I. Regulatory Limits on Claims-Handling

A. Timing for Responses and Determinations

All relevant time limits are found in the Unfair Life Insurance Claims Settlement Practices Rule, Utah Admin. Code R590-191 (2014), and in the Unfair Accident and Health Claims Settlement Practices Rule, Utah Admin. Code R590-192 (2014). Key provisions applicable to life and health claims include:

- After receipt of notice of loss, 15 days to provide “necessary claim forms, instructions, and reasonable assistance so the claimant can properly comply with company requirements for filing a claim” (R590-191-4(5); R590-192-7(1)-(2));

- After receipt of proof of loss, 15 days to acknowledge receipt, request additional information, and commence an investigation or provide the claim settlement and a written explanation if no additional information or investigation is necessary (R590-191-4(7));

- 15 days to provide a substantive response to a claimant’s request (R590-191-4(8));

- 30 days after receipt of properly executed proof of loss to complete investigation and advise claimant of the acceptance / denial of the claim. If more time is needed, claimant must be notified of reasons within 30 days of proof of loss. Additional notices must be sent each 30 days that the investigation remains incomplete. (R590-191-4(9); see also R590-192-10(1)-(2) (45 days to accept/deny with 30 day periods following thereafter)); and

- 15 days after completion of investigation to provide the claim settlement and a written explanation or provide a written denial of the claim with an explanation of the reasons. (R590-191-4(10)). Closing a claim file without a settlement is considered a denial, and notice must be given accordingly. (R590-191-4(11); R590-192-7(4)).

B. Standards for Determinations and Settlements

Rule, Utah Admin. Code R590-192, set forth claims handling standards for life and health claims, respectively. Additionally:

- Utah Admin. Code R590-98 (2014) specifies unfair practices in payment of life insurance and annuity policy values;
- R590-131 (2012) sets forth coordination of benefits rules for health insurance policies;
- R590-148 (2012) sets forth rules for long-term care insurance, including the setting of reserves;
- R590-200 (2011) sets forth minimum coverage standards for diabetes treatment and management; and

No private right of action exists for violation of the insurance regulations, or of their enabling statutes. Machan v. UNUM Life Ins. Co. of America, 2005 UT 37, ¶ 31, 116 P.3d 342; see also, e.g., R590-191-2; R590-192-2. However, there may be other consequences. For example, the argument has been made that the 60-day rescission period is triggered at the end of the prescribed period for an investigation to be completed.

C. State Privacy Laws, Rules, and Regulations

As of July 1, 2001, generally all licensees in Utah were required to be in compliance with the Privacy of Consumer Financial and Health Information Rule, Utah Admin. Code R590-206 (2016). The rule specifies notice requirements, limits the disclosure of personal health and financial information, and provides methods for individuals to prevent such disclosure.

II. Principles of Contract Interpretation

An insurance policy is a contract, so ordinary rules of contract interpretation, including the “four corners” rule, are used in determining its provisions. Basic Research, LLC v. Admiral Ins. Co., 2013 UT 6, ¶¶ 6-7, 297 P.3d 578. However, “ambiguous or uncertain language in an insurance contract that is fairly susceptible to different interpretations should be construed in favor of coverage” and “provisions that limit or exclude coverage should be strictly construed against the insurer.” Fire Ins. Exch. v. Oltmanns, 2012 UT App 230, ¶ 6, 285 P.3d 802 (internal quotations and citations omitted). In the absence of an ambiguity, policy terms are interpreted according to their plain meaning. Pollard v. Truck Ins. Exch., 2001 UT App 120, ¶ 7, 26 P.3d 868.

By statute, Utah law prohibits the incorporation of “any provision not fully set forth in the policy or in an application or other document attached to and made a part of the policy at the time of its delivery, unless the policy, application, or agreement accurately reflects the terms of the incorporated agreement, provision, or attached document.” Utah Code § 31A-21-106(1)(a) (2003).

III. Choice of Law
In the absence of an effective choice-of-law clause, Utah applies the "most significant relationship" test to determine the law that governs a contractual issue. This test requires the application of several factors, including "the place of contracting," "the place of negotiation of the contract," "the place of performance," "the location of the subject matter of the contract," and "the . . . place of incorporation and place of business of the parties." See One Beacon Am. Ins. Co. v. Huntsman Polymers Corp., 2012 UT App 100, ¶¶ 22, 28, 276 P.3d 1156.

