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Utah

REGULATORY LIMITS ON CLAIMS HANDLING

Timing for Responses and Determinations

- 15-days to acknowledge the receipt of claim, unless payment is made within such period of time, or the insurer has a reason acceptable to the Insurance Department. UTAH ADMIN. CODE R. 590-190-6(1).
- 15-days to provide a substantive response to a claimant whenever a response has been requested; and upon receiving notification of a claim, provide all necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. UTAH ADMIN. CODE R. 590-190-6(2) and (3).
- 30-days after receipt by the insurer of a properly executed proof of loss, the insurer shall complete its investigation of the claim and the first party claimant shall be advised of the acceptance or denial of the claim by the insurer unless the investigation cannot be reasonably completed within that time. UTAH ADMIN. CODE R. 590-190-10(2).
- 30-days, after the receipt of proof of loss, for insurer to notify the first party claimant if the insurer needs more time to determine whether a first party claim should be accepted or denied. UTAH ADMIN. CODE R. 590-190-10(2).
- 45-days after sending the initial notification (and within every 45-days thereafter) if the investigation remains incomplete, the insurer shall send to the first party claimant a letter setting forth the reasons additional time is needed for the investigation, unless the first party claimant is represented by legal counsel or public adjuster. UTAH ADMIN. CODE R. 590-190-10(2).
- Unless otherwise provided by law, an insurer shall promptly pay every valid insurance claim. A claim shall be overdue if not paid within 30-days after the insurer is furnished written proof of the fact of a covered loss and of the amount of the loss. Payment shall mean actual delivery or mailing of the amount owed. If such written proof is not furnished to the insurer as to the entire claim, any partial amount supported by written proof or investigation is overdue if not paid within 30-days. Payments are not deemed overdue when the insurer has reasonable evidence to establish that the insurer is not responsible for the payment, notwithstanding that written proof has been furnished to the insurer. UTAH ADMIN. CODE R. 590-190-10(3).
- If negotiations are continuing for settlement of a claim with a claimant, who is not represented by legal counsel or public adjuster, notice of expiration of the statute of limitation or contract time limit shall be given to the claimant at least 60 days before the date on which such time limit may expire. UTAH ADMIN. CODE R. 590-190-10(4).

Standards for Determination and Settlements

- The “Minimum Standards for Determination and Settlements” are set forth in the Utah Admin. Code R. 590-190-10.
- The standards for “Prompt, Fair and Equitable Settlements to Automobile Insurance” are set forth in Utah Admin. Code R. 590-190-11.
- The standards for “Unfair Claims Settlement Practices Applicable to Automobile Insurance” are set forth in Utah Admin Code. R. 590-190-12.
- The “Standards for Prompt, Fair and Equitable Settlements Applicable to Fire and Extended Coverage Type Policies with Replacement Cost Coverage” are set for in Utah Admin. Code R. 590-190-13.
- Note: Utah courts have held that Utah Admin Code. R. 590-190-10 through 13 does not create a private cause of action. *See Cannon v. Travelers Indem. Co.*, 994 P.2d 824, 829 (Utah App. 2000).

PRINCIPLES OF CONTRACT INTERPRETATION

Utah courts have held that insurance policies are generally interpreted according to rules of contract interpretation. *Utah Farm Bureau Ins. Co. v. Crook*, P.2d 685, 688 (Utah 1999). The rules provide that courts interpret words in insurance policies according to their usually accepted meanings and in light of the insurance policy as a whole. *See id.* Insurers "may exclude from coverage certain losses by using language which clearly and unmistakably communicates to the insured the specific circumstances under which the expected coverage will not be provided." *See id.* (quoting, *Alf v. State Farm Fire & Cas. Co.*, 850 P.2d 1272, 1275 (Utah 1993)).

Additionally, Utah courts have held that insurance policies should be strictly construed against the insurer and in favor of the insured. Insurance policies are intended for public sale. *United States Fidelity & Guar. Co. v. Sandt*, 854 P.2d 519, 521–22 (Utah 1993). When drafted, these policies are drafted by the insurers and delivered to the insured who is typically not in a position to understand the details, terms, and meaning of the policy. *See id.* Therefore, as a matter of public policy, ambiguous or uncertain language in an insurance contract must be interpreted and construed as an “ordinary purchaser” would understand it. *See id* at 523.

CHOICE OF LAW

If a policy does not contain a choice-of-law provision, Utah courts have applied the guidelines of the Restatement (Second) of Conflicts of Law. It states: “[t]he rights and duties of parties with respect to an issue of contract are determined by the local law of the state, which, with respect to that issue, has the most significant relationship to the transaction of the parties.” Restatement (Second) of Conflicts of Law, § 188(1). In evaluating which state has the “most significant relationship,” courts consider the following: (a) the place of contracting; (b) the place of negotiating the contract; (c) the place of performance; (d) the location of the subject matter of the contract; and (e) domicile, residence, nationality, place of incorporation and place of business of the parties. *Overthrust Constructors, Inc. v. Home Ins. Co.*, 676 F. Supp. 1086 (D. Utah 1987).

DUTIES IMPOSED BY STATE LAW

Duty to Defend

1. Standard for Determining Duty to Defend

A policy containing motor vehicle liability coverage imposes on the insurer the duty to defend, in good faith, any person insured under the policy against any claim or suit seeking damages which would be payable under the policy. Utah Code Ann. § 31A-22-303(5). This is the only statute which addresses the duty to defend, the remaining law in Utah is common law established by the courts.

Utah courts have held that an insurer's duty to defend arises when the insurer ascertains facts giving rise to potential liability under the insurance policy. *Sharon Steel Corp. v. Aetna Cas. & Sur. Co.*, 931 P.2d 127, 133 (Utah 1997). This potential liability is determined by referring to the allegations in the underlying complaint. *See id.* When those allegations, if proved, could result in liability under the policy, then the insurer has a duty to defend. *See id.* The Utah Supreme Court has held that the scope of the insurer's duty to defend is based on the insurance contract itself. *Equine Assisted Growth & Learning Ass'n v. Carolina Cas. Ins. Co.*, 2011 UT 49, ¶ 8, 266 P.3d 733, 736 (Utah). An insurance contract may base the duty to defend on the face of the complaint and its allegations, or on the facts and circumstances underlying the complaint. *See id.* The Utah Supreme Court further held that whether an insurer must consider extrinsic evidence in determining a duty to defend turns on the contractual terms of the policy. *See id.* ¶¶ 10-11. If the language found within the collective "eight corners" of the policy clearly and unambiguously indicates that a duty to defend does or does not exist, then the analysis is complete and extrinsic evidence is not needed. *Travelers Prop. Cas. Co. of Am. v. Fed. Recovery Servs.*, 156 F. Supp. 3d 1330, 1334 (D. Utah 2016). However, when that language is not found the Court held the following:

If the parties make the duty to defend dependent on the allegations against the insured, extrinsic evidence is irrelevant to a determination of whether a duty to defend exists. However, if, for example, the parties made the duty to defend dependent on whether there is actually a 'covered claim or suit,' extrinsic evidence would be relevant to a determination of whether a duty to defend exists.

