I. Regulatory Limits on Claims Handling

A. Timing for Responses and Determinations

The Fair Claims Settlement Practice Regulations set forth the relevant time limits for claims handling responses and determinations. The most important time limits are: 15 days to acknowledge receipt of claim (10 Cal. Code Reg., § 2695.5(e)(1)); 15 days to respond to communications from claimant, regarding a claim, to which reply is expected (10 Cal. Code Reg., § 2695.5(b)); 40 days after proof of loss to accept or deny claim, or notify that more time is needed (10 Cal. Code Reg., § 2695.7(b)).

As to the requirement to reply within 15 days after receipt of any communication from a claimant that suggests a reply is expected, the response must be complete and based upon the facts as then known. This requirement ends when there is receipt of notice of legal action. Note that as to the 40 day requirement, it is triggered by proof of claim, which means evidence or documentation in the possession of the insurer, whether submitted by the claimant or obtained by the insurer in the course of its investigation, showing any evidence of the claim and reasonably supporting the magnitude or amount of the claimed loss. If an insurer requires more than 40 days to make a claims determination, the insurer must provide the claimant with written notice that additional time is required to make a determination and specify what further information is required and the continuing reasons for the inability to make a determination.

B. Standards for Determinations and Settlements

C. **State Privacy Laws, Rules, and Regulations**

The Insurance Information and Privacy Protection Act (Cal. Ins. Code, § 791.01 et seq.) creates a statutory right of privacy for an insured and claimants for information maintained by insurance companies, including claims files. Disclosure of the information can be compelled in discovery; however, any order allowing discovery of such information must be conditioned on the written consent of the affected parties in response to a court-approved request form. (Cal. Ins. Code, § 791.13; Mead Reinsurance Co. v. Superior Court (1986) 188 Cal.App.3d 313, 321-22. Cf. Federal HIPAA law.)

In addition, claims files may contain privileged communications made in the course of an attorney-client relationship, or documents that are work-product of either the insurer or the insurer.

II. **Principles of Contract Interpretation**

An insurance policy is a binding, legal contract between the insurer and the insured under which the insurer agrees to defend and indemnify the insured against loss, damage, or liability arising from a contingent or unknown event in exchange for payment of a premium by the insured. (Cal. Ins. Code, §§ 22-23; Fraser-Yamor Agency, Inc. v. County of Del Norte (1977) 68 Cal.App.3d 201, 213.) There must be a meeting of the minds of the parties as to the essential terms of the insurance contract. (Long v. Keller (1980) 104 Cal.App.3d 312, 321 (providing essential terms including the subject matter to be insured, the hazards covered, the policy term, and others).)

An insurance policy should generally be interpreted under the same rules governing the interpretation of any contract. (State Farm Mutual Auto. Ins. Co. v. Eastman (1984) 158 Cal.App.3d 562, 566.) If an insurance policy’s terms are clear, the terms are given the plain meaning that a layman would ordinarily attach to them. (Reserve Ins. Co. v. Pisciotta (1982) 30 Cal.3d 800, 807.) As to terms of the policy that are ambiguous or uncertain, those terms are resolved by giving effect to the insured’s objectively reasonable expectations, or, if this fails, by construing the ambiguous language against the insurer. (E.M.M.I. Inc. v. Zurich Am. Ins. Co. (2004) 32 Cal.4th 465, 470.)

In determining whether the circumstances give rise to an exception to the general rule that ambiguous language is construed against the insurer, courts have examined the size, sophistication, and bargaining strength of the insured, as well as other factors. Such other factors include, among others: the insured’s ability to negotiate policy changes (Advanced Micro Devices, Inc. v. Great American Surplus Lines Ins. Co. (1988) 199 Cal.App.3d 791, 801); representation and assistance of insurance brokers or risk managers, or both, on behalf of the insured (Fireman’s Fund Ins. Co. v. Fibreboard Corp. (1986) 182 Cal.App.3d 462, 468); and whether the policy was a manuscript policy negotiated and prepared specifically for the insured, rather than a standardized form (Garcia v. Truck Ins. Exch. (1984) 36 Cal.3d 426, 438).

