In this Issue

Section News

From the Chair .......................................................... 2
Adam Kutinsky

Editor’s Note ........................................................................... 3
Hal O. Carroll

Scenes from the Annual Meeting.............................................. 3

Insurance & Indemnity Law Section 2016-2017 Officers and Council .................................................. 23

Columns

Insurance and Indemnity 101: More Words About Words ................................................................. 10
Hal O. Carroll

Business Court Report........................................................................... 12
Kassem Dakhlallah

ERISA Decisions of Interest ........................................................ 13
K. Scott Hamilton Kimberly J. Ruppel

Selected Insurance Decisions.............................................................. 16
Deborah A. Hebert

No Fault Corner: Not Dead Yet – the Current Status of the “Innocent Third Party Doctrine” ............ 19
Ronald M. Sangster, Jr.

Feature Articles

Michigan No-Fault & Third Party Practice: Is the Tide Turning in the McCormick Era? .................. 4
Javon R. David

Insurable Interest and a Claimant’s Status in Property Insurance Policies: Some Prerequisites to Recovery ........................................................................................................... 8
Rabih Hamawi
From the Chair

It is an honor to serve as the 2016-2017 chair of the Insurance & Indemnity Section for the State Bar of Michigan. I offer a big “thank you” to the Section’s past chairperson Kathleen Lopilato for her excellent service over the past two years. I not only count Kathleen as a learned colleague but also a friend.

Annual Meeting – Elections of Officers and Council Members

As I write this piece, our section boasts 814 registered members and three new council members, Rabih Hamawi, Patrick Crandell and Gail Storck. We are also fortunate to have the continued service of Larry Bennett (chairperson elect), Gus Igwe (secretary), and Jason Liss (treasurer). And, our section would not be possible without the active participation of council members Lauretta Pominville, Nicole Wilinski, Hal O. Carroll, Steven Hicks, Jim Thome, Renee Vanderhagen and Doug Young. Together, we have helped grow this section from a small start up to the size that it is today.

Our Annual Program

Our annual program was a success. It focused on commercial property and featured professionals from each stage in the commercial property insuring process (broker, appraiser, policy holder, and underwriter). As usual, there were passionate discussions between attorneys that represent different parties to the insurance policy. It is through these types of good natured debates that we learn more about other perspectives and viewpoints, which in turn make us better attorneys and counselors.

Planned Programs

During our new term, we expect to offer members at least three substantive programs on insurance or indemnity. If you are reading this piece and would like to suggest ideas for a program, please contact our chairperson elect, Larry Bennett or any other Council person. We are always open to ideas and very welcoming of new members’ active participation.

The Journal of Insurance and Indemnity Law

This section continues to strive towards balance and neutrality in the treatment of its subject matter. This means that we welcome viewpoints from all aspects of insurance and indemnity transactions and all parties to litigation. The *Journal of Insurance & Indemnity Law* is a quarterly publication and the backbone of our section. It offers quality articles on various subjects of interest to our members as well as case and statutory updates in each issue. The *Journal* editor, Hal O. Carroll, is always looking for quality articles to include in each quarterly publication, so please contact him should you have something of value to offer. It is important to take risks in life and we invite you to take the risk of publishing your legal views to prompt discussion among your colleagues. Many times, I have heard from other attorneys in response to articles that I have authored and learned more about the subject as a result.

Bylaws Amendments

We recently revised the Section bylaws and published the amendments in the last *Journal*. Law students can become members without paying dues. Council terms have been reduced from 2 years to 1 and the number of Council members is reduced to “no more than 10” in addition to the immediate past chairperson and the four officers. Council members are now expected to actively participate in Section Committees or author an article for the *Journal*. Committees are required to meet at least one time per year and report to the Council on activities. Council meetings shall continue to be held at least 4 times per year.

Our section has served an important role in my 15-year career by introducing me to colleagues who share my interest in insurance. With each meeting of the Council and each program that I attend, I learn from my colleagues by listening to their experiences and by debating points that arise from the different perspectives to the insurance contract. Simply put, this section enhances my practice and increases my legal knowledge. I therefore highly recommend that attorneys become actively involved if they are looking to improve themselves professionally.
The Journal – now in its ninth year – is a forum for the exchange of information, analysis and opinions concerning insurance and indemnity law and practice from all perspectives. The Journal – like the Section itself – takes no position on any dispute between insurers and insureds. 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.

Scenes from the Annual Meeting - September 2016

1. Speaker Patrick King
2. Speaker Bill Butler
3. Presentation of the plaque by Incoming Chair Adam Kutinksy to Kathleen Lopilato, Outgoing Chair
4. Speaker Don Balmes
5. Speaker Allen Philbrick
Michigan No-Fault & Third Party Practice: Is the Tide Turning in the McCormick Era?

By Javon R. David, Secrest Wardle

Under the Michigan No-Fault Act, tort liability for non-economic loss arising out of the ownership, maintenance, or use of a motor vehicle is limited to circumstances when a person has sustained a “threshold” injury. MCL 500.3135(1). An individual may pursue a tort claim after a motor vehicle accident “if the injured person suffered death, serious impairment of body function, or permanent serious disfigurement.” MCL 500.3135(1). To determine whether a person has suffered a “serious impairment of body function,” the Michigan Supreme Court has promulgated a three-part test requiring: (1) an objectively manifested impairment; (2) of an important body function; (3) that affects the person’s general ability to lead his normal life.” McCormick v Carrier, 487 Mich 180, 195 (2010).

In the McCormick era, victories for the defense on dispositive motions are certainly noteworthy in third-party cases. Since McCormick was decided, many judges have been quick to find a question of fact in denying defendants’ dispositive motions. Further, too often, dispositive motions are denied on the basis that even the slightest impairment establishes a “serious impairment of an important body function” as defined by the No-Fault Act. But the tide seems to be turning as the Court of Appeals has helped define the meaning of “serious impairment” in recent decisions, as outlined below. Could these decisions signal the closing of the bodily injury lawsuit floodgates? Perhaps. At the very least, the recent decisions demonstrate that McCormick was not intended to allow just any injury to qualify as a serious impairment.

Within the last two years, the Michigan Court of Appeals has issued six opinions analyzing McCormick and ruling in favor of the defense. The opinions are unpublished, but they establish a pattern that is favorable to defendants. The recent cases are briefed below.

Neck and Back Pain, Without Objective Physical Evidence, Is Insufficient to Support a Claim


In Lenk, the plaintiff filed suit seeking underinsured motorist benefits following a motor vehicle accident that occurred on Interstate 96. The tortfeasor’s vehicle struck plaintiff’s car while both vehicles traveled on I-96. Plaintiff denied injury at the scene of the accident. Several hours after the accident, plaintiff sought treatment for neck and back pain. CT scans of plaintiff’s cervical and thoracic spine revealed no abnormalities. Plaintiff was prescribed anti-inflammatory medication and was discharged. Plaintiff’s back and neck pain persisted after the accident. More sophisticated imaging studies were performed, but again revealed no spinal injuries or irregularities. Nevertheless, plaintiff’s physicians recommended that she undergo a series of injections, followed by thermal radiofrequency treatment. According to plaintiff, these therapies only temporarily relieved her pain. Two years after the accident, Plaintiff filed suit seeking underinsured motorist benefits. Defendant sought summary disposition under MCR 2.116(C)(10), contending that plaintiff had failed to demonstrate a serious impairment of body function as required by MCL 500.3135(1). The circuit court issued a written opinion granting defendants’ motion, and plaintiff appealed.

On appeal, the Court of Appeals assessed plaintiff’s claim under McCormick, finding stark differences in the McCormick case versus the case at bar. Specifically, the court noted that, in McCormick, the plaintiff demonstrated an objectively manifested impairment by presenting evidence “that he suffered a broken ankle and actual symptoms or conditions that someone else would perceive as impairing body functions, such as walking, crouching, climbing, and lifting weight.” Specifically, “[e]ven 14 months after the accident” the plaintiff’s ankle pain and his reduced range of ankle motion “inhibited these body functions” and substantiated the objective nature of the plaintiff’s impairment. Id.
In contrast, Plaintiff Lenk provided no objective support for her claim that she suffered a threshold injury as a result of the 2010 accident. Despite plaintiff’s back and neck pain, she missed only five days of work as a mill operator. Other than a snow-shoveling restriction issued at her specific request, plaintiff’s activities were medically unlimited. Additionally, according to her medical records, the plaintiff had no obvious or measurable neurologic deficits. Instead, [plaintiff predicated her impairment claim on wholly subjective symptoms and complaints, such as neck stiffness and pain with movement. Accordingly, the court determined plaintiff failed to advance any evidence of an objective impairment that would satisfy McCormick’s first prong, and affirmed the trial court’s granting of defendant’s motion for summary disposition.

