WOLF

IN SHEEP'S CLOTHING

{ WHAT YOUR INSURANCE COMPANY DOESN'T WANT YOU TO KNOW AND WON'T TELL YOU UNTIL IT'S TOO LATE! }

FEATURING

Anthony D. Castelli, Esq.

WOLF IN SHEEP'S CLOTHING

Published by CelebrityPress™, Orlando, FL
A division of The Celebrity Branding Agency®

Celebrity Branding® is a registered trademark
Printed in the United States of America.

ISBN: 978-0-9829083-5-8
LCCN: 2010941478

Read This Notice, Please!

This publication is designed to provide accurate and authoritative information with regard to the subject matter covered. It is sold with the understanding that the publisher is not engaged in rendering legal, accounting, or other professional advice. If legal advice or other expert assistance is required, the services of a competent professional should be sought. The opinions expressed by the authors in this book are not endorsed by CelebrityPress™ and are the sole responsibility of the author rendering the opinion.

While the lawyers who have contributed articles to this terrific book have all given very useful information, remember that "YOUR CASE IS DIFFERENT." The information given here is in the nature of general legal information. The laws, practices and customs in each state vary. What might be true in New York might not be true in Alaska. Obviously, no attorney client relationship is being formed just because you bought this book (and if you believed otherwise, feel free to return the book.)

If you feel you need an attorney, you should consult with an experienced professional in your area. There are many resources available. If one of the contributors to this book is in your state, feel free to initiate contact with that attorney. If they can't help you, they will generally be able to help you find the right attorney for your case or situation.

Most CelebrityPress™ titles are available at special quantity discounts for bulk purchases for sales promotions, premiums, fundraising, and educational use. Special versions or book excerpts can also be created to fit specific needs.

For more information, please write:

CelebrityPress™,
520 N. Orlando Ave, #44,
Winter Park, FL 32789

or call 1.877.261.4930

Visit us online at www.**CelebrityPressPublishing**.com

WOLF IN SHEEP'S CLOTHING

{ WHAT YOUR INSURANCE COMPANY DOESN'T WANT YOU TO KNOW AND WON'T TELL YOU UNTIL IT'S TOO LATE! }

TABLE OF CONTENTS:

FOREWORD

"The first thing we do, let's kill all the lawyers!"
~ William Shakespeare

(More on this famous quote later.)

Lawyers are a much maligned group. "No one" likes them. "They" are the cause of the economic meltdown, doctors leaving town and the high cost of medical care.

"You can tell a lawyer is lying because his lips are moving."

While the insurance industry and big business have spent millions of dollars to convince you that lawyers are bad news, the truth is that the vast majority of attorneys are hardworking men and women who, day-by-day and case-by-case, seek to achieve a level of justice for their individual clients. They are good people. They run small businesses in your community, take their children to the same schools you do and volunteer to coach soccer and baseball teams. They often spent countless hours giving advice to people they will never end up representing or charging for their knowledge.

I know this because I have been one for 28 years here in Fairfax, Virginia and I work with lawyers across the country who are striving to be even better servants to their com-

munities, and heroes to their families. I know what goes on "behind closed doors" in law offices across the country, in the never-ending battle against the efforts of the insurance industry to defeat and diminish justice.

Thus, it is my great pleasure to have assembled the team of lawyers who have contributed to this book. Here you have literally hundreds of years and tens of thousands of cases of experience and advice that will be useful to you — should you ever find yourself doing battle with the 'giants' of the insurance industry.

This book explores the many ways that the insurance industry uses to maximize profit at your expense. Now, there is nothing wrong with maximizing profit and most all businesses know that they won't be able to stay open if they don't make money. But, as the contributors to this book point out, there are literally hundreds of ways to make sure that you aren't the one singled out for a luscious meal by the "Wolf in Sheep's Clothing." You don't want to be "kill-of-the-week" that ends up on the lunch room bulletin board of some insurance company.

There is one thing that all of the authors would really like you to do before this week is out. Check out your own insurance policies right now, while you are healthy and before you actually need to make a claim. Charles Bledsoe, Daryl Dixon and Karl Truman walk you through the biggest mistakes that most everyone makes in buying car insurance. Pull out your life insurance policy as you read Patrick Phancao's chapter. I highly suggest that you and your employer sit down with my chapter on disability insurance. Michael Strong explains why, if you are ever in a car accident, your own health insurance company may try to grab

your entire claim for itself!

Should you ever need to actually make a claim, you'll want to read the "what goes on inside the insurance company's computers" chapters by Richard Hastings and Mark Blane. Tony Castelli and Thomas Kiley explain the psychological tactics insurance adjusters use to convince you to settle for less, and Gary Hazelton explains why that 'independent medical exam' may have nothing to do with seeking justice.

Jason Schultz shows how the whole claims process has changed (for the worse) over the years. Tim Miley helps you rebut the most common arguments an insurance company will make to diminish the value of your claims, and John Bisnar shows you how you can settle your own case while avoiding some of the most common mistakes that claimants make. Last but not least, Brent Adams outlines the true measure of an insurance company's duty and how, in some states, insurance bad faith laws keep them honest.

Oh, yes, back to the Shakespeare quote. Remember, it was Jack the Butcher who uttered this famous sound bite. He and his bunch sought to overthrow the government by anarchy. They realized that they could not defeat the forces of democracy without first getting rid of the lawyers. Think about that the next time an insurance adjuster says "we can help you, you don't need an attorney."

Ben Glass

Fairfax, VA

CHAPTER 1

A WOLF IS SLY: SEVEN "WEASEL CLAUSES" YOU NEVER WANT TO SEE IN YOUR DISABILITY INSURANCE POLICY

BY BEN GLASS, ESQ.

"One third of all Americans between the ages 35 and 65 will become disabled for more than 90 days."

"One in seven workers will be disabled for more than five years."

"The loss of income can be so devastating that it forces

some people to foreclose on their home or even declare bankruptcy."

These are the headlines and talking points that disability insurance companies use to sell their policies to you. They are right; most people should purchase some form of disability insurance policy. The problem is that some disability policies have so many "weasel clauses," that the likelihood that they would actually send you a check if you were not able to work is low. To make matters worse, some of these clauses make challenging your insurance company's denial of benefits almost impossible.

People are often shocked to find that even though their doctors fully support their disability and in some cases they have been awarded disability benefits by the Social Security Administration, their policies are so bad that the insurance company does not have to pay benefits. Employer-provided policies tend to be much more difficult to collect benefits under than individual policies.

Check your disability insurance policy right now. The "weasel language" discussed in this chapter is <u>not</u> required by law and most policies do not have any of this language. If your policy has <u>any</u> of this language, however, it renders the policy just about useless. Many of the worst insurance policies are bought by employers and used as a "benefit for employees." If you have a policy with the language discussed here, you will probably want to go 'kicking and screaming' to Human Resources.

Here is a list of "weasel clauses" that may make recovering benefits very difficult should you ever become disabled.

WEASEL LANGUAGE #1

(THE SIX MOST DANGEROUS WORDS YOU WILL EVER SEE IN ANY INSURANCE POLICY): **"WE HAVE DISCRETION TO DETERMINE BENEFITS."**

Imagine this: You make a claim for disability benefits under your employer's group disability policy. The claim is denied by the insurance company. You are allowed an appeal of that claim, but your appeal goes back to the same company that just denied your claim.

If they (surprise!) deny your claim again, you are allowed to file suit, but if you do, you will find that the playing field is not level if the insurance company has "discretion to determine benefits."

You won't have a jury decide your case. Instead, a judge will decide your case and he must rule in favor of the insurance company unless he finds their decision to be totally unreasonable. In other words, he can rule against you even if he believes you are actually correct. To make matters worse, you are not allowed to question any of the people who made the decision (to see, for example, if they are actually qualified to review your situation or if they are biased in favor of the insurance company) or call any of your own doctors as witnesses at a trial. In fact, there is no trial.

BAD LANGUAGE #2:

A DEFINITION OF DISABILITY THAT PAYS BENEFITS ONLY IF YOU CAN'T PERFORM "EACH AND EVERY" MATERIAL DUTY OF YOUR OCCUPATION.

(IN OTHER WORDS, "WE'LL ONLY PAY YOU IF YOU ARE IN A COMA.")

Courts have held that this language means that you will only be paid if you cannot perform "every" material duty of your regular occupation. In other words, if you were a

journalist, and you were not able to travel, meet with people or type at a computer, but you could still read, then you would not be disabled from your occupation as a journalist because you could perform at least one of the substantial duties of your occupation.

In one case, the claimant was the assistant manager of computer information systems for his company. He worked 40 hours a week. The physical requirements of his job included using a personal computer, talking on the phone, and attending meetings. He was frequently required to stand, walk and sit, and the job could not be performed by alternating between sitting and standing. He became injured and everyone agreed that his injury limited him to doing "some sedentary work for up to three hours in an eight-hour day." In fact, he was limited to working three hours a day. Unfortunately, his policy had the "each and every" language.

The insurance company argued that if he could perform even one material duty (i.e., working a little bit for three hours a day) that he was not disabled and entitled to payments.

The court bought this argument! It said that the "plain language" of the policy meant that the claimant lost. At a hearing in this case, the Court likened this policy to a "coma policy." In other words, it was a policy that only paid if you were in a coma.

This was a disability policy bought and paid for by the claimant's employer. The Court basically ruled that the employer was perfectly free to buy a crummy policy for its employees and that it was the employees' responsibility to read the policy and go buy a private policy if they didn't like what the employer bought.

BAD LANGUAGE #3:
"OWN OCCUPATION" LESS THAN TWO YEARS

Most disability insurance policies work this way: You can be paid benefits for two years if you are not able to work at your own occupation. After two years, you are entitled to benefits only if you are not able to work at *any* occupation.

The theory behind this is that two years is enough time to be able to become newly trained to be able to produce income in some business or employment.

Ninety-nine point nine percent of all policies have this standard two-year protection for your own occupation. Amazingly, however, some policies afford less than two years of protection, with some providing as little as six months of benefits. What this means is that if your sickness or illness prevents you from working in your own occupation, but after six months there is some job in the marketplace that you could do, then your benefits would be cut off. Believe me when I tell you that the insurance companies work day and night to "find" a job that theoretically you would be able to do. In some cases, claimants who had no use of their arms were told by the insurance company that they could work as telemarketers with automatic dialing and voice recognition capability. It does not matter to the adjuster that the closest job may be the 11:00 p.m. to 7:00 a.m. shift 80 miles away.

BAD LANGUAGE #4:
INCOME PROTECTION OF LESS THAN 60 PERCENT OF PRIOR EARNINGS

Most long-term disability insurance policies promise to pay somewhere between 60 and 66 percent of your prior earnings. This is standard. Of course, what they forget to tell you

is that if your employer paid the premiums, income taxes will still be taken out of this amount, so the protection is actually much lower. If you get Social Security benefits, this reduces the benefits from your employer's policy even more.

Some policies provide less than 60 percent of prior earnings coverage. Employers who buy policies with such limited coverage should be spending the money upgrading the lunch room food because, after taxes, these policies offer almost no benefit at all. At the very least, employees need to know that policies providing less than 60 percent of benefits are not standard and there are much better policies available on the market, probably at the same rate.

BAD LANGUAGE #5:
YOUR BENEFITS WILL BE TERMINATED IF YOU ARE ABLE TO WORK PART TIME, BUT DO NOT

While the sales agents selling these policies focus on the benefits that will be paid if a person meets a definition of disability, hardly anyone will explain the "termination of benefits" clause in the policy. This is very, very important, as people lose their benefits because of these clauses.

The most heinous of these termination clauses says that all of your benefits will be terminated if you are able to work part time, but do not. Think about this for a minute. It does not say that it will terminate benefits if you can make 60 percent of pre-disability earnings on your own. It does not say it will terminate your benefits if you can work 60 percent of the time you used to be able to work. <u>It says it will terminate benefits if you are able to work part time, but do not</u>.

Almost anyone could work "part time," couldn't they? Does "part time" mean an hour or two a week? I have seen

cases where the medical records and the doctors all agreed that the claimant could not work more than two hours at a time during the week because of severe pain and fatigue. It is no longer surprising that some insurance companies will insist that the ability to work "up to two hours at a time" is an ability to work "part time." All they need is one doctor to say that you can do this, and the fact that you do not go out to work these hours means that all of your benefits are terminated. Remember, they do not need to actually prove that there is any employer who would hire you.

Any individual or employer who buys a policy which allows benefits to be terminated if the claimant "can work part time, but does not" must have been sleeping when the policy was being explained to them.

BAD LANGUAGE #6:
DISCRIMINATION AGAINST THE MENTALLY ILL

The next outrage to be aware of in long-term disability policies is the blatant discrimination against the mentally ill. Some policies limit payment of benefits if mental illness is the disability keeping the person from working. Courts have held that this blatant discrimination against the mentally ill is legal in long-term disability policies. (This is especially true in employer-provided policies. An employer is not required to offer any policy and courts have said, time and time again, that if an employer does offer a disability policy, it can offer any policy it wants. In other words, it doesn't have to provide a policy that actually pays benefits if you are disabled.)

What happens with these policies is that when you make a claim, the insurance company will seek to label your claim a "mental illness." Have chronic pain? You are depressed.

Suffer from fibromyalgia? "It's all in your head." Suffer from lyme disease? Your "mental illness" is causing you to "exaggerate your complaints."

Many policies go a step further, however. For example, some policies limit payments for disability benefits if "mental illness plays any part" in the disability. This is a very dangerous clause. (Think about it—the one thing that almost always happens when an otherwise productive member of society gets ill and can't work is that they become depressed. Insurance companies LOVE TO SEE "DEPRESSION" in the medical records. It's their ticket out of paying you!)

Insurance companies also love to see "cognitive" problems arising out of head trauma. You hit your head in a car accident, for example. You suffer a brain injury. The insurance company will attempt to label your "brain injury" as "mental illness."

Do you see how dirty their little game is? Many policies do not discriminate against the mentally ill. You need to look for a policy that does not contain a "mental illness" limitation of benefits.

BAD LANGUAGE #7:
LIMITATION OR REFUSAL TO PAY FOR "SELF-REPORTED" CONDITIONS

Another outrageous limitation that appears in some policies is a limitation for so-called "self-reported conditions." Sometimes the insurance policy will list specific conditions like chronic fatigue, fibromyalgia, chronic pain, headache, migraines and the like, but other times it will not. What these insurance companies then turn around and do in de-

nying claims is say that "there is no objective evidence that you are in pain" or there is no objective evidence that you are really fatigued. Therefore, the diagnosis is being made upon your own report of pain or fatigue and, thus, we are going to either not cover this benefit or limit it severely.

There are many well-recognized and documented diagnosable conditions related to pain and/or fatigue. There are physician specialists who make these diagnoses after exhaustive testing. The fact that there is sometimes not any one test or lab study that can be done to "make the diagnosis" should not be a reason for an insurance company to limit or eliminate benefits.

Note: This language is still relatively rare, and only the cheapest companies include this clause. If you are an employer, you need to be on the lookout, especially when the insurance company sends you a big batch of paperwork in advance of a policy renewal. The instinct is to not read the fine print.

ABOUT BEN

Ben Glass is an attorney in Fairfax, Virginia. He is the author of numerous consumer books on the law, including "*Robbery Without a Gun, Why Your Employer's Long-Term Disability Insurance Policy May be a Sham*" (available at RobberyWithoutAGun.com). Mr. Glass has been featured or quoted in numerous publications, including *The Washington Post, Washington Post Magazine, Newsweek, USA Today,* ABC News Online, *Wall Street Journal,* and "The Next Big Thing" radio show. He has been interviewed on television, including ABC, NBC, Fox and Cox, as well as the show, "Leading Experts TV." For more information and a complete list of books, visit BenGlassLaw.com.

CHAPTER 2

THE INSURANCE COMPANY OFFERED ME MONEY BUT I DON'T KNOW WHAT MY CASE IS WORTH

BY RICHARD P. HASTINGS, ESQ.

I am told that a potential personal injury client is on the phone waiting to speak with me. "Hello, this is Richard Hastings, how may I help you? Hi, Attorney Hastings, I was injured in a car accident several weeks ago, and the insurance company called me and told me they would pay me $1,000.00 for my injuries. They said they would not pay any more than that and if I wanted to hire a lawyer they would still not pay any more money, but I would then have

to pay legal fees and end up with less money. Should I take the $1,000.00?"

Often times, I receive this type of call from a confused injured party. My response is always the same: "Let me first ask you a question," I state to the caller, "How do you like my tie?" The caller is caught off guard. "Well, I can't really comment on that since I can't see your tie," I am typically told. "How then can I comment on the value of your claim when I don't know the details of your unique case?"

Insurance companies make money by not paying out fair and reasonable settlements to injured parties. The insurance adjuster wants to pay the least amount of money out to a claimant, and they are provided with that opportunity every time they deal with a person who is not represented by an attorney.

So why should an injured party hire a lawyer? More money is the primary reason. An insurance industry research institution studied personal injury claims processed by the injured person alone versus those that were handled by attorneys. The study determined that those represented by attorneys had a higher net recovery for themselves (more money in their pocket after attorney's fees and costs) than those without attorneys.

The number one question that is on the mind of most injured parties when they come in to see me for a consultation is… "What is my case worth?" Therefore, I would like to provide you with the answer to that question, which should emphasize why it is NEVER a good idea to settle your own claim, without first speaking with an experienced personal injury lawyer.

DETERMINING THE VALUE OF ANY PERSONAL INJURY, WRONGFUL DEATH, OR MEDICAL MALPRACTICE CASE IS BOTH AN ART AND A SCIENCE.

The science in determining the value of a claim is making sure that all the necessary facts and figures are gathered and put together in a complete package that answers all possible questions. The art of the process lies in being able to present this information persuasively enough to convince the reader of the significance of the great value of your injuries.

Because there is no mathematical formula that can be used to put a value on a case, it is very important that you have an experienced personal injury lawyer apply his or her knowledge, experience, and visceral feel for determining the worth of your particular case.

It should be stressed that no case should be settled until such time as the injured party has reached maximum medical improvement – which occurs when the injured party has reached a point where their medical condition can no longer improve and their situation is stationary and permanent.

If the claimant's medical condition is subject to change, has not stabilized, and will continue to improve, then settlement discussions should not be started. The only exception to this situation occurs when there is not enough insurance coverage to compensate the individual for the damages suffered to date, and there is no hope of recovering any other funds. In general, however, once you have reached maximum medical improvement, your attorney can begin to assess the value of your case.

THE FIRST MAJOR ISSUE THAT MUST BE

EVALUATED IS THE STRENGTH OF YOUR CASE BASED ON LIABILITY.

In other words, a determination must be made as to who is at fault. In many instances, this question is relatively easy to answer, yet in other cases, the issue becomes much more complicated. In a typical case, an injured party must prove that their injuries were caused by the fault of another.

In many states, an injured party may pursue a claim even if he or she is partly responsible for the injuries sustained, due to the principle of comparative negligence. In those instances, an injured party will have the award reduced by the amount of fault assessed against them. For example, if the injured party is found to be 20 percent responsible for his or her injuries and a jury finds the case to have a value of $100,000, the injured party's award would be reduced by the comparative fault (20 percent), which would result in an award to the injured party of $80,000.

Some states follow the principle of contributory negligence, which holds that if the injured party is in any way at fault, there is no recovery whatsoever. Still other jurisdictions follow a modified comparative negligence standard.

In still other cases, fault is assessed on public policy grounds, which results in a finding of strict liability. Certain states hold that a person or a company is automatically liable for the injured party's injuries. In such states, the owner of a dog may be strictly liable for the injuries suffered by a person who is bitten by their dog, and the manufacturers of certain products may be strictly liable for injuries caused by their use.

THE SECOND MAJOR ISSUE THAT MUST BE ANALYZED IS THE QUESTION OF DAMAGES.

Essentially, two types of damages are recoverable in a negligence action: economic damages and non-economic damages.

Economic damages are intended to cover injuries for which an exact dollar amount can be calculated. These could include the following:

- Medical expenses that have been incurred to date, along with future medical expenses likely to be incurred as a result of the injury;
- Lost wages or loss of income incurred to date, as well as loss of the ability to earn the same or more income in the future, which are likely to result from the injury sustained;
- The cost of past and future special services and/or medical devices needed to assist with activities that were previously performed without aids by the injured party;
- The cost of any vocational or other training that might be reasonable in order to retrain or otherwise assist an injured party who has a permanent disability; and
- All reasonable out-of-pocket expenses.

Non-economic damages are intended to cover injuries for which an exact dollar amount cannot be calculated. Non-economic damages could include compensation for the following:

- Pain and suffering to date, as well as future pain and suffering
- Loss of enjoyment of life's activities normally

experienced by the injured party;
- Emotional distress; and
- Loss of companionship by a loved one (generally this is a separate claim available to a spouse).

The determination of economic damages is generally regarded as a science. Medical expenses can be obtained from health care providers (including doctors, hospitals, and therapists). Future medical expenses can be addressed by the injured party's treating physician or other medical experts.

Past lost wages or loss of income can generally be calculated from tax returns or pay stubs. Future loss of income is usually determined by an economist and/or vocational rehabilitation expert. All out-of-pocket expenses can be calculated and documented by the injured party.

The determination of a person's non-economic damages is generally an art. There is no formula or other "objective" way to calculate the dollar value of the loss of function of a certain body part or permanent injury to a person's body, or of the loss of one's enjoyment of life.

An experienced attorney knows, through personal experience and jury verdict research, what juries have awarded in similar cases. This experience and professional access to research may help your attorney arrive at a range of values for a particular case.

TO FURTHER COMPLICATE MATTERS, THE VALUE OF AN INJURED PERSON'S CASE CAN ALSO BE INFLUENCED BY ANY ONE OR MORE OF THE FOLLOWING FACTORS AND/OR CONSIDERATIONS:

- The age of both the injured party and the at-fault party
- The likeable qualities of both the injured party and the at-fault party, including the impression each party might have on a jury
- The ability of each party's lawyer to influence the jury to side with his or her particular client
- The willingness of the injured party to go to trial
- The willingness of the injured party's lawyer to go to trial
- The willingness of the at-fault party to go to trial
- The willingness of the at-fault party's lawyer to go to trial
- The cost of defending the case
- The cost of prosecuting the case
- The experience, skill, and history of the trial judge
- The speed with which the case is likely to come to trial
- The available insurance limits and any risk that there may be a verdict in excess of the available coverage
- The assets of the at-fault party
- The injured party's life expectancy and any unrelated conditions that might shorten the injured party's life
- The chance of the injured party being awarded punitive damages from the at-fault party
- The injured party's need for the money
- The assessment of the injured party's treating physicians
- The assessment of the injured party's expert witnesses
- The assessment of the at-fault party's

expert witnesses
- The strength of the claims for future damages
- The probability of success for future medical treatments for the injured party
- Any claimed lien amounts on file by any health care professionals, insurance companies, or other parties
- The nature and extent of any scarring or deformity
- The sex of the injured party
- The extent of any preexisting conditions
- Any statutory caps for damages
- The applicable law of the particular jurisdiction

The above factors are just some of the considerations that make the evaluation of a case an art.

THE ABILITY TO KNOW WHAT INFORMATION TO LOOK FOR, HOW TO EVALUATE IT, AND HOW TO PRESENT IT, MAKES THE PROPER EVALUATION OF A CASE VERY DIFFICULT.

An experienced personal injury attorney will be able to gather all the needed information and properly weigh each piece, and will then be able to persuasively present it to the insurance adjuster, judge, or jury to help maximize the amount of money an injured party can receive.

In addition to the complications that arise from determining the value of a case, there are a number of other vital steps that should be taken to maximize the value of an injured party's claim.

PEOPLE NOT REPRESENTED BY ATTORNEYS OFTENTIMES MAKE IRREVERSIBLE MISTAKES THAT COMPROMISE OR REDUCE THE VALUE OF THEIR CLAIM.

There are also a number of "value drivers" that can increase the value of your case. Generally speaking, a value driver is anything that will drive the value of your case upward. Value drivers could include the total of your medical bills for reasonable and necessary treatment; positive test results; buzz words and key phrases in your medical records; documented out-of-pocket expenses; the use of medical aids or devices; and medical insurance premiums paid. Likewise, there are things you should tell your doctor that will increase the value of your claim as well.

There are also a number of things you can do to improve your loss of income claim that can positively affect your case. These would include properly documenting all lost overtime, sick time and vacation time used for any time lost from work as a result of your injury — including trips to the doctor. If you are self-employed or a commissioned salesperson, you need to obtain the proper documentation from your doctor and accountant, and properly develop all needed supporting information for your claim.

These are just a few of the many reasons why it is imperative that you consult with an experienced personal injury lawyer before proceeding with your case.

ABOUT RICHARD

Richard P. Hastings, Esq.

Attorney Richard P. Hastings is a member of the Million Dollar Advocates Forum which is one of the most prestigious groups of trial lawyers in the United States. Membership is limited to attorneys who have won million and multi-million dollar verdicts and settlements. Fewer than 1% of U.S. lawyers are members. He is rated superb, 10/10, by AVVO an online consumer legal rating service.

Richard has collected millions of dollars for his clients in cases including motor vehicle accidents, defective products, wrongful death, dog bite incidents, general accident cases, slip and fall incidents, breach of contract claims, unfair trade practice cases, construction litigation, will contests, and general litigation matters.

Mr. Hastings sits on the Board of Directors of a number of corporations, is involved in numerous general partnerships and serves as legal counsel to countless others.