In interpreting an insurance policy, a court’s fundamental goal is to give effect to the parties’ intent at the time of contracting. (Bank of the West v. Superior Court (1992) 2 Cal.4th 1254, 1265.) Some courts have held that relevant extrinsic evidence can assist in interpreting the policy if such evidence can establish the intent of the parties at the time of contracting. (See Gribaldo, Jacobs, Jones & Assoc. v. Agrippina Versicherungen A.G. (1970) 3 Cal.3d 434, 443 (testimony allowed on how
deductible on errors and omissions indemnity policy operated); Heston v. Farmers Ins. Group (1984) 160 Cal.App.3d 402, 412 (insurer's statements about “contract value” provisions held admissible.) Extrinsic evidence of the intent of the parties can be admitted only if the evidence is relevant, and the language in the policy is fairly susceptible to either of two interpretations. (Gribaldo, Jacobs, Jones & Assoc., supra, at p. 443.)

For example, extrinsic evidence of “the type of information sought upon application for such a policy and the relatively small premiums charged” was admissible to show that the parties never intended coverage. (Herzog v. National American Ins. Co. (1970) 2 Cal.3d 192, 197.) Extrinsic evidence of the circumstances surrounding the making of a contract may also be admissible. (E.g., Heston, supra, at p. 412 (express representations on status as “independent businessman” made during negotiations are clearly relevant to determining meaning of ambiguous contract).)

Additionally, the Insurance Code includes a broad variety of regulations that affect the formation, interpretation, and coverage of an insurance contract. For example, the concealment or misrepresentation in the formation of contract of material facts by the insured or insurer is prohibited (Cal. Ins. Code, §§ 330–331, 359); and a violation of a material warranty or other material provision of a policy, on the part of either party, entitles the other to rescind (Id. § 447).

III. Choice of Law

The interpretation process of a policy begins with a determination of which jurisdiction’s law should be applied. If all contacts involving the action have occurred in California, a choice of law issue does not arise, and California law applies. When out-of-state contacts exist, however, and the laws of the other state(s) and those of California differ, a choice of law analysis must be applied. Litigation over insurance contracts can involve complicated choice of law issues, often because insurance contracts do not include a choice of law provision and the insurer and insured are from different states. For example, determination of whether an excess policy provides coverage may require a choice of law analysis, which may result in the application of the law of a jurisdiction other than California. This issue is important because the applicable state law may determine issues such as the insurability of punitive damages or the existence of a bad faith tort.

California courts have adopted the governmental interest test for choice of law problems in both contract and tort cases. (Kearney v. Salomon Smith Barney, Inc. (2006) 39 Cal.4th 95, 100; Robert McMullan & Son, Inc. v. United States Fid. & Guar. Co. (1980) 103 Cal.App.3d 198, 204 (contract issue); Offshore Rental Co. v. Continental Oil Co. (1978) 22 Cal.3d 157, 161 (tort issue).) The governmental interest test is a three-step analysis: (1) determine whether the laws of the various states that have contacts with the action conflict on the issue to be interpreted (Offshore Rental Co., supra, at p. 161); (2) if the laws conflict, assess whether the states each have an interest in having their own state law applied by examining the relative interests of the litigants and states involved (e.g., the place of contracting, negotiation, and performance; location of subject matter; and domicile, residence, place of incorporation of parties (Robert McMullan & Son, Inc., supra, at p. 204-05)); and (3) if both (or two or more) states have an interest in having their own law applied, there is a true conflict, and the comparative impairment analysis must be applied, i.e., the court must
determine which state’s interest would be more impaired if its law were not applied (Zimmerman v. Allstate Ins. Co. (1986) 179 Cal.App.3d 840, 846).

In performing the comparative impairment analysis, a court examines the history and current status of the conflict laws, as well as the function and purpose of those laws. (Kearney, supra, at p. 123–24.) For example, if a state’s law is outmoded and infrequently applied when compared with the law of another state, the interests of the state with the newer law will generally prevail. (E.g., Offshore rental Co. v. Continental Oil Co. (1978) 22 Cal.3d 157, 169; Rosenthal v. Fonda (9th Cir. 1988) 862 F.2d 1398 (holding that New York’s law on breach of an oral employment contract applied because its statute of frauds was stricter than California’s, thereby demonstrating that New York had a stronger interest in protecting people).) Another factor to consider is California Civil Code section 1646, which provides, “A contract is to be interpreted according to the law and usage of the place where it is to be performed; or, if it does not indicate a place of performance, according to the law and usage of the place where it is made.” (Arno v. Club Med Inc. (9th Cir. 1994) 22 F.3d 1464, 1468 n.6 (noting there is a difference of opinion as to whether the governmental interest test or Civil Code section 1646 applies, but holding that under either test, California law applied).)