Utah courts have not specifically addressed the enforceability of a choice-of-law clause in an insurance contract and have not applied any analysis that could be considered unique to the insurance context in answering this question.

IV. Extra Contractual Claims Against Insurers: Elements and Remedies

A. Bad Faith

Each insurance contract contains an implied contractual duty of good faith and fair dealing under Utah law. At a minimum, the duty includes diligent investigation, a fair evaluation, a prompt and reasonable decision on the claim, treating the insureds as lay persons and not as experts in insurance law, and refraining from actions that will injure the insured’s ability to obtain the benefits of the contract. Gibbs M. Smith v. U.S. Fid. & Guar. Co., 949 P.2d 337, 344 (Utah 1997) (quoting Beck v. Farmers Ins. Exch., 701 P.2d 795, 801 (Utah 1985)); Jenkins v. Percival, 962 P.2d 796 (Utah 1998); Young v. Fire Ins. Exch., 2008 UT App 114, ¶ 22, 182 P.3d 911 ("When an insurer receives an insured’s claim for benefits, the insurer must respond reasonably and objectively, it must diligently investigate the facts, fairly evaluate the claim, and act promptly and reasonably in rejecting or settling the claim") (ellipses omitted).

Because Utah law imposes duties beyond payment itself (e.g., diligent investigation, etc.), bad faith can exist without coverage. Christiansen v. Farmers Ins. Exch., 2005 UT 21, 116 P.3d 259. An insurer is insulated from first-party bad faith liability if the underlying claim was "fairly debatable," which is not only a question of law, but also a matter to which the district court is afforded significant discretion. Billings v. Union Bankers, 918 P.2d 461, 464 (Utah 1996). In Prince v. Bear River Mutual Insurance Company, 2002 UT 68, 56 P.3d 524, the Utah Supreme Court suggested that a claim is fairly debatable as a matter of law if the insurer consulted with an expert. However, dictum in Machan v. UNUM Life Ins. Co. of America, 2005 UT 37, 116 P.3d 342, suggests that the court would not extend Prince to experts who are not sufficiently independent. More broadly, the Utah Supreme Court recently clarified in Jones v. Farmers Ins. Exch., 2012 UT 52, 286 P.3d 301 that "a bad faith claim need not be resolved on summary judgment whenever an insurance company argues that the claim was fairly debatable:

We take this opportunity to clarify that a bad faith claim need not be resolved on summary judgment whenever an insurance company argues that the claims was fairly debatable. Summary judgment is only appropriate if, viewing the facts and all reasonable inferences drawn therefrom in the light most favorable to the nonmoving party. An analysis of whether an insurance claim is fairly debatable is closely related to the analysis of whether an insured fulfilled its duty under Beck to evaluate the claim.
fairly. When making the determination of whether a claim is fairly debatable, a judge should remain mindful of an insurer’s implied duties to diligently investigate claims, evaluate claims fairly, and act reasonably and promptly in settling or denying claims. Only when there is a legitimate factual issue as to the validity of the insured’s claim, such that reasonable minds could not differ as to whether the insurer’s conduct measured up to the required standard of care, should the court grant judgment as to a matter of law.

Id. at ¶ 12 (internal quotation marks and brackets omitted); but see Prince v. Bear River Mut. Ins. Co., 2002 UT 68, 56 P.3d 524 (summary judgment on the fairly debatable defense was affirmed where insurer retained medical expert who provided a report which created a legitimate factual question regarding the continued validity of the insured’s claim for medical benefits).

Consequential damages are available for violation of either the express or implied covenants in an insurance policy. Machan v. UNUM Life Ins. Co. of Am., 2005 UT 37, 116 P.3d 342.

B. Fraud

Generally, a cause of action for fraud in Utah requires:

1) A false representation of fact made by the defendant;

2) knowledge or belief of the defendant that the representation was false (“scienter”);

3) an intention to induce the defendant to act or refrain from acting in reliance;

4) Justifiable reliance by plaintiff upon the representation in taking action or in refraining from it;

5) Damages suffered by plaintiff as a result.


