

Oklahoma

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REGULATORY LIMITS ON CLAIMS HANDLING

Timing of Responses and Determinations

Okla. Stat. tit. 36 § 3629 governs the forms of proof of loss and offer of settlement or rejection of claim:

- An insurer shall furnish, upon written request of any insured claiming to have a loss under an insurance contract issued by such insurer, forms of proof of loss for completion by such person, but such insurer shall not, by reason of the requirement so to furnish forms, have any responsibility for or with reference to the completion of such proof or the manner of any such completion or attempted completion.
- It shall be the duty of the insurer, receiving proof of loss, to submit a written offer of settlement or rejection of the claim to the insured within sixty (60) days of receipt of that proof of loss. Upon a judgment rendered to either party, costs and attorney fees shall be allowable to the prevailing party. For purposes of this section, the prevailing party is the insurer in those cases where judgment does not exceed written offer of settlement. In all other judgments the insured shall be the prevailing party. If the insured is the prevailing party, the court in rendering judgment shall add interest on the verdict at the rate of fifteen percent (15%) per year from the date the loss was payable pursuant to the provisions of the contract to the date of the verdict. This provision shall not apply to uninsured motorist coverage.

This section does not apply if the core element of recovery sought and awarded did not consist of an insured loss. *Badillo v. Mid Century Insurance Co.*, 2005 OK 48, 121 P.3d 1080. The lapse of the 60 day time period in 36 O.S. § 3629 does not trigger liability under the insurance policy nor does it establish a timeframe after which evidence must be excluded. Violation of the 60 day period does not in itself trigger bad faith liability; instead, the 60 day offer period encourages the prompt resolution of insurance claims by allowing an award of attorney fees. *Hale v. A.G. Ins. Co.*, 2006 OK CIV APP 80, 138 P.3d 567.

The attorney fee provision of 36 O.S. § 3629(B) does not apply to uninsured/underinsured motorist coverage because UM/UIM coverage as “accident and health insurance.” *Barnes v. Oklahoma Farm Bureau Mutual Ins. Co.*, 2004 OK 25,94 P.3d 25. The plain language of section 3629(B) simply imposes an affirmative duty on an insurer to submit a written offer of settlement or rejection of the claim to the insured within a definite time period: sixty days. *Hamilton v. Northfield Ins. Co.*, 2020 OK 28, ¶ 9, 473 P.3d 22, 26.

Additionally, until the insured became legally obligated to pay money damages in excess of the self-insured amount and gives notice of that loss to the insurer, the insurer has no obligation to submit formal proof of loss forms to the insured or to make

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a settlement offer and did not trigger application of statute entitling prevailing party to attorney's fees. *Ass'n of County Comm'rs of Oklahoma v. National American Ins. Co.*, 2005 OK CIV APP 44, 116 P.3d 206.

Under the Oklahoma Unfair Claims Settlement Practices Act: "Every insurer, upon receipt of any pertinent written communication including but not limited to email or other forms of written electronic communication, or documentation by the insurer of a verbal communication from a claimant which reasonably suggests that a response is expected, shall, within thirty (30) days after receipt thereof, furnish the claimant with an adequate response to the communication." 36 O.S. § 1250.4(C). Any violation subjects the insurer to discipline including a civil penalty of \$100 to \$5,000. 36 O.S. § 1250.4(D).

36 O.S. § 707 defines casualty insurance to include accident and health insurance and automobile insurance, including liability insurance. Although it is usually referred to separately, property insurance is also included in the definition of casualty insurance. 36 O.S. § 704. 36 O.S. § 707 defines casualty insurance to include accident and health insurance. However, life insurance is not included within casualty insurance. See 36 O.S. §§ 702, 703 (defining life insurance and accident and health insurance). Under 36 O.S. § 1250.6:

- Every property and casualty insurer, within thirty (30) days after receiving notification of a claim, shall acknowledge the receipt of such notification unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgement shall be made in the claim file of the property and casualty insurer, and dated. Notification given to an agent of a property and casualty insurer shall be notification to the insurer.
- Every property and casualty insurer, upon receiving notification of a claim, promptly shall provide necessary claim forms, instruction, and reasonable assistance so that first party claimants can comply with the policy conditions and the reasonable requirements of the property and casualty insurer. Compliance with this paragraph within thirty (30) days after notification of a claim shall constitute compliance with subsection A of this section.

Another provision applicable to property and casualty insurers, which includes accident and health insurance, with respect to the timing of events within a claim evaluation is 36 O.S. § 1250.7:

- Within sixty (60) days after receipt by a property and casualty insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer, or if further investigation is necessary. No property and casualty insurer shall deny a claim because of a specific policy provision, condition, or exclusion unless reference to such provision, condition, or exclusion is included in the denial. A denial shall be given to any claimant in writing, and the claim file of the property and casualty insurer shall contain a copy of the denial. If there is a reasonable basis supported by specific information available for review by the Commissioner that the first party claimant has fraudulently caused or contributed to the loss, a property and casualty insurer shall be relieved from the requirements of this subsection. In the event of a weather-related catastrophe or a major natural disaster, as declared by the Governor, the Insurance Commissioner may extend the deadline imposed under this subsection an additional twenty (20) days.
- If a claim is denied for reasons other than those described in subsection A of this section, and is made by any other means than writing, an appropriate notation shall be made in the claim file of the property and casualty insurer until such time as a written confirmation can be made.
- Every property and casualty insurer shall complete investigation of a claim within sixty (60) days after notification of proof of loss unless such investigation cannot reasonably be completed within such time. If such investigation cannot be completed, or if a property and casualty insurer needs more time to

determine whether a claim should be accepted or denied, it shall so notify the claimant within sixty (60) days after receipt of the proofs of loss, giving reasons why more time is needed. If the investigation remains incomplete, a property and casualty insurer shall, within sixty (60) days from the date of the initial notification, send to such claimant a letter setting forth the reasons additional time is needed for investigation. Except for an investigation of possible fraud or arson which is supported by specific information giving a reasonable basis for the investigation, the time for investigation shall not exceed one hundred twenty (120) days after receipt of proof of loss. Provided, in the event of a weather-related catastrophe or a major natural disaster, as declared by the Governor, the Insurance Commissioner may extend this deadline for investigation an additional twenty (20) days.

- Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.
- Insurers shall not continue or delay negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney, for a length of time which causes the claimant's rights to be affected by a statute of limitations, or a policy or contract time limit, without giving the claimant written notice that the time limit is expiring and may affect the claimant's rights. Such notice shall be given to first party claimants thirty (30) days, and to third party claimants sixty (60) days, before the date on which such time limit may expire.
- No insurer shall make statements which indicate that the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying a third party claimant of the provision of a statute of limitations.
- If a lawsuit on the claim is initiated, the time limits provided for in this section shall not apply.

Finally, Okla. Stat. tit. 36 § 1219 requires the following with regarding to the administration, servicing or processing of accident and health insurance policies:

- In the administration, servicing, or processing of any accident and health insurance policy, every insurer shall reimburse all clean claims of an insured, an assignee of the insured, or a health care provider within forty-five (45) calendar days after receipt of the claim by the insurer.
- As used in this section:
 - “Accident and health insurance policy” or “policy” means any policy, certificate, contract, agreement or other instrument that provides accident and health insurance, as defined in Section 703 of this title, to any person in this state, and any subscriber certificate or any evidence of coverage issued by a health maintenance organization to any person in this state;
 - “Clean claim” means a claim that has no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt payment; and
 - “Insurer” means any entity that provides an accident and health insurance policy in this state, including, but not limited to, a licensed insurance company, a not-for-profit hospital service and medical indemnity corporation, a health maintenance organization, a fraternal benefit society, a multiple employer welfare arrangement, or any other entity subject to regulation by the Insurance Commissioner.
- If a claim or any portion of a claim is determined to have defects or improprieties, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment, the insured, enrollee or subscriber, assignee of the insured, enrollee or subscriber, and health care provider

shall be notified in writing within thirty (30) calendar days after receipt of the claim by the insurer. The written notice shall specify the portion of the claim that is causing a delay in processing and explain any additional information or corrections needed. Failure of an insurer to provide the insured, enrollee or subscriber, assignee of the insured, enrollee or subscriber, and health care provider with the notice shall constitute prima facie evidence that the claim will be paid in accordance with the terms of the policy. Provided, if a claim is not submitted into the system due to a failure to meet basic Electronic Data Interchange (EDI) and/or Health Insurance Portability and Accountability Act (HIPAA) edits, electronic notification of the failure to the submitter shall be deemed compliance with this subsection. Provided further, health maintenance organizations shall not be required to notify the insured, enrollee or subscriber, or assignee of the insured, enrollee or subscriber of any claim defect or impropriety.