IV. Extra-Contractual Claims Against Insurers: Elements and Remedies

A. Bad Faith

Generally speaking, to plead a cause of action for bad faith, or more technically breach of the implied covenant of good faith and fair dealing, plaintiff must allege a duty owed by the insurer, breach of the duty by the insurer, and damage sustained by the plaintiff. (Gruenberg v. Aetna Ins. Co. (1973) 9 Cal.3d 566.) The cause of action finds its genesis in the insurance contract. Thus, a plaintiff alleging bad faith must usually establish coverage under the insurance contract as forming the basis for the benefits due (and the duty to) the plaintiff under the policy. (Samson v. Transamerica Ins. Co. (1981) 30 Cal.3d 220; Waller v. Truck Ins. Exch. (1995) 11 Cal.4th 1 (concluding that plaintiff’s alleged emotional and physical distress flowed from noncovered economic loss, so there was no potential for coverage and no duty to defend the plaintiff in the underlying lawsuit; thus, it could not be found liable for statutory bad faith or breach of the implied covenant of good faith and fair dealing for its denial of a defense).)

However, a mere denial of benefits is not bad faith. (Hanson v. Prudential Ins. Co. (9th Cir. 1985) 783 F.2d 762, 766 (affirming judgment for the insured on the issue of bad faith, the Ninth Circuit, applying California law, held that "[b]ecause Prudential's interpretation of the policy was not unreasonable...[its] conduct did not rise to the level of bad faith.").)

The opinions in Chateau Chamberay Homeowners Assoc. v. Associated International Ins. Co. (2001) 90 Cal.App.4th 335, 346; Fraley v. Allstate Ins. Co. (2000) 81 Cal.App.4th 1282, 1292; and Guebara v. Allstate Ins. Co. (9th Cir. 2001) 237 F.3d 987, 992, reiterate the long-standing principle that bad faith hinges on reasonableness. It is not bad faith for an insurer adjusting a first party claim to delay or refuse payment of disputed benefits where there exists a “genuine issue” over the existence or scope of the insurer’s obligation for policy benefits. Thus, an insurer that denies benefits reasonably, but incorrectly, will be liable only for damages flowing

The Chateau Chamberay court elaborated on factors that could support bad faith, including whether the insurer: (1) misrepresented the nature of its investigatory activity, (2) provided any false documents or testimony, (3) did not honestly select independent experts to make the appropriate loss evaluations, (4) relied upon expert reports that were not reasonable or, (5) failed to conduct a thorough investigation." (Id. at 349.) Note that the court in FEI Enterprises, Inc. v. Kee Man Yoon (2011) 194 Cal.App.4th 790, refused to apply both an objective and subjective standard, finding: "The majority view is that in determining whether the dispute is 'reasonable,' the proper test to apply is an objective one. An insurer’s subjective state of mind is immaterial."

Under current California law, only insureds have original standing to bring a bad faith claim. In addition, even though typically each party in California bears his or her own attorney’s fees, if an insured sues for bad faith and wins, attorney’s fees incurred in pursuing contract benefits can be recovered. (Brandt v. Superior Court (1985) 37 Cal.3d 813, 819 (“The fees recoverable, however, may not exceed the amount attributable to the attorney’s efforts to obtain the rejected payment due on the insurance contract”.)

When an insured assigns a bad faith cause of action against an insurer, the assignee also receives the right to recover the policy benefits in full, plus the right to Brandt fees. (Essex Ins. Co. v. Five Star Dye House, Inc. (2006) 38 Cal.4th 1252, 1255.)

A plaintiff who proves bad faith is entitled to recover under tort law all damages proximately caused by the insurer’s conduct, including punitive damages. (Crisci v. Security Ins. Co. (1967) 66 Cal.2d 425, 433.)

B. Fraud

Under the California Civil Code, the term “fraud” encompasses independent causes of action for a number of types of claims, including intentional or negligent misrepresentation, concealment, or false promise. (Cal. Civ. Code §§ 1709-1710.) To recover, “There must be (1) a false representation or concealment of a material fact (or, in some cases, an opinion) susceptible of knowledge, (2) made with knowledge of its falsity or without sufficient knowledge on the subject to warrant a representation, (3) with the intent to induce the person to whom it is made to act upon it; and such person must (4) act in reliance upon the representation (5) to his damage.” (South Tahoe Gas Co. v. Hofmann Land Improvement Co. (1972) 25 Cal.App.3d 750, 765 (emphasis in original).)