Id. at 1335 (quoting *Fire Ins. Exch. v. Estate of Therkelsen*, 2001 UT 48, 27 P.3d 555, 561) see [Hamlet Homes Corp. v. Mid-Continent Cas. Co., 2013 U.S. Dist. LEXIS 3616, 10 \(D. Utah 2013\)](#) (court ruled that extrinsic evidence was relevant in the determination of duty to defend, but when insurer seeks discovery as to the extrinsic evidence, the insurer owes a duty to defend the insured while conducting that discovery); but compare *Fire Ins. Exch. v. Estate of Therkelsen*, 2001 UT 48, ¶¶ 21-23, 27 P.3d 555 (identifying as an example of policy language requiring "eight corners" rule, as being when the policy language states that the insurer has a duty to defend even if the suit is "groundless, false or fraudulent). See also *Atain Specialty Ins. Co. v. R. White Constr., Inc.* 2022 WL 4290098 (D. Utah 2022)

Where factual questions render coverage uncertain, the liability insurer must defend until those uncertainties can be resolved against coverage. *Benjamin v. Amica Mut. Ins. Co.*, 2006 UT 37, 140 P.3d 1210, 1215 (complaint alleged intentional sexual assault or negligent infliction of emotional distress in the alternative; insurer had duty to defend until the factual dispute was resolved;

"Where an insurance policy obligates an insurer to defend claims of unintentional injury, the insurer is obligated to do so until those claims are either dismissed or otherwise resolved in a manner inconsistent with coverage . . . [w]hen in doubt defend"). In the Summer of 2014, the Utah Supreme Court reaffirmed the foregoing tenet by stating: "If the underlying complaint alleges *any facts* or claims that might fall within the ambit of the policy," the insurer must offer a defense." *Summerhaze Co., L.C. v. FDIC*, 2014 UT 28, ¶ 36, 332 P.3d 908 (emphasis within) (quoting *Cyprus Amax Minerals Co. v. Lexington Ins. Co.*, 74 P.3d 294, 301 (Colo. 2003)).

Moreover, the *Summerhaze* case contains dicta articulating a two-option rule for an insurer in responding to an insured's tender of defense, either file a declaratory judgment proceeding or defend under a reservation of right. The court stated:

Once presented with a tender of defense, an insurer that believes it is not liable for coverage has two options. The insurer may either "protect its interests through a declaratory judgment proceeding" asking the court to determine coverage under an insurance policy, or it may "defend the suit under a reservation of its right to seek repayment later." However, an insurer "may not refuse the tendered defense of an action unless a comparison of the policy with the underlying complaint shows on its face that there is no potential for coverage." An insurer "that refuses a tender of defense by its insured takes the risk not only that it may eventually be forced to pay the insured's legal expenses but also that it may end up having to pay for a loss that it did not insure against."

Id. at ¶ 38 (footnotes omitted). The issue before the court in *Summerhaze* was whether the district court properly dismissed a creditors' suit against an insolvent bank which was filed prior to the bank going into receivership for lack of subject matter jurisdiction because the creditor failed to timely comply with the administrative creditor claim requirements once the receivership was filed. The creditor's suit had been tendered to the bank's liability insurer prior to receivership and the insurer had filed a declaratory judgment suit to contest coverage. The issue of the duty to defend was only addressed in relation of whether the bank, rather than the insurer, was the real party in interest in the district court suit. The court found that the insured bank and the FDIC were the real parties in interest and retain the ability to resolve the claims and therefore those claims fell within the parameters of the receivership.

2. Issues with Reserving Rights

An insurer may reserve its rights to invoke coverage defenses, and it is common practice. Retained counsel are assumed to represent both the insurer and the insured unless a conflict arises, in which event counsel's duty of loyalty is exclusively toward the insured. Additionally, it is fairly rare in Utah for a reservation of rights to be invoked after its initial issuance. As a result of these factors, insurers who are defending under a reservation of rights generally are not required to provide independent counsel.

The Utah Supreme Court addressed the question of whether an insurer can seek reimbursement against its insured. In *U.S. Fidelity v. U.S. Sports Specialty*, the Utah Supreme Court declined to adopt the proposed approach in the Restatement (Third) of Restitution and Unjust Enrichment. *U.S. Fidelity v. U.S. Sports Specialty*, 2012 UT 3, 270 P.3d 464. The Court noted that restitution and unjust enrichment are extra-contractual remedies. See *Id.* at ¶ 12. The Court further noted

that Utah's insurance code requires all terms of an insurance policy be set forth in writing. *Id.* at ¶ 18; *see also* Utah Code Ann. § 31A-21-106(1)(a). Consequently, under the *U.S. Fidelity* case, an insurer may claim a right to reimbursement for a claim filed in Utah only if the express terms of the insurance contract create an enforceable right to reimbursement. *Id.; see also Hartford Cas. Ins. v. Swapp L., PLLC*, 2019 WL 3500520 at * 5, fn. 4 (D. Utah 2019).

Notwithstanding the ruling in *U.S. Fidelity*, the Utah Supreme Court in the 2014 *Summerhaze* case may have possibly opened a door for an exception to the no reimbursement rule when the insurer seeks repayment of defense fees when it accepts defense under a reservation of rights. The Court made a statement about an insurer seeking repayment of defense fees when it generally discussed an insurer's options for responding to a tender of defense: "Once presented with a tender of defense, an insurer that believes it is not liable for coverage has two options. The insurer may either "protect its interests through a declaratory judgment proceeding" asking the court to determine coverage under an insurance policy, or it may "defend the suit under a reservation of its right to seek repayment later." *Summerhaze*, 2014 UT 28, ¶ 38 (quoting Hartford Accident & Indem. Co. v. Gulf Ins. Co., 776 F.2d 1380, 1382 (7th Cir. 1985)). However, as stated above, the portion of the *Summerhaze* opinion addressing tenders of defense is dicta.

The Utah Supreme Court affirmed a jury verdict finding in favor of the insured based on promissory estoppel that the insurer was estopped from denying coverage and had to reimburse the insured for the settlement it reached with the claimant because insurer defended an insured for eight years without questioning or reserving its right to deny coverage. *UMIA Insurance, Inc. v. Saltz*, 2022 UT 21, 515 P.3d 406 (Utah 2022).

State Privacy Laws; Insurance Regulatory Issues; Arbitration/Mediation

1. Criminal Sanctions

Under Utah's Fraudulent Insurance Act, a violation of UTAH CODE ANN. § 76-6-521(1)(a) is a class B misdemeanor. See UTAH CODE ANN. § 76-6-521 (2)(a). A violation of UTAH CODE ANN. § 76-6-521(1)(b) through (1)(g) is punishable as in the manner prescribed by UTAH CODE ANN. § 76-10-1801 for communication fraud for property of like value. See UTAH CODE ANN. § 76-6-521 (2)(a).