A person, including a corporation, commits insurance fraud if, with intent to deceive or defraud, the person gives the insurer misleading information concerning a material fact in the issuance or renewal of an insurance policy. Such information is also fraudulent if used to obtain benefits under an insurance policy. Utah Code § 76-6-521(1) (2004). Penalties range from a Class B misdemeanor to a second degree felony depending on the value of the claim. Id. § 76-6-521(2).

Insurers are allowed to request information from government agencies regarding fraud and are required to release information to an agency investigating fraud. Released information may be classified as protected under the Governmental Records Access and Management Act and is not subject to discovery unless, after reasonable notice, a court determines that the
public interest and any ongoing criminal investigations will not be compromised. An insurer who properly releases such information is immune from suit for doing so unless the insurer itself is guilty of fraud. Utah Code §§ 31A-31-104 (2013) and -105 (2012).

Although the Insurance Fraud Act requires insurers to provide information to law enforcement officials upon request, it does not override the physician-patient privilege. Physicians have standing to assert the privilege on behalf of patients because the Utah Supreme Court has held that health care providers are liable in tort if they unlawfully disclose confidential patient information. Sorensen v. Barbuto, 2008 UT 8, 177 P.3d 614.

C. Intentional or Negligent Infliction of Emotional Distress

1. Intentional Infliction of Emotional Distress

Intentional infliction of emotional distress claims (IIED) are unpopular with courts in Utah, and more often than not are thrown out on summary judgment.

To sustain a clause of action for IIED, a plaintiff much show that (i) the conduct complained of was outrageous and intolerable in that it offended against the generally accepted standards of decency and morality; (ii) the defendant intended to cause, or acted in reckless disregard of the likelihood of causing, emotional distress; (iii) the plaintiff suffered severe emotional distress; and (iv) the defendant’s conduct proximately caused severe emotional distress. Retherford v. AT&T Comm. of the Mountain States, Inc., 844 P.2d 949, 970-71 (Utah 1992).

Conduct is not deemed “outrageous” if it is nothing more than “unreasonable, unkind, or unfair,” even if it is tortious, injurious, malicious, or illegal. Franco v. The Church of Jesus Christ of Latter-day Saints, 2001 UT 25, ¶ 28, 21 P.3d 198 (citations omitted). If an insurer’s reason for denying benefits under the policy is fairly debatable, then as a matter of law, the denial does not rise to the level of outrageous conduct that could give rise to liability for IIED. Prince v. Bear River Mut. Ins. Co., 2002 UT 68, ¶ 39, 56 P.3d 524.

“[T]he element of emotional distress is specific to the plaintiff in each case,” and “is to be gauged subjectively.” The question is when “[the plaintiff] experienced severe emotional distress, not when an ordinarily sensitive person would have experienced such suffering.” Retherford, 844 P.2d at 975-76. Plaintiffs “must only show that they subjectively experienced severe emotional distress regarding the situation they found themselves in, not that an ‘ordinary reasonable person’ would have experienced it that way.” Campbell v. State Farm, 2001 UT 89, ¶ 110, 65 P.3d 1134, rev’d on other grounds.

2. Negligent Infliction of Emotional Distress

Negligent infliction of emotional distress (NIED) claims require a showing of (i) negligence; (ii) that the actor “should have realized that his conduct involved an unreasonable risk of causing the stress”; and (iii) that the distress “might result in illness or bodily harm.” Restatement (Second) of Torts § 313(1), quoted in Campbell, 2001 UT 89; Straub v. Fisher and Paykel Health Care, 1999 UT 102, 990 P.2d 384. Unlike in claims for IIED (see
above), NIED claims require a showing that the actor’s conduct would cause severe emotional distress in a reasonable person—the “thin-skulled plaintiff” rule does not apply. Handy v. Union Pacific R.R. Co., 841 P.2d 1210, 1220 n.13 (Utah Ct. App. 1992). Additionally, to survive a summary judgment dismissal of an NIED the plaintiff must provide evidence that the distress he or she claimed to have suffered manifested itself through severe mental or physical symptoms. Carlton v. Brown, 2014 UT 6, ¶¶ 57-58.

