



California Attorneys for the
Insurance and Financial Services Industries

12657 Alcosta Boulevard, Suite 150 ♦ San Ramon, California 94583-4698
Voice: (925) 973-0300 ♦ Fax: (925) 973-0330 ♦ www.califehealth.com

Enforcing Exclusions and Limitations in Life, Health and Disability Policies

by Robert R. Pohls

*(Presented at the Defense Research Institute
Life, Health, Disability and ERISA Claims Seminar
in Chicago, Illinois on April 10-11, 2003)*

1. Introduction

Not all insurers are alike. However, insurers in today's marketplace have few opportunities to distinguish themselves in the minds of insurance consumers.

Many companies therefore invest in marketing campaigns that are designed to "brand" their products and operations. Those marketing campaigns often tout a company's financial strength and/or its record for customer service as unique qualities that should attract insurance consumers. In reality, though, few consumers consider – let alone appreciate – the difference between two insurers' financial ratings. In addition, a substantial percentage of the insurance-buying public either assumes they will receive poor customer service from every insurer or, at best, reserves judgment on the level of service a particular insurer may provide. Consequently, insurance consumers often choose their policies on the basis of other factors.

One such factor is price. For example, consumers who are choosing between term life policies offered by competing insurers rarely consider anything but price. At the same time, those consumers may not realize that each insurer's pricing reflects a set of sophisticated actuarial assumptions. In light of those actuarial assumptions, each insurer constructs its policies to carefully limit the risks it insures. For that reason, there can be significant differences between the policies offered by any two life, health, or disability insurers, if not also between two policies offered by the same insurer.

All too often, consumers first learn of those differences when their insurers give notice of an adverse claims decision. The letter communicating that decision typically explains that the insurer considers it to be consistent with and, indeed, based upon express terms found in the policy. In most instances, though, the insured has never read the policy, never suspected it had the language on which the insurer relies, and has no meaningful understanding of the policy's specific terms. As a result, an insured whose claim is denied often comes to view exclusions and limitations as nothing but "fine print" that is made part of the policy only to relieve the insurer of its contractual obligations.

After consulting with legal counsel, more sophisticated insureds sometimes restate that view as an objection that enforcing the exclusions or limitations would defeat their reasonable expectations about what the policy was meant to cover. Whether presenting their case to a jury or trying to avoid litigation altogether, then, insurers who intend to rely on a policy's exclusions and limitations should develop a strategy for demonstrating that an insured's professed expectation of coverage is unreasonable. In the end, an insurer's ability to enforce the

exclusions and limitations that make its policy different than a competitor's may depend on little else.

2. Step One: Assemble the Policy Documents

To dissuade an insured from challenging its denial of a claim or to convince a trial judge (or jury) that it is entitled to judgment in claim-related litigation, an insurer must at least show that its claims decision is supported by the terms of the applicable policy. In fact, the claims practices regulations of many states require that insurers do so. See, e.g., 10 *Cal. Code of Reg.* §2695.7(b)(1) ["Where an insurer's denial of a first party claim, in whole or in part, is based on a specific policy provision, condition or exclusion, the written denial shall include reference thereto and provide an explanation of the application of the provision, condition or exclusion to the claim."]. An insurer's handling of a disputed benefit claim therefore should begin with assembling the policy documents.

Among other things, the policy documents usually include a basic policy form that can be identified from the insurance company's computer records and retrieved from its archived documents. Portions of the basic policy form sometimes are changed by riders or endorsements. In addition, certain terms used in the policy documents often derive their meaning from information on a policy data sheet (or declarations page) that is prepared for each individual policy.

The law in many states prohibits insurance companies from rescinding a policy or denying a benefit claim on the basis of the insured's statement in the application unless the application is physically attached to and made a part of the policy when it is delivered. See, e.g., *Cal. Ins. Code* §10113 [Nothing shall be incorporated by reference into a policy of life or disability insurance unless "indorsed upon or attached to the policy."]. For that reason, a complete copy of the insured's application should be included among the relevant policy documents, and care should be taken to not admit that any set of documents is a correct copy of the policy if the application is omitted.