2. The Standards for Compensatory and Punitive Damages

o Compensatory Damages

The Model Utah Jury Instructions, Second Edition ("MUJI 2d") provides the following standards for compensatory damages in tort:

- Economic Damages (previously identified as "special damages"): Economic damages are the amount of money that will fairly and adequately compensate the plaintiff for the measurable losses off money or property caused by the defendant's fault.
- Noneconomic Damages (previously identified as "general damages"): Noneconomic damages are the amount of money that will fairly and adequately compensate the plaintiff for losses other than economic losses. Noneconomic damages are not capable

of being exactly measured, and there is no fixed rule, standard or formula for them. In awarding noneconomic damages, among the things that you may consider are:

- the nature and extent of injuries;
- the pain and suffering, both mental and physical;
- the extent to which plaintiff has been prevented from pursuing her ordinary affairs;
- the degree and character of any disfigurement;
- the extent to which plaintiff has been limited in the enjoyment of life; and
- whether the consequences of these injuries are likely to continue and for how long.

Other specific standards for compensatory damages (e.g., loss of earnings, injury to real property, personal property, loss of use etc.) are set forth in Civil Instructions 2000 of the MUJI 2d.

o Punitive Damages

Utah has a punitive damage statute, Utah Code Ann. § 78B-8-201 (formerly 78-18-1), and it provides, in relevant part:

- (a) Except as other provided by statute, punitive damages may be awarded only if compensatory or general damages are awarded and it is established by clear and convincing evidence that the acts or omissions of the tortfeasor are the result of willful and malicious or intentionally fraudulent conduct, or conduct that manifests a knowing and reckless indifference toward, and a disregard of, the rights of others.

* * * *

- Evidence of a party's wealth or financial condition shall be admissible only after a finding of liability for punitive damages has been made.
- (a) In any case where punitive damages are awarded, the judgment shall provide that 50% of the amount of the punitive damages in excess of \$20,000 shall, after an allowable deduction for the payment of attorney's fees and costs, be remitted by the judgment debtor to the state treasurer for deposit in the General Fund.

Utah courts have ruled that punitive damages "cannot be awarded for a breach of contract unless the breach amounts to an independent tort." *Highland Constr. Co. v. Union Pacific R.R. Co.*, 683 P.2d 10424, 1049 (Utah 1984); *see also Christensen v. Mid-Century Ins. Co.*, 2020 WL 619437, at *3 (D. Utah 2020) (ruling that punitive damages not available in case of first-party breach of insurance contract and bad faith claims).

3. Insurance Regulations to Watch

Utah's insurance regulations are set forth in Rule 590 of the Utah Administrative Code. Those regulations addressing unfair claims settlement practices are set forth in subsections 190-192 of Rule 590. These regulations are promulgated under the authority of Utah's claims practices statutes, Utah Code Unann. §§ 31A-26-301 *et seq.* Section 31A-26-303(5) expressly states that the unfair claims settlement practices provisions do not create any private cause of action. *See Machan v. Unum*, 2005

UT 37, 116 P.3d 342 (acknowledging that the Unfair Claims Settlement Practices Act does not create a private cause of action).

4. State Arbitration and Mediation Procedures

Title 78B Chapter 10 of the Utah Code is entitled to the Utah Uniform Mediation Act and applies to all mediations other than conducted within collective bargaining relationship or conducted by a judge who might make a ruling on the case. Utah Code Unann. §§ 78B-10-101 *et seq.*

As it relates to arbitration in the realm of third-party bodily injury claims, Utah Code Unann. 31A-22-321 allows a plaintiff, whose bodily injury claim is limited to a recovery of \$50,000 or less, to elect to submit his/her claim to arbitration within 14 days after the complaint has been answered. These are known as 321 Arbitration. The statute requires that discovery be completed within 150 days, and generally, the parties agree to a single arbitrator to resolve their claims. There is a right to appeal the arbitrator's decision to the district court level, but the moving party may owe nonmoving party's costs if they are not successful in their appeal.

As it relates to arbitration in the realm of underinsured motorists claims, Utah's Underinsured Motorist statute, Utah Code Unann. § 31A-22-305.3(8), specifically permits the "covered person"/claimant to elect either binding arbitration or litigation in resolving their UIM claim. That election is only available to the claimant unless the insurance policy provides that arbitration can be elected by either the insured or insurer. Subsection (8) of § 31A-22-305.3 sets the specific procedures and rules governing the arbitration.

Additionally, Rule 590-122 of the Utah Administrative Code regulates and establishes what is a permissible contract arbitration provision for insurance policies.

5. State Administrative Entity Rule-Making Authority

The Utah Insurance Department Commissioner has the authority to make rules to implement the provisions of the Utah's Insurance Code according to the procedures and requirements of Utah Code Unann. §§ 63G-3-301 *et seq.* and § 31A-2-201.

EXTRACONTRACTUAL CLAIMS AGAINST INSURERS: ELEMENTS AND REMEDIES

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

All contracts, and particularly insurance contracts, include an implied covenant or duty of good faith and fair dealing. Failure to comply with this implied duty has given rise to the shorthand reference of "bad faith." No ill will, evil motive, or malice need be shown by the insured in order for one party to the contract to make out a case of "bad faith" against the other. The duty of good faith and fair dealing applies equally to all parties to the contract, the insured and the insurer. Under this covenant, the contracting parties each impliedly promise not to "intentionally or purposefully do anything [that] will destroy or injure the other party's right to receive the fruits of the contract." *Brown v. Moore*, 973 P.2d 950, 954 (Utah 1998).

In *Machan v. Unum*, 2005 UT 37, 116 P.3d 342, the Utah Supreme Court reiterated that "the unique nature and purpose of an insurance contract," which is "not only to provide funds in case of loss, but to provide peace of mind for the insured or his beneficiaries." *Id.* at ¶ 12 (citing *Beck Farmers Insurance Exchange*, 701 P.2d 795, 802

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(Utah 1985)). Essentially, what the insured has bargained for in the context of an insurance contract includes both “peace of mind” and the insurance company’s payment of whatever sum is owed “within a reasonable period of time.” *See id.*

It should be noted that in most “bad faith” cases there are essentially two separate claims, one for breach of the express terms of the policy, *i.e.*, for coverage, and one for breach of the implied duty of good faith and fair dealing. The Utah courts have concluded that these two duties have separate theoretical underpinnings and give rise to independent recoveries. *Christiansen v. Farmers Insurance Exchange*, 2005 UT 21, 116 P.3d 259. The claim for coverage is based upon the express terms of the policy, which can be negotiated, modified, or even waived by the parties. By contrast, the duty of good faith and fair dealing is implied in law and cannot be altered or waived by either party. *Id.* ¶ 10. The result is that some remedies may be available for breach of the duty of good faith and fair dealing that are not available for breach of the express provisions of the policy. *Id.* Additionally, since they are separate (breach of express provisions of the policy vs. breach of implied covenant), Utah courts have found that the absence of coverage does not preclude a bad faith claim. *Id.*

1. First Party

- General Duties

In *Beck v. Farmers Insurance Exchange*, 701 P.2d 795 (Utah 1985), a case involving a claim for uninsured motorist benefits, the Utah Supreme Court first identified the duties required of an insurer to comply with the implied covenant of good faith and fair dealing in the first-party context (or pre-suit period in the third-party liability context, as in our case). These duties are: [1] that the insurer will diligently investigate the facts to enable it to determine whether a claim is valid; [2] will fairly evaluate the claim; [3] will thereafter act promptly and reasonably in rejecting or settling the claim; [4] to deal with laymen as laymen and not as experts in the subtleties of law and underwriting; and [5] to refrain from actions that will injure the insured’s ability to obtain the benefits of the contract. *Id.* at 801. Utah Courts have referred to these duties collectively as the *Beck* duties or duty to bargain or settle in good faith.