He is trained as a mediator by Harvard Law School and the Center for Mediation in Law. He has also received advanced negotiation training through Harvard Law School, and is a member of the Connecticut Bar Association's Pro Bono School Expulsion Project.

He holds the title of Distinguished Toastmaster from Toastmasters International, its highest designation. He is involved in a number of philanthropic endeavors, has held board positions in a number of charitable organizations and has received a number of governmental appointments.

He was named a recipient of The National Republican Congressional Committee's prestigious Businessman of the Year Award. He is the author of the books: *How to Find a Great Lawyer*, *How to Explode Your Practice*, *Understanding and Improving the Value of Your Personal Injury Case*, *The Crash Course on Personal Injury Claims in Connecticut*, *The Workbook for The Crash Course on Personal Injury Claims in Connecticut*, *The Crash Course on Child Injury Claims, The Workbook for The Crash Course on Child Injury Claims, The Crash Course on Motorcycle*

Accidents, The Workbook for The Crash Course on Motorcycle Accidents, The Crash Course on Heart Attacks and Cardiac Arrest Claims, and What You Need to Know About Connecticut DUI.

He is the founding partner of Hastings, Cohan & Walsh, LLP in Ridgefield, CT. He can be reached at (888) 842-8466 or at www.hcwlaw.com

He is a graduate of the University of Connecticut (Business Administration) and Fordham University School of Law. He resides in Ridgefield and enjoys outdoor activities with his family and riding his Harley.

CHAPTER 3

BEING UNDERINSURED CAN TAKE *YOU* UNDER

BY CHARLES L. BLEDSOE, ESQ.

Everyone wants to sell us the "lowest-priced" car insurance; lizards, former Presidents of the United States (at least the one from the TV drama, "24"), not to mention a very enthusiastic woman with bright-red lipstick in an all-white store.

Whether you're familiar with those constant auto insurance campaigns or not, you've undoubtedly been bombarded by ads promising to save you hundreds of dollars a year on your coverage. And it's tempting to take advantage of the savings they offer, especially when money is tight. Es-

pecially if you've never been in an accident and consider yourself a very safe driver.

If you bite at these offers, it's true that you may end up saving what usually comes down to pennies a day. But you might also end up being liable for hundreds of thousands of dollars down the line, if not a million or so. Or worse, end up with your own medical costs that could also reach 6 or 7 figures.

No one wishes that kind of unthinkable situation on anyone. Unfortunately, it's the after-effect every single day of car accidents on America's roadways – and a potential life-changing event of such enormous gravity that we all need to consider if we're properly protected if it happens.

These insurance companies provide their advertised savings by bottom-lining your coverage and, more importantly, not including the options that can be critically important, but not-necessarily required in the state you live in. Not only that, but the minimum amount of coverage provided by insurance companies and required by states is, in most cases, woefully inadequate.

As a personal injury lawyer with over 20 years of experience dealing with victims of car crashes, I see all too often the consequences of insufficient auto insurance coverage. Currently, I have a female client who was in an auto accident that was not her fault. Her medical expenses alone will run to $200,000 and her total claim will be anywhere from $750,000 to a million. Well, the person who hit her only had the basic $25,000 minimum coverage. She can sue for the rest – but that person can easily file for bankruptcy and she'll only get what their policy and her policy will cover.

That leaves quite a shortfall – and quite a dilemma for my client.

In contrast, another client was rear-ended by a coal truck. He suffered permanent injury and also has a substantial medical claim. In this case, however, the company required a million dollars worth of coverage be carried on its vehicles – and my client will at least get properly compensated for his injuries and his suffering.

At my law office, when we represent someone injured in an accident, one of the first things we do is investigate all possible insurance coverage that's relevant to the situation. There are two categories of auto insurance - first party coverage and third party coverage. First party coverage covers you and your property (such as medical expenses, damage to your vehicle and the insurance company's duty to defend you in the event that you are sued as the result of your operation of a vehicle, etc.). Third party coverage helps you meet your responsibility to pay for injury caused to other people (and vice versa), whether in your vehicle, or another vehicle involved in the accident.

To ensure you can "protect and defend" you and your loved ones if you do have the misfortune to be in a car accident, here's a brief overview of a few car insurance coverage issues you should be informed about, and, if you do suspect you're underinsured, you can take action on.

UNDERSTANDING UNINSURED AND UNDERINSURED MOTORIST BENEFITS

The hard facts are these: there are over 6 million car accidents in the United States every year, and studies indicate that almost 15% of them involve drivers that are either un-

insured or underinsured.

It's also important to note that the Great Recession has increased the number of uninsured motorists. When people lose their jobs or end up with lower-paying part-time positions, they look at things like car insurance as a luxury – and they either cut their coverage or eliminate it altogether, even though it may be illegal to do so in the state they live in. Studies show a definite correlation between rising unemployment and a growth in the number of uninsured drivers on the road.

You just can't know who's on the road with you – whether that person has minimal coverage or no coverage at all. While odds are you won't be in an accident involving underinsured or uninsured motorists, if you are, the effect on your life can be devastating financially - as I detailed in the case of the woman with the $200,000 medical bills at the beginning of this chapter. In this case, taking the relatively cheap but incredibly protective uninsured and underinsured insurance options on your premiums means you can feel safe and secure no matter what happens.

Frankly, many motorists don't even know these options exist – most people, unsurprisingly, aren't experts on insurance. They simply take the 'bare-bones' car insurance without much thought and believe there's really no way to be protected if you should get into an accident with an uninsured driver. But this is definitely a box you should consider checking when you're thinking about what coverage you need.

Some states, such as Illinois, Maryland and New York, require you have some form of this kind of insurance. Even when they do, however, it's generally minimal coverage

that simply won't completely cover major accidents.

When a motorist has this clause in a policy, it means that, when they are involved in an accident with a motorist who does not have adequate money or insurance to cover the cost of the collision, the insured motorist's insurance company will pay the difference between the total cost of damage and the amount that the uninsured / underinsured motorist is able to pay out of pocket.

Going back to my client with the $200,000 medical claim, if she had had this provision in her insurance coverage, this would have made sure her medical bills were paid (depending, of course, on the level of the coverage she had opted for). As it stands, if the other driver who was involved in her accident has no other assets and files for bankruptcy, she can't cover her expenses.

MEDICAL PAYMENTS (MED-PAY) COVERAGE

There is, fortunately, yet another auto insurance option that helps with medical bills – Medical Payments Coverage, which actually is a requirement to have in many states, including Virginia, the state in which I practice law.

Medical Payments coverage will pay medical bills and/or funeral costs, should a covered motorist and/or accompanying passengers be injured or killed while in an insured vehicle. It doesn't matter who's regarded as being at fault in the accident – the coverage still applies.

This kind of coverage may also cover policyholders and their families when riding in others' vehicles – or even

when they are pedestrians and are on foot when hit by a car. The buyer of the policy determines the dollar amount of this coverage – naturally, the more costs that are covered, the higher the insurance premium. Still, it's an incredibly affordable way to be prepared for the worst-case scenario.

How does Medical Payments coverage work with your health insurance? Well, if your health plan requires that you pay a deductible, as most do, Medical Payments may cover that deductible. It may also pay for items not covered by your health plan that still need to be addressed as a result of a car accident – items such as professional nursing services, funeral costs, prostheses, and dental treatment.

Obviously, you should check with your health plan to see how much additional coverage you might require from Medical Payments coverage.

Personal Injury Protection, or PIP, is more powerful form of Medical Payments coverage and it's only available in several states, where it's often mandatory to have it as part of your car insurance policy. In addition to covering medical, dental, and funeral expenses, this type of auto insurance coverage also addresses the costs of rehabilitation, psychiatric treatment, lost wages, and similar costs relating to an accident.

WHY MINIMUM COVERAGE ISN'T ENOUGH

Every state requires a certain minimum of auto insurance coverage – the problem is that, in most cases, those requirements are outdated and don't provide nearly enough protection in the case of an accident that's beyond a simple fender-bender.

Most states only require $25,000 liability coverage – and, again, serious injuries can easily cost in the hundreds of thousands of dollars in medical costs, not to mention the other associated costs I've previously mentioned, such as lost wages, rehabilitation and professional nursing services.

This is why you should seriously consider, in addition to adding on uninsured and underinsured motorist benefits, increasing your overall liability coverage amounts. You can partially compensate for the added costs to your premium by raising your deductibles if you're comfortable with that.

A serious car accident can end up financially devastating yourself and/or the other motorist involved in the incident. As a personal injury lawyer in Virginia, I see more than my share of car accident cases in which this is the situation. There's no need for the financial aftermath of an accident to be even worse than the accident itself.

The time to find out what coverage you have and what your insurance will provide is *not* in the immediate hours after you've had a serious collision. I strongly advise you to work with your car insurance agent now to find affordable solutions to boost your coverage in the key areas I've discussed in this chapter.

And the next time a lizard tries to sell you discount auto insurance on TV? I'd advise you to change the channel.

ABOUT CHARLES

Charles L. Bledsoe, Esq.

Bledsoe Law Office, PC is a professional corporation established by Charles L. Bledsoe, Attorney at Law, and which currently has three (3) convenient locations in South Western Virginia and Northeastern Tennessee. These offices are located in (Wise County) Big Stone Gap, Virginia, (Lee County) Jonesville, Virginia and (Washington County, Virginia / Sullivan County, Tennessee) the City of Bristol.

Bledsoe Law Office, PC concentrates its practice primarily on personal injury and disability matters. The law office handles such personal injury claims as car wreck cases, work related car wrecks, wrongful death claims, product liability, medical malpractice claims, nursing home abuse claims, and Social Security / Disability claims.

Charles L. Bledsoe has been practicing in these fields for twenty (20) years and currently practices in all Federal and State Courts. Recently, and in an effort to educate the public, Bledsoe Law Office, PC has been organizing and publishing special reports in each of its practice areas.

It is the law firm's hope that by providing these materials free of charge to the general public, it can provide the general public with much needed information — to determine whether or not they may have a particular claim and actually need assistance. Since Bledsoe Law Office, PC limits its acceptance of cases to those that meet certain criteria; these special reports will assist the reader to determine whether their case is one that this law firm is able to accept employment and provide assistance. In the event that this law firm is unable to accept employment, it is the law firm's policy to assist, if requested by the individual, to secure alternate counsel.

CHAPTER 4

WHAT IS THE MOST IMPORTANT AUTO INSURANCE COVERAGE THAT YOU MUST HAVE AND HOW MUCH YOU SHOULD BUY? …(UM/UIM)

BY DARYL T. DIXON, ESQ.

FIVE THINGS YOU MUST KNOW ABOUT UM / UIM COVERAGE

1. WHAT IS UM/UIM COVERAGE?

Under Kentucky Law all Owners of a Motor Vehicle must carry a minimum of 25,000/50,000 in Bodily Liability Coverage.

However, the two most important types of coverage are what is called UM and UIM Coverage. Bodily Liability Coverage covers the other person if you cause an accident. UM/UIM covers you and your injuries if the other party is at Fault.

UM coverage is short for Uninsured Motorist Coverage. With Uninsured Motorist Coverage you will be protected in the event of an accident with another motorist who is uninsured. This coverage will protect you and allow you to recover for damages caused by a collision with an uninsured motorist. The recovery will be from your own insurance company and will cover you for injuries UP TO THE LIMIT OF COVERAGE PURCHASED. This coverage is available from all insurance carriers and as you will see the cost of adding the maximum policy limits of UM coverage to your current policy is not unreasonably expensive, especially when you consider the benefits it can have for you and your family in the event of a collision.

What if the other motorist is insured but does not have enough coverage to sufficiently cover my damages? This is where UIM coverage will protect you. UIM stands for Under Insured Motorist Coverage. With Under Insured Motorist Coverage you will be protected in the event of an accident with another motorist who does not have adequate coverage to provide sufficient funds to cover for the damages they caused. When you have UIM coverage you will be protected from other motorists who only carry the minimum required policy limits in Kentucky. If you are involved in an accident and injured more severely than the limits of the other party's Insurance, you will still be covered. Again the recovery of this policy will be from your own insurer and will only be available UP TO THE LIMIT YOU PURCHASE.

2. UM / UIM COVERAGE IS THE MOST IMPORTANT COVERAGE AVAILABLE IN THE STATE OF KENTUCKY.

IT IS IMPERATIVE that you understand that UM/UIM coverage is the MOST IMPORTANT COVERAGE AVAILIBLE IN THE STATE OF KENTUCKY TO PROTECT YOU AND YOUR FAMILY!

Insurance companies must offer UM/UIM coverage. However, they normally do not tell you how important it actually is. Since the insurance agent isn't telling you the reason why you need UM/UIM coverage, most people think they are just trying to sell you something you don't need. THIS IS NOT THE CASE!! When considering how much UM/UIM coverage to purchase, you should always look at your family's assets to start. For example, if you are single you probably will not need as much coverage as you would if you were married and had children. This is the thought process you must go through and this is what you need to discuss with your agent when you are considering how much UIM/UM Coverage to purchase.

You must choose to opt out of UM/UIM coverage in the Commonwealth of Kentucky. THIS IS THE LAW IN KENTUCKY!! PLEASE DO NOT EVER SIGN ANYTHING OPTING OUT OF UM/UIM COVERAGE!! If you find yourself in the position of having already done so, contact your agent and tell him you want UM/UIM coverage. It is not impossible to add the coverage to your existing policy. Once again it is important to note that UM/UIM coverage is not unreasonably priced and is available through ANY insurance carrier and comes in various policy limits.

3. UNINSURED MOTORIST COVERAGE WILL PROTECT YOU IN THE EVENT OF A "HIT AND RUN."

One of the most important aspects of Uninsured Motorist coverage or UM is if you are the victim of a "Hit and Run." If you never catch the other driver, your UM coverage will protect you as long as there was "Physical Contact" with the other car. This is one of the "secret" benefits of UM Coverage. It is now a Felony to Leave the Scene of an Injury Accident in the Commonwealth of Kentucky. (See DarylT-DixonLaw.com for Article.) This is referred to as a "Hit and Run." Once you have proper UM Insurance on your policy you can rest easy knowing that you will be protected in the event this ever happened to you or a family member.

Of course, UM coverage is designed to cover you if you are injured by a Driver who has no insurance. In addition it is also a great comfort to know that if you are injured in a "hit and run", where the other driver in the accident cannot be determined or found, then your injuries will be covered. Your damages will only be covered up to the policy limits that YOU purchase. UM Coverage is worth the money and is a very good way to protect yourself if the unthinkable should happen to you or a family member. There are a lot of people out there on the roads and not all of them have insurance. This particular type of coverage will allow you to drive with piece of mind knowing that if an accident should occur with an Uninsured Motorist, you will be protected.

4. HOW MUCH DOES IT COST?

Comparing quotes is actually very simple. For example,

The Commonwealth of Kentucky offers free online and instant quotes through the Kentucky Division of Motor Vehicles Licensing and Division of Driver Licensing at: http://transportation.ky.gov/drlic or The Kentucky Department of Insurance has a website at: http://www.doi.state.ky.us/kentucky. Other states have similar websites and you can link to them by going to the Secretary of State Website of your particular state. In addition, all major Insurance Companies have their own websites where you can go and compare quotes online that tailor to your specific situation. Remember though to get plenty of UM/UIM!

I have conducted my own research to help you understand just how little it costs to buy more coverage. Insurance Companies will factor in your driving history when they are preparing your quote. They look at such things as traffic tickets, past wrecks, age and other factors in addition to the specific coverages that you need to come up with your quote. You may find that your quotes are not the same as mine. However, you will get some idea of how Insurance Companies prepare these quotes.

An Insurance Company's quote is not a bill but rather an offer that you may accept by paying the Premium. In the quote, the Insurance Company will itemize the costs for the coverages that make up your Policy. This makes it easy to analyze your Policy and add the coverages that will protect you. For example, your Quote may itemize that Personal Injury Protection (PIP) Coverage costs $25.00 and the Towing is $3.00 per Policy Period. If your quote does not contain these itemized coverage figures, ask your agent to break them down for you. It is important to note that most Insurance Companies will only allow you to buy as much UM/UIM Coverage as you have in Liability Coverage.

I began my research with the Grange Insurance Company and my quote reveals some very interesting figures. First, my Itemized Bodily Injury Liability Quote was $106.00 for $250,000/$500,000 in coverage. That figure only increased $22.00 for coverage of $500,000/$1,000,000.00, which is the maximum coverage available to me.

My Itemized UM/UIM Quote was $59.00 for $250,000/$500,000 in coverage and only increased $7.00 for coverage of $500,000/$500,000, which is the maximum coverage available to me.

My Overall Quote for the maximum coverage available to me only increased some $33.00 and I almost doubled my coverage. Furthermore, I added $10,000 in PIP Coverage. Again, this is for a Six Month Policy Period.

I conducted further research with four different major Insurance Companies. I wanted to see the difference in my overall Policy Premium Quotes between the *minimum coverage* and the *maximum coverage*. All of these quotes contain the difference in Policy Premiums between the Minimum Bodily Injury Liability and UM/UIM Coverage and the Maximum Bodily Injury Liability and UM/UIM Coverage.

1. **GRANGE**- The difference between $25,000/$50,000 and the $500,000/$1,000,000 is estimated at around $350 over a Six Month Policy Period.
2. **ALLSTATE**- The difference between $25,000/$50,000 and $250,000/$500,000 is estimated at around $150 over a Six Month Policy Period.
3. **PROGRESSIVE**- The difference between $25,000/$50,000 and $250,000/$500,000 is estimated at around $125 over a Six Month Policy Period.
4. **STATE FARM**- The difference between

$25,000/$50,000 and $250,000/$500,000 is estimated at around $150 over a Six Month Policy Period.

5. **GEICO**- The difference between $50,000/$100,000 and $250,000/$500,000 is estimated at around $125 over a Six month Policy Period.

5. NOW THAT YOU KNOW IT'S THE MOST IMPORTANT COVERAGE – GO GET SOME!

Now that you know that UM/UIM coverage is the most important coverage in the state of Kentucky, go out and get as much as you can. Do not settle when the insurance agent balks at your inquiry to get as much as you can. The agent will likely try to sell you an Umbrella Policy instead. BE FIRM. Ask that they give you quotes on UM/UIM coverage. Then work your way back down through the policy limits until you find what is appropriate for you and your family. Remember this is a consideration of your personal situation so don't be afraid to ask for help in your evaluation, but also don't be pressured to take less than you need. Finally, if you need additional help, send me an E-mail or give me a call.

A TALE OF TWO CLIENTS

CASE NUMBER ONE

On July 25, 2003, two of my clients were driving through a small town in Kentucky when a negligent driver ran through a stop sign, slammed into the side of their car and forced them into a chain link fence. The steel bar of the chain link came through the front window and narrowly missed one of my clients head.

This Client suffered a broken pelvis, several broken ribs and multiple contusions and abrasions. His wife suffered broken ribs, multiple contusions and abrasions, as well as further damage to her knee. Doctors had to perform surgery to correct an injury to her back. The negligent driver had the minimum limits of $25,000 / $50,000. There were no personal assets to collect to help pay for my clients' medical expenses.

However, my clients had outstanding UM/UIM coverage on their own policy. One of the clients collected a handsome six-figure settlement while the other received a little under six figures. This would not have been possible had they not purchased plenty of UM/UIM Coverage.

These clients have a happy ending to their story. As you can see from the next example, the wrong insurance coverage can make a big difference in how the story turns out.

CASE NUMBER TWO

This client and her two children had been hit by a negligent driver who was driving under the influence of alcohol. The negligent driver eventually pled guilty to a DUI. The driver had the minimum liability coverage of $25,000/ $50,000. My client and her two children had injuries that far exceeded the coverage available. We helped them recover the maximum of the policy limits. Unlike the clients in the first story, this client did not have UM/UIM coverage. Her insurer allowed her to opt out of the coverage to save on premium costs.

Before she could correct this mistake on her new policy, the unthinkable happened. Several days after reaching a settle-

ment for the first accident, this client and her passenger were hit by another negligent driver. Although the liability limits carried by the second driver were higher, they still did not cover the costs of this client's medical care; and she was still without UM/UIM coverage on her own policy. She was forced to live in a nursing home for a year and a half to recover from multiple injuries – including fractures to both legs. She was unable to be fully compensated for the injuries that she sustained from the second negligent driver, because he was underinsured.

In comparing the two cases, you can see how important your Automobile Insurance Policy is and especially your own UM/UIM Insurance. When you are not at fault in a car accident, UM/UIM Coverage protects you from the other Negligent Party up to the limits of your UM/UIM Policy.

ABOUT DARYL

Daryl T. Dixon, Esq. has been practicing Personal Injury Law in Kentucky since returning to Paducah, Kentucky from South Florida in 2000. Daryl is a native Kentuckian who attended the University of Kentucky where he received his Bachelors of Arts in 1992. Daryl then went on to Nova Southeastern University - Shepard Broad Law Center in Ft. Lauderdale, Florida, where he received his Juris Doctorate Degree in 1998.

Daryl T. Dixon has been on the front lines of Kentucky Personal Injury Law fighting for victims and their families since 2000. For over 10 years, Daryl has limited his practice to Personal Injury cases — because it gives him the ability to focus his energy on his Clients and their needs. Daryl handles cases involving Auto, Semi-Truck and Motorcycle Accidents; Medical Malpractice; Railroad, River and Boating Accidents; Airplane and Bus Crashes; and Defective Products.

Daryl is a leading expert in the field of Automotive Insurance and has written several articles on the topic. He has over ten years of experience dealing with Insurance Companies, and has been advising Kentuckians about their automotive Insurance needs as part of his Law Practice. His articles include "Five Simple Questions Insurance Companies will not answer about Your Kentucky Personal Injury Case", "Kentucky's Ultimate Guide to Buying Car Insurance" and "Kentucky Hit and Run Law Becomes a Felony". Daryl has other articles available on his website for review by concerned Kentuckians.

To learn more about Daryl T. Dixon Law, receive your free copy of "Five Simple Questions Insurance Companies will not answer about Your Kentucky Personal Injury Claim," or to find out about the information Daryl freely gives about Accidents and Auto Insurance in Kentucky, please visit him at: www.daryltdixonlaw.com or call toll free 1-866-529-7745.

You can also contact Daryl on Facebook and Twitter.

Daryl@DarylTDixonLaw.com

CHAPTER 5

WOLVES IN WHITE COATS: HOW TO PROTECT YOURSELF FROM THE INSURANCE COMPANY DOCTOR

BY GARY M. HAZELTON, ESQ.

Janice was a widowed 66 year old retired schoolteacher when a rear-end crash damaged her neck. Nearly six years later she walked into my office. The statute of limitations (the time within which you must start your lawsuit or it will be forever barred) was about to expire, her attorney had dumped her case, ostensibly because her injuries were not significant enough to warrant a lawsuit, and she was in misery because her neck pain had never gone away. Incredi-

bly, review of her medical records revealed not a single complaint of neck pain in the 66 years leading up to the injury. We took her case and got the lawsuit started.

I referred Janice to a neurologist, suspecting her pain was being caused by injured facet joints in the neck. After a careful examination the neurologist suspected the same and Janice underwent a series of diagnostic injections. These objectively confirmed the facet joints as the source of the pain. Janice underwent what is known as a Radiofrequency Facet Neurotomy (RFN) procedure and her pain was gone, all of it.

Janice's restored faith in the legal system and doctors would be short-lived, however. In personal injury litigation, the other side has a right to have the injured person examined by a doctor of their own choosing. These doctors are referred to as Adverse Medical Examiners (AME's) or Independent Medical Examiners (IME's). They are paid by the insurance company for the at-fault party. Despite a 66 year pain-free history and six solid years of pain following the collision, the insurance company doctor, after a mere 15-minute examination, said that although Janice was injured in the accident – that injury healed 12 weeks after the crash and all ongoing pain was just because she was old. He literally said that after 12 weeks the cause of the ongoing pain transformed from being related to the crash and would have occurred even if she had not been in the crash! Absurd? Yes, but this absurd scenario is the rule in personal injury cases. *The AME's are truly wolves in white coats.*

Why would a medical doctor do this kind of thing to the Janices of the world? The answer is MONEY! AME doctors charge insurance companies 6 to 10 times what they charge their own patients for the same examination. The insurance

companies happily pay because they use the opinions to offer injured people like Janice far less than what is fair. If the AME does not consistently give opinions favorable to the insurance companies, they will take their business to a doctor who will. It is not uncommon for AME's to do 200 to 400 AME's per year at $1000 to $1500 per exam while devoting only a day or two a week to doing the exams. It is very, very lucrative and a great retirement income for some. Insurance companies will handle thousands of claims in a year. If they can save a few thousand bucks on each case through the use of 'bought and paid for' AME opinions it adds up to a huge sum each year. Understand that no physician patient relationship exists between you and the AME like it does between you and your treating physician. THE AME OWES YOU NO LEGAL DUTY TO BE ACCURATE OR TRUTHFUL. They can say what they want.

BITING BACK

No matter what the truth is, you need to understand it is the extremely rare circumstance in which an AME will write a report that is favorable to you. I believe there is a tacit understanding between the AME's and the insurance companies that occasionally an opinion will be adverse to the insurance company's interest just so it looks like the AME's are not biased. When it is your turn to undergo an AME do not expect you will be able to persuade the examiner with facts (the truth). They often appear friendly, leading you to believe they are truthful and will be fair. Rest assured that 99.9% of the time they will not. For the rest of this chapter we will look at what you must do to have the best chance to undermine the AME doctor's credibility.