Common examples of fraud in the context of insurance include: improperly denying claims; misrepresenting to claimants certain facts or insurance policy provisions; and improperly denying coverage.

In Tenet Healthsystem Desert, Inc. v. Blue Cross of California (2016) 245 Cal.App.4th 821, the court held that a health insurer’s preauthorization for emergency services following an auto accident, without notice of a coverage limitation for injuries sustained when driving while intoxicated,
not only estopped the insurer from relying on the exclusion, but constituted fraud and negligent misrepresentation.

Although generally punitive damages cannot be awarded for breach of contract (Cal. Civ. Code, § 3294), punitive damages are available in fraud causes of action, such as in the context of insurance bad faith.

C. **Intentional or Negligent Infliction of Emotional Distress**

1. **Intentional Infliction of Emotional Distress**

An action for intentional infliction of emotional distress may be an alternative theory of recovery in a bad faith action against an insurer for mishandling a claim. (See Fletcher v. Western National Life Ins. Co. (1970) 10 Cal.App.3d 376, 394.) To prevail, an insured must show: (1) extreme and outrageous conduct by the insurer directed at the insured; (2) the insurer’s intent to cause severe emotional distress to the insured thereby, or reckless disregard of the probability that such distress will result; and (3) the insured’s severe emotional distress proximately caused by the insurer’s conduct. (Christensen v. Superior Ct. (Pasadena Crematorium) (1991) 54 Cal.3d 868, 903.) Courts tend to apply these requirements strictly. (Ibid.)

However, to recover emotional distress as a component of damages in an action for tortious breach of the implied covenant, plaintiff need not plead or prove outrageous conduct, “severe” emotional distress, or an intent on the part of the insurer to cause emotional distress. Provided the bad faith conduct has caused economic loss, emotional distress damages are recoverable in a bad faith action independent of the tort of intentional infliction of emotional distress. (Gruenberg v. Aetna Ins. Co. (1973) 9 Cal.3d 566, 580.)

2. **Negligent Infliction of Emotional Distress**

An action for negligent infliction of emotional distress may also be available as an alternative to a bad faith action. However, because of the restrictive treatment accorded emotional distress claims generally and the lack of authoritative precedent, the viability of a negligent infliction action against an insurer is presently unclear. (See Bates v. Hartford Life & Acc. Ins. (C.D. Cal. 2011) 765 F.Supp.2d 1218, 1222; Bogard v. Employers Cas. Co. (1985) 164 Cal.App.3d 602, 618 (denying recovery for negligent infliction of emotional distress); Krupnick v. Hartford Accident & Indem. Co. (1994) 28 Cal. App. 4th 185, 209 (same).) Further, as a general rule, negligence is not among the theories generally available against insurers. (Sanchez v. Lindsey Morden Claims Services, Inc. (1999) 72 Cal.App.4th 249, 254.)

D. **State Consumer Protection Laws, Rules and Regulations**

California has long led the nation in consumer action statutes, which are now very frequently used against health and life insurers.

The capstone of California consumer statutes is the Unfair Competition Law (UCL) contained in Business and Professions Code sections 17200, et seq. The UCL prohibits unfair competition and allows recovery for “any unlawful, unfair or fraudulent business act or practice and unfair, deceptive, untrue or misleading advertising.” (Cal. Bus. & Prof. Code, § 17200.) By prohibiting “unlawful” business practices, the UCL borrows violations of
other laws and makes a violation of those laws a per se violation of the UCL. Thus, the UCL remains a predominant vehicle for California plaintiffs who seek to enforce marginal or tangential consumer rights, including against healthcare providers.

Until recently, there was a split in authority over whether a UCL action could be brought against an insurer for unfair settlement practices in violation of the Unfair Insurance Practices Act (UIPA). (Cf. Safeco Ins. Co. v. Superior Court (1990) 216 Cal.App.3d 1491 (affirming dismissal of UCL claim based on unfair settlement practices); State Farm Fire & Cas. Co. v. Superior Court (1986) 45 Cal.App.4th 1093 (holding that a cause of action against an insurer was properly brought under the UCL by a group of insured homeowners whose homes were damaged in an earthquake, based on the insureds’ allegations of fraudulent deceit and breach of the covenant of good faith implied in their policies), overruled by Cel-Tech Communications, Inc. v. Los Angeles Cellular Telephone (1999) 20 Cal.4th 163, 184–87 (disapproving State Farm’s definition of “unfair” for purposes of section 17200).)