- Upon receipt of the additional information or corrections which led to the claim's being delayed and a determination that the information is accurate, an insurer shall either pay or deny the claim or a portion of the claim within forty-five (45) calendar days.
- Payment shall be considered made on:
 - The date a draft or other valid instrument which is equivalent to the amount of the payment is placed in the United States mail in a properly addressed, postpaid envelope; or
 - If not so posted, the date of delivery.
- An overdue payment shall bear simple interest at the rate of ten percent (10%) per year.
- In the event litigation should ensue based upon such a claim, the prevailing party shall be entitled to recover a reasonable attorney fee to be set by the court and taxed as costs against the party or parties who do not prevail.
- The Insurance Commissioner shall develop a standardized prompt pay form for use by providers in reporting violations of prompt pay requirements. The form shall include a requirement that documentation of the reason for the delay in payment or documentation of proof of payment must be provided within ten (10) days of the filing of the form. The Commissioner shall provide the form to health maintenance organizations and providers.
- The provisions of this section shall not apply to the Oklahoma Life and Health Insurance Guaranty Association or to the Oklahoma Property and Casualty Insurance Guaranty Association.

Standards for Determination and Settlements

Oklahoma has an Unfair Claims Settlement Practices Act, 36 O.S. § 1250.1 et seq., which defines certain unfair claim settlement practices:

- Failing to fully disclose to first party claimants, benefits, coverages, or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim;
- Knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue;
- Failing to adopt and implement reasonable standards for prompt investigations of claims arising under its insurance policies or insurance contracts;
- Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;
- Failing to comply with the provisions of Section 1219 of this title;
- Denying a claim for failure to exhibit the property without proof of demand and unfounded refusal by a

claimant to do so;

- Except where there is a time limit specified in the policy, making statements, written or otherwise, which require a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if the time limit is not complied with unless the failure to comply with the time limit prejudices the rights of an insurer;
- Requesting a claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment;
- Issuing checks or drafts in partial settlement of a loss or claim under a specified coverage which contain language which releases an insurer or its insured from its total liability;
- Denying payment to a claimant on the grounds that services, procedures, or supplies provided by a treating physician or a hospital were not medically necessary unless the health insurer or administrator, as defined in Section 1442 of this title, first obtains an opinion from any provider of health care licensed by law and preceded by a medical examination or claim review, to the effect that the services, procedures or supplies for which payment is being denied were not medically necessary. Upon written request of a claimant, treating physician, or hospital, such opinion shall be set forth in a written report, prepared and signed by the reviewing physician. The report shall detail which specific services, procedures, or supplies were not medically necessary, in the opinion of the reviewing physician, and an explanation of that conclusion. A copy of each report of a reviewing physician shall be mailed by the health insurer, or administrator, postage prepaid, to the claimant, treating physician or hospital requesting same within fifteen (15) days after receipt of the written request. As used in this paragraph, "physician" means a person holding a valid license to practice medicine and surgery, osteopathic medicine, podiatric medicine, dentistry, chiropractic, or optometry, pursuant to the state licensing provisions of Title 59 of the Oklahoma Statutes;
- Compensating a reviewing physician, as defined in paragraph 10 of this section, on the basis of a percentage of the amount by which a claim is reduced for payment;
- Violating the provisions of the Health Care Fraud Prevention Act;
- Compelling, without just cause, policyholders to institute suits to recover amounts due under its insurance policies or insurance contracts by offering substantially less than the amounts ultimately recovered in suits brought by them, when the policyholders have made claims for amounts reasonably similar to the amounts ultimately recovered;
- Failing to maintain a complete record of all complaints which it has received during the preceding three (3) years or since the date of its last financial examination conducted or accepted by the Commissioner, whichever time is longer. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. For the purposes of this paragraph, "complaint" means any written communication primarily expressing a grievance;
- Requesting a refund of all or a portion of a payment of a claim made to a claimant or health care provider more than twenty-four (24) months after the payment is made. This paragraph shall not apply:
 - if the payment was made because of fraud committed by the claimant or health care provider, or
 - if the claimant or health care provider has otherwise agreed to make a refund to the insurer for overpayment of a claim; or
- Failing to pay, or requesting a refund of a payment, for health care services covered under the policy of a

health benefit plan, or its agent, has provided a preauthorization or precertification and verification of eligibility for those health care services. This paragraph shall not apply if:

- the claim or payment was made because of fraud committed by the claimant or health care provider,
 - the subscriber had a pre-existing exclusion under the policy related to the service provided, or
 - the subscriber or employer failed to pay the applicable premium and all grace periods and extensions of coverage have expired.
- Denying or refusing to accept an application for life insurance, or refusing to renew, cancel, restrict or otherwise terminate a policy of life insurance, or charge a different rate based upon the lawful travel destination of an applicant or insured as provided in Section 4024 of this title; or
 - As a health insurer that provides pharmacy benefits or a pharmacy benefits manager that administers pharmacy benefits for a health plan, failing to include any amount paid by an enrollee or on behalf of an enrollee by another person when calculating the enrollee's total contribution to an out-of-pocket maximum, deductible, copayment, coinsurance or other cost-sharing requirement.

36 O.S. § 1250.5. Notably, there is no private right of action for violation of Oklahoma Unfair Settlement Practices Act. *See, e.g., McWhirter v Fire Ins. Exchange, Inc.*, 1994 OK 93, 878 P.2d 1056; *Walker v Choteau Lime Co., Inc.*, 1993 OK 35, 849 P.2d 1085; *Lewis v. Aetna U.S. Healthcare, Inc.*, 78 F. Supp. 2d 1202 (N.D. Okla. 1999). Although no private right of action exists under the Unfair Claims Settlement Practice Act, conduct violating the Act can be considered bad faith. *Beers v. Hillory*, 2010 OK CIV APP 99, 241 P.3d 285. Thus, as a practical matter, the Act's requirements often come into evidence in claims handling litigation via experts who opine that in their opinion any violation of the Act is unreasonable. However, not all violations of section 1250.5 are "bad faith." At section 1250.3, the legislature expressly states that the acts listed above are unfair claims practices if done flagrantly with a conscious disregard of the law, or with such frequency as to indicate a general business practice. *See also* 25 O.S. § 9 (defining "good faith" as an honest intention to abstain from taking any unconscientious advantage of another, even though the forms or technicalities of law, together with an absence of all information or belief of facts which would render the transaction unconscientious.").

PRINCIPLES OF CONTRACT INTERPRETATION

Insurance contracts are subject to the same general rules of interpretation as any other contract. *Brown v. Patel*, 2007 OK 16, 157 P.3d 117. An insurance contract is one of adhesion, and any ambiguity is resolved by liberally construing words of inclusion and strictly construing words of exclusion. *Cranfill v Aetna Life Ins. Co.*, 2002 OK 26, 49 P.3d 703. Under Oklahoma law, "[a]n insurance policy, like any other contract of adhesion, is liberally construed, consistent with the object sought to be accomplished, so as to give a reasonable effect to all of its provisions, if possible." *Dodson v. St. Paul Ins. Co.*, 1991 OK 24, 812 P.2d 372, 376. "Parties to an insurance contract are at liberty to contract for insurance to cover such risks as they see fit and are bound by the terms of the contract and courts will not undertake to rewrite terms thereof." *Id.* (quoting *Wiley v. Travelers Ins. Co.*, 1974 OK 147, 534 P.2d 1293, 1295). "The construction of an insurance policy should be a natural and reasonable one, fairly construed to effectuate its purpose, and view in the light of common sense so as not to bring about an absurd result." *Id.* "The terms of the parties' contract, if unambiguous, clear, and consistent, are accepted in their plain and ordinary senses, and the contract will be enforced to carry out the intention of the parties as it existed at the time the contract was negotiated." *Id.* "The rule that policies are to be construed against the insurer has no application where the provisions are susceptible of only one reasonable construction." *Wynn v. Avemco Ins. Co.*, 1998 OK 75, 963 P.2d 572.

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If a contract is not ambiguous, a court will not re-write a contract to provide better terms than the parties agreed to. A policy is to be read as a whole, giving words and terms their ordinary meaning and enforcing each part of the contract. *BP America, Inc. v. State Auto Property and Casualty Ins. Co.*, 2005 OK 65, 148 P.3d 832. “Insurance contracts are ambiguous only if they are susceptible to two constructions.” *Max True Plastering Co. v. U.S. Fidelity and Guar. Co.*, 1996 OK 28, 912 P.2d 861. “[W]e accept the contract language in its plain, ordinary, and popular sense.” *Haworth v. Jantzen*, 2006 OK 35, 172 P.3d 193. Courts “do not indulge in forced or constrained interpretations to create and then to construe ambiguities in insurance contracts.” *Max True Plastering Co.*, ¶ 20, 912 P.2d at 869.