Utah courts have not had occasion to determine whether an insurer’s handling of a claim may give rise to NIED liability. There is at least some Utah case law suggesting that “creating unjustified confusion” in payment or settlement practices would not give rise to NIED liability. See Olsen v. Univ. of Phoenix, 2010 UT App 327, ¶ 6, 244 P.3d 388 (holding that for-profit university’s enrollment and collections practices were insufficient as a matter of law to give rise to an NIED claim). However, a plaintiff who could prove that the potential for physical harm to an insured was commonly known to insurers might be able to prove an NIED claim. See Handy, 841 P.2d at 1220 (no NIED liability for employer where employer had no notice of plaintiff’s susceptibility to stress-related ailments and where employees other than plaintiff found the work environment “at least tolerable”).

D. State Consumer Protection Laws and Regulations

Utah’s consumer protection laws have not been applied to insurance contracts or disputes. The Utah Consumer Sales Practices Act specifically excludes insurance contracts from its terms. Utah Code § 13-11-3(2)(a) (2004).

E. State Class Actions

Class actions are not common in Utah, particularly in the area of insurance, where judges tend to believe there are inherently too many differences between individual insurance claims. However, the number of attempts by plaintiffs’ attorneys to bring class actions has been increasing in recent years.

Class actions may be brought in Utah pursuant to Rule 23 of the Utah Rules of Civil Procedure. Under Rule 23(a), “[O]ne or more members of a class may sue or be sued as representative parties on behalf of all only if (1) the class is so numerous that joinder of all members is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and (4) the representative parties will fairly and adequately protect the interests of the class.”

Additional requirements for maintenance of a class action are a risk of inconsistent judgments, disposition of all claims by resolution of the named plaintiff’s claim, and common questions of law or fact. See U.R.Civ.P. 23(b)(1)-(3).

V. Defenses In Actions Against Insurers

A. Misrepresentation/Rescission of Insurance Contract for Misrepresentation

The insurer may cancel an insurance policy for a material misrepresentation. Utah Code § 31A-21-303(2) (2010). However, a
misrepresentation does not affect an insurer’s obligations unless (1) the statement is relied on by the insurer and was either material or made with intent to deceive, or (2) the misrepresentation contributes to the loss. Id. § 31A-21-105(2) (2003).

A misrepresentation is material if it diminishes an insurer’s opportunity to evaluate or estimate risk. The test for whether a fact is material to the risks assumed under an insurance policy is whether reasonable insurers would regard the fact as one which substantially increases the chance that the risk insured against will happen and therefore would reject the application. See ClearOne Communications, Inc. v. Lumbermens Mut. Cas. Co., 2005 WL 2716297, 2005 U.S. Dist. LEXIS 26187 (D. Utah 2005) (rev’d on other grounds), and Utah cases cited. A federal district court judge granted summary judgment in favor of a life insurer who denied a claim and rescinded a policy, finding that the insured had misrepresented material information during the application process regarding her medical history and that the insurer had relied upon that information when determining whether life insurance coverage should be extended. Chowdury v. United of Omaha Ins. Co., 2009 WL 1851005, 2009 U.S. Dist. LEXIS 54554 (D. Utah 2009). See also PHL Variable Ins. Co. v. Sheldon Hathaway Family Ins. Trust, 2013 U.S. Dist. LEXIS 169823, 12, 2013 WL 6230351 (D. Utah 2013) (grant of summary judgment in favor of life insurer where Plaintiff Trust knew or should have known about the clear misrepresentations contained in [applicant] Mr. Hathaway’s insurance application).


An innocent misstatement is not a “misrepresentation.” Derbidge v. Mut. Protective Ins. Co., 963 P.2d 788 (Utah Ct. App. 1998) (misstatement due to memory disorder); see also ClearOne Communications, Inc. v. National Union Fire Ins. Co. of Pittsburgh, PA, 494 F.3d 1238 (10th Cir. 2007). The Tenth Circuit Court of Appeals held that misstatements in financial statements provided as part of corporation’s application for D&O insurance could be imputed to corporation, for purposes of rescission of policy, if corporate officer certifying accuracy of application knew or should have known about misstatements. See ClearOne, 494 F.3d at 1248-49.

