I. Regulatory Limits on Claims Handling

A. Timing for Responses and Determinations

Florida statutes require health insurance companies to respond to claims within 45 days of receipt of a claim. The insurer must either pay, or notify the insured that the claim is being contested or denied within 45 calendar days. Failure to comply with time limitations under §627.613, Fla. Stat. subjects an insurer to a 10% per year interest rate on unpaid amounts. Additional penalties for failure to pay claims are found in the Florida Administrative Code 690-142.011, which provides that a knowing and willful violation of §627.613 will result in fines of up to $10,000 per violation, while nonwillful violators may be subject to penalties of up to $2,000.

Section §627.6131(4)(e), Fla. Stat. provides that an insurer must pay or deny an electronically submitted claim within 90 days of receipt of the claim. §627.6131(4)(e), Fla. Stat. Failure by the insurer to pay or deny the electronically submitted claim within 120 days after its receipt creates an uncontestable obligation to pay. Id. For non-electronically filed claims, payment or denial must occur within 120 days, and a failure to do so within 140 days of receipt triggers the uncontestable obligation to pay. §627.6131(5)(e), Fla. Stat.

B. Standards for Determinations and Settlements

If a claim or a portion of a claim is contested, the insurer must notify the insured in writing, specifying the contested portion of the claim and the reasons why the claim is contested. §627.613(2), Fla. Stat. A notice of contested claim must be accompanied by an itemized list of additional information reasonably required by the insurer to process the claim. Documentation must be produced by a provider within 35 days of receipt of the request, and an insurer may not request duplicate documents. §§627.6131(4), (5), Fla. Stat.

Every insured has the right, upon the denial of any claim by an insurer as not medically necessary, to appeal the denial of the claim. Appeals are made to the insurer’s licensed physician responsible for medical necessity review, and
the insurer's physician must respond within a reasonable time, which may not exceed 15 business days. §627.6141, Fla. Stat.

C. Privacy Protections

Florida has no specific statutory provisions governing privacy in the insurance context. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) does, of course, preempt any state privacy provisions which are less stringent than those in the federal guidelines. See Fla. Stat. 456.057(a); 45 C.F.R. 164.512(e)(1)(I); but see Murphy v. Dulay, 768 F.3d 1360 (11th Cir. Fla. 2014) (state statute requiring an authorization to disclose protected health information as a prerequisite to a patient's medical negligence action against a doctor was not preempted by HIPAA, since HIPAA permitted disclosures based on authorization and the state statutory authorization form complied with the requirements for an authorization under HIPAA).

In 2004, Florida passed Amendment 7, which grants patients the right to access any records made or received in the course of business by a health care facility or provider relating to any adverse medical incident. Fla. Const. Art. X, §25. In providing such access, the identity of patients involved in the incidents shall not be disclosed, and any privacy restrictions imposed by federal law shall be maintained. Fla. Const. Art. X, §25(b). Soon after the passage of Amendment 7 by the electorate, the Florida Legislature enacted Florida Statute §381.028, which essentially operated to limit Amendment 7. For example, Florida Statute §381.028 only permitted final reports to be discoverable, while Amendment 7 provided that "any records" relating to adverse medical incidents are subject to disclosure. Additionally, Florida Statute §381.028 limited the production to only those records generated after November 2, 2004, but Amendment 7 did not contain any time limitation. Until recently, Florida law was unsettled on the application of Amendment 7.

In Fla. Hosp. Waterman, Inc. v. Buster, 984 So. 2d 478 (Fla. 2008), the Supreme Court of Florida held that (1) the right of access granted pursuant to Amendment 7 is retroactive and applies to adverse medical incident records existing prior to Amendment 7's effective date of November 2, 2004; and (2) the subsections of Fla. Stat. § 381.028 that conflict with the rights granted pursuant to Amendment 7 are severed from the remainder of Fla Stat. § 381.028. Following the clarification in Buster, the issue of whether Amendment 7 altered the common law work-product privilege was addressed in various opinions. In Fla. Eye Clinic, P.A. v. Gmach, 14 So. 3d 1044, 1048 (Fla. 5th DCA 2009), the Court found the plain language of Amendment 7 indicates an intent to abrogate any "fact work-product" privilege that may have existed prior to the passage of Amendment 7. According to Fla. Eye Clinic, only the "opinion work-product" of an attorney (i.e., the attorney's mental impressions, conclusions, opinions, or theories concerning his client's case) will be protected from disclosure pursuant to Amendment 7. See also Lakeland Reg'l Med. Ctr. v. Neely, 8 So. 3d 1268 (Fla. 2d DCA 2009); Lower Keys Med. Ctr. v. Windisch, 29 So. 3d 351 (Fla. 3DCA 2010); Columbia Hosp. Corp. v. Fain, 16 So. 3d 236 (Fla. 4th DCA 2009). This issue was subsequently resolved by the Supreme Court of Florida in W. Fla. Reg'l Med. Ctr., Inc. v. See, 79 So. 3d 1, 21 (Fla. 2012) (holding that Section 381.028(7)(b)(1) impermissibly attempts to limit the disclosure requirements of Amendment 7).