As an initial matter, “[t]he general declaration of insurance coverage, as established by the insurance policy and limited to its provisions, normally determines the insurance carrier’s liability, and the insured’s respective rights under the contract by identifying what risks are covered and excluded by the policy.” *Dodson, supra*, at 377. Additionally, “[t]he policy exclusions are read seriatim; each exclusion eliminates coverage and operates independently against the general declaration of insurance coverage and all prior exclusions by specifying other occurrences not covered by the policy.” *Id.* “Thus, subsequent exclusions can further limit or even remove a covered risk from the general declaration of insurance coverage.” *Id.* “In case of doubt, exclusions exempting certain specified risks are construed strictly against the insurer.” *Id.*

Oklahoma recognizes the Doctrine of Reasonable Expectations. It is applied only when a policy is ambiguous or contains unexpected exclusions arising from technical or obscure language or which are hidden in the policy provisions. *BP America, Inc. v. State Auto Property and Casualty Ins. Co.*, *supra*.

CHOICE OF LAW

Generally, the law of the place where the policy was made and executed applies in determining the liability of an insurer. *Aetna Life & Casualty Co. v. Lumbermen’s Mutual Casualty Co.*, 446 F.2d 217 (10th Cir. 1971). If an insurance policy is issued outside of Oklahoma, that state’s law applies to contract interpretation, but Oklahoma law applies to all other issues. *Gay & Taylor, Inc. v. St. Paul Fire & Marine Ins. Co.*, 550 F. Supp 710 (W.D. Okla. 1981). When a policy incorporates the law of a foreign country, the foreign insurer permitted a direct action against it even though Oklahoma law did not. *Campbell v. American International Group, Inc.*, 1999 OK CIV APP 37, 976 P.2d 1102. Where Oklahoma is the intended location of performance, Oklahoma law will apply in an ERISA case. *Dang v. UNUM Life Insurance Co. of America*, 175 F.3d 1186 (10th Cir. 1999). Where application of the law of the state where the contract was made will violate Oklahoma public policy, Oklahoma law will apply. *Bohannon v. Allstate Ins. Co.*, 1991 OK 64, 820 P.2d 787.

Under Oklahoma law, “the traditional *lex loci contractus* rule governs the validity, interpretation, application and effect of the motor vehicle insurance contracts **except** where (1) the provisions would violate Oklahoma public policy or (2) the facts demonstrate another jurisdiction has the most significant relationship to the subject matter and the parties.” *Bernal v. Charter Cnty. Mut. Ins. Co.*, 2009 OK 28, 209 P.3d 309 (emphasis in original). The *lex loci contractus* rule requires the contract be interpreted according to the laws of the place where the contract was made. *Id.* “In first-party UM coverage, location of the insured automobile does not attain greatest significance. The place of performance and the place of contracting are of greatest significance in this contract area pervaded by state statutes.” *Bohannon*, 820 P.2d at 796. Additionally, an insurance policy may provide its coverage determinations are to be made according to the law of the state where the accident occurred. *Leritz v. Farmers Ins. Co.*, 2016 OK 79, 385 P.3d 991.

DUTIES IMPOSED BY STATE LAW

Duty to Defend

1. Standard for Determining Duty to Defend

The duty to defend is separate from, and broader than, the duty to indemnify, but the insurer's obligation is not unlimited. The defense duty is measured by the nature and kinds of risks covered by the policy as well as by the reasonable expectations of the insured. "An insurer has a duty to defend an insured whenever it ascertains the presence of facts that give rise to *the potential of liability* under the policy." "The phrase 'potentially covered' means that 'the insurers duty to defend its insured arises whenever the allegations in a complaint state a cause of action that gives rise to the *possibility of a recovery* under the policy; there *need not be a probability of recovery*.'" The insurer's defense duty is determined on the basis of information gleaned from the pleadings, from the insured, and from other sources available to the insurer at the time the defense is demanded or tendered. The insurer has the duty to look behind the third party's allegations to analyze whether coverage is possible. *First Bank of Turley v. Fid. and Deposit Ins. Co. of Maryland*, 1996 OK 105, 928 P.2d 298; *see also Mount Vernon Fire Ins. Co. v. Okmulgee Inn Venture, LLC*, 451 Fed. Appx. 745 (10th Cir. 2011).

2. Issues with Reserving Rights

Delay in asserting a reservation of rights constitutes an estoppel to assert as well as an implied waiver of defenses. *See, e.g., Zahn v. Gen. Ins. Co. of Am.*, 1980 OK 79, 611 P.2d 645; *Hartford Accident & Indemnity Co. v. Sanford*, 344 F. Supp. 969 (W.D. Okla. 1972); *Gay & Taylor, Inc. v. St. Paul Fire & Marine Ins. Co.*, 550 F. Supp. 710 (W.D. Okla. 1981); *Sec. Ins. Co. of New Haven v. Greer*, 1968 OK 3, 437 P.2d 243 ("An insurer may by his action or conduct be estopped from denying that his policy affords coverage for a risk which the insured has been led honestly to believe was assumed under the terms of the policy. Where the equities are in favor of the insured, slight evidence will sustain a waiver against an insurance company."); *Insurors Indemnity & Ins. Co. v. Archer*, 1953 OK 29, 254 P.2d 342; *Tri-State Cas. Ins. Co. v. McDuff*, 1943 OK 54, 134 P.2d 342.

In *Braun v. Annesley*, 936 F.2d 1105 (10th Cir. 1991), the insurance company defended two defendants without giving a reservation of rights. After a judgment was rendered, it disclaimed liability, stating the defendant was not an insured under the policy. The court held that it could not avoid paying under the policy because it failed to reserve its rights, even where the defendant was not an insured under the policy. Here is what the court said:

Under Oklahoma law, an insurer may by its conduct be estopped from denying that its policy provides coverage for a risk that the insured has been led honestly to believe was covered under the terms of the policy. *Security Ins. Co. of New Haven v. Greer*, 437 P.2d 243, 245-46 (Okla. 1968). The doctrine of estoppel, however, cannot be invoked to broaden the coverage of an insurance policy to bring within its protection risks that are not included under the terms of the policy. *Western Ins. Co. v. Cimarron Pipe Line Const., Inc.*, 748 F.2d 1397, 1399 (10th Cir. 1984); *Lester v. Sparks*, 583 P.2d 1097, 1100 (Okla. 1978); *Greer*, 437 P.2d at 246. The rationale for this rule is that estoppel cannot be used to create a contract. *Greer*, 437 P.2d at 246. An exception is that when an insurer assumes the defense of an action knowing the grounds which would permit it to deny coverage, it may be estopped from subsequently raising the defense of noncoverage. *City of Carter Lake v. Aetna Cas. & Sur. Co.*, 604 F.2d 1052, 1059 (8th Cir. 1979); *Pendleton v. Pan Am. Fire & Cas. Co.*, 317 F.2d 96, 99 (10th Cir.), cert. denied, 375 U.S. 905, 11 L. Ed. 2d 145, 84 S. Ct. 196 (1963); *Gay & Taylor, Inc. v. St. Paul Fire & Marine Ins. Co.*, 550 F. Supp. 710, 714 (W.D. Okla. 1981). Although Oklahoma has not previously addressed appellant's argument, we are aided by a review of our cases addressing the general rule and its exception.

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In *Cimarron Pipe Line*, the insured, a company in the business of laying gas pipelines, argued that it was covered for physical injuries and property damage resulting from work it had completed. The policy specifically excluded this “completed operations” coverage. Nonetheless, the insured argued that the insurer was estopped from denying such coverage because its general agent had stated that he thought it was included in the policy. We interpreted Oklahoma law and determined that the insurance policy could not be extended by estoppel to bring within its terms a risk that was specifically excluded from coverage. *Cimarron Pipe Line*, 748 F.2d at 1399-1400.

