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**CLAIM
DENIED**

What **You** Need to Know Before and After an Insurance Claim



Mark Nation,
Trial Attorney and Consumer Advocate

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A Consumer's Guide to Insurance in Florida

For Wendy

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Note: This document contains general discussions regarding very complex legal issues. There is no attorney client relationship between you and Mark Nation or The Nation Law Firm created by your reading or utilizing this guide. As discussed in this guide, when purchasing insurance you should utilize the services of a competent insurance agent to determine the right coverages and the appropriate limits of liability for your particular circumstances.

Why You Should Read This

I live and breathe insurance claims, and I truly love what I do. Since the beginning of my legal career, I've evaluated and litigated thousands of insurance claims on behalf of policy holders in state and federal courts. Day after day, month after month, and year after year, I've met with policy holders, explained their coverages to them in simple terms, and represented them in court in cases against their insurance companies. Whether it is automobile, health, life, homeowners, condo, business owners, or disability claims, I've had the honor and privilege of standing with men and women who dared to stand up and fight their insurance companies.

Grinding through all those cases, one sad fact stands out to me. Across the socio-economic spectrum, people have only a vague notion at best of how insurance works, what insurance they have, what insurance they need, and what to do if an insurance company denies or delays a claim.

There is probably nothing we pay more money for and understand less than insurance. With something so common, and so necessary to our modern lives as insurance, we need a handy reference to help us understand it. That is my hope with this Consumer Guide.

In my experience, most people don't consider what insurance they need or have until after there is a claim. I understand why this is. People think insurance is complicated, and they are right. But, there are some simple concepts you need to know before purchasing insurance.

Don't wait until after you suffer a loss to find out what insurance you need or have. One of my favorite Proverbs is: "*A prudent person foresees danger and takes precautions. The simpleton goes blindly on and suffers the consequences.*" Be prudent; use this Guide to take precautions.

Don't become paralyzed with fear or indecision if an insurance company denies or delays a claim. There are options; you have more power than you think to make the insurance company do the right thing.

For the latest information on insurance claims, visit my websites at:

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About the Author: Mark Nation is a civil trial lawyer and consumer advocate who has litigated thousands of cases against most of the world's largest insurance companies. He is Board Certified in Civil Trial Law and Business Litigation by the Florida Bar. He was born and raised in central Florida.

What You Don't Know CAN Hurt You

Many times, an insurance company can word a denial in such a way that the policy holder believes that the denial is legitimate, when in fact it is not. Evaluating an insurance company's denial is not something a policy holder should do on their own. Evaluating a denial takes experience, and a knowledge of how the Court's actually apply the law. Many denials that sound legitimate on their face are not. I've seen many examples in my career where a denial may sound legitimate, but it was not. Below are just a few.

What happened: Ron was killed by a drunk driver in an auto accident. Although Ron was intoxicated as well, he had no blame in the accident. Ron's widow had an accidental death policy on Ron's life and submitted the claim to the insurance company after his tragic death. The insurance company refused to pay, citing a clause that excludes payment for any accidental death where the insured is intoxicated.

The Result: Courts in Florida refuse to enforce this clause as written. Instead, the insurance company is required to show that the insured's intoxication caused or contributed to causing the death.

What happened: Carolyn's roof sustained hail and wind damage, but the insurance company sent out an engineer who said the damage was simply "wear and tear."

The Result: The jury found that the damage was actually from hail and wind.

What happened: Jack's home sustained water damage from a pipe which had been leaking for several months. His insurance policy had a clause excluding water losses that are the result of continuous or repeated seepage or leakage over a period of 14 days.

The Result: I requested that the insurance company simply pay for all the water damage that occurred in the first 13 days. They said, "In order to do that, we'd have to fix the whole thing." I said, "Exactly."

What happened: A car dealership has insurance that provides liability coverage for \$500,000 per year. The dealership was sued in a class action that included thousands of deals over a four-year period. The insurance company said it would provide only \$500,000 to pay the entire claim.

The Result: The Court ruled that the dealership was entitled to \$500,000 *per year* for each of the four years, or \$2,000,000 in coverage.

What happened: Doug was crushed at work by a 5,000-pound roll of steel. Doug had residue from marijuana in his system. His accidental death policy has a clause that

excludes any death where the insured has illegal drugs in his system, and the insurance company denied the claim

The Result: The insurance company reversed its decision when I showed them that the courts will not enforce this exclusion unless the illegal drug caused or contributed to the death—which it did not.

A Short (and interesting) History of Insurance

No one knows for sure what was in the baker's oven, but one thing seems clear: it burned. The fire began on Pudding Lane in the house of the king's baker. Horse fodder was ideal kindling for what quickly became a blazing inferno of wooden houses and businesses. When the fire finally burned out, 373 acres inside London's city walls lay in ashes. But much more was lost than the 13,000 buildings including 87 churches. Lives were lost. And so were the fortunes of many of London's wealthiest citizens.

The Great Fire of London took place on Sunday, September 2, 1666. Out of the ashes rose a new city, built more with stone than with wood. Not surprisingly, it incorporated the first organized firefighting brigades. And the first insurance company.

After the fire, landowners knew they needed protection from the risk of another fire. So in 1667, the first insurance company opened its doors. It was given the uninspired name of "The Insurance Office." Soon after, other insurance companies sprang up and began issuing policies.

In order to protect the houses and other buildings they insured, these insurance companies hired men to put out the fires on properties they covered. Policyholders were issued a metal badge or "fire mark," which was attached to the outside of the building. When a fire broke out, various brigades would respond, giving first attention to buildings that bore their fire mark and sometimes leaving others to burn. Over time, the insurance companies realized it was in their best interest to have their fire brigades cooperate and work together to put out all fires. This cooperation led to the founding of the London Fire Engine Establishment in 1833.

Gradually, the insurance industry expanded into other arenas until it became possible to insure virtually anything including the legs and arms of professional athletes.

As important as the Great Fire of London was to the creation of insurance as a commercial product, it was not the first time a form of risk sharing had occurred. In ancient times, farmers in China would pool their produce and then divide it and assign it to several ships. If a ship sank, the loss would be spread between several farmers, with any given farmer losing only a small amount.

As early as the 13th century, ship owners entered into insurance contracts to avoid large losses. Under these insurance contracts, wealthy individuals would agree to receive a payment in exchange for their promise to pay for losses resulting from a sunken ship.

The purpose of these first risk-sharing arrangements is the same as our modern insurance policies: to spread the risk of financial loss among a large group of people so that the loss does not financially ruin any one individual or company.

When Insurance Doesn't Work

Inaccuracy on the Application

I am stunned by the number of times people come to my office and I can't help them because there is inaccurate information on the application. This can happen in a number of different ways, but the three most common issues are: 1) the person applying for insurance either intentionally or mistakenly puts down inaccurate information; 2) the insurance agent writes down the wrong information; or 3) the insurance agent tells the applicant to misstate the information because "it's not important."

All of these problems can allow the insurance company to deny a claim that would otherwise be paid. The common excuses: "I didn't know it was *that* important," or "That's not fair," or "The agent said it didn't matter," will not work.

If the insurance agent or one of his staff writes down the information on the application, make sure you check it for accuracy. Don't just sign the application without reading it. If you see something wrong, change it! Don't worry that you may offend the agent or staff member. Like the excuses mentioned above, the excuse that the agent wrote it down wrong will not work.

I know this may seem excessive, but insurance companies in Florida deny claims day in and day out for inaccurate information on an application. It is their right, and they take full advantage of it. Don't let anyone mislead you; the information on the application must be accurate—not "accurate to the best of my knowledge"—*accurate*.

I have purposely stated that nearly any "inaccurate" information on the application allows the insurance company to void the policy and deny the claim. I can't overemphasize it. The inaccuracy doesn't have to be a lie, and it doesn't have to be intentional. Nor does it need to have anything whatsoever to do with a loss that occurs later. Let me give a typical example.

An application for car insurance may ask if there are any residents in the home who are 14 years old or older. Let's say that the applicant fails to disclose a child who just turned 14. Two months later, while the child is still 14, the mother causes a traffic accident. The accident has nothing to do with the 14-year-old; he isn't even in the car at the time. The mom submits the claim to her insurance company. If the insurance company discovers that there was a 14-year-old living in the house at the time the application was filled out, they will undoubtedly void the policy and deny the claim. And they will probably win. I have seen this and similar unfortunate situations play out hundreds of times in my career as a lawyer for policyholders.

There is an exception to this rule for individual health, life and disability policies. The Florida legislature has enacted statutes that prohibit an insurance company from voiding these types of policies after the policies have been in effect for two years unless the

inaccurate statement was fraudulent. After this two year period, the insurer must prove that the statement was fraudulent in order to void the policy.

The moral of the story is simple: make sure the information on the insurance application is accurate. If you see any inaccurate information on the application, fix it. If your insurance agent says “that’s not important,” run the other way.

Agent Malpractice

Insurance agents have a duty to exercise due care in correctly advising you of the availability of appropriate insurance, including the recommendation to obtain higher limits. This duty of care is similar to the duty owed by a doctor or a lawyer. Insurance agents are professionals required to use reasonable skill, care and diligence in advising you of available coverages for your particular and individual circumstances.

Agents are occasionally found negligent in the performance of their duty. This most often occurs when they fail to obtain requested coverage or to properly advise their client about available coverage they should consider.

Agents are also negligent if they fail to provide or suggest adequate coverage limits. For example, high-net-worth individuals should be counseled to have high limits in order to protect themselves against loss. Agents need to properly acquaint themselves with their insured’s businesses, homes, vehicles, and other assets in order to properly advise them on the various coverages they may need. Prudent agents meet regularly with their clients in order to update their information and make sure they are properly covered.

When agents are negligent in obtaining insurance or in advising the insured about what insurance is appropriate, it can cost them. If clients suffer damages as a result of such malpractice, they can file a malpractice case against the agent.

For example, suppose someone goes to an agent to obtain coverage for his business. In this business, he provides drivers to drive cars through the auction line at an auto auction. The agent recommends a particular insurance policy, and the client accepts it. After an accident by one of the drivers, the insured submits a claim. The insurance company denies the claim, citing an exclusion in the policy for “any loss arising from the use of an automobile.” (This is a real example from one of my cases).

The insured in this scenario has a malpractice claim against the agent for failing to obtain the appropriate coverage. The agent, knowing his client was in the business of driving cars, was obligated to obtain coverage that would protect him in the event one of his drivers caused an accident.

Insurance Company Insolvency

Insurance companies sometimes go under. This is known as going “insolvent.” Although this is not good, you do have some backup protection. In order to help policyholders of

insolvent insurance companies, in 1970, the Florida Legislature established a nonprofit corporation known as “The Florida Insurance Guaranty Association,” or FIGA. In essence, when an insurance company is declared insolvent, FIGA steps into the shoes of the insurance company and begins administering and paying claims.

It is important to understand that FIGA pays up to the limit of the policy but no more than \$300,000 for any claim—even if the policy had a limit of \$1,000,000 or more. If your claim exceeds the \$300,000 FIGA limit, you are allowed to file a claim against the insolvent insurance company for amounts that exceed \$300,000. This type of claim will be paid out by a receiver when the assets of the insurance company are sold off. Typically, you will receive only pennies on the dollar, if anything, for these excess claims.

If your insurance company goes insolvent you should immediately obtain another insurance policy from a different insurance company. While FIGA will cover pending claims, you should immediately obtain alternative coverage for any new claims which may arise after the insolvency.

Choosing an Insurance Agent and Company

Choosing the Right Agent

Since you don't know what you don't know, it's important to find someone who does. Insurance is a complicated world. What should you cover? What kind of insurance will cover it? How much should you cover and at what cost? When does the insurance become more costly than the risk?

It's complicated enough in the simple world of car insurance: should you get coverage that includes uninsured motorists? Medical payments? Rental car coverage? The list goes on.

It gets even more complicated for business people. They may own various buildings under different corporate entities, employ people, own company cars that get driven on personal time.... Many of these circumstances require analyzing literally dozens of important questions to make good decisions regarding insurance.

So where do you start?

You start by choosing the right agent. You don't want to buy insurance and pay for it for years and then have a loss that doesn't get covered because of an avoidable mistake. The right agent helps you prevent your good intent from going sour.

In Florida, all insurance agents are regulated by the Florida Department of Financial Services, Office of Insurance Regulation. Licensed agents can be found on their website at www.fldfs.com. This common regulation does not mean that one is as good as another. Just as with doctors, lawyers, or any other profession, there is a wide disparity in the quality of insurance agents. An agent who is not well-qualified or experienced can ultimately do great damage to you and your family.

To find a good agent, start with word-of-mouth references. Then run their names on the internet and see what you find. Check the Better Business Bureau. Interview a few different agents, being careful to postpone any decision until after all the interviews are complete. You also may want to consider whether the agent has received any important industry designations. You can find these listed in Part Two on page 44.

Taking the time to make a good decision at the beginning of the process is vitally important; a mistake there has an impact on everything that follows. The right agent is an important ally for years to come. Get someone you can communicate with who is trustworthy and competent.

Once you decide on an agent, make sure to fully explain all your concerns, disclosing all your properties, vehicles, boats, businesses, and other information that you think could be important. Question the agent: ask her to explain to you what coverages she thinks are important for you. Listen carefully and ask more questions. If you are uncomfortable with the answers, or the agent is put off by your questions, consider another agent.

Choosing the Right Insurance Company

I am frequently asked which insurance company is best. That is hard to answer, and I am somewhat prejudiced because I have sued just about every insurance company that does business in the state of Florida. However, there are three important factors you should consider when choosing an insurance company.

First, listen to what your insurance agent suggests. But, don't just listen; ask questions. Your agent should be familiar with the various insurance companies and which one is best for your particular situation.

Second, shop around for price. Different insurance companies charge different amounts for the same coverage. Just make sure you are comparing the same coverages. Your agent should be able to help you compare various quotes to make sure that you are comparing "apples to apples." For example, one quote may be cheaper simply because it provides less coverage or lower limits.