II. Principles of Contract Interpretation

The policy terms should be given their plain and unambiguous meaning as understood by the man-on-the-street. State Farm Fire & Cas. Co. v. Castillo, 829 So. 2d 242, 244 (Fla. 3d DCA 2002). A court may resort to construction of a contract of insurance only when the language of the policy in its ordinary meaning is indefinite, ambiguous or equivocal. If the language employed in the policy is clear and unambiguous, there is no occasion for construction or the exercise of a choice of interpretations. In the absence of ambiguity, it is the function of the court to give effect to and enforce the contract as it is written. Siegle v. Progressive Consumers Ins. Co., 819 So. 2d 732, 735 (Fla. 2002).

If the language is ambiguous, the contract should be construed in favor of the insured; but if it is unambiguous, it must be given effect as written. Courts may not rewrite contracts, add meaning that is not present, or otherwise reach results contrary to the intentions of the parties. Harrington v. Citizens Prop. Ins. Corp., 54 So. 3d 999, 1002 (Fla. 4th DCA 2010). Because insurance policies are often adhesion contracts, the ambiguities are construed against the insurer who prepared the policy.

Florida courts apply an objective theory of contractual intent when interpreting insurance policies: The making of a contract depends not on the agreement of two minds in one intention, but on the agreement of two sets of external signs—not the parties having meant the same thing but on their having said the same thing. State Farm Fire & Cas. Ins. Co. v. Deni Assocs., 678 So. 2d 397 (Fla. 4th DCA 1996). Thus, meaning is derived from the parties' unambiguous language, not from their subjective understandings.

If an insurer does not define a policy term, the insurer cannot take the position that there should be a narrow, restrictive interpretation of the coverage provided. State Farm Fire & Cas. Co. v. CTC Dev. Corp., 720 So. 2d 1072, 1076 (Fla. 1998). Strict construction does not mean that a court must always find coverage. Strict construction does not mean that clear words may be tortured into uncertainty so that new meanings can be added. Where the insurer has defined a term used in the policy in clear, simple, nontechnical language, strict construction does not mean that judges are empowered to give the defined term a different meaning deemed more socially responsible or desirable to the insured. State Farm Fire & Cas. Ins. Co. v. Deni Assocs., 678 So. 2d 397 (Fla. 4th DCA 1996).

If more than one interpretation could be given to an insurance policy provision, an ambiguity results. State Farm Fire & Cas. Co. v. CTC Dev. Corp., 720 So. 2d 1072, 1076 (Fla. 1998). If the relevant policy language is susceptible to more than one reasonable interpretation, one providing coverage and another limiting coverage, the insurance policy is considered ambiguous. Garcia v. Fed. Ins. Co., 969 So. 2d 288, 291 (Fla. 2007). To find in favor of the insured on this basis, however, the policy must actually be ambiguous. A provision is not ambiguous simply because it is complex or requires analysis. If a policy provision is clear and unambiguous, it should be enforced according to its terms.

The lack of a definition of an operative term in a policy does not necessarily render the term ambiguous and in need of interpretation by the courts. Swire Pac. Holdings, Inc. v. Zurich Ins. Co., 845 So. 2d 161 (Fla. 2003). Insurance policy terms must be given their every day meaning and should be read with regards to ordinary people's skill and experience. Watson v. Prudential Prop. & Cas. Ins. Co., 696 So. 2d 394, 396 (Fla. 3d DCA 1997). Florida courts will often use legal and nonlegal dictionaries to ascertain the plain meaning of
words that appear in insurance policies. Harrington v. Citizens Prop. Ins. Corp., 54 So. 3d 999, 1002 (Fla. 4th DCA 2010) (citing Brill v. Indianapolis Life Ins. Co., 784 F.2d 1511, 1513 (11th Cir. 1986)).

When courts construe insurance policies, they should read the policies as a whole, thereby giving every provision its full meaning and operative effect. Gen. Star Indem. Co. v. W. Fla. Vill. Inn, Inc., 874 So. 2d 26, 30 (Fla. 2d DCA 2004) (citing Auto-Owners Ins. Co. v. Anderson, 756 So. 2d 29, 34 (Fla. 2000)). Additionally, a single policy provision should not be considered in isolation, but rather, the contract shall be construed according to the entirety of its terms as set forth in the policy and as amplified by the policy application, endorsements, or riders. Harrington, 54 So. 3d 999, 1002 (Fla. 4th DCA 2010). Like other contracts, a court should only resort to rules of construction in interpreting an insurance contract when the language is ambiguous; otherwise, it should apply the plain and unambiguous meaning of the policy's language. Sunshine State Ins. Co. v. Jones, 77 So. 3d 254 (Fla. 4th DCA 2012).