By contrast, in *Pendleton v. Pan American Fire and Casualty Company*, we ruled that the insurer was estopped from denying coverage for an explosion caused by a defect in a liquefied gas distribution despite the fact that this risk was specifically excluded from the policy. Significantly, the claimed basis of estoppel was the insurer assuming control of the insured's defense without reserving its rights to later contest coverage. *Pendleton*, 317 F.2d at 99-101. Similarly, in *Gay & Taylor Inc, v. St. Paul Fire & Marine Ins. Co.*, the United States District Court for the Western District of Oklahoma interpreted Oklahoma law and determined that the insurer was estopped from denying coverage after defending the insured without a reservation of rights, although the insured was sued for fraud and the policy specifically excluded fraud from coverage. *St. Paul*, 550 F. Supp. at 714-15.

Tri-State defended Mr. Bradley without a reservation of rights. *Braun v. Bradley*, No. CIV-82-366-P, Order at 5 (W.D. Okla. Nov. 30, 1989). In addition, Tri-State stated at trial that it was “unclear” whether Tri-State would be liable for Mr. Bradley by virtue of Oklahoma statute and the Tri-State policy on file with the Oklahoma Corporation Commission. Record, vol. 2, doc. 5 at 4. Thus, Tri-State acknowledged that Mr. Bradley might be covered under its policy. Given that the insurers in *Pendleton* and *St. Paul* were estopped from denying coverage after providing a defense without a reservation of rights when the claimant was not even arguably covered, Tri-State is also estopped when Mr. Bradley is arguably covered, and, like the circumstances in *Pendleton* and *St. Paul*, the basis of estoppel is Tri-State's defense of Mr. Bradley without a reservation of rights.

The inequitable consequences of a contrary ruling provide support for our conclusion. We do not believe the Supreme Court of Oklahoma would allow an insurer to defend an individual who might be covered and then permit the insurer to deny coverage after the individual is found liable. Such a result grants the insurer the unfettered right to induce an individual to relinquish control of his or her defense. We think our result today creates a better rule, one that encourages an insurer to thoroughly investigate its policy and notify persons before assuming their defense that it is reserving its right to later contest coverage. *Id.* at 1110-1111. The Oklahoma Court of Civil Appeals adopted this rationale in *T.V. v. Columbia National Insurance Co.*, explaining the rule of estoppel as it applies to insurers:

When an insurer undertakes, without reservation, to defend an action against the insured, and a judgment is rendered against the insured, the insurer is estopped to deny liability under the policy. Estoppel arises when the insurer commits to an unqualified defense *with knowledge* that the action may not be within the coverage of its policy. If a liability insurer, *with knowledge* of a ground of forfeiture or noncoverage under the policy, assumes and conducts the defense of an action brought against the insured, without disclaiming liability and giving notice of its reservation of rights, it is thereafter precluded in an action upon the policy from setting up such ground of forfeiture or noncoverage.

2013 OK CIV APP 100, ¶ 20, 313 P.3d 1022, 1027 (emphasis in original)(citations omitted).

State Privacy Laws; Insurance Regulatory Issues; Arbitration/Mediation

1. Criminal Sanctions

Oklahoma law provides no person shall disclose any nonpublic personal information contrary to the provisions of the Gramm-Leach-Bliley Act. 36 O.S. § 307.2. Oklahoma insurers are required to adopt policies to ensure the confidentiality of individual medical records. See 36 O.S. § 6559(A)(4); Okla. Admin. Code 365:35 *et. seq.* (setting forth notice requirements for release of personal information and privacy requirements). Oklahoma insurers are also required to protect the privacy of an insured's financial information and to maintain specific standards for safeguarding consumer information. Okla. Admin. Code 365:35 *et. seq.* However, Oklahoma lacks criminal sanctions relating to the release of private insurance information.

Okla. Stat. tit. 36 § 4513 provides the following with regard to disclosure of patient insurance coverage and benefit information to medical service providers, health plans or health plan sponsors:

- All entities providing health insurance or health care coverage to individuals residing within the state shall provide such information on coverage and benefits as may be required by any health care provider, health plan, health plan sponsor or their agent regarding the coverage provided by the entity to any patient or beneficiary of the medical service provider, health plan, or health plan sponsor.
- Any health care provider, health plan, health plan sponsor or their agent is authorized to transmit the simple human identifiers in ANSI X.12 270 inquiries including the name, gender, date of birth, and member number or policyholder identification number if required by the health plan of a patient to any and all entities licensed or registered to provide health insurance or health care coverage to individuals residing within the state to establish the coverage in force for a patient presenting or about to present a claim.
- Any party named in subsection A of this section shall have a cause of action for injunctive relief and costs including, but not limited to, attorney fees for the enforcement of this section against any noncompliant health plan.

A violation of the privacy regulations set out in Okla. Admin. Code 365:35 *et seq.* constitutes a violation of the Okla. Stat. tit. 36, Art. 12. Okla. Admin. Code § 365:35-1-52. Under Title 36, Art. 12 cease and desist orders restraining the offender from continuing the practice and civil fines of \$100 to \$1,000 per violation may be assessed; however, no criminal sanctions have been enacted at this time.

2. The Standards for Compensatory and Punitive Damages

While Okla. Stat. tit. 36 § 307.2 provides the Insurance Commissioner may promulgate rules to protect nonpublic personal information from disclosure, this statute does not create a private cause of action for disclosure of such information. 36 O.S. § 307.2(C). Thus, the general standards for punitive damages located in Okla. Stat. tit. 23 § 9.1 would apply as would general negligence principles. See, *e.g.*, *Akin v. Missouri Pac. R. Co.*, 1998 OK 102, 977 P.2d 1040 (“Three evidentiary elements are essential to a prima facie case of negligence: (1) a duty owed by the defendant to protect the plaintiff from injury, (2) a failure properly to exercise or perform that duty, and (3) an injury to plaintiff proximately caused by the defendant's breach of that duty.”).

3. State Arbitration and Mediation Procedures

Oklahoma does not have arbitration or mediation procedures designed specifically for insurance contracts. Instead, it follows the laws of arbitration/mediation agreements applicable to all contracts as controlled by the Oklahoma Dispute Resolution Act, 12 O.S. §§ 1801-1840, and the Oklahoma

Uniform Arbitration Act, 12 O.S. §§ 1851-1881.

The Oklahoma Dispute Resolution Act allows the Oklahoma court systems to provide mediation to parties free of charge. Otherwise, private mediation is controlled by contractual law and is only applicable if required by contract.

For arbitration, under Oklahoma law, it is not the arbitrator, but the court that determines whether a person enters into a valid, enforceable agreement to arbitrate the dispute.” *Carter v. Schuster*, 2009 OK 94, 227 P.3d 149. “The primary purpose of both the FAA and the OUAA is to ensure that private agreements to arbitrate are enforced according to their terms.” *Coulter v. First Am. Res., LLC*, 2009 OK 53, 214 P.3d 807. “Applying either act, ‘[t]he courts will enforce arbitration agreements according to the terms of the parties’ contract, as arbitration is a matter of consent, not coercion.’” *Id.* (quoting *Okla. Oncology & Hematology PC v. U.S. Oncology, Inc.*, 2007 OK 12, 160 P.3d 936. “[A]lthough the FAA favors arbitration when it is the parties’ contractual choice of a remedial forum, the courts will not impose arbitration upon parties where they have not agreed to do so.” *Okla. Oncology*, ¶ 22, 160 P.3d at 944 (citations omitted); see also *KWD River City Investments, L.P. v. Ross Dress For Less, Inc.*, 2012 OK 76, 288 P.3d 929 (“Courts will enforce arbitration agreements according to the terms of the parties contract and will not impose arbitration upon parties where they have not agreed to do so.”). “Therefore, arbitration may be initiated only . . . under the law which the parties designated in the arbitration agreement.” *Coulter*, ¶ 8, 214 P.3d at 809. “The courts will not require a party to submit a controversy to arbitration where it has not been so agreed.” *Okla. Oncology*, ¶ 22, 160 P.3d at 945.

4. State Administrative Entity Rule-Making Authority

The Oklahoma Insurance Commissioner may promulgate rules necessary to prohibit the disclosure of nonpublic personal information contrary to the provisions of Title V of the Gramm-Leach-Bliley Act of 1999. 36 O.S. § 307.2.