Without assembling the policy documents, no insurer can be certain that its claims decision is based upon the contract terms that govern its obligations to the insured. More importantly, each of the documents which forms a part of the policy provides the insurer with an opportunity to demonstrate that the scope of coverage was accurately communicated to the insured well before the subject claim arose. Many of those documents also have useful terms that are important to defenses the insurer may need in litigation and which otherwise allow the insurer to resist the insured's efforts to disregard the policy language. A complete copy of the policy documents therefore should be assembled for use by the insurer's outside counsel, if not also by its claims personnel.

3. Step Two: Identify the Applicable Contract Provisions

As a general rule, an insurer does not impliedly waive any defenses it fails to mention when denying a claim. Rather, most courts view waiver as the *intentional* relinquishment of a *known* right after knowledge of the facts. The majority rule therefore places the burden "on the party claiming a waiver of a right to prove it by clear and convincing evidence that does not leave the matter to speculation, and 'doubtful cases will be decided against a waiver.'" See, e.g., *City of Ukiah v. Fones* (1962) 64 Cal.2d 104, 107-108; *DRG/Beverly Hills, Ltd. v. Chopstix Dim Sum Cafe & Takeout III, Ltd.* (1994) 30 Cal.App.4th 54, 60 ["Waiver always rests upon

intent."]; *Brookview Condominium Owners' Assn. v. Heltzer Enterprises-Brookview* (1990) 218 Cal.App.3d 502, 512; *National Union Fire Ins. Co. v. Siliconix Inc.* (N.D.Cal. 1989) 726 F.Supp. 264, 270 [applying California law and finding no waiver in absence of evidence insurer had intentionally relinquished right to contest coverage].

California courts follow the general rule that waiver requires the insurer to intentionally relinquish its right to deny coverage and that a denial of coverage on one ground does not, absent clear and convincing evidence to suggest otherwise, impliedly waive grounds not stated in the denial. *Waller v. Truck Insurance Exchange* (1995) 11 Cal.4th 1, 31-32. At least 32 other states agree. *Id.*, at 32, citing *Schiff Assoc. v. Flack* (1980) 51 N.Y.2d 692, 699 [no waiver of coverage defenses by failure to assert them in disclaimer notice]; *Tobi Engineering v. Nationwide Mut. Ins.* (1991) 214 Ill.App.3d 692 [insurer not required to assert all defenses to liability in denial letter to insured]; *Terre Haute First Nat. v. Pacific Employers* (Ind.App. 1993) 634 N.E.2d 1336, 1337 [no waiver of defenses to coverage in absence of prejudice to insured]. Still other states have held that the doctrine of waiver cannot be applied to expand coverage. See, e.g., *Pearce v. American Defender Life Ins. Co.* (1986) 316 N.C. 461.

In contrast, just one state has held that an insurer waives coverage defenses not stated in its initial denial letter. *Armstrong v. Hanover Insurance Company* (1971) 130 Vt. 182.

In light of those authorities, insurers should carefully consider whether it makes sense to list all possible grounds for denying a claim in the correspondence by which they advise the insured of an adverse claims decision. Uninformed claims personnel may believe that they have do so to protect the company's rights. They also may believe that lengthy recitations of policy provisions will suggest that the barriers to recovering benefits are too many and too significant to warrant further pursuit by the insured. In the long-run, though, insurers who attempt to identify all potential grounds for their claims decision in a denial letter will needlessly cloud their primary reasons for concluding that no benefits are payable. In the process, they also may put their claims personnel in the unenviable position of having to provide deposition testimony about why the company is not willing to waive obscure and/or seemingly irrelevant defenses.

4. Step Three: Understand the Burden of Proof

As a general rule, each party in a lawsuit has the burden of proving the existence (or nonexistence) of every fact that is essential to the claim or defense he or she is asserting. With regard to claims for insurance coverage, it therefore is axiomatic that the insured has the burden of establishing that the occurrence upon which the claim is based falls within the basic scope of coverage provided by the insuring agreement. See, e.g., *Weil v. Federal Kemper Life Assurance Co.* (1994) 7 Cal.4th 125, 148; *Royal Globe Ins. Co. v. Whitaker* (1986) 181 Cal.App.3d 532, 537.