The California Supreme Court resolved this split in authority in Zhang v. Superior Court (2013) 57 Cal.4th 364. In Zhang, the Court held that alleged false advertising was a proper basis for a civil cause of action against the insurer under the UCL. But the Court acknowledged that UCL actions based solely on violations of the UIPA are precluded.

The plaintiff in a UCL action must prove that a company’s practices were unfair and/or deceptive, an extremely amorphous standard, often criticized in decisions yet never substantively overturned. The principal form of relief is either restitution or disgorgement of ill-gotten gains, i.e., the profits the company made in the course of committing the unfair trade practice. General damages and attorneys’ fees are customarily not allowed as part of recovery. However, an exception exists when the plaintiff is acting on behalf of the general public as a “private attorney general.”

The UCL is ripe for use against medical insurers, just as it has been used against homeowner and other personal lines carriers in the earthquake context. The statute is particularly dangerous and well-suited for use with alleged claims violations (like the unfair and deceptive acts or practices provisions of Insurance Code Section 790.03 et. seq.) because the statute itself “piggybacks” onto some underlying offense or pattern of offenses. In Tenet Healthsystem Desert, Inc. v. Blue Cross, supra, the court held that a health insurer’s preauthorization of services, coupled with a failure to give notice of a coverage exclusion, not only constituted fraud, but also supported a cause of action for violation of the UCL, because “An unfair business practice includes anything that can properly be called a business practice and that at the same time is forbidden by law.”

Because healthcare providers and health plans are intensely regulated by federal and state laws, any alleged violation of these laws can form the basis for a UCL claim, and thus, the breadth and complexity of healthcare laws makes healthcare business practices an easy target for UCL claims. Firms specializing in the defense of health, life, and disability insurers would be well advised to groom their business litigators for battle against UCL plaintiffs ranging from complaints for over-billing, utilizing unfair leverage in settling claims, misleading patients regarding scope of benefits, and refusing to adequately and promptly pay benefits.
E. State Class Actions

In California, class actions are specifically authorized by statute: “[W]hen the question is one of a common or general interest, of many persons, or when the parties are numerous, and it is impracticable to bring them all before the court, one or more may sue or defend for the benefit of all.” (Cal. Civ. Proc. Code, § 382.) A more detailed statutory scheme also appears in the Consumers Legal Remedies Act (Cal. Civ. Code, § 1750 et seq.), however, this is limited to class actions based on unfair practices in connection with consumer sales transactions (Cal. Civ. Code, § 1770.) The Judicial Council has adopted California Rules of Court governing procedures in class actions. (See Cal. Rules of Court, rules 3.760-3.771.) Before these rules were adopted, the California Supreme Court directed state courts to look to Rule 23 of the Federal Rules of Civil Procedure, governing class action procedures. Rule 23 may still be followed where gaps exist in the California Rules of Court.

Under California law, the party seeking class certification must establish three things: (1) the existence of an ascertainable and sufficiently numerous class; (2) a well-defined community of interest; and (3) substantial benefits from certification that render proceeding as a class superior to the alternatives. (Brinker Restaurant Corp. v. Sup.Ct. (2012) 53 Cal.4th 1004, 1021.) These are commonly known as: (1) ascertainable class; (2) community of interest; and (3) manageability.

V. Defenses in Actions Against Insurers

A. Misrepresentation/Rescission of Insurance Contract for Misrepresentation

Generally, the rules of rescinding a contract on a non-consensual basis are codified in Civil Code section 1689, subdivision(b). The Insurance Code also provides that a policy of insurance may be rescinded on the following grounds: (1) where the insured has misstated or concealed a material fact in the application for insurance, even if unintentional (Cal. Ins. Code §§ 331 et seq.); (2) where a mistake exists (Cal. Civ. Code § 1689(b)(1)); or (3) where the insured’s breach of a policy provision or warranty materially affects the risk (Cal. Ins. Code, § 447).