Third, check the financial stability of the company. Insurance companies can and do go bankrupt. A list of Florida insurance companies currently in receivership or insolvency can be found at www.figafacts.com. You can check out the financial stability of your potential insurance company at any of the following insurance rating companies:

- A.M. Best www.ambest.com
- Duff & Phelps www.duffllc.com
- Moody's www.moody.com
- Standard & Poors <http://www.standardandpoors.com/home/en/us>
- Weiss Ratings Inc. www.weissratings.com

Car Insurance

The most common type of insurance most of us will ever deal with is car insurance. It is hard to imagine how something so common and ingrained in our everyday lives can be so complicated. But it is. This chapter discusses what insurance is required by law as well as what optional insurance you should consider and reasons why an insurance company can and can't cancel you. For more detailed information on the following topics, turn to page 47 in Part Two:

- Insurance When You Hurt Someone Else
- Insurance When You Damage Someone Else's Car or Property
- Insurance When You are Hurt
- Insurance When Your Car is Damaged or Stolen
- Insurance to Pay off Your Loan

What Insurance is Required

In Florida, there are only two types of car insurance required by the State. They are: 1) No-fault insurance, often referred to as Personal Injury Protection (PIP); and 2) Property Damage Liability insurance (PDL). PDL is discussed below (page 15), and PIP is discussed in detail in Part Two, beginning on page 47. A simple explanation is that *your own* PIP pays *you* for your medical expenses and lost wages sustained as a result of an accident regardless of who causes the accident. PDL repays *other people* if you damage *their* property or their car.

Unfortunately, these are the only two insurance coverages drivers are required to carry in Florida. These two coverages are woefully inadequate to protect you, your family and others in the event of a crash. Contrary to what you may believe, you are not required to carry liability insurance that provides coverage if you injure another person. Nor are you required to carry uninsured motorists coverage. Do not be deceived into believing that because the state only requires PIP and PDL, that they are the only coverages you need. They are minimal and insufficient for almost everyone.

Insurance agents often misinform their clients that they are getting "full coverage" when they have only PIP and PDL. Whenever someone comes into my office and says they have "full coverage," I know I am about to give them bad news. The name should be changed to "lame coverage," or "inadequate coverage," or "I hope I don't get in an accident because I don't have enough coverage."

What Additional Insurance Should You Carry?

You, like many other people, may think that because Florida is a "no-fault" state, you don't need Bodily Injury Liability coverage. Wrong! You may think that if someone else causes an accident and totals your car, their insurance must pay off the car loan. Wrong! You may think that other drivers are only liable to you for the limits of the insurance they carry. Wrong! The list goes on and on.

Each of these faulty assumptions and how to protect you and your family is discussed in detail—some below and some in Part Two beginning on page 47. For quick reference, however, I recommend that you get at least the following additional coverages:

Additional Coverages	Required?	Recommended?
Bodily Injury	No	Yes
Medical Payments	No	Yes
Uninsured Motorists	No	Yes
Comprehensive and Collision	No	Yes
Rental Car	No	Yes
GAP	No	Yes

Three Coverages You Dare Not Underestimate

1. Insurance When You Hurt Someone Else – “Bodily Injury Liability”

If you cause an accident and physically injure others, they can sue you. Also, if their insurance company pays them for their injuries under an uninsured motorist policy or under medical payments coverage, the insurance company can sue you. And they do—often. There are law firms whose only job is to help insurance companies recover money they have paid out. They do this by suing people who cause accidents whether those people have any insurance or not.

Your best protection from being sued for causing physical injury to another person in a car accident is to have adequate Bodily Injury Liability coverage, or BI. BI pays others for medical expenses, lost wages, and pain and suffering if you injure them in an accident.

Ironically, although the state of Florida does not require you to carry BI coverage, the state will promptly suspend your driver’s license, if you injure someone and you cannot reimburse them for their bodily injuries. This includes payments to the injured party for past and future medical expenses, past and future lost earnings, and pain and suffering. Few people can pay people for these personal injuries without insurance. And, remember, there are often several injured people in a typical accident, including the other driver, and passengers in your car and the other car.

In addition to having your driver’s license suspended if you cannot pay for all the personal injuries, the injured parties or their insurance companies will probably sue you for reimbursement. This could result in a sizeable judgment or multiple judgments against you. In Florida, we have strong laws that allow someone with a judgment to garnish wages, seize bank accounts, and auction off certain property. Make no mistake about it: these very bad things happen to people throughout Florida every day.

BI coverage is available to you from your insurance company in varying amounts. The lowest amount of protection you can buy in Florida is \$10,000 per person in an accident. But this \$10,000 is limited to a total limit of \$20,000 per accident. This is typically designated on your policy as “10/20.” For example, if you have 10/20 coverage and injure two people in an accident, your insurance company will pay up to \$10,000 per person in the accident but no more than a total of \$20,000. If you injure five people, your insurance company will still pay no more than \$10,000 to any one person and no more than \$20,000 for the entire accident.

Other available coverage limits are 15/30, 25/50, 50/100, 100/300, 250/500, on up into the millions. The amount of coverage you should get depends on what you are trying to protect and what premium you can afford.

Regardless of the BI limits you purchase, the other person or their insurance company can sue you for their “full damages.” This means that they are not limited to collecting the BI limits that you chose. Your policy limits are something you purchase to protect you. So, when it comes to determining what limits you need, always remember, the more the better. You should also periodically review and increase your BI limits if your financial situation has improved.

2. Insurance When You Damage Someone Else’s Car or Property – “Property Damage Liability”

Insurance that pays another person if you damage their car or other property is called Property Damage Liability coverage, or PDL. Florida requires that you carry a minimum of \$10,000 in PDL. This modest limit is not enough; it can be used up quickly in a minor accident, leaving you to pay the rest. Remember, other people are not limited to your policy limits. They can sue you for their full damages regardless of the amount of insurance you carry.

An example. Suppose you rear-end someone else’s car and push them into another car which then strikes a telephone pole. This type of accident happens all the time. In this scenario, you would be responsible to the owners of the two cars for the physical damage to their cars, as well as the reduction in value to their cars as a result of being in an accident; and you would be responsible for the damage to the telephone pole.

The car you hit may have \$6,000 worth of body damage and require a new paint job, which adds \$2,500 to the total. Plus, there is a reduction in value of the car of \$2,000 because it has now been in an accident. Total damage to car number one is \$10,500. The other car may need \$2,500 in body work and paint of \$1,000, with a reduction in value of \$1,000. Total damage to car number two is \$4,500. The telephone company then sends you a bill for \$1,000. Total property damage for the accident is \$16,000. Your insurance company pays \$10,000, leaving the \$6,000 balance for you to pay.

And, this is just the property damage. This does not take into consideration that the other drivers and passengers may have suffered bodily injuries, that you may be injured yourself, that other passengers in your car may be injured, or the damage to your car, which may be out of commission.

My recommendation with regard to PDL is to increase the minimum limits as much you reasonably can. With expensive cars on the road today, it is not uncommon to cause \$50,000 of property damage in a simple accident. You can acquire PDL in varying limits of \$20,000, \$25,000, \$50,000, \$100,000 and more. As with Bodily Injury Liability, the more the better.

3. Insurance When Someone Uninsured or Underinsured Injures You – “Uninsured Motorists”

One of most important optional coverages you should have is Uninsured Motorists coverage, or UM. In fact, UM is so important, that the state of Florida requires that you sign a special state-approved form if you intend to reject UM coverage. *This coverage is critical, and I believe everyone needs it.*

UM pays you for physical injuries and lost wages in the event someone injures you and they do not have any—or enough—Bodily Injury Liability coverage. This happens all the time.

As with other coverages, you can buy a range of UM limits, but unlike other coverages, UM can be “stacked.” This means that available UM for different cars is added together if you are injured in an accident.

An example will be helpful. Suppose you and your wife each own a car and you have \$100,000 per person and \$300,000 per accident in UM coverage. Suppose further that you have not rejected stacking. If you are in an accident with an uninsured or underinsured driver, your available UM limits are “stacked” or added together so that you now have coverage limits of \$200,000 per person, and \$600,000 per accident. This is very beneficial.

A word of caution. Some agents or insurers send you a new UM rejection form each year and simply advise you to “sign here.” Do not do it. Be careful of what you sign. Insurance companies do not like selling UM coverage, and they will repeatedly and consistently try to get you to reject it. Fortunately, they are required to offer it in Florida.

UM coverage is extremely important for you and your family because so many people drive in Florida with either inadequate liability insurance or none at all. And the sad fact is that people without liability insurance are often the worst drivers. That’s one reason they don’t have liability insurance – they’ve been in so many accidents that they either can’t get it or can’t afford it. Not only do many poor drivers have no liability insurance, many don’t even have a driver’s license. This makes UM coverage critical for you and your family. Please make sure you have adequate UM coverage.

Two Common Questions

1. Will your insurance company cover you in a rental car?

Most of your coverages will still apply if you rent a car. For example, your Bodily Injury Liability, Personal Injury Protection, and Property Damage Liability coverage should apply. However, in the event of an accident, the rental car company may charge certain administrative fees, loss of income, and other fees that are not covered by the standard insurance policy. Also, certain small items such as scratches and dents of unknown origin may not be covered by your insurance.

The “Loss Damage Waiver” offered by the rental car company may cover these uncovered items that your standard insurance does not cover. However, be aware that if you charge your rental car on a credit card, your credit card company may provide you with additional insurance protection that covers these items as well as any applicable deductibles.

As discussed in the next section, your Personal Injury Protection will not provide coverage for you if you go outside the state in a rental car or are out of state in any other car that you do not specifically insure.

2. Will your insurance company cover you out of state?

Most automobile policies will continue to provide you with your insurance protection anywhere in the United States. One exception is that your Florida Personal Injury Protection (PIP) will only cover you out of state if you are in your insured car. Your other coverages should apply anywhere in the United States.

Reasons Why Your Auto Insurance Company Can and Can’t Cancel You

People are often concerned that they will be cancelled by their auto insurer if they file a claim. When and how an auto insurer can cancel a policyholder is strictly governed by Florida law.

It is illegal for an insurance company to increase your premium, cancel or refuse to renew a policy solely because the insured was involved in a motor vehicle accident unless the insurer's file contains information from which the insurer in good faith determines that the insured was substantially at fault in the accident. However, if the insurer increases the premium, cancels the policy or fails to renew it because it thinks that the insured was “substantially at fault in the accident,” the insurer must notify the insured in writing that he is entitled to reimbursement of such amount or renewal of the policy if the named insured demonstrates that the operator involved in the accident was:

- Lawfully parked;

- Reimbursed by, or on behalf of, a person responsible for the accident or has a judgment against such person;
- Struck in the rear by another vehicle headed in the same direction and was not convicted of a moving traffic violation in connection with the accident;
- Hit by a "hit-and-run" driver, if the accident was reported to the proper authorities within 24 hours after discovering the accident;
- Not convicted of a moving traffic violation in connection with the accident, but the operator of the other automobile involved in such accident was convicted of a moving traffic violation;
- Finally adjudicated not to be liable by a court of competent jurisdiction;
- In receipt of a traffic citation which was dismissed or nolle prossed; or
- Not at fault as evidenced by a written statement from the insured establishing facts demonstrating lack of fault which are not rebutted by information in the insurer's file from which the insurer in good faith determines that the insured was substantially at fault.

In addition, an insurer cannot cancel or refuse to renew a policy if the insured has had only one accident in which he or she was at fault within the current three-year period. However, the insurer can refuse to renew a policy if while insured under that policy the insured has had three or more accidents, regardless of fault, during the most recent three-year period.

An insurance company cannot charge an addition premium or cancel or refuse to renew a policy solely because the insured committed a noncriminal traffic infraction unless the infraction is:

- A second infraction committed within an 18-month period, or a third or subsequent infraction committed within a 36-month period.
- A violation of s. 316.183, when such violation is a result of exceeding the lawful speed limit by more than 15 miles per hour.

If there is an increase in premium or cancellation or refusal to renew, the insurer and agent shall supply to the insured the complete proof of fault or other criteria which justifies the additional charge or cancellation.

Additionally, no insurer shall impose or request an additional premium for motor vehicle insurance, cancel or refuse to issue a policy, or refuse to renew a policy because the insured or the applicant is a handicapped or physically disabled person, so long as such handicap or physical disability does not substantially impair such person's mechanically assisted driving ability.

No insurer shall, with respect to premiums charged for motor vehicle insurance, unfairly discriminate solely on the basis of age, sex, marital status, or scholastic achievement.

Nor can an insurer impose or request an additional premium for motor vehicle comprehensive or uninsured motorist coverage solely because the insured was involved in a motor vehicle accident or was convicted of a moving traffic violation.

Finally, no insurer shall impose or request an additional premium, cancel a policy, or issue a nonrenewal notice on any insurance policy or contract because of any traffic infraction when adjudication has been withheld and no points have been assessed. However, this does not apply to traffic infractions involving accidents in which the insurer has incurred a loss due to the fault of the insured.

Home Insurance

Your home is probably your most valuable asset. Is it insured properly? There are various kinds of homeowners insurance policies in Florida. They are designated HO-1, HO-2, HO-3, HO-4, HO-5, HO-6 HO-7 and HO-8. A general description of these various policies follows:

- HO-1. This is the most basic homeowners policy available. This type of policy is typically purchased by mortgage lenders when the borrower's homeowners insurance is cancelled.
- HO-2. Broad Coverage Form. This provides the same coverage as HO-1 but includes some additional protection.
- HO-3. Special Homeowners Form. This is the most common type of homeowners insurance available
- HO-4. Renter's Insurance. This covers contents but not the building.
- HO-5. Provides more coverage than HO-3 but is rarely sold anymore.
- HO-6. Condominium Owner's Insurance
- HO-7. Manufactured (Mobile) Home Insurance
- HO-8. Homeowners Insurance that provides only actual cash value instead of replacement cost, usually because some historic or architectural aspect of the home makes replacement cost significantly higher than its market value.

Insurance for My House

There are innumerable ways your home can be damaged. You may immediately think of fire and storm damage like a tornado or hurricane. However, there can be water damage from a broken washing machine or ice maker line, vandalism, sinkhole, hidden decay, hail damage, tear gas (yes, tear gas), sewage back-up, damage from blasting nearby or even from vibrations sent through the earth by heavy equipment being used in the vicinity.