KNOW WHAT IS IN YOUR MEDICAL RECORDS

Remember this: Whatever is documented in a written record, whether in an accident report, medical record or elsewhere is given inordinate weight by jurors and claims adjusters whether or not it is accurate.

In a personal injury case your credibility is critical. The attorney on the other side (the defense attorney) and the Adverse Medical Examiner will try to find or create, no matter how small or irrelevant, every single discrepancy between what you are saying now and what you have said or are reported to have said before. Every discrepancy will be used to undermine your credibility.

The single most fruitful source for generating these discrepancies is your medical records. Very few people have ever reviewed their own medical file. During your deposition (your testimony under oath before a court reporter), the defense attorney will ask you and during your AME the examiner will ask you, whether you have ever in your life complained to your doctor about "back pain" or whether you have suffered any other "accidents." You may well have forgotten that many years ago, you saw your family doctor complaining of low back pain, or that when you saw your doctor for the low back pain it was because you had slipped and fallen on the ice. It may even be that the source of that old low back pain turned out to be a bladder infection or something clearly not related to your back. If you now testify that you have never had back complaints or accidents the attorney or AME will impeach you with your own medical records. A thorough review of your medical file is, therefore, critical to jogging your memory about pri-

or incidents and complaints so there will be no discrepancy and no lost credibility.

Review of the records may also jog your memory about specifics of prior incidents and complaints, thereby allowing you to distinguish them from what you are now experiencing. Also, some of your prior complaints or the details of a traumatic incident may have been taken down inaccurately. Review will prepare you to point out discrepancies and correct the record. Finally, although rare, there are occasions where medical information has been recorded in the wrong patient's chart. Review will catch such errors.

Reviewing records relating to the medical care you have received as a result of the current traumatic incident is equally as critical. The records may contain totally inaccurate descriptions of how the accident happened, making it look like you are at fault, or may totally omit some of your complaints. ER doctors are looking for life threatening or serious problems and to treat you just enough for you to get by until you get to your treating doctor. Emergency rooms are busy places with doctors often seeing many patients before getting a break to sit down and dictate their notes. It is very common for errors to appear in these records, particularly when a person has multiple injuries; the doctor forgets to write down some of the complaints. The problem this poses for you is that the defense attorney and AME examiner will claim because you never complained of a particular problem in the emergency room and are complaining of it now, you are either making it up or the problem was caused by something else. The standard line is that if that injury happened in the accident you surely would have told the ER doctor about it, and the highly trained ER doctor surely would have written it down. Knowing of these errors

or omissions will allow you to prepare to firmly testify that the doctor made mistakes, or forgot to write down some of the things you said.

KNOW HOW TO DESCRIBE YOUR SYMPTOMS

Doctors are busy people and their purpose is to treat you and not document your chart for legal purposes. I very frequently see old records stating that my client had "back pain." So if the client now has back pain, even if it is 10 times worse than it was at the time the old record was made it still looks and sounds the same. This makes it easy for the defense attorney and AME to say you are complaining of exactly the same thing you complained of years ago and so if you do have problems they are pre-existing. Knowing how to accurately describe the symptoms to your doctor greatly helps distinguish the old from the new. (Remember, inordinate weight is giving to something in writing, so get it in the records). Use the following guide:

Location pain: Be precise! "Left side of my neck 2" out from the spine ½ way between the base of the skull and base of the neck." Not, "My neck hurts."

Nature of pain: Stabbing, gnawing, aching, piercing, electrical shock, squeezing, pressure. Not, "It hurts."

Frequency of pain: How often does it occur? What you say will be taken literally. "Always" means 24/7. So if it is 6 hours a day say 6 hours a day.

Intensity of pain: On a scale of 1 to 10 with 1 being minimal pain and 10 being excruciating pain describe

the intensity. If the intensity varies, explain how it varies and what makes it vary, such as a certain activity or time of day.

Duration of pain: Describe how long the pain lasts when you get it and what makes it better or worse. If you typically take pain medication and the pain drops from an 8 to a 4, explain that is because of the pain medication.

Affect: Describe what you don't do or do differently because of the pain. Real life examples are very helpful. "When I bent over to shovel snow on Thursday my back locked up and I crawled back to the house and rested" has far more impact than "Shoveling snow hurts my back."

Distinguish from any pre-existing problems: Using the above as guides, explain to your doctor how the current symptoms are different than any pre-existing problems you had. Particularly explain how your ability to function is now different than it was before, by telling your doctor what kinds of things you were doing right up to the recent incident of trauma that you now have trouble with, or have stopped doing.

WHAT TO DO DURING AND IMMEDIATELY AFTER THE ADVERSE MEDICAL EXAMINATION

My clients get a lengthy letter explaining what to expect during the AME. They also get a lengthy form to complete immediately after they leave the AME doctor's office. Many AME's spend just minutes on their exam and skip important parts or orally tell the client things that are

completely different than what they put in their report. The letter I send explains what to look for and record after the exam. This information can be gold during the cross-examination of the doctor. Jurors are less than impressed when the AME who is making $500,000 per year part time testifying for the insurance companies only spent 8 minutes with you, and concluded there was nothing wrong with you. In short, write down everything you remember about the exam immediately after the exam. If you will visit my website: www.HazeltonInjuryAttorneys.com and send us a note we will be pleased to send the letter and form to you for your own use.

Here are some of the tricks the examiners use that you should watch for and how to counter them:

- If you have a pre-existing condition, you are not asked how the symptoms from the current trauma are different from the ones you had before or how they affect you now. Tell the doctor even if you are not asked.
- If your medical records contain some unhelpful or damaging information, you are not asked if that information is accurate but rather the AME puts it in the report as though it were the Gospel. If you know of this information, tell the AME of the error. Then if he/she does not put it in the report they look even more biased.
- The doctor does not ask about prior incidents of trauma or complaints, or asks in a very confusing way you don't understand. Know your records and pre-empt the doctor by explaining and delineating how this is different in terms of symptoms and effect on your functioning, using the factors

described above.

- The doctor cuts you off and does not let you fully answer questions. Don't be intimidated!!! Make the doctor hear you out.
- Ask the doctor questions like: Will I ever get better? Can this get worse? Why aren't I getting better? Is there some other kind of care that could help? The doctor will probably refuse to answer the questions saying he/she is not your doctor. Great, you can testify to that statement. But the doctor also just might answer the questions and by the answers indicate his or her true feelings about your injury. Stuff you will never see in the report.

Do your homework, be prepared and you can do much to undermine the damage the AME can do to your case.

Gary M. Hazelton

ABOUT GARY

Gary M. Hazelton, Esq. is the founder and owner of Hazelton Injury Attorneys, located in Bemidji, Minnesota. He has been practicing since 1985, and practicing exclusively in the personal injury field since 1990. The mission of Hazelton Injury Attorneys is to be a resource, where personal injury victims and their families can turn to educate themselves about their rights and about how to find the right lawyer — without the pressure of having to meet with a lawyer. Educational materials are available through the firm website at: www.HazeltonInjuryAttorneys.com or by calling toll free: 1-888-711-4529 at any time (24/7).

Both Gary, and his associate Michael R. Hughes, are graduates of the intense Gerry Spence's Trial Lawyers College in Dubois, Wyoming, and commit to return yearly for additional training and practice. Gary is a Certified Civil Trial Specialist by the Minnesota State Bar Association and a four-time Minnesota SuperLawyer. It is the philosophy of the firm that every case must be fully developed from the beginning as if it will go to trial. The firm accepts a limited number of cases to ensure a full development of each case, and thereby, an increased likelihood of full compensation for the injured clients.

Contact info:

Toll Free: 1-888-711-4529

www.HazeltonInjuryAttorneys.com

CHAPTER 6

GAINING THE GOLDEN FLEECE INSTEAD OF GETTING FLEECED

BY THOMAS M. KILEY, JR., ESQ.

Jason's famous quest for the Golden Fleece seems like a walk in the park compared to navigating the world of insurance claims. You may not have to deal with harpies, sirens, or dragons, but the waters you must traverse in order to navigate the world of accident claims are just as fraught with difficulties.

My name is Tom Kiley, and my law firm specializes in cases involving automobile accidents, birth injuries, child injury and abuse, product liability, medical malpractice, and wrongful death. My firm has gone head to head with countless insurance companies over the years, and after more

than thirty years representing accident victims in Massachusetts, we are disturbed by the extent to which insurance companies take advantage of accident victims.

The unfortunate fact of the matter is that if you or someone you love is injured or killed in an accident due to the negligence of another, you will, in the process of your claim, have to deal with an insurance company. During more than three decades of representing injured victims against individuals, doctors who didn't care enough about their patients, and large corporations – and their insurance companies – our firm has encountered first-hand the methods they use to take advantage of innocent people who have been traumatically injured as a result of someone else's carelessness.

When you are injured, you face wily adjustors, aggressive defense attorneys, and an overwhelming mass of information with which you must make daunting choices. For this journey, Hercules himself could not help. You will need the help of modern day heroes. An experienced lawyer and his or her team can make the difference between gaining the golden fleece of what you are due, or getting fleeced by the insurance company.

I run head-on into insurance tactics on a daily basis. I have been contacted by countless individuals who have suffered serious injuries in all types of accidents and are unable to work, pay their bills, or provide for themselves or their families. All too often, during an individual's convalescence at home or in a hospital, they are visited by a seemingly friendly adjustor from the negligent driver's insurance company. The adjustor, while acting as if he were visiting out of concern for the victim, persuades him or her to sign a document in exchange for a small and inadequate settlement.

Our firm often gets calls after the money is long gone and the medical bills continue to mount. Unfortunately, the releases people sign are often full releases of all claims against the negligent driver who caused the injury. These people often have no idea what they are signing and as a result, suffer huge financial loss. Often cases are settled for pennies on the dollar and the releases, signed without legal counsel are binding

These calls have a great impact on me and as a result, I have made it my business to learn how insurance companies work. People are always asking me if they need a lawyer in an injury, malpractice, or wrongful death case. The short answer is – almost always – Yes.

Big insurance companies have basically declared war on the injured and their attorneys. These companies wage this war in both legislatures and in the media, and the hundreds of millions of dollars they have spent on propaganda have had a tremendously negative impact on juries and jury verdicts. Juries have become skeptical of injury, malpractice, and wrongful death claims.

At ground level, insurance companies and their adjustors don't wage this battle alone. They hire aggressive attorneys and experts whose loyalty is to their client, and they will work to protect that client by any legal means necessary.

After an accident for instance, while you are receiving treatment for your injuries, the party at fault will presumably notify his or her insurance company. Adjusters and investigators recognize the importance of immediately investigating and processing accident sites. They are, however, under no legal obligation to inform you of your legal rights. Every insurance company employs experienced defense at-

torneys who operate behind the scenes and whose sole responsibility is to protect the financial interests of their client. Insurance companies are in business to make money, and the less they pay out on claims, the greater their profit margins. And they've been quite successful. The average profit of the insurance industry in the United States averages over $30 billion a year.[1]

Insurance adjustors are trained to take advantage of the fact that most claimants have little knowledge or experience in determining the fair value of their claim, or in navigating the complicated waters of injury, malpractice, or wrongful death claims. The defendant's adjustor may be pleasant, appear concerned, and even try to be your friend. Always remember though that an adjustor's job is to protect the insurance company. He or she will work as hard as possible to find a reason to not pay you or, if the insurance company must pay, to minimize the payment and "make the matter go away."

Let me share with you some of the most common tactics used by adjustors and their lawyers to make your matter go away. It should become obvious why you need a lawyer as you try to maneuver through the difficult and dangerous waters of Big Insurance.

Befriending you. Adjustors and insurance lawyers are not your friends. While as individuals they may indeed feel sorry about your situation, as professionals their job is to protect their client. They are hired to make sure you get as little as possible while they take as much ground from you as they can.

---

1. American Association for Justice. "Tricks of the Trade: How Insurance Companies Deny, Delay, Confuse, and Refuse." Pg. 2. < http://www.justice.org/cps/rde/xbcr/justice/InsuranceTactics.pdf>

Misrepresenting policy benefits. Insurance policies are complex and confusing. Insurance companies have a bevy of experts at their disposal who are able to weave words into a web far too complex for you to find your way through alone. You need help from someone who is on your side and who can accurately translate policy information for you. This is an area where you will reap much benefit from retaining legal counsel.

Making false promises. I cannot emphasize this enough: Do not accept any offer from an insurance company or any of its agents without first obtaining legal counsel. The companies have been doing this for years and you are new to the game. Don't let yourself get bamboozled into a deal that will lead to little or no follow-through or fall short of your needs.

Requesting unnecessary information. Consult with your attorney before producing any information for insurance companies. Some insurance companies will go so far as to deny your claim because you provided the information they requested, rather than the information required by your policy. Your attorney will know what information is necessary, what is merely busy work intended to wear your resolve, and what will actually harm your case instead of help.

Disputing medical treatment. Adjustors may claim that certain medical treatments are or were unnecessary for the recovery and health of you or a loved one, or that the treatments, while necessary, are unrelated to the claim injury. First, trust your doctors. Second, consult with your attorney. Be prepared, if your attorney deems it advisable, to provide second and third opinions to substantiate any medical treatment. You can bet that the insurance company will be hiring experts whose job it is to contradict the claim of a single doctor.

Disputing medical charges. Adjustors may dispute not only treatment, but also their cost. They may also, again, dispute which charges are actually related to the claim injury. Again, consult with your attorney. You may be asked to confer with your doctor(s) about reasonable fees and charges. If you have retained an attorney who is experienced in injury law, he or she will have knowledge of and access to further knowledge regarding medical expenses.

Discrediting you. As I said before, insurance companies hire aggressive attorneys and experts whose sole purpose is to defend their client against their claim, regardless of how in the right you may be. They may try to discredit you, your family, your doctors – anyone involved in testifying on your behalf. You must document your situation as fully as possible – the accident or negligent act, all relevant actions and conversations – and communicate fully with your attorney. You cannot help your attorney too much, and this tactic is particularly difficult to combat without an attorney.

Undermining your confidence. Adjustors and insurance lawyers will work in both blatant and subtle ways to undermine your confidence. They will almost always try to convince you that it will be difficult for you to win your case in court, regardless of your actual chances. They may try to underplay the time, energy, cost, and pain involved in your situation. They may try to get you to minimize the nature and extent of the pain or impact of any injury, going so far as to cause you to doubt your own experience. They may even push you to accept full or partial responsibility for your plight when it was in no way your fault.

I recently read a story about a 60-year-old woman who is now in a wheelchair due to an automobile accident. Her

insurance company denied her claim, professing that the driver who caused the collision acted in a way that didn't satisfy the definition of "accident." The state insurance commissioner eventually stepped in and required the insurance company to honor the claim, but how much money, time, and energy were spent before she received the compensation she deserved from the policy she had been paying on for years?[2]

An adept attorney can help you avoid such a traumatic experience. He or she will back you up and stand with you against these kinds of denials. You do not have to give the insurance company the last word, and you do not have to do this alone.

Delaying you. Most commonly, adjustors will try to put you off until you are simply too worn down to continue your fight. You do have a right to demand recompense from a negligent party. And you have a right to ask for terms that you find reasonable.

This tactic has become particularly insidious. Many insurance companies are simply delaying claims until their clients die. The American Association for Justice shares that, according to Mary Beth Senkewicz, a former senior executive at the National Association of Insurance Commisioners (NAIC), 'the bottom line is that insurance companies make money when they don't pay claims... They'll do anything to avoid paying, because if they wait long enough, they know the policyholders will die.'[3]

Don't give in to this wearying tactic. Don't settle without

2 Ibid, pg.4-5

3 Ibid, p.6

legal advice and don't give up – these are the goals of delay tactics. Trust your attorney and let him or her push back against the wall of delay.

Trying to convince you to not hire a lawyer. Don't let the insurance company fool you. They wit have lawyers. And those lawyers will be combative, contentious, and fully focused on protecting their client from your claim. Adjustors or lawyers may approach you with deals that are "too simple and too good to require a lawyer." I strongly recommend that you obtain legal advice before accepting any offer from anyone acting as agent for an insurance company.

Insurance companies don't want you to hire a lawyer because they know odds are they will have to pay you more money. Don't let any insurance adjustor or lawyer push or bully you into proceeding without an attorney if you feel you need one. Don't let anyone push, force, threaten, or intimidate you into signing any document, making any decision, or eschewing legal advice. These are common gambits used by insurance companies. If you give in to them, you will most likely regret your decision later. Join forces with an experienced attorney who can stop you from getting fleeced by big insurance companies, and help you gain the golden fleece of the compensation you deserve.

ABOUT THOMAS

Thomas M. Kiley Jr., Esq. is a third generation personal injury trial lawyer and a proud member of the Kiley Law Group — where he concentrates on representing plaintiffs who have suffered personal injuries.

Mr. Kiley has achieved substantial results for his clients in wrongful death and catastrophic injury cases. His focus and dedication as a lawyer is leveling the playing field between insurance companies and accident victims.

Tom deals with insurance company tactics on a daily basis. He is concerned with how insurance companies take advantage of accident victims, especially those who are not represented by counsel.

Mr. Kiley is co-author of the soon to be released book “Wrongful Death Cases in Massachusetts.”

To find out more about Tom and Kiley Law Group, LLC visit:
www.KileyLawGroup.com.

CHAPTER 7

WHY NOT NEGOTIATE WITH A WOLF?

BY JASON R. SCHULTZ, ESQ.

No matter what kind of warm, fuzzy feeling you get from an insurer's TV commercials, insurance companies and their legions of claims representatives are not your friends. State Farm is not a good neighbor. The cradling hands of Allstate will not comfort and protect you. You will get wet under the Travelers' umbrella. Insurance adjusters, or claims representatives, as they are now known, are solely focused on paying you as little as possible. The claims representative will likely be pleasant, sound concerned with your plight, and even try to be a "friend". You must always remember that his/her job is to protect the insurance company--to find a reason not to pay you, or pay as

little as possible to "make the matter go away".

Traditionally, claims adjusters were taught to "pay what was owed." Fairness was the goal. Adjusters had independence to exercise judgment and an obligation to assist policy holders and claimants in their time of need. In the early 1990s, there was a seismic shift as many major insurance companies reconsidered how the claims process worked. Intense internet price competition and a new corporate culture that worshipped growth and profit led to new claims management strategies. Because payment of claims is the insurance company's biggest expense, the claims process was completely transformed into a corporate profit center. "Fairness" was tossed aside in favor of managing claims payments to increase the insurance company's profits. Adjusters' obligations to claimants diminished as their obligation to the company's bottom line increased.

Today, claims are no longer treated individually. Now the key to the claims process is the "system," not the claims representative. The "system"--not the individual--controls. The "system" is designed to make the company money by using computers to "set" the amounts offered. Here's how it works. When the claims representative receives information on your case (medical records, medical bills, wage loss documents), the information is separated and tabbed. The medical bills are then sent through an automated billing review system specifically designed to provide "cost containment services to the auto insurance industry." A "processor" puts in the dates of service on your medical bills, along with the "ICD-9" and "CPT" codes, all of which must be correctly matched to the patient and provider. The computer reviews the amounts billed for a "reasonable and necessary" allowance, and flags certain medical providers that may be under

investigation by the company's fraud unit. The packet is then returned to the claims rep, who reviews the medical records. The adjustor looks only for specific factors—or value drivers – and enters those into the computer by marking an "X" in the appropriate box. If the information does not fit into a "box," it is not considered in the valuation process. The computer system then determines a range of value for the claim, which the claims rep prints out and attaches to the claim file for review by the supervisor.

A computer evaluation of general damages (your pain and suffering) is largely imaginary, as the systems are not capable of assessing all pertinent factors and cannot replace a human being's judgment. Here's the limitation in a nutshell: the computer can only process the facts the claims representatives give it—and the claims representatives can only give the computer the kinds of facts it can process. Evaluations are frequently based upon inaccurate and "discounted" medical information and bills and an inadequate basis of comparison due to the insurance company's "tuning" of the system to produce the numbers it wants. These computer systems are usually "tuned" to exclude arbitration awards, jury verdicts, and post litigation settlements, using only the smaller pre-litigation settlements.

Once a valuation range for your claim is set, the claims rep's job is to convince you to take the least amount possible. Today's claims representatives are evaluated on the amount paid out--or saved--in claims. For the most part, adjusters are now data input clerks with limited ability to negotiate fair settlements. Knowing and understanding this process—its programs and procedures focused on computer evaluation of your medical bills and records—is essential in dealing with the insurance industry. Individuals

trying to settle their own claims who do not understand the process will likely be frustrated, angry, and confused. More importantly, they may not get paid.

Insurance companies fully understand the effect of this "system" on claimants. For example, let's suppose you are in a low-speed auto crash with minor vehicle damage and you have a whiplash-type neck injury. The insurance company offers you what seems like a token amount to settle your claim—maybe even less than the total of your medical bills. Your claim has been categorized as a MIST (minor impact soft tissue) claim. The insurance company knows your options now are to take the money and go away, or try to pursue your claim in court. The company also knows it will be hard for you to find a lawyer for a small claim. This routine approach to MIST claims occurs despite the fact that, in most states, insurers are required by law to promptly and fairly settle claims in which liability has become reasonably clear, and are prohibited from acting "in bad faith" by offering low-ball settlements that force individuals to take them to court. Letting the insurance company know you are aware of the obligation to act in good faith and that you are prepared to complain to your state's insurance commissioner may help, but it doesn't always work.

Minor car accidents have become a major source of litigation as insurers have adopted the strategy of routinely and systematically denying and stonewalling smaller claims. The only avenue for an individual to fight this approach is a lengthy and expensive court battle against an industry willing to spend $10,000 to fight a $2,000 claim. Insurers routinely bring in biomechanical and medical experts to prove a low speed crash could not have caused the victim's injuries. This expert testimony in the "small" cases has

made it increasingly uneconomical to pursue a fair recovery. Additionally, insurance companies now have their own "in house" law firms (i.e. employees) to handle claims and litigation strategies to further reduce their expenses. Although this strategy costs the companies more in the short run, it saves money in the long run because injury victims end up settling for unfair low offers rather than fighting an expensive battle in court.

Claims representatives are trained to establish a trust-based relationship by getting in touch with claimants early and staying in touch, handling property damage issues quickly, and by being empathetic. By doing so, the claimant will then believe that the company is interested in a fair and favorable resolution of their injury claim.

Never give an oral statement to the other insurance company. If you do, you will regret it. Just because an insurance adjuster calls and talks does not mean you have to talk. It is unwise to discuss your injuries with the insurance company immediately after an accident as you may not know how badly you may have been hurt. Telling the adjuster that you were not injured is music to the claims representative's ears. Days later when you can't move your neck without terrible pain, it will be much more difficult to receive fair compensation. It's far better, and much more accurate, to say that you "don't know" and that you will soon be examined by your doctor.

In order to pay as little as possible, insurance companies frequently resort to unreasonable interpretations of the facts and law, in order 'to lowball and stonewall'. As you pursue an injury claim, you are likely to hear something similar to these non-exhaustive, somewhat humorous, at-

tacks from your friendly, helpful claims representative:

- Your injuries were caused by something other than the accident, but they will not ever really have any proof of what that "something" was.
- You were not "seriously" injured in the accident, with the insurance company's definition of "serious" being somewhere between messed up for life and dead.
- You were injured in the accident. Yet, for reasons known only to the insurance company, you should have gotten better sooner.
- You were injured once before in your life. Therefore, your injuries pre-existed the accident, regardless of the severity of the prior injury, the similarity of the prior injury to the present injury, or the number of years in the past that the prior injury occurred.
- You saw the doctor for "too long". Therefore, you are a fraud.
- You weren't loaded into an ambulance and rushed off to a hospital emergency room immediately after the accident. Therefore, you were not hurt and…you are a fraud.
- You now have pain that did not exist at the emergency room, was not reported at the emergency room, or was not recorded at the emergency room. Therefore, any current pain complaints are not related to the accident…and you are a fraud.
- Now that you have received medical care, you claim injuries that you did not complain of in your recorded statement taken very soon after the incident. Therefore, you are a fraud.

- You failed to tell your doctor about past injuries to similar areas of your body, regardless of whether the doctor even asked, or whether any past injury is even relevant.
- You missed doctor or therapy appointments. There may have been a legitimate reason you missed the appointment(s). However, insurance companies only like their own excuses for things, not yours. Therefore, you are not really hurt, and you are a fraud.
- You waited too long to see a doctor after the incident. Therefore, you are not hurt and you are a fraud.
- You were referred to your current doctor by a lawyer. Even though you have no health insurance, poor health insurance, or have no idea what type of doctor you may need for the type of injuries you sustained, the insurance company does not care. Therefore, you, your doctor, and your lawyer are all in some kind of conspiracy together to commit insurance fraud.
- You did not miss any time from work or you only missed one or two days. Therefore, you could not have been seriously injured….and you are a fraud.
- You did not give a recorded statement to us even though the law does not require you to do so. Therefore, we must deny your claim. Or, when we already know it's our insured driver's fault, we simply tell you that we cannot "fully evaluate" your claim.
- You were not wearing a seat belt. Therefore, you are at fault for causing your own injuries.
- This type of car accident could not have caused the specific injuries you are claiming.

- There was little damage to one or both vehicles. Therefore, you could not have been too seriously hurt…and you are a fraud.
- Other people in one or both cars were not injured. Therefore, you could not have been injured….and you are a fraud.