To satisfy that burden, the insured normally must prove the existence of the contract, its general terms, and the occurrence of a loss generally covered by the policy. See, e.g., *Executive Aviation, Inc. v. National Ins. Underwriters* (1971) 16 Cal.App.3d 799, 806. If that proof is lacking, the insurer has no burden to prove that the policy excludes coverage for the loss. See, *Ells v. Order of United Commercial Travelers of America* (1942) 20 Cal.2d 290, 304. However, if the insured makes his or her proof, the burden typically shifts to require that the insurer prove an exclusion or limitation in the policy works to preclude coverage for an otherwise covered loss. *Ells, supra*, 20 Cal.2d at 304; See also, *Travelers' Ins. Co. v. McConkey*, 127 U.S. 661, 666 (1988).

Knowing which party bears the burden of proof on a particular issue can have a dramatic impact on how a claim is handled and whether the related lawsuit is won. Two cases illustrate that point especially well.

The first case is *Johnson v. Minnesota Mutual Life Insurance Company*, 799 F.Supp. 75 (N.D.Cal. 1992), which involved a policy of mortgage accidental death insurance. The insured in that case disappeared, having last been seen in the garage of his home when his wife left for work. After five years, the insured's wife obtained a court order establishing the fact of her husband's death. Thereafter, she submitted a claim for benefits under the subject policy.

The insured's body never was found, and no admissible evidence ever was developed to explain his disappearance. At the same time, the subject policy provided for benefits only upon proof that the insured "died as a result of an accidental injury." The insurer reasoned that the court order served only to establish the fact of the insured's death and did not constitute evidence that he had died "as a result of an accidental injury." It therefore denied the benefit claim for insufficient proof of loss.

The district court agreed with the insurer's analysis, explaining that there were "no facts from which a jury could reasonably infer that the insured's death resulted from an accidental injury." Because the claimant had the burden of proof on that issue, it then granted the insurer's motion for summary judgment.

In contrast, the policy involved in *Searle v. Allstate Life Ins. Co.* (1985) 38 Cal.3d 425 generally insured against a loss of life. There was no dispute that the insured was dead. Indeed, the parties stipulated that he had died as the result of "an act of self-destruction." *Id.*, at 430. The parties' dispute instead involved a policy provision that limited the insurer's liability to a return of premiums if the insured's death results from "suicide, whether sane or insane."

The insurer initially reasoned that the insured's state of mind was irrelevant because suicide can be either intentional or unintentional. However, the California appellate court rejected the insurer's analysis, holding that "[t]he plain meaning of the word suicide is to intentionally take one's life." See, *Searle v. Allstate Life Ins. Co.* (1979) 96 Cal.App.3d 614, 616. On remand, the trial court instructed the jury that it was the beneficiary's burden to prove that the insured did not intend to commit suicide. *Searle, supra*, 38 Cal.3d at 437. Ultimately, though, the California Supreme Court concluded that the trial court's allocation of the burden of proof was erroneous. *Id.*

In reaching that conclusion, the *Searle* court explained that "the burden of proving an excepted risk or condition subsequent which negates full liability is on the insurer and not the beneficiary." *Id.*, citing *Executive Aviation, Inc. v. National Ins. Underwriters* (1971) 16 Cal.App.3d 799, 806 [" . . . the burden of bringing itself within any exculpatory clause contained in the policy is on the insurer."]. It therefore reversed and remanded the trial court's verdict with an admonition that, "before [the insurer] could claim exception from full liability, it ha[s] the burden of showing an intentional act of self-destruction." *Id.*, at 439.

As the outcomes in those two cases suggest, understanding which party to the insurance contract will bear the burden of proof on a particular issue can be enormously important to an insurer's handling of a benefit claim and its defense in subsequent litigation. To that end, many insurers have begun marketing policies with significantly narrower coverage promises. Accordingly, defense counsel should carefully review the policy documents to identify

the types of proof the insured and/or beneficiary, as well as the type of proof the insurer must make when and if the burden shifts.