I have handled many actual cases involving all these types of damage and many more. I even had a case where someone's wooden floors were damaged by someone dancing on them in high heels. It would be impossible to list all the various ways a home can be damaged. As a result, coverage for your home is typically provided as "all-risk" coverage, which means your home is covered for damage from all risks unless there is a specific exclusion. See Part Two beginning on page 50 for legal details on "all-risk" coverage.

Here are some of the risks commonly covered.

Sinkhole Coverage

By statute, Florida requires insurance companies to offer coverage for sinkhole damage. Thus, an insurance company cannot exclude losses due to sinkhole. The definition of a sinkhole, and how sinkhole claims are resolved is governed strictly by Florida Statutes. (This is not true for certain “surplus lines” insurers.)

Hurricane Coverage

Florida does not require that insurance companies provide coverage for hurricanes, but most do. Some companies exclude windstorm coverage in certain “high-risk” areas. If you cannot obtain hurricane coverage, you will be able to get coverage from the Citizens Property Insurance Corporation. Citizens is essentially an insurance company established by the state of Florida to help insure high-risk properties from wind losses.

Flood Coverage

Most homeowners insurance policies do not cover damage by “flood.” It’s important to understand that not all water damage is flood damage. A broken water line on your clothes washing machine may flood your home, but it is not “flood” damage. Likewise, rain water that comes through a hole in your roof or a window is not “flood” damage. A river that overflows its banks and enters your house may be “flood” damage. If your insurer denies a water damage claim, please refer to the chapter entitled “What to Do if Your Insurance Company Denies or Delays a Claim” for more information.

Flood insurance is administered by the National Flood Insurance Program. You can obtain more information at www.floodsmart.gov.

Replacement Cost Coverage

By statute, insurance companies in Florida must offer “replacement cost” coverage as opposed to “actual cash value” coverage. Replacement Cost coverage is much better coverage because it pays the cost to replace or repair the damage to your home. Actual Cash Value coverage only pays the market value (depreciated) for the damage. Your policy limits will still apply.

For example, assume that your house is insured for \$500,000 and is destroyed by fire. The cost to rebuild it is \$600,000. However, the actual cash value right before the loss was only \$400,000. If you have Replacement Cost coverage, your insurance company will pay the entire \$500,000 policy limit. However, if you have only Actual Cash Value coverage, you will receive only \$400,000.

Further, if you have Replacement Cost coverage, your insurance company is prohibited from keeping money back for depreciation whether or not you actually replace or repair the home. In the past, even if you had Replacement coverage, insurance companies would

hold back certain funds for depreciation until you actually repaired or replaced the property. That is no longer legal if you carry Replacement Cost coverage.

Law and Ordinance Coverage

When a home is damaged or destroyed, it is often necessary to “bring it up to code” when repairing or rebuilding it. For instance, the current code may require that the contractor use certain tie-downs for the roof, or that certain roofing material be used in order to permit the rebuilding of a roof. Most insurance policies exclude coverage for any increased expenses due to complying with the current building codes.

However, the Florida Legislature has enacted a statute which requires insurance companies to offer additional coverage to homeowners to compensate for these code upgrades. This additional protection has a separate limit which must be offered at either 25 percent or 50 percent of the total dwelling limit. I strongly recommend that you opt for this type of coverage. It will generally be referred to as “code upgrade” coverage or “law and ordinance” coverage.

If the insurer does not obtain your written refusal to accept “code upgrade” coverage, the policy will be deemed to have law and ordinance coverage of 25 percent of your dwelling limit.

Inflation Guard

Some insurers offer an additional coverage called “inflation guard.” Inflation guard increases your dwelling policy limits to reflect current prices and inflation. If your policy does not have this coverage, you should contact your insurance company annually to increase your dwelling limit of liability.

How does inflation guard work? Assume, for example, that your home was worth \$200,000 when you insured it, and you obtained a \$200,000 limit for your home. Five years later, your home is worth \$300,000. However, you haven’t raised your policy limits since taking out the insurance. If you don’t have inflation guard, you will be limited to the \$200,000 policy limits for your \$300,000 home. If you have inflation guard, your policy limits will automatically increase to reflect the increased value of your home.

Innocent Insured Doctrine

I frequently see cases where one member of an insured family is accused of intentionally damaging the home. This often occurs when one spouse is accused of intentionally burning down the home in order to obtain insurance proceeds without the knowledge or consent of the other spouse. All policies exclude coverage for such intentional conduct. However, the wording in many policies will still allow an “innocent insured” to recover the insurance proceeds. This is known as the “innocent insured doctrine.” (The insurance company is allowed to sue the insured who caused the damage and try to recover its payments from that person).

Insurance for My Personal Property

As contrasted with the “all-risk” coverage for your dwelling, coverage for your personal property that is damaged or stolen is only covered if the loss is caused by a particular peril identified in the policy. These perils are called “named perils.” If the loss to your personal property is due to one of these named perils, it is covered. If the loss is caused by something that is not on the list of named perils, then the loss is not covered.

For instance, I had a case where my client’s personal property in her home was shot up in a gun battle. The insurance company did not believe that gun shots fell under any named peril and denied the claim. I was able to prove that each gunshot was actually a small “explosion”: the firing pin hits the primer, which ignites the gunpowder and causes an explosion. Explosion was a named peril under the policy.

The insurance packages offered most commonly to owners of single-family homes insure against the following “named perils”:

1. fire or lightning
2. windstorm or hail
3. explosion
4. riot or civil commotion
5. aircraft
6. vehicles
7. smoke
8. vandalism or malicious mischief
9. theft
10. falling objects
11. weight of ice, snow or sleet
12. accidental discharge or overflow of water or steam
13. sudden and accidental tearing apart, cracking, burning or bulging
14. freezing
15. sudden and accidental damage from artificially generated electrical current
16. volcanic eruption

Loss to your personal possessions is not limited to losses which occur at your home. Most homeowners policies provide coverage for damaged or stolen personal property no matter where the loss occurs, as long as the loss occurs in the United States. Accordingly, items stolen from a hotel room while on vacation out of state are most likely covered under your homeowners policy.

Insurance for Someone Else’s Injury or Property Damage on Your Property

Your homeowners insurance offers two types of coverage in the event someone is injured on your property or their property is damaged. The first is Liability coverage, and the second is Medical Payments. Liability coverage comes standard with most homeowners

policies. Medical Payments coverage is optional. The differences and purposes of these two coverages are discussed below.

Liability Coverage

Most homeowners policies provide Liability coverage that protects you if someone is injured on your property or if you damage their property. For instance, suppose someone is injured on a defective diving board, or is bitten by your dog in your front yard. If that person sues you, your insurance company will provide you with a lawyer to defend you at their expense, and they will pay the claim up to your stated policy limit.

Your Liability coverage also protects you if you damage someone else's property. This can occur in various ways. Maybe your child throws a ball causing someone to lose control of their car and they hit a parked car. In that case, your homeowners Liability coverage will pay to repair the cars involved. Or, suppose a dead tree on your property falls on your neighbor's house. Again, the Liability coverage in your homeowners policy will pay for the loss and provide you with an attorney if you are sued.

You, like most people, might be surprised to learn that your Liability coverage also applies if you negligently injure someone away from their property. For instance, suppose you are out of state on vacation and accidentally knock someone over and injure them. Your homeowners Liability coverage will apply wherever you injure someone within the United States.

You should be aware of two major exclusions under your Liability coverage: 1) injuries that are the result of intentional acts, such as punching someone in a fight; and 2) losses resulting from the operation of a motor vehicle. So do not assume that you can get rid of the Liability coverage on your auto policy just because you have Liability coverage on your homeowners policy. You cannot.

Medical Payments Coverage

Medical Payments is an optional coverage under your homeowners policy. It pays for medical bills incurred as a result of any injury which occurs on your property. The injured person does not have to prove that you were negligent in causing the injury for this coverage to apply; it applies regardless of who caused the injury or how it was caused.

Medical Payments coverage can be purchased in various amounts. The typical amount of available coverage is \$2,000 or \$5,000. I recommend that you get the Medical Payments optional coverage for your home.

Insurance for My Rental Home

Many people own a second home, which they rent out. If you do this, you'll certainly want to know whether the homeowners policy on your primary home covers your rental

home. The answer is a simple maybe. To know for sure, you will need to discuss it with your agent. Some policies cover the primary home and your rental home, and some don't. Be careful to make sure you are adequately covered. Have your agent actually point out on the policy and declarations sheet where both homes are covered. A good safeguard is to send your agent a letter documenting that you want coverage on both your primary residence and the rental home. Keep a copy of the letter as well as any written response you receive.

Umbrella Coverage

Umbrella coverage is very important as an inexpensive way to increase your Bodily Injury Liability protection over and above your primary homeowners and automobile insurance policies.

For instance, suppose you carry \$100,000 in Liability limits on your homeowners policy, and \$100,000 in Bodily Injury Liability limits on your auto policy. If those are the only policies you have, then your maximum protection is \$100,000. However, if you carry a \$1,000,000 Umbrella, then you have \$1,100,000 in protection under both policies.

Your Umbrella can also provide you with added protection on your Uninsured Motorists coverage. You will need to have Uninsured Motorists coverage on your underlying policy, and you will be asked on the application if you want the Umbrella coverage to extend to your Uninsured Motorists coverage. You should say "yes" to have the Umbrella extend your Uninsured Motorists coverage.

Renter's Insurance

If you rent your home or apartment, you will need renter's insurance to cover your personal property for loss or damage. This insurance also provides you with Liability protection in the event you accidentally hurt someone.

You should see the sections in the chapter on "Homeowners Insurance" dealing with "Insurance for My Personal Property" and "Insurance for Someone Else's Injury or Property Damage on My Property" for a description of your available coverages. Essentially, your renter's policy is almost the same as a homeowners policy, except that there is no coverage for the actual structure. The structure should be covered by your landlord's insurance policy.

Condominium Insurance

There are typically two types of policies that cover your condominium unit. One policy is purchased by the condo owner, and the other is purchased by the condo association. These two different types of policies will be discussed below. Additionally, there will be a brief discussion on Director's and Officer's Liability protection for the condo association's board of directors and officers.

Unit Owner Insurance

Your Declaration of Condominium requires that each owner carry certain minimum coverages. The typical Unit Owner policy will cover your actual condo unit, “from the paint in.” This means that in the event of damage to your unit, your policy covers everything literally from the paint on the wall inward. The condo association policy covers those items which are on the other side of the paint, i.e., the structure from the drywall outward.

Like a homeowners policy, the Unit Owner policy on the structure is an “all-risk” policy. This means that losses to the unit are covered for any and all causes except for certain limited exclusions. For a more in-depth discussion of what an “all-risk” policy is, please see the discussion above concerning homeowners insurance.

Your Unit Owner policy will also cover your personal possessions in the event they are stolen or damaged. However, the loss must be due to one of the same “named perils” as in the homeowners section.

As with the homeowners policy, losses to your personal property are not limited to losses which occur at your condo. Most condo policies provide coverage for damaged or stolen personal property no matter where the loss occurs as long as the loss occurs in the United States. Accordingly, items stolen from a hotel room while on vacation out of state are most likely covered under your Unit Owner policy.

Your Unit Owner policy also provides you with liability protection in the event that you injure someone. If you negligently injure someone, your condo insurer will pay for covered losses up to the stated policy limit and provide you with a defense lawyer at their expense if you are sued.

The liability coverage also protects you if you negligently damage someone else’s property. This most often occurs when there is a water leak in an upstairs unit that floods a unit below, or when a condo owner negligently starts a fire that damages other units.

As with a homeowners policy, your condo policy provides you with liability protection no matter where in the United States you may be. Accordingly, if you are accused of negligently injuring someone while out of state, your condo policy liability coverage may protect you.

Association Insurance

Your condo association is required to purchase an insurance policy that covers the condo association’s property, including the common areas. This coverage typically does not cover any of the individual condo owners’ property. In simple terms, the condo association policy covers “up to the paint” on the walls of the individual condo units; the policy obtained by individual condo owners covers “from the paint in.”

This means the condo association policy covers things like shingles, roof decking and trusses, outside walls, and support beams up to and including the drywall in each unit. The individual condo owners' policies cover everything from the drywall in, including the paint on the walls.

The condo association's insurance policy also provides the association with liability protection in the event of an injury on the condo property. This liability protection will provide the association with a defense lawyer and money to pay the claim (up to the stated policy limit) in the event of an injury claim. The policy may also provide some liability protection for individual condo owners.

The liability coverage also provides the condo association with liability protection in the event the association causes property damage. For instance, suppose the sewage system backs up into an individual condo unit, and the condo association knew or should have known there was an ongoing problem, or they neglected routine maintenance. The individual unit owner could bring a claim against the condo association. The condo association insurance policy would pay for the damage (up to the stated policy limit) and provide a defense lawyer in the event the association was sued.

Director's and Officer's Liability Insurance

As you are likely aware, your condo association is governed by a board of directors and officers. Your directors and officers should carry liability insurance to protect the board (and ultimately the condo association) in case of their negligent acts. This is separate and distinct from the policy that protects the condo association itself.

For instance, a condo association might be responsible for a fire that damages several condos because of improper maintenance or failing to implement maintenance schedules. The individual condo owners could then bring a claim against the condo association for their losses. If the condo association is found negligent, the condo association may have a claim against the individual members of the board and directors for negligently performing their duties. If such a claim is brought, the Director's and Officer's liability insurance would be available to reimburse the condo association for what it was required to pay the individual condo owners.

Health Benefits

Notice that I didn't call this chapter "Health Insurance." That is because traditional health insurance is relatively rare these days. Most people now are members of Health Maintenance Organizations, or Preferred Provider Organizations—HMOs and PPOs. Technically, HMOs and PPOs are not insurance policies. They have their own set of rules and regulations and are exempt from many insurance regulations. To summarize, there are generally three types of health benefits: health insurance policies, HMOs and PPOs.

Vastly different rules apply based on the source of your health benefits. One set of rules applies if you purchase your benefits privately. Another set of rules applies if you receive your benefits through your employer, and these rules differ depending on whether the benefit plan is "self-funded" by the employer or the benefits are provided by an insurance company. Yet another set of rules applies if you receive your benefits through your employer and the employer is a governmental entity like a school board or police department, or is a religiously affiliated organization like a church.