At some point, the trusted claims rep will give you his or her expert advice about your case, explaining your injuries to you, and telling you that your injuries are worth 'X' dollars. Until you know the full nature and extent of your injuries, which may be up to a year after the wreck, no one can possibly know how much your case is "worth". But that won't stop the claims rep from offering you some money early so "you can get on with your life". After explaining what your claim is "worth", the nice claims rep will offer to cut you a check, and will be quick to tell you that you are getting a fair shake – all you have to do is sign a release form, get your check, and your problems will be over. Once the release is signed, you are barred from further recovery if you need further medical treatment or miss time from work. You will not be compensated for the pain you may endure for months, years, or for the rest of your life.

Don't necessarily believe it when the claims rep says that their offer is all you will ever get. Now, it is possible that an insurance company will never offer as much money as they do within the days, weeks or months after the wreck. It's also possible that 'pigs may sprout wings and fly' someday. I have never seen an insurance company make good on this threat. Usually, the value of a case increases in the year following the wreck because injuries develop, the doctor has a better idea of what type of treatment is going to be needed, and the injured person has figured out whether they are go-

ing to have to miss any significant time from work. Don't let an insurance adjuster convince you to settle your claim too quickly or too cheaply. You might need the money, and a quick settlement may seem like a good idea at the time, but far more often than not, folks that settle early end up regretting it. Rest assured, the claims rep will be rewarded for duping you into settling your claim for 'cents on the dollar'.

Be careful even when you are dealing with own insurance company on an uninsured/underinsured (UM) claim. UM coverage is designed to protect you in the event another person injures you in an accident and that driver does not have insurance or does not have enough insurance to cover your claim. However, the same principles of claims handling discussed above apply equally to interactions with your own company. "Your insurance company" becomes "their insurance company" when it comes to making a claim for your medical bills, lost wages and pain and suffering damages. Regardless of how long you have been with your insurance company, the claims rep will protect the company's interests first.

In claims with your own insurance company, it is okay to write the adjuster and state you expect: (1) their help; (2) that they provide every benefit that you are entitled to under the policy; and (3) that the adjuster will handle the claim promptly and fairly. You should also let them know you will take all reasonable steps to cooperate with them in the handling of the claim, including providing a recorded statement (your policy requires you to do so). Understand what documentation the adjustor will need and respond to your company's reasonable requests for information. You should also document your interactions with your insurance company.

Claimants generally expect "their" insurance company to treat them fairly and "do the right thing". Unfortunately, that is usually not the case. One of my own clients, a 58 year old man, was struck by an unknown hit-and-run driver that was clearly at fault. My client suffered neck injuries which ultimately led to surgery. The client had a condition known as degenerative disc disease in his neck, which is very common for those 40 years of age and older. The surgery and hospitalization alone cost well over $100,000. In his surgeon's opinion, the wreck necessitated the need for surgery. The client had never before made a claim against his or any other insurance company. He had uninsured motorist coverage of only $50,000 to cover the claim. After months and months of delay, his insurer offered him $1,500.00 on a take it or leave it basis, claiming that his condition pre-existed the wreck and that was all they were going to pay. I was hired and filed a lawsuit. His insurance company hired a well known insurance hired-gun radiologist to look at some x-rays and an MRI. This "expert"stated that the car wreck had nothing to do with surgery and that all of the findings on the x-rays and MRI pre-existed the car wreck. Ultimately, almost 2 years after the wreck--and three days before trial--they finally offered the policy limits of $50,000.

It takes skill and knowledge to counteract insurance company shenanigans. Unfortunately, for many victims, asking a jury to force insurance companies to pay what is fair is the only way to make them do the "right thing," which leads to the next question. Are you better off pursuing your insurance claim yourself or hiring a professional to work with you? For some claims, the answer is obvious. If you are in a fender bender with a few hundred dollars worth of damage to your car and are sure no one was hurt,

it doesn't make economic sense to hire a lawyer. If you sustain serious injuries in a major car crash, you need an experienced personal injury lawyer. For claims in between these extremes, whether you get help depends on the claim and on you. Do you have the expertise, time, resources, and energy to pursue the claim yourself? Many claims involve complex legal questions and time/notice deadlines that only a lawyer can address properly. If you've suffered physical injury, you may be physically unable to deal with the stress of the claim, or you may be unable to detach yourself emotionally from the process to a sufficient degree to deal dispassionately with the insurance company. When you are not sure whether to retain a professional, it usually pays to talk to one or several so that they can help you assess your situation.

Over the past twenty years, many insurers have made systematic efforts to make sure the claimant does not hire a lawyer. Insurance companies know from their own studies that injury victims recover at least two to five times more with a lawyer than without the aid of a lawyer. The goal is keep you negotiating--claims reps know that if they can keep a claimant negotiating, there is a high probability of a successful settlement in favor of the insurance company. Some claims reps will misrepresent the true "cost" of hiring a lawyer. Quite often, "friendly" claims representatives take the opportunity to explain that attorneys commonly take between 25 and 40 percent of the total settlement received, plus expenses. Claimants are told that if they settle directly with the insurer, the total amount of the settlement will belong to them. They tell claimants that if they really want to hire a lawyer, to just wait and let the company make an offer first. Should they decide to then go to a lawyer, they can "negotiate" with the attorney so his or

her fees would only apply to the amounts over what has already been offered. What they won't tell you is that this approach makes it practically impossible for an injury victim to get a lawyer. Few, if any, quality lawyers, would agree to a smaller and uncertain fee before taking the case. The ultimate result of this exchange, if the bait is taken, is that the claimant will end up without a lawyer and the insurance company will maintain an overwhelming advantage in settlement.

In short, trying to handle your own injury case is akin to taking out your own appendix or doing a root canal on yourself. While I imagine it could be done, no sane person would attempt it. It is doubtful that any claimant can recreate three years of law school and decades of experience in dealing with insurance companies. Insurance companies often get very creative when they defend injury claims. Hiring an experienced personal injury lawyer is the best way to make sure you don't become a victim twice. A good attorney, who understands the process, will be better able to negotiate with the claims representative, having already heard all the twisted logic and tired excuses that are in the insurance company's bag of tricks.

ABOUT JASON

Jason R. Schultz, Esq. is an attorney who concentrates his practice on personal injury and wrongful death matters — on behalf of plaintiffs in state and federal courts primarily in Atlanta, Georgia. Mr. Schultz received his law degree *summa cum laude* from Cleveland State University in 1991, where he also served as an associate editor of the Cleveland State Law Review. He is a Life Member of the Million Dollar Advocates Forum – The Top Trial Lawyers in America ™; *AV Rated* by Martindale-Hubbell®; named to *Georgia Super Lawyers*® 2007 and 2009; named in the *Top 100 Trial Lawyers*® in Georgia 2008, 2009 and 2010.

Mr. Schultz authored the book "The Ultimate Guide to Accident Cases in Georgia: The Truth About Your Injury Case" as well as numerous articles and seminars relating to trucking safety and litigation. To learn more about Jason Schultz and how you can obtain his book and free special reports on matters relating to personal injury claims, visit www.JasonSchultzPC.com or call toll free (866) 455-4709.

CHAPTER 8

FATAL MISTAKES TO AVOID WHEN NEGOTIATING WITH AN INSURANCE COMPANY

BY JOHN BISNAR, ESQ.

About a month after I started law school at Pepperdine University School of Law – with the goal of becoming a real estate developer – I had an auto accident that changed my life. While I was driving to school in my Volkswagen 'beetle', someone turned left directly in front of me.

I crashed head-on into the side of his much larger vehicle. The crash snapped my body forward and my face hit

the windshield. My hands bent the steering wheel to the column as my seat broke from the impact. My immediate physical ailments included a broken septum, a separated sternum, two black eyes, and a swollen face. The long-term effects linger to this day. One disc in my neck completely disintegrated over time and three discs bulge in my lower back. Every day since the accident, I have had to live with the residual damage caused by someone else's carelessness.

But physical injuries were not all that I suffered. I suffered the disappointment of doing the right thing by hiring an attorney to represent me, only to receive significantly less than I was entitled, because—in a nutshell—I hired the wrong attorney. He was one of my law professors and was a fairly well known personal injury attorney. I thought that he would help me. He wanted my business; I wanted and needed a counselor and an advocate. I didn't get what I needed. My attorney missed several critical areas of law that he could have pursued on my behalf. My settlement did not adequately compensate me for my long-term losses associated with the crash.

While my accident, settlement, and experience with my lawyer were not what I had planned for or hoped for, I have managed to turn that experience into a positive. I know, first-hand, the pain and struggles accident victims face and how difficult it can be for them to obtain justice for themselves. Through my experience as a victim, as well as my years as an attorney who represents average, everyday people, I have gleaned a list of critical, yet simple mistakes that people often make when dealing with insurance companies. I am sharing the list with you in the hope that your outcome will be a better one than mine was.

THE FIRST MISTAKE – FAILURE TO KEEP ACCURATE RECORDS

If you are a parent you might have kept a baby book from the time your child was born. In the beginning you were very good about jotting down daily occurrences – first smile, first time he noticed his hand, how many steps he took today. You probably also noticed how easy it was to forget what had happened on which day when you hadn't been diligent about keeping records for a week or two!

Accidents, especially those with injuries, create chaos in peoples' lives. It is during those times that you will need the same methodical record-keeping you might have employed in the days and weeks following a child's birth. To maintain accurate records of what happened to you in the accident and in the days, weeks, and months that follow will mean the difference between your getting justly compensated for your losses or your receiving what the adjuster sees fit. Writing down your observations of injuries and losses when they are fresh in your mind will allow you to recall a greater number of details - and details equal compensation. After an accident there can be appointments at clinics and doctors' offices, pharmacy runs, phone calls, meetings with insurance companies, contact with police, and visits to body shops and wrecking yards. There are the special arrangements that need to be made with employers and schools, the missed family and social events and an abundance of other challenges. That isn't even counting the pain, suffering, discomfort, or depression one suffers from the humiliation of not being able to take care of yourself or your normal daily chores and responsibilities.

Why is it important to maintain records when you are so

busy and so exhausted in the weeks following the accident? The simple answer is that no one else will. Do not be misled into thinking that the kind-hearted insurance adjuster is your friend or that he is keeping track of what has happened to you so that you can get what you deserve. The insurance adjuster, even if he is from your own insurance company, doesn't work for you. He works for the insurance company. His job is to make money for his employer – even receiving bonuses for doing his job well. In fact, he is planning to use every bit of his negotiating skill to reduce the amount of your settlement.

Your goal is to receive just compensation for the losses incurred as a result of the accident, as well as for future losses. You want to present a record of expenses and damages and not misstate your losses. But what information should you record?

Economic Damages

Medical, pharmaceutical and therapeutic expenses; cost of household services (such as the cleaning lady you hired because you couldn't bend over to clean your house yourself), the expense of household modifications to accommodate you following the accident; lost wages; loss of employment and fringe benefits; and property damage.

Non-Economic Damages

These are commonly known as "pain and suffering." Because there are no real guidelines for this type of damages, the burden of proof falls on the victim. It is essential that you document your daily levels of pain and inability to perform your normal daily functions.

Make notes regarding the things that you couldn't do that you normally would have done, the events that you would have gone to, but didn't due to pain or disability. Keep track of moments of humiliation, embarrassment, loss of friendship, loss of romantic affection and any other personal suffering or indignity that you suffered as a result of your accident and injuries. Write down everything that helps tell the story of what your life was like during your recovery period. Your log should include issues such as anxiety or difficulty sleeping and also missed activities, vacations and family gatherings.

THE SECOND MISTAKE – FAILURE TO PREPARE WITH SKILL

As I mentioned before, the insurance adjuster doesn't work for you. As a matter of fact, you and the adjuster have conflicting interests! The insurance company is not in the business of making sure they adequately compensate you. The adjuster is highly trained to settle claims for the lowest possible amount regardless of your injuries or losses; in fact, he may have settled thousands of claims prior to yours. He is practiced, so you need to acquire some measure of skill in two areas. The first area is preparation.

If you plan to take on the insurance company you need a pre-determined destination in mind and a planned route to take you there. Prepare yourself by asking – and answering – these five basic questions:

What is the strength (evidence) of your claim? – This includes witness statements, police reports, photos,

and documentation of your losses.

What are similar claims generally resolved for? – You may find this information at the nearest law library by researching several cases similar to yours. Learn what amounts the juries have awarded for such claims. Get the opinions of a few highly experienced personal injury attorneys.

What is your settlement goal? – What amount within reason would you like to come away with?

What is your settlement bottom line? – Your bottom line is the amount you would not go below in settling your claim.

And what are your alternatives if you don't settle? – If you and the adjuster cannot agree on terms, what will you do next? Will you take your claim to small claims court? Or will you hire an attorney and possibly take your case to trial?

Generally, well before you have even prepared your plan, the insurance company will have made an offer. Now negotiation begins. When you have assembled the evidence of your claim, know what your pain and suffering are worth, established a settlement goal and bottom line, and know what you will do if you don't settle – it is time to send a demand package to the insurance company.

Your demand package will begin with a cover letter that lists the total amount of the damages and summarizes what the evidence indicates. You will need to include copies of all evidence with the cover letter. Request that the adjuster place a fair value on your claim and make you an offer to

settle. If the adjuster has made a previous offer, mention something to the effect, "…now that you have more information about my losses, I am hoping that you will make a fair and reasonable offer…" I strongly suggest not making a specific dollar demand in your demand package. You want the adjuster to make the first offer as well as the second, if possible. This brings us to the second area –negotiating.

THE THIRD MISTAKE – FAILURE TO NEGOTIATE WITH SKILL

At this point you might feel a little like you are at the mercy of the insurance adjuster. The primary difference between you and him is that he has probably negotiated thousands of cases and he has the money. Here are some keys to successful negotiation that you can use to level the playing field a bit.

Submit Your Demand after the Adjuster's First Offer

Let him and not you make the first offer and hopefully the second. His first offers will, of course, be low-ball offers. In your cover letter, you could total all the damages and request the adjuster make a more meaningful offer. Or you can do what I often do and demand the total amount of the insured's coverage. When you ask for the policy limit you accomplish two things: First, you make a demand that is within the insurance company's liability limits. Second, by making this demand you expose the insurance company to the possibility of a judgement that exceeds the policy limit, giving you the upper hand. When you have requested the limit of the offender's policy,

the adjuster has only three options. He must pay that amount, negotiate for less, or go to court and risk a judgement of more than you demanded. Confirm your policy limit demand in writing via a method that you will have proof of the adjuster's receipt. Adjusters are notorious for "not receiving" documents.

Ask for more than you expect to get

Don't ask for your bottom line. You need room to negotiate. The adjuster is never going to pay you the first amount you ask for unless it is much lower than he intended to pay on your claim. Your first number should be much more than you expect to receive. If you don't leave room to negotiate, you will not be able to reach your settlement goal. He will want to negotiate you down, but you may still receive more than you had hoped for.

Ask Questions

Make him give specific figures as to how much he has allotted for each item. Ask him how he arrived at the amount he's offering for your pain and suffering. Make him do the math with you. The more questions you ask, the more you will learn about the claims process. Your questions will give you bargaining power and keep the adjuster on his toes and somewhat more honest. Write down everything he says in the negotiations so that you can refer back to it in your responses.

Make Small Concessions

The best negotiators don't give it all up at once. Make small concessions. A major concession might ruin

your bargaining position because the adjuster will think you have inflated your demand, and that you will make further major concessions in your bargaining position. Reducing your demand in smaller amounts may mean that after the insurance adjuster's counter offers, you might receive a greater settlement than you had hoped. Additionally, each time you make a small concession you show the adjuster that you are flexible and trustworthy. Each concession should be smaller than the last.

Be Patient

Good negotiation outcomes take time. You do not want the adjuster to think that you are desperate for a deal. Every time he makes an offer, tell him you need to think about it. Do not accept or counter the offer in the same meeting or phone call. If the adjuster's final offer is far less than what you think you are entitled to, tell him you are going to wait before settling. Tell him that you want to consult others more knowledgeable than you about what you should do. You could add that you are thinking of consulting an attorney. Adjusters loathe hearing that.

Maintain Your Composure

Much of negotiating is about attitude. Whatever you do, you do not want to offend the adjuster with your attitude. He isn't taking these negotiations personally – and neither should you! It is never to your advantage to lose your temper. If you get on his bad side, you might make the adjuster even stingier with your settlement. No matter what happens, always remain professional in your attitude.

Refrain from Showing Interest in the Offer

Give the impression that you are willing to wait for a better deal. You might say "You'll have to do better than that." You want your facial expressions and body language to reflect your displeasure at the current offer. Showing enthusiasm could hurt your case.

Resort to a Higher Authority

In the end, you need to let the adjuster know that you will not make the final decision without assistance. You can tell him that your spouse, a parent, or an attorney friend will be helping you 'think through' the negotiation process. Remind the adjuster that you will have to check with that person before responding to his latest offer.

My goal in writing this chapter has been to educate men and women who wish to handle their own claim, so that they can achieve a better outcome than I did in my own settlement while in law school. Your goal in representing yourself may be the satisfaction of handling the case on your own; or your goal may be to save yourself some money by taking on the insurance company alone. Either way, you must be very careful to not hurt your bottom line in the process.

Before you utilize the tips I have shared with you, it may be in your best interest to get a consultation with a very experienced personal injury attorney, one that will give you some guidance and approximate for you what your claim is worth. Generally the best personal injury attorneys will provide you a free consultation. You will want to be completely sure you are up to the

task of battling the insurance company alone before you begin that journey.

ABOUT JOHN

John Bisnar, Esq. is the founder of the BISNAR | CHASE law firm, whose roots can be traced back to Bisnar & Associates, founded in 1978. He is the visionary of the firm and the creator of the firm's mission statement: To provide superior client representation in a professional and ethical manner, while experiencing high job satisfaction, earning a high standard of living and having fun; and to make our world a safer place for us all." The firm's mission statement is its guiding principle. It is the yardstick against which all actions and decisions are measured. Every BISNAR | CHASE employee can recite the mission statement, tell you what it means, and how the firm lives up to it.

Mr. Bisnar is the businessman of the firm. He handles the business affairs, marketing, and client care programs. Ask any of the BISNAR | CHASE employees and they will tell you he is their professional growth coach and their personal mentor. He works with every employee to improve their professional performance and encourage their personal growth. John believes that assisting the firm's employees in reaching their personal goals is essential to their professional performance in furtherance of the firm's mission.

When asked about the firm's guiding principles, Mr. Bisnar will point out, "The Seven Spiritual Laws of Success" by Deepak Chopra as the bible by which the firm is run. One of his philosophies is "Do the right thing by the client and profits will follow." Another is "Our employees will treat our clients no better than we treat our employees."

Client care programs and "improving the client experience" are pet projects of Mr. Bisnar. They are regular subjects of the training seminars he leads for the firm's staff. He also teaches teamwork, listening skills and conducts negotiating workshops for the firm's staff.

John is a native of Southern California. He served active duty in the US Army in the Pacific and South East Asia from 1968 to 1970. In 1974 he graduated from California State University, Long Beach, *cum laude* with a B.S. Degree in Finance/Investments. John was on the Dean's List every semester. In 1978 John received his Juris Doctor degree

from Pepperdine University School of Law. John was admitted to the California State Bar in July 1978. Not long after he graduated from Pepperdine University College of Trial Advocacy.

John began Judge Pro-Tem work in the California State Courts in 1984. He won his first Million Dollar case in 1986. In 1996 he was named a "Community Hero" by The United Way, Orange County, California and in that same year was an Olympic Torch carrier transporting the Olympic flame through Orange County on foot. Check out the Olympic Torch proudly displayed in his office.

In 2009, Avvo.com, an online attorney rating service, gave Bisnar a "perfect 10" score and "superb" rating based on his background, years of experience as a personal injury lawyer, successful track record, impeccable reputation with clients and peers, and professional accomplishments. In addition to being named a 2010 Super Lawyer, Bisnar was also named a Super Lawyer in 2008 and 2009.

John has lectured at schools, colleges, universities and civic groups on the topic of the causes, effects and recovery from childhood abuse. He is also a frequent lecturer and speaker at lawyer continuing education programs on law office management and client care techniques. He has been an active member of two men's support groups since 1996: one is devoted to personal growth and the other to growth of your business.

Mr. Bisnar is a former member of the Board of Directors and Board of Trustees of various businesses, non-profit and religious organizations.

He is a devoted husband and a father to three adult children and one grandchild, so far. John and wife Kimberly are avid world travelers, seeking to experience different cultures, people, religions, flora, fauna and the beauty of our physical world. Meditation, personal growth, scuba diving, skiing, organic gardening, photography, exotic travel, Internet marketing, the Lakers and most of all Kimberly, are his passions.

CHAPTER 9

WHEN THE NUMBERS DON'T ADD UP

BY KARL TRUMAN, ESQ.

I had a client recently who was driving to work and got 't-boned' by an uninsured, drunk driver. He came to me to discuss his case, hoping to hear some good news. When I asked him about his insurance coverage, he told me that he had "full coverage." Red flags went up immediately in my mind. I don't know who coined the phrase "full coverage," but I suspect it was an insurance agent who wanted to sell a policy. Nowhere in the law does the term "full coverage" exist. In my experience, "full coverage" tends to be a phrase used by insurance agents to imply to consumers that the agent has that person's best interest in mind – that the person should have no worries with his policy.

Not only does "full coverage" not mean that you are cov-

ered fully, but also it might mean that you have less than adequate coverage and don't even realize it! When you purchase auto insurance, the agent's job is to sell you a policy. What he perceives to be your needs based on the conversations you have had may not match what your real needs are.

In the case of my client, when I reviewed his actual auto insurance policy, I learned that he had signed a waiver opting out of Uninsured Motorist coverage, also called "UM". My client informed me that his insurance agent told him to sign the documents and that he hadn't really asked a lot of questions regarding what he was signing. Unfortunately for my client, his ignorance of his own policy coverage meant that he was not going to be getting the compensation that he deserved for his medical bills, lost wages, and pain and suffering. If he had known that Uninsured Motorist coverage would have ensured that he was compensated in case he were hit by a driver who did not have insurance, he may not have waived that coverage. In fact, the agent had relied on the fact that my client had medical insurance coverage and "wouldn't need" the additional coverage that Uninsured Motorist coverage would have provided him.

My experiences with my clients have made me want to educate consumers to make them better informed, so that they know what they are buying when they select an auto insurance policy. Almost daily in my practice I see clients for whom the numbers don't add up. In my opinion, this is a fraud against the public by some insurance companies who sell virtually useless products to uninformed consumers.

Another important type of coverage often overlooked is *Unde*rinsured Motorist coverage, also known as "UIM".

This is coverage on your own policy to pay for your injury claim if you are hit by another driver who does not have enough policy limits on their car. For example, I have had clients who were severely injured but the driver who hit them only had $25,000.00 in liability policy limits – which is the minimum required by law. However, my client's claim was worth much more than that. Doing the right thing, my client had purchased $100,000.00 in Underinsured Motorist coverage. Since they had significant medical bills and a substantial claim, wouldn't you think that $25,000.00 from the other driver's policy, plus the $100,000.00 in Underinsured Motorist coverage would total $125,000.00? Well, you might, unless you happened to live in Indiana. Under Indiana law, there is an "anti-stacking" provision. This means that your own automobile insurance policy gets a credit for whatever you collect from the other driver. So, if you have a $100,000.00 Underinsured motorist policy and you collect $25,000.00 from the other driver, you actually are only able to collect an additional $75,000.00. ($100,000.00 - $25,000.00 = $75,000.00) You would NOT be able to collect your policy limit of $100,000. In other words, you would not be getting what you thought you were paying for.

But wait – there's more! I often see situations where the other driver has a liability policy limit equal to the amount of my client's Underinsured Motorist coverage. For example, let's say the other driver has liability coverage of $50,000.00 and you have $50,000.00 in Underinsured Motorist coverage. Again, you would think that $50,000.00 + $50,000.00 = $100,000.00 wouldn't you ? If you live in Indiana, you would actually have no claim for Underinsured motorist benefits because your Underinsured Motorist insurance carrier would get a complete offset against

their coverage. This means that if you have $50,000.00 in Underinsured motorist coverage, your insurance company gets to subtract the $50,000.00 liability limit of the other driver, so $50,000.00 - $50,000.00 = 0. You literally have no claim with your insurance company for coverage you thought you were paying for.

Since I practice in both Indiana and Kentucky, I see situations involving a client who lives in one state involved in an accident in the other state. This requires knowledge of the laws in both states to coordinate benefits and reimbursement claims. Fortunately for those living in Kentucky, the law is better for the client because Kentucky does allow "stacking" of policies in order to recover from more than one policy.

PIP and Medical Payments coverage is another area where "reading the fine print" is imperative. One of the common misperceptions I often hear from clients is about medical bills. This is an area that can really affect a client's claim and their own credit. I had a client come to see me almost two years after trying to handle her accident claim herself. The deadline for her to make a claim was approaching quickly. The other driver's insurance company made the usual statement, telling her "just send us the bills," implying that they would pay them. My client, based on the insurance company's advice and her own belief that the other driver was at fault, told all of her doctors and hospitals to send the bills to the other driver's insurance company. Did they pay her bills? Of course not. What happened? All of the bills were now on her credit report as delinquent. This client had health insurance, but now it was too late to submit the bills to her health insurance. When I told my client this, all she could do was cry. She assumed since the wreck

was not her fault the insurance company would "do the right thing" and "be fair with her" just like they assured her they would so she "didn't need a lawyer."

No one comes into my office saying "You know I was really looking forward to this accident today." Nobody plans to get into an automobile accident. But everyone should plan for and prepare for the possibility that auto accidents don't always happen to "someone else." There are some steps you can take to protect yourself and your family from suffering financial consequences in addition to the physical and emotional damages suffered in an automobile accident.