III. Choice of Law

In determining which state's law applies to contracts, the Supreme Court of Florida has long adhered to the rule of lex loci contractus. That rule, as applied to insurance contracts, provides that the law of the jurisdiction where a contract was executed governs the rights and liabilities of the parties in determining an issue of insurance coverage. State Farm Mut. Auto. Ins. Co. v. Roach, 945 So. 2d 1160 (Fla. 2006). When parties come to terms in an agreement, they do so with the implied acknowledgment that the laws of that jurisdiction will control absent some provision to the contrary. The doctrine of lex loci contractus directs that, in the absence of a provision specifying the governing law, the insurance contract is governed by the law of the state in which the contract is made. Clarendon Am. Ins. Co. v. Miami River Club, Inc., 417 F. Supp. 2d 1309, 1317 (S.D. Fla. 2006). Florida respects choice-of-law provisions in insurance contracts. See Shaps v. Provident Life & Accident Ins. Co., 826 So. 2d 250, 254 n.3 (Fla. 2002) (citing Fioretti v. Mass. Gen. Life Ins. Co., 53 F.3d 1228, 1235 (11th Cir. 1995)).

Absent a choice-of-law provision in the insurance contract, the laws of the place in which a contract was made govern matters concerning its execution, interpretation, and validity, unless public policy requires the assertion of Florida's paramount interest in protecting its citizens from inequitable insurance contracts. Florida courts have carved out this narrow exception to the lex loci rule known as the "public policy exception," which results in application of Florida law. The exception requires both a Florida citizen in need of protection, a paramount Florida public policy, and the insurer must be on reasonable notice that its insured is a Florida citizen. State Farm Mut. Auto. Ins. Co. v. Roach, 945 So. 2d 1160 (Fla. 2006).

Contract choice-of-law principles apply to bad faith actions. While questions bearing on the interpretation, validity, and obligation of contracts are substantive and governed by the rule of lex loci contractus, matters concerning performance of the obligations, i.e. to provide insured a good faith defense to the action, are determined by the law of the place of performance. Gov't Emps. Ins. Co. v. Grounds, 332 So. 2d 13, 14 (Fla. 1976) (third-party bad faith claim brought by the insured tortfeasor against the insurer for failing to defend the insured in Florida in good faith; the place of performance was Florida, where the cause of action against the insured was maintained and was defended in bad-faith by the insurer); but see Higgins v. W. Bend Mut. Ins. Co., 85 So. 3d 1156, 1158 (Fla. 5th DCA 2012) (insurer's refusal to tender UM benefit
limits presented a substantive question in first-party bad faith action, rather than a performance-based issue, thus the law to be applied was the law of Minnesota, where the insurance contract was executed).

IV. Extracontractual Claims Against Insurers: Elements and Remedies

A. Bad Faith

Florida has long allowed third-party bad faith claims against insurance companies under the common law. See Time Insurance Co. v. Burger, 712 So. 2d 389 (Fla. 1998). In considering whether bad faith exists, courts have applied a totality of the circumstances analysis. State Farm Mut. Auto. Ins. Co. v. Laforet, 658 So. 2d 55 (Fla. 1995). Negligence and reasonable diligence are material to the issue of bad faith. See Campbell v. Government Employees Insurance Co., 306 So. 2d 525, 530 (Fla. 1974).

Both compensatory and punitive damages may be awarded for bad faith in denial of benefits. Punitive damages are allowed where the insurer’s conduct is wanton or outrageous, or based upon moral turpitude or malice. Campbell, 306 So. 2d at 532; see Winn & Lovett Grocery Co. v. Archer, 171 So. 214 (Fla. 1936). Conduct by an insurer involving concealment or misrepresentation suffices for an award of punitive damages.

Florida also provides for statutory first party bad faith claims against insurers. Insurers are liable to civil suit for violation of several statutory provisions. In addition insurers may be subject to civil actions for not attempting to settle claims in good faith. §624.155(b)(1), Fla. Stat. An insured may bring a civil action against an insurer for “[n]ot attempting in good faith to settle claims when, under all circumstances, it could and should have done so, had it acted fairly and honestly toward its insured and with due regard for her or his interests.” See Time Insurance Co. v. Burger, 712 So. 2d 389 (Fla. 1998); superseded by statute, as stated in Fridman v. Safeco Ins. Co. of Illinois, 185 So.3d 1214 (Fla. 2016).

The Florida Supreme Court in Dadeland Depot, Inc. v. St. Paul Fire & Marine Ins. Co., 2006 Fla. LEXIS 2953 (Fla. 2006), determined that the requirement of §626.9541, Fla. Stat. that a plaintiff provide proof that an insurer’s unfair claim settlement practices be frequent enough to evidence a “general business practice” is eliminated in a civil suit under §624.155, Fla. Stat. Id. at *47-48.

Additionally, in Macola v. Gov’t Employees. Ins. Co., 2006 Fla. LEXIS 2532 (Fla. 2006), the Supreme Court of Florida addressed application of the “cure provision” in §624.155, Fla. Stat. There the Supreme Court held that tender of the policy limits to an insured in response to the filing of a civil remedy notice under 624.155 by the insured, after the initiation of a lawsuit against the insured but before entry of an excess judgment, did not preclude a common law cause of action against the insurer for third-party bad faith. Id. at *20.