5. Step Four: Reconstruct the Point of Sale

As noted above, an insured who learns of a policy's exclusions and limitations when his or her claim is denied sometimes will object that those policy provisions contradict his or her reasonable expectations about what the policy covers. To be certain, there are numerous legal defenses (discussed elsewhere in this paper) an insurer can raise in response to such claims. However, insurers and their defense counsel should not overlook the importance of reconstructing the series of events by which the insured selected, applied for and received the policy in question.

Theoretically, all of the documents presented to the insured at the point of sale influenced his or her decision to purchase the subject policy. At a minimum, then, defense counsel should contact the agent to obtain any separate copies of the application and, more importantly, any ancillary documents used at the point of sale. Those documents may show that the insured considered and rejected policies with more favorable terms. Alternatively, they may show that the insured never considered the specific terms of any policy or that his or her selection of the subject policy was motivated solely by factors unrelated to the claim in question. Contacting the agent to review the events that led to the insured's selection and application of the policy therefore can produce evidence of the kinds of factual defenses in which many jurors may be keenly interested.

6. Step Five: Make Sure the Policy Controls

When an insurer concludes that the terms of a particular policy exclude or limit coverage for a particular loss, the insured can respond in any of several ways. Among other things, the insured may claim that solicitation materials, representations by the agent or other events that transpired before (or after) the policy was issued somehow alter or eliminate the exclusions or limitations on which the insurer relies.

Defending against such claims can be problematic. However, by keeping the court and/or trier of fact focused on the express terms of a well-drafted policy, insurers and their defense counsel can effectively use established legal principles to combat the insured's efforts to disregard the applicable policy language.

A. *Integration and the Parol Evidence Rule.* The Parol Evidence Rule is not merely a rule of evidence concerned with the method of proving an agreement. Rather, it is a principle of substantive law. In *Hayter Trucking, Inc. v. Shell Western E&P, Inc.* (1993) 18 Cal.App.4th 1, the Court of Appeal more fully explained that:

"The rule derives from the concept of an integrated contract. When the parties to an agreement incorporate the complete and final terms of the agreement in a writing, such an integration in fact becomes the complete and final contract between the parties. Such a contract may not be contradicted by evidence of purportedly collateral agreements. As a matter of law, the writing is the agreement."

Hayter Trucking, supra, 18 Cal.App.4th at 14. Extrinsic evidence therefore is excluded “because it cannot serve to prove what the agreement was, this being determined as a matter of law to be the writing itself.” *Id.*

Most insurance policies have an integration clause which provides that the policy is the entire contract between the policyholder and insurer. Even in the absence of such a clause, there may be statutory authorities which require integration. See, e.g., California *Insurance Code* §10113 [“Every policy of life, disability or life and disability insurance issued . . . shall contain and be deemed to constitute the entire contract between the parties.”]. In any event, if the insurer can establish that the policy is an integrated agreement, the Parol Evidence Rule should foreclose the policyholder from alleging that representations by the agent gave rise to a separate contract.

The Parol Evidence Rule also bars claims of promissory fraud which are “directly at variance with the terms of the written agreement.” *Bank of America v. Pendergrass* (1935) 4 Cal.2d 258, 263. It therefore requires that the terms of the underlying policy, rather than some unwritten agreement about premium payments, govern the rights of the parties.

The Parol Evidence Rule thus promotes at least two important policies. First, it reflects the assumption that “written evidence is more accurate than human memory.” *Banco do Brasil, S.A. v. Latian, Inc.* (1991) 234 Cal.App.3d 973, cert. denied, 504 U.S. 986 (1992). Second, it is based on the notion that “fraud or unintentional invention by witnesses interested in the outcome of the litigation will mislead the finder of fact” if allowed to introduce extrinsic evidence on a subject covered by a written, integrated agreement. *Id.*

The Parol Evidence Rule serves those ends by forbidding parties to a contract from offering evidence regarding the pre-contract negotiations that contradicts the express terms of the written agreement. *Pendergrass, supra*, 4 Cal.2d at 263. It therefore properly keeps the focus on the terms of the contract which defines the parties’ relationship, rather than allowing “parties to litigate disputes over the meaning of contract terms armed with an arsenal of tort remedies inappropriate to the resolution of commercial disputes.” *Price v. Wells Fargo Bank* (1989) 213 Cal.App.3d 465, 485.