Whether an insurer acts reasonably in performing all of the *Beck* duties is determined from an objective rather than subjective standpoint. *Billings v. Union Bankers Ins. Co.*, 918 P.2d 461, 465 (Utah 1996). However, the insurer’s duty to investigate and reasonably evaluate a claim “does not require that the insurer’s evaluation ultimately prove correct.” *Black v. Allstate Ins. Co.*, 2004 UT 66, ¶ 21 (case involving third-party liability claim); An insurer discharges its duties if its conduct is “fair and reasonable.” *Id.* at ¶ 21; *see also The Human Ensemble, LLC*, 2013 UT App. 68 at 11, 299 P.3d 1149 (granting summary judgment in favor of Scottsdale Insurance Co. ruling that failure to inform the insured that its claim for property damage was not covered by the general liability policy Scottsdale issued to it was not bad faith).

- The Fairly Debatable Defense

Utah courts have adopted and recognized the “fairly debatable” defense for insurers. Simply stated, if the insured’s claim is fairly debatable the insurer has the legal right to debate it, and the insurer cannot be found to have breached the implied duty of good faith and fair dealing for making the decision to deny coverage, even if the insurer was ultimately wrong in its decision. See *Prince v. Bear River Mutual Insurance Co.*, 56 P.3d 524, 530 (Utah 2002). The debate of the insured’s claim can concern either matters of law, such as contract or statutory interpretation, or matters of fact, such cause of loss. *See id.* at 842 (“[w]hen a claim is fairly debatable, the insurer

is entitled to debate it, whether the debate concerns a matter of fact or law."); *see also Fort Lane Village L.L.C. v. Travelers Indem. Co. of America*, 2011 WL 3180487 (D. Utah 2011); *Larson v. Allstate Ins. Co.*, 857 P.2d 262, 266 (Utah Ct. App.), cert denied, 862 P.2d 1356 (Utah 1993).

Prior to 2012, many Utah attorneys, jurists and insurers assumed that the fairly debatable defense was, for the most part, a matter for determination on a motion for summary judgment, relying upon the Utah Supreme Court's statement in *Prince* that "[i]f the evidence presented creates a factual issue as to the claim's validity, there exists a debatable reason for denial ... eliminating the bad faith claim." *Prince*, 56 P.3d at 530. In 2012, the Utah Supreme Court addressed such claim made by Farmers Insurance Exchange ("Farmers") and rejected it, ruling that in certain cases the fairly debatable defense may present questions of fact for the jury to determine. *Jones v. Farmers Insurance Exchange*, 286 P.3d 301 (Utah 2012). *See also Baker v. Progressive Direct Ins. Co.*, 2023 WL 3044954 (D. Utah 2023) (citing to *Jones* and stating that "if an insurance company wants to avoid a trial on a bad faith claim when a plaintiff submits a qualified medical opinion before claim denial, then the insurance company should use a qualified medical opinion too.").

2. Third-Party

Utah courts have explained and addressed an insurer's duty of good faith and fair dealing in the third-party context of defending the insured primarily in one situation, thus far, accepting or rejecting a settlement offer. However, many attorneys and trial courts consider the *Beck* duties addressed above as applying within the third-party context.

In relation to the acceptance or rejection of a settlement offer, Utah appellate courts have discussed the duties of the insurer in a number of cases, the first being *Ammerman v. Farmer's Ins. Exch.*, 430 P.2d 576 (Utah 1967). In *Ammerman*, the primary issue addressed by the Supreme Court of Utah was whether a claimant creditor, after obtaining a judgment against the insured, had standing to sue an insurer for bad faith. The court answered that question as no. *See id.* at 578 ("Soliz, merely because he is Ammerman's creditor, cannot appropriate to himself a tort claim Ammerman may have against the defendant insurance company.")

The *Ammerman* Court, however, did not end its decision with that holding. The court chose to make further "observations" regarding an insurer's duty to evaluate a settlement offer which falls within the liability limits of the insured's policy:

The covenant in the policy requiring the insurer to defend the insured imposes upon it a fiduciary responsibility. Where there is an offer to compromise a claim for less than the policy limit, the acceptance of which would relieve the insured of liability, a conflict of interests may exist. The question then arises as to the extent of the duty of the insurance company to safeguard the interest of its insured as compared to its own. It is true that the company cannot properly gamble with or sacrifice the insured's interest simply to protect itself. By the same token it is neither practical nor reasonable to expect it to subvert its own interests entirely to protect the insured by requiring it to accept any offer below the policy limits, regardless of circumstances, and however questionable the issues of liability and damage may be.

* * * *

While the expressions of courts have varied somewhat as to the duty of insurance companies with respect to making and accepting proposals of settlement to protect its insured, we believe that the best view is that it must act in good faith and be as zealous in protecting the interests of its insured as it would in looking after its own. Whether it discharges that duty may depend upon various considerations including the certainty or uncertainty as to the issues of liability, injuries, and damages.

Id. at 578-579 (citations omitted).

A little less than twenty years later, the Utah Supreme Court discussed the duty which an insurer owes its insured, comparing the insurers duties in first-party versus third-party contexts. *Beck v. Farmers Ins. Exch.*, 701 P.2d 795 (1985). As it concerns the third party situation, the court found that an insured has a cause of action in tort, rather than in contract, for an insurer's alleged breach of its fiduciary obligations. The court explained:

In a third-party situation, the insurer controls the disposition of claims against its insured, who relinquishes any right to negotiate on his own behalf. An insurer's failure to act in good faith exposed its insured to a judgment and personal liability in excess of the policy limits. . . . In essence, the contract itself creates a fiduciary relationship because of the trust and reliance placed in the insurer by its insured. . . . The insured is wholly dependent on the insurer to see that, in dealing with claims by third parties, the insured's best interests are protected. In addition, when dealing with third parties, the insurer acts as an agent for the insured with respect to the disputed claims. Wholly apart from the contractual obligations undertaken by the parties, the law imposes upon all agents a fiduciary obligation to their principals with respect to matters falling within the scope of their agency.

Id. at 799-800 (citations omitted).

Several years later, the Utah Court of Appeals added to the discussion in *Campbell v. State Farm Mut. Auto. Ins. Co.*, 840 P.2d 130. (Utah Ct. App. 1992) (*cert. denied* 853 P.2d 897 (Utah 1992)). *Campbell* involved a vehicular accident in which the insured attempted to pass a caravan vehicles on a two-lane highway and caused the driver of an oncoming vehicle to lose control of his vehicle and collide with another vehicle, resulting in one death and a serious injury. The insurer defended the insured asserting no liability since the insured's vehicle never made any contact with any of the vehicles involved in the accident. *Id.* at 132. The claimants offered to settle for the \$50,000 per occurrence policy limits, but the insurer refused. The case was tried and the jury found the insured 100% at fault for the accident and rendered a verdict of a little over \$250,000. The insurer appealed and took a position after the verdict and through a good portion of the appeal (which the insurer eventually lost) that the excess judgment was the responsibility of the insured. The insured, fearing owing the judgment, agreed to settle with the claimants for assignment of his claim for bad faith against the insurer and they all sued the insurer.