The insurer is estopped from claiming misrepresentation if it had notice of the falsity or if it had made an independent but insufficient inquiry into the facts. Hardy v. Prudential Ins. Co. of Am., 763 P.2d 761, 770 (Utah 1988). Furthermore, if the insurer, after issuance of the policy, acquires knowledge of sufficient facts to constitute a defense to all claims under the policy, the defense is only available if the insurer notifies the insured of its intent to defend against a claim within 60 days of acquiring knowledge. Utah Code § 31A-21-105(5) (2003); see also Chowdury v. United of Omaha Ins. Co., 2009 WL 1851005, 2009 U.S. Dist. LEXIS 54554 (D. Utah 2009). An insurer’s burden of proof to show fraud or misrepresentation is by a preponderance of the evidence. Horrell v. Utah Farm Bureau Ins. Co., 909 P.2d 1279, 1281-82 (Utah Ct. App. 1996).

An insurance company may waive its right to rescind a policy for material misrepresentation if it has knowledge of facts that would give it the right to rescind the policy and does not act promptly to assert or reserve the right to rescind the policy or otherwise treats the policy as valid, such as by earning and collecting premiums. Continental Ins. Co. v. Kingston, 2005 UT App 233, 114 P.3d 1158 (homeowner’s policy; insurer waived right to rescind policy based upon misrepresentation of home’s age; insurer’s investigator informed insurer a week after fire that home was over 100 years old; insurer did not check application at that time, reservation-of-rights letter was not sent until eight months after fire, and insurer informed insured that loss was covered, authorized demolition of home’s interior, and obtained commitments from contractors for restoration work).

B. Preexisting Illness or Disease Clauses

1. Statutes

The 2005 Utah Legislature enacted specific provisions regarding preexisting condition clauses:

31A-22-605.1 Preexisting condition limitations.

(1) Any provision dealing with preexisting conditions shall be consistent with this section, Section 31A-22-609\(^1\) and rules adopted by the commissioner.

\(^1\) Section 31A-22-609 of the Utah Codes provides:

31A-22-609. Incontestability for accident and health insurance.

(1)(a) A statement made by an applicant relating to the person’s insurability, except fraudulent misrepresentation, may not be a basis for avoidance of a policy, coverage, or denial of a claim for loss incurred or disability commencing after the coverage has been in effect for two years.

(b) The insurer has the burden of proving fraud by clear and convincing evidence.

(2) Except as provided under Section 31A-22-605.1, a claim for loss incurred or disability commencing after two years from the date of issue of the policy may not be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage, unless the condition was excluded from coverage by name or specific description in a provision that was in effect on the date of loss.

(3) Except as provided in Subsection (1)(a), a specified disease policy may not include wording that provides a defense based upon a disease or physical condition that existed prior to the effective date of coverage except as allowed under Subsection 31A-22-605.1(2).
(2) Except as provided in this section, an insurer that elects to use an application form without questions concerning the insured's health or medical treatment history shall provide coverage under the policy for any loss which occurs more than 12 months after the effective date of coverage due to a preexisting condition which is not specifically excluded from coverage.

(3)(a) An insurer that issues a specified disease policy may not deny a claim for loss due to a preexisting condition that occurs more than six months after the effective date of coverage.

(b) A specified disease policy may impose a preexisting condition exclusion only if the exclusion relates to a preexisting condition which first manifested itself within six months prior to the effective date of coverage or which was diagnosed by a physician at any time prior to the effective date of coverage.

(4)(a) Except as provided in this Subsection (4), a health benefit plan may impose a preexisting condition exclusion only if:

(i) the exclusion relates to a preexisting condition for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date from an individual licensed or similarly authorized to provide those services under state law and operating within the scope of practice authorized by state law;

(ii) the exclusion period ends no later than 12 months after the enrollment date, or in the case of a late enrollee, 18 months after the enrollment date; and

(iii) the exclusion period is reduced by the number of days of creditable coverage the enrollee has as of the enrollment date, in accordance with Subsection (4)(b).

(b)(i) The amount of creditable coverage allowed under Subsection (4)(a)(iii) is determined by counting all the days on which the individual has one or more types of creditable coverage.