The Supreme Court of Florida has ruled on the discoverability of claim files in bad faith claims. Allstate Indem. Co. v. Ruiz, 899 So. 2d 1121 (Fla. 2005). In Florida, all claim files and materials involved in claims processing, which are created up to and including the date of the resolution of the underlying claim pertaining in any way to coverage, benefits, liability or damages, are now discoverable in both first-party and third-party bad faith claims. Id. at 1129-1130. Where both the coverage and bad faith claims are
filed simultaneously, the court may use available tools such as abatement of action and in-camera inspection to ensure full and fair discovery. Id. at 1130. See Blanchard v. State Farm Mutual Automobile Ins. Co., 575 So. 2d 1289 (Fla. 1991). When the bad faith claim is abated pending the determination of coverage and damages, a party is not entitled to discovery related to the claims files or to the insurer's business policies or practices regarding handling of claims. State Farm Mut. Auto. Ins. Co. v. Tranchese, 49 So. 3d 809 (Fla. 4th DCA. 2010).

The Ruiz decision, however, left open the applicability of the attorney-client privilege in bad faith claims and has caused Florida courts some confusion. Provident Life & Accident Ins. Co. v. Genovese, 943 So. 2d 321 (Fla. 4th DCA 2006). The Supreme Court of Florida clarified the issue of bad faith claims and the attorney-client privilege in Genovese v. Provident Life & Accident Ins. Co., 2011 Fla. LEXIS 621 (Fla. 2011). The Supreme Court of Florida held an insured party asserting a bad faith claim against its insurer generally may not discover the privileged communications that occurred between the insurer and its counsel during the underlying action. Id. Nevertheless, the Court cautioned there may be circumstances where an insurer hires an attorney to investigate both the underlying claim and render legal advice. Id. Consequently, the materials requested by the opposing party may implicate both the work product doctrine and the attorney-client privilege, and the trial court should conduct an in-camera inspection to determine whether the sought-after materials are truly protected by the attorney-client privilege. Id. If the trial court determines that the investigation performed by the attorney resulted in the preparation of materials that are required to be disclosed pursuant to Ruiz and did not involve the rendering of legal advice, then that material is discoverable. Id. Lastly, Genovese also contemplated that discovery of attorney-client privileged communications between an insurer and its counsel is permitted when the insurer raises the advice of its counsel as a defense in the action and the communication is necessary to establish the defense. Id. See also State Farm Fla. Ins. Co. v. Puig, 2011 Fla. App. LEXIS 3902 (Fla. 3d DCA. 2011).

B. Fraud

The essential elements of a fraud claim in Florida are: (a) a false representation of fact, known by the party making it to be false at the time it was made; (b) that the representation was made for the purpose of inducing another to act in reliance on it; (c) actual reliance on the representation; and (d) resulting damage to the plaintiff. Essex Ins. Co. v. Universal Entertainment & Skating Ctr., 665 So. 2d 360, 362 (Fla. 5th DCA 1995).

C. Intentional or Negligent Infliction of Emotional Distress (IIED or NIED)

Florida has adopted the Restatement (Second) of Torts' definition of a claim for intentional infliction of emotional distress. Metropolitan Life Insurance Co. v. McCarson, 467 So. 2d 277 (Fla. 1985). To succeed in such a claim, a plaintiff must show that the extreme and outrageous conduct of another person intentionally or recklessly caused the plaintiff severe emotional distress. Eastern Airlines, Inc. v. King, 557 So. 2d 574, 575-76 (Fla. 1990). A plaintiff need not have suffered any physical injury to succeed in a claim for intentional infliction of emotional distress. R.J. v. Humana of Florida, Inc., 652 So. 2d 360 (Fla. 1995).

In claims of negligent infliction of emotional distress, however, Florida’s “impact rule” requiring that a plaintiff’s emotional distress suffered must be in
conjunction with or flow from physical injuries sustained by the plaintiff applies. R.J. v. Humana of Florida, Inc., 652 So. 2d 360 (Fla. 1995).

Notably, however, the Supreme Court of Florida has held that in claims against health insurers, the common law impact requirement is superseded by Florida Statutes 624.155, which allows for various statutory claims against insurers. Time Insurance Co. v. Burger, 712 So. 2d 389 (Fla. 1998). Because the statute is in derogation of common law and must therefore be strictly construed, and because the statute does not provide specific standards for recovery on such claims, the court has set forth standards by which a plaintiff may recover. In cases where proof of bad faith by an insurer is evident, and where the insurer’s conduct results in an insured not receiving health care, an insured may recover for emotional distress if the insured can prove the following: (1) that the bad faith conduct resulted in the insured’s failure to receive necessary or timely health care; (2) that, based upon a reasonable medical probability, this failure caused or aggravated the insured’s medical or psychiatric condition; and (3) that the insured suffered mental distress related to the condition or the aggravation of the condition. The plaintiff/insured must additionally substantiate these allegations with the testimony of a qualified health care provider, not a mere lay witness. Id. at 393.

In Aguilera v. Inservices, Inc., 905 So. 2d 84, 93 (Fla. 2005), the Supreme Court of Florida recognized that an insurer’s conduct during the claims process sufficed to support a claim for intentional infliction of emotional distress against the insurer. The court listed conduct by the insurer such as denial of the insured’s request for emergency treatment as medically unnecessary even though it had medical reports to the contrary and blocking receipt of prescription medication.