Shortly after filing the bad faith suit, the insurer moved for summary judgment arguing that the Complaint failed to state a cause of action for bad faith because: 1) a bad faith action could not have arisen while the appeal was pending and judgment was not final; and 2) following the appeal and affirmance of the judgment, State Farm paid the entire judgment against the Campbells such that they were never exposed to personal liability and therefore had no cognizable damages. The

trial court granted the insurers motion and the insured and claimants appealed.

The Utah Court of Appeals reversed the trial court's grant of summary judgment. The court began its analysis by reviewing and quoting the *Ammerman* and *Beck* decisions' language explaining the fiduciary duties owed to an insured in the third-party context. The court then established a standard for determining whether an insurer breached its fiduciary duty in evaluating a policy limits offer of settlement:

Part of the insurer's implied duty to its insured is to zealously guard the insured's interest when deciding whether to accept an offer of settlement of the third-party's claim or to take the case to trial. **Stated generally, an insurer owes its insured a duty to accept an offer of settlement within the policy limits when there is a substantial likelihood of a judgment being rendered against the insured in excess of those limits. . . . The test of the insurer's conduct is one of reasonableness. . . .** As regards offers of settlement, the insurer must give the insured's interests at least as much consideration as it gives its own. . . . If the insurer breaches this duty, Utah law provides the insured with a cause of action in tort.

Id. at 138-39 (footnotes and citations omitted) (emphasis added). In footnote, the court of appeals gave further guidance with respect to the standard of reasonableness:

Courts have articulated various standards for a finding of "bad faith," some requiring an element of willfulness or recklessness, . . . and others holding that merely negligent conduct will suffice. . . . In practice, however these formulations of the test of the insurer's conduct tend to coalesce; courts claiming to hold an insurer liable for failure to settle in an appropriate case; even though the failure was attributable solely to negligence We prefer the more objective formulation of courts which inquire whether the insurer's decision was reasonable or unreasonable under all the circumstances. . . . Thus, irrespective of whether the insurer's unreasonable decision not to settle resulted from willful misconduct or simple ineptitude, the insurer has violated the duty of good faith owed to the insured. Moreover, we think this formulation is consistent with the essentially objective test of good faith conduct in the context of first-party insurance claim, that is, an insurer who denies a claim has acted in "good faith" so long as the claim was "fairly debatable." See *Calliou v. Progressive Ins. Co.*, 745 P.2d 838, 842 (Utah App. 1987).

Id. at 138 n.16 (citations omitted). Thereafter, the court of appeals addressed State Farm's argument that the insured had no cause of action for bad faith because the insurer eventually paid the excess judgment (after losing the appeal), thereby vitiating any action for bad faith. The court rejected that argument, stating "it is clear as a matter of simple logic, as well as law, that the insurer cannot avoid liability by eventually paying the excess judgment if damages apart from the judgment have been proximately caused by the insurer's unreasonable failure to settle." *Id.* at 139.

Since *Campbell*, the issue of an insurer's duty to settle and the more general concept of bad faith in the third-party context has had little discussion, but for one case, *Rupp v. Transcontinental Ins. Co.*, 627 F.Supp.2d 1304, 1324 (D. Utah 2008). In *Rupp*, the injured assignee filed a personal injury action in Utah state court against the insured contractor. After the primary insurer rejected two offers to settle within the policy limits, the assignees, the insured and its excess insurer, entered into a settlement agreement with the claimant, assigning any claims they have against the primary insurer to the claimant assignee. The U.S. District Court for Utah found that the assignees' cause of

action against the primary insurer was one sounding in tort, not contract. The court predicted that the Utah Supreme Court would hold that an insured facing the significant likelihood of an excess judgment was not required to take the case to trial before a cause of action for bad faith accrued. Utah court decisions did not bar the assignees' claims as a matter of law or limit the damages to the amount actually paid by the parties above their deductible. *Id.*

In 2022, the Utah Supreme Court affirmed a jury verdict finding that a professional liability insurer breached the implied covenant of good faith and fair dealing in failing to act in good faith to settle within policy limits by contesting and reserving coverage for the first time eight years into the case. *UMIA Insurance, Inc. v. Saltz*, 2022 UT 21, 515 P.3d 406 (Utah 2022). In affirming the jury verdict, the Utah Supreme Court cited with approval its rulings in *Ammerman* and *Beck* (cited above) which generally explain the fiduciary responsibilities of insurers in the third-party context. And with respect to the duty to "fairly and reasonably" settle claims against the insured, the Utah Supreme Court cited with approval the analysis of the duty to settle set forth by the Utah Court of Appeals in the *Campbell v. State Farm* case (cited above), which provides that an insurer has a duty to accept a settlement offer at or below policy limits if there is a substantial likelihood of an excess verdict.

Notwithstanding the foregoing, the Tenth Circuit Court of Appeals, in 2021 ruled that the duty to settle within the policy limits is not an absolute duty, rather the test of the insurer's duty and conduct is one of reasonableness. *See Owners Ins. Co. v. Dockstader*, 861 Fed. Appx. 210. (10th Cir. 2021). The Tenth Circuit affirmed a summary judgment in favor of liability insurer in this case finding that the insurer had not breached the implied covenant of good faith and fair dealing in not accept settlement within the policy limits where the insurer defended the insured under a full reservation of rights and had filed a declaratory judgment action contesting both its duty to defend and indemnify its insured. *See id.* at 218.

Fraud

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

- A false representation of fact made by the defendant;
- knowledge or belief of the defendant that the representation was false ("scienter");
- an intention to induce the defendant to act or refrain from acting in reliance;
- Justifiable reliance by plaintiff upon the representation in taking action or in refraining from it;
- Damages suffered by plaintiff as a result.

Bennett v. Jones, Waldo, Holbrook & McDonough, P.3d 17 (Utah 2003). Each element must be proved by clear and convincing evidence. *Secor v. Knight*, 716 P.2d 790, 794 (Utah 1986). Statements of opinion as to the legal effect of contract are not generally a proper basis for a claim of fraud. *Berkeley Bank for Cooperatives v. Meibos*, 607 P.2d 798 (Utah 1980). However, false statements of a defendant's future intent may be actionable. *Id.*

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 Ann. 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

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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 Ann. 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.

Intentional or Negligent Infliction of Emotional Distress

Intentional infliction of emotional distress claims (IIED) are unpopular with courts in Utah, and are often thrown out on summary judgment.

To sustain a cause of action for IIED, a plaintiff “must 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.” *Rutherford v. AT&T Comm. of the Mountain States, Inc.*, 844 P.2d 949, 970-71 (Utah 1992); *Anderson Development Co. v. Tobias*, 2005 UT 36, 116 P.3d 323.

Conduct that occurs outside the presence of a plaintiff may not contribute to a claim of intentional infliction of emotional distress except under particularly compelling circumstances. *Hatch v. Davis*, 2006 UT 44, 147 P.3d 383.