B. The Essential Element of Reliance. Some courts have held that, as a matter of law, a party cannot rely on pre-contractual representations that are directly contrary to the terms of a written, integrated agreement. See, e.g., *Hadland v. NN Investors Life Ins. Co.* (1994) 24 Cal.App.4th 1578. Therefore, insurers whose policies clearly, prominently and unambiguously state the terms of a particular exclusion or limitation can use the policy itself to disprove an allegation that the policyholder relied on an agent’s oral representations that contradict those terms.

The decision in *Hadland, supra*, is particularly instructive. In that case, the plaintiffs allegedly purchased a health insurance policy in reliance on the sales agent’s representation that coverage under the subject policy was “as good if not better” than the coverage under their existing policy. Had the plaintiffs read their new policy when it was delivered, they would have discovered that its coverage was not as good as the coverage under their previous policy. The plaintiffs therefore alleged that they had not read their policy and had instead relied on the agent to explain its terms to them. *Id.*, at 1586.

The trial court granted a nonsuit on the plaintiffs' fraud claim, and the Court of Appeal affirmed. In reaching that result, the Court of Appeal found guidance in an earlier decision by the California Supreme Court, explaining that:

“As the Supreme Court stated in *Sarchett v. Blue Shield of California* (1987) 43 Cal.3d 1, 15, a court ‘must hold the insured bound by clear and conspicuous provisions in the policy even if evidence suggests that the insured did not read or understand them.’ The Hadlands, having failed to read the policy and having accepted it without objection, cannot be heard to complain it was not what they expected.”

Id., at 1589. The Court therefore concluded that the plaintiffs' “reliance on representations about what they were getting for their money was unjustified as a matter of law.” *Id.*, at 1589.

The Court in *Hackethal v. National Casualty Company* (1987) 189 Cal.App.3d 1102 reached a similar conclusion. In that case, the Court found that the agent had materially misrepresented the coverage afforded by the policy he sold to the plaintiffs. However, it also found that the documents furnished to the plaintiffs in connection with their policy contradicted those misrepresentations. *Id.* at 1111. As a result, it held that the plaintiffs could not have justifiably relied on any such misrepresentations. *Id.*¹ As a result, insurers can use those authorities and the policy documents to establish that the policyholder is unable “to establish the requisite fraud element of justifiable reliance.” *Hadland, supra*, 24 Cal.App.4th at 1588-89; See, also, *Hackethal v. National Casualty Co.* (1987) 189 Cal.App.3d 1102.

C. Statute of Limitations. One who claims to have been defrauded is charged with constructive knowledge of the facts constituting the fraud (so as to start the running of the statute of limitations) once he has both notice of facts sufficient to put a prudent person on inquiry and the means for discovering those facts. *Sime v. Malouf* (1949) 95 Cal.App.2d 82.

Under California law, an insured has a duty to read his or her policy and is bound by its terms, notwithstanding any contrary oral statements. *Malcolm v. Farmers New World Life Ins. Co.* (1992) 4 Cal.App.4th 296, 304, n. 6; See also, *Hackethal, supra*, 189 Cal.App.3d at 1108-11 [same]. Indeed, well-drafted policies usually caution policyholders to read their policies upon delivery and invite them to surrender any policy that does not conform to their expectations. *Taff v. Atlas Assurance Co.* (1943) 58 Cal.App.2d 696, 702 [“Not only did ordinary prudence require that [each plaintiff] examine [the policy] to see that it was the policy he had intended to purchase but in bold letters on the very face of it he was admonished to read and return it for correction.”]. The receipt and acceptance of a policy without objection therefore can give the policyholder constructive knowledge of the policy's terms and prevent any complaint that “he did