D. Statutory Protections

Florida Statute §624.155(1)(a) provides that a civil remedy is available to insureds for violation of several statutory provisions by their insurers.

§624.155(1)(a), Fla. Stat. provides that any person may file a claim for an insurer’s violation of the following statutory provisions:

1. 626.9541-- Unfair methods of competition and unfair or deceptive acts or practices:
   a) 626.9541(1)(i): Unfair claim settlement practices.

This section includes as violations attempts to settle claims based on documents altered without the knowledge or consent of the insured, material misrepresentations made to the insured with the intent to settle at terms less favorable to the insured, or committing or performing with such frequency as to indicate a general business practice any of the following:

a. Failing to adopt and implement standards for the proper investigation of claims;

b. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

c. Failing to acknowledge and act promptly upon communications with respect to claims;
d. Denying claims without conducting reasonable investigations based upon available information;

e. Failing to affirm or deny full or partial coverage of claims, and, as to partial coverage, the dollar amount or extent of coverage, or failing to provide a written statement that the claim is being investigated, upon the written request of the insured within 30 days after proof-of-loss statements have been completed;

f. Failing to promptly provide a reasonable explanation in writing to the insured of the basis in the insurance policy, in relation to the facts or applicable law, for denial of a claim or for the offer of a compromise settlement;

g. Failing to promptly notify the insured of any additional information necessary for the processing of a claim; or

h. Failing to clearly explain the nature of the requested information and the reasons why such information is necessary.

b) 626.9541(1)(o): Illegal dealings in premiums; excess or reduced charges for insurance

An insurer violates this section by charging reduced or excess rates for insurance. Further provisions within this section relate to motor vehicle insurance, not applicable here.

c) 626.9541(1)(x): Refusal to insure

An insurer who refuses to insure an individual based upon race, color, creed, marital status, sex, or national origin violates this section. Further prohibited reasons for a refusal to insure include the fact that the individual is a public official, has previously been refused insurance coverage, fails to purchase non-insurance service or commodities or services from the insurer, or the individual’s age, residence, or lawful occupation.

2. Section 626.9551: Prohibits favoring insurers or carriers or coercing debtors.

3. Section 626.9705: Prohibits refusal to provide life or disability insurance to an individual on the basis that the individual suffers from a severe disability.

4. Section 626.9706: Prohibits the denial of life insurance coverage to an individual on the basis of the sickle cell trait.

5. Section 626.9707: Prohibits the denial of disability insurance to an individual on the basis of the sickle cell trait.

Additionally, there are statutory protections pertaining to health insurance policies that are contained within the newly enacted Patient Protection and Affordable Care Act (PPACA). State statutes pertaining to health insurance regulation may be preempted by the federal law and these specific issues have not yet been addressed by Florida courts.
E. State Class Actions

Class actions may be brought against insurers under Florida Rule of Civil Procedure 1.220, which provides that the court will permit a class action if it finds that “(1) the members of the class are so numerous that separate joinder of each member is impracticable; (2) the claim or defense of the representative party raises questions of law or fact common to the questions of law or fact raised by the claim or defense of each member of the class; (3) the claim or defense of the representative party is typical of the claim or defense of each member of the class; and (4) the representative party can fairly and adequately protect and represent the interests of each member of the class.”

If no named plaintiffs purporting to represent a class can demonstrate an actual case or controversy with the defendant, none may seek relief on behalf of herself or any member of the class. Chinchilla v. Star Casualty Insurance Co., 833 So. 2d 804, 805 (Fla. 3d DCA 2002). If an insurer discovers a billing error prior to certification of the class and the insurer wishes to correct the error, the court will allow it to do so, even though it will eliminate the case or controversy and effectively quash the class action. Id. at 806; see Taran v. Blue Cross Blue Shield of Florida, Inc., 685 So. 2d 1004, 1006 (Fla. 3d DCA 1997).

V. Defenses in Actions Against Insurers

A. Misrepresentations/Omissions: During Underwriting or During Claim

Section 627.409(1), Fla. Stat., provides the following:

627.409 Representations in applications; warranties.--

(1) All statements and descriptions in any application for an insurance policy or annuity contract, or in negotiations therefor, by or in behalf of the insured or annuitant, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy or contract unless:

(a) They are fraudulent;

(b) They are material either to the acceptance of the risk or to the hazard assumed by the insurer; or

(c) The insurer in good faith would either not have issued the policy or contract, would not have issued it at the same premium rate, would not have issued a policy or contract in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or contract or otherwise.

Materiality is more than a subjective question of whether the insured would have issued the policy, as that scenario is adequately addressed in §627.409(1)(c). Singer v. Nationwide Mutual Fire Insurance Co., 512 So. 2d 1125, 1128 (Fla. 4th DCA 1987). A misrepresentation is material if it “does not enable a reasonable insurer to adequately estimate the nature of the risk in determining whether to assume the risk.” Id. at 1129; see Mutual Life Insurance Co. v.
Denton, 112 So. 53 (Fla. 1927). Materiality under §627.409(1)(b) is considered an objective test, and therefore a question of law. Id.