Conduct is not deemed “outrageous” if it is nothing more than “unreasonable, unkind, or unfair,” even if it is “tortuous, injurious, malicious, or illegal.” *Franco v. The Church of Jesus Christ of Latter-day Saints*, 21 P.3d 198, 207 (Utah 2001). 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. See *Prince v. Bear River*, 2002 UT 68 ¶ 39, 56 P.3d 524; *Saleh v. Farmers Ins. Exchange*, 2006 UT 20, ¶ 24, 133 P.3d 428; *Westport v. Ray Quinney & Nebeker*, 2009 WL 24740005 (D. Utah 2009).

“[T]he element of emotional distress is specific to the plaintiff in each case,” and “is to be gauged subjectively.” The question is when “[plaintiff] experienced severe emotional distress, not when an ordinarily sensitive person would have experienced such suffering.” *Rutherford*, 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, 1165.

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

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severe mental or physical symptoms. *Carlton v. Brown*, 2014 UT 6, ¶¶ 57-58. Also, Utah courts, until 2019 required a showing of presence in the zone of danger to recover for NIED. *See Hansen v. Sea Ray Boats, Inc.*, 830 P.2d 236, 239-40 (Utah 1992).

Utah appellate courts have not had occasion to determine whether an insurer's handling of a claim may give rise to NIED liability. The cases within the business context, prior to 2018, indicate that such claims are unlikely to be recognized. *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); *see also Handy*, 841 P.2d at 1220 (no NIED liability for employer where it had no notice of plaintiff's susceptibility to stress-related ailments and where employees other than plaintiff found the work environment "at least tolerable").

However, in 2018, the Utah Supreme Court recognized a new test to establish a limited duty to refrain from inflicting severe emotional distress outside of zone-of-danger cases. *See Mower v. Baird*, 2018 UT 29, 422 P.3d 837. The *Mower* case involved a parent suing his child's therapist for malpractice and for NIED claim for allegedly helping to create false memories and false allegations of sexual abuse against the parent.

In order to establish that a class of defendants owe a limited emotional distress duty to a class of plaintiffs, the *Mower* Court established a two-step analysis: (1) Does the defendant owe a traditional duty of reasonable care to the plaintiff?; and (2) Is the relationship, activity, or undertaking of the type that warrants a special, limited duty to refrain from causing severe emotional distress? *See id.* at ¶ 78. The first step is the traditional duty analysis. If such a traditional duty exists, then the second step is to analyze whether a special, limited duty to refrain from causing severe emotional distress is supported. The second step itself requires a three-prong analysis: (1) Does the relationship, activity, or undertaking necessarily implicate the plaintiff's emotional well-being? (2) Is there an especially likely risk that the defendant's negligence in the course of performing obligations pursuant to such relationship, activity, or undertaking will result in severe emotional distress? and (3) Do general public policy considerations warrant rejecting a limited emotional distress duty where prongs one and two would otherwise find one to exist? *See id.* at ¶ 80. All three prongs must be satisfied for a duty to refrain from causing severe emotional distress to exist. *See id.*

Given that there is now a new second test for establishing a limited duty, it is far more likely that Utah appellate courts could find this new test applies to insurers' duties owed to insureds. That seems particularly like, in the third-party context, where Utah courts have already recognized that the duty of good faith and fair dealing sounds in tort, not contract. As of May 2021, no Utah appellate court and no federal district court of Utah has found that an insured can bring a claim of negligent infliction of emotional distress claim against an insurer.

State Consumer Protection Laws, Rules 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).

DISCOVERY ISSUES IN ACTIONS AGAINST INSURERS

Discoverability of Claims Files Generally

Utah has no appellate opinion that addresses the scope of the discovery of claims files within the context of claims for insurance coverage or claims of bad faith. In the context of claims against insureds, Utah courts take a case-by-case approach to determining whether documents in insurance claims files are discoverable or protected

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by the work product doctrine prepared in anticipation of litigation with trial courts considering the nature of the requested documents, reason for preparation of documents, relationship between preparer of document and party seeking protection from discovery and relationship between litigating parties. Attorney involvement is not required in order to fall under the work product doctrine and being prepared in anticipation of litigation. See *Askew v. Hardman*, 918 P.2d 469 (Utah 1996); see also *Green v. Louder*, 29 P.3d 426 (Utah 2001) (trial court did not abuse its discretion in denying motion to compel peace of mind letter which insurer sent to insured stating that insurer would unconditionally promise to pay any judgment rendered against insured, as such letter was protected by work product doctrine even though attorney did not prepare letter).

Discoverability of Reserves

Utah has no appellate opinion that addresses whether reserves are discoverable. However, a federal district court magistrate judge recently ruled that insurance reserve information is discoverable in a case brought against a title insurance company alleging breach of contract and breach of the implied covenant of good faith and fair dealing. See *Wells Fargo Bank, N.A. v. Stewart Title Guar. Co.*, 2020 WL 2064007, at * 1 (D. Utah 2020).

Discoverability of Existence of Reinsurance and Communications with Reinsurers

Utah has no appellate opinion addressing the discoverability of reinsurance or communications with reinsurers.

Attorney/Client Communications

Utah has no appellate opinion addressing the discovery of attorney client communications in the context of claims for insurance coverage or claims of bad faith. However, when considering whether there was a waiver of the attorney-client privilege in the context of a medical malpractice case, the Utah Supreme Court recognized the general rule that “[a] party may [] waive the privilege by placing the attorney-client communications at the heart of a case, as where a party raises the defense of good faith reliance on advice of counsel.” *Doe v. Maret*, 984 P.2d 980 (Utah 1999)(overruled in part on other grounds by *Munson v. Chamberlain*, 173 P.3d 848 (Utah 2007)).

DEFENSES IN ACTIONS AGAINST INSURERS

Misrepresentations/Omissions: During Underwriting or During Claim

An insurer may cancel an insurance policy for a material misrepresentation. Utah Code Ann. § 31A-21-303(2). 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).

An innocent misstatement is not a “misrepresentation.” *Derbridge 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). In the *ClearOne Communications* case, the 10th 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.

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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. *Id.* at 1250 citing *Burnham v. Bankers Life & Cas. Co.*, 470 P.2d 261, 263 (Utah 1970). See also *PHL Variable Ins. Co. v. Sheldon Hathaway Family Ins. Trust*, 918 F.2d 1283 (10th. Cir. 2016) (grant of summary judgment affirmed in favor of life insurer where Trust knew or should have known about the clear misrepresentations contained in Mr. Hathaway's insurance application and ruling permitting insurer to retain premiums also affirmed).

A material misrepresentation makes a policy voidable, not void. *Continental Ins. Co. v. Kingston*, 114 P.3d 1158 (Utah 2005) (For that reason, the defense can be waived. See *infra*.)

The insurer is estopped from claiming misrepresentation if it has notice of the falsity or if it has made an independent but insufficient inquiry into the facts. *Hardy v. Prudential Life Ins.*, 763 P.2d 761, 770 (Utah 1988); see also *ClearOne*, 494 F.3d at 1250-51. 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).

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 Ann. § 31A-21-105(5); see *Seneca Ins. Co., Inc., v. Alton Coal Dev., LLC*, 2017 WL 1379337 (D. Utah 2017) (analyzing Section 31A-21-105(5) and finding that there is a factual dispute as to when the insurer acquired the knowledge required by the statute to trigger the 60 day time and the insurer's obligations under the statute).