1. Avoid taking an agent's word for it that you have "full coverage." Be an informed consumer.

   Begin by carefully reading the declaration page of your insurance policy. Learn what your policy covers: Do you have uninsured motorist coverage? Is it stacked or unstacked? Do you carry *under*sinsured motorist coverage? – meaning that the other party has coverage, but not enough to pay your claim. You may have adequate medical expense or PIP coverage, but your policy most likely will still pay for only "legitimate" medical tests and procedures? If so, who will determine what is "legitimate?" Most insurance companies send medical claims to doctors – some who are in another part of the country—to do what is called a paper review. The doctor looks over your records of what tests and treatments YOUR physician ordered, and determines which ones were necessary and will be paid, and which ones he considers un-necessary and will be denied.

2. The cheapest premium policy won't always fully protect you!

   Insurance companies may be surprised when I say that most people don't have enough insurance. At risk of sounding like an advertisement for the insurance industry, I suggest you purchase the maximum coverage that your budget will allow. Most people look for the cheapest price for their insurance. Don't skimp on insurance to save a few dollars. There is also a little talked about coverage available to you – a best-kept secret of the insurance industry – called an Umbrella Policy. Such a policy covers above and beyond your regular policy limits. A $1million umbrella policy can cost as little as $200 per year.

   Compare policies. Make sure that you are comparing 'apples to apples'. Not all automobile insurance policies are created equal.

3. Ask questions.

   Whether you purchase your insurance from a local agent or from an online automobile insurance company, you will always have access to a licensed agent. Ask questions before you sign on the dotted line. Ask the agent to explain your policy limits – what type of policy you have. What are your deductibles? Is there a deductible on medical coverage? Is there a deductible on PIP (personal injury protection)? Consider if you generally have enough cash reserves to pay that deductible should you need to. A $1000 deductable on medical payments coverage may seem like a

reasonable amount when you sign your policy but will you have that much on hand if you have been injured and in the hospital?

Your policy with $10,000 in medical benefits minus the $1,000 deductible is only a $9,000 policy.

4. Do not assume that the "other guy's" insurance is going to pay your damages.

   Time and time again I hear "well, it wasn't my fault; why don't we just send my bills to the other guy's insurance company. The other driver's policy should cover me because he was at fault." But I can tell you that driver's policy will not pay your expenses up front. Your policy and your health insurance coverage is what will cover your bills. The last thing you need after an automobile accident is to have your credit destroyed for non-payment of medical bills.

5. Know where to look.

   Much of the information you need regarding your insurance policy is found in the pages that many people never take the time to read. You will want to read your policy provisions – the pages that follow the declaration page-- that lists the coverage and the amount you pay. Look past the dollar amount to the "fine print" of your policy. You do not want to be lying in a hospital bed after an auto accident when you first learn what your insurance policy will cover.

6. Do not be afraid to make a claim with your own

insurance company.

It doesn't make sense to pay a significant amount of your hard-earned money in premiums annually for insurance and never make a claim when you have been injured or your property has been damaged. Don't be one of the people who is afraid to make a claim for fear of being dropped by your insurance company or having your premium go up. It is your coverage and is supposed to be there when you need it.

When I was a Boy Scout, we learned the motto "Be Prepared." This applies equally well to knowing your rights in case of an automobile collision. Automobile insurance policies can be very confusing. The best way to "Be Prepared" is by being an educated consumer about your insurance company and your policy.

ABOUT KARL

Karl Truman, Esq. is a Board Certified Civil Trial Specialist by the National Board of Trial Advocacy. He is licensed and has offices in both Indiana and Kentucky. After receiving his Bachelor of Business Administration from the University of Kentucky and his law degree from the University of Louisville, he has been practicing law for more than 23 years. His legal career began as a Deputy Prosecuting Attorney, then promoted to Chief Deputy Prosecuting Attorney.

Karl's passion was always in the field of personal injury litigation, helping those injured hold others accountable for their bad decisions. So, he started the Karl Truman Law Office to help clients obtain a fair, equitable and timely financial settlement in all areas of personal injury litigation, such as automobile accidents, Workers Compensation claims, Social Security Disability, medical malpractice, nursing home claims, premises liability and maritime claims on the Ohio River.

The goal of the Karl Truman Law Office is to provide every client with the care, patience and respect they deserve, and treating each client the way we would expect to be treated.

He serves on the Board of Directors for the Indiana Trial Lawyers Association and is a member of the Kentucky Justice Association, American Association for Justice, Indiana and Kentucky Bar Associations and the American Bar Association.

Karl is the recipient of the Indiana Trial Lawyers Association Consumer Advocate of the Year Award in recognition of his pro bono work with the 9/11 Victim Compensation Fund.

Karl Truman also has a military career with the United States Army Reserve, which spans over 28 years, retiring as a Lieutenant Colonel. He was commissioned as an Armor Officer through Army ROTC, with assignments ranging through all levels of command, from serving as Commanding Officer of an Armor Training Company, Deputy Chief of Staff for a Division Commanding General, and as an instructor with the Command and General Staff College. He served as a Brigade training

and operations officer when his unit was mobilized in direct support of Operation Desert Storm. His training includes the Armor Officer Basic and Advanced Course, Airborne, Air-Assault and an Anti-Terrorism Instructor Course with the J.F.K. Center for Special Warfare.

Karl Truman can be contacted at: karltruman@trumanlaw.com and found on the web at: www.TrumanLaw.com

CHAPTER 10

SUBROGATION: PAYBACK FOR THE INSURANCE COMPANIES

OR – WHAT THE INSURANCE COMPANIES GIVETH, THE INSURANCE COMPANIES TAKETH AWAY…

BY MICHAEL R. STRONG, ESQ.

Recently, one of our clients, who we will call Tammy to preserve her anonymity, came into our office with a new auto accident personal injury claim. The client was driving her own car, and was hit in the rear by a young inexperienced driver who had been on the cell phone. The young driver failed to stop at the red light and hit Tammy

doing about 35 miles per hour. The crash was fairly severe, leaving our client with a severe neck and lower back muscle strain. Worse yet, Tammy hit her head on the steering wheel even though she was wearing a seat belt (yes that can happen even when the belt is working properly). Because it was a rear end collision, no air bags deployed.

As a result of her head impact with the steering wheel, she sustained a subdural hematoma. That's a bruise on the brain, not on the outside of the head, but a bruise inside - where permanent brain damage can result, or worse, even death. The emergency room realized our client's injury right away through careful screening, and ordered a barrage of special tests, EEG, MRI and a host of other procedures. She was kept overnight for observation, and was released the next day with a $17,500 medical bill. In the months after the accident, she had follow up care for her head injury (which fortunately was not life threatening and left no permanent brain injury) and physical therapy for her back and neck sprains. In the end, Tammy was left with another $7,500 in medical expenses on top of the $17,500 hospital bill. Her total medical expenses and wage loss came to well over $25,000.

We found in talking further with Tammy that she lived on a tight budget, and in an effort to control her expenses – being just out of college doing an entry level job - she had spent the minimum she could under the law for auto liability insurance, which meant that her policy would pay no more than $25,000 in coverage for liability and uninsured motorist coverage. So, if an uninsured motorist hit her, she could recover no more than the policy limit of $25,000. Unfortunately, the person who hit her failed to pay their insurance bill prior to the accident, and their auto liability policy was canceled. Now Tammy was in a real dilemma, as she had only $25,000

in uninsured motorist coverage, and over $25,500 in medical expenses to pay. So if the medical expenses were more than the uninsured motorist insurance limits, you may ask, what was going to be left for Tammy?

When she came to see us, she was at a loss to find a way to pay her medical bills, as she, being a young single healthy woman, whose insurance was provided through her employment, had the type of health insurance known as a group health plan offered through her employer under a self insured plan operated under the federal law known as ERISA. Her health plan administrator, a very large health insurance company who was hired to administer her employer's health benefits plan, had sent her a letter telling her they would not pay her medical bills from this accident unless she signed something called a "Subrogation Agreement", giving them the right to repayment in full of all expenses they paid related to this accident. Tammy had no clue what this "subrogation agreement" was, but felt somehow the insurance company might be trying to take advantage of her and so sought our help to review the agreement.

After hearing this story, we suspected that her health care administrator was up to no good. We sent a written demand to the plan administrator at her work to get a copy of the plan and related documents. We warned the administrator that they were required under law to provide this information within 30 days or face a stiff financial penalty. Well, when the plan documents arrived, we were able to confirm our suspicions. The plan documents provided no right of subrogation against an uninsured motorist recovery, such as the claim Tammy would be applying for. Some low level clerk had just assumed that this claim would be like the rest of the auto liability claims that they have recovered under

their subrogation rights before. But, the clerk was wrong on this claim, because a careful reading of the documents we received confirmed that the Plan did not give the company a right to recover against this type of insurance, because it was not insurance covering the responsible driver, but was Tammy's own policy.

Now, as a result of our careful reading of the Plan, Tammy was able to force her health Plan to pay her medical bills without signing any special subrogation agreement. She also got a hefty net recovery from the uninsured motorist claim, without having to pay back her health plan for the medical bills they had paid. That my friend, is why I started practicing law. There are just too many injustices to count in today's complex world of insurance. But, as between an inexperienced young lady injured on her way to work, and the gargantuan insurance company sweeping up the crumbs of her paycheck for insurance premiums, I always know whose side feels right to represent!

So, you may be wondering how we pulled this rabbit out of the hat for our client, Tammy, when all seemed hopeless on the day of our first meeting? Here is our behind the scenes account of what the insurance industry does to take undue advantage in some cases, and due although harsh advantage in others, including our client's case, to let you see how your own insurance company may try to take undue advantage in your next accident claim through the law of subrogation:

WHAT IS SUBROGATION?

Insurance law is complex, and usually favors the insurance company over the people it insures. Most will argue that without insurance, where would we all be in the event of a

large catastrophe? I can't dispute that a world without insurance would be difficult for modern industry, and also helps the little guy, to a point. But, in my recent experience, insurance companies have been getting the best end of the stick most of the time. It's no surprise that some of our richest companies, like Berkshire Hathaway, have made huge profits from investing in insurance companies. Maybe when you and I become as rich as Warren Buffet we might see this insurance swindle from a different perspective, but until then, I can tell you plainly that the insurance industry holds the key to the castle in this country!

There are a lot of advantages built into the legal system that favor these companies. Insurance companies always try to reduce their claim payments, and increase their policy premium revenues. So, if there is a big loss like the claims from Hurricane Katrina or the 9 – 11 attacks, the insurance companies who wrote that coverage will typically trot down to Capitol Hill for special compensation funds out of our tax dollars, and more tax benefits to allow them to offset or delay the write-off for their claim payments.

When you think about it, there should be very few instances in which an insurance company has a losing year in earnings. (Oh, I suppose that ever since the AIG scandal last year when AIG posted a huge operating loss, we have to take pity on these poor whimpering – FRAUDSTERS!) That is because they set aside money out of their earnings from policy premiums to pay claims. And, they often buy re-insurance from other insurance companies to cover their own losses, which offsets their own claims payments by payments from other insurance companies for the really big claims. So, if you like insurance companies, you will feel relatively confident investing in their racket, at least for the foreseeable

future, as they have a pretty tight lock on the right to print money, in the form of premium notices sufficient to offset even the worst of their losses. Finally, when they really screw up, like in the case of the AIG fraud scheme, they just knock on Uncle Sam's door for a handout. After all, they are just too big to fail! (…and they write your congressman's re-election fund checks!)

SUBROGATION – A SECOND BITE AT THE APPLE.

One of the slickest ways for an insurance company to avoid taking a loss on its claim payments is by means of a special legal doctrine called subrogation. In this field of law, an insurance company has the right under certain circumstances to get paid back for any claim payments they make. So, for example, when a claim is paid for uninsured motorist coverage, the insurance companies have actually been able to write their entitlement to subrogation into law. In most states, the company that pays a claim for an uninsured motorists' liability is entitled to subrogation against that uninsured motorist. As a result, the courts dockets are often full of cases filed by insurance companies trying to recoup a judgment against the person who caused an accident who had no insurance. When your own insurance company pays your claims under uninsured motorist coverage, they can take a judgment for the full amount of their payment against the other person who caused the accident even if they had no insurance. Eventually, some of these claims get paid back by the uninsured driver who caused the accident. Often, an insurance company will garnish their wages and levy on their bank accounts if a voluntary payment plan cannot be set up. Also, as a result, many of these claims force the uninsured

driver to file a personal bankruptcy to avoid this type of subrogation judgment.

HOW DOES SUBROGATION WORK?

Subrogation usually operates after a claim occurs. The primary insurance pays the claim, and then tries to figure out who it can go after to get paid back. Was there another person partly at fault in the accident? Did the workplace injury involve some stranger to the employment who could be hit up for some of the claim payment? What about chasing a manufacturer, or even a doctor, for some allegation of worsened condition or heightened injury caused in part by a faulty lap belt or medical malpractice? Sure, all of these claims have been tried at some point by insurance companies seeking a right of subrogation for their loss. If they are able to prove a case against these "third parties" who contributed or who may have been entirely responsible for the accident, then they have a chance at offsetting the claim payment loss incurred, and get paid back by that third party.

There are a number of special laws and concepts accepted by courts to allow an insurance company to go after subrogation. These special subrogation laws usually center on special risks such as worker's compensation coverage or auto insurance.

WORKER'S COMPENSATION – SUBROGATION IS THE LAW

In the law of worker's compensation, an insurance company will insure the employer against injuries suffered by his workers on the job. In exchange for a limited payment of compensation and lifetime medical expenses, the insur-

ance company gets a statutory right to recover part of its claim payments against any third party who was a stranger to the employment, for their negligence that contributed to the loss. Better still, the insurance company might get repaid in full for the loss if it can find someone who was the *sole* cause of the injury.

There have been many cases over the years involving subrogation suits for auto accidents where the injured party had to repay part of a recovery against an insured negligent driver who caused an accident that happened while the injured person was working. Traveling salesmen, delivery drivers, and construction workers are frequently injured in these types of accidents, and submit worker's compensation claims. Then, the insurance company that provided the worker with limited compensation and medical expense payments will go after the third party to recover the entire claim. Doesn't it seem unfair that the employer had to pay a large premium for the worker's compensation insurance, but gets no money back from the insurer after it recovers subrogation funds? Well, that is the way of insurance, my friends. Maybe we can console ourselves by the supposed savings that the employer gets from lower insurance premiums due to the subrogation repayment his carrier got. If only that was true in the real world. My experience shows such repayments rarely if ever result in a net premium savings to the poor employer, and the only party making out in such recoveries is – you guessed it – the insurance carrier.

UM/UIM SUBROGATION RIGHTS – WE PAY YOU NOW, AND MAKE HIM PAY US LATER

Another source of law providing a right of subrogation is in

the auto insurance laws of most states, known as uninsured motorist coverage. Under this concept of insurance, your own policy of auto insurance provides coverage that will protect you against uninsured drivers that case accidents. Uninsured motorist insurance is generally required by state law. If your insurance company wants to write insurance in your state, it is obligated by state law to provide this coverage to you, the policyholder, as a mandatory coverage benefit. What is not mandatory is the amount of coverage. Minimum coverage limits vary state by state, with the average minimum limit being $25,000. Some states require less, however.

Uninsured motorist coverage has an additional benefit in most states, known as underinsured motorist coverage. This special type of coverage will supplement what another negligent driver's coverage will pay for an accident, up to the limit of your own policy. Your limits can be set separately from the liability limits on your own policy as well. What happens when an insurance company pays a claim for underinsured motorist benefits is that the other driver whose insurance was insufficient to pay the full claim must again face the prospect of a subrogation lawsuit. Here, your own insurance company will try to recover back the additional funds it paid under your policy from the other driver, personally. Since his own insurance was insufficient to pay the full claim, his insurance company is off the hook for this extra claim payment, and the underinsured driver must pay your company back personally.

We have already seen how the uninsured motorist law will require your auto policy to pay you for damages you sustain from an uninsured driver's negligence. It is always a smart proposition to buy as much of this kind of coverage as you can possibly afford. There are huge numbers of unin-

sured motorists operating on our public streets, and during times of recession, this number goes up substantially due to adverse economic conditions. So, for example, it has been estimated that as many as one in three drivers in Colorado operate without any insurance on their car, in 2007. Other states report figures higher than 25%. That gives you a one in four chance that the person who causes your next accident will have no insurance to pay for your injuries!

ERISA SUBROGATION

A recent federal court case shows a way around some of the most onerous insurance company practices in subrogation recoveries for ERISA health plans. The Burgett v. MEBA Medical & Benefits Plan case, decided in 2007, found that because the Summary Plan Description (SPD) given to employees to describe their health coverage is the primary document provided to the beneficiaries, in the event of conflicts between the Plan and the SPD, the language of the SPD controls. Hansen v. Continental Ins. Co., 940 F.2d 971, 982 (5th Cir.1991); Hamilton v. Pilgrims Pride Employee Group Health Plan, 37 F.Supp.2d 817, 822 (E.D.Tex.1998). This is because the average beneficiary relies upon the SPD, not the plan. Accordingly, the SPD most nearly represents the intention of the parties. Fallo v. Piccadilly Cafeterias, Inc., 141 F.3d 580, 584 (5th Cir.1998). In the Burgett case, the SPD contained no requirement that the beneficiaries or participants execute any subrogation agreement prior to having their claims for benefits processed. Burgett v. MEBA Medical and Benefits Plan, Slip Copy, 2007 WL 2815745 (E.D.Tex.) (September 25, 2007). Therefore, the plan could not avoid payment of the health care bills.

This district court opinion highlights two important principles of health plan reimbursement or subrogation provisions. A self-funded ERISA group health plan may condition payment of medical claims – and eventually deny payment entirely – if participants refuse to execute assurance documents, because it's required by the plan. The only way around this contingency is to prove that the plan does not contain a provision that requires signing such assurance documents. Secondly, it's worth looking carefully at the language to determine whether the assurance documents try to impose more limitations and conditions than those contained in the Plan documents themselves.

A WAY OUT: MAKE ME WHOLE!

The Make Whole Rule vs. First Dollar reimbursement: The "Make Whole" rule renders the ERISA health plan administrator in last place to collect reimbursement of medical expenses in a subrogation claim under ERISA. But most courts have allowed carefully drafted plan language to eliminate the Make Whole Rule. Still, a careful lawyer will review the plan language to see if the Make Whole Rule can be used to put the insurance company in last place to collect from third party settlements.

The Promise to Repay Rule: Here, the insurance company retains the right to make you sign an agreement to repay them (usually on a "first dollar received" basis) as a condition of advancing funds to pay your medical bills. If you don't sign the agreement, as onerous as it is, they don't have to pay a dime towards your medical bills. The companies are usually careful to avoid any possible exclusions under which you might try to avoid repayment, such as allocating

the funds of settlement to non-plan participants, or to specify the items of payment included in a settlement funds, such as funeral expenses, not medical bills. The most obvious problem with these "Subrogation Agreements" is that many of these agreements include language far more restrictive on you, and include broader rights to recapture payments made by the plan from funds that are not even paid by a third party recovery source. For example, the Plan subrogation agreement might make you repay them out of med pay recoveries, or from funds paid from life insurance proceeds.

Incidentally, the ERISA plans usually also go after OTHER SUBROGATION payments too! This means that the health plan pays your medical bills, and you have a worker's comp claim in the same accident, even though your worker's comp carrier has a subrogation right against the responsible party, the ERISA plan's rights include reimbursement against the other party's liability policy in a first priority.

Another nasty element of the reimbursements they claim has to do with the litigation expenses they incur to defend or enforce their rights to reimbursement. Let say that you and your lawyer try to review the policy language, and you have found some vague language that might give you an "out" from having to repay the medical bills on a first dollar basis, and your recovery is not sufficient to make you whole from the third party. This might happen where, for example, you collect from a small liability insurance policy that had limits of only $25,000 and your medical expense to cure a fractured leg or arm was $18,000, or almost as much as the policy limits. In that case, the ERISA plan may try to get repaid their $18,000, leaving you with only $7,000 in net recovery. If you go to court to ask for an interpretation of the plan language, you might not win, and the Plan's language

now gives it a right to include its legal fees on top of the medical expenses to be paid by your third party settlement. In conclusion, you might lose the entire settlement fund to your ERISA plan, because their legal fees are undoubtedly going to exceed $7,000. Can you believe that you might actually have to pay the ERISA plan their fees even if they are more than the fund you collect from the third party's insurance? It's true!

My medical bills show substantially higher service fees than what my ERISA plan paid. Then, there is a "discount" on the bill, or reduction for contracted limits of payments. Do I have to pay the full balance of the bill out of my third party settlement? Or do I only owe the ERISA plan the amount they paid to the doctor? Does the doctor have a right to get paid for his discount?

First, the plan only gets paid back what it paid. They can't get a windfall profit of repayment for the full bill, when they only paid their discounted or negotiated rates. The balance of the doctor's bills are generally lost forever to the doctor. He has signed a provider agreement that prohibits him from collecting from you the balance he agreed to write off. His agreement to do that is with the Plan, but you are a beneficiary of the Plan's negotiated rates, so you get the benefit and wont have to pay back the doctor for his write off.

So where do you go to find out what your ERISA plan language says? You will need two key documents, the "Plan" and the "Summary Plan Description". These are frequently included in the same plan brochure or booklet given to you as a new employee. If you don't have your copy, you will need to order a replacement to give to your attorney to review and analyze. The attorney will look for ambiguities and con-

flicts between the Plan and the SPD, and resolve language discrepancies by relying on the SPD language. But, much uncertainty will remain if the Plan allows its own Administrator to interpret the language, which simply gives them the right to change the ambiguous language into language that will favor the plan, not you. Secondly, many plans now include the right to retroactively amend the Plan language. That will change the Plan even more certainly to favor the Plan over you.

What happens if the Plan administrator does not give me a copy of the Plan and I lost my own copy? Well, here you are given a large benefit of a financial penalty that can be charged to the administrator for refusal or late compliance. A copy of your Plan has to be provided within 30 days, or a fine of $100 per day is assessed until the Plan is sent to you.

Now that we have an overview of what subrogation is, and what laws make subrogation apply to your pending personal injury claim, I want to share with you what are the all time most frequently asked questions that my clients ask me, when it comes time to discuss the final settlement and those subrogation repayment demands from your health insurer, worker's comp carrier, and primary insurance carrier:

WHO IS RESPONSIBLE FOR PAYING THE SUBROGATION CLAIM BACK TO MY INSURANCE COMPANY?

So, we have seen so far that many insurance laws protect insurance companies by giving them a second bite at the apple – recovering from others for the loss they paid (and charged a premium for!). Now you may be wondering, do

I have to repay my insurance company if I get a payment directly from them? One would hope that this answer would carry an easy "NO WAY" answer. But, as in most insurance matters, the truth is not so simple.

Did you know that you could be made to repay your own insurance company if you take funds that should have been paid to them under a subrogation right? Lets say that you settle a personal injury claim against a negligent driver's insurance. Then, you take all the money from the settlement yourself. No funds are repaid to your insurance company for funds they paid for medical expenses. If your medical bills were paid under worker's compensation insurance, then you might indeed owe your own carrier the funds it paid for your medical bills at the time of your third party settlement.

The most frequent source of repayment under subrogation, however, is from the responsible party who caused your accident. But, if their insurance pays the claim, new insurance settlement practices now require that you provide written assurances that all other insurance will be fully repaid from your settlement, and you must agree to repay the carrier if you don't pay your own insurance back for a legitimate subrogation claim.

The trouble with this field of law is that the certainty of one insurance company's right to get repaid is anything but certain! Not only do you have to look at all applicable state laws that affect the right of subrogation, but you also need to consider special court rulings to determine if the repayment is due to your carrier. There are many instances where, for example, you are not made "whole" by the third party settlement, that will offset the otherwise legitimate subrogation claim by your employer-funded health benefits plan at work.

DO I HAVE TO GO TO COURT TO HELP PROVE MY INSURANCE COMPANY'S SUBROGATION CLAIM?

Another way in which your insurance company can at least inconvenience you, if not outright confound you, is to require your assistance to provide testimony and a supporting hand in proving their entitlement to subrogation. Let's say, for example, that your car was stolen, and you made a claim for the damage to the car and lost contents like a CD player and your new jacket. When the police find the whacko who stole your car, you may be surprised to learn that its your neighbors' son who took your car and had such a great time in the car that he had to pawn the CD player to pay for a hotel room downtown that night. Well, much to your consternation, you may get a letter from your insurance company stating that you are required to identify this neighbor's son in court, and describe the loss, and prove your ownership of the vehicle, while your neighbor sits fuming in the court gallery wonder what kind of a jerk would sue his own neighbors' kid for such an inconsequential prank. Too bad your neighbor doesn't know that it wasn't even you who filed the suit, and that you wish you could be anywhere but in court taking a day without pay from work, to accommodate the economic interests of your own insurance company. I know many friends and clients who have had such bad experiences with these types of insurance practices that they actually cancel their policies and look elsewhere for a new policy.

If there were any way around this type of insane economic grab bag, I would let you know, but unfortunately, if you want to get repaid for that lost Madonna CD, you're going to have to play ball with your carrier on its subrogation claim!

AM I SUBJECT TO BEING SUED BY MY OWN HEALTH INSURANCE CARRIER FOR SUBROGATION?