EXTRACONTRACTUAL CLAIMS AGAINST INSURERS: ELEMENTS AND REMEDIES

Bad Faith Claim Handling/Bad Faith Failure to Settle Within Limits

1. First Party

The duty to *insureds* in handling first and third party claims are the same. *Timmons v. Royal Globe Ins. Co.*, 1982 OK 97, 653 P.2d 907. An insurer has an implied duty to deal fairly and act in good faith with its insured and violation of that duty gives rise for an action in tort for which consequential and, in a proper case, punitive damages may be sought. *Christian v. American Home Assur. Co.*, 1977 OK 141 577 P.2d 899. The minimum level of culpability necessary for liability against an insurer to attach is more than simple negligence, but less than the reckless conduct necessary to sanction a punitive damages award against said insurer. *Badillo v. Mid Century Insurance Co.*, 2005 OK 48, 121 P.3d 1080. The essence of a bad faith action is the reasonableness of the insurer’s actions. Reasonableness is judged based on what the insurer knew or should have known at the time its performance was requested. *Buzzard v. McDanel*, 1987 OK 157, 736 P.2d 157. The tort of bad faith does not require an evil intent to mislead or deceive. *Timmons v. Royal Globe Ins. Co.*, 1982 OK 97, 653 P.2d 907.

An insurer must promptly offer to settle a first-party claim with the insured for the amount it evaluated the claim to be worth. *Newport v. USAA*, 2000 OK 190, 11 P.3d 190. However, a claim of bad faith will not lie where there is a “legitimate dispute” as to coverage or the amount of the claim. *Garnett v. Gov’t Employees Ins. Co.*, 2008 OK 43, 186 P.3d 935; *Manis v. Hartford Ins. Co.*, 1984 OK 760, 681 P.2d 760.

Under Oklahoma law, the insurer must conduct an investigation reasonably appropriate under the circumstances before denial of a claim. *Buzzard v. Farmers Ins. Co., Inc.*, 1991 OK 127, 824 P.2d 1105; *Vining v. Enterprise Financial Group Inc.*, 148 F.3d 1206 (10th Cir. 1998).

Additionally, delay alone is insufficient to constitute bad faith. The delay must be unreasonable under the circumstances. *Porter v. Farmers Ins. Co., Inc.*, 505 Fed. Appx 787, 791 (10th Cir. 2012) (“[I]t would be improper to hold [insurer] liable for delays beyond its control.”).

The bad faith cause of action does not “regulate insurance” and therefore does not fall within ERISA’s savings clause. Accordingly, an Oklahoma bad faith cause of action cannot be brought on an ERISA insurance plan. *Holloway v. UNUM Life Ins. Co. of Am.*, 2003 OK 90, 89 P.3d 1022; *but see Allison v. UNUM Life Ins. Co. of Am.*, 381 F.3d 1015 (10th Cir. 2004) (rejecting *Holloway* as not binding on federal courts and finding bad faith cause of action is preempted by ERISA).

Generally, agents of an insurer do not owe a duty of good faith and fair dealing to the insured because they are not parties to the contractual relationship. *Wathor v. Mutual Assurance Administrators, Inc.*, 2004 OK 2, 87 P.3d 559. However, in a situation where a plan administrator performs many of the tasks of an insurance company, has a compensation package that is contingent upon the approval or denial of claims, and bears some of the financial risk of loss for the claims, the administrator has a duty of good faith and fair dealing to the insured. *Id.* The duty may be imposed upon a plan administrator where, under the specific facts and circumstances of the case, the plan administrator acts sufficiently like an insurer such that there is a “special relationship” between the plan administrator and the insured that gives rise to the duty. *Id.* Additionally, independent insurance investigators owe a duty to the insured as well as to the insurer to conduct a fair and reasonable investigation of the insurance claim. *Brown v. State Farm Fire & Cas. Co.*, 2002 OK CIV APP 107, 58 P.3d 217.

The duty of good faith ends when full payment of policy limits is made on the claim. *Skinner v. John Deere Ins. Co.*, 2000 OK 18, 998 P.2d 1219. The tort of bad faith breach of an insurance contract must be based upon wrongful denial of a claim; it cannot be based upon the insurer selling and issuing the policy. *Hays v. Jackson Nat’l Life Ins. Co.*, 105 F.3d 583 (10th Cir. 1997).

2. Third-Party

Third parties who are strangers to an insurance contract cannot maintain an action against an insurer on grounds that insurer failed to negotiate faire and in good faith a settlement with third parties on behalf of the insured because without a contract of insurance, no bad faith can exist. *Allstate Ins. Co. v. Amick*, 1984 OK 15, 680 P.2d 362.

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Fraud

Fraud may be a false statement, a statement made without regard to its truth, or the suppression of the truth. 15 O.S. § 58. The elements of fraud are:

- Defendant made a material misrepresentation that was false;
- Defendant knew when the representations were made that it was false; or Defendant made the representation with disregard for its truth or falsity;
- The representation was made with the intention that Plaintiff act upon it; and
- Plaintiff actually acted upon it to his detriment.

Silk v. Phillips Petroleum Co., 1988 OK 93, 760 P.2d 174, 176-77. The plaintiff has the burden of proving fraud by clear and convincing evidence. *Tice v. Tice*, 1983 OK 108, 672 P.2d 1168, 1171. State law fraud claims arising out of employee benefits package are preempted by ERISA. *Felix v. Lucent Technologies, Inc.*, 2007 OK CIV APP 33, 157 P.3d 769.

Intentional or Negligent Infliction of Emotional Distress

Oklahoma recognizes only intentional infliction of emotional distress as an independent tort, “outrage.” In doing so, the Oklahoma Supreme Court adopted the narrow standards of § 46 of the Restatement (Second) of Torts. In Oklahoma, to recover on a claim of intentional infliction of emotional distress, the plaintiff must prove two elements: 1) The Defendant’s actions in the setting in which they occurred were so extreme and outrageous as to be beyond all possible bounds of decency and would be considered atrocious and utterly intolerable in a civilized society; and 2) the Defendant intentionally or recklessly caused severe emotional distress to plaintiff beyond that which a reasonable person could be expected to endure. *Breeden v. League Serv. Corp.*, 1978 OK 27, 575 P.2d 1374; *see also Computer Publications Inc. v. Welton*, 2002 OK 50, 49 P.3d 732; *Kraszewski v. Baptist Med. Ctr. of Okla., Inc.*, 1996 OK 141, 916 P.2d 241. “[T]he more recent pronouncements of the supreme court have clearly required the actor’s conduct to have been extreme and outrageous and not merely unreasonable.” *Floyd v. Dodson*, 1984 OK CIV APP 57, 692 P.2d 77.

In the context of an bad faith claim, however, damages for mental suffering may be recovered as an element of the tort of bad faith, and the insured need not show severe mental distress or outrageous conduct to recover such damages. *Timmons v. Royal Globe Ins. Co.*, 1982 OK 97, 653 P.2d 907.

State Consumer Protection Laws, Rules and Regulations

The Oklahoma Consumer Protection Act, 15 O.S. § 751 *et seq.*, provides an exception for transactions regulated by other regulatory bodies. 15 O.S. § 754(2). This exception has been held to prohibit application of the Consumer Protection Act to the business of insurance but not to all activities of an insurance company. *See Conatzer v. Am. Mercury Ins. Co.*, 2002 OK CIV APP 141, 15 P.3d 1252.

The Oklahoma Insurance Code prohibits “any trade practice which is ... an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.” 36 O.S. § 1203. Unfair practices in the business of insurance are statutory defined as the following:

- Misrepresentations and false advertising of policy contracts. Making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of

any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies, or making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or using any name or title of any policy or class of policies misrepresenting the true nature thereof, or making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender his or her insurance.

- False information and advertising generally. Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his or her insurance business which is untrue, deceptive or misleading. No insurance company shall issue, or cause to be issued, any policy of insurance of any type or description upon life, or property, real or personal, whenever such policy of insurance is to be furnished or delivered to the purchaser or bailee of any property, real or personal, as an inducement to purchase or bail said property, real or personal, and no other person shall advertise, offer or give free insurance, insurance without cost or for less than the approved or customary rate, in connection with the sale or bailment of real or personal property, except as provided in Section 4101 of this title. No person that is not an insurer shall assume or use any name which deceptively infers or suggests that it is an insurer.
- Defamation. Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance.
- Boycott, coercion and intimidation. Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.
- False financial statements. Filing with any supervisory or other public official, or making, publishing, disseminating, circulating or delivering to any person, or placing before the public or causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person or placed before the public, any false statement of financial condition of an insurer with intent to deceive.
 - Making any false entry in any book, report or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer.
- Stock operations and advisory board contracts. Issuing or delivering or permitting agents, officers, or employees to issue or deliver agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance.