(ii) Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

(A) Days in a waiting period or affiliation period are not taken into account in determining whether a significant break in coverage has occurred.

(B) For an individual who elects federal COBRA continuation coverage during the second election period provided under the federal Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred.

(c) A group health benefit plan may not impose a preexisting condition exclusion relating to pregnancy.

(d)(i) An insurer imposing a preexisting condition exclusion shall provide a written general notice of preexisting condition exclusion as part of any written application materials.

(ii) The general notice shall include:

(A) a description of the existence and terms of any preexisting condition exclusion under the plan, including the six-month period ending on the enrollment date, the maximum preexisting condition exclusion period, and how the insurer will reduce the maximum preexisting condition exclusion period by creditable coverage;

(B) a description of the rights of individuals:

(I) to demonstrate creditable coverage, including any applicable waiting periods, through a certificate of creditable coverage or through other means; and
(II) to request a certificate of creditable coverage from a prior plan;
(C) a statement that the current plan will assist in obtaining a certificate of creditable coverage from any prior plan or issuer if necessary; and
(D) a person to contact, and an address and telephone number for the person, for obtaining additional information or assistance regarding the preexisting condition exclusion.

(e) An insurer may not impose any limit on the amount of time that an individual has to present a certificate or other evidence of creditable coverage.

(f) This Subsection (4) does not preclude application of any waiting period applicable to all new enrollees under the plan.

Utah Code § 31A-22-605.1 (2005). Additionally, with respect to those policies falling under Utah’s Individual, Small Employer and Group Health Insurance Act, the policies have additional requirements:

31A-30-107.5 Preexisting condition exclusion – Condition-specific exclusion riders – Limitation periods.

(1) A health benefit plan may impose a preexisting condition exclusion only if the provision complies with Subsection 31A-22-605.1(4).

(2) (a) In accordance with Subsection (2)(b), an individual carrier:
(i) may, when the individual carrier and the insured mutually agree in writing to a condition-specific exclusion rider, offer to issue an individual policy that excludes all treatment and prescription drugs related to:
(A) a specific physical condition;
(B) a specific disease or disorder; and
(C) any specific or class of prescription drugs; and
(ii) may offer an individual policy that may establish separate cost sharing requirements including, deductibles and maximum limits that are specific to covered services and supplies, including drugs, when utilized for the treatment and care of the conditions, diseases, or disorders listed in Subsection (2)(b).

(b) (i) Except as provided in Section 31A-22-630 and Subsection (2)(b)(ii), the following may be the subject of a condition-specific exclusion rider:
(A) conditions, diseases, and disorders of the bones or joints of the ankle, arm, elbow, fingers, foot, hand, hip, knee, leg, mandible, mastoid, wrist, shoulder, spine, and toes, including bone spurs, bunions, carpal tunnel syndrome, club foot, cubital tunnel syndrome, hammertoe, syndactylyism, and treatment and prosthetic devices related to amputation;
(B) anal fistula, anal fissure, anal stricture, breast implants, breast reduction, chronic cystitis, chronic prostatitis, cystocele, rectoceles, enuresis, hemorrhoids, hydrocele, hypospadias, interstitial cystitis, kidney stones, uterine leiomyoma, varicocele, spermatocele, endometriosis;
(C) allergic rhinitis, nonallergic rhinitis, hay fever, dust allergies, pollen allergies, deviated nasal septum, and sinus related conditions, diseases, and disorders;
(D) hemangioma, keloids, scar revisions, and other skin related conditions, diseases, and disorders;
(E) goiter and other thyroid related conditions, diseases, or disorders;
(F) cataracts, cornea transplant, detached retina, glaucoma, keratoconus, macular degeneration, strabismus and other eye related conditions, diseases, and disorders;
(G) otitis media, cholesteatoma, otosclerosis, and other internal/external ear conditions, diseases, and disorders;
(H) Baker's cyst, ganglion cyst;
(I) abdominoplasty, esophageal reflux, hernia, Meniere's disease, migraines, TIC Doulourex, varicose veins, vestibular disorders;
(J) sleep disorders and speech disorders; and
(K) any specific or class of prescription drugs.