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*, 114 P.3d 1158 (Utah App. 2005) (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).

None of these rules displace the common law right of contract rescission. Utah Code Ann. § 31A-21-303(11).

Failure to Comply with Conditions

- Assistance and Cooperation

By statute, a notice of proof of loss is considered timely if the insured shows that "it was not reasonably possible to give the notice or file the proof of loss within the prescribed time and that notice was given or proof of loss filed as soon as reasonably possible." Utah Code Ann. § 31A-21-312(1). Moreover, "failure to give notice or file proof of loss . . . does not bar recovery under the policy if the insurer fails to show it was prejudiced by the failure." Utah Code Ann. § 31A-21-312(2).

In Utah, an insurer seeking to avoid coverage of a claim for reason of failing to abide by the condition of cooperating in the defense of a claim must establish two things: (1) that it used "reasonable diligence" to

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secure the insured's cooperation; and (2) that the noncooperation "substantially prejudiced" its ability to defend against the claim in question. *The Doctors' Company v. Drezga*, 218 P.3d 598 (Utah 2009). The Utah Supreme Court also held that an insurer was contractually barred from retroactively avoiding coverage for the malpractice claim because the policy's provision regarding cooperation was ambiguous as to the prospective or retroactive effect of non-cooperation. *Id.* at ¶ 29 (policy language was that failure to cooperation "will result in loss of coverage.").

- Late Notice

Under Utah law, "failure to give any notice or file any proof of loss required by the policy within the time specified in the policy does not invalidate a claim made by the insured, if the insured shows that it was not reasonably possible to give the notice or file the proof of loss within the prescribed time and that notice was given or proof of loss filed as soon as reasonably possible." Utah Code Ann. § 31A-21-312(1)(b). Utah generally follows the notice-prejudice rule, i.e., coverage cannot be denied unless the failure to give notice was prejudicial. *See 8865 North Cove, LLC v. Am. Family Mut. Ins. Co.*, 612 Fed. Appx. 492 (10th Cir. 2015) (affirming grant of summary judgment in favor of insurer finding that two-year delay in insured providing notice of claim and in making repairs to the property prejudiced the insurer such that it owed no coverage); *see also Utah Transit Authority v. Liberty Mut. Ins. Co.*, 2006 WL 2992715 (D. Utah 2006). However, that rule does not apply to claims-made policies as such requirement of showing prejudice would alter a fundamental term of a claims-made policy, expanding the overall scope of claims-made coverage. *Westport Ins. v. Ray Quinney & Nebeker*, 2009 WL 2474005 (D. Utah 2009).

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

Utah has no appellate opinion that addresses an insurer's ability to challenge a stipulated judgment between the insured and third party claimant. However, Utah courts have addressed a similar question of the insurer's ability to challenge a settlement between the insured and third party claimant where the insurer denied coverage, and finds that where the insurer improperly denied coverage it is estopped from "second-guessing [the insured's] decision to settle." *Benjamin v. Amica Mut. Ins. Co.*, 2006 UT 37, 140 P.3d 1210, 1216 (Utah 2006). In *Gibbs M. Smith, Inc. v. USF&G*, 949 P.2d 337 (Utah 1997), the Utah Supreme Court stated that no consent "provisions prohibiting out-of-court settlements between an insured and a claimant without the consent of the insurer are not enforced when the insurer repudiates coverage or denies liability.") *see also Summerhaze Co., L.C. v. FDIC*, 2014 UT 28, ¶ 38, 332 P.3d 908 (An insurer "that refuses a tender of defense by its insured takes the risk not only that it may eventually be forced to pay the insured's legal expenses but also that it may end up having to pay for a loss that it did not insure against."). A federal court has extended the scope of such rule finding that an insured's bad faith claim against insurer for refusing to settle underlying claim within policy limits was not barred by the insurance policy's no action/legal action limitation and no consent provisions. *See Rupp v. Transcontinental Ins. Co.*, 627 F.Supp.2d 1304 (D. Utah 2008).

Preexisting Illness or Disease Clauses

- Statute

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

31A-22-605.1 Preexisting condition limitations.

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(1) Any provision dealing with preexisting conditions shall be consistent with this section, Section 31A-22-609¹ and rules adopted by the commissioner.

(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

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).

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, syndactylysm, and treatment and prosthetic devices related to amputation;

(B) anal fistula, anal fissure, anal stricture, breast implants, breast reduction, chronic cystitis, chronic prostatitis, cystocele, rectocele, enuresis, hemorrhoids, hydrocele, hypospadius, 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 Douloureux, 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

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(d) the limitation period is reduced in compliance with Subsections 31A-22-605.1(4)(a) and (4)(b).

Utah Code § 31A-30-107.5 (2011).

- 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 was the exclusive cause of death. *Draughon v. CUNA Mut. Ins. Soc.*, 771 P.2d 1105 (Utah Ct. App. 1989).

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.

Statutes of Limitations and Repose

Any action on a written policy or contract of first-party insurance 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.*, 53 P.3d 947 (Utah 2002).

In 2022, the Utah Court of Appeals reversed dismissal of a childrens’ claim of mutual mistake as to change of beneficiaries for a life insurance policy. *See Zubiate v. American Family Ins. Co.*, 2022 UT app. 144, 524 P.3d 148 (Utah Ct. App. 2022). The court reasoned that the statutory discovery rule of 31A-21-313(1) applied and was tolled due to the children’s minority.

There is no specific statute of limitation for an action on written policy or contract of a third-party liability insurance. Since there is no specific statute of limitation for third-party contracts, some trial courts have rejected application of Section 31A-21-313’s three-year period, and ruled that Utah’s general six-year statute of limitation for an action on a written contract, which is Utah Code Unann. § 78B-2-309. No Utah appellate court has taken a position on this issue.

There is no repose statute for any action against an insurer or concerning an insurance contract.

TRIGGER AND ALLOCATION ISSUES FOR LONG-TAIL CLAIMS

Trigger of Coverage

Utah appellate courts have not addressed the issue of trigger of coverage issues for long-tail claims. However, there is one case from the U.S. District Court for the District of Utah which analyzed, at length, the trigger of

coverage issue in a case involving insurance coverage for environmental clean-up costs for contamination of ground and water at an oil recycling center between 1967 and 1988. *Quaker State Minit-Lube v. Fireman's Fund Insurance Co.*, 868 F.Supp. 1278 (D. Utah 1994). The case was affirmed by the Tenth Circuit Court of Appeals, but the parties did not appeal the issue of the trigger of coverage. See *Quaker State Minit-Lube v. Fireman's Fund Insurance Co.*, 52 F.3d 1522 (10th Cir. 1995).

During the years in which the contamination occurred, the automobile service center was insured under general liability and garage operation insurance policies issued by several different insurance companies. The policies provided coverage for property damage which "occurs during the policy period." The insurers which provided insurance to the automobile service center early in the years of contamination alleged that no occurrences took place during their periods of coverage.