The unfortunate answer is yes. If you don't pay back the subrogation money that is due to your carrier, they are likely to sue you to make you give it back. But, if you had a lawyer help you settle the case, then it may be that your lawyer has to pay back the funds out of his own money! Wow, a lawyer has to pay himself? Let's see how likely it is that your lawyer will let you settle the case without payment of that subrogation claim, though. If he knows what he is doing, that money will at least be held in escrow until you get a final resolution of whether the carrier is entitled to get repaid, and how much. So, you might still end up named in a lawsuit before that battle is over. Many lawyers are actually forced into filing what is known as a declaratory judgment action for you to prove that you don't owe the subrogation money back. While this sounds tough, it may be that you never have to appear on court on that type of lawsuit. It usually gets resolved by examination of the policy language, on what we call a "stipulation" of facts. What that means is that you don't have to testify! The lawyers work out what you would say, as all of it is likely undisputed and easily summarized into a legal document. So, when you get ready to panic at the thought of a lawsuit being filed over your repayment obligations, don't fret too much, it's in your best interest, and you may not even notice the suit is resolved (at least until you get that extra bonus of medical reimbursement in your net settlement check!).

WHO GETS THE MONEY OUT OF SUBROGATION?

Who gets the money out of an insurance company subrogation claim? Its sure not Santa Claus, and its sure not you! That is, unless you hire a competent lawyer to aggressively investigate the policy language and the applicable law to see if your insurance carrier really has a legal right to repayment of its asserted subrogation claim. That's when you should thank your lucky stars that some well meaning young ladies and men devoted hours of time and personal insults from law professors to study up on personal injury law and make a career out of it. Yes, those humble and usually overworked lawyers you hired might just save your bacon when it comes to subrogation claims. They might in fact bring you an extra pound of bacon before its all said and done. That money is yours, subject to certain limited legal rights based on technical contract language that is always drafted by some 'goon' in a backroom wearing a visor and squinting under green lights. Well, maybe they aren't quite that arcane, but to have a light conversation with an insurance contract lawyer is equivalent to considering tax lawyers good candidates for stand-up comedy!

WHAT IS AN INSURANCE LIEN ON MY PERSONAL INJURY RECOVERY?

As many ERISA-based employer-sponsored health benefit plans were written, you must repay your own health insurer for the funds paid on your behalf for medical expenses related to an accident. That is what is known as a lien. A lien is a legal right to go against certain funds on a priority basis. So, if there is a lien in favor of your health insurance plan, you

have to repay the lien before you can get any of the funds yourself. Now, your health insurance company got that lien by making a contract with your employer, and you accepted the terms of that contract by agreeing to take the health benefits offered under your employer's health plan.

What may surprise many people is that personal health insurance policies, by that I mean the policy you buy on your own, not through your employer, usually do not carry any right of subrogation against your personal injury claim. In fact, in one of the few instances of successful consumer rights legislation passed in this past century, the laws of most states carry prohibitions that prevent health insurance companies issuing personal health insurance policies from recovering subrogation payments against third party liability settlements or judgments. As a result, when you settle a personal injury case and you have a personal policy of health insurance, there is no subrogation requirements and no lien on your personal injury claim to interfere in your settlement money.

WHO GETS TO ASSERT A LIEN ON PERSONAL INJURY SETTLEMENTS?

You might be able to guess from all you have read above that liens do exist on your personal injury recovery in many different types of cases, employment related, health Plan related, and otherwise. In most of these cases, the lien is asserted in favor of the person or company who paid a bill that should have been paid by others, usually the one who caused your accident and injuries. When that person is ready to pay for their negligence, through insurance or other funds, then the subrogation liens will come out of the closet and make haste to be repaid out of your settlement funds. Again, because

there may be a lien, you have to wait for payment of your share of the settlement until the entitlement to the subrogation money is resolved. That lien is a priority, remember?

WHAT TYPES OF INSURANCE CARRY SUBROGATION CLAUSES?

Health, accident, casualty, property, and liability insurance all typically include the contractual right of subrogation. Again, this is the right to have someone else pay back your insurance company for the payment it made to you for the loss someone else caused.

LIEN ON PERSONAL INJURY CLAIMS: DOES MY LAWYER HAVE TO PAY THE HEALTH INSURANCE SUBROGATION CLAIM OUT OF MY SETTLEMENT FUNDS?

You bet the lawyer has to pay that subrogation claim out of your settlement funds. Unless of course he wants to give you a gift and pay it out of his own funds! That is one of the emerging trends in personal injury law that is most onerous on lawyers, but is required universally in every state. Pay the legitimate claims against your client's money, or you will be told to pay it out of your own funds. So, there is little a competent and ethical lawyer can do other than verify the legitimacy of the claim, and pay it if required. But as we have also seen, there are many instances in which contract language has been defeated in court that an insurance company wrongly believed gave them a subrogation lien against your personal injury recovery. There is no substitute for careful

and thorough investigation of the contract language in these policies and plans, and that is what you pay your lawyer to do for you.

DOES FEDERAL OR STATE LAW REQUIRE SUBROGATION IN MY HEALTH INSURANCE PLAN?

No, federal law does not require a right of subrogation to be included in your employer sponsored ERISA health plan. It is, however, allowed to have subrogation plans in ERISA plans. In effect, it is an optional element of coverage that federal law allows the plan to include. By contrast, State law, as we have discussed above, prohibits subrogation in *individually issued* health insurance policies. State law, unfortunately, only applies to policies that are not organized under ERISA, the federal law.

Again, ERISA is a federal law that was passed to enable cost effective health benefit plans to be offered by employers. What has developed in many such plans is a right of subrogation by contract. That means that your employer's plan included in the contract a clause entitling the plan to recover payments it made from your personal injury award. Because the plan was written under ERISA, the state's laws which prohibit health insurance subrogation recoveries no longer apply. That has to do with the U.S. Constitution's Supremacy Clause, which states that a federal law must be given greater, and often exclusive control over a field of law if it intended to replace state law. Since the ERISA law was long ago established to be exclusive of contrary state law, it now controls employer sponsored health benefit plans and supercedes state law as to those types of health benefit plans.

It should be noted, though, that health plans offered by small employer groups may not fall under ERISA, and those plans still have to obey the state law restriction against subrogation recovery against personal injury awards. What matters is whether the employer is large enough to be an ERISA-sized employer, and the language of the plan. Usually, if the employer bought insurance, and did not set up a self funded plan, it is not an ERISA plan and you will be protected against subrogation claims.

In summary then, we see a long standing trend that seems to be accelerating over the past twenty years to expand the scope of subrogation in favor of insurance companies. While the history of subrogation focused on repayment from third party sources for primary insurance payouts on claims for property damage, the trend is to expand the concept of subrogation into health insurance programs offered through ERISA formulated health plans. The second area of subrogation that is allowed in the context of recoveries involving personal injury is for uninsured motorist claims and worker's compensation claims. In each instance, if your personal injury settlement involves these issues, you will want to be sure to get competent legal advice to prevent any prejudice to the carrier's right of subrogation, and to maximize your personal injury net recovery.

ABOUT MICHAEL

Michael R. Strong, Esq. is a practicing lawyer licensed in Virginia, Maryland and the District of Columbia. He has practiced law since 1980. He is a graduate, with Honors, of the University of Dayton School of Law, and was a member of the Law Review and National Moot Court Team during his studies at the University of Dayton. He is a former member of the Virginia Boyd Graves Conference on Legislative liaison between the Bar and legislature of Virginia. He is a member of the Virginia Trial Lawyers Association, the Maryland Trial Lawyers Association, and the District of Columbia Trial Lawyers Association.

His practice of law began as an associate attorney, working for a nationally renowned author of products liability treatises for lawyers, and as an associate to the now Senior United States District Judge Robert G. Doumar, of the Eastern District of Virginia. His initial experience working as an associate attorney for clients such as St. Paul Fire & Marine Insurance Company (formerly the largest U.S. medical malpractice insurer) and Liberty Mutual Insurance Company provided him with valuable insights into the many tricks and traps used by Insurance Companies to defeat or delay claims to their own financial advantage. He thereafter established his own law firm and now operates a private law practice in Falls Church, Virginia and Bethesda, Maryland, representing exclusively plaintiff's personal injury cases against insurance companies and self insured employers.

Mr. Strong has handled complex auto accident, trucking accident, and products liability claims for over thirty years. He has achieved many six figure settlements and verdicts for his clients involving highway accidents, products liability claims, and medical malpractice claims. His practice now handles over a hundred personal injury cases per year, and is renowned for personal attention to his client's needs, formulating case specific plans to obtain proper medical care while personal injury cases are in process, and litigating cases to achieve better recoveries and positive outcomes for his clients in state and federal courts in Virginia, Maryland and the District of Columbia.

Mr. Strong is the author of several articles involving personal injury recov-

ery advice, development of sources of insurance coverage in complex accident cases, and creative solutions for compromise of medical provider and subrogation liens.

CHAPTER 11

HOW TO MAXIMIZE CASE VALUE WHEN INSURANCE COMPANIES USE COMPUTER SOFTWARE TO REVIEW YOUR INJURY CLAIM

BY MARK C. BLANE, ESQ.

Maximizing injury case value when insurance companies use a computer may sound a little strange but it is very real; the next time you sustain an injury due to the negligence of another, a computer program may be used to evaluate your injury claim by the claims adjuster with the insurance company you are going against. A recent study has shown that over 70% of insurance companies in

the United States are using a computer software program to determine case value, and there are about 300 insurance companies that govern injury claims nationwide. This phenomenon is world-wide as well, with most of Asia, Europe, and Australia using computers on injury claims to adjust settlement value. This process officially started in the early 1990's, and has been steadily growing ever since, despite some criticisms of the practice. There are about four different computer programs as of the date of this writing, and they are supposed to help the claims adjuster ascertain "claim value" on a given injury case to help expedite the claims review process, and save the insurance companies money in the interim. First, let me tell you my story of how I discovered this process.

I first learned of the insurance computer software programs when I started practicing personal injury law in San Diego, California back in 1999. I heard rumors of a mysterious computer program collectively known as "Colossus" that claims adjusters would quietly use to come up with first offers on a claim. The program is actually named after the giant Greek Statute that stood guard over the Greek Island of Rhoades as one of the *Seven Wonders of the Ancient World*. One day, I was on the telephone negotiating an injury claim with a very good claims adjuster that I had known for a couple years in town, and that I had come to respect. Yet, that particular day he did something that I thought was very strange and unconventional. On the phone he asked me for very *precise* information (evidence) found in the medical chart notes which I quickly provided to him; immediately his settlement offer to my client changed from one amount to a dramatically increased amount. I remember asking him what he did to move the numbers so dramatically and so quickly. He simply responded: "Mark,

you simply gave me what I needed to compute data on my end to come up in value on your client's case." This claim adjuster did not remain long with the same insurance company, and I now fondly look back at that experience as the time when a claims adjuster was effectively telling me, in not so many words, that he was using a computer program that needed certain data in order to substantiate a certain value for settlement. This experience motivated me to seriously investigate this intriguing computer program known as "Colossus", as I knew this knowledge could help my injured clients one injury case at a time. I did not stop with Colossus; I researched the other computer programs known as Claims Outcome Advisor (COA); Injury IQ; and Injury Claims Evaluator (ICE).

In order to maximize case value, one must first understand how the adjuster uses the program in their everyday practice. The adjuster inputs data about you in the computer; for example, he or she inputs your social security number as your entire medical history is linked to this number; this will also show whether or not you have been injured before in the same body parts you are presently claiming injury. Your height, sex, and weight are also analyzed. This is important for the computer because different forces that cause injuries affect certain body types in different ways. Then the adjuster inputs data about their own insured, if the case is a car accident for example. Here, the computer analyzes property damage to both vehicles and whether their insured was also injured. The property damage is important as it is one of many pieces of evidence that can help determine bio-mechanical force to cause bodily injury.

Next, the adjuster inputs the zip code of where the accident occurred, because eventually the computer program will

match your specific demographics that were previously put into the computer to the nearest courthouse in the zip code where the accident happened; the software will analyze how high the jury awards are with your particular case. This is called "tuning" your injury case, and statistical data has to be continuously fed to the computer program in order for it to work in this way. Having to continually update statistical data makes having the computer program very expensive for the insurance company using it, and you have to ask yourself why is an insurance company spending millions of dollars every year to use a computer on your injury case. Then, the adjuster enters your injuries into the program. Injuries are documented by your treating physicians using the *International Classification of Diseases, Ninth Edition* (ICD-9 Codes). These codes are entered in the computer screens. Thus, if you do not have proper medical evidence that is precisely documented then there is a good chance the computer will not give you value for that particular injury. Hence, this is where the crux of the matter lies because ***if an adjuster makes a mistake or completely ignores a crucial piece of medical evidence*** on your injury claim, it can skew, to your detriment, what the computer is allowing as fair settlement value on your claim.

To make matters worse, if your lawyer is unaware of the software, this entire process can either increase the chance that a lawsuit will need to be filed, or you will find yourself with a low value settlement. Now, you can see why insurance companies like using the computer programs. Computer programs consolidate the claim review process into an efficient machine, and encourage the adjuster to follow systematic rules of engagement on most injury cases. It also takes the autonomy out of the claim review process; it removes the "human element" and helps create a calculat-

ing negotiation process by the claims adjuster.

Another method insurance companies are implementing is the "team approach" to adjust injury claims. They have different teams you can contact in the phone queue. You can contact team one, two, or three, and so on. In fact, some insurance companies have stopped using telephone extensions for their individual adjusters all together. The first person you now reach on the phone is a "member" of a team assigned to the specific claim. This is done so no one in particular can be held accountable for specific conclusions, or actions; namely settlement claim value. If the insurance companies can eliminate the human element, or human heart, in the claim review process, then it can potentially better increase their profits by standing firm in lower claims payout that do not make it to a jury trial. It is a known fact that insurance companies make more money in saving one dollar in a claims payout than one dollar they make in collected premiums. This is why the insurance companies that use computer software programs have no problem spending millions of dollars each year to license the use of these computer programs, and train their claims adjusters on them accordingly.

The way to combat computer programs is to know how to use them. A key element is knowing how to prepare the demand package that will blend with the program. A knowledgeable attorney will know how to present the medical evidence the computer programs are designed to compute. On a positive note, the existence of the computer program reviewing claims can make the lawyers better lawyers, and the doctors better doctors because the name of the game is now ***in the details of the medical findings***. Lawyers must be proactive in gathering the medical evidence the comput-

ers need, and the doctors must be proactive in documenting their patients injuries in language that is precise, and detailed enough to explain the relationship between the injuries and the type or modality of medical care. In essence, the ICD-9 Codes must match or have a foundation for the *Current Procedures Terminology Codes* (CPT Codes).

Here are the Top Eleven Areas that must be included in demand packages:

1. Injury descriptions with their respective ICD-9 Codes;
2. Description of how their personal life has been impacted by the injury(s); for example, duties under duress, and loss of enjoyment of life;
3. Wage loss claims need to be duly documented by ***both*** doctors and employer;
4. Loss motion segment integrity needs to be thoroughly documented by the doctor(s) on severe soft tissue injuries;
5. If the claim warrants it, a permanent impairment needs to be documented under the **American Medical Association (AMA) guidelines** by a respected medical doctor in the community;
6. Mileage reimbursement requests;
7. Credit damage requests;
8. Aggravation ***or*** exacerbation medical documentation of a prior injury or medical condition must be appropriately documented in the medical findings;
9. Adequate or apportioned subsequent injury documentation;
10. If there is a gap in medical care, an explanation by the doctor as to what the client did to mitigate his or her damages, and what the client did to

participate in his or her recovery before beginning therapy is crucial. For example, if the patient self-medicated, guarded their daily activities, stayed in bed longer than usual, took off work earlier than usual, or took prescription medication from a previous injury (all active care by the patient that can prove any gap in care is merely an illusion);

11. A review of symptoms that include, but are not limited to: radiating pain, muscle spasms, and range-of-motion issues.

It is fundamental that doctors and attorneys know how the computer systems work when documenting your injuries because the medical findings will be the evidence and ***value drivers*** for your case. Therefore, the doctors need to seriously understand the importance of their medical reports, and how they can improve them; if not, the insurance company using a computer software program will not input the value drivers from the medical evidence. Long gone are the days where you simply triple your medical findings to substantiate general (pain and suffering) damages. In fact, some adjusters are trained to not put in a value driver in their review if it is not in the demand package.

It is essential for attorneys to understand how vital it is to have an impairment injury documented by the AMA guidelines in their demand packages. If you have a body part that is medically impaired, how is your attorney going to prove it? The AMA guidelines are an accepted standard for impairment assessment that is used world-wide. The game the insurance companies have created has changed, and it now becomes paramount your lawyer understands the computer programs, and how to be proactive in documenting your medical findings on your injury case. There are attorney

"mavericks" in the legal industry that understand this, and it is important that more and more attorneys grow in their practice to adopt it.

The attorney you ultimately choose has to be diligent in following up with the injury claims adjuster to make sure every piece of evidence is being utilized in the claim review process, and how to best communicate it to the adjuster so it is appropriately evaluated and put into the computer program if one is being used. I call it "proving your case to the adjuster through the medical findings" just like you would if you were speaking and showing medical evidence to a jury, the eventual fact finder, and ultimate equalizer. Remember, the insurance company *will* pay out what the computer dictates. If a soft tissue case is worth sixty-thousand dollars because the medical evidence proves it, the computer will have no problem telling the claims adjuster this value. So the next time you are shopping for the best attorney on your injury case, one of the questions you need to ask in your interview is regarding the computer software programs; more specifically, ask your potential lawyer what he or she knows about the computer programs and what they plan to do to combat them on your injury case.

ABOUT MARK

California trial lawyer, Mark C. Blane is a solo-practicing attorney, and legal author, that specializes in personal injury law in downtown San Diego, California. A few of his previous literary works include "The Ten Secrets You Need To Know About Regarding Your Injury Case*, Before You Call A Lawyer*," also available in Spanish as "Los Diez Secretos Que Necesita Saber Sobre Su Caso De Lesión, *Antes De Llamar a Un Abogado***,**" and "Justice For The Injured Child: *A Parent's Legal Survival Guide For Their Child's California Accident Case*." He was born and partly raised in Bremerhaven, Germany, eventually moving to Louisiana where he graduated from Louisiana State University in Shreveport with two degrees, one in Psychology in May 1994, and the other in Criminal Justice in August 1995, and went on to earn a law degree (J.D.) from Thomas Jefferson School of Law in San Diego in December 1998. He speaks both German and Spanish fluently. He has remained in San Diego ever since, and he was admitted to the California State bar since June 1999; he has also been admitted to the Minnesota and Texas State Bars, in addition to various Federal Courts across the United States. Mr. Blane represents people in Southern California who have been injured by the negligence of others due to defective products, automobile/motorcycle accidents, slip and falls, and other various accidents that have caused catastrophic loss. He finds himself against some of the largest insurance companies across the United States, in addition to some of the most respectful defense law firms in California.

Mr. Blane recognized early in his career that he wanted to represent ordinary people instead of corporate interests. He enjoys the courtroom and understands the necessity of having jury trials available when needed to right the wrongs of those injured by the negligence of others. By practicing personal injury law, he is able to combine his two passions: law and human anatomy science. He further understands that not every injury case will need a lawyer, but every injury case, no matter how minor, should be discussed with good legal counsel. The initial consult he provides is always without charge, and he works exclusively on a contingency fee basis with all of his cases. This means if he accepts and works on an injury case, he only charges a fee when

he successfully resolves the case; otherwise there is no charge for his legal services. Thus, there is no financial risk to the client.

Some of his early successes have been featured in National Publications and Legal Journals including the *San Diego Business Journal*, *National Jurist Magazine*, the *ABA Journal*, and the *Shreveport Times* (Louisiana), to name but a few. He has litigated, and continues to litigate, cases against some of America's biggest Corporations including: *Ford/Firestone (Defective Tire/Ford Roll-Over Cases); Amercian Home Products, Inc.,* drug makers of the once popular diet drug Fen-Phen; Johnson & Johnson, Inc.; and most recently against both *Merck, Inc.,* drug makers of the heart drug *Vioxx*, and *Metabolife, Inc.,* the San Diego based drug makers of the once popular ephedra based diet-drug of the same name. He was one of the first plaintiff attorneys in the U.S. to successfully settle against *Ford/Firestone* in California/Texas in the widely reported "tire defect/roll-over cases" in 2001. All of his clients in the above litigation suffered from heart valve injuries; spinal cord injuries; liver and brain injuries.

His focal area includes serious injuries of the Brain/Spinal Cord, Loss Motion Segment Integrity of the Spine/Vertebrae, and effectively documenting these injuries for the insurance company, and jury if necessary. This includes properly digitizing MRI/X-ray findings in order to appropriately document injury "impairment" by utilizing Permanent Impairment Ratings per the American Medical Association (AMA), 5th Edition. He is a master of the AMA 5th Edition, a medical assessment used worldwide to document medical impairment; and he is one of the few personal injury trial attorneys in the United States that have knowledge of utilizing this particular type of powerful medical documentation to prove medical damages in all injury/accident claims. Thus, he is proud to have set a "new bar" in terms of representing his injured clients with powerful results. Moreover, he is very effective in communicating this medical documentation to the jury should litigation become necessary. He works closely with both medical doctors and chiropractors including an entire spectrum of other doctors that best benefit his clients' individual injuries and needs. He is always mindful that every case needs careful and detailed documentation for not only the adjuster handling the claim, but for the jury that may need to see each aspect of an injury in straight-forward terms. As he is fond of saying, *"appropriately*

and properly documenting the medical impairment of any given injury makes all the legal difference in the world."

His law office is primarily comprised of a team of paralegals, and one *Of Counsel* attorney member. He likes keeping his legal team small and approachable; he makes sure his clients get his personal attention. In fact, when you become a client with his law firm, you meet with Mr. Blane directly; he never delegates a first meeting to an associate or paralegal team member. Since all of his clients have been injured in some way, he is extremely proactive in documenting the medical care each client receives. This is extremely important as he knows how most insurance companies utilize a computer software program to ascertain case value on a given injury.

CONTACT INFORMATION FOR ATTORNEY MARK C. BLANE

Mr. Blane and his legal staff speak Spanish, and his law offices are located in downtown San Diego. He can be reached Toll Free at (888) 845-6269, or direct at (619) 813-7955. You can also find him on the web at www.blanelaw.com.

CHAPTER 12

WHAT TO DO WITH LUMP SUM PAYMENTS FROM THE INSURANCE COMPANY?

BY PATRICK PHANCAO, ESQ.

So here you are, you've managed to navigate through the haze of insurance companies, spoken to slick agents, and made the best of bad offers and policies thrown your way. Heck, you may have even come out ahead with a nice settlement.

Now what? Well, I'm here to discuss a different sort of insurance – Life Insurance. More precisely, life insurance as it relates to your family's welfare and financial independence. In the last several years, insurance companies have come up

with such a wide array of insurance products that many of their potential customers simply get lost in the choices available to them. It is truly a shame, as some of these products can have a tremendous positive impact on your family.

In an attempt to clear out some of the confusion, I encourage you to join me in the next few pages as we explore the *simple* approach to what a Life Insurance Trust is, and what it can do for you and your loved ones. The goal is to give you a practical view of the subject, and get back to fundamentals.

THE BENEFITS TO YOUR DEATH

See, I could have entitled this section everything and anything about life insurance, but what are the chances you would have kept reading? Thus, I thought telling you the upswing of what life insurance could do would keep your interest. Assuming I succeeded, let us continue.

First of all, what is life insurance? The Web Dictionary states it to be a financial instrument which pays the named beneficiaries when the insured person dies. Simply stated, it is a financial vehicle that enables you to provide your loved ones with a lump sum of money in the event of your death. That particular amount is usually received in a large sum that as an individual, would be hard to accumulate over time without the help of an insurance company. More precisely, in the event of premature death, your loved ones would benefit from a significant lump sum that would be unavailable to you as an individual putting a minimal dollar amount aside every month.

Let us now look at the real-life application of this concept within the Estate Planning universe. First, we will study

the main tools available within life insurance, then classify the major benefits that derive from such, for both you and your family.

THE VARIOUS TYPES OF LIFE INSURANCE

Going through the countless options, various policies available, and the varying degrees of return you can get with life insurance – things can get confusing. Truth be told, there are only two primary categories to be focused upon – term and permanent. Naturally, each of these categories offers an array of different types of life insurance within them, and how they may apply to your specific situation. But before we delve into the details, let us build up our fundamental knowledge.

Term Insurance: This insurance provides a death benefit payment to your designated beneficiaries in the event of your death, but only should that death happen within a specified period. Thus, should you exceed your contract terms (time) of that policy, the premiums you would have paid over time would be gone.

Permanent Insurance: This insurance has all the components of a term policy, but it also provides a cash value over time which you can withdraw during times of need. For instance: If you have a family emergency, need to borrow money for a down payment to a home, need capital to start a business venture, and so forth; the cash value you will have built up over time can be used for those purposes.

WHAT INSURANCE SHOULD YOU GET?

The next question naturally becomes which one applies to you? Please don't shoot the messenger (even if he happens to be an attorney!), but the fact is that the answer is – it depends. The first thing you must determine for yourself is "Why am I getting life insurance?" If you are the main provider in your family, or even if a significant portion of the family revenues come from you; the objective is to sustain your family's standard of living for as long as possible. If that is your case, then both term and permanent insurance may apply and fulfill that need.