Don't worry, I won't bore you with all the rules; it would take volumes. I'll just give you the important concepts.

ERISA vs. Non-ERISA Plans

If you receive your health benefits through your employer, and your employer is not a governmental entity or a religiously affiliated organization, your health benefits are probably governed by the Employee Retirement Income Security Act of 1974, known as ERISA. If you purchased an individual insurance policy, HMO or PPO, or receive your health benefits through your governmental or religiously affiliated employer, then your plan is known as non-ERISA.

This is a very important distinction. The main distinction from my point of view as an attorney is that it is much more difficult to get your bills paid under an ERISA plan. Conversely, it is much easier to get your bills paid under Non-ERISA programs. People often come to my office and are surprised that their employer sponsored plan isn't paying their medical bills. Frankly, I am more surprised when an ERISA plan *does pay* than when it doesn't. There is very little incentive for an ERISA plan to pay your medical bills, and very little we can do to them if they don't.

Under most ERISA plans, if insurers refuse to pay for medical treatment, we must go through an administrative appeal. If they continue to refuse, we can file a lawsuit in Federal Court. In Federal Court, depending on the language employed in the benefit plan, we typically must prove two things to win: 1) that the treatment is covered under the plan; and 2) that the insurer's refusal to pay for the treatment is an *abuse of discretion*.

It is not enough to prove that their decision was wrong. We must also overcome the added burden of proving that the insurer's wrong decision was an abuse of discretion.

Further, the court bases its decision only on the written documents that the insurer had at the time the decision was made. This means that at the trial there will be no witnesses, no cross-examination, just the bare written record. If this seems insignificant to you, it is because you have not seen what I've seen. Frequently, a client will come to me having sent a letter to the insurer as their appeal. The client's appeal letter may be heartfelt, but it typically provides very little in the way of proof. Unfortunately, it becomes the client's entire evidence base.

On the other hand, the insurer will obtain a letter from their "medical director" saying the treatment is not covered. By the time the client gets to me, the administrative record is "written in stone," and I'm stuck with a bad record. With no way to cross-examine the medical director or offer additional proof to the judge, there is no way to show that the insurer abused its discretion. Finally, even if we win, many times the insurer is not responsible for paying our attorney's fees.

Contrast this with non-ERISA plans. If the insurer fails to pay for medical treatment, then we can typically file a lawsuit. If we prove that the bill is a covered benefit, then the insurer must pay for it. We do not have to prove that the refusal to pay was an abuse of discretion. Also, we can present evidence and testimony as well as cross-examine their witnesses. Finally, if we win, the insurer is responsible to pay our attorney's fees and costs.

Traditional Insurance Policies

Traditional private insurance policies are somewhat rare these days. Bought by individuals, there is a wide range of what these policies cover. Some provide comprehensive coverage for medically necessary care; others simply provide for major medical expenses.

The Florida Legislature requires that certain things be covered under all individual policies. To see a list of these mandatory coverages including some explanation of them, see Traditional Health Insurance Mandatory Coverages beginning on page 54 in Part Two.

Pre-existing Conditions

Many people are justifiably concerned about changing jobs or changing insurance companies for fear that they will later not be covered for pre-existing conditions. Both Florida and Federal Statutes protect you from losing coverage for pre-existing conditions when changing jobs or changing insurance companies.

Non-ERISA Plans

Non-ERISA policies are individual policies or those policies issued through governmental or religiously affiliated employers. In Florida, if your non-ERISA policy has a clause that excludes coverage for pre-existing conditions, the insurance company

can only enforce that clause for two years from the date the policy is issued. After this initial two-year-period, the insurance company can no longer deny bills related to that condition simply because it pre-existed your policy. Keep in mind that the insurance company can deny claims for conditions that are specifically excluded by name in the policy. For instance, a policy that excludes coverage for lupus for everyone insured under the policy can continue to exclude coverage for lupus.

Sometimes, in addition to a general exclusion for all pre-existing conditions, insurance companies will issue a rider to an insured which excludes coverage for a particular condition. Like general pre-existing condition exclusions, such a rider is only enforceable for two years from date the policy is issued.

As you might imagine, insurance companies prefer to give a broad definition of what conditions pre-existed the issuance of a policy, thereby allowing them to exclude more items. For instance, an insurance company may want to define pre-existing conditions as “any condition that existed before the issuance of the policy” regardless of whether the person knew of the condition or how long ago the person had the condition.

However, Florida insurance companies are prohibited from giving the word “pre-existing condition” such a broad and expansive meaning. By statute, a pre-existing condition can relate only to conditions that, during the 24 months prior to the issuance of the policy, had “manifested themselves” in such a manner as would cause an ordinary person to seek medical treatment, or for which the person *did* seek treatment.

Now, very importantly, even if your new policy has a pre-existing condition exclusion, it may not be enforceable! A pre-existing condition clause will not be enforceable if you had a prior policy that covered the condition *and* there is not gap in coverage greater than 62 days between the two policies. For example, suppose your prior policy covered your longstanding knee arthritis. You cancel your insurance policy, and 60 days later you get a new policy. The policy covers knee arthritis but contains a clause that excludes coverage for pre-existing conditions. That pre-existing condition clause would be unenforceable because there was no gap in coverage greater than 62 days. The pre-existing condition clause in the new policy may apply, however, if your old policy did not cover the condition for which you are now seeking coverage.

ERISA Plans

If you receive your health benefits through your employer, your benefits are most likely governed by ERISA. However, pre-existing conditions clauses in ERISA plans are regulated under another law known as the Health Insurance Portability and Accountability Act, or HIPAA. HIPAA took effect on April 14, 2003.

Under HIPAA, the only conditions which can qualify as “pre-existing conditions” are those conditions for which you actually received or were recommended to receive a diagnosis, treatment, or medical advice within the six months before your enrollment date in the plan. Your “enrollment date” is the first day of coverage or, if there is a waiting

period, the first day of the waiting period. This is different from non-ERISA plans in Florida where a pre-existing condition is any condition that “manifested itself” such that a reasonable person would have sought treatment during the 24 months before the policy is issued.

If there is an actual pre-existing condition (meaning a condition for which you actually received or were recommended to receive care or treatment), the maximum exclusion period is 12 months, beginning on your enrollment date. This 12-month exclusion period is increased to 18 months if you don’t enroll during a regular or special enrollment period.

The exclusion period will be reduced by your prior “continuous creditable coverage.” Continuous coverage is almost any health coverage where there is no break in coverage greater than 63 days.

Suppose you have high blood pressure. You have health coverage from Employer A for 9 months. Then you quit Employer A and take a new job with Employer B. You were only uninsured for 50 days between jobs. Both of those insurers covered your high blood pressure. You have insurance from Employer B for 2 months. You then leave Employer B and one day later take a job with Employer C. Employer C has health insurance that covers high blood pressure, but this insurance has a 12-month exclusion period for pre-existing conditions.

Under this scenario, the 12-month pre-existing condition clause is reduced by the 11 months of coverage from Employers A and B. Thus, there is only a one-month exclusion period. The insurer would still have to show that you actually received or were recommended treatment or medical advice during the six months prior to the effective date of the new policy.

You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer under the following circumstances:

- You lose coverage under the plan.
- You become entitled to elect COBRA continuation coverage.
- Your COBRA continuation coverage ceases.
- You request it before losing coverage.
- You request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in a new plan.

If you can’t obtain a certificate of creditable coverage for some reason, or if you disagree with the information on the certificate, you are allowed to demonstrate creditable coverage through the presentation of documents or other means. A plan or issuer is

required to take into account all information it obtains or that is presented on behalf of an individual to make a determination of creditable coverage.

A plan or issuer shall treat the individual as having furnished a certificate if three conditions are met: (1) the individual attests to the period of creditable coverage; (2) the individual also presents relevant corroborating evidence of some creditable coverage during the period; and (3) the individual cooperates with the plan's or issuer's efforts to verify the individual's coverage.

Disability Insurance

You are much more likely to become disabled during your work life than to die during your work life. Thus, disability insurance is very important to protect you and your family from financial ruin in the event of a disability.

Short-term Disability and Long-term Disability

Short-term disability (STD) policies usually pay you for a short period of time, say six months. The purpose of the STD policy is to help you during short-term illnesses or accidents. Long-term disability (LTD) policies provide coverage for longer periods of time. LTD policies vary, but a typical LTD policy will pay you for the entire period of disability or until a particular age, say 62 or 65.

Own-occupation vs. Any-occupation Policies

Own-occupation policies generally define disability as the inability to perform the material duties of *your own* occupation at the time you become disabled. Any-occupation policies generally define disability as the inability to perform *any* occupation.

You can determine whether your policy is own-occupation, or any-occupation by looking at the definition section of the policy. Many, but not all, LTD policies are own-occupation policies for the first two years they pay out, after which they change to any-occupation policies. Under this type of policy, the insurance company will pay your disability benefits for two years if you cannot perform the material duties of the job you were doing at the time of your disability. After two years, they will pay you only if you cannot perform *any* occupation. There are, however, some LTD policies that remain own-occupation policies for the entire life of the policy and some LTD policies that are solely any-occupation policies during the entire life of the policy.

In Florida, there is a statute which requires that a disability policy must be an own-occupation policy for at least the first 12 months of disability. After 12 months, if it was designed to be an any-occupation policy, it will become so.

For additional information, please see the Disability Insurance section in Part Two beginning on page 60.

Life Insurance

Standard life insurance policies pay the beneficiaries when an insured person dies regardless of the cause. Accidental death insurance policies pay the beneficiaries only if the death results from an accident.

Standard Life Insurance Policies

Standard life insurance policies pay a set amount of money to the beneficiaries if the insured person dies while the life insurance policy is in force. In Florida, several statutes provide you with certain protections.

Incontestability

One important protection is called “incontestability.” With most types of insurance policies in Florida, the insurance company is allowed to void the policy if, when a claim is filed, they determine that there was a material misstatement on the Application. The material misrepresentation does not have to be intentional; the insurer can void the policy for any inaccurate information that is “material.” This is a harsh rule, and it is strictly enforced in favor of the insurance industry. In most types of policies, a person could pay premiums for years, and then when a claim is filed, the insurance company could review the application for insurance and void the policy for any material misstatements on the original Application. Not so with life insurance.

After a life insurance policy has been in force for two years, the policy becomes “incontestable.” This means that after two years, the insurance company cannot cancel or void the policy for misstatements on the application—even fraudulent misstatements. This does not mean that none of the terms and conditions of the policy apply anymore, it just means that the insurance company can no longer cancel or void the policy for misstatements on the application.

Incontestability also applies to a policy that is reinstated after it has lapsed for nonpayment of premium. A new two-year period begins from the time of reinstatement, during which the insurance company could show material misstatements—not related to the original Application but to the reinstatement.

For example, in one case, a policy was issued, and the insured person died more than two years later. When the beneficiaries submitted the claim, the insurance company denied the claim, saying that the insured person had sent an impostor to the medical evaluation in order to qualify to buy the policy. The court ruled that the insurance company was not allowed to raise this defense because the policy became “incontestable” after being in force for two years.

The court recognized that this ruling may seem harsh, but noted that the two-year incontestability period provided by the Florida legislature is similar to a statute of limitations. If the insured person dies within two years of the policy coming into force,

then the insurance company can challenge the policy for misrepresentations; if the person dies after two years from the date the policy is issued, then the insurance company cannot challenge the policy for misrepresentations.

One slight exception to this is a misstatement of age or gender on the application for insurance. There is a specific Florida statute that states that if the insured person misstates his age or gender on the application, the insurance company can reduce the benefit: “the amount payable or benefit accruing under the policy shall be such as the premium would have purchased according to the correct age or sex” (Florida Statute Section 627.456). There are no cases that discuss whether this statute allows the insurance company to reduce the benefits only if the insured person dies within two years of the policy being issued.

Secondary Addressee

It is not unusual for some elderly people to forget to make their life insurance premium payments. They may faithfully pay premiums for years, but as they age and become less able to care for themselves, they frequently forget to pay bills—including life insurance premiums. In Florida, insurance policies for people 64 and older must give the insured person an option of specifying a “secondary addressee.” Such a person must be notified of the missed payment so that they can make the payment.

Reinstatement

If a life insurance policy lapses or is cancelled for failure to pay the premium, the insured must be allowed to reinstate the policy within three years after the default. To do so, the insured person will have to demonstrate insurability *and* will have to pay all overdue premiums. If a loan was taken against the policy, the insurer can also require that the loan be repaid. Reinstatement does not apply if the policy was surrendered for its cash value or if the policy is a term policy and the term has expired.

Agent’s Ability to Make Changes

Be careful if the agent who sells the policy tells you he can change or alter the terms of the policy—even if he says so in writing. An agent *may* be able to modify the terms by writing a letter that provides you with a special protection not contained in the actual policy. These letters *can* become part of the policy and actually override the policy under certain circumstances. However, Florida law states that an insurer might not be bound by these alterations or changes unless the change is signed by “a duly authorized officer of the insurer.” Depending on the circumstances, an agent will sometimes be considered a duly authorized officer and sometimes not.

If the agent proposes to modify the terms of the policy by a letter, you will want something from the insurance company attesting to the agent’s authorization to make the change. There is no clear “bright line” test for this; always proceed with caution when the agent is proposing changes to the policy.

Accidental Death Insurance Policies

Accidental death policies pay beneficiaries upon the “accidental” death of the insured during the time the policy is in force. Although this sounds simple and straightforward, what constitutes an “accident” is often in dispute. Also, there are numerous exclusions that apply to these types of policies.

“Accidental” death means any death resulting from “fortuitous and undesigned injury.” Sometimes it is easy to determine if a death was the result of an accident. An unexpected car crash would be considered an accident, but a car crashed by someone intending to commit suicide is not considered an accident. An unexpected allergic reaction to prescription medication may constitute an accident for purposes of an accidental death policy, but an intentional overdose is not considered an accident.