McCormick Criteria Are Not Met Where Plaintiff Continues Prior Activities, Even with Pain


In _Mehdi_, the plaintiff filed a third-party lawsuit seeking damages for injuries allegedly sustained to his neck and back in a motor vehicle accident. Following the accident, plaintiff’s physician diagnosed him with cervical radiculopathy secondary to whiplash. Plaintiff had a history of neck and back pain, and testified that he continued to engage in certain pre-accident activities. Defendant moved for summary disposition on the basis that plaintiff’s alleged impairments did not rise to the requisite level of serious impairment prescribed by the No-Fault Act and case law interpreting the act. The trial court granted summary disposition in favor of defendant, finding that plaintiff failed to establish he sustained a serious impairment of an important body function, as required by the No-Fault Act.

On appeal, the Court of Appeals reviewed plaintiff’s deposition testimony and medical records in assessing whether plaintiff’s alleged injuries constituted a serious impairment under the No-Fault Act. Plaintiff testified that his ability to engage in recreational activities was affected by his back pain, headaches, and nerve problems. He further testified that he jogged before the accident, but did not participate in any sports with a particular frequency. Plaintiff also testified that he could no longer perform household chores due to his pain. Despite this claim, the Court of Appeals noted that plaintiff testified that he continued to drive, traveled to Canada frequently, fed himself, dressed himself, and did his own grocery shopping. Plaintiff stated that he is physically capable of performing such activities yet experiences pain when performing them.

Based upon plaintiff’s medical records, which indicated a medical history consistent with the injuries alleged in the lawsuit, along with his testimony that he could perform many activities of daily living, the Court of Appeals ruled that the trial court properly granted summary disposition in favor of defendant.

No Recovery Where Plaintiff Continued Work and Offered No Quantitative Evidence of Diminution of Activities


In _NBunh_, Defendant Pitkin was unable to stop at a red light and collided with the rear end of the vehicle behind the plaintiff, which in turn collided with plaintiff’s vehicle. On the date of the accident, plaintiff presented to the emergency room with complaints of pain in his left shoulder and chest. Plaintiff continuously treated after the impact and was eventually diagnosed with chronic pain that necessitated ongoing treatment.

Throughout the course of litigation, plaintiff testified that he was attending Calvin College at the time of the accident and he later graduated in May 2013 with a bachelor’s degree. Plaintiff was also employed at a community assisted living center at the time of the accident, missing only three days of work after the accident. Plaintiff continued to work at the assisted living center without restrictions. In addition, Plaintiff had a second job at the time of filing suit where he lifted products and stocked shelves. Plaintiff testified he occasionally suffered from pain while stocking shelves, but he never requested work accommodations. In addition, plaintiff testified he used to enjoy gardening, working out, and playing soccer with his son, but he is no longer able to enjoy these activities because of pain complaints. Plaintiff also experienced pain while driving, but testified improvement in pain while driving as a result of deep tissue massage therapy.

... the plaintiff had no obvious or measurable neurologic deficits. Instead, [plaintiff predicated her impairment claim on wholly subjective symptoms and complaints, such as neck stiffness and pain with movement. Accordingly, the court determined plaintiff failed to advance any evidence of an objective impairment ...

Defendant moved for summary disposition in the trial court, arguing that plaintiff failed to demonstrate his alleged injuries affected his general ability to lead his normal life. The trial court granted defendant’s motion and plaintiff appealed. On appeal, the Court of Appeals determined that the trial court record established that plaintiff’s injuries did not affect his ability to pursue his education or his ability to work two
walk more than four blocks, needed to stop and rest due to
naire authored by plaintiff in 2001, claiming she could not
ous 1995 accident. Further, pefendant attached a question-
summary disposition in the trial court, attaching documenta-
was caused by a traumatic event, which caused her to have
plaintiff's treating physician opined that Plaintiff's ankle injury
mitted that she had preexisting medical conditions, she ar-
resulting in surgery, and experienced an exacerbation of her
plaintiff's daily life was devoted to gardening, working out,
and playing soccer with his son, how long these limitations
ircraft regarding whether the injury affected his normal man-
The Court of Appeals affirmed the trial court's
determination that plaintiff did not establish that his injury
affected his general ability to lead his daily life.

No Recovery When Plaintiff's Limitations from Prior
Accident Continued

(Unpublished Mich Ct App June 2, 2015)

In Sigan, Plaintiff was involved in a motor vehicle accident
in 2010 and allegedly sustained injuries to her right ankle,
resulting in surgery, and experienced an exacerbation of her
preexisting arthritis and fibromyalgia. Although Plaintiff ad-
mitted that she had preexisting medical conditions, she ar-
gued that “they were worsened by the accident.” In addition,
plaintiff's treating physician opined that Plaintiff's ankle injury
was caused by a traumatic event, which caused her to have
difficulty walking post-surgery. Defendant filed a motion for
summary disposition in the trial court, attaching documentation
showing that plaintiff was totally disabled from a previous
1995 accident. Further, defendant attached a questionnaire
authored by plaintiff in 2001, claiming she could not
walk more than four blocks, needed to stop and rest due to
her pain, ceased any recreational activities, and her household
chores were often delayed due to a need for frequent breaks to
alleviate her pain complaints.

Further, in its dispositive motion, defendant presented
 evidence that in 2005 an administrative law judge determined
that plaintiff could not perform a full range of even seder-
tary work. Despite this, plaintiff testified that, as a result of
the 2010 accident, she isolated herself and could not work or
participate in recreational activities. The trial court granted
summary disposition in favor of defendant.

On appeal, the Court of Appeals affirmed the trial court's
ruling granting defendant's motion for summary disposition
as plaintiff had not established that the accident and impair-
ment affected her general ability to lead her normal life. Spe-
cifically, the Court of Appeals held that plaintiff's life follow-
ing the accident was not “significantly different from her life
in the years preceding the accident.” Indeed, both before and
after the accident, the record showed that plaintiff had dif-
culty walking, was disabled from work, and her recreational
activities were essentially the same. In all, there was “no appreciable
difference” between her pre- and post- accident life and,
therefore, she did not meet the threshold requirement.

No Recovery Where Plaintiff's Activities Were Not
Changed by Accident

Fuller v Howard, 2015 Mich App LEXIS 2231 (Unpublished

In Fuller, the plaintiff allegedly sustained injuries to his
neck and back as a result of a motor vehicle accident. Al-
though the parties disputed whether the accident caused
plaintiff's alleged injuries, the parties did not dispute the na-
ture or extent of the injuries. Plaintiff's medical records sup-
ported a finding that he had bulging discs in his back. Plain-
tiff's remaining claims—including tinnitus, vision problems,
and headaches—were never corroborated by medical records
or deemed to be the result of bulging discs in his back.

Defendant moved for summary disposition on the basis
that Plaintiff's injuries failed to satisfy the requisite threshold
of serious impairment under MCL 500.3135, which is an "(1)
objectively manifested impairment (2) of an important body
function (3) that affects the person's general ability to lead his
or her normal life." Defendant relied upon the plaintiff's tes-
timony to demonstrate that his life essentially remained un-
altered by the subject accident. The trial court granted defen-
dant's dispositive motion, finding that plaintiff's testimony
regarding his post-accident lifestyle failed to demonstrate his
daily life was altered by the accident.

The Court of Appeals affirmed the trial court's ruling in
favor of defendant. The Court of Appeals held that a serious
impairment had not been established as plaintiff's ability to
lead his normal life was unaltered. Prior to the accident, plain-
tiff did not have a job, engage in hobbies, play sports, or have a

... the Court of Appeals held that plaintiff's life
following the accident was not "significantly
different from her life in the years preceding
the accident." Indeed, both before and after
the accident, the record showed that plaintiff
had difficulty walking, was disabled from work,
and her recreational activities were essentially
the same.
girlfriend. Plaintiff spent most of his time watching television. Following the accident, plaintiff testified that he “basically stays home and watches television.” Plaintiff’s only change in lifestyle was his alleged inability to ride a bicycle or perform yardwork. However, plaintiff testified that he had not tried to ride a bicycle. As to the alleged inability to perform yardwork, the court found that the aches and pains precluding him from performing yardwork were not themselves enough to establish a serious impairment.