¹ See also, *Rennick v. O.P.T.I.O.N. Care, Inc.*, 96 C.D.O.S. 1153, 1156 (9th Cir., Feb. 22, 1996) [under California law, plaintiffs are precluded from reasonably relying on oral representations contrary to written letter of intent]; California law is consistent on this point with a host of other jurisdictions. See, e.g., *Assoc. in Adolescent Psychiatry v. Home Life*, 941 F.2d 561, 571 (7th Cir. 1991) [under RICO, “no jury could find that a reasonable investor would be misled . . . when the truth was under his nose in black and white.”]; *Runnemedede Owners, Inc. v. Crest Mortgage Corp.*, 861 F.2d 1053, 1058-59 (7th Cir. 1988) [same under Illinois law]; *Louisiana Gaming Corp. v. Jerry's Package Store, Inc.*, 629 So.2d 479, 481 (La.Ct.App. 1993) [same]; *DiGrazia v. U.S. Life Ins. Co. in N.Y.*, 170 A.D.2d 247, 565 N.Y.S.2d 525 (1991) [same].

not read it or know its terms.” *Aetna Casualty & Surety Co. v. Richmond* (1977) 76 Cal.App.3d 645, 652.

When the representations attributed to the sales agent directly contradict the express terms of the subject policies, it follows that the policyholder would have discovered that fact if he or she had reviewed the policies. By using these authorities, insurers therefore can charge policyholders with constructive knowledge of the falsity of the agent’s alleged representations at the time that the policy was delivered. See, e.g., California *Civil Code* §19. In turn, claims of delayed discovery may be untenable, and the statute of limitations may constitute a complete defense to the policyholder’s claims.

D. Requirements for Altering Contract Terms. The Parol Evidence Rule only prohibits the policyholder from offering evidence of pre-contract representations and conduct which contradicts the terms of a written, integrated agreement. Therefore, to escape the effect of the Parol Evidence Rule, policyholders sometimes allege that conduct which occurred after the policy was issued created a separate contract that modified the original contract’s terms.

Well-drafted policies usually contain language providing that an alteration of policy terms is void unless written and signed by an officer of the issuing company. In such a case, the insurer should force the policyholder to admit that no signed writing exists. In addition, the premiums paid for coverage under the subject policy cannot constitute consideration for a subsequent contract because consideration must confer some benefit upon the promisor to which it is not otherwise entitled. See, e.g., Cal. *Civil Code* §1605. Paying premiums for coverage under the written policy, even in amounts which exceed the minimum premium required, may not be enough. As a result, insurers also should challenge the policyholder to prove that it gave adequate consideration for the alleged separate contract regarding premium payments.

E. Limitations on Agent’s Authority. Even when the subject policy has no integration clause, insurers can sometimes foreclose the policyholder from alleging the existence of a separate contract by demonstrating that the sales agent had no authority to create such a contract.

Most courts recognize that an insurance company has the right to limit the authority of its soliciting agents. *Duarte v. Postal Union Life Ins. Co.* (1946) 75 Cal.App.2d 557, 571. In *Duarte*, the Court further explained that:

“A mere soliciting agent or other intermediary operating between the insured and the insurer has authority only to initiate contracts, but not to consummate them, and cannot bind his principal by anything he may say or do during the preliminary negotiations.”

Id. The insurer’s counsel therefore should carefully inspect the application and other policy documents for statements regarding the limits of the sales agent’s. If those statements exist, they can be used to disprove an allegation that the agent had actual or ostensible authority to make a separate contract for the company.

7. Step Six: Know How the Policy Will be Interpreted

The interpretation of an insurance policy is a question of law. *AIU Ins. Co v. Superior Court* (1990) 51 Cal.3d 807, 818. The rules governing policy interpretation require courts to look first to the language of the contract in order to ascertain its plain meaning or the meaning a layperson would ordinarily attach to it. Cal. *Civil Code* §1638; *Reserve Insurance Co. v. Pisciotta* (1982) 30 Cal.3d 800, 807. Thus, courts must consider both the language in the policy, and the endorsements broadening coverage, if any, included in the policy terms. *Collin v. American Empire Ins. Co.* (1994) 21 Cal.App.4th 787, 803.

The fundamental rules of contract interpretation are based on the premise that the interpretation of a contract must give effect to the "mutual intention" of the parties. In *AIU*, *supra*, the California Supreme Court more fully explained that:

"Under statutory rules of contract interpretation, the mutual intention of the parties at the time the contract is formed governs interpretation. (Civ. Code, § 1636.) Such intent is to be inferred, if possible, solely from the written provisions of the contract. (Id., § 1639.) The 'clear and explicit' meaning of these provisions, interpreted in their 'ordinary and popular sense,' unless 'used by the parties in a technical sense or a special meaning is given to them by usage' (id., § 1644), controls judicial interpretation. (Id., § 1638.)"