In one case, a person thought a gun was empty and tried to scare his friends by pointing the gun at himself and pulling the trigger. Guess what? The gun was not empty, and the man died from the gunshot wound. In that case, the court found that although the act of pulling the trigger was intentional, the insured only intended to scare his friends, not to cause himself harm. Therefore, the death was considered accidental.

Even when a death may be considered accidental, accidental death policies may include exclusions that apply. The four most common exclusions that allow an insurance company not to pay are when death results from:

1. Intentional injury or suicide
2. Sickness
3. Medical treatment
4. Intoxication or impairment by illegal drugs or alcohol

Although intentional injury, suicide, and sickness are relatively straightforward, exclusions for deaths that result from medical treatment can be complicated. Depending on the language of the particular policy, a death that results from a known complication from a medical treatment may not be covered, while a death that results from medical malpractice may be covered.

Deaths that arise because the insured person was intoxicated or impaired can be quite complicated. The policy might say that the insurance company does not have to pay for “any death resulting while the insured person is intoxicated or impaired by illegal drugs or alcohol.” In a case with just such an exclusion, the insurance company denied coverage for the *passenger* in a car who happened to be intoxicated at the time he was killed in a car crash. The court overruled this denial and held that the insurance company cannot deny such a claim unless it can prove that the intoxication caused the death.

Since there are two very different ways that intoxication can “cause” a death, the specific wording of the policy is critical. A person can die because of the physiological effects of

alcohol on the person's biological system; or a person can die by reason of acts he commits because his mind is impaired by alcohol. Again, depending on how the policy is written, drug- or alcohol-related deaths may or may not be covered.

In a case I handled, the insurance policy stated that it would not pay for any loss that occurred as a result of being "under the influence of narcotics or alcohol." The insured person died in a car accident with cocaine in his system. The insurance company denied the claim based on the narcotics exclusion. However, I was able to avoid this exclusion on two simple grounds. First, cocaine is not a "narcotic." In fact, by pharmacological definition, cocaine is the opposite of a narcotic. Narcotics are derivatives of opium, and are considered depressants to the system; cocaine derives from coca and is a stimulant to the system. Second, there is no known level at which a person using cocaine is considered "under the influence."

This last case gives a vivid real-world example of an important point. You should not try to figure out by yourself whether something is covered or not. Determining what is covered takes a lot of experience, and a great familiarity with the applicable court cases, statutes, and administrative code regulations. Although this particular case was a simple one to win, most people—even lawyers who do not focus on this area of the law—would not have known that this death was covered under the policy. It took me less than five minutes to know this case was covered. It took the insurance company a little longer to be convinced, but they had an outcome to protect.

Long-term Care

The demographic and workforce study, "*Mapping the Future—Estimating Florida Aging Services Needs 2008 to 2030*," recently concluded that Florida's 85-and-over population is forecast to grow by 126 percent in the next 22 years. This huge increase, in addition to the fact that Florida already has the highest percentage of senior citizens in the United States, points out the growing need for Long-term Care Insurance for Florida's citizens.

Long-term care insurance pays when you need assistance with one or more activities of daily living over an extended period of time. You may need long-term care as a result of an injury, illness, disease, or simply because of the infirmities of old age. The need for long-term care may last for only a few weeks or for years, depending on the underlying reasons.

Experts believe that at least 60% of all individuals will need the type of help covered by long-term care insurance during their lifetime. Consider the implications of this statement: the probability of suffering a house fire is 1 in 1200; the probability of suffering a major auto accident is 1 in 240; the probability of needing long-term care is 1 in 2. People need this valuable coverage.

Long-term care policies fill in the gap for what is not covered by private health insurance, Medicare, or Medicare Supplement Insurance. Medicaid will pay for many items covered by long-term care policies, but you must be below the poverty level to qualify for Medicaid, and you cannot have more than \$2,000 in assets as an individual or \$3,000 if you are married.

Long-term care policies can be purchased as stand-alone policies or in combination with life or disability policies. Stand-alone policies are usually purchased with monthly, quarterly, semiannual or annual premiums that are paid for the life of the insured.

A life insurance policy may have a rider known as an "accelerated death benefit." Accelerated death benefits pay part of the death benefit for terminal illnesses or doctor-certified, long-term care confinement while the insured is alive. Since very little long-term care could be certified as terminal, this policy feature is a poor substitute for true long-term care insurance.

Another way to purchase long-term care insurance is an "either/or" feature in life insurance. When the insured dies, a death benefit results. If the insured needs long-term care before death, stipulated benefits are paid instead of life insurance. If all benefits are paid before death, the policy expires. Any benefits not used result in a reduced pay-out at death.

Finally, you can also couple your long-term care insurance with a disability policy. Typically, prior to age 65, the policy can only be used for disability income.

In Florida, long-term care policies are “guaranteed renewable.” This means that once a company issues a policy, it cannot cancel, or refuse to renew the policy except for nonpayment of the premium. Nor can the company simply raise your rates because of your declining health or because you are growing older. If they raise the rates, they have to raise them for everyone. When setting their rates, long-term care insurers are prohibited from raising rates solely based on age.

There are two ways insurance companies pay benefits under a long-term care policy. Indemnity based policies pay a fixed dollar amount per day. Expense based policies pay certain actual expenses you incur. However, be aware that even under the expense based coverage, there are certain exclusions, and most plans also have a daily maximum amount they will cover.

An individual long-term care insurance policyholder has the right to return the policy within 30 days after its delivery and to have the premium refunded if, after examining the policy, the policyholder is not satisfied for any reason. An individual long-term care insurance policy must have a notice prominently printed on the first page of the policy or attached to it stating this right.

In Florida, a long-term care insurance policy must contain a stamp prominently displayed on the first page of the policy that the policy has been approved as a "Long-term Care Insurance Policy" meeting the requirements of Florida law. In addition, the following statement shall be prominently displayed on the first page of the policy: "Notice to Buyer: This policy may not cover all of the costs associated with long-term care which may be incurred by the buyer during the period of coverage. The buyer is advised to periodically review this policy in relation to the changes in the cost of long-term care."

All of these rules and regulations attempt to help Florida’s consumers actually receive what they think they are buying. Without them, our legislature has found that insurers sometimes provide “coverage” that is worth little or nothing. Whenever considering Long-term Care insurance, make sure your agent has good references and takes the time to clearly explain all of your options.

For additional information regarding pre-existing conditions, exclusions and other details, please see Long-term Care in Part Two beginning on page 64.

What to do if Your Insurance Company Denies or Delays a Claim

You Have More Power than You Think

Having the right agent and getting the right insurance coverage does little good if your insurance company denies or delays a claim. I have seen many people in this situation become paralyzed with indecision or fear. The good news is that you have more power than you think.

Sometimes an insurance company will simply deny a claim. Sometimes they will delay a claim by refusing to make a decision, refusing to communicate with you, repeatedly asking for documents that you have already sent them, or asking for documents that do not exist. If this happens, you should contact a lawyer who is experienced in handling insurance claims on behalf of policyholders. Insurance is a relatively narrow and complicated field of law, and you should make sure your attorney has handled these types of claims in the past.

Attorney's Fees and Costs

Under Florida law, you can frequently force the insurance company to pay all of your legal costs if your attorney is successful in prosecuting your claim. This is true regardless of the amount of the claim. For example, suppose your insurance company refuses to pay a \$2,000 claim under your automobile Collision coverage. If your attorney is successful in presenting that claim, the insurance company would owe you the attorney's fees and costs as well as your entire \$2,000.

Don't Go it Alone

You should not try to decide whether the insurance company has properly denied your claim. There are many cases where you could assume, based on the language of the insurance policy, that a denial was proper. However, you may misunderstand the actual meaning of the policy, or you may not be aware of a regulation or statute that changes the policy. Your assumption that the insurance company is correct could be mistaken.

Some examples will be helpful. Most homeowners insurance policies exclude losses caused by "earth movement." Suppose your home's foundation and walls are cracked due to earth movement caused by excavation in the lot next to yours; this happens more frequently than you might think. Many insurance companies will deny this claim under their "earth movement" exclusion, and a simple reading of the policy may confirm such a conclusion. However, this *is* a covered loss. The "earth movement" exclusion typically only applies to earth movement caused by natural occurrences, not earth movement that is manmade.

Likewise, your roof may be old and need repair. Suppose it leaks and causes damage to the interior of your home. Most homeowners policies exclude losses caused by ordinary wear and tear. You submit the claim, but the insurance company denies the claim based

on the wear and tear exclusion. While the denial is correct as far as the roof is concerned, the insurance company would be on the hook for the interior damage that results from the roof leak.

Suppose you were injured when your car was run off the road by a vehicle that fled the scene. And suppose this vehicle did not actually touch yours but merely ran you off the road. You submit your injury claim to your Uninsured Motorists carrier, but they deny the claim because the policy specifically states that such a claim will be covered only if the other vehicle actually strikes yours. Is the denial correct? No! By Florida statute, such a requirement is unenforceable by the insurance company. The claim is covered.

Another example is late reporting. Most insurance policies state that a claim must be reported within a certain time, say 90 days for example, from the loss. Many times, for various good (or not so good) reasons the insured fails to report the claim timely. Not to fear! Case law in Florida holds that the insurance company cannot enforce this reporting requirement unless they can prove that the late reporting “prejudiced” them. The insurance company frequently cannot prove such prejudice.

There are many, many examples where people inexperienced in the intricacies of insurance claims—even lawyers who do not concentrate in this area—will look at a policy and wrongly conclude on their own that the policy does not provide coverage. Don’t make the mistake of being one of them. Don’t go it alone.

My Recommendation

If your insurance company denies or delays your claim, call or email me *for free*. I truly love talking with people about their insurance claims. If the insurance company has done the right thing, I will tell you. If not, you need to know that also. Either way, you deserve peace of mind. My promise is that I will look at your case and tell you if I think you have a case or not—*for free*. You can call me at 1-800-Nation Law, or email me at mark@nationlaw.com.

Winning Without Your Help

I have often found my efforts to help clients thwarted by their efforts to help me. Let me give you some real-world hints on what *not* to do.

When the insurance company asks for receipts and you do not have them, do not make them up with your fancy computer and printer.

Do not “borrow” letterhead from a contractor and make your own estimates on their letterhead—even if the estimates are reasonable.

If you burn your house down for the insurance money, don’t put all your good stuff in that new storage unit—you know, the one you charged to your credit card four days before the fire.

Don’t call your insurance company to “up the limits” the week before your stuff is “stolen.”

If you claim that someone stole your car and wrecked it, do not leave your DNA on the airbag or call the insurance company before your facial bruising and abrasions heal.

In all seriousness, you should not embellish your claim whatsoever. Your integrity is too valuable. The facts are the facts. I can often win with difficult facts, but I cannot help you if you are not truthful.

It may take some work, but you should expect fair compensation for your claim if it is covered and you act fairly and honorably. On the other hand, if you do not act fairly and honorably, you will probably lose a claim—even a legitimate claim.

Let’s do it right. Together.

PART TWO The Fine Print You Don't Need (Until You Need It)

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Choosing an Insurance Agent and Company

Insurance Designations

Personal and Commercial

- AIS, Associate in Insurance Services – The AIS designation signifies that an agent demonstrates knowledge of insurance principles and practices, and is able to work with a wide range of the most popular insurance contracts.
- AMIM, Associate in Marine Insurance Management – The AMIM designation is the undisputed professional credential for persons who typically advise clients in marine insurance—coverage for the loss or damage of ships, cargo, hulls, terminals, etc.
- API, Associate in Personal Insurance – The API designation is the undisputed professional credential for agents whose area of specialty is personal lines insurance—personal insurance business (including underwriting), marketing practices, the personal insurance environment, etc.
- ARM, Associate in Risk Management – The ARM designation signifies that an agent working in this field has attained a comprehensive understanding of the risk management process, from analysis to implementation and monitoring; risk retention and transfer; and the latest in advanced risk financing techniques.
- ASLI, Associate in Surplus Lines Insurance – The ASLI designation signifies that an individual working in the insurance field has attained comprehensive knowledge of the following subject matter: Insurance Regulation, Surplus Lines Insurance Marketing, Underwriting, Ratemaking, The Claim Function, Reinsurance, Financial Analysis of Insurers and Intermediaries, and various Surplus Lines Insurance Products.
- CAS, Certified Annuity Specialist – The CAS designation demonstrates the agent's expertise in helping individuals work toward their retirement goals with annuities as a suitable option. The designation includes study in the traditional aspects of fixed-rate and variable products; a detailed part of the materials also covers various titling options and the estate and income tax ramifications of each.
- CIC, Certified Insurance Counselor – The CIC designation signifies that an individual working in the insurance field has attained comprehensive knowledge by virtue of completing the five 'institutes' that comprise the program: Agency Management, Commercial Casualty, Commercial Property, Life & Health, and Personal Lines.
- CPCU, Chartered Property Casualty Underwriter – The CPCU designation signifies that an individual working in the field of property and casualty insurance has gained a broader understanding of property and casualty insurance, usually with a concentration in either commercial or personal risk management insurance.

- AFSB, Associate in Fidelity and Surety Bonding – The AFSB designation signifies that the agent works with the fidelity and surety bonding industry.

Life and Health Industry Designations

- CLU, Chartered Life Underwriter – CLU is the premier designation in the life insurance profession. The program is home study and provides in-depth knowledge and greater skills to assist clients with their insurance and other financial concerns. Agents must complete ten courses, eight of which are required and two elective. Some course titles include: Fundamentals of Financial Planning, Individual Life Insurance, Investments, and Group Benefits.
- ChFC, Chartered Financial Consultant – Once the agent earns the CLU designation, the ChFC may be attained by taking three more courses from the American College. ChFC emphasizes comprehensive financial planning services including techniques of data gathering.
- LUTCF, Life Underwriter Training Council Fellow – To satisfy course requirements for LUTCF, agents must earn a total of 300 Study and Practice Equivalents (SPE's). Since each 13-week classroom course is worth 60 SPE's, a minimum of five courses can earn this designation. Courses are offered only through a local Life Underwriters Association. Some course titles include: Exploring Personal Markets, Meeting Client Needs, Business Continuity, Employee Benefits, Disability Income.
- MSM, Master of Science in Management – This designation is designed for general agents and managers in life insurance and related financial services. Graduate-level courses focus on the interrelationship between leadership and efficient management.
- MSFS, Master of Science in Financial Services – Graduate level program for professionals in financial services working with the most sophisticated clients. Course work is highly focused on tax and business planning, enabling graduates to become expert advisors and handle a wide spectrum of financial needs.
- CFP, Certified Financial Planner – There are four elements required for certification as a CFP: education, examination, experience, and ethics. Course work involves the areas of financial planning, insurance planning, investment planning, retirement planning, employee benefits, and estate planning. An agent may waive the course work requirement and sit for the CFP exam if she has previously passed approved financial planning courses from other accredited institutions. Certain degrees and professional credentials will also allow agents to sit for the exam.
- RHU, Registered Health Underwriter – The RHU designation signifies that an individual working in this field has attained comprehensive knowledge of the following subject matter: managed care plans; individual and group medical,

disability income, long-term care insurance; group dental and voluntary benefit plans, COBRA, ERISA, and HIPAA; cafeteria plans; Medicare and Medicaid.