The Court of Appeals looked to the entirety of plaintiff’s testimony, finding that plaintiff’s vague testimony was insufficient to create a question of fact on the issue of serious impairment. Reviewing the totality of plaintiff’s testimony, the court upheld the trial court’s determination that Plaintiff failed to satisfy the requisite threshold of serious impairment under the No-Fault Act.

The “Objective Manifestation” Requirement Necessitates an Observable Impairment


In *Oehmke*, the plaintiff allegedly sustained an exacerbation of pre-accident injuries, including impairments of her brain, arms, legs, and ability to function, as a result of the motor vehicle accident with Defendant Walker. In support of this claim, plaintiff offered her own affidavit and two letters authored by her treating physicians, both stating that the accident worsened or exacerbated her prior symptoms and pain complaints. Defendant moved for summary disposition on the basis that plaintiff did not sustain a serious impairment of a body function as a result of the 2012 accident. Defendant further argued that the plaintiff’s personal affidavit and correspondence from two treating physicians did not create a question of fact sufficient to survive a dispositive motion. The trial court granted defendant’s dispositive motion.

Notably, the trial court correctly found that a party’s “representations in [an] affidavit regarding another person’s observations do not establish a factual question because they are inadmissible hearsay.” As such, plaintiff’s personal affidavit did not present admissible evidence of “actual symptoms or conditions that someone other than the injured person would observe or perceive as impairing a body function,” as required by *McCormick*.

Upon determining that plaintiff’s personal affidavit and two letters from treating physicians were insufficient to create a question of fact, the Court of Appeals explained that the requirement that the impairment be “objectively manifested” meant that the impairment must be “evidenced by actual symptoms or conditions that someone other than the injured person would observe or perceive as impairing a body function.” In other words, an “objectively manifested” impairment is commonly understood as one observable or perceivable from actual symptoms or conditions. A plaintiff must introduce evidence demonstrating a physical basis for subjective complaints of pain and suffering, which generally will require medical testimony. Consequently, Plaintiff’s subjective assessment that her pain complaints were worse after the second accident failed to establish an “objectively manifested impairment” as clarified by our Supreme Court in *McCormick*. The Appellate Court affirmed summary disposition in favor of Defendant.

Analysis: What Do the Recent Cases Mean for Bodily Injury Cases?

These six recent Appellate Court decisions provide three solid bases for attacking a third party claim – (1) Lack of objective evidence to support subjective pain complaints; (2) No change in pre-accident lifestyle despite an objective injury; (3) Insufficient proofs proffered by the plaintiff to create a question of fact for trial. While all three arguments derive from the No-Fault Act and are supported by *McCormick*, the recent Court of Appeals cases certainly clarify the scope of the act as intended by the legislature. Further, the recent cases can be used as persuasive or analogous authority when arguing dispositive motions at the trial court level, giving the defense the ability to argue that the above common factual scenarios have already been rejected by the Court of Appeals.

Is the bodily injury tide turning in favor of the defense? Well, it is clear that the waters are anything but still.

About the Author

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Endnotes

5. *Id.*
6. *Id. at 198.*
Insurable Interest and a Claimant’s Status in Property Insurance Policies: Some Prerequisites to Recovery

By Rabih Hamawi, Fabian, Sklar & King

Claimants in first party property-damage cases may believe that being the named insured on the Declarations of a property insurance policy is, by itself, sufficient to guarantee them recovery for their insured losses: but they are wrong. In order for a claimant to recover under a property insurance policy, he or she must first have an insurable interest in the insured property at the time of the loss. This article will briefly discuss the concept of insurable interest in property insurance policies, and how the claimant’s status may affect his or her rights to recovery.

Introduction

The insurable-interest doctrine originated in the United Kingdom in the 18th century. It was created to separate insurance contracts from wagering contracts, and the moral hazards associated with profiting from another’s losses. Existence of an Insurable Interest: Michigan Focuses on the Claimant’s Pecuniary Gain or Loss

When examining the existence of an insurable interest, American jurisdictions are split between the factual-expectancy test, representing the majority view; and the legal-interest test, representing the minority view.

Michigan follows the majority view, the so-called “factual-expectancy” test, which focuses on the claimant’s real-world expectations, rather than his or her title to the property. It is insufficient that an insurable interest existed at the policy’s inception, an insurable interest must exist on the date of the loss for the insured to be entitled to recover under the policy. The Requirement of Establishing an Insurable Interest Affects All Claimants

Below are examples of claimants who may be affected by the requirement of insurable interest.

Named insureds

A named insured is any person or entity specifically identified in the policy’s Declarations. An improperly identified named insured, one without an insurable interest, may not automatically bar the claimant’s recovery, as recovery may still be available under a reformation or a third-party beneficiary theory. Historically, spouses who were not named insureds, but who had an insurable interest in the damaged property, were not permitted to recover under the policy for property owned by his or her spouse. But after the Insurance Services Office changed its standard homeowners policy language, policies now automatically include spouses as insureds under the policy provided they reside in the same household as the named insured.

Mortgagees and loss payees

Another type of a claimant with an insurable interest is a mortgagee or a loss payee when named in an insurance policy. A mortgagee’s or a loss payee’s insurable interest will be limited to its financial interest in the insured property. Another limiting right to recovery depends on the type of loss-payable clause protecting its interest. In general, insurance policies contain two types of loss-payable clauses that protect lienholders: a standard mortgagee clause and an ordinary loss-payable clause.
An ordinary loss-payable clause “directs the insurer to pay [the policy’s proceeds] to the lienholder, as its interest may appear, before the insured receives payment on the policy.” It does not create a separate contract between the lienholder and the insurer, and an insured’s breach of the insurance contract conditions (nonpayment of premium or failure to secure the property after a loss) may prevent the lienholder’s recovery.

A standard mortgagee clause, on the other hand, creates a separate and independent contract of insurance between the insurer and the lienholder. A standard mortgage clause shields the mortgagee from the defenses available to the insurer against the mortgagor.

The failure to list a mortgagee as a lienholder on the insurance policy does not automatically bar the mortgagee’s recovery. Courts have held that proceeds payable to the mortgagor may be subject to an equitable lien in the unlisted mortgagee’s favor.

A foreclosure may affect the insurable interest of both the mortgagor and the mortgagee. A mortgagor has an insurable interest in the mortgaged property until the expiration of the redemption period. A mortgagee also maintains an insurable interest during the redemption period.

But for a loss occurring before the sheriff’s sale, the mortgagor’s insurable interest will be lost if the mortgagee later purchases the property at the sheriff’s sale for an amount which extinguishes the mortgage debt.

Land-contract vendors and vendees
The vendor (seller) and vendee (buyer) in a land contract have separate insurable interests. After the land contract is executed, the vendor retains legal title, while the vendee has equitable title. Both vendors and vendees have an insurable interest in the property, and the land contract’s terms govern their respective rights to insurance proceeds.

Other potential claimants
Other parties who may have an insurable interest include a lessee who makes improvements to the leased property; a building contractor, in a building under construction; and a person or entity who has paid consideration for an option to purchase the insured property.

If a partnership owns the insured property, each partner has an insurable interest in the partnership property to the extent of his or her individual financial interest, and he or she may insure the property in his or her own individual name.

Conclusion
In summary, for a claimant to recover under a property insurance policy, he or she must have an insurable interest at the time of the loss. Michigan courts broadly define insurable interest and they focus on the financial loss that a claimant has suffered from the damage or destruction to the insured property, or the financial gain that the claimant would have received from its continued existence.

About the Author
Rabih Hamawi is an associate attorney at Fabian, Sklar and King, P.C. and focuses his practice on representing policyholders in property-damage 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 RHamawi@fabiansklar.com.

Endnotes
2 Id.
3 Crossman v Am Ins Co of Newark, N J, 198 Mich 304, 308–09; 164 NW 428 (1917).
4 Id.
5 Id.
6 Id.
8 Morrison v Secura Ins, 286 Mich App 569, 572; 781 NW2d 151 (2009).
10 MCL 600.1405.
12 Insurance Services Office is an advisory organization providing statistical, actuarial, underwriting, and claims information and
analytic; compliance and fraud identification tools; policy language; and information about specific locations for the property and casualty insurance industry.


14 Id.

15 Id. at 384.

16 Id.

17 Id.


24 Cadillac Theatre Co v Fitzgerald, 210 Mich 6; 177 NW 288 (1920).


26 Crossman v Am Ins Co of Newark, N J, 198 Mich 304, 308–09; 164 NW 428 (1917).


The previous column had some observations about words and usage and a few of this writer’s pet peeves, and got some favorable feedback. Maybe that’s because words are the tools that lawyers use. Words are to lawyers what numbers are to engineers – the tools of the trade. And if words can never be as precise as numbers, that’s all the more reason to be careful how we use them.