On the other hand, where a dispute exists as to questions asked by an agent, the accuracy of answers provided, and the nature of the insured’s misrepresentation, materiality of a misrepresentation is a question of fact. Cox v. American Pioneer Life Insurance Co., 626 So. 2d 243 (Fla. 5th DCA 1993).

If an insurer is on notice that it should investigate further, the insurer is bound by what a reasonable investigation would have uncovered. Misrepresentations on an application by an insured, therefore, may not provide grounds for denial of coverage where the insured has provided an agent with information that placed the insurer on notice. Cox, 626 So. 2d at 246. If, on the other hand, an applicant knowingly misrepresents his or her health history and the misrepresentation is material to the insurer, then the policy is void ab initio and no proceeds are payable. See Fla. Stat. 627.409 (2005). However, an insurance company may not rely on the defense of the insured’s misrepresentation if it had actual knowledge of the facts justifying forfeiture of the policy before the policy’s issuance. Hynes v. Am. Gen. Life Ins. Co., 2006 U.S. Dist. LEXIS 3067 (S.D. Fla. 2006).

Where questions in an insurance contract contain prefatory language that states “to the best of my knowledge and belief” in regard to answers by the insured, the insurer will be bound by that lower standard of accuracy and cannot be protected by the more stringent statutory requirements regarding misrepresentations. Green v. Life & Health of America, 704 So. 2d 1386 (Fla. 1998).

Florida law provides that for individual health policies, after two years from the issue date, only fraudulent misstatements in the application may be used to void the policy or deny any claim for a loss incurred after the two-year period. See Fla. Stat. 627.607. Alternatively, the policy may have an incontestability provision that after the policy has been in force for two years, the insurer cannot contest the statements in the application. Id. For group health policies, Florida law provides that in the absence of fraud, all statement made by applicants are deemed representations and not warranties and no statement shall void the insurance or reduce benefits unless contained in a signed, written statement. See Fla. Stat. 627.657. For HMO contracts, after two years from the issue date, only fraudulent misstatement in the application may be used to void the policy or deny any claim for loss incurred after the two-year period. Fla. Stat. 641.31(23). Nonetheless, with the implementation of the Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010, state statutes pertaining to health insurance regulation may be preempted by the federal law; these specific issues have not yet been addressed by Florida courts. Under the PPACA, a health insurer may not rescind coverage except for fraud or intentional misstatement of a material fact, as prohibited by the terms of the policy, and the insurer must provide at least 30 days advance written notice of rescission to the policyholder; this does not prohibit retroactive cancellation to the extent that it is due to failure to timely pay required premiums.

B. Preexisting Illness or Disease Clauses

Exclusionary clauses of any kind in insurance contracts are strictly construed against the insurer. See Prudential Prop. & Cas. Ins. Co. v. Swindal, 622 So. 2d 467 (Fla. 1993). Insurance policies are construed in the broadest

Florida statutes require that preexisting condition clauses in insurance contracts may not preclude coverage for more than 24 months after the effective date, and may only relate to "(a) Conditions that, during the 24-month period immediately preceding the effective date of coverage, had manifested themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received; or (b) a pregnancy existing on the effective date of coverage." §627.6045(1), Fla. Stat.

Moreover, the statute mandates that if an insured was covered by a previous policy with similar or greater coverage, the insured must be credited for the time covered under the previous policy, so long as the previous coverage ended not more than 62 days before the effective date of the new coverage. §627.6045(2), Fla. Stat.

Short-term, nonrenewable health insurance policies of no more than a 6-month policy term do not qualify as previous coverage to exempt the insured from having to meet the preexisting requirements. However, those policies must clearly disclose to the insured in both advertising and the application itself, in 10-point contrasting type, that it does not meet the requirement of §627.6699, and that "As a result, if purchased in lieu of a conversion policy or other group coverage, [the insured] may have to meet a preexisting condition requirement when renewing or purchasing other coverage." §627.6045(3), Fla. Stat.

The PPACA may preempt some of these regulations, including prohibiting health insurance policies from excluding coverage for any pre-existing condition; these issues have not yet been addressed by Florida courts.

C. Statutes of Limitation

Suits against insurers based on written contracts/policies must be brought within five years. §95.11(2)(b), Fla. Stat. When a claim sounds in tort, is based upon statutory liability, or is a contract action not founded on a written instrument, Florida provides a four-year statute of limitation for the action. §95.11(3), Fla. Stat. In claims against insurers, the limitations period begins to run from the date of the alleged breach. Saenz v. State Farm Fire & Cas. Co., 2003 Fla. App. LEXIS 15078 (Fla. 3d DCA 2003); State Farm Mut. Auto. Ins. Co. v. Lee, 678 So. 2d 818, 821 (Fla. 1996).

The incontestability clause of Fla. Stat. §627.455 acts as a statute of limitations and once effective, bars the insurer from any attempt to rescind or cancel the policy for any grounds, other than those specifically enumerated in the statute, including imposter fraud. Allstate Life Ins. Co. v. Miller, 424 F.3d 1113, 1115 (11th Cir. 2005) (applying Florida law); See also Pruco Life Ins. Co. v. Brasner, 2011 U.S. Dist. LEXIS 1598 (S.D. Fla. 2011) (discussing the issue of whether an incontestability clause bars the claim/defense that a contract is void ab initio). Again, some of these health insurance regulations may now be preempted by PPACA.