Car Insurance

Various coverages that comprise car insurance are discussed below in more detail.

1. Insurance When You Are Hurt

Three types of insurance can help you if you are physically injured in an auto accident. These three coverages are: 1) No-fault, otherwise known as Personal Injury Protection or PIP; 2) Medical Payments; and 3) Uninsured Motorists coverage. Each of these is discussed in detail below.

A word of caution: Many people think that these three coverages are unimportant if they have health insurance. In my experience in handling thousands of auto accident cases, health insurance frequently doesn't help. Some health insurance policies have limitations or exclusions for injuries sustained in a car accident. Many times, the doctors in a managed care system refuse to take car accident victims under their health insurance. If there is coverage, the health insurer will often refuse to authorize the proper treatment for a car accident victim, or make it difficult for the insured to see specialists.

A common surprise to accident victims who utilize their health insurance to pay for their injuries and subsequently make a financial recovery from the other driver: their health insurer requires you to repay them for any money they paid for accident-related treatment *before* you can get any of the money. Sometimes this means they can get your entire settlement with you receiving nothing.

1) PIP (No-fault)

PIP stands for "Personal Injury Protection" and is often referred to as "No-fault" insurance. You are required to carry a minimum of \$10,000 PIP in Florida. This \$10,000 is limited to \$2,500 if a physical determines the injured person did not have an emergency medical condition.

PIP pays for 80 percent of your medical expenses, and 60 percent of your lost wages up to the limit of \$10,000 or \$2,500 as a result of injuries sustained in the "use, operation, or maintenance" of a motor vehicle. Once the limit is met, PIP has no more responsibility for any payments.

You can purchase additional PIP coverage, but you have to ask your agent for this additional coverage. If you can afford a higher limit, I advise you to get it. You can purchase PIP with a deductible, but I do not recommend it.

The great benefit of PIP is that you can immediately go to any doctor you choose regardless of who is at fault in the accident. Your insurance company will pay the doctor's bill, usually within 30 days. Because your insurance company pays your medical expenses and lost wages regardless of fault, this type of insurance is referred to as "No-

fault.” Do not make the mistake of thinking that “No-fault” means you cannot be sued if you cause an accident. Anyone can be sued for anything.

There are many other reasons why PIP is so beneficial. Without PIP, you would have to pay for all your medical expenses yourself and then fight with the other driver or his insurance company for reimbursement. This is very difficult for the ordinary person, to say nothing of frustrating and time-consuming. You often have a hard enough time getting your own insurance company to reimburse you for medical expenses; can you imagine submitting your medical bills to the guy who hit you? Or to his insurance company? What a hassle! Rest assured; you do not want to be dealing with these issues when you need to focus on your medical condition. Fortunately, with PIP, you can do just that.

2) Medical Payments

Medical Payments coverage is very similar to PIP, but it reimburses you for the 20 percent that PIP does not pay. It also reimburses you for any deductibles and any medical expenses in excess of the PIP limit. Although PIP is not available for a motorcycle accident, you should get Medical Payments coverage to help in the event of a motorcycle accident.

Medical Payments coverage is relatively inexpensive and comes in a range of limits from \$2,000 to \$100,000 or so.

2. Insurance When Your Car Is Damaged or Stolen

1) Comprehensive and Collision

As you might imagine, collision coverage protects you if your car is damaged in a collision. This is true whether the collision is with another car, a tree, a wall or virtually anything. I once successfully recovered for a client when he “collided” with a large mud puddle and blew his engine. Comprehensive and Collision coverage usually has a \$500 or \$1,000 deductible.

You are also entitled to coverage under collision for something referred to as “upset.” This typically refers to a car that overturns.

Collision coverage will pay for collision damage regardless of who causes the accident. If the accident is caused by another driver, your insurance company will go after the other driver or his insurance company to be reimbursed and to recover your deductible.

Comprehensive coverage covers you for loss to your car for all causes other than collision or upset. Typical comprehensive claims involve losses due to theft, vandalism, fire, things that fall on the car (hail, a tree, etc.), and flood.

Comprehensive will also cover some items that are stolen out of your car. These items may also be covered under your homeowners insurance policy.

Your lender will require that you carry Comprehensive and Collision on your car if you have a loan on the car. However, you should consider carrying these coverages on your car whether there is a loan or not depending on the age and value of the car. Carrying Comprehensive and Collision on an older car that is not worth a lot may not be cost effective.

2) Rental Car Coverage

Rental Car coverage provides you with a rental car if your car is damaged or stolen. This coverage is very inexpensive and saves you a lot of hassle if your car is out of commission.

If your car is damaged by another driver, he or his insurance company is liable to pay for your rental car, but things are rarely so simple. Often, during the early days after an accident—the precise time when you will need a rental car—there is a dispute as to who caused the accident. You may be totally innocent, but the other driver may tell her insurance company—and anyone else who will listen—that the accident was your fault. Eventually it will get sorted out, but maybe not during the time when you need a rental car. Further, many drivers don't have the required insurance, or their Property Damage Liability limits are paid out on physical damage to the cars, leaving nothing to pay to you for your rental car.

3) GAP Insurance

GAP insurance is very important if you have a loan on your car or if you lease it. Frequently, the loan balance on a car exceeds the car's value. For example, you may owe your lender \$10,000, but your car is worth only \$7,000.

Many people are under the mistaken belief that if someone else causes an accident that totals their car, the other driver or his insurance company must pay off the remaining balance on the loan. Wrong! If someone totals your car, he or his insurance owes you only the market value of the car at the time of the accident, not the loan amount.

As the name implies, GAP insurance pays you the “gap” or difference between the market value of your car and your loan amount. If you have a loan on your car, consider GAP insurance.

You should also consider GAP insurance if you lease your car. If your leased car is damaged you will still owe the leasing company the difference between the car's market value and the full amount of the remaining lease payments.

Homeowners Insurance

“All Risk” Coverage Details

“An all-risk policy provides ‘a special type of coverage extending to risks not usually covered under other insurance.’ And coverage is available for all loss not resulting from the insured’s willful misconduct or fraud unless the policy contains ‘a specific provision expressly excluding the loss from coverage.’ *Id.* (internal citations omitted). “This type of contract has been said to cover every conceivable loss or damage that may happen except when occasioned by the willful or fraudulent act or acts of the insured.” *Egan v. Washington General Insurance Corp.*, 240 So.2d 875, 879 (Fla. 4th DCA 1970), *See, Fayad v. Clarendon National Insurance Company*, 899 So.2d 1082, 1085-86 (Fla. 2005).

“The specific type of insurance policy involved in this case is ... an all-risk policy. Unless the policy expressly excludes the loss from coverage, this type of policy provides coverage for all fortuitous loss or damage other than that resulting from willful misconduct or fraudulent acts.” *Phoenix Insurance Co. v. Branch*, 234 So.2d 396, 398 Fla. 4th DCA 1970).

“In recent years, the so-called ‘all risks’ insurance policy has been used with increasing frequency. Such a policy is to be considered as creating a special type of coverage extending to risks not usually covered under other insurance, and recovery under the ‘all risks’ policy will as a rule be allowed for all fortuitous losses not resulting from misconduct or fraud unless the policy contains a specific provision expressly excluding the loss from coverage.”

“Once the insured establishes a loss that appears to be within the terms of the all-risk policy, the burden is on the insurer to prove that the loss was caused by an excluded risk.” *Wallach*, at 1388. “Starting with the well-settled law in Florida that exclusionary clauses are construed more strictly than coverage clauses, the insurer’s burden is even heavier under an all-risk policy.” *Id.*

In deciding whether an all-risk policy excludes coverage for an insured's claimed damages, we are guided by well-established principles of insurance contract interpretation. We begin with the guiding principle that insurance contracts are construed in accordance with “the plain language of the polic[y] as bargained for by the parties.” *Auto-Owners Ins. Co. v. Anderson*, 756 So.2d 29, 33 (Fla.2000) (quoting *Prudential Prop. & Cas. Ins. Co. v. Swindal*, 622 So.2d 467, 470 (Fla.1993)) (alteration in original).

Ambiguous Coverage

However, if the salient policy language is susceptible to two reasonable interpretations, one providing coverage and the other excluding coverage, the policy is considered ambiguous. *See Anderson*, 756 So.2d at 34; *Swire Pac. Holdings, Inc. v. Zurich Ins. Co.*, 845 So.2d 161, 165 (Fla.2003). Ambiguous

coverage provisions are construed strictly against the insurer that drafted the policy and liberally in favor of the insured. *See Anderson*, 756 So.2d at 34; *State Farm Fire & Cas. Co. v. CTC Dev. Corp.*, 720 So.2d 1072, 1076 (Fla.1998); *Deni Assocs. of Florida, Inc. v. State Farm Fire & Cas. Ins. Co.*, 711 So.2d 1135, 1138 (Fla.1998).

Further, ambiguous “exclusionary clauses are construed even more strictly against the insurer than coverage clauses.” *Anderson*, 756 So.2d at 34; *see also Demshar v. AAACon Auto Transport, Inc.*, 337 So.2d 963, 965 (Fla.1976) (“Exclusionary clauses in liability insurance policies are always strictly construed.”). Thus, the insurer is held responsible for clearly setting forth what damages are excluded from coverage under the terms of the policy. *Fayad v. Clarendon National Insurance Company*, 899 So.2d 1082 (Fla. 2005).

Losses by a Combination of Factors

Sometimes a loss is caused by a combination of factors. There are two different ways these combinations can occur. The first scenario involves an unbroken chain of events, each setting the next one in motion like a row of dominoes. For instance, a lightning bolt may cause a fire, which causes an electrical problem, which causes a loss of refrigeration, which causes a loss of food in a restaurant.

The second scenario involves two unrelated things that occur at the same time to cause a loss. For instance, a lightning bolt and an earthquake may occur at the same time to cause a natural gas fire that causes an apartment building to burn down. The problem for policyholders arises when one of the causes is covered, and one of them is excluded under the policy.

The “efficient proximate cause doctrine,” as explained by Florida’s First District Court of Appeal in *Hartford Accident and Indemnity Co. v. Phelps*, 294 So.2d 362, 364 (Fla. 1st DCA 1974), mandates that coverage shall be provided for loss caused by multiple perils when the efficient proximate cause of the loss is a covered peril. *Hartford*, quoting Couch on Insurance explains, “[T]he efficient cause—***the one that sets the others in motion***—is the cause to which the loss is to be attributed, though the other causes may follow it, and operate more immediately in producing the disaster.” *Id.* at 364.

“The efficient proximate cause rule allows recovery for a loss caused by a combination of a covered and excluded risk only if the covered risk was the efficient proximate cause of the loss, meaning that the covered risk *set the other causes in motion which, in an unbroken sequence, produced the result for which recovery is sought*. This rule is essentially a simple restatement of the traditional views that proximate cause is the efficient cause, which may also be stated as proximate cause being the cause which sets in motion an unbroken chain of events which produces the loss.” 7 Couch on Insurance §101.57.

The earliest Florida case following the “efficient proximate cause doctrine” is *Fire Association of Philadelphia v. Evansville Brewing Associates*, 75 So. 196 (Fla. 1917). In *Fire Association of Philadelphia*, a building was destroyed by fire (a covered cause of loss) and/or explosion (an excluded cause of loss). The Florida Supreme Court held that:

While the insurer is not liable for a loss caused by an explosion which was not produced by a preceding fire, ***yet if the explosion is caused by a fire during its progress in the building, the fire is the proximate cause of the loss***, the explosion being a mere incident of the fire, and the insurer is liable. Where an explosion is an incident to a fire already in progress, the burning of the building is a ‘direct loss or damage by fire,’ within the meaning of the policy. *Id.* at 910-11.¹

After Hurricane Charley in 2004, I had a case where the hurricane (a covered cause of loss) caused the loss of power (also a covered cause of loss) that resulted in the change in temperature (an excluded cause of loss), which resulted in the loss of food and beverages in a restaurant. The insurance company denied the claim, citing the change in temperature exclusion. However, I was able to prove that the hurricane was the efficient proximate cause of loss to the food and beverages. As such, the loss to the food and beverages was covered and not excluded.

Some courts confuse the “efficient proximate cause doctrine,” with the “concurrent cause doctrine.” The “efficient proximate cause doctrine” applies where there are “dependent” causes, i.e., where there is one cause that is dependent on another, such as where a fire causes an explosion. The “concurrent cause doctrine” applies where there are “independent” causes, such as where an earthquake and an unrelated lightning bolt independently combine to cause a loss. *Hrynski v. Allstate Floridian Ins. Co.*, 844 So.2d 739, 743 (Fla. 5th DCA 2003). Under the “concurrent cause doctrine” there is coverage “when a loss results from multiple independent causes, as long as one of the causes is an insured risk.” *Transamerica Ins. Co. v. Snell*, 627 So.2d 1275, 1276 (Fla. 1st DCA 1993); and *Hrynski v. Allstate Floridian Ins. Co.*, 844 So.2d 739, 743 (Fla. 5th DCA 2003).