AIU, *supra*, 51 Cal.3d at 821-822; *Bank of the West v. Superior Court* (1992) 2 Cal.4th 1254, 1264-1265. A policy provision will be considered ambiguous when it is capable of two or more constructions, both of which are reasonable. *Bay Cities Paving Grading, Inc. v. Lawyers' Mutual Insurance Co.* (1993) 5 Cal.4th 854, 867. But language in a contract must be interpreted as a whole, and in the circumstances of the case, and cannot be found to be ambiguous in the abstract. *Bank of the West*, *supra*, 2 Cal.4th at 1265.

Stated differently, courts will not strain to create an ambiguity where none exists. *Reserve Insurance*, *supra*, 30 Cal.3d at p. 807.

If the Court does find an ambiguity, it usually will construe that ambiguity against the insurer because it drafted the policy. See, e.g., *Neal v. State Farm Insurance Companies* (1961) 188 Cal.App.2d 690, 695. Importantly, though, a different rule may apply if the allegedly ambiguous language is mandated by statute. In *Prudential-LMI Com. Insurance v. Superior Court* (1990) 51 Cal.3d 674, the California Supreme Court more fully explained that:

" . . . where an insurance policy provision is authorized by statute it should not be construed strictly against the insurer, but instead is to be deemed consistent with public policy and must be construed to implement legislative intent."

Id., at 684; emphasis in original; Accord, *Jacobs v. Fire Ins. Exchange* (1991) 227 Cal.App.3d 584, 590. In other words, language that is required by statute must be construed to effect the intent of the Legislature, rather than the intent of the parties.

Even when the language of a policy is unambiguous, courts sometimes will reform certain policy terms to achieve a stated objective. See, e.g., *Erreca v. Western States Life Insurance Co.* (1942) 19 Cal.2d 388, 396 [rejecting policy language that purports to make



benefits available only when the insured has “an absolute state of helplessness” to find total disability when he or she is “unable to perform the substantial and material acts necessary to the prosecution of a business or profession in the usual or customary way.”]; *Moore v. American United Life Insurance Co.* (1984) 150 Cal.App.3d 610, 630 [despite absence of corresponding policy language, insured will be considered “totally disabled” if a sickness or injury prevents the insured from working with “reasonable continuity”]. Insurers therefore may wish to consult an attorney who is familiar with the laws of the jurisdiction in question to confirm that the courts will read their policy to mean what it says.

8. Conclusion

Logically, actuaries should be well-equipped to explain why insurance policies contain the various exclusions and limitations that consume so much of their text. From a litigation perspective, though, there are several reasons to avoid asking an actuary to participate in claim decisions and several more reasons to not ask that an actuary testify at trial. Insurers and their outside counsel therefore should look to other sources for information that can be used to explain why, regardless of a policy’s exclusions and limitations, a particular claim decision makes sense.

The documents used at the point of sale, the insured’s application and the policy itself all may contain text the insurer can use to put the insured on notice of the policy’s exclusions and limitations. In the end, though, the trier of fact may be unwilling to use the policy’s exclusions and limitations to resolve claims-related litigation unless someone explains why those terms originally were made part of the policy. Defense counsel therefore should review those issues with the key claims personnel. Even if those claims people never have an opportunity to explain why a particular policy excludes coverage for a particular risk, their understanding of that issue should make them more confident in the claims decision that the company is being forced to defend.

About the Author

Rob Pohls has been shaping California insurance law for more than 20 years. He is the principal of *Pohls & Associates*, a firm in the San Francisco Bay Area that he established in 1999 to represent life, health, disability and long term care insurance companies in bad faith, ERISA and other forms of complex litigation. As a member of the Association of Life Insurance Counsel and a former Chair of the American Bar Association’s Health & Disability Insurance Law Committee, he is a prolific author and frequent speaker on issues of interest to the insurance and financial services industries. More information about Rob, his firm and his practice is available online at: www.califehealth.com. Contact him by e-mail at: rpohls@califehealth.com.