D. Other Defenses

Payment by the insurer in accordance with the terms of the policy or of any written assignment thereof, fully discharges the insurer from all claims under
the policy or contract unless, before payment is made, the insurer has received
at its home office written notice by or on behalf of some other person that such
other person claims to be entitled to such payment or some interest in the policy
or contract. §627.423, Fla. Stat.

An insurance clause requiring an insured to obtain continuous, regular care
from a treating physician during any alleged period of total disability is
enforceable. The insured has a duty "to avail himself of all reasonable means
and remedies to remove" any impediment that purportedly causes a totally

Lost policies present a unique problem. Ordinarily, when a document has been
lost, clear and convincing proof is required as to the contents of the agreement.
Fries v. Griffin, 35 Fla. 212, 17 So. 66, 68 (Fla. 1895) (lost deed); Am. Sav. &
Loan Ass'n of Fla. v. Atl. Inv. Corp., 436 So. 2d 442, 443 (Fla. 4th DCA 1983)
(loss lease agreement); Weinsier v. Soffer, 358 So. 2d 61 (Fla. 3d DCA 1978)
(loss loan agreement); Locke v. Pyle, 349 So. 2d 813 (Fla. 1st DCA 1977) (lost
deed). Insurance policies identified by number and known to have been issued by
the insurer, on the other hand, are not as vulnerable to fraud as these other
instruments. This is so because "[t]he evidence used to establish the existence
and contents of [insurance] policies is usually comprised of business records and
standard forms made by and found in the possession of the party against whom they
are being offered." American Home Insurance Company v. Junger, 982 So. 2d 90
(Fla. 3rd DCA 2008).

VI. Beneficiaries

The right to change the beneficiary of a life insurance policy depends on
the contract between the insurer and the insured as expressed in the insurance
policy. Cooper v. Muccitelli, 661 So. 2d 52 (Fla. 2d DCA 1995). Where the right
to change the beneficiary rests solely with the insured, the beneficiary acquires
no vested right or interest during the life of the insured, but only an
change-of-beneficiary request must be in strict compliance with the terms of the
policy. Id.; see also Brown v. Di Petta, 448 So. 2d 561, 562 (Fla. 3d DCA 1984).

A life insurance provision that gave the insured the right to change the
beneficiary designation while he was alive could not be used to defeat the
beneficiary change where the change of beneficiary form was executed while the
insured was alive, but transmitted to the insurer after the insured's death. If
the insured has complied with the terms of the policy, the fact that the change
of beneficiary form was not transmitted until after the insured's death is
immaterial. Martinez v. Saez, 650 So. 2d 666 (Fla. 3d DCA 1995). The insured's
failure to comply with procedures of the insurance company required to effectuate
a change of beneficiary is fatal. The mere intent to change the beneficiary of
the policy is legally insufficient absent an effective designation of beneficiary
on the form required by the insurer. Brown v. Di Petta, 448 So. 2d 561 (Fla. 3d
DCA 1984). A change of beneficiary request need only contain enough information
to allow the insurance company to act on the request. O'Brien v. McMahon, 44 So.
3d 1273, 1279 (Fla. 1st DCA 2010).

There is no Florida authority establishing that a life insurance company
has a duty to notify an insured or a substitute beneficiary that its change of
beneficiary request is unacceptable. To the contrary, some courts have found that
it is the duty of the insured to make certain that his life insurance company

**A. Effective Date of Change Forms**

If an insured dies before the insurer endorses a change of beneficiary on an insurance policy pursuant to prior notice by the insured, the change is ineffective under a policy which provides that such change shall take effect only upon such endorsement. Under the same set of facts, when a policy provides that the change is effective endorsement, the change shall relate back and take effect as of the date the insured executed the change of beneficiary notice. Shuster v. New York Life Ins. Co., 351 So. 2d 62 (Fla. 3d DCA 1977) (Quashed by N.Y. Life Ins. Co. v. Shuster, 373, So. 2d 916 (Fla. 1979) on different grounds).

**B. Divorce**

Absent the marital settlement agreement providing who is or is not to receive the death benefits or specifying who is to be the beneficiary, courts should look no further than the insurance contract–named beneficiary. Crawford v. Barker, 64 So. 3d 1246 (Fla. 2011). General language in a marital settlement agreement, such as language stating who is to receive ownership, is not specific enough to override the plain language of the beneficiary designation. Magic words are not required, however, if the parties wish to specify in a marital settlement agreement that a spouse will not receive the death benefits or wish to specify a particular beneficiary, this should be done clearly and unambiguously. Id.

A marital settlement agreement that specifically requires one of the parties to maintain a named individual as beneficiary will control the disposition of proceeds upon notice to the insurer. Without specific reference in a property settlement agreement to life insurance proceeds, the beneficiary of the proceeds is determined by looking only to the insurance contract. Id. When a marital settlement agreement mentions the disputed policy or plan, but does not specifically mention who should receive the death benefits or does not require a spouse to name a particular beneficiary as a condition of dissolution of marriage, the reviewing court should look no further than the beneficiary designation. Id.