In discussing the “concurrent cause doctrine,” the court in *Wallach v. Rosenberg*, 527 So.2d 1386 (Fla. 3rd DCA 1988), stated that there is coverage “where an insured risk constitutes a concurrent cause of the loss even where ‘the insured risk [is] not ... the prime or efficient cause of the accident.’” *Id.* (quoting 11 Couch, *Couch on Insurance 2d* §44:268 (rev. ed. 1982)). *Wallach* went on to state that “it seems logical and reasonable to find the loss covered by an all-risk policy even if one of the causes is excluded from coverage.” *Wallach*, at 1388. *Wallach* favorably cited the following cases: *Safeco Ins. Co. v. Guyton*, 692 F.2d 551 (9th Cir. 1982)(coverage was available where a covered risk,

¹ In *Wallach v. Rosenberg*, 527 So.2d 1386 (Fla. 3rd DCA 1988), negligent seawall construction (a covered cause of loss) and bad weather (an excluded cause of loss) combined to cause a seawall to tumble into the sea. The 3rd DCA, said that under the efficient proximate cause doctrine, there would be coverage if the negligent construction was the cause which set loss in motion. *Id.* at 1387. However, the *Wallach* court did note that this was actually a “concurrent cause doctrine” case.

negligent maintenance of flood control structures, combined with an excluded risk, a flood, to cause a loss); and *Mattis v. State Farm Fire & Casualty Co.*, 118 Ill.App.3d 612, 619, 73 Ill.Dec. 907, 911, 454 N.E.2d 1156, 1160 (Ill.App.Ct.1983) (“Where a policy expressly insures against loss caused by one risk but excludes loss covered by another risk, coverage is extended to a loss caused by the insured risk even though the excluded risk is a contributory cause”).

Wallach’s reasoning was followed in *Paulucci v. Liberty Mutual Fire Insurance Company*, 190 F.Supp.2d 1312, 1319 (M.D. Fla. 2002). The *Paulucci* court in discussing when to use the “efficient proximate cause doctrine,” versus the “concurrent cause doctrine,” gave the following example: where an “excluded earthquake and covered fire were independent such as where loss is caused by an unrelated simultaneous earthquake and lightning strike, the efficient proximate cause doctrine would be inapplicable. In this scenario, the concurrent causation doctrine would apply and mandate coverage regardless of which peril was covered and which peril excluded.”² See also, *W. Am. Ins. Co. v. Chateau La Mer II Homeowners Ass’n*, 622 So.2d 1105, 1108 (Fla. 1st DCA 1993) holding that pursuant to the subject insurance policy and Florida law, coverage existed for damage to balconies which resulted from both a covered cause (hidden decay) and an excluded cause (faulty design).

Although the homeowners policy will be “all-risk,” the insurance company is free to exclude certain causes of loss, and they do. Typical exclusions involve intentional destruction of the property, ordinary wear and tear, and construction defects.

² Some policies attempt to abrogate the “concurrent cause doctrine” by inserting what is known as an “anti-concurrent cause” language. Typical anti-concurrent cause language states that a loss is excluded “regardless of any other cause or event *that contributes concurrently or in any sequence to the loss.*” While it is questionable whether Florida will recognize anti-concurring cause clauses, it is not relevant in this case. The relevant Policy exclusions do not contain the anti-concurring cause language. Interestingly, another section of exclusions in the Policy – that are not applicable to this case – does include anti-concurring cause language.

Health Benefits

Traditional Health Insurance Mandatory Coverages

Ambulatory surgical care centers

No individual health insurance policy shall be issued in Florida “unless coverage provided for any service performed in an ambulatory surgical center, as defined in s. 395.002, is provided if such service would have been covered under the terms of the policy or contract as an eligible inpatient service.” Florida Statute Section 627.6056.

Maternity care

Any policy of health insurance that provides coverage for maternity care must also cover the services of certified nurse-midwives and midwives licensed pursuant to chapter 467, and the services of birth centers licensed under Sections 383.30-383.335.

An insurer issuing a health insurance policy that provides maternity and newborn coverage may not limit coverage for the length of a maternity and newborn stay in a hospital or for follow-up care outside of a hospital to any time period that is less than that determined to be medically necessary by the treating obstetrical care provider or the pediatric care provider.

Any policy of health insurance that provides coverage, benefits, or services for maternity or newborn care must provide coverage for post-delivery care for a mother and her newborn infant. The post-delivery care must include a postpartum assessment and newborn assessment and may be provided at the hospital, at the attending physician's office, at an outpatient maternity center, or in the home by a qualified licensed health care professional trained in mother and baby care. The services must include physical assessment of the newborn and mother, and the performance of any medically necessary clinical tests and immunizations in keeping with prevailing medical standards.

An insurer who provides maternity care must not:

- (a) Deny to a mother or her newborn infant eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the policy for the purpose of avoiding the requirements of this section.
- (b) Provide monetary payments or rebates to a mother to encourage the mother to accept less than the minimum protections available under this section.
- (c) Penalize or otherwise reduce or limit the reimbursement of an attending provider solely because the attending provider provided care to an individual participant or beneficiary in accordance with this section.
- (d) Provide incentives, monetary or otherwise, to an attending provider solely to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

- (e) [R]estrict benefits for any portion of a period within a hospital length of stay required under subsection (2) in a manner that is less favorable than the benefits provided for any preceding portion of such stay. Florida Statute Section 627.6406.

Diabetes treatment

A health insurance policy or group health insurance policy sold in this state must provide coverage for all medically appropriate and necessary equipment, supplies, and diabetes outpatient self-management training and educational services used to treat diabetes, if the patient's treating physician or a physician who specializes in the treatment of diabetes certifies that such services are necessary.

The policy may require that diabetes outpatient self-management training and educational services be provided under the direct supervision of a certified diabetes educator or a board-certified endocrinologist. The policy may further require that nutrition counseling be provided by a licensed dietitian. Florida Statute Section 627.6408

Osteoporosis screening, diagnosis, treatment, and management

Any health insurance policy that covers a resident of this state and that is issued, amended, delivered, or renewed in this state after October 1, 1996, must provide coverage for the medically necessary diagnosis and treatment of osteoporosis for high-risk individuals, including, but not limited to, estrogen-deficient individuals who are at clinical risk for osteoporosis, individuals who have vertebral abnormalities, individuals who are receiving long-term glucocorticoid (steroid) therapy, individuals who have primary hyperparathyroidism, and individuals who have a family history of osteoporosis. This section does not apply to specified-accident, specified-disease, hospital-indemnity, Medicare supplement, or long-term-care health insurance policies or to the state employee health insurance program. Florida Statute Section 627.6409.

Newborn care

A health insurance policy that provides coverage on an expense-incurred basis for a member of the family of the insured or subscriber shall, as to the family member's coverage, also provide that the health insurance benefits applicable for children will be payable with respect to a newborn child of the insured or subscriber, or covered family member of the insured or subscriber, from the moment of birth. However, with respect to a newborn child of a covered family member other than the spouse of the insured or subscriber, the coverage for the newborn child terminates 18 months after the birth of the newborn child.

The coverage for newborn children required by this section consists of coverage for injury or sickness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, and transportation costs of the newborn to and from the nearest available facility appropriately staffed and equipped to

treat the newborn's condition, when such transportation is certified by the attending physician as necessary to protect the health and safety of the newborn child. The coverage of such transportation costs may not exceed the usual and customary charges, up to \$1,000. Florida Statute Section 627.641.

Natural-born, adopted, and foster children; children in insured's custodial care

A health insurance policy that provides coverage for a member of the family of the insured shall, as to the family member's coverage, provide that the health insurance benefits applicable to children of the insured also apply to an adopted child or a foster child of the insured placed in compliance with chapter 63, prior to the child's 18th birthday, from the moment of placement in the residence of the insured. Except in the case of a foster child, the policy may not exclude coverage for any pre-existing condition of the child. In the case of a newborn child, coverage begins at the moment of birth if a written agreement to adopt the child has been entered into by the insured prior to the birth of the child, whether or not the agreement is enforceable. This section does not require coverage for an adopted child who is not ultimately placed in the residence of the insured in compliance with chapter 63. Florida Statute Section 627.6415

Child health-supervision services

Insurance policies providing coverage on an expense-incurred basis which provide coverage for a member of a family of the insured or subscriber must, as to such family member's coverage, also provide that the health insurance benefits applicable for children include coverage for child health supervision services from the moment of birth to age 16 years. Such services must be exempt from any deductible provisions that are in force in such policies or contracts.

The term "child health supervision services" means physician-delivered or physician-supervised services that include, at a minimum, services delivered at the intervals and scope stated in this section.

Child health supervision services must include periodic visits which shall include a history, a physical examination, a developmental assessment and anticipatory guidance, and appropriate immunizations and laboratory tests. Such services and periodic visits shall be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this section. Florida Statute Section 627.6416.

Surgical procedures and devices incident to mastectomy

Any health insurance policy that provides coverage for mastectomies must also provide coverage for prosthetic devices and breast reconstructive surgery incident to the mastectomy. The insurer may charge an appropriate additional premium for the coverage

required by this subsection. The coverage for prosthetic devices and breast reconstructive surgery shall be subject to any deductible and coinsurance conditions and all other terms and conditions applicable to other benefits. Breast reconstructive surgery must be in a manner chosen by the treating physician, consistent with prevailing medical standards, and in consultation with the patient.

The term "mastectomy" means the removal of all or part of the breast for medically necessary reasons as determined by a licensed physician and the term "breast reconstructive surgery" means surgery to reestablish symmetry between the two breasts. Florida Statute Section 627.6417.

Length of stay and outpatient postsurgical care for breast cancer

Any health insurance policy that is issued, amended, delivered, or renewed in this state which provides coverage for breast cancer treatment may not limit inpatient hospital coverage for mastectomies to any period that is less than that determined by the treating physician to be medically necessary in accordance with prevailing medical standards and after consultation with the insured patient.

Any health insurance policy that provides coverage for mastectomies must also provide coverage for outpatient postsurgical follow-up care in keeping with prevailing medical standards by a licensed health care professional qualified to provide postsurgical mastectomy care. The treating physician, after consultation with the insured patient, may choose that the outpatient care be provided at the most medically appropriate setting, which may include the hospital, treating physician's office, outpatient center, or home of the insured patient.

An insurer that provides coverage for breast cancer may not:

- Deny to an insured eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the policy for the purpose of avoiding the requirements of this section;
- Provide monetary payments or rebates to an insured patient to accept less than the minimum protections available under this section;
- Penalize or otherwise reduce or limit the reimbursement of an attending provider solely because the attending provider provided care to an insured patient under this section;
- Provide incentives, monetary or otherwise, to an attending provider solely to induce the provider to provide care to an insured patient in a manner inconsistent with this section; or
- Restrict benefits for any portion of a period within a hospital length of stay or outpatient care as required by this section in a manner that is less than favorable than the benefits provided for any preceding portion of such stay. Florida Statute Section 627.64171.

Requirements with respect to breast cancer and routine follow-up care

Routine follow-up care to determine whether a breast cancer has recurred in a person who has been previously determined to be free of breast cancer does not constitute medical advice, diagnosis, care, or treatment for purposes of determining pre-existing conditions, unless evidence of breast cancer is found during or as a result of the follow-up care. Florida Statute Section 627.64172.

Coverage for mammograms

An accident or health insurance policy issued, amended, delivered, or renewed in this state must provide coverage for at least the following:

- (a) A baseline mammogram for any woman who is 35 years of age or older, but younger than 40 years of age.
- (b) A mammogram every 2 years for any woman who is 40 years of age or older, but younger than 50 years of age, or more frequently based on the patient's physician's recommendation.
- (c) A mammogram every year for any woman who is 50 years of age or older.
- (d) One or more mammograms a year, based upon a physician's recommendation, for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister, or daughter who has or has had breast cancer, or because a woman has not given birth before the age of 30.

Except for mammograms done more frequently than every 2 years for women 40 years of age or older but younger than 50 years of age, the coverage required by subsection (1) applies, with or without a physician prescription, if the insured obtains a mammogram in an office, facility, or health testing service that uses radiological equipment registered with the Department of Health for breast cancer screening.

Every insurer subject to the requirements of this section shall make available to the policyholder as part of the application, for an appropriate additional premium, the coverage required in this section without such coverage being subject to the deductible or coinsurance provisions of the policy. Florida Statute Section 627.6418

Requirements with respect to breast cancer

An insurer may not deny the issuance or renewal of, or cancel, a policy of accident insurance or health insurance, nor include any exception or exclusion of benefits in a policy solely because the insured has been diagnosed as having a fibrocystic condition or a nonmalignant lesion that demonstrates a predisposition, or solely due to the family history of the insured related to breast cancer, or solely due to any combination of these

factors, unless the condition is diagnosed through a breast biopsy that demonstrates an increased disposition to developing breast cancer.

An insurer may not deny the issuance or renewal of, or cancel, a policy of accident insurance or health insurance, nor include any exception or exclusion of benefits in a policy solely due to breast cancer, if the insured has been free from breast cancer for more than 2 years before the applicant's request for health insurance coverage. This section also applies to a policy of group, blanket, or franchise accident or health insurance and to a contract or evidence of coverage issued by a health maintenance organization. Florida Statute Section 627.6419.

Required coverage for cleft lip and cleft palate

A health insurance policy that covers a child under the age of 18 must provide coverage for treatment of cleft lip and cleft palate for the child. The coverage must include medical, dental, speech therapy, audiology, and nutrition services only if such services are prescribed by the treating physician or surgeon and such physician or surgeon certifies that such services are medically necessary and consequent to treatment of the cleft lip or cleft palate. The coverage required by this section is subject to terms and conditions applicable to other benefits. This section does not apply to specified-accident, specified-disease, hospital indemnity, limited benefit disability income, or long-term care insurance policies. Florida Statute Section 627.64193.

In addition to these statutory minimum standards, Florida Statute Section 627.643 requires the Department of Financial Services, Office of Insurance Regulation to establish certain minimum standards with regard to:

- (a) Basic hospital expense insurance
- (b) Basic medical expense insurance
- (c) Basic surgical expense insurance
- (d) Hospital confinement indemnity insurance
- (e) Major medical expense insurance
- (f) Disability income protection insurance
- (g) Accident-only insurance
- (h) Limited benefit insurance
- (i) Supplemental insurance
- (j) Home health care coverage
- (k) Nonconventional coverage

The minimum standards for these various policies have been adopted by administrative rule. These administrative rules can be accessed at <https://www.flrules.org/gateway/RuleNo.asp?ID=69O-154.106>.