Now, what about having life insurance as a means of emergency financial back-up? If you purchase permanent insurance, after several years the insurance company will allow you to draw against your policy in times of financial need. Over time, some lending institutions will even look at your insurance as an asset to be counted towards your benefit. It provides that additional financial investment component that a term policy does not.

Still unclear? Don't worry, I have clients run into this issue countless times. If it helps at all, I will give you my personal opinion on this subject, but please do not take it as financial or legal 'gospel.' I reiterate that this is my *personal* rule-of-thumb in dealing with this issue. When broached with the dilemma, my recommendation is - the younger the family, the more I would lean towards a term insurance policy. The older the couple is, permanent insurance would be more advisable. Here is the reason: The way I look at life insurance is, it is exactly that… Insurance! You are paying for a large benefit to your family for an unlikely event, a premature death. The premium you pay is small in

comparison to the large pay-out your family would receive if you were not around.

However, add the whole-life component to your insurance, and your premiums are going to skyrocket. If you are looking for a sound financial investment, my personal view is that considering all the other vehicles available to you – from a 401(k), Roth IRA, company matching retirement plans, etc… I believe there are far better investment options, rates of return and tax benefits that would out-perform life insurance.

Many life insurance agents will claim that as much will power as all their clients claim to have, none have taken the discipline to do just that, set aside money for a saving / retirement / college education plan for their kids. That answer may very well have been true years ago. However, with the strength of today's financial institutions, automatic withdrawals, and other systematized savings plans available to the consumer, that argument no longer holds true.

But whatever option you end up selecting for your particular family, I am the first to say that your choice far outweighs the alternative to doing nothing. Now, let us explore together what the benefits are in the real-life application.

THE VERY COMPELLING, AND ATTRACTIVE, LIFE INSURANCE TRUST

The reason for the title is that it is a shame for the unappealing and 'off-putting' name this Trust has, despite all the advantages and support it provides. Assuming you've surpassed the mental hurdle of the concept of life insurance, accept the advantages it provides, and are still intrigued by

this universe, then this section will package the whole application for you in a practical manner.

In 2001, Congress extensively overhauled the federal estate and gift tax laws. With the exception of a law providing for a marital deduction in 1948, this was the first major change in these estate tax laws since 1942. As a result, death tax payments were assessed only against the wealthy and the moderately wealthy. With these laws, the majority of the population benefited since smaller estates did not have to pay estate taxes; Come January 1, 2011, the estate tax law will revert to past tax laws unless Congress revisits the issue. As of 2011, any estate over the $1,000,000 mark will pay estate taxes.

In states such as CA, a home alone could get you very close to the exemption amount. That, combined with various assets accumulated over a lifetime of investments could suffice to have your estate be forced to pay estate taxes close to 50% or above, depending on your net worth above the $1 million mark. Here comes the Life Insurance Trust (herein "LIT").

An estate includes all property owned by the decedent at the time of death: investments, cash, real estate, vehicles, personal property, life insurance proceeds from policies owned by the decedent within three years of death, life insurance paid to the estate, retirement assets and business interests. The gross estate also includes assets passing through probate, as well as assets inherited directly by joint owners or beneficiaries. In the context of our conversation, you can save your life insurance proceeds by placing it within an Irrevocable LIT, thus solving the problem of ownership by removing the value of that policy and preventing it from being included in your estate. This would remove the assets

from exposure to estate taxes. Here are additional benefits it can provide:

- Gifts of life insurance premiums can be placed into a trust to purchase necessary, even large amounts of life insurance, without potentially increasing your exposure to federal estate taxes;
- Gifts of life insurance premiums up to $13,000 (if married, up to $26,000) qualify for federal gift tax exclusion and avoid any current gift tax that might otherwise be due;
- A current estate is decreased through gifts of life insurance premiums – which potentially avoids or lowers federal estate taxes;
- Cash value inside the trust may be created by gifts of insurance premiums – which, after a few years, may be utilized to pay the premiums of the permanent life insurance premiums;
- Proceeds of the life insurance can eventually be used as liquidity to pay for the grantor's estate tax, final expenses, inheritances and charitable gift funding.

As with everything in life, there are some drawbacks to an Irrevocable LIT. As its name implies, it is irrevocable, so you can no longer change it. In reality, you can change it under certain circumstances, but it becomes a tedious process. Some very specific steps must be followed, so it is imperative you hire competent legal counsel for such service. For instance, if the beneficiaries are not sent notices that withdrawals are permitted when the client transfers gift funds, then the client becomes liable for federal gift taxes.

CONCLUSION

Well, my hope is to have imparted to you a practical knowledge of what many would consider a dry subject. Hopefully, having an overview of what life insurance and a life insurance trust can do for you and your family will motivate you to learn more about the entire Estate Planning universe.

There are many misconstrued notions about this field of law; life insurance and Irrevocable LIT are just two of the components of a proper estate plan. However, imagine the best legal drafted document executed on your behalf, would your beneficiaries truly know what to do in case of an emergency if they had no relationship with your legal advisor? Would your children have the financial means to pay your advisor at an hourly rate, if he / she billed for every phone call? Most importantly, does your legal counsel really know your family?

Here at Asset Protection & Elder Law Center (founded by Phancao & Shaffer, LLP), we are strong advocates of building a lifetime relationship with you and your family. We believe that an effective legal document begins with a strong legal team backing you up. This can only be achieved with communication lines open, with the client feeling free to call at will for any of their financial and legal questions without the fear of a legal fee attached to it. That is why we are strong advocates of the flat-fee approach no matter what the legal need, so there is never any surprise on the part of the client.

A well-informed client is a better served client, that is why we are an education based firm, first and foremost. If there are any aspects of Estate Planning, Asset Protection, and Medicaid (Medi-Cal in California) you would like to learn

about, please visit us at: www.apelcenter.com, and receive our completely free monthly newsletter filled with fun, informative facts from a broad range of legal topics, light news and updates on every day issues. We also provide reports on specific subject matters.

Thank you for spending this time with me, and I look forward to meeting you in person very soon…

ABOUT PATRICK

Patrick Phancao, Esq. is an Estate Planning Attorney licensed in CA, FL, and the U.S. Patent & Trademark Office. He is a member of the Wealth Counsel and the National Academy of Elder Law Attorneys. His entire focus is ensuring that his clients and their families are protected from unnecessary legal and tax issues regarding their assets.

In 2003, Attorney Phancao participated in the largest tax case of 2003 for an individual. From there, his experience grew in the fields of estate planning, asset protection, and elder law / medicaid applications. Mr. Phancao takes great pride in putting his client's "voice" into their estate plan, creating a lifetime legacy for future generations that reach far beyond mere wealth.

CHAPTER 13

WHEN YOUR FRIEND BECOMES YOUR ENEMY

BY ANTHONY D. CASTELLI, ESQ.

A hard working nurse was riding her motorcycle when a car going in the opposite direction turned directly into her path. The nurse had no time to stop her motorcycle to avoid the collision, so she laid her bike down and slid into the car. Her leg was shattered. It required surgery to put the bones back together.

The insurance company for the car driver made contact with the nurse right away. They paid for her motorcycle. They offered alternative transportation but of course she could not use it since she was too badly injured to drive. They offered to pay any out-of-pocket medical expenses

that she incurred and even offered to pay her lost wages.

They told her that they would like to make a settlement with her when she was ready, and that although she had the right to hire an attorney, they would like to work with her first. They really did not see the need to have an attorney take a fee out of her settlement.

So the nurse tried to work with the insurance company. She figured, 'What do I have to lose?' They had been nice to her so far, so why would she need the help of an attorney, especially when she had to pay an attorney's fee, which meant - she thought - she would take home less money. She *believed* the insurance company would make her a fair offer.

So the day came when she was ready to settle. Much to her shock and displeasure the insurance company offered her only $70,000.00. This was not much more than the medical bills and lost wages she had incurred.

She had thought the insurance company was her friend. After all, they paid for the motorcycle and had done a lot of nice things and said a lot of nice things, but she felt 'in her gut' that this settlement offer just was not fair.

She came to me and wanted to know what I thought. Was there anything I could do to get a better settlement? Since she had been treated some time ago, I was able to look at some of her medical records describing her injury. I could also listen to her story and determine that she was still having significant trouble with the leg, and it appeared that these problems would be permanent.

The insurance company told her that there really was not any reason to hire an attorney. They said that they had eval-

uated the case fairly, and it was unlikely that the attorney could get her any more money. Furthermore, they told her that the attorney would take a fee. Finally, they made some 'noise' about the fact that she laid down the bike. They said if she would have been a better motorcycle rider, she could possibly have avoided the accident. And …'this accident could be partially attributed to her.'

Based upon similar kinds of injuries, results, verdicts and settlements I was familiar with, it was easy for me to see that her case was likely worth two to three times what the insurance company was offering. I felt so strongly that I based my fee on 50 percent of the amount in excess of the offer, not to exceed one-third of the total recovery.

Have you ever heard of the saying "You can catch more flies with honey than you can with vinegar." That's exactly what the insurance company was trying to do. They were hoping by acting as her friend and moving fast and doing something positive for her that she would not go to an attorney. They wanted her to blindly take a lowball offer – thinking it's a fair offer from a friend.

Why do the insurance companies do this? Because insurance companies have found by acting as your friend you are less likely to seek an attorney and they will save money on settlements.

Insurance companies' entire claims philosophy behind acting as your friend, or, as my mentor used to call it, "The Love Affair", is designed to keep you away from hiring an attorney. This "Love Affair" is driven by this underwriting fact stated in insurance companies' own words – "a realization that the way we approach claimants and develop relationships will significantly alter representation rates and

contribute to lower severities." Translated, this means that if the insurance company can keep the injury victim away from hiring an attorney, they do not have to pay as much.

In fact, an Allstate insurance company document states that gross payments to 'represented' claims range up to twice the size of 'unrepresented'. Indeed another insurance document states that 'represented' claimants get paid as much as three times what 'unrepresented' claimants get paid.

Yet another insurance industry study found that attorney-represented claimants account for a disproportionately high amount of the total claim dollars paid for most injury categories. For instance, although BI (Bodily Injury) claimants who were represented by attorneys accounted for slightly more than only one-half of all BI claimants, these claimants received more than 80 percent of the total dollars paid for bodily injury coverage.

Thankfully, the nurse decided to call the insurance company's bluff before it was too late, although by waiting she had created a problem. It was too late to track down any witnesses to the accident. So the only witnesses were the car driver and his wife and the nurse. We needed to prove that my client had acted reasonably, wasn't speeding, and could not have stopped in time even if she had *not* laid down the bike. It would have been nice to have an independent witness to state that the car turned right in front of my client just as my client entered the intersection, and that there was nothing that my client could do. But, unfortunately, any witnesses were long gone.

I filed the lawsuit, submitted written questions called interrogatories, and then took the sworn statement of the car driver. Luckily, the police had taken a statement from the

car driver. I used this to 'nail home' the fact that he never saw my client. Therefore, he could not estimate her speed, nor the distance from him when he made the turn. It became clear that he did not see what was clearly there to be seen and that he was surely at fault. Moreover, some of his statements in deposition indicated that he would make a very poor witness at trial.

We further developed stronger evidence as to the nature and extent and the long term effects that my client's injury would have on her, by working with her doctors. We got the complete medical records and specific answers to our questions from her doctors about her future problems with her leg. By alternative dispute resolution, we were able to get a substantially higher settlement. Even with my attorney fee, my client netted out much more than she would have if she would have taken the insurance company's $70,000.00 offer.

Many people are not so lucky. Many unsuspecting people have blindly taken the insurance company's offer without realizing that it was terribly low. Others decide to talk to an attorney when it's too late in the process. The attorney has no time to evaluate the case and tell them what it would probably be worth and whether a better offer is probable. Potential witnesses disappear. The insurance company raids your private records, with authorizations you have given them to get your doctors' records, and even statements from your doctor. Mistakes are made that decrease the value of the case.

So how do you protect yourself from "The Love Affair … When Your Friend Becomes Your Enemy?" First of all you need to know some of the tricks they use. Here are eight:

1. Immediate contact with you, paying for your car,

and offering alternative transportation.
2. Offering sympathy for your injuries and recognition of the inconvenience they are causing you.
3. Assurances that they will pay your out-of-pocket bills and expenses that are related to the accident.
4. Stating to you that they want to settle the claim quickly and fairly but at your own pace.
5. Frequent contact to check your status – along with the question …'Are you ready to settle or not?'
6. Face to face contact with you.
7. Taking a statement from you as well as having you sign medical releases, so they can gather all your medical records, bills, employment records and even your own doctor's report.
8. Telling you that some people hire an attorney but that it is not necessary. They would like to work with you directly to settle the claim as an attorney commonly takes up to 40 percent of the total settlement expenses. (Generally, attorney fees are less than 40%.)

If you are not ready to settle when they give you an offer, they will attempt to determine why you are not ready to settle. Then they work to overcome your will in that regard. Here again, your enemy slyly still tries to pass as your friend.

Here are five things that the insurance adjuster may do to get you to settle, even though you may not feel ready or do not feel that they settlement offer is right:

1. Offer to compensate you for wage loss and medical bills and inconvenience to date and allow you to keep your claim open for future medical bills for another six months.

2. They will say that they do not blame you for being concerned about the settlement amount as most people do not understand how it is determined.
3. They may tell you not to mistrust them as their claims philosophy and claims handling has changed and their goal is to provide you with quality service and a fair offer.
4. They may tell you that "Haven't we treated you fairly so far? So why would you question that the figure we offered is not fair?"
5. If all of this fails they may dare you to seek the services of an attorney but tell you not to let the attorney take anything out of the settlement they have offered. Or the insurance company may say …this is our best offer and hiring an attorney will not change our offer.

At this point, they think that your resolve will be overcome, and you will settle. Many people do settle without ever talking to an attorney. Some injury victims will find an attorney that is willing to take their case, but wants their fee to be taken out of the full settlement. A few luckily will find a competent attorney that has an opportunity to fully evaluate the case by reviewing the medical records. You may be able to find an attorney that thinks that your case is worth much more and will only take a fee out of any recovery in excess of the offer. That is how I sometimes handle the cases that have <u>not</u> been ruined by delay. The problem is that it may be way too late for an experienced trial attorney to do anything. So, having been taken in by your "friend" that has become your enemy, the only option is to take the low-ball offer.

Here are seven tips to help you avoid being taken in by "The Love Affair":

1. Always know that the insurance company never was your friend and never will be. That is because your interests are directly in conflict. They want to pay you as little as possible. They exist to make a profit. They do this by taking in premiums and paying out as little as they can on claims. You deserve a fair settlement commensurate with the kind the best attorneys in your area are able to get for their clients.
2. The insurance company wants to keep control over you so that you do not get an attorney. In their own words and studies, you may be able, with a skillful attorney, to get two to three times what the insurance company is willing to offer, depending on the circumstances.
3. An experienced personal injury trial attorney knows how to guide and advise you. When the time is right they can evaluate your case and give you an informed opinion about what amount of money should be offered to compensate you for your injury. Your attorney can fully document your injuries and prepare a comprehensive settlement brochure with a reasonable demand. If the insurance company comes back with a low ball offer and negotiations fall through, your attorney can reject the offer and file suit.
4. If you delay in seeking an attorney's advice some important evidence may be lost and you may make a mistake that negatively affects the value of your claim forever.
5. The attorney has a selfish interest to help you get as much money as they can. Since most attorneys take these cases based upon a percentage of the recovery, commonly one-third, but not always, the

attorney has every incentive to get as much money for you that is fair and reasonable.

6. If you do not hire an attorney you are relying on the enemy to advise you. Remember this phrase, "Do Not Sleep With The Enemy!"
7. If you do not hire an attorney, your only option will be to take the insurance companies' low ball offer.

If you want to work with the insurance company and see what their offer is and then take it to an attorney, it could easily blow up in your face. You must know exactly what step to take at every twist and turn. You must not make any mistake that could cause your case to be permanently devalued. You must not miss the important time limits that would cause you to lose your case totally. You may not be able to find an attorney who is willing to take your case with so much water over the dam. With so little time to evaluate and prepare your case, you may not be able to find an attorney willing to take your case, even though your offer is low.

Here is my wish for you. That you no longer think the insurance company is your friend and get fooled into taking a low ball offer. My goal in writing this chapter is to educate you about your best course of action if you have a serious injury. Every case does not require an attorney. I often tell people if they have a small case, such as an injury that only requires an emergency room visit and perhaps one or two follow-ups with a doctor or a few chiropractic visits, that I will not take their case because I cannot add value to the case. This is because the injury is too small and small injuries only are entitled to a small amount of money, whereas serious injuries are entitled to significant compensation.

Now you know that if you have a serious injury, the insur-

ance company is going to romance you so you do not hire an attorney – so they can pay you as little as possible. If you hire an experienced accident injury trial attorney you can probably get enough money to more than compensate you for the fee they earn.

ABOUT ANTHONY

Anthony D. Castelli, Esq. is a Greater Cincinnati bodily injury accident trial attorney. With 29 years of experience, he knows that the best way to get the best settlement for his clients is to prepare every case as if it is going to trial. This gives his clients a position of strength in the negotiation process, and makes it more likely they will receive a fair settlement, without the necessity of going to trial.

Anthony's focus is on client service. This means if he decides to take your case, his focus is on you throughout his representation. Anthony understands your injuries can affect every area of your life and he works to keep your case moving towards a favorable result. That is why he promises… "To fight with all of his heart for you." With hundreds of client settlements for thousands of dollars, and over 25 civil jury trials under his belt, Anthony is uniquely positioned to fight big insurance companies for injury victims.

Anthony is one of relatively few attorneys to have a jury verdict in excess of $1,000,000. This case, Bowling v. Heil, was about a young man who lost his life as a result of a defectively-designed dump truck. This landmark case went all the way to the Ohio Supreme Court and helped define product injury law in Ohio. More importantly, the money recovered helped a proud and courageous young widow raise her five children without resort to welfare or handouts.

If you are looking for a lawyer to be your legal counsel, friend, bodyguard, and warrior, look to Anthony and his team. It is noteworthy that one of his clients recently wrote Anthony a thank you note. It stated, "Dealing with you and your staff feels like dealing with family. I know that I am in good hands and will be treated with a warm smile. You took my case with nothing to gain, but fought for me with all your might. Thank all of you, I will never be able to put into words or monetary value what you all meant to me."

Anthony is active in the community. He has coached youth basketball and served on the Board of Directors of Power Inspires Progress and Serenity House. He also has mentored area high school students.

Anthony dedicates this chapter to his wife, Victoria, the love of his life. She brought him a loving stepson Mitchell, a Fulbright scholar; son Anthony, a basketball player and boxer; and daughter Kennedy, his beautiful ballerina.

You can learn more about Anthony through his website: www.castelli-law.com. There, you can also find educational articles and videos about personal injury cases — including car, truck, and motorcycle crashes and serious bodily injury cases.

Or you can call Anthony toll free at 1-800-447-6549.

CHAPTER 14

SEVEN 'SNEAKY' WAYS INSURANCE COMPANIES SABOTAGE YOUR INJURY CLAIM

BY TIMOTHY R. MILEY, ESQ.

You're in good hands with Allstate……..
Nationwide is on your side……..
Like a good neighbor, State Farm is there…….

You probably recognize these slogans from thousands of television commercials sponsored by three of the largest insurance companies in the United States – Allstate, Nationwide, and State Farm. Believing these slogans makes you

no different than thousands of other unsuspecting citizens who fail to proceed with caution when dealing with insurance companies. It is naïve to expect an insurance company to treat you fairly, with kindness, and generously. You will ultimately learn that insurance companies put their own interests ahead of yours – they are not on your side. Even your own insurance agent owes his or her loyalty to the company and not to you.

If you are injured because of someone else's negligence and are forced to deal with an insurance company, you should expect to find that….

- Allstate's hands are actually **tightly clenched fists** refusing to pay for your injuries…..
- Nationwide is on its **own** side (**not yours**)…… and
- State Farm is the **nightmare neighbor** that makes you want to sell your house.

I have been an attorney for nearly 20 years. The first ten years of my career I worked for law firms representing insurance companies. I saw firsthand how insurance companies used certain 'sneaky' techniques to prevent someone like you from receiving little or no money for their injury claim. Some of these 'sneaky' tricks were used to settle an injury claim very cheaply and for less than its fair value, while others were used in trial for the purposes of destroying the credibility of the injured victim.

Given my experience working for insurance company law firms, I will share with you seven sneaky ways that insurance company lawyers undermine your injury case, hoping that you receive as little as possible for the harms and losses suffered by you and your loved ones.

SNEAKY TRICK #1:
INSURANCE COMPANIES MAKE YOU BELIEVE THAT THEY 'JUST WANT TO FIND OUT WHAT HAPPENED'

Rev. Gary Smith was what anyone would consider "the salt of the earth." He was a country pastor who had dedicated his life to running a Mission for rural West Virginians. Gary did not care about money – he had given all of his to the Mission. One day he was shopping in a local retail store when he fell on a soap-like substance on the store's tile floor. As a result, his leg and back were injured, requiring very expensive medical care. The evidence suggested that the store was aware of the soap, but had not taken the time to clean it up. However, knowing that he had nothing to hide, but realizing that he could not afford to pay for his medical care, Gary volunteered to give a statement to the store's liability insurance company. During that recorded statement, taken by a veteran insurance adjuster who knew exactly what she was doing, Gary was confused and was made to sound as if he was aware of the soap before he fell and therefore should have avoided it. Needless to say, the store's insurance company denied Gary's claim based upon the statement and left him with tens of thousands of dollars in unpaid medical expenses.

****

The 1st, and most common sneaky trick that insurance companies use to undermine your injury case, is to have one of its adjustors contact you immediately after an accident (sometimes even before you have filed an injury claim), wanting you to give a recorded statement. Adjusters typically try to convince you that their only purpose in taking a recorded statement from you is to "find out what happened." This is not entirely true. The goal of an insurance

adjustor who is taking your statement (usually by phone) is to: (a) confuse you so that you might admit that you don't really know how the incident happened that caused your injuries, (b) 'guilt' you into admitting that you did something wrong to cause your own injuries, (c) get you to admit that you are not injured or, if you were injured in the accident, you have fully recovered by the time you give your recorded statement, or (d) all of the above.

Based upon my experience as a former insurance company lawyer, you should **NEVER** give a recorded statement to an insurance adjustor. Why? The only information that an insurance adjustor cares about obtaining from you is that which will hurt your injury claim. In all my years working for insurance companies, I have never seen the contents of a recorded statement help someone's injury claim.

Think about it – much of the relevant information needed by an insurance company adjustor can be found in: (a) a law enforcement crash report which will determine the cause of an accident (if dealing with a car accident), or (b) in your medical records which will detail the nature and extent of your injuries. Despite alternative methods of capturing information necessary for the adjustor to evaluate your injury claim, he/she will still try and convince you to give a recorded statement over the phone.

In a typical interview, the insurance adjustor will contact you and ask how the incident which caused your injuries occurred. During that part of the conversation, the adjustor may try and confuse you and get you to say that you are not sure as to how certain facts occurred. Sometimes, the adjustor will make you feel guilty about bringing the claim and convince you that you did something wrong to cause

your own injuries.

The second part of the recorded interview consists of the adjustor asking how you are feeling from your injuries. In my experience, it is at this point that almost everybody falls victim to sneaky insurance company trick #1. Specifically, most people respond that they are feeling "pretty good." I have represented many clients who have already given statements to insurance companies before hiring me and, without exception, when they told the insurance company that they felt "pretty good" it was meant only to be a description of how they were feeling in comparison to how they felt immediately following the accident.

For example, if the injuries caused by an accident reduced your quality of life to 50%, then recovering up to 75% of your quality of life is a significant improvement above your initial condition. However, it is still substantially less than 100% recovery. The reason why this is significant is that, later during the course of your claim process, the insurance company will have the interview transcribed and when your answers are read, it will appear as if you are stating you are "feeling pretty good." When your statement is later shown in court, a jury will think that "pretty good" means fully recovered and that any claim you make to a jury for any medical bills, pain, or suffering made **after** the date you gave your statement will likely be rejected.

RULE TO FOLLOW: Never give a statement to an insurance adjuster because it will only be used against you. Most, if not all, of what the insurance company needs to know can be obtained from other sources, such as the Police Crash Report, your medical records, etc.

SNEAKY TRICK #2:
WAITING FOR YOUR INJURIES TO HEAL WILL KILL YOUR CASE

Charlie, a 53-year-old construction worker, was on his way home from work on a Friday afternoon when he was rear-ended by another driver. Charlie was startled at the scene, but his adrenaline kept him from feeling any pain. When asked by the police officer that responded whether he wanted an ambulance called to the scene, Charlie declined. The officer indicated in his report that Charlie was not injured, which Charlie didn't find out about until much later.

Charlie did not go to the emergency room that evening even though he began developing pain and stiffness in his neck – like many, he was stubborn and did not want to incur substantial medical bills. He also thought that with some rest over the weekend, a heating pad, and some Advil, he would be fine. Over the weekend, Charlie avoided any strenuous activity, but his condition did not get better. By Monday morning when it was time to go to work, his neck was still sore and stiff, nonetheless, he had to work to earn money to support his family. About a month later, Charlie began noticing numbness and tingling in a couple of his fingers on his left hand. For the next three weeks Charlie continued to have the same problems with no improvement.

Because he wasn't showing signs of improvement and he didn't know what to do, Charlie called his family doctor, who scheduled an appointment for Charlie a week following Charlie's call. He relayed to his doctor the problems he was having with his neck as well as the numbness and tingling in his fingers. His doctor referred him for an MRI, the result of which revealed a herniated disc in his neck. He was referred to a neurosurgeon and ultimately Charlie

had surgery. The insurance company denied his claim by arguing that, because Charlie did not seek treatment immediately following the car accident, Charlie's condition was caused by something other than the car accident, such as a work related injury, his age, or the pre-existing conditions in his neck.