Where the application for insurance contains misstatement or concealment of material facts, even if unintentional, the insurer is entitled to rescind the policy. The question of materiality is to be tested subjectively. “The most generally accepted test of materiality is whether or not the matter misstated could reasonably be considered material in affecting the insurer’s decision as to whether or not to enter into the contract, in estimating the degree or character of the risk, or in fixing the premium rate thereon.” (Old Line Life Ins. Co. v. Superior Court (1991) 229 Cal.App.3d 1600, 1604.)

Generally speaking, “[m]ateriality is determined solely by the probable and reasonable effect which truthful answers would have had upon the insurer. . . . The fact that the insurer has demanded answers to specific questions in an application for insurance is in itself usually sufficient to establish materiality as a matter of law.” (Imperial Cas. & Indem. Co. v. Sogomonian (1988) 198 Cal.App.3d 169, 179 (citations omitted.).) A material misrepresentation made by an insured during the course of a claim’s submission not only bars the portion of the loss that relates to the

B. Preexisting Illness or Disease Clauses

1. Statutes

A preexisting condition provision excludes coverage for charges or expenses incurred during a specified period following the enrollee’s effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage. (Health & Saf. Code, § 1357.50(c).) Regulation of preexisting condition exclusions in individual and small group health insurance plans is left to the individual states as a result of the McCarran-Ferguson Act of 1945, 15 U.S.C. sections 1011-1015.

In 2010, Congress enacted and the President signed into law the Patient Protection and Affordable Care Act in order to increase the number of Americans covered by health insurance and decrease the cost of health care. One key provision is the individual mandate, which requires most Americans to maintain “minimum essential” health insurance coverage. On June 28, 2012, the Supreme Court rendered a final decision to uphold most provisions of the health care law, including the individual mandate. (National Federation of Independent Business v. Sebelius (2012) 132 S. Ct. 2566.) Starting in 2014, the Affordable Care Act guaranteed that all Americans, regardless of their health status or preexisting conditions, will have access to quality, affordable coverage.

2. New Developments

As of January 2017, the state of the law with regard to the Affordable Care Act remains in flux. Legislators have vowed to enact changes but as of this writing the law remains intact.

C. Statutes of Limitation

The statute of limitations in an insurance coverage action depends upon whether the plaintiff asserts a cause of action based upon contract or tort theories. Actions based upon breach of contract are subject to a four-year limitations period (see Cal. Civ. Proc. Code, § 337), while actions based upon tort (i.e., bad faith breach of the implied covenant of good faith) are subject to a two year limitations period. (E.g., Richardson v. Allstate Ins. Co. (1981) 117 Cal.App.3d 8, 13.)

The limitations period generally begins to run once the insurer has unconditionally denied the insured’s claim. (See State Farm Fire & Cas. Co. v. Superior Court (1989) 210 Cal.App.3d 604, 609 (action to recover policy benefits).) A contractual limitations period may be “equitably tolled from the time the insured files a timely notice, pursuant to policy notice provisions, to the time the insurer formally denies the claim in writing.” (Prudential-LMI Commercial Ins. v. Superior Court (1990) 51 Cal.3d 674, 678.) However, an insurer’s offer of an optional appeal process does not toll running of the statute of limitations following an unequivocal written denial. (Vishva Dev, M.D., Inc. v. Blue Shield of Cal. (2016) 2 Cal.App.5th 1218.)
VI. **Beneficiary Issues**

As a general rule, California requires a change to a beneficiary designation to be made in accordance with the terms of the policy. (Moss v. Warren (1975) 43 Cal.App.3d 651, 655.) A change in beneficiary cannot be accomplished by mere intent. (Wicktor v. Los Angeles County (1956) 141 Cal.App.2d 592, 596.) Where one spouse is named as beneficiary in a policy of insurance on the life of another, such spouse is entitled to the proceeds of the policy, even though the parties were divorced, in the absence of any terms of the policy to the contrary. (Thorp v. Randazzo (1953) 41 Cal.2d 770, 773-74; Dierdorff v. Homesteaders Life Ass’n (1941) 47 Cal.App.2d 674, 678; Jenkins v. Jenkins (1931) 112 Cal.App. 402.) There are three well-recognized exceptions to this general rule: “(1) where the insurance company has waived strict compliance with its own rules and pursuant to the request of the insured to change the beneficiary has issued a new certificate; (2) where it is beyond the power of the insured to comply literally with the regulations; and (3) where the insured has pursued the ways indicated by the laws of the company and has done all in his or her power to change the beneficiary but before the new certification is actually issued he or she dies.” (Moss, supra, at pp. 15-16.) Furthermore, California demands that substantial steps be taken to actually change a beneficiary before the formal requirements of the contract may be ignored. (Id. at p. 17.)

