an improper benefit determination and by mismanaging plan assets. The court disagreed on both counts and ultimately affirmed the lower court’s grant of summary judgment in favor of the employer.

About the Authors

**K. Scott Hamilton** is a Member and commercial litigator in Dickinson Wright’s Detroit office. He specializes in ERISA, insurance, business and appellate litigation.

**Kimberly J. Ruppel** is a Member and commercial litigator in Dickinson Wright’s Troy office. She specializes in ERISA, insurance, healthcare and probate litigation.