- Unfair discrimination. (a) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.
 - Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.
 - As to kinds of insurance other than life and accident and health, no person shall make or permit any unfair discrimination in favor of particular persons, or between insureds or subjects of insurance having substantially like insuring, risk, and exposure factors, or expense elements, in the terms or conditions of any insurance contract, or in the rate or amount of premium charged therefor. This subsection shall not apply as to any premium rate in effect pursuant to Article 9 of the Oklahoma Insurance Code.
- Rebates.
 - Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of insurance or agreement as to such contract other than as plainly expressed in the contract issued thereon; or paying or allowing, or giving or offering to pay, allow or give, directly or indirectly, as inducement to any contract of insurance, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; except in accordance with an applicable rate filing, rating plan or rating system filed with and approved by the Insurance Commissioner; or giving or selling or purchasing or offering to give, sell, or purchase as inducement to such insurance, or in connection therewith, any stocks, bonds or other securities of any company, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract or receiving or accepting as inducement to contracts of insurance, any rebate of premium payable on the contract, or any special favor or advantage in the dividends or other benefit to accrue thereon, or any valuable consideration or inducement not specified in the contract.
 - Nothing in subsection 7 or paragraph (a) of this subsection shall be construed as including within the definition of discrimination or rebates any of the following practices:
 - In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided, that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interest of the company and its policyholders;
 - In the case of life or accident and health insurance policies issued on the industrial debit or weekly premium plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense;
 - Making a readjustment of the rate of premium for a policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year;
 - In the case of life insurance companies, allowing its bona fide employees to receive a

- commission on the premiums paid by them on policies on their own lives;
- Issuing life or accident and health policies on a salary saving or payroll deduction plan at a reduced rate commensurate with the savings made by the use of such plan; and
 - Paying commissions or other compensation to duly licensed agents or brokers, or allowing or returning to participating policyholders, members or subscribers, dividends, savings or unabsorbed premium deposits.
- As used in this section, the word “insurance” includes suretyship and the word “policy” includes bond.
- Coercion prohibited. Requiring as a condition precedent to the purchase of, or the lending of money upon the security of, real or personal property, that any insurance covering such property, or liability arising from the ownership, maintenance or use thereof, be procured by or on behalf of the vendee or by the borrower in connection with such purchase or loan through any particular person or agent or in any particular insurer, or requiring the payment of a reasonable fee as a condition precedent to the replacement of insurance coverage on mortgaged property at the anniversary date of the policy; provided, however, that this provision shall not prevent the exercise by any such vendor or lender of the right to approve or disapprove any insurer selected to underwrite the insurance; but any disapproval of any insurer shall be on reasonable grounds.
 - Inducements. No insurer, agent, broker, solicitor, or other person shall, as an inducement to insurance or in connection with any insurance transaction, provide in any policy for or offer, sell, buy, or offer or promise to buy, sell, give, promise, or allow to the insured or prospective insured or to any other person in his or her behalf in any manner whatsoever:
 - Any employment.
 - Any shares of stock or other securities issued or at any time to be issued or any interest therein or rights thereto.
 - Any advisory board contract, or any similar contract, agreement or understanding, offering, providing for, or promising any special profits.
 - Any prizes, goods, wares, merchandise, or tangible property of an aggregate value in excess of One Hundred Dollars (\$100.00).
 - Any special favor, advantage or other benefit in the payment, method of payment or credit for payment of the premium through the use of credit cards, credit card facilities, credit card lists, or wholesale or retail credit accounts of another person. The provisions of this paragraph shall not apply to individual policies insuring against loss resulting from bodily injury or death by accident as defined by Article 44 of the Oklahoma Insurance Code.
 - Premature disposal of premium notes prohibited. No insurer or agent thereof shall hypothecate, sell, or dispose of a promissory note received in payment of any part of a premium on a policy of insurance applied for prior to the delivery of the policy.
 - Fraudulent statement in application; penalty. Any insurance agent, examining physician, or other person who knowingly or willfully makes a false or fraudulent statement or representation in or relative to an application for insurance, or who makes any such statement to obtain a fee, commission, money, or benefit shall be guilty of a misdemeanor.
 - Deceptive use of financial institution's name in notification or solicitation. Verbally or by any other means notifying or soliciting any person in a manner that:

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- mentions the name of an unrelated and unaffiliated financial institution,
- mentions an insurance product or the possible lack of insurance coverage,
- does not mention the actual or trade name of the insurance agency or company on whose behalf the notification or solicitation is provided, and
- thereby creates an impression or implication, including by omission, that the financial institution or a financial-institution-authorized entity is or may be the one making the notification or solicitation.

36 O.S. § 1204.

The Oklahoma legislature has set forth certain insurance handling in Okla. Stat. tit. 36 § 1250.5, but violation of the statute does not rise to a private cause of action. *McWhirter v. Fire Ins. Exchange, Inc.*, 1994 OK 93, 878 P.2d 1056. However, violation of the law may be relevant to determining the reasonableness of an insurer's action in a bad faith suit. *Beers v. Hillory*, 2010 OK CIV APP 99, 241 P.3d 285.

Oklahoma Administrative Code, Title 365, Insurance, §§ 365:35-1-10 *et seq.*, requires privacy notices to be sent to consumers advising them of the type of non-public personal information it collects, and categories of affiliates and non-affiliated third parties to whom such information is disclosed. Consumers may opt out of having information shared with nonaffiliated third parties. Regardless of any privacy rights, reports to licensing agencies, those holding beneficial interests, etc., are proper. It also enacts privacy safeguards for confidential medical information.

36 O.S. § 6551 *et seq.*, permits hospital and medical records to be reviewed by private review agents, to determine eligibility for payment and requires insurance companies to enact policies and procedures that ensure all applicable state and federal laws to protect the confidentiality of all medical records are followed. See 36 O.S. § 6559(A)(4).

The conduct of an insurer in falsifying a sworn statement, surreptitiously obtaining confidential government records, actually deceiving by misrepresentation of identity and successfully attempting to gain an advantage over the insured by discouraging legal representation in a legal controversy justified by a substantial award of punitive damages. *Timmons v. Royal Globe Ins. Co.*, 1982 OK 97, 653 P.2d 907.

DISCOVERY ISSUES IN ACTIONS AGAINST INSURERS

Discoverability of Claims Files Generally

Claims files may be discovered in bad faith cases. In *Hall v. Goodwin*, 1989 OK 88, 775 P.2d 291, the court found that investigative material is not privileged unless the investigation was specifically done to assist in litigation, whether in progress or contemplated. "The fact that a defendant anticipates the contingency of litigation resulting from an accident or event does not automatically qualify an 'in house' report as work product.... A more or less routine investigation of a possibly resistible claim is not sufficient to immunize an investigative report developed in the ordinary course of business." *Id.* ¶ 9, 775 P.2d at 774 (citations omitted); see also *Darzenkiewicz v. Jackson*, 1994 OK 151, 904 P.2d 66 (issuing writ of mandamus to permit discovery of claim file and claims manual). There is a rebuttal presumption that neither attorney work product or attorney client privilege protects from discovery an insurer's investigatory file prior to a decision being made on the claim. *Lindley v. Life Inv. Ins. Co. of Am.*, 267 F.R.D. 382 (N.D. Okla. 2010); see also *Scott v. Peterson*, 2005 OK 84, 126 P.3d 1232 (an attorney's claim file is not blanketly protected from discovery if attorney is acting as insurance adjuster in evaluating claim).

Discoverability of Reserves

There is no published Oklahoma case law on point. However, there are several unpublished discovery orders out of federal courts requiring the production of reserves. *See, e.g., Global Client Solutions, LLC v. Executive Risk Indem., Inc.*, Case No. 13-CV-35, 2013 WL 4482992 at *3 (N.D. Okla. Aug. 19, 2013)

Discoverability of Existence of Reinsurance and Communications with Reinsurers

Okla. Stat. tit. 12 § 3226(B)(1)(b) provides that a party “shall produce . . . any insurance under which any person carrying on an insurance business may be liable to satisfy part or all of a judgment which may be entered in the action or to indemnify or reimburse for payments made to satisfy the judgment.” (Emphasis added). Reinsurance or pooling agreements fit into this category, and Oklahoma, since it follows the federal rules when there is no Oklahoma law on point, would likely allow discovery of such agreements as federal courts routinely allow discovery of reinsurance agreements under Rule 26. *See, e.g., U.S. Fire Ins. Co. v. Bunge No. Am., Inc.*, 244 F.R.D. 638, 641-42 (D. Kan. 2007) (production of re-insurance agreements required by rule); *Tardiff v. Knox County*, 224 F.R.D. 522, 523 (D. Me. 2004) (“Federal courts have held that reinsurance agreements are discoverable under Rule 26” because “[r]einsurers . . . are insurer=s own insurers.”); *Potomac Elec. Power Co. v. Ca. Union Ins. Co.*, 136 F.R.D. 1, 2 (D.D.C. 1990) (“[E]xistence and contents of defendants’ reinsurance policies . . . are discoverable”).