(ii) Subsection (2)(b)(i) does not apply:
(A) for the treatment of asthma; or
(B) when the condition is due to cancer.

(iii) A condition-specific exclusion rider:
(A) shall be limited to the excluded condition, disease, or disorder and any complications from that condition, disease, or disorder;
(B) may not extend to any secondary medical condition; and
(C) shall include the following informed consent paragraph: "I agree by signing below, to the terms of this rider, which excludes coverage for all treatment, including medications, related to the specific condition(s), disease(s), and/or disorder(s) stated herein and that if treatment or medications are received that I have the responsibility for payment for those services and items. I further understand that this rider does not extend to any secondary medical condition, disease, or disorder."

(c) If an individual carrier issues a condition-specific exclusion rider, the condition-specific exclusion rider shall remain in effect for the duration of the policy at the individual carrier's option.

(d) An individual policy issued in accordance with this Subsection (2) is not subject to Subsection 31A-26-301.6(7).

(3) Notwithstanding the other provisions of this section, a health benefit plan may impose a limitation period if:
(a) each policy that imposes a limitation period under the health benefit plan specifies the physical condition, disease, or disorder that is excluded from coverage during the limitation period;
(b) the limitation period does not exceed 12 months;
(c) the limitation period is applied uniformly; and
(d) the limitation period is reduced in compliance with Subsections 31A-22-605.1(4)(a) and (4)(b).


2. Case Law

No cases have been issued yet construing these statutory provisions. In a case applying the common law to a credit disability policy, the Utah Court of Appeals held that an exclusion when a "material contributing cause" of death was from sickness or injury that first became manifest prior to commencement of coverage could not be invoked when an injured died of pancreatitis as a complication of a kidney transplant, which was undertaken as an alternate treatment for a kidney disease which was being controlled through dialysis. The average person would construe such a provision as excluding coverage when death was a natural, medically connected consequence of preexisting sickness or injury, but not as excluding coverage where a totally different illness caused by medical treatment for preexisting disease.

Numerous Utah cases follow the general rule that ambiguities are construed against the drafter, *i.e.*, the insurance carrier. Insurance provisions are interpreted as they would be by the reasonable average person; exclusions are strictly construed.

**C. Statutes of Limitation**

Any action on a written insurance policy must be commenced within three years from inception of the loss. Utah Code § 31A-21-313(1) (2015). The insurer may not shorten this period by contract or otherwise. *Id.* § 31A-21-313(3)(a).

"This period is tolled while the parties engage in appraisal or arbitration procedures . . . as agreed to by the parties. *Id.* § 31A-21-313(5). However, a mere willingness to consider additional information does not toll limitations. *Tucker v. State Farm Mut. Auto Ins. Co.*, 2002 UT 54, ¶ 15, 53 P.3d 947.

**VI. Beneficiary Issues**

**A. Effectiveness of a Change Form**

An assignment of rights under a life insurance policy or annuity contract is valid if it would be valid under general contract law. Utah Code § 31A-22-412(1) (1986). An assignee’s right to proceeds takes priority over any beneficiary except a person designated as an irrevocable beneficiary prior to the assignment. *Id.* § 31A-22-412(2).

By statute, a life insurance policy must allow a policyholder to make an irrevocable beneficiary designation effective at any time specified by the policyholder, as well as to change a revocable designation without the previous beneficiary’s approval. Utah Code § 31A-22-413(1) (2013). The insurer may prescribe formalities to be complied with in changing a beneficiary, but those formalities must be designed for the insurer’s protection only. *Id.* § 31A-22-413(2). The insurer discharges its obligations under the policy by paying the designated beneficiary unless it receives actual notice of an assignment or change in beneficiary designation. *Id.* Actual notice occurs when the insurer’s specified formalities are complied with, or when a change in beneficiary has been requested and delivered to an agent of the insurer at least three days prior to payment to the earlier-designated beneficiary. *Id.*