The date that the change becomes effective is typically designated in the policy itself.

VII. **Interpleader Actions**

**A. Availability of Fee Recovery**

Insurers can often find themselves dealing with claimants competing for the same funds. A common example is life insurance benefits held by an insurer where conflicting claims are made by the named beneficiary and someone else. An interpleader allows a stakeholder that fears the prospect of multiple liability to file suit, deposit the property with the court, and withdraw from the proceedings. By statute in California, “[a]ny person, firm, corporation, association or other entity against whom double or multiple claims are made, or may be made, by two or more persons which are such that they may give rise to double or multiple liability, may bring an action against the claimants to compel them to interplead and litigate their several claims.” (Cal. Civ. Proc. Code, § 386, subd. (b).) The purpose of interpleader is to prevent a multiplicity of suits and double vexation. (Farmers New World Life Ins. Co. v. Rees (2013) 219 Cal.App.4th 307, 315.)

Code of Civil Procedure section 386, subdivision (a), allows the neutral stakeholder to seek reimbursement for its costs and reasonable attorney fees. The stakeholder may commence an interpleader action, deposit the funds into court, and obtain a discretionary fees/costs recovery by the court from the amount deposited. Thus, with respect to attorney fees and costs, a party to an action who follows the procedure for interpleader set forth in Code of Civil Procedure section 386 may insert in the motion, petition, complaint, or cross-complaint a request for allowance of costs and reasonable attorney fees incurred in the action. The court may, in its discretion, award a party the costs and reasonable attorney fees from the amount in dispute which has been deposited with the court. (Cal. Civ. Proc. Code, § 386.6.) No attorney fees are awardable unless the interpleader procedure in section 386 is closely followed.
For example, in Farmers New World, supra, the court held that an award of attorney fees and costs to the interpleading party was permitted where the life insurance benefits were in dispute due to the beneficiary’s status as a suspect in the death of the insured. The wife’s death had been investigated as a homicide because the husband was the sole beneficiary on the wife’s life insurance policy. The appellate court determined that the policy benefits were indeed in dispute, in light of the ongoing criminal investigation of the matter as a possible homicide. The court also noted that a party who seeks to challenge a fee award on the ground the interpleader action is improper, must contest the propriety of the interpleader action during the initial phase of the proceeding. Failure to do so results in a waiver of the objection.

B. Differences in State vs. Federal Circuit

Under federal law, interpleader is authorized by 28 U.S.C. section 1335 and Fed. R. Civ. P. 22, and governed by equitable principles. As in California, federal interpleader enables a person holding funds or property to which others are making conflicting claims to join them and require them to litigate who is entitled to the funds or property. (Libby, McNeill & Libby v. City Nat’l Bank (9th Cir. 1978) 592 F.2d 504, 507.)

There are two types of federal interpleader actions, each having distinct jurisdictional requirements and procedural characteristics: (1) statutory interpleader (28 U.S.C. § 1335), which authorizes interpleader actions in federal courts and contains special provisions for jurisdiction, venue, and service of process; and (2) Rule 22 interpleader (Fed. R. Civ. P. 22), which permits interpleader in any action that meets the normal jurisdiction requirements in federal court (e.g., amount in controversy exceeds $75,000).

As with California interpleader, federal courts have discretion to award attorney fees and costs to a disinterested stakeholder. Under federal interpleader, however, the authority is the court’s equitable discretion, not by statute.

There are several major differences between the state and federal remedies. Under California law, the stakeholder must be a truly disinterested party. Under federal interpleader, however, the stakeholder may be liable to one or more of the parties; interpleader is available to protect the stakeholder from multiple claims on the same liability. Additionally, under California law, the court’s power to stay is more limited. As a matter of comity, state courts are usually reluctant to enjoin proceedings pending outside the state, so California interpleader may be only partially effective.

Nonetheless, sometimes only California interpleader is available because there is no federal jurisdiction (i.e., stakeholder and all claimants are citizens of the same state and no federal question is involved). But when both are available, the same factors affecting choice of forum generally apply (e.g., different pleading requirements, discovery rules, summary judgment standards, jury issues). Interpleader defendants served in state court should not overlook the possibility of removing the action to federal court if the matter could originally have been brought in that forum.