The District Court of Utah began its analysis of the coverage trigger by stating that courts throughout the United States have addressed the issue of when an occurrence occurs and those courts developed four tests for triggering coverage. Those tests are: 1) the "exposure trigger; 2) the "actual injury" or "injury-in-fact" trigger, 3) the "manifestation" or "discovery" trigger; and 4) the "continuous" trigger. *Id.* at 1299. After reviewing each test, the district court ruled that the trigger test best applicable for the circumstance of multiple occurrences of open contamination is the "actual injury or injury-in-fact trigger". The Court stated:

This Court concludes that the Utah courts, under the facts of this case, would adopt the "injury-in-fact" or "actual injury" trigger. Using an actual injury trigger, an "occurrence" for purposes of CGL insurance policy coverage took place each time hazardous waste such as drain oil was discharged onto the Ekotek Site property and, by definition, inflicted "property damage" at that site. This reading seems most closely consistent with both the policy language and the particular factual circumstances at issue in this case; where property damage, *i.e.* hazardous waste contamination, is known to have occurred because of a release, an "occurrence" has taken place. Where releases resulting in contamination are continuing "injuries-in-fact" triggering coverage are also continuing.

While the "manifestation" trigger may provide a meaningful starting point in a case of hidden, gradual, and probably underground hazardous waste contamination, the Ekotek Site does not present such a case. Nor is the Court persuaded that a "continuous" trigger represents a fair reading of "occurrence" in the defendants' policies.

Id. at 1304-05. Based upon that determination, the court found that occurrences took place under each of the insurers' policies.

Allocation Among Insurers

The Utah Supreme Court has ruled that when determining how to apportion liability coverage (defense and indemnification) among multiple insurers, a court applies equitable principles unless express policy language decrees the method of apportionment. *Ohio Cas. Ins. Co. v. Unigard*, 2012 UT 1 at ¶ 11, 268 P.3d 180 (quoting *Sharon Steel Corp. v. Aetna Cas. & Sur. Co.*, 931 P.2d 127, 140 (Utah 1997)). If the express policy language does not decree the method of apportionment among insurers, the Utah Supreme Court, in the *Sharon Steel* case, rejected equal shares method and adopted a "time-on-the-risk" apportionment method as to indemnification costs. The *Sharon Steel* Court established the "time-on-the-risk" method as proration on the basis of policy limits, multiplied by years of coverage. *Sharon Steel*, 931 P.2d at 141 (following *Armstrong World Indus., Inc. v. Aetna Cas. & Sur. Co.*, 52 Cal. Rptr. 2d 690, 707-08 (Cal. App. 1996)). Fifteen years later, the Utah Supreme Court in the *Unigard* case again rejected the equal shares method as the method of allocating defense costs among multiple

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insurers, and adopted the “time-on-the risk” apportionment method. *Unigard*, 2012 UT 1 at ¶ 30.

CONTRIBUTION ACTIONS

Claim in Equity vs. Statutory

Utah does not have a statute which addresses contribution actions. Rather, the Utah Supreme Court, in the *Sharon Steel* case, cited above, recognized the right of an insurer “which settled a claim that should have been covered by another insurance company,” to file suit and “recover the amount paid in settlement under the equitable doctrine of subrogation.” *Sharon Steel*, 931 P.2d at 137. The court also extended that right to an action to recover defense expenditures from multiple insurers who should have shared in the defense. *See id.* at 138 (“We agree with those jurisdictions that have allowed contribution where one insurer has paid more than its fair share of the defense costs.”).

Elements

The Utah Supreme Court recognized the right of equitable subrogation between insurers as to coverage, but has not specifically established elements of the claim, other than the statements set forth above from the *Sharon Steel* case. *See Sharon Steel*, 931 P.2d at 137-138.

DUTY TO SETTLE

A liability insurer owes its insured a duty to settle a third-party's claim within policy limits when there is a “substantial likelihood” of an excess judgment against the insured and potential for punitive damages liability for the insured. *Rupp v. Transcontinental Ins. Co.*, 627 F.Supp.2d 1304, 1324 (D. Utah 2008); *see also Campbell v. State Farm Mutual Automobile Ins. Co.*, 840 P.2d 130 (Utah App. 1992), cert. denied. The duty to accept a reasonable settlement offer within policy limits is an extension of the duty to defend. *Rupp*, 627 F.Supp.2d at 1324. The insurer's conduct is judged by a “reasonableness” standard. *Campbell v. State Farm Mutual Automobile Ins. Co.*, 840 P.2d 130 (Utah App. 1992), cert. denied. See Section V.A.2 of this Compendium for a detailed discussion of the above cases.

An insurer who refuses to participate in settlement discussions on the wrongful belief that it does not owe defense and indemnification coverage is estopped from challenging a settlement reached by its insured. *Benjamin v. Amica Mut. Ins. Co.*, 140 P.3d 1210 (Utah 2006); *Gibbs M. Smith Inc. v. USF&G*, 949 P.2d 337 (Utah 1997).

For settlement purposes, it should also be noted that step-down provisions (household exclusions) that purport to reduce liability coverage to the statutory minimums for injury to a named insured are invalid in Utah. *Liberty Mut. Ins. Co. v. Shores*, 147 P.3d 456 (Utah 2006).

LH&D BENEFICIARY ISSUES

Change of Beneficiary

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 Ann. Code § 31A-22-413(1)(2017). The insurer may prescribe formalities to

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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*, 776 P.2d 659 (Utah 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.*, 241 P.3d 385 (Utah App. 2010). 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 Ann. 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*, 241 P.3d 385.

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.*

Effect of Divorce on Beneficiary Designation

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 Ann. Code § 75-2-804(2)(a) (2013). The Utah Supreme Court has ruled that Section 75-2-804(2) "creates a rebuttable presumption that beneficiary designations of a former spouse on a life insurance policy are revoked in a divorce proceeding. This revocation can be rebutted using section 30-3-5(1)(e) in divorce proceedings only through inclusion of the statutory language in the decree of divorce." *Hertzke v. Snyder*, 2017 UT 4, ¶ 9, 390 P.3d 307, 311. The court also ruled that "[t]he generic language found in almost every life insurance policy regarding the standard method to change a beneficiary does not constitute "express terms" enabling the beneficiary designation to survive revocation under section 75-2-804(2)." *Id.* at ¶ 14.

The Tenth Circuit 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.

INTERPLEADER ACTIONS

Availability of Fee Recovery

- 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).

In *Wilson v. Educators Mut. Ins. Ass'n*, 2018 UT App 155, 436 P.3d 144, the Utah Court of Appeals ruled that the trial court did not abuse its discretion in allocating \$100,000 in interpleaded funds deposited by motorist's insurer as settlement of claim against motorist by pedestrian's insurer to recover medical expenses paid on behalf of pedestrian, whom motorist had struck and killed, and as settlement of wrongful-death claim against motorist by pedestrian's parents, which the trial court allocated by awarding \$24,182.31 to pedestrian's insurer and \$75,817.69 to parents. Trial court did not abuse its discretion in providing funds to the pedestrian's insurer where pedestrian's policy with insurer contracted away the common-law principles of equitable subrogation. The trial court first divided the funds equally between pedestrian's insurer and parents after recognizing that the funds were insufficient to satisfy all claims, and trial court then equitably reimbursed parents, out of insurer's portion, for one-half of their attorney fees and costs.

- 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. *Transamerica Premier Ins. Co. v. Grownay*, LEXIS 31836 (10th Cir. 1995).

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.*, 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.*