So here are some suggestions sources of information for any lawyer who wants to improve his or her skill with the tools of our trade.

First, The Winning Brief, by Bryan A. Garner. Oxford University Press, 1996, 1999. This is the gold standard of effective legal writing. The subtitle is “100 tips for persuasive briefing in trial and appellate courts.” Each of the tips is stated succinctly, and with examples and illustrations of the point it makes. This is a book that bears re-reading from time to time. You can open it anywhere and jump into a particular point. There is even a summary of the points inside the front and back covers.

The Careful Writer, by Theodore M. Bernstein. Atheneum, 1984. This is a book of correct English usage and word choice. For example, “farther” refers to physical distance and “further” to extent. “Practicable” means it can be done; “practical” means that doing it is useful. “Precipitate” as an adjective means “hasty”; “precipitous” means “steep.”

There are many other useful books. Probably the earliest and the spiritual progenitor to many that follow is the little book by Strunk & White’s Elements of Style. It’s called “the little book” because it is. You can tuck it in your pocket and review it while waiting to be called on motion day.

... you could say “navel-gazing,” but “omphaloskepsis” sounds better than “navel-gazing,” and any word that befuddles spell-check is inherently good.

You also might want to join Scribes – the Society of Legal Writers. Go to Scribes.com. The cost is minimal and in addition to a regular publication, you get emails with writing tips. Tip 89 arrived a few days ago; it discusses whether block quotes are a good idea. We all like to use them, but do we – or our readers – actually read them? Here’s a suggestion: if you are going to use a block quote, introduce it by paraphrasing what it says, and then follow it with a short restatement.

Eat Shoots and Leaves, by Lynne Truss, is a book about punctuation. The title comes from the dietary habits of the Armadillo. The story is that an armadillo walks into a saloon, orders a meal, finishes eating, pulls out his pistol, fires one shot into the ceiling and walks out.
There are many other useful books but these are a good start.

But there’s more to life than work and words can be more than tools. So, for the committed logophile, here are some suggestions.

The Thinker’s Thesaurus by Peter E. Meltzer. Mr. Melzer is a practicing attorney in Pennsylvania. He grew tired of conventional thesauruses, with their poverty of synonyms. So he put in a lot of work to come up with better ones too often ignored. An example is “façade,” he gives “Potemkin village,” and explains the origin.

The Morris Dictionary of Word and Phrase Origins, by William and Mary Morris, Harper Rowe 1962. Here you will find little stories to amuse yourself and bore others at parties. For example, the 21-gun salute comes from naval usage. Firing one gun was an act of deference because once fired a muzzle-loading cannon was disarmed. Since there were usually 21 guns on the side of a ship, a 21-gun salute was as deferent as you could get.

Then there are collective nouns. We all know that it’s a pride of lions, a gaggle of geese, a pod of whales and a murder of crows. But there are many more, and they are collected in An Elegance of Larks, by James Lipton, Penguin Books. Lawyers come off surprisingly well with “an eloquence of lawyers” (p 83). Someone with a dimmer view of our profession might say “a quibble of lawyers.” For judges, perhaps “a ponder of judges” would be a good collective noun.

For the irredeemable word-nerd, there is Words on Words, by John B. Bremner. Columbia University Press, 1980. Reading this is the ultimate surrender because the subject is words themselves. For example, when Lincoln said “government of the people, by the people, for the people,” and left out the “and,” that was asyndeton. Likewise Caesar in “I came, I saw, I conquered.” It’s a poetic device, best left to the experts.

Or when you stick one word inside another, as in “I wish I were somewhere else,” or “that’s unflippinbelievable,” or “that’s a whole nother thing,” you are using tmesis.

Finally, a personal favorite. “Omphalos” is Greek for “navel.” “Skepsis” is Greek for looking at. So someone who is engaged in navel-gazing (dreaming up ideas unrelated to reality) is engaged in “omphaloskepsis.” Sure, you could say “navel-gazing,” but “omphaloskepsis” sounds better than “navel-gazing,” and any word that befuddles spell-check is inherently good. There’s a big difference between a skeptic and an omphaloskeptic.

Some attorneys merely use words for their work. But for those who enjoy words for their own sakes, there are many books that cater to the addicted.

Next time, we will return to insurance-specific words and the jargon of the trade.

About the Author

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Insurable Interest Does Not Require Legal Ownership of Insured Property

Court: Court of Appeals; Hon. Mark Cavanagh, Hon. Henry Saad, Hon. Karen Fort Hood
Case: A.B. Petro Mart Inc. et al v Ali T. Beydoun Insurance Agency, Inc. et al; No 327481 (for publication)
Date: September 15, 2016
Issue: whether the trial court correctly applied Michigan law to hold that the insured must have a legal interest or must be financially responsible for any damages to the insured property in order to constitute an insurable interest.

Ruling: This dispute arises from an incident where an automobile ran into and caused the destruction of one of the gas pumps located at the gas station at 3735 East Vernor in Detroit. The crash started a fire and destroyed the pump. Aref Bazzi (Bazzi) was the sole shareholder and owner of A.B. Petro Mart (Petro Mart), and Petro Mart is the entity that operated the gas station. However, the gas pumps, themselves, were owned by Bazzi. Petro Mart insured the gas pumps by purchasing an insurance policy with Prime One, which provided, among other things, $30,000 in coverage for gas pumps. After the accident, Petro Mart filed a claim with Prime One, which eventually declined coverage because it asserted that Petro Mart did not have an insurable interest in the gas pumps, as Bazzi—not Petro Mart—owned the pumps.

Michigan's common law instructs that an “insurable interest” is not synonymous with “ownership.” Instead, an insurable interest can arise from “any kind of benefit from the thing so insured or any kind of loss that would be suffered by its damage or destruction.” Morrison v Secura Ins, 286 Mich App 569, 572; 781 NW2d 151 (2009) (emphasis added); see also VanReken v Allstate Ins Co, 150 Mich App 212, 219; 388 NW2d 287 (1986); 3 Couch, Insurance, 3d, § 41:1 (“Insurable interest may be defined as any lawful and substantial economic interest in the safety or preservation of the subject of the insurance free from loss, destruction, or pecuniary damage.”). Michigan's Supreme Court instructed a hundred years ago that “[a]n insurable interest may be derived by possession, enjoyment, or profits of the property, security or lien resting upon it, or it may be other certain benefits growing out of or dependent upon it.” Crossman v. American Ins Co of Newark, NJ, 198 Mich 304, 308; 164 NW 428 (1917).

In Michigan, legal interest is not synonymous with insurable interest because an insured's pecuniary interest in the insured property is sufficient to constitute an insurable interest. And because Petro Mart’s ability to operate its gas station is financially affected by the functioning or non-functioning of the insured gas pumps, regardless of whether it was responsible to repair any damage to the pumps, we hold that it had an insurable interest in the pumps, and the trial court erred when it ruled otherwise.

Note: The Court of Appeals relied on nearly 100 years of Michigan jurisprudence in overturning the lower court's decision to grant summary disposition to the insurance company on the insurable interest issue. This decision will be published. It provides a modern day illustration of what insurable interest means in the context of a small business.

About the Author

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ERISA Decisions of Interest

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Sixth Circuit Update

Insurer Arbitrarily and Capriciously Applied 12 Month Limitation for “Mental or Nervous Disorders” By Not Separately Considering Plaintiff’s Physical Disorders


The plan’s “Mental or Nervous Disorders” limitation provided that “Monthly Benefits for Total Disability caused by or contributed to by mental or nervous disorders will not be payable beyond an aggregate lifetime maximum duration of twelve (12) months.” The plaintiff insured claimed she was disabled from Crohn's disease, maclepsy, and Sjogren's syndrome (an autoimmune disease). The defendant insurer determined that the insured was impaired due to depression and anxiety, and “approved her claim for benefits for a twelve-month period under the Plan's Mental or Nervous Disorders Limitation.” The insurer reasoned that because the insured’s “medical records support 'the continued presence of a psychiatric component,'” the insured “was eligible to receive benefits for a maximum of twelve months.” The district court granted the insurer’s motion to affirm its decision “largely on this basis.”