Where the settlement agreement contains no mention of the life insurance policy, but rather only general releases, the owner of the policy can designate whomever he or she wishes as the beneficiary, and the beneficiary designation controls. Id. The spouse, who owns the policy, plan, or account, is free to name any individual as the beneficiary unless the marital settlement agreement requires a spouse to name a particular beneficiary as a condition of a dissolution of marriage. Id.

**VII. Interpleader Actions**

Fla. R. Civ. P. 1.240. Interpleader:

Persons having claims against the plaintiff may be joined as defendants and required to interplead when their claims are such that the plaintiff is or may be exposed to double or multiple liability. It is not ground for objection to the joinder that the claim of the several claimants or the titles on which their claims depend do not have a common origin or are not identical but are adverse to
and independent of one another, or that the plaintiff avers that the plaintiff is not liable in whole or in part to any or all of the claimants. A defendant exposed to similar liability may obtain such interpleader by way of crossclaim or counterclaim. The provisions of this rule supplement and do not in any way limit the joinder of parties otherwise permitted. Fla. R. Civ. P. 1.240.

The plain language of Fla. R. Civ. P. 1.240 clearly articulates but one requirement for the commencement of an interpleader action: that the stakeholder is or may be exposed to double or multiple liability. Florida courts continue to recite the four common law requirements for interpleader. However, the only absolute requirement remaining under Fla. R. Civ. P. 1.240 is that the stakeholder is or may be exposed to double or multiple liability for competing claims to a single fund. A party may not object to interpleader on the grounds that one of the remaining three common law requirements is not met. The sole requirement for the maintenance of an interpleader action is that the stakeholder is or may be exposed to double or multiple liability w

A. Availability of Fee Recovery

A party who is entitled to sue in interpleader is ordinarily permitted to recover reasonable attorney's fees from the interpleaded fund. As a general rule, to be entitled to attorney's fees, a stakeholder must prove his total disinterest in the stake he holds other than that of bringing it into court so that conflicting claims thereto can be judicially determined and show that he did nothing to cause the conflicting claims or to give rise to the peril of double vexation. Rainess v. Estate of Machida, 81 So. 3d 504 (Fla. 3d DCA 2012). Florida case law also requires an interpleader to make a showing that he has "not instituted the action for its own protection." Ray v. Travelers Ins. Co., 477 So.2d 634, 637 (Fla. 5th DCA 1985). Florida's Third District Court of Appeal held that "a plaintiff in interpleader is not entitled to attorneys' fees when the interpleader action is brought after he has been sued by one of the defendants in the interpleader proceeding." Rafter, 428 So.2d 351 at 353. The Rafter court went on to explain that "because the [interpleader company] had waited until after it had been sued before filing its claim in interpleader, the interpleader action was one brought for [its] own protection, disentitling it to fees and costs." Id. at 354. There are circumstances under which a party may properly sue in interpleader and yet be denied attorney's fees if the need for interpleader was unnecessarily precipitated by his conduct. Bache Halsey Stuart Shields v. Witous, 411 So. 2d 1324 (Fla. 2d DCA 1982). The award of attorneys' fees and costs lies within the sole discretion of the court given that it is not expressly authorized under Fla. R. Civ. P. 1.240, Fed. R. Civ. P. 22, or the federal interpleader statute 28 U.S.C. § 1335. Campbell v. N. Am. Co. for Life & Health Ins., 2007 U.S. Dist. LEXIS 54886 (M.D. Fla. July 30, 2007).

Courts often use their discretion to exclude insurance companies from recovering attorneys' fees based on the "disinterested plaintiff" rule. First, courts have found that insurance companies should not be compensated merely
because conflicting claims to proceeds have arisen during the normal course of business. Second, courts have denied them an award of attorneys' fees because insurance companies, by definition, are interested stakeholders; filing the interpleader action immunizes the company from further liability under the contested policy. Third and finally, some courts have denied attorneys' fees based on the policy argument that such an award would senselessly deplete the fund that is the subject of preservation through interpleader. Campbell, 2007 U.S. Dist. LEXIS 54886 (M.D. Fla. July 30, 2007).

In Am. Nat'l Ins. Co. v. Glass, 2008 U.S. Dist. LEXIS 60722 (M.D. Fla. July 31, 2008), the Court held the insurer was not entitled to an award of fees and costs because the insurer contributed to the necessity for filing this case due to an ambiguous beneficiary designation form and the amount of fees and costs requested would have seriously depleted the interpleader funds by 1/3. Id. Conversely, in Nat'l Life Ins. Co. v. Southeast First Nat'l Bank, 361 So. 2d 432 (Fla. 4th DCA 1978), the Court upheld an award of attorneys’ fees because it found only that the insurer desired to have conflicting claims judicially determined and did nothing to cause the conflicting claims. Id.

B. Differences in State vs. Federal Circuit

The Florida interpleader rule, Fla. R. Civ. P. 1.240, is virtually identical to Fed. R. Civ. P. 22(a), and cases interpreting the federal rule are persuasive in cases arising under the Florida rule. Rainess v. Estate of Machida, 81 So. 3d 504 (Fla. 3d DCA 2012).