Utah courts have stated that substantial compliance with the insurer’s requirements is all that is needed to effect a change in beneficiary. *Bergen v. Travelers Ins. Co. of Illinois*, 76 P.2d 659 (Utah Ct. App. 1989). Substantial compliance occurs when it is clear that the insured intends the change, has the right to make the change, and takes reasonable steps to bring about the change. *Id.* Utah courts have not addressed the interplay between the “substantial compliance” language in *Bergen* and the more specific language used in § 31A-22-413(2).
Utah courts will enforce a change form as against a previous beneficiary once it has been executed by the policyholder and delivered to an agent to be sent to the insurer, even if the insured dies before the insurer actually receives the form. In re Knickerbocker, 912 P.2d 969 (Utah 1996). Moreover, the fact that the previous beneficiary paid the premiums for the policy is irrelevant in determining whether the change form is effective. See id. (estranged husband’s payment of premiums held irrelevant for purposes of determining whether wife’s change of beneficiary was effective).

A court-appointed guardian lacks the power to execute an effective change form. Andrus v. Northwestern Mut. Life Ins. Co., 2010 UT App 265, 241 P.3d 385. Rather, in order for a change form executed by a third party to be effective, the third party must have the powers of a conservator and must have been specifically delegated authority from a court to change beneficiaries. See Utah Code § 75-5-408(1)(c)(vii) (2014). Similarly, a guardian of a minor must institute a protective proceeding and receive the court’s approval before changing a beneficiary designation. See Andrus, 2010 UT App 265, ¶ 9 n.5.

Requirements for adding or changing beneficiaries for employer-provided health insurance policies are governed by ERISA. See Peckham v. Gem State Mut. of Utah, 964 F.2d 1043 (10th Cir. 1992). ERISA preempts any state-law equitable estoppel rules but does not preempt state-law doctrines regarding substantial compliance with an insurer’s requirements. See id.

B. Effect of Divorce

A divorce or annulment revokes any revocable “disposition or appointment of property” to the former spouse, including a beneficiary designation in favor of the former spouse, unless a provision of the insurance contract or another agreement between the parties (such as prenuptial agreement) so specifies. Utah Code § 75-2-804(2)(a) (2013). The Tenth Circuit has held that this statute applies retroactively to encompass documents executed or policies purchased prior to its enactment. Stillman v. Teachers Ins. & Annuity Ass’n, 343 F.3d 1311 (10th Cir. 2003). In order for § 75-2-804(2)(a) to apply, the insurance contract must have been executed prior to the parties’ divorce; it does not matter that the parties may not have yet married at the time of its execution. See Farmers New World Life Ins. Co. v. Allen, 2011 WL 1657756, 2011 U.S. Dist. LEXIS 46906 (D. Utah 2011).

VII. Interpleader Actions

A. Availability of Fee Recovery

1. State Court

In Utah, the interpleader plaintiff can generally recover attorney fees and costs from the losing—not the prevailing—party. See Capson v. Brisbois, 592 P.2d 583, 584-85 (Utah 1979).
Exceptions to the general rule arise where the interpleader plaintiff "contested or delayed payment of the fund," id., in which case the claimant could be entitled to costs and interest from the interpleader plaintiff. Maycock v. Continental Life Ins. Co., 9 P.2d 179, 182 (Utah 1932).

2. Federal Court

In federal court, although attorney fee awards in interpleader actions are discretionary, "fees are normally awarded to an interpleader plaintiff who

(1) is disinterested (i.e., does not itself claim entitle to any of the interpleader fund); (2) concedes this liability in full; (3) deposits the disputed fund in court; and (4) seeks discharge, and who is [not] in some way culpable as regards the subject matter of the interpleader proceeding.


Courts may decline to award attorney fees to interpleader plaintiffs where (1) the insurer seeks to interplead funds via a counterclaim against the claimant, Holman v. N.Y. Life Ins. Co., 2012 WL 253202, 2012 U.S. Dist. LEXIS 9586, at *29-30 (D. Utah 2012); see also Liberty Nat’l Bank & Trust Co. v. Acme Tool Div. of Rucker Co., 540 F.2d 1375, 1382 (10th Cir. 1976); (2) the insurer waits several months after suit is filed to seek to interplead the funds, Holman, 2012 U.S. Dist. LEXIS 9586, at *30; and/or (3) direct claims are asserted against the insurer, stripping the insurer of its status as a disinterested interpleader, id.