The Sixth Circuit reversed. The insured argued that the insurer “erroneously interpreted the Mental or Nervous Disorders Limitation to apply 'whenever a claimant's medical history includes a "psychiatric component",'” and that where “the evidence establishes that a claimant is 'disabled by physical conditions alone, then the mere presence of a "psychiatric component" does not justify application of the one-year mental health limitation.'”

The Sixth Circuit found that “[t]his reasoning has been widely adopted” in other circuits:

We follow the analyses of our sister circuits and apply the but-for inquiry to the Mental and Nervous Disorders Limitation . . . . Thus, an application [for disability benefits] is not properly denied on the basis that a mental or nervous disorder “contributes to” a disabling condition; rather, the effect of an applicant’s physical ailments must be considered separately to satisfy the requirement that review be reasoned and deliberate.

Thus, having found that the insurer capped benefits for twelve months “due to the presence of ‘a psychiatric compo-
because of the absence of “objective medical documentation” that the insured was unable to work. The plan required the insured to “furnish . . . additional objective medical records, clinical notes or testing results to indicate that [she was] disabled as defined by the Plan.” None of the insured’s physicians’ records showed any work restrictions, and the administrator ended benefits.

On administrative appeal, the insured provided a physician’s statement that said “because of the severity of her pain, . . . she is unable to remain mentally focused enough to perform any form of work activities,” yet the physician’s actual records showed the insured’s “[m]entation [was] clear,” and that she had “[g]ood recent and remote recall” with [n]ormal affect.” Another physician’s note reflected she was “[a] nxious and exhibited pain behaviors such as wincing and moaning,” and an acupuncturist noted her “pain level is so extreme that it is hazardous to her physical function and mental-emotional being.” The plan’s independent reviewing physician concluded “there is no objective medical information documented to substantiate an inability to work in any capacity, including sedentary . . . .” The plan administrator therefore affirmed the denial.

The Sixth Circuit affirmed the district court’s opinion affirming the administrative decision, noting that “[a]ccepting that [the insured] suffers from unexplained, severe, and constant pain, we still must assess whether [she] has submitted objective evidence that she is disabled as defined by the Plan.” Significantly, “several of her treating physicians have specifically indicated that [she] can work.” Moreover, the insured presented “no evidence of any physical restrictions, such as on the length of time she may sit or stand, or the amount of weight she may lift.” The court concluded that “[o] verall, the record does not support a finding that [the insured’s] pain condition renders her totally disabled.”

Sixth Circuit Affirms Award of Plan Benefits Under §502(a)(1), Reverses and Reinstates Dismissal of §502(a)(3) Claim for “Other Appropriate Equitable Relief”


The plaintiff was the beneficiary on his father’s Hartford Insurance Company life insurance policy. Before the father died, he elected to obtain $30,000 in coverage that cost $4.58 per week and which his employer withheld from his earnings. Hartford issued a policy effective February 1, 2012. On February 1, 2012, plaintiff’s employer switched coverage from Hartford to United of Omaha. United took over coverage of policies in effect as of January 31, 2012 without insureds needing to show evidence of insurability. The employer began withholding $28.34 per week on March 21, 2012, a premium amount that corresponded to $181,666.67 in coverage. The father died in November 2014, and the plaintiff beneficiary filed a claim, which United denied on the grounds that the Hartford policy was not in effect as of February 1, 2012 and the insured did not provide evidence of insurability. The district court reversed the administrative decision, holding that the insurer’s interpretation of the plan as requiring evidence of insurability was arbitrary and capricious. The Sixth Circuit affirmed that part of the district court’s decision, thus giving the plaintiff relief under §502(a)(1).

The district court also granted United summary judgment on the plaintiff’s §502(a)(3) claim, which allows “other appropriate equitable relief” as long as it is not a “repackaged” §502(a)(1) claim or one that would give a “duplicative or redundant remedy.” The district court held that the plaintiff obtained a full and complete remedy under §502(a)(1), and so “did not directly address whether . . . he would be entitled to equitable relief under §502(a)(3).” The Sixth Circuit reversed and remanded the §502(a)(3) claim, holding that the plaintiff “may have another remedy if he has asserted an injury separate and distinct from the denial of benefits - such as injury from United’s acceptance and retention of premiums.” The Sixth Circuit posited that “[i]f the district court finds a separate injury, an equitable remedy such as surcharge, reformation of the contract, or estoppel might be appropriate . . . .”

District Court Update

Coordination of ERISA Plan and No-Fault Benefits: Exclusion Or Escape Clause?


A typical ERISA medical benefit plan contains a “coordination of benefits” provision which explains what happens when a plan participant, who is also insured under an automobile policy, sustains injuries and requires medical care as a result of a motor vehicle accident. Such provisions often refer to “coverage required by federal, state or local law” and may even expressly refer to no-fault auto insurance, workers’ compensation, or other types of benefits.

No-fault policies also typically contain a coordination of benefits provisions which set forth the priority of payment of claims when “other insurance” is available to the insured, such as employer provided medical benefits. When an injured party’s medical insurance and automobile insurance policies both contain coordination provisions, Michigan’s No-Fault Act requires that the medical insurance policy is primarily liable unless the medical insurance policy expressly excludes coverage for injuries sustained in a motor vehicle accident.
According to ERISA’s “deemer clause” (29 U.S.C. § 1144(b)(2)(B)), self-funded ERISA plans are exempt from application of state no-fault laws. However, insured ERISA plans in Michigan are subject to this state’s No-Fault Act.

The dispute in this case involved whether the insured ERISA plan should be interpreted to contain an express exclusion of coverage for the insured’s automobile accident related injuries, or whether the plan language should be construed as an “escape clause,” which served to coordinate priority of payment but not exclude coverage altogether. The court’s inquiry centered on whether the plan language at issue was conditioned on the existence of “other insurance.”

Here, the court found that the plan’s provision said nothing about the existence of another policy, but rather referred to coverage required by law, regardless of whether coverage was actually being in effect. The court rejected the argument that the provision in question did not specifically reference motor vehicle accidents because the reference to a state’s no-fault law made it “clear” that the provision excluded coverage for such injuries. Accordingly, the court concluded that the disputed provision was in fact an express exclusion and the No-Fault carrier was solely liable for payment of the insured’s claims.

Court Rejected Procedural Challenge Seeking Production of Test Data Underlying Independent Review Which Was Not Part of The Claim File

_Buchanon v The Prudential Ins Co of America_, 2016 WL 4087233

Regular readers of this column and ERISA practitioners are aware that discovery in ERISA denial of benefits claims is typically limited to production of the medical records and other information that was reviewed by the claim administrator when rendering a claim determination. In litigation, a claimant may assert a “procedural challenge” to the decision making process, that he or she was denied a “full and fair review,” and request that other discovery be allowed.

Here, the insured underwent an independent medical examination, including a neuropsychology test. The defendant relied in part on the resulting report to terminate payment of disability benefits. In the course of the administrative review, the plaintiff’s counsel objected that he was not allowed to assess the “raw data” from the neuropsychology test, which was not part of the claim file. Plaintiff asked the court to allow discovery as to this raw data, and to supplement the administrative record accordingly.

The court found that the plaintiff had not specifically requested raw data during the course of the administrative appeal of the claim, and that plaintiff could have requested that information directly from the physician who performed the examination. Because the plaintiff did not convince the court how the raw data was significant or outcome determinative, the court held that the plaintiff was not prevented from obtaining information necessary to contesting the adverse benefit determination, such that there was no procedural defect in the claim review process. Accordingly, the court denied the plaintiff’s request to permit additional discovery and to supplement the administrative record.

About the Authors

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Selected Insurance Decisions
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Michigan Court of Appeals – Published Decisions

The MCCA Is Exempt from FOIA

Coalition Protecting Auto No-Fault v MCCA
(On remand)(Gleicher, J, concurring, dissenting)
___ Mich App ___ (2016)
Docket No. 314310
Released August 25, 2016

On remand from the Supreme Court, the Court of Appeals held that the Michigan Catastrophic Claims Association (MCCA) is a public body subject to the Freedom of Information Act, under MCL 15.232(d)(iv), which applies to any entity “created by state or local authority.” It is not necessary that the MCCA be primarily funded by a state or local authority. But the insurance code, and in particular MCL 500.134, expressly exempts from FOIA disclosure any “record of an Association or Facility” and for purposes of that section, an Association or Facility “means an Association of Insurers created under this Act” particularly including the MCCA. MCL 500.134(4) and (6)(c). This statutory exemption from FOIA does not violate the Michigan Constitution because the 1988 amendment was not “an amendment by implication.”