Attorney/Client Communications

Where insurer retains counsel to represent insured, insurer and insured are joint clients for purposes of the attorney-client privilege, and each is entitled to disclosure of confidences from the other. 12 O.S.. § 2502(D)(6). Additionally, whether the attorney-client privilege and/or attorney client privilege protects a document from disclosure is determined by the primary purpose of the information. *Lindley v. Life Inv. Ins. Co.*, 267 F.R.D. 382 (N.D. Okla. 2010). Information with a primary purpose of serving the insurer’s business interests is not protected. *Id.*

Additionally, if an insurer asserts that it relied upon the advice of counsel as a defense to a bad faith claim, the attorney-client privilege and work product protection would obviously be waived.

DEFENSES IN ACTIONS AGAINST INSURERS

Misrepresentations/Omissions: During Underwriting or During Claim

36 O.S. § 3609 provides that statements in insurance applications are considered representations, not warranties, and that misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent recovery under the policy unless: 1) fraudulent, 2) material to the risk of hazard of the insurer, or 3) the insurer in good faith would not have issued the policy at all, or would have issued a policy with different terms if it knew the true facts.

In order for an insurer to escape liability under this section for misrepresentation in the application process, the insurer bears the burden of proof to show not only that the statements were untrue, but also that the statements were willfully false, fraudulent and misleading, that the statements were made in bad faith, and that the

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applicant's alleged misstatements were relied on by the insurer. *City Bank and Trust Co. v. Jackson Nat. Life Ins. Nat'l.*, 1990 OK CIV APP 89, 804, P.2d 463. When an insurer seeks to void an insurance contract on the basis of a misrepresentation by the insured, the burden is on the insurer to plead and prove the facts necessary to sustain its defense of misrepresentation, fraud or concealment. *Adams v. Nat'l Cas. Co.*, 1957 OK 6, 307 P.2d 542.

Oklahoma law requires a finding of intent to deceive before an insurer can avoid the policy for statements made in an application. *Hays v. Jackson Nat'l Life Ins. Co.*, 105 F.3d 583 (10th Cir. 1997). The existence of a single material misrepresentation in an application, knowingly made, is sufficient to support rescission of an insurance policy. *Burgess v. Farmers New World Life Ins. Co.*, 12 F.3d 992 (10th Cir. 1993). In 2005, the Oklahoma Supreme Court reaffirmed its prior holding in three cases that a finding of the insured's intent to deceive is required before a misrepresentation, an omission or incorrect statement in an application can void a policy under 36 O.S. § 3609. *Scottsdale Ins. Co. v. Tolliver*, 2005 OK 93, 127 P.3d 611 (citing *Massachusetts Mutual Life Ins. Co. v. Allen*, 1965 OK 203, 416 P.2d 935); *Brunson v. Mid-Western Life Ins. Co.*, 1976 OK 32, 547 P.2d 970; *Claborn v. Washington National Ins. Co.*, 1996 OK 8, 910 P.2d 1046. Whether or not an insured intended to deceive the insurer is a matter for the jury, whose decision cannot be reviewed upon appeal. *Benson v. Leaders Life Ins. Co.*, 2012 OK 111, 339 P.3d 843.

Public policy prohibits an insurer from avoiding liability to an innocent third party under a voidable policy of compulsory automobile liability insurance because of a misrepresentation by the insured in the insurance application after an accident has occurred in such a way as to trigger coverage. *Harkrider v. Posey*, 2000 OK 94, 24 P.3d 821.

However, false swearing by an insured during the process of a claim's investigation may create a legitimate dispute as to coverage sufficient to preclude a claim for bad faith. *Thompson v. State Farm Fire & Cas. Co.*, 34 F.3d 932 (10th Cir. 1994).

Failure to Comply with Conditions

The failure to comply with notice conditions will be a defense to a claim. *First Bank of Turley v. Fidelity and Deposit Ins. Co.*, 1996 OK 105, 928 P.2d 298. Generally, prejudice must be shown by the insurer before it can rely upon failure to comply with policy provisions. *Independent School District v. Jackson*, 1980 OK 38, 608 P.2d 1153. "The general rule is that a provision in an automobile liability policy requiring that the insured forward to the insurer every demand, notice, summons or other process received by the insured is unambiguous, reasonable, valid, and a condition precedent to recovery on the policy. The purpose of this policy provision is to enable the insured to inform the insurer of the lawsuit so that it may investigate the accident, and prepare a timely defense for the insured. However, unless the insurer is prejudiced from the lack of notice, failure to give the insurer notice will not relieve the insurer from liability for the accident." *Id.* at § 6, 608 P.2d at 1155. This is no longer true, however, in cases involving compulsory automobile insurance. The public policy behind compulsory insurance, to protect the public, prohibits the insurer from utilizing the insured's failure to cooperate to avoid coverage. *Baldrige v. Kirkpatrick*, 2003 OK CIV APP 9, 63 P.3d 568.

Challenging Stipulated Judgments: Consent and/or No-Action Clause

Neither consent to sue clauses nor no action clauses will be upheld in UM cases. *Keel v. MFA Ins. Co.*, 1976 OK 86, 553 P.2d 153; *Biles v. State Farm Mut. Auto. Ins. Co.*, 1974 OK CIV APP 15, 521 P.2d 890. If an insurer had notice of an action and fails to defend, it will be bound by the judgment. *First Bank of Turley v. Fidelity and Deposit Ins. Co.*, 1996 OK 105, 928 P.2d 298. However, the insurer is only bound to the material facts established in that suit.

In *United States Fidelity & Guaranty Co. v. Dawson*, 1937 OK 317, 68 P.2d 105, the Oklahoma Supreme Court held:

One who is required either by law or contract to protect another from liability is bound by the result of the litigation to which such other is a party, provided the former had notice of such litigation and an opportunity to control its proceedings; a judgment against a party indemnified is conclusive in a suit against his indemnitor only as to the material facts therein established.

Id. Thus, where the suit was not dependent upon establishing that the plaintiff was the defaulted defendant's employee, the insurance company could still litigate the issue of whether the plaintiff was an employee. *Id.* This holding was reaffirmed in *Henderson v. Eaves*, 1973 OK 139, 516 P.2d 270, where the Supreme Court held an insurer who had denied coverage for a claim was not bound to facts recited in a judgment which were not essential to the judgment.

Preexisting Illness or Disease Clauses

Oklahoma follows the rules of contract interpretation when there is any question about an insurance policy provision. An insurance policy provision precluding recovery for pre-existing disabilities is strictly construed against the insurer. *C.I.T. Fin. Serv. Inc. v. McDermitt*, 1975 OK CIV APP 69, 544 P.2d 913.

The typical policy provision interpreted by Oklahoma courts provides that there is no coverage for disability or sickness caused by a pre-existing for which medical advice, consultation, or treatment was required or recommended by a physician within a certain time prior to the effective date of the policy, or which first manifests itself after the effective date of the policy. *Harrell v. All-American Ins. Co.*, 1991 OK CIV APP 91, 829 P.2d 75. Under Oklahoma law, accident provisions that disallow recovery if bodily infirmity or disease contributes to death, or if death is the result or occurrence of accidental injury and pre-existing bodily infirmity or disease are binding. *Minyen v. American Home Assur. Co.*, 443 F.2d 788 (10th Cir. 1971). Proximate cause is not applicable. If pre-existing condition contributes in some degree to the loss, recovery is barred. Whether a pre-existing condition contributes to the condition creating the disability is a fact question. *Hart v. Ins. Co. of North America*, 458 F.2d 379 (10th Cir. 1972).

Statutes of Limitations and Repose

There is a five-year statute of limitations under Oklahoma law for "[a]n action upon any contract, agreement, or promise in writing." 12 O.S. § 95 (A)(1). The statute of limitations begins to run upon breach of contract. *Willie v. Geico Cas. Co.*, 2000 OK 10, 2 P.3d 888. The limitations period for bad faith is two years, and begins to run when the insured knows, or should know, that the right to such a claim exists. *Miller v. Liberty Mutual Fire Ins. Co.*, 2008 OK CIV APP 65, 191 P.3d 1221.

TRIGGER AND ALLOCATION ISSUES FOR LONG-TAIL CLAIMS

Trigger of Coverage

In an "occurrence" policy, coverage is triggered by a covered event occurring during the policy period. The date the insured learns of the occurrence and the date the insured provides notice of the covered occurrence are not relevant. In a "claims made" policy, coverage is triggered when the insured becomes aware of either a claim against the insured, or an occurrence that might give rise to a claim, and notifies the insurer of the claim or occurrence during the policy period. *Ass'n of County Commissioners of Okla. v. Nat'l Am. Ins. Co.*, 2005 OK CIV APP

44, 116 P.3d 206.