Disability Insurance

Definition of “totally disabled”

Many insurance companies have tried to equate the term “totally disabled,” with “totally helpless.” In effect, insurance companies will argue that you are not totally disabled unless you are totally helpless. In Florida, you will be considered totally disabled under an own-occupation policy “if the person is unable to perform the material and substantial duties of the person's regular occupation.” Florida Statute Section 627.4233. Under an any-occupation policy, you will be considered totally disabled if you are unable “to perform any work or occupation for which the person is reasonably qualified or trained.” *Id.* These are minimum standards in Florida. An insurance company can write a policy that is more favorable to the insured, but not less favorable.

Suppose an insurance company denied a disability claim by asserting that there is some menial job you can do. Courts have determined that this is not sufficient grounds for the insurance company to deny your claim. The court will take into consideration the wages you earned before your disability in comparison with the wages of the job the insurance company is proposing that you can now do. Courts have said that even if you can perform some job, you should be entitled to recover disability benefits if you cannot earn a wage that approaches “the dignity of a livelihood.”

One court has recognized that: “Common knowledge of the occupations in the lives of men and women teach us that there is scarcely any kind of disability that prevents them from following some vocation or other, except in cases of complete mental incapacity. Although the achievements of disabled persons have been remarkable, we will not adopt a strict, literal construction of such a provision which would deny benefits to the disabled if he should engage in some minimal occupation, such as selling peanuts or pencils, which would yield only a pittance. The insured is not to be deemed “able” merely because it is shown that he could perform some task.” *Helms v. Monsanto Co., Inc.*, 728 F.2d 1416 (11th Cir. 1984).

Definition of “regular occupation”

Some own-occupation policies specifically spell out your occupation. For instance, a policy may provide you with benefits if you can no longer perform your duties as a “medical doctor.” It may be even more specific and say you are entitled to benefits if you can no longer perform your duties as an “invasive cardiovascular surgeon.” Other policies simply provide benefits if you can no longer perform the duties of your “regular occupation.”

If your policy does not specifically define your regular occupation, your regular occupation will be considered the specific work you were doing at the onset of your disability.

However, what if you can no longer do your prior occupation, but you can do some job that generates an income? What if that income is greater than the income you made before you became disabled? Can you still receive your disability payments? The answer is...“it depends.”

Let’s take our invasive cardiovascular surgeon for instance. Suppose he can no longer work as a cardiovascular surgeon because of a tremor in his hands. However, he can work in an office practice. He begins an office practice that becomes very successful, soon paying him more money than he made as a surgeon. In general, he will be entitled to his disability payments from the insurance company?

The disability policy promised to pay him disability payments if he could no longer work as an invasive cardiovascular surgeon. So, in this sense, yes, he can continue to receive disability payments. However, many policies have a clause that allows the insurance company to discontinue benefits if the insured begins to make x% or more of his earnings prior to the disability.

Sometimes it is easy to determine what type of job a person was doing at the time of her disability because she becomes disabled as the result of a single catastrophic event. However, quite often people do not become disabled on one particular day but through a process over time. This is known as an insidious onset.

In the insidious onset situation, people generally give up their day-to-day responsibilities over a long period of time until they can no longer work at all. This presents an issue when you have an own-occupation policy. What was your regular occupation when you became disabled? The job you had when you began your decline in health, or the job you were doing the day before your last day working?

In just such a case, a woman who worked for 20 years in the securities industry had to slowly give up responsibilities because of an illness. Finally, the time came when she could no longer work at all. At that time, she filed a claim for own-occupation disability benefits. Incredibly, the insurance company denied the claim and argued that her “regular occupation” at the time of her disability was “unemployment,” and that illness did not prevent her from performing the essential duties of unemployment.

The court rejected the insurance company’s argument and held that the insurance company’s interpretation “strains credulity as it does the words of the contract. In the layperson’s terminology that [the insurer] was required to apply in the context of a disability policy, the terminology ‘unable to perform the substantial and material duties of your regular occupation in which you were engaged just prior to the disability’ would seem to refer to [the insured’s] last employment in her regular occupation as an executive in the securities industry, not her condition of being unemployed. An unemployed person is not performing ‘the substantial and material duties’ of a ‘regular occupation’ or ‘working in another occupation’ by performing the daily activities of living. Nor is a person’s ‘regular occupation’ composed of whatever activities the person was performing the previous day. The phrase ‘regular occupation’ signifies something of longer

vocational duration than a day's activities.... As insurers are well aware, the major motivation for obtaining disability insurance is to provide...peace of mind and security in the event the insured is *unable to work*.” *Amadeo v. Principal Mutual Life Insurance Company*, 290 F.3d 1152 (9th Cir. 2002).

Elimination periods

Some policies require that you meet an “elimination period” prior to receiving your disability benefits. Say your policy has a four-week elimination period. This means that you must be disabled for a period of four weeks before you become entitled to your disability payments.

Social Security offsets

Most policies will reduce your monthly disability benefits by the amount you receive from Social Security disability. Some policies also require that you apply for Social Security disability benefits.

For example, suppose you start receiving LTD benefits of \$2,000 per month. Eighteen months later the Social Security Administration determines that you are entitled to Social Security disability benefits of \$1,000 per month. (This is not unusual; it often times takes this long or longer for Social Security to verify and activate your Social Security disability benefits.)

When Social Security finally determines that you are entitled to disability benefits Social Security will: 1) send you a lump sum check for all back benefits, i.e., your monthly benefits from the date you became disabled to the current date; and 2) start sending you your monthly benefit check.

In our example, when this happens you will, unfortunately, need to send the lump sum check for back benefits to your LTD carrier, and your LTD carrier will begin reducing your \$2,000 monthly benefit check by the \$1,000 amount you receive from Social Security. If you fail to send the lump sum check to your LTD carrier, the LTD carrier will simply stop paying monthly benefits until they recoup the amount of your back benefits.

Submitting to medical evaluations and submitting requested information

Your disability insurance company can and will request that you submit certain supporting documentation to verify that you are disabled. The most commonly requested information includes the medical records from your physicians and “Attending Physician Reports.” Attending Physician Reports are forms that need to be filled out by your doctor(s). In these forms, your doctor is asked to explain your medical condition(s), explain any medical restrictions you may have, and verify that you are disabled.

Your insurance company can request updates of this information at regular intervals. Unfortunately, I have had many, many cases where the physician either fails or simply

refuses to fill out the Attending Physician Reports. This can lead to disastrous consequences for you. If your physician fails to return the Attending Physician Report to the insurance company, the insurer will often terminate your disability benefits. Depending on the type of policy you have, it may be extremely difficult to have your benefits reinstated if your physician fails to return the Attending Physician Report.

Please speak with your doctor when you file for disability benefits. Make sure he is willing to fill out the Attending Physician Reports when requested by the insurance company. Many physicians are familiar with the reports and have no hesitation in helping you. But some physicians, for whatever reason, simply will not fill them out. If you sense any hesitancy on your physician's behalf in filling out these forms, you should discuss the matter with him and consider changing doctors if you are not confident that he will follow through.

The insurance company can also request that you submit to examinations by doctors of their choosing in order to assess your condition. The insurance company can request that you go to these examinations at regular intervals. If you refuse or fail to attend these examinations, the insurance company can terminate your disability benefits. The insurance company is required to pay for the evaluation, and to pay any costs you incur in travelling to the appointment.

Long-term Care Insurance

Pre-existing Conditions

Many people are rightfully concerned about purchasing a policy but then being denied care because of some pre-existing condition. A long-term disability policy may not use a definition of "pre-existing condition" which is more restrictive than the following: "Pre-existing condition" means a condition for which medical advice or treatment was recommended by or received from a provider of health care services within six months preceding the effective date of coverage of an insured person.

Further, an insurance company may not exclude coverage for a loss or confinement which is the result of a pre-existing condition unless the loss or confinement begins within six months following the effective date of coverage of an insured person. Therefore, even if the insured person has a pre-existing condition, the insurance company cannot deny coverage unless the pre-existing condition results in loss or confinement during the first six months after the policy is issued.

Although it is not crystal clear, it would appear that our Florida Statutes do not allow an insurer to exclude care for a pre-existing condition past six months from the effective date of the policy. Accordingly, if there is an actual pre-existing condition as defined by statute, and that pre-existing condition arises during the first six months after the policy is issued, the insurer cannot deny care for more than six months from the effective date of the policy.

Mandatory Provisions

Inflation protection

There are certain mandatory items that all long-term care policies in Florida must provide. Every long-term care policy in Florida must provide "inflation protection." Inflation protection provides that benefit levels increase to account for reasonably anticipated increases in the costs of services covered by the policy. The inflation protection option must be no less favorable to the policyholder than one of the following:

1. A provision that increases benefits annually at a rate of not less than five percent, compounded annually.
2. A provision that guarantees to the insured person the right to periodically increase benefit levels without providing evidence of insurability or health status if the option for the preceding period has not been declined. The total amount of benefits provided under this option must be equal to or greater than the existing benefit level increased by five percent compounded annually for the period beginning with the purchase of the existing benefits and ending with the year in which the offer is accepted.
3. A provision that covers a specified percentage of actual or reasonable charges and does not include a specified indemnity amount or limit.

The following information must be included in or with the outline of coverage for every long-term care policy sold or delivered in Florida:

1. A graph comparing the benefit levels of a policy that increases benefits over the policy period and a policy that does not increase benefits, showing benefit levels over a period of at least 20 years.
2. Any premium increases or additional premiums required for automatic or optional benefit increases. If the amount of premium increases or additional premiums depends on the age of the applicant at the time of the increase, the insurer must also disclose the amount of the increased premiums or additional premiums for benefit increases that would be required of the applicant at the ages of 75 and 85 years.

Non-forfeiture protection

An insurer that offers a long-term care insurance policy in Florida must offer a “non-forfeiture protection” provision with every policy. This important protection is optional and can be rejected by the insured.

A non-forfeiture protection provision protects an insured from losing their entire policy if all or part of a premium is not paid. Under the non-forfeiture protection provision, if a premium is not paid, the insurance company cannot simply cancel the policy. With this valuable protection, if all or part of a premium is not paid, the insurance company is required to provide the insured with a policy that contains reduced benefits or a shortened benefit period, or some other benefit which is approved by the Florida Office of Insurance Regulation. Non-forfeiture benefits and any additional premium for such benefits must be computed in an actuarially sound manner, using a methodology that has been filed with and approved by the Office of Insurance Regulation.

At the time of lapse, or upon request, the insurer must disclose to the insured the insured's then-accrued non-forfeiture values. At the time the policy is issued, the insurer must provide schedules demonstrating estimated values of non-forfeiture benefits; however, such schedules must state that the estimated values are not a guarantee of non-forfeiture values.

When and how payments are triggered (begin)

An important issue concerns when payments from the insurance company are “triggered” under the long-term care policy. Different policies may provide when payments are triggered in various different ways. For example, an insurance company might want to say that an insured is entitled to payments only when confined to a certain type of nursing home. However, in Florida, our legislature has enacted a statute that provides when and how long-term care policies are triggered.

In Florida, a long-term care insurance policy can use only two conditions to determine the payment of benefits: (1) the insured's ability to perform activities of daily living and (2) cognitive impairment. The insurance company cannot condition payment on any other factors. Every insured is entitled to benefits if he (1) cannot perform three activities of daily living or (2) has cognitive impairment.

By statute, activities of daily living shall include at least:

1. "Bathing," which means washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower.
2. "Continence," which means the ability to maintain control of bowel and bladder function or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for catheter or colostomy bag.
3. "Dressing," which means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
4. "Eating," which means feeding oneself by getting food into the body from a receptacle, such as a plate, cup, or table, or by a feeding tube or intravenously.
5. "Toileting," which means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
6. "Transferring," which means moving into or out of a bed, chair, or wheelchair.

Insurers may be more generous and add to this list, but they cannot subtract from it. If an insurer wishes to use additional activities of daily living to trigger covered benefits, those activities must be defined in the policy.

The determination of a deficiency due to loss of functional capacity or cognitive impairment shall not be more restrictive than:

1. Requiring the hands-on assistance of another person to perform the prescribed activities of daily living, meaning physical assistance, minimal, moderate, or maximal, without which the individual would not be able to perform the activity of daily living; or
2. Due to the presence of a cognitive impairment, requiring supervision, including verbal cueing by another person in order to protect the insured or others.

The assessment of activities of daily living and cognitive impairment must be performed by licensed or certified professionals, such as physicians, nurses, or social workers.

Types of care, including home health care

There are various types of care that a long-term care policy can provide. Most provide care for the insured while in a nursing home or a skilled nursing facility. Some policies

also provide for care while the insured is still at home. This is known as “home health care.” However, insurance companies often try to include so many exclusions and limitations that the home health care coverage is virtually meaningless. Florida statutes provide some strong protections. Any long-term care insurance policy that contains a home health care benefit cannot exclude benefits by any of the following means:

1. Providing that home health care cannot be covered unless the insured or claimant would, without the home health care, require skilled care in a skilled nursing facility.
2. Requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services in a home setting or community setting before home health care services are covered.
3. Limiting eligible services to services provided by registered nurses or licensed practical nurses.
4. Requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide or by another licensed or certified home care worker acting within the scope of his or her license or certification.
5. Requiring that a licensed home health agency provide services covered by the policy that can be provided by a nurse registry licensed under chapter 400.
6. Excluding coverage for personal care services provided by a home health aide.
7. Requiring that the provision of home health care services be at a level of certification of licensure greater than that required by the eligible service.
8. Requiring that the insured have an acute condition before home health care services are covered.
9. Limiting benefits to services provided by Medicare-certified agencies or providers.
10. Excluding coverage for adult day care services.

All of these rules and regulations attempt to help Florida’s consumers actually receive what they think they are buying. Without them, our legislature has found that insurers sometimes provide “coverage” that is worth little or nothing. Whenever considering Long-term Care insurance, make sure your agent has good references and takes the time to clearly explain all of your options.