Court of Appeals Declines to Convene a Special Panel on Innocent Third-Party Rule

Southeast Michigan Surgical Hospital, LLC v Allstate Ins Co
___ Mich App ___ (2016), reconsideration pending
Docket No. 323425
Released August 9, 2016

This is one of three cases decided by the Court of Appeals this past quarter applying Bazzi v Sentinel Insurance Company, ___ Mich App ___ (2016), which eliminated the “innocent third-party” rule for PIP coverage under fraudulently obtained policies. These cases will be discussed more thoroughly elsewhere in this Journal, but are also reported here because of their broader application to insurance contracts generally. In this case, the Court of Appeals stated that it would have applied the innocent third-party rule but for Bazzi. Other members of the Court of Appeals, however, declined to convene a conflicts panel.

Another Case Enforcing Bazzi

State Farm Mut Automobile Ins v
Mich Mun Risk Mgt Authority (On remand)
___ Mich App ___ (2016)
Docket No. 319710 (S Ct app lv pending)
Released August 30, 2016

This is another case in which the Court of Appeals applied Bazzi v Sentinel Ins Co, ___ Mich App ___ (2016) and held that the “innocent third-party” rule did not bar the insurer from seeking rescission of a PIP policy obtained through fraud in the application for insurance. The case was remanded for findings on the insurer’s allegation of fraud.

Michigan Court of Appeals – Unpublished

No UM Coverage for Injuries Incurred After Vehicle Is Parked

Graber v Lintz (and Farm Bureau Mut Ins Co of Mich)
Docket No. 326646 (S Ct app lv pending)
June 16, 2016

Injuries sustained by stepping into deep ruts left by a truck that ran up on plaintiff’s lawn did not fall within the insuring agreement for UIM coverage because the injury occurred after the insured vehicle was parked and thus did not arise out of the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle.

Lack of Coverage Under “Claims Made” Policy for Suit Served After the Policy Expired

Walker v Aleritas Capital Corp
Docket No. 326354 (S Ct app lv pending)
Released July 12, 2016

Plaintiff obtained a default judgment against Aleritas Capital Corporation and then proceeded to garnish its professional malpractice insurer. But the policy was a “claims made” policy and applied only to claims first made against the insured during the policy period. The term “claim” was defined in the policy as “a written demand received by the Assured for money or services including the service of suit or demand for arbitration against the Assured.” The policy specifically stated that the “filing of suit . . . shall not constitute a claim within the mean-
Insurers Have No Duty to Advise of Need for Higher Limits –Even Where Policy Is Obtained Through a Captive Agent

Chemical Technology, Inc v Berkshire Agency, Inc  
Docket No. 326394  
Released July 26, 2016

Plaintiff insured’s commercial building and personal property was destroyed by fire, resulting in damages far in excess of the limits of its commercial property coverage. The insurer sued its insurance agency for negligence and breach of contract for failure to advise of the types and amount of insurance that should have been purchased. The Court of Appeals affirmed summary disposition for the agency because insurance agents, even where they are captive agents of the insurer, have no common law duty to advise of the adequacy of coverage and because none of the “special relationship” exceptions to that rule applied.

Another Bazzi Decision  
Frost v Citizens Ins Co of America (On Remand)  
Docket No. 316157  
Released July 28, 2016

This is another of the three “Bazzi cases” decided this past quarter by the Michigan Court of Appeals. The lower court’s order denied the insurer’s rescission defense based on the innocent third-party rule. The Court of Appeals reversed and remanded the case for further consideration of the insurer’s allegations of fraud.

Homeowners Policy Reformation  
Miller v Farm Bureau Mut Ins Co of Mich  
Docket No. 325885 (S Ct app lv pending)  
August 2, 2016

This fire loss case addresses several evidentiary rulings, but the interesting coverage question concerns the decision to reform this homeowners’ insurance policy issued to a married couple (Jansen, J. dissenting). When first issued, the policy named the husband as the sole named insured; the wife otherwise fit the policy definition of “who is an insured” because she was a member of the named insured’s household. After five years, the couple separated and the husband moved out of the home. The wife stayed but was no longer “an insured” because she was no longer a member of the named insured’s household. Coverage for her personal property destroyed in the fire was disputed because personal property owned by someone other than an insured was limited to property located “on the part of the residence premises occupied by an insured.” The trial judge and the majority of judges on the Court of Appeals agreed the policy should be reformed to cover the wife’s personal property, citing statements made by the insurance company’s captive insurance agent. The majority found sufficient evidence of a special relationship and a mutual mistake to support reformation. The dissenting opinion found no such evidence and did not agree reformation was warranted.

UM Coverage Denied Absent Physical Contact With Another Vehicle  
Buchman v Memberselect Ins Co  
Docket No. 326838 (S Ct app lv pending)  
Released August 11, 2016

Plaintiff’s UM Policy defined “uninsured motor vehicle” to include a hit-and-run vehicle, but only if that vehicle made direct physical contact with the insured or the insured vehicle. This insured encountered an object in the road, which she described as a deer wrapped in a tarp. Upon seeing the object, plaintiff swerved, lost control of her vehicle, and crashed into a concrete barrier. Because there was no direct physical contact with another car, UM benefits were not available.

Homeowners Policy Exclusion Enforced  
McCartha v State Farm Fire & Cas Co  
Docket No. 326689 (S Ct app lv pending)  
Released August 16, 2016

The Court of Appeals enforced a homeowners policy exclusion barring coverage for losses attributable to the insured’s neglect or failure to preserve the insured property. This homeowner made a claim for damage to his roof after a large tree limb fell near or on a gutter. An inspection revealed that the roof was severely worn and deteriorated, with missing shingles and a large hole covered by a tarp, all unrelated to the fallen limb. State Farm paid for the removal of tree debris and for repairs to the gutter, the fencing, and that part of the roof damaged by the limb. It refused to replace the entire roof, a decision affirmed by the Court of Appeals. The court also upheld the lower court’s refusal to allow plaintiff to amend the complaint to challenge State Farm’s decision to terminate the policy. Michigan does not recognize an independent cause of action for bad faith. Nor does it recognize a private cause of action for violation of the Michigan Insurance Code, the Uniform Trade Practices Act, or the Essential Insurance Act.

Insurers have no duty to advise of Need for Higher Limits –the Term “Replacement” Is Not Misleading  
Sarkozy v Hanover Ins Co  
Docket No. 326454 (reconsideration pending)  
Released August 30, 2016

After a fire at plaintiff’s bakery, the commercial property insurer paid full limits under the insured’s replacement policy.
But the limits were insufficient to compensate for the insured’s actual loss and so the insured sued the insurer and the agency for failing to advise of the need for a higher limit. The Court of Appeals affirmed the trial court’s dismissal of the suit. Insurers and agents have no common law duty to advise insureds of the adequacy of coverage. Nor did the insured have any basis for claims of misrepresentation or fraud based on the labeling of the policy as a “replacement cost” policy. The dollar limit of coverage was plainly stated.

“One-Shot” Builder’s Risk Policy Expired

Brother Construction LLC v Rathad (and ACA)
Docket No. 323380 (reconsideration pending)
September 1, 2016

Builder’s risk policy did not cover fire loss that occurred after the one-year period of coverage expired because the terms of the policy limited coverage to one-year. Notice of termination of coverage was required only if the insurer decided not to renew: “If we decide not renew this policy, we will mail or deliver to the first Named Insured’s last mailing address known to us or our authorized agent written notice of the nonrenewal not less than 30 days before the expiration date.” In this case, the insurer was willing to renew but the insured did not seek renewal and submit any new premium. “The circuit court properly found that a notice of nonrenewal is not required when the policy is going to expire and ACA is willing to renew the policy.”

No UM Coverage Because Insured Not Occupying the Vehicle

Banks II v Laster
Docket No. 327416
September 15, 2016

UM policy limited coverage to persons occupying the insured vehicle at the time of injury. Plaintiff was standing on the ground, leaning against the bumper, with his upper body above the trunk of the insured Honda Civic when he was struck by a passing uninsured vehicle. Because he was not occupying the vehicle, he was not entitled to coverage.

Fraud in the Application

Electric Stick, Inc v Primeone Ins Co
Docket No. 327421
September 15, 2016

Insured’s failure to report prior bankruptcies and tax liens in application for insurance where requested supported the insurer’s claim for rescission, even if the omitted information was otherwise available to the insurer.