Allocation Among Insurers

As between insurers with similar coverage, the “other insurance” provisions control allocation. In *Equity Mutual Ins. Co. v. Spring Valley Wholesale Nursery, Inc.*, 1987 OK 121, 747 P.2d 947, the Court identified three types of “other insurance” clauses, primary, pro-rata and excess. The Court outlined how each is to be interpreted. As between a primary policy and either a pro-rata or excess policy, the primary policy is primary. A pro-rata policy is primary over an excess policy. When a policy contains an “escape” clause, providing that no coverage exists if there is any other coverage, such policy is primary over an excess policy, but the provision is effective as to a pro-rata policy, which becomes primary. If two excess or “escape” policies exist, both become pro-rata.

Regardless, a primary insurer has an independent duty to defend and indemnify its insured according to the policy terms, and the appropriate response to an allocation issue is to defend/indemnify the insured, then seek reimbursement from other primary insurance companies in an ancillary proceeding. *Mustain v. U.S. Fidelity & Guar. Co.*, 1996 OK 98, 925 P.2d 533.

CONTRIBUTION ACTIONS

Claim in Equity vs. Statutory

Oklahoma statutorily recognizes a right of contribution amongst joint tortfeasors who are jointly and severally liable for the same injury and who have paid more than their pro rata share of common liability. 12 O.S. § 832(A)-(B). The right does not exist in favor of any tort-feasor who has intentionally caused or contributed to an injury or death. 12 O.S. § 832(C). A tortfeasor’s liability insurer who discharges the tortfeasor’s liability is subrogated to the tortfeasor’s right of contribution to the extent it has paid in excess of the tortfeasor’s share of common liability. 12 O.S. § 832(E). Oklahoma does not have a statutory basis for allowing contribution directly between insurance companies who insure the same risk.

Oklahoma recognizes the doctrine of equitable contribution between insurance companies in certain situations. In *U.S. Fidelity and Guar. Co. v. Federated Rural Elec. Ins. Corp.*, 2001 OK 81, 37 P.3d 828, the court distinguished between equitable subrogation and equitable contribution. The latter is designed to allow an insurer which has paid more than its proportionate share to recover from another insurer which has coverage on the same risk and the same insured at the same level. Contribution does not lie between a primary and excess insurer, absent an agreement. Contribution does not extend to cost of defense, which is personal to each insurer. *Fidelity & Casualty Co. of New York v. Ohio Casualty Insurance Co.*, 1971 OK 31, 482 P.2d 924; *see also United Svcs. Auto Ass’n v. State Farm Fire & Cas. Co.*, 2005 OK CIV APP 21, 110 P.3d 570 (duty to defend is personal to each insurer and the insurer is not entitled to divide the duty nor require contribution from another insurer); *but see Am. Cas. Co. of Reading, PA v. Health Care Indem., Inc.*, 520 F.3d 1131 (10th Cir. 2008) (refusing to following *United Svcs. Auto Ass’n* and dividing defense costs on a pro rata basis).

Elements

For equitable contribution, an insurer must be insuring the same risk, for the same insured, and at the same level (i.e., both primary or both excess), as another insurer, and must have paid more than the company’s proportionate share of the loss. *U.S. Fidelity and Guar. Co. v. Federated Rural Elec. Ins. Corp.*, 2001 OK 81, 37 P.3d 828. If the insureds are different, or the level of coverage is different, contribution is not allowed. *Id.*; *Home*

Indemnity Co. v. Thompson, 1967 OK 201, 434 P.2d 250.

DUTY TO SETTLE

An insurer has a duty to tender the policy limits when damages would clearly exceed available insurance coverage. *Barnes v. Okla. Farm Bureau Mut. Ins. Co.*, 2000 OK 55, 11 P.3d 162. Additionally, an insurer must timely and adequately inform the insured of the progress of settlement negotiations, and an insurer must act to protect its insured facing an excess judgment and offer settlement even if the claimant has not tendered an unconditional settlement offer. *Badillo v. Midcentury Ins. Co.*, 2005 OK 48, 121 P.3d 1080.

LH&D BENEFICIARY ISSUES

Change of Beneficiary

A person may procure an insurance contract on his or her own life for the benefit of any person. 36 O.S. § 3604(A)(1). A change of beneficiary form can be considered effective as of the date the form is signed, where the form has been given to the financial planner, and the only step not performed is the planner's ministerial act of mailing the form. *Am. Fin. Life Ins. & Annuity Co. v. Youn*, 7 Fed. Appx. 913 (10th Cir. 2001). While a change of beneficiary must be performed by following the method set out in a policy, liberal interpretation will be given if the intent of the insured is clear and the insured did everything reasonable within his power to effectuate the change. *Dalton v. LeBlanc*, 350 F.2d 95 (10 Cir. 1965); *Shaw v Loeffler*, 1990 OK 81, 796 P.2d 633. The effective date of the beneficiary change will be the date the insured signed the beneficiary change form and delivered it to his agent. *Youn*, 7 Fed. Appx. at *5.

Effect of Divorce on Beneficiary Designation

Okl. Stat. tit. 15 § 178 provides for automatic revocation of a former spouse as a life insurance beneficiary upon divorce as follows:

- If, after entering into a written contract in which a beneficiary is designated or provision is made for the payment of any death benefit (including life insurance contracts, annuities, retirement arrangements, compensation agreements, depository agreements, security registrations, and other contracts designating a beneficiary of any right, property, or money in the form of a death benefit), the party to the contract with the power to designate the beneficiary or to make provision for payment of any death benefit dies after being divorced from the person designated as the beneficiary or named to receive such death benefit, all provisions in the contract in favor of the decedent's former spouse are thereby revoked. Annulment of the marriage shall have the same effect as a divorce. In the event of either divorce or annulment, the decedent's former spouse shall be treated for all purposes under the contract as having predeceased the decedent.
- Subsection A of this section shall not apply:

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- If the decree of divorce or annulment is vacated;
- If the decedent had remarried the former spouse and was married to said spouse at the time of the decedent's death;
- If the decree of divorce or annulment contains a provision expressing an intention contrary to subsection A of this section;
- If the decedent makes the contract subsequent to the divorce or annulment;
- To the extent, if any, the contract contains a provision expressing an intention contrary to subsection A of this section; or
- If the decedent renames the former spouse as the beneficiary or as the person or persons to whom payment of a death benefit is to be made in a writing delivered to the payor of the benefit prior to the death of the decedent and subsequent to the divorce or annulment.
- For purposes of subsection A of this section, “death benefit” shall not include:
 - Any interest in property in which the decedent's former spouse has an interest as a joint tenant; or
 - Any interest in property in which the decedent's former spouse has a beneficial interest in an express trust created by the decedent during the decedent's lifetime for which provision is made in Section 175 of Title 60 of the Oklahoma Statutes.
- This section shall apply to any contract of a decedent made and entered into on or after November 1, 1987 and to depository agreements and security registrations made and entered into on or after September 1, 1994.

INTERPLEADER ACTIONS

Availability of Fee Recovery

An interpleader in Oklahoma is governed by 12 O.S. § 2022. It provides that a party who may be exposed to double or multiple liability may join as defendants any party having a claim against the party. It is not a ground for objection to the joinder that the claims of the several claimants do not have a common origin or are not identical, but are adverse to and independent of one another. Likewise, the fact that the plaintiff claims that he is not liable in whole or in part is not a basis for objection. A defendant exposed to similar liability may interplead by way of a cross-claim or counterclaim. 12 O.S. § 2022 (A).

If the party seeking relief claims no interest in the subject of the action, and the subject of the action has been deposited with the court (or person designated by the court), the party is to be discharged from the action and from liability, and awarded its costs, and in the discretion of the court, a reasonable attorney fee. 12 O.S. § 2022 (C).

Differences in State vs. Federal

The federal counterpart to Oklahoma’s interpleader statute, Fed R. Civ. P. 22, does not contain a provision similar to Oklahoma’s subsection C, providing for costs and discretionary attorney fees. Additionally, unless an insurer is a defendant before filing the interpleader action, the insurer would have to satisfy the elements for federal

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jurisdiction found in 28 U.S.C. § 1332 (amount in controversy exceeding the jurisdictional minimum, currently \$75,000, and parties having complete diversity of citizenship).