Sixth Circuit Court Of Appeals Decisions

Claims Made Coverage Lost for Failure to Report Known Error

Thomson v Hartford Cas Ins Co
Case No. 15-1501 (unpublished)
July 28, 2016

The 6th Circuit upheld the decision of the lower court barring legal malpractice coverage for an attorney who failed, upon renewing her policy, to report a known error or omission that could result in a professional liability claim. The terms of the “claims made” contract expressly disavowed coverage for any acts or omissions the insured knew or could have foreseen would result in a claim and was not reported.

No Duty to Defend Against Claims of Trademark Infringement

Bertram v Citizens Ins Co of America
Case No. 15-2552, ___ Fed. Appx. ___
August 26, 2016

Observing that “if something looks like a duck, walks like a duck, and quacks like duck, then it probably is a duck,” the Sixth Circuit held that Citizens properly declined to defend this insured against claims of trade infringement because the CGL policy expressly excluded coverage for such claims and nothing about the lawsuit suggested that the insured was really facing covered claims of product disparagement or trade dress infringement. Insureds “cannot simply rename” claims “and make them so.”

Federal District Court Opinions

Contractual Liability Exclusion Applied to Named Insured’s Assumption of Predecessor’s Contract Obligations

Northern Ins Co of New York v Target Corporation
___ F3d ___ (ED Mich 2014)
Case No. 14-13458 (appeal pending)
August 16, 2016

Named insured Walsay, Inc. acquired a company called Home Niches and agreed to assume certain of its contractual obligations. Home Niches provided products to Target under an agreement that required Home Niches to indemnify Target for any liability arising out of Home Niches’ products. Target settled a tort action for bodily injury caused by such a product and looked to Home Niches and Walsay for indemnity. Because Walsay’s liability to Target was based on its assumption of a contractual liability rather than tort liability, the indemnity obligation was not contained in an “insured contract” and
so did not fall within the exception to the contractual liability exclusion.

UM Policy Cannot Be Reformed by Non-Insured

Gault v Esurance Property and Cas Ins Co
Case No. 15-13819 (unpublished)
July 29, 2016

The parties in this case did not dispute that plaintiff was not an insured under the auto policy issued by Esurance. Plaintiff failed to identify any equitable ground for awarding UM coverage and did not have standing to seek reformation of the policy.

One-year limitations period for first-party property claim enforced

Anderson v Liberty Ins Co
Case No. 16-11356 (unpublished)
August 2, 2016

Claim for homeowners coverage denied where the insurance contract required the insured to file suit within one year after denial of a claim and the insured failed to do so.

In our last article, we discussed at some length the Court of Appeals’ long-awaited decision in Bazzi v Sentinel Ins Co, __ Mich App __, __ NW2d __ (Court of Appeals docket no. 320518, rel’d 6/14/2016). In that case, the Court of Appeals, in a controversial 2-1 decision, determined that the “Innocent Third Party” Doctrine did not survive the Michigan Supreme Court’s ruling in Titan Ins Co v Hyten, 491 Mich 547, 817 NW2d 562 (2012). As a result, no-fault insurers were free to rescind coverage, even as it may have affected the rights of “innocent third parties” and their claims for first-party, no-fault insurance benefits, arising out of any given loss.

Over the summer, there has been a flurry of activity at the Michigan Appellate Court level regarding the rights of “innocent third parties” under policies of insurance that are subject to rescission, based upon a fraud perpetrated by the policyholder. This article will bring the reader up to date as to where matters stand on various cases that have been decided since Bazzi was released on June 14, 2016.

The Bazzi Case Itself

Following the release of the Court’s Opinion on June 14, 2016, Plaintiff Ali Bazzi and Intervening Plaintiff Citizens Insurance Company filed motions for reconsideration. In an order dated August 5, 2012, the Court of Appeals, in a 2-1 decision denied both motions for reconsideration. Judge Beckering would have granted both motions, for the reasons set forth in her dissenting opinion in Bazzi.

On September 16, 2016, counsel for Plaintiff Bazzi filed an application for leave to appeal with the Michigan Supreme Court. Significantly, Citizens Insurance Company, as assignee of the Michigan Assigned Claims Plan, did not file a separate application for leave to appeal. This application for leave to appeal remains pending before the Michigan Supreme Court as of the date this article is being written.

Cases Held in Abeyance Pending Bazzi – Frost v Progressive Michigan Ins Co, and State Farm v Michigan Municipal Risk

Readers of this column will recall that in September 2014, the Court of Appeals, in Frost v Progressive Michigan Ins Co, Court of Appeals docket no. 316157, ruled that a no-fault insurer could rescind coverage, even as to “innocent third party,” based upon the Supreme Court’s decision in Hyten. The court’s previous opinion was subsequently vacated by the Michigan Supreme Court and remanded back to the Court of Appeals for reconsideration following its decision in Bazzi. See Frost v Progressive Michigan Ins Co, 497 Mich 980, 860 NW2d 636 (2015).
On July 28, the Court of Appeals issued its decision on remand. In a unanimous unpublished decision, the Court of Appeals (Judges Owens, Jansen and O’Connell) reaffirmed its earlier decision allowing the no-fault insurer to rescind coverage even as to an “innocent third party.” In doing so, the court recognized that it was bound by its earlier decision in *Bazzi*. Accordingly, the matter was remanded back to the Wayne County Circuit Court in order for Progressive Michigan Insurance Company to “establish proper grounds for rescission.” Neither plaintiff nor Citizens Insurance Company, as assignee of the Michigan Assigned Claims Plan, filed an application for leave to appeal in *Frost and*, as a result, the Court of Appeals’ unpublished decision stands.

With regard to the *State Farm v Michigan Municipal Risk Mgmt Authority*, 498 Mich 870, 868 NW2d 898 (2015) decision, Court of Appeals docket no. 319710, readers will recall that in that case, the Court of Appeals had earlier determined that the no-fault insurer could not rescind coverage even as to an “innocent third party.” Judge Boonstra was on the Court of Appeals’ panel in *State Farm*, and was also on the panel that decided *Bazzi*. In fact, in *Bazzi*, Judge Boonstra issued a concurring opinion in which he explained how he had changed his mind on this issue, given the extensive briefing submitted by both parties in *Bazzi*. Readers will recall that the Supreme Court likewise vacated the Court of Appeals’ earlier decision and remanded this matter back to the Michigan Court of Appeals for reconsideration, once *Bazzi* had been decided. See *State Farm Mut’l Ins Co v Michigan Municipal Risk Mgmt Authority*, 498 Mich 870, 868 NW2d 898 (2015).

The Court of Appeals issued its published decision, on remand, on August 30, 2016. In its decision, the Court of Appeals affirmed the ability of the no-fault insurer to rescind coverage even as to the “innocent third party” and remanded the matter back to the circuit court in order to allow QBE Insurance Company to establish proper grounds for rescinding coverage, based upon its insured’s failure to disclose the actual ownership of the vehicle being insured under the QBE policy.

Of more interest is Judge Murphy’s concurring opinion, which reads almost like a dissent. In his concurring opinion, Judge Murphy points out that in *Hyten*, the Michigan Supreme Court expressly recognized that an insurer’s ability to rescind coverage may be “limited in relation to statutorily-mandated insurance coverage and benefits.” Specifically, Judge Murphy pointed out that at the end of the Court’s opinion in *Hyten*, the Supreme Court stated:

“Should Titan prevail on its assertion of actionable fraud, it may avail itself of a traditional legal or equitable remedy to avoid liability under the insurance policy, notwithstanding that the fraud may have been easily ascertainable. However, as discussed earlier in this opinion, the remedies available to Titan may be limited by statute.”


Judge Murphy then made note of the footnote that was attached to the end of this sentence:

“For example, MCL 500.3009(1) provides the policy coverage minimums for all motor vehicle liability insurance policies.”

The minimum insurance policy limits specified in the cited statute, of course, are $20,000.00/$40,000.00. As noted by Judge Murphy:

“When footnote 17 is read in conjunction with the sentence to which it was appended, it necessarily signified the Supreme Court’s stance that the $20,000.00/$40,000.00 residual liability coverage mandated by MCL 500.3009(1) cannot be diminished or limited by legal or equitable remedies generally available to an insurer for actionable fraud. There can be no other reasonable construction of the sentence and corresponding footnote. Optional insurance coverage above the minimum liability limits contained in a policy procured by fraud might not be reached by an injured third party seeking damages arising out of a motor vehicle accident, but footnote 17 in *Titan* makes abundantly clear that the mandatory liability minimums are to be paid by the insurer under the policy despite any fraud.”

*State Farm*, slip opinion at p. 1-2 (Murphy, J. concurred)

Judge Murphy then observed that like the minimum policy limits set forth in MCL 500.3009, PIP benefits are likewise mandated under MCL 500.3101(1). Therefore, according to Judge Murphy:

“Given the mandatory nature of PIP coverage under the NoFault Act, and considering the logic gleaned from examining footnote 17 of *Titan*, one can reasonably extrapolate that MCL 500.3101(1) (requiring PIP coverage) would be another example, along with MCL 500.3009(1), of a statute that limits the availability of remedies for actionable fraud.

In sum, *Bazzi’s* construction of *Titan* must be honored, and thus I concur in the majority’s holding. It is my belief, however, that the opinion in *Titan* cannot be interpreted as abolishing the ‘innocent third-party’ rule in the context of statutorily-mandated automobile insurance coverage, as to reach such a conclusion would require a wholesale disregard of *Titan’s* footnote 17.”

*State Farm*, slip opinion at pp. 2-3 (Murphy, J., concurring)

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On September 15, 2016, counsel for Michigan Municipal Risk Management Authority (which is now solely responsible for paying the motorcyclist's PIP benefits) filed an application for leave to appeal with the Michigan Supreme Court. Significantly, State Farm Mutual Automobile Insurance Company, as assignee of the Michigan Assigned Claims Plan, did not join in the application for leave to appeal.

As counsel for Titan Insurance Company in Titan Ins Co v Hyten, I would like to offer the following thoughts on the issue raised by Judge Murphy in his concurring opinion in this case. First, there is a fundamental difference between recovery on a tort claim and recovery on a PIP claim. On a tort claim, unless the injured person has purchased uninsured or underinsured motorist coverage, there are no other sources of recovery for non-economic damages (or excess economic losses) from a tortfeasor, other than whatever insurance policy limits the tortfeasor may have carried on his or her insurance policy.

The “innocent third party” doctrine was designed to prevent an injured party from being “left out in the cold” completely, with no source of recovery for the damages suffered as the result of another’s negligence. Therefore, it only makes sense that if the tortfeasor was insured (no matter how much fraud may have been involved in the procurement of the policy), limiting the injured party’s recovery to the minimum policy limits of $20,000.00/$40,000.00 at least provided a modicum of recovery for the injured party.

By contrast, an injured “innocent third party” always has other sources of recovery for payment of his or her PIP benefits — lower priority insurers (as in the State Farm case) or the Michigan Assigned Claims Plan, as “the insurer of last resort.” An injured “innocent third party” should never be “left out in the cold” when it comes to payment of PIP benefits. Thus, a no-fault insurance carrier should be permitted to rescind coverage even as to an “innocent third party,” as the injured party should be able to obtain benefits from lower priority insurers or the Michigan Assigned Claims Plan.

Southeast Michigan Surgical Hosp v Allstate Ins Co, __ Mich App __, __ NW2d __ (Court of Appeals docket no. 323425, rel’d 8/9/2016)

The divisions in the Court of Appeals regarding the current status of the “Innocent Third Party” Doctrine are exemplified in the Court of Appeals’ 2-1 decision in Southeast Michigan Surgical Hosp LLC v Allstate Ins Co, __ Mich App __, __ NW2d __ (Court of Appeals docket no. 323425, rel’d 8/9/2016). In Southeast Michigan Surgical Hosp, Judges Ronayne Krause and Stephens issued an opinion, indicating that but for the binding nature of the Court of Appeals’ earlier decision in Bazzi, they would have held that the “Innocent Third Party” Doctrine remains viable in the State of Michigan, and that a nofault insurer cannot be permitted to rescind coverage as to “innocent third parties.” In this regard, Judges Ronayne Krause and Stephens adopted Judge Beckering’s dissent in Bazzi, and concurred in her reasoning. Therefore, the Court of Appeals majority requested that a conflict panel be convened, pursuant to MCR 7.215(J) to resolve the conflict.

In addition to its arguments regarding the continuing viability of the “Innocent Third Party” Doctrine, plaintiffs also raised an estoppel argument. The accident itself occurred on December 12, 2010. Plaintiffs did not file suit against Allstate until December 18, 2011, more than one year post accident. However, plaintiff claimed that it gave notice to Allstate in a timely manner, and because the fraud perpetrated by Allstate’s insured was not discovered until discovery was well under way, Allstate should be estopped from denying coverage. However, the Court of Appeals noted that plaintiff’s claims against any other insurers were already time barred by the time suit was filed against Allstate. Therefore, Plaintiffs were not prejudiced by Allstate’s decision to rescind coverage more than one year post accident:

“Other than Allstate, there is no evidence that any nofault insurer in the chain of priority to pay Plaintiffs’ claims was ever identified, or that such insurer made a payment of PIP benefits or received written notice of Letkemann’s injuries. Likewise, there is no evidence that Allstate ever made a payment of PIP benefits for Letkemann’s injuries (LCF), but it was, within a year of the accident, evidently provided with notice of the injuries. The accident at issue occurred on December 12, 2010, and Plaintiffs did not file suit against Allstate until December 18, 2011. Because this was more than one year after the accident causing Letkemann’s injuries, they evidently relied on the notice exception in MCL 500.3145(1).

As a consequence, Plaintiffs were already time barred by the time Allstate became a priority. Had Allstate asserted a valid affirmative defense immediately, the result would have been the same: it would have been too late for Plaintiffs to file a new claim against a different insurer, MCL 500.3145(1), and also too late to file the requisite notice for an ACF claim, MCL 500.3174, Spencer v Citizens Ins Co, 239 Mich App 291, 608 NW2d 113 (2000). Accordingly, whether or not Allstate’s delay in asserting the claim could be considered good practice, it did not have a practically prejudicial effect . . .

Plaintiffs also assert that Allstate is equitably estopped from rescinding the policy. Plaintiffs argue that Allstate’s initial representations that it insured the vehicle induced Plaintiffs to believe that it was in fact insured, Plaintiffs justifiably relied on that
belief, and if Allstate could not deny that it insured the vehicle, Plaintiffs would be prejudiced because it was too late for them to file a claim seeking payment of no-fault benefits for the accident from the ACF. As discussed, Plaintiffs were already time-barred from pursuing an ACF claim before the Complaint was filed in this action. Prejudice is an essential element of establishing an equitable estoppel. [Citation omitted]. The party seeking equitable estoppel bears ‘a heavy burden’ of proving its applicability. [Citation omitted]. Because Plaintiffs cannot establish prejudice, they cannot establish an equitable estoppel.”

*Southeast Michigan Surgical Hosp*, slip opinion at p 4 (italics in original)

Having decided that estoppel did not apply under the facts of this case, the Court of Appeals then addressed the “Innocent Third Party” Doctrine, and how it should not apply under the facts of this case, notwithstanding the Court of Appeals’ earlier decision in *Bazzi*. Ironically, Judge David Sawyer, who authored the lead opinion in *Bazzi*, was also on the panel in *Southeast Michigan Surgical Hosp*. Judge Sawyer dissented from the majority’s opinion, and stated that because *Bazzi* was correctly decided, there was no need to convene a conflict panel at all.

On August 30, 2016, Plaintiff filed a Motion for Reconsideration, which has not yet been addressed by the Court of Appeals. On August 31, 2016, the Court of Appeals declined to convene a conflict panel. Absent a change in the Court’s ruling on reconsideration, it appears that this matter may be headed to the Michigan Supreme Court.

**Concluding Remarks**

Given the opinion of Judge Ronayne Krause and Judge Stephens in *Southeast Michigan Surgical Hosp*, requesting that a conflict panel be convened pursuant to MCR 7.215(J), and the concurring opinion by Judge Murphy in *State Farm*, the Michigan Supreme Court may very well be interested in taking up this matter by granting the applications for leave to appeal in *Bazzi*, *State Farm*, or both. The author finds it interesting that the MACP insurers have not filed an application for leave to appeal, even though in two of the four cases (*Bazzi* and *Frost*), the MACP-assigned insurers are now responsible for adjusting the claims filed by the “innocent third parties.” In the meantime, smart practitioners will place every conceivable no-fault insurer, in any order of priority, on notice of any claim for no-fault benefits. The MACP and its assigned insurers will undoubtedly be seeing an increase in the number of filings, as injured claimants and their attorneys scramble to protect the “innocent third party” claimants from being “shut out” of a claim for no-fault benefits if the insurer subsequently determines, more than one year post accident, that the policy of insurance was procured by fraud. It is imperative that practitioners in this area, on both sides of the aisle, keep a careful eye on any developments that occur on this issue at the appellate court level. ■
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