This injustice could have been prevented if Charlie would have only sought medical attention shortly after the crash.

****

The 2nd sneaky trick that insurance companies use to deny or to undermine your injury claim is to place unfair emphasis on, and blatantly mischaracterize, the reasons why you may have delayed in getting treatment for your injury. Specifically, the insurance company will argue (either with you, your attorney, or in front of a jury) that if you were injured in a crash, you would have obtained medical treatment immediately after the crash, or within a very short period of time following the crash. The basis the insurance company makes for its argument is that: (a) if you were truly injured you would've sought immediate medical relief, or (b) because the accident was someone else's fault you should've received medical treatment because the responsibility for paying the cost of such medical treatment will be borne by somebody else. However, there are many reasons why you may not seek to get immediate medical treatment.

First, you may believe that you were not seriously injured and that the injuries you received will heal on their own, with time. If your injuries don't fully heal, you are then forced to schedule a doctor's appointment, which may take a couple of weeks.

Second, you may not want to incur the costs of medical care because you don't have health insurance. The insurance company of the person who caused your injuries will certainly not pay for the medical bills until you have recovered, and maybe not even then. Nonetheless, even though the other person may ultimately be responsible for your injuries (and the payment of the medical bills in treating those injuries), you may still have to pay for the medical costs up front if you don't have health insurance coverage. Even if you have insurance coverage, there is likely a co-pay that you will have to make.

Third, you may not have sick leave (or enough of it) at your place of employment that would allow you to take the time off work to get medical care (even if you have health insurance coverage). In that case, you are forced to make a tough choice – risk losing your job or, at the very least, go without pay, or get medical treatment. In some instances, you may just suffer through your injuries and keep working to earn money to support your family. On other occasions, you will need to get the medical treatment and may be forced to go without pay from your employer.

As you can see, these are not easy choices and because your circumstances may differ from somebody else's, the choice you make to get treatment is a very personal decision. In any event, you can see how the insurance company will manipulate and mislead a jury into believing you delayed getting treatment because you were not injured.

RULES TO FOLLOW: Always get examined (or treated) following an accident to be sure any injury receives prompt medical attention. Additionally, NEVER hire a lawyer to represent you in your accident claim until **after** you have

been examined or begun receiving treatment. You do not ever want to be accused of receiving medical care because a lawyer advised you to do so. The decision to receive medical care can only be made by you or in conjunction with a medical professional.

SNEAKY TRICK #3:
LACK OF CONTINUOUS TREATMENT IS THE KISS OF DEATH

John and Mary, who were dating, were both injured in a crash. Both were treated at the scene, were immediately examined at a local emergency room, and both followed up with their respective family doctors. Both were advised, separately, to go to physical therapy. After the first month of therapy, with some improvement in his condition, John missed three weeks of physical therapy appointments. After the gap, John returned to therapy and treated for two more months before reporting a complete resolution of his symptoms. Mary's treatment with her physical therapist, however, was continuous over a three and a half month period before she was better and released from care.

At trial, the insurance company's attorney argued that John must not have been hurt that bad since he skipped three weeks of physical therapy. John tried to explain that his only vehicle was demolished by another car while it was parked on the street and it took three weeks to repair. When it was finally repaired, he immediately returned to therapy. He had no one to depend on for rides and he stopped seeing Mary shortly after the crash.

After a several day trial, the jury returned verdicts in favor of both clients. While the verdict for Mary was fair, John's

verdict was not. Jurors later reported that the crucial difference between the two cases was John's gap in physical therapy treatment.

****

As mentioned above, if you are hurt in a crash it is critical that you seek prompt and appropriate medical treatment. It is just as critical that you continue to receive **all** treatment necessary in order for you to fully recover from your injuries. The 3rd sneaky trick that insurance companies and their lawyers use is to question the legitimacy of your complaints of pain and injury if you fail to completely follow the course of treatment that was prescribed for you by your health care provider. Lawyers for insurance companies will always point out to a jury when you fail to completely follow through with the treatment plan provided to you by your healthcare provider. The reason? That lawyer would argue to a jury that your health is the most important thing in the world, for without it, everything else in life suffers. Therefore, if you are injured in an accident that was someone else's fault, and you skipped treatment appointments or failed to completely follow through with prescribed treatment, then the jury should, and could, only assume that you were fully recovered from your injuries and that continued treatment was unnecessary.

RULE TO FOLLOW: Do not allow there to be any interruption in your treatment without a good reason. In the absence of a death or critical injury in your family or your own illness, there really is never a good reason not to completely follow the advice of a medical professional and fully complete your treatment plan, regardless of how you were hurt.

SNEAKY TRICK #4:
PRIOR COMPLAINTS WILL BE USED AGAINST YOU

Gary had the misfortune of needing to have neck surgery – he had a physically demanding job and he injured his neck, requiring the surgery. He was lucky, however, that there was a world-renowned neurosurgeon at the state university hospital who performed the initial surgery to repair the herniated disc in his neck. Following the surgery, Gary attended physical therapy and reported to his doctor that his condition was improving tremendously. All of his medical records supported this. He was anxious to return to his job because the time off was creating some financial burdens, he loved his job, and it provided him a tremendous feeling of self-worth.

Sadly, a couple of weeks before he was to return to work, he was hit in the rear by a large truck while he was stopped at a stop sign. The problems in Gary's neck, while close to resolution before, had worsened afterwards. When he returned to his neurosurgeon following the accident, it was determined that he had another disc herniation, at the level of his spine immediately above the level where the prior surgery was performed. Accordingly, at his doctor's suggestion, he underwent a second neck surgery. However, this time his recovery was very limited due to now having two levels of his spine fused with plates and screws. He underwent therapy following the second surgery, but it was unsuccessful. He remains in significant pain and has been unable to return to work.

He filed a claim with the insurance company for the truck that rear-ended him. With the medical records and bills from the second surgery, Gary also provided the insurance

company with records of his prior surgery. The records regarding his initial neck surgery demonstrated a significant improvement and a course plotted for his return to work. Gary even submitted a report from his doctor - the world renowned neurosurgeon who performed both surgeries – which stated unequivocally that the second herniation was not present at the time of the first surgery and was caused by the rear-end collision with the truck. The report further stated that Gary had progressed significantly following the first surgery, that he was about to go back to work, but that due to the second surgery he has been rendered unable to return to any physical labor of any kind.

Despite the evidence presented and in the face of the opinion of an immensely respected neurosurgeon who performed both surgeries, the insurance company chose to deny the claim and force Gary into a lengthy and expensive litigation process.

****

The 4th sneaky way in which insurance companies destroy your injury claim is to convince a jury that your injuries were caused by conditions that existed **prior to** the accident for which you are making a claim. This is what is referred to as a pre-existing condition.

You may have been involved in an accident that caused neck, back, shoulder or other joint injuries. These areas of your body are commonly injured in any collision with a high degree of force. However, it is also common to injure a part of your body in a car wreck that has troubled you in the past. The older you are, the more likely it is that you made some previous complaint of pain to a certain part of your body. The fact that there is a previous complaint of

pain in that part of the body which was later injured in an accident shouldn't undermine your case. However, insurance companies use such 'pre-existing conditions' to either deny your claim or offer you substantially less than what you should receive based upon your injury.

Here's how the insurance company tricks and deceives you. When you submit an injury claim to an insurance company, it has the right to review your medical records and bills to appropriately determine the nature and extent of your injuries and, hence, the value of your injuries. If your medical records reveal prior treatment for a complaint to the same part of your body that is now injured, your injury claim will likely be denied. The insurance company will assert that your current pain and discomfort is not caused by the recent accident, but rather, is due to a condition that existed prior to the injury-producing event. At the very least, the insurance company will argue that the current injury-producing event only made the condition slightly worse than how it existed prior to the accident.

You can overcome these insurance company tricks by: (1) articulating very clearly how the pain in your body has changed pre- and post-accident; (2) comparing the nature, extent, type, and frequency of pre- and post-accident treatment for your condition, (3) have your treating doctors describe the differences in your pre- and post-accident condition, and (4) have your family, friends, co-workers and neighbors describe your condition pre- and post-accident. Sometimes, these 4 methods may not be enough to overcome the insurance company's objection to fairly compensating you for your injuries. If not, then you may need to hire a lawyer to represent you.

You should note, however, that your injury claim can be destroyed if you **deny** past treatment for that same body part that was hurt again in the crash. If you make any attempt to deny the existence, or minimize the impact, of a pre-existing complaint or condition involving the same part of your body, then your credibility is destroyed and a jury will assume that you are lying about any increased pain or discomfort caused by the accident.

Juries give better results to individuals who embrace and are up front about pre-existing complaints of pain and talk about how the crash worsened or re-injured the condition.

RULE TO FOLLOW: If you find yourself in a position of having experienced an accident that caused you injury to an area of your body that previously received medical care, you need to be able to articulate, and support with evidence, how your condition and pain in your body has changed pre- and post-accident, as well as how the changes have affected your life.

SNEAKY TRICK #5:
GUESS WHO IS SPYING ON YOU!!!

Robert Wilson worked tirelessly at a local plant for almost 25 years. All of his friends and family agreed that Robert never complained and that you would just about have to kill him to keep from getting up in the morning and going to work, regardless of how he felt. The perfect attendance plaques given by his employer still hang on his wall. However, a serious car wreck left him with a very real and debilitating back injury. After months of recovery, including physical therapy and painful injections, Mr. Wilson reached the point where he could begin to try to do things

around his home and his yard. He insisted on being active and helping out, even though it left him in pain.

What Mr. Wilson did not know was that the insurance company hired an investigator to spy on him and video tape him every time he left his home. When the videotape was professionally edited by the insurance company, it painted a very misleading and false impression of Robert's injuries – essentially suggesting that he could do what he wanted when he wanted. Needless to say, the portions of the video tape which reflected Mr. Wilson in pain and discomfort were left on the editing room floor. As a result, the insurance company attempted to use the tape to strong arm Mr. Wilson by offering him much less compensation than he deserved.

****

The 5th sneaky way insurance companies will destroy your injury claim is to hire a private investigator to put you under surveillance for any physical activities in which you engage following an accident. Typically this means that you are videotaped from a distance and you do not know you are being watched.

What happens is that an investigator may take hours and hours of surveillance video of you and not find anything in your activity that can be perceived as inconsistent with your condition and/or injury. However, if an investigator is able to capture even a few seconds of video of you engaging in some activity or act that would seem to be inconsistent with your complaints of pain or discomfort, then the sneaky insurance company will play that few seconds of video to try to persuade the jury that it is an example of the type of activity that is typically done every hour of every day.

To avoid this trap, assume that following the accident and the submission of your injury claim to the insurance company, that every move that you make is being watched and videotaped. By operating under this assumption, you will obviously know what, if any, physical activities you performed that may have been caught on videotape.

Also, there will likely come a time when you are asked questions about the effects your injuries have had on your life. It is imperative that you not deny the ability to do a certain physical activity if you have ever done that act at any time following your injury. Be certain to recall as accurately as you can everything you have done, even if done for only a few short moments. Obviously, if you ever deny being able to engage in certain activities that are caught on videotape, a jury will not only question the integrity of your testimony on that particular issue, but it will cause your entire injury claim to be undermined and your case lost.

Additionally, if you are later asked, either in an interview or in a deposition or in trial, whether you are able to perform certain activities, it is important that you identify those activities that: (1) you are absolutely not able to do at all, (2) you are able to do but with much less frequency, intensity, and duration, (3) can be done but are done so with pain and discomfort, and (4) can be done without any limitation or discomfort. By doing so, you will be in a position to explain any of your activity that may have been caught on videotape.

RULE TO FOLLOW: Assume that everything you do after an accident is being monitored. Never embellish on the severity of your injuries, especially the physical activities that you can or cannot do.

SNEAKY TRICK #6:
ARE YOU ALLOWED TO HAVE FUN IF YOU ARE INJURED?

John and his wife of 43 years had four grandchildren. Unfortunately for John and Betty, their grandchildren all lived in Florida. Because of the distance and the cost of travel, John and Betty only went to Florida to visit once per year. Because these trips were typically the only times they could get to see their grandchildren, they were planned out long in advance of the actual trip. Arrangements were made to board their dogs, routine maintenance was performed on the cars, and plenty of presents were purchased so John and Betty could spoil their grandkids when they arrived in Florida. For John and Betty, their annual trip to Florida to see the grandkids was better than Christmas.

Unfortunately, several weeks before one of their anticipated trips, John was involved in a car accident, caused when a careless teenager was trying to "text" while he was driving. The teenager ran the red light and t-boned John's car. The impact was significant and John felt immediate pain in his lower back. John continued to hurt and followed up with his doctor over the next several weeks. He and Betty had a long talk about his injuries and whether they could or should still make the trip. John had great difficulty sitting for more than an hour or two without having excruciating pain and numbness in his back and down into his legs. Despite this, John and Betty decided to proceed with their trip. They did not know when John would feel better and did not want to have to wait another year before seeing the kids again.

John let Betty do the driving on the trip to and from Florida. He took the medication his doctor had prescribed. Frequent stops were made so John could stand up and stretch his legs.

For much of the way, John laid in the back seat, stretched out with pillows, trying to find a comfortable position. It was a good thing John and Betty stayed for a week, because John needed that much time just to regain his strength for the trip home. While they had hoped to take the grandkids to the beach and to Sea World, John did not feel up to it. He enjoyed visiting with his son, his daughter-in-law, and the grandkids, but quite frankly John did not feel up to doing much at all while he was there.

Unfortunately for John, the insurance company for the young man who caused the crash did not want to treat John fairly so he was forced to file a lawsuit. As part of the litigation process, John's deposition was taken. John was specifically asked about limitations that he experiences as a result of his injuries. John told the insurance company's lawyer about many affects the injuries had on his life, including the fact that he could not sit for long periods of time. John specifically said anything more than a couple of hours were unbearable and he could not do it. Later in the case, the same lawyer for the insurance company took the deposition of John's wife, Betty. When Betty was asked in her sworn testimony about any vacations they had taken since the crash, Betty answered that they had driven to Florida a few weeks after the accident to see their grandkids.

As you can imagine, the lawyer for the insurance company used these statements from John and Betty to attack the case. He first argued that John was not telling the truth about not being able to sit for long periods of time since he took a car ride to Florida. The lawyer for the insurance company also argued that, in fact, John wasn't really that hurt since he was able to take a vacation within weeks of the crash. John's credibility was now attacked simply be-

cause he was willing to live in agony to take a trip which had been planned long in advance and which presented him with a limited opportunity see his grandkids.

****

The 6th sneaky way in which insurance companies sabotage your injury claim is to investigate all types of activities in which you have been involved following the accident. That act alone is not underhanded and sneaky, but if the insurance company (or lawyer) find out that you participated in an activity that, on the surface, looks 'fun' or 'enjoyable', the insurance company will manipulate the facts and suggest that you were not hurt at all, or not severely, simply because you did something that appears to be fun. The types of activity to which I refer are family vacations, golf trips, hunting, jogging, bicycling, motorcycle riding, or any other type of "fun" activity. But, as you know, appearances can be deceiving.

As stated above, some of this fact-finding will be done with the use of surveillance video, while other types of information may be gathered from family, co-workers, and neighbors. During your injury claim, you may be interviewed, deposed, or give testimony under oath in court before a jury and will be asked about the activities in which you have engaged. If you are asked these questions, it is important that you do not deny engaging in certain acitivities that appear fun, but you must indicate how your injuries have affected your ability to engage in these activities. For example, do you now need assistance to do certain things that you never needed before? Do you have to now be in a position to be able to sit and stand as often as you need? Are you able to engage in these activities as frequently, or with

as much intensity, as you used to do? Are there certain 'fun' activities that you simply can't do because of your injuries?

Rest assured that, if you are asked about whether you have engaged in certain 'fun' activities, the insurance company lawyer will also ask the same questions of your family members, friends, neighbors, and co-workers. If any of their answers differs from yours, or you have not articulated the limitations you have doing such activities, your credibility and your case will be damaged and a jury and/or insurance company will not believe that you were injured.

RULE TO FOLLOW: Live your life and do what you can, assuming that it isn't contrary to doctor's orders. However, be clear about your capabilities and limitations following an injury.

SNEAKY TRICK #7:
FAILING TO DISCLOSE PRIOR ACCIDENTS AND PRIOR INSURANCE CLAIMS

Susan was a 39 year old, extremely healthy professional who liked to stay in shape by jogging approximately 20 miles/week. Unfortunately, she was in a car accident, caused when another driver ran through a red light t-boning Susan's car in the side. As a result of that accident, Susan felt excruciating pain in her lower back and left hip, was taken to the hospital by ambulance, and later treated by her family doctor, who referred her for physical therapy treatment.

Within a few days of the accident, Susan received a call from an insurance adjustor, who 'just wanted to find out what happened.' During the recorded interview, the adjustor asked Susan if she had ever had any prior complaints of

pain in the same area of her body. She was also asked if she had ever been involved in a car accident prior to the one for which the adjustor was calling. Susan answered "no" to both questions.

After Susan finished her 3 months of physical therapy treatment, she attempted to negotiate with the insurance company adjustor to settle her injury claim. The insurance adjustor offered to pay Susan for her vehicle damage, the cost of the ambulance ride to the hospital, and the cost of getting "checked out" in the emergency room of the local hospital. The adjustor firmly told Susan that she would not receive any payment for the cost of physical therapy, nor would she receive any payment for the 3 months of pain and suffering she endured. The adjustor based his position on the fact that Susan had previously made a claim for injuries after being hit by a vehicle when she was 16 (she was a pedestrian) and having made an injury claim at that time. The adjustor claimed Susan lied about never having filed a claim for injuries or ever having been in a car accident. Susan was outraged and couldn't believe that the adjustor was accusing her of lying – Susan had forgotten about the incident that happened 23 years prior. Also, Susan's parents filed the injury claim on her behalf and she never really understood what happened as part of that process. Finally, the minor injuries she received when she was 16 years old healed and never gave her any further trouble. As a result, Susan was forced to hire a lawyer to pursue her case against the insurance company.

****

The seventh sneaky way insurance company lawyers attack your injury claim is to get you to deny that: (a) you were

ever involved in any prior accident, or (b) you ever made any prior claim for injuries. You should know that there is a huge insurance database to which all insurance companies subscribe, and on which is a history of every claim presented to any insurance company. This database even includes claims for property damage, even if there were no injuries claimed from that accident. It also includes claims paid under the medical payments or personal injury protection (PIP) coverage of your insurance policy as well as any other claim for injuries you may have made against anyone else. As stated above, in presenting your injury claim, you will likely be interviewed, deposed, and/or give testimony in court regarding the injuries you have received from an accident. If you deny ever having been involved in a prior accident and/or deny ever having made any prior injury claim (and the insurance company finds out otherwise), your credibility and that of your injury claim will be destroyed and a jury will not render a verdict for fair compensation in your favor. You should operate with the assumption that the database to which insurance companies subscribe will reveal every claim for property damage or injuries that you have ever made.

RULE TO FOLLOW: Assume that the insurance company already knows about every claim that you have made in the past. Thus, do your best to remember everything so that you can report prior claims and injuries accurately and honestly.

ABOUT TIM

Timothy R. Miley, Esq. has practiced law for nearly 20 years. At first, Tim represented insurance companies. Currently, however, he represents injured people who are the victims of negligence. This unique background gives Mr. Miley the insight to know exactly how insurance companies delay, deny, and defend against injury claims brought by innocent victims. The emptiness Tim felt in representing insurance companies and denying worthy and deserving individuals from receiving fair compensation is what led him to abandon his insurance company work to pursue his passion of fighting for injured individuals against multi-billion dollar insurance companies.

Tim Miley is recognized by lawyers around the country as a highly-skilled lawyer representing individuals and their families who have suffered severe and debilitating injuries and wrongful deaths at the hands of careless individuals and corporations. Mr. Miley's practice includes representing individuals who suffer severe injuries as a result of careless drivers, tractor-trailer truck accidents, defective products, and medical malpractice. He has received in excess of $15,000,000 in verdicts and settlements on behalf of his injured clients and their families.

Additionally, since 2005, Tim Miley has represented West Virginia's 41st District in the House of Delegates where he focuses on preserving and creating laws that protect the rights of West Virginia citizens. Mr. Miley currently serves in the prestigious position as the Chair of the House Judiciary Committee which provides him the opportunity to stop laws that restrict or reduce the rights of individuals and consumers, especially those that provide immunity for negligent conduct.

Mr. Miley is a member of the American Association for Justice, the West Virginia Association for Justice, the West Virginia State Bar, and the Harrison County Bar Association. He resides in Bridgeport, West Virginia, with his wife, Susan, and stepdaughter, Jordin. Given his time spent fighting for clients and serving in the West Virginia Legislature, Mr. Miley finds very little relaxation time. When he does find spare time, Tim enjoys spending it with his family, travelling, golfing, bicycling, hiking, and whitewater rafting.

CHAPTER 15

INSURANCE BAD FAITH

BY BRENTON D. ADAMS, ESQ

There are special rules which govern the responsibility of an insurance company to pay claims.

Insurance companies are not allowed to drive a "hard bargain" with their insured. Some people feel that it is acceptable for an insurance company to negotiate the best settlement possible for themselves when attempting to settle a claim which arises under an insurance policy. Indeed, some insurance companies do try to drive a hard bargain with their insured, and try to get the most favorable settlement for themselves, even if the facts do not justify such a low settlement.

This type of conduct by an insurance company is not al-

lowed. What may be considered good negotiating tactics and 'fair game' for parties to a contract when an insurance company is not involved, does not apply to insurance companies.

The law imposes two separate requirements in each insurance contract. These requirements are in the contract by operation of law, and they apply even if the wording of the contract does not include these provisions.

These two requirements are that the insurance company must:

1. Act in good faith with respect to its insured.
2. Deal fairly with its insured.

This legally imposed obligation upon the insurance companies is sometimes referred to by lawyers as an insurance company's obligation to act in good faith and deal fairly with its insured. When an insurance company does not treat its insured fairly and does not act in good faith, this conduct is considered to be in bad faith. When an insurance company fails to act in good faith, the insurance company has committed a bad faith insurance practice and it is subject to liability beyond the insurance policy itself.

One court has defined bad faith as the opposite of "good faith." Good faith has been defined by the courts as: "An equitable concept premised on honest belief and fair dealings with another. Failure to act in good faith implies that an offending party's conduct will preclude another person from obtaining a benefit to which that person is entitled."

Another court has stated that: "Bad faith means not based on a legitimate, 'honest disagreement' as to the validity of a claim."

Good faith insurance practices requires that insurance companies treat the interest of its insured the same as its own.

It is not permissible for an insurance company to settle a claim for less than the claim is really worth just because they can get the policyholder to agree to a lower amount. It is not permissible for an insurance company to browbeat an insured into taking less than full value for their claim.

Certainly, reasonable minds can differ as to the true value of a claim. For instance, if a house is damaged by fire certainly reasonable minds can differ as to the nature and extent of the loss and the reasonable costs to properly repair the home. Most claims involve some element of subjective value. However, an insurance company's position must be reasonable and must be based upon a true evaluation of the facts. An insurance company has not committed bad faith if the position it takes on a claim is based on an honest disagreement or an innocent mistake.

In North Carolina and in most other states, a lawsuit based upon a claim of bad faith insurance practices involves three elements. In order to prevail on a claim for bad faith in connection with an insurance policy, the claimant must establish three things:

1. A refusal by an insurance company to pay after recognition of a valid claim.
2. "Bad faith" &
3. Aggravating or outrageous conduct.

Aggravating or outrageous conduct has been defined by the courts to include fraud, malice, such degree of negligence as indicates a reckless indifference to the consequences of these actions, gross negligence, oppression, rudeness, caprice, insult and willfulness. The burden of proving aggravating or outrageous conduct is not as difficult as it may sound. The courts generally hold that there is sufficient evi-

dence of aggravating conduct to support a bad faith claim when there is evidence that the insurance company failed to pay promptly and reasonably under the circumstances, "once liability had become reasonably clear."

An example of a case involving aggravating conduct is a North Carolina case in which the insurance company delayed paying a medical payments claim. The facts were that although the insurance company's liability for the medical payments claim was clear, the insurance company delayed payment and attempted to settle a related wrongful death claim for a low amount. The insurance company attempted to use the payment of the medical payments claim as a wedge to obtain for itself a favorable settlement on the wrongful death claim. In that case, the jury imposed $225,000.00 in punitive damages against the insurance company in a case involving a $2,000.00 medical payments claim.

In civil cases, there are generally two types of damages. The first type is compensatory damages which is intended to compensate or to fully pay the claimant for loss. The second type of damages is punitive damages. The only purpose of punitive damages is to punish wrongful conduct and to set an example for others so as to discourage wrongful conduct. In the case mentioned above, the jury felt that $225,000.00 was appropriate for punishment of the defendant insurance company, and to set an example for other insurance companies to deter or discourage such wrongful conduct. The Appellate Court upheld this punitive damages verdict as being proper.

The Association of Insurance Commissioners, a nationwide group consisting of insurance commissioners for the

various states of the United States have drafted a Code of Conduct for insurance companies to follow. This Code of Conduct has been adopted in most states with very little modification. This Code of Conduct is generally referred to in each state as the Unfair Claims Settlement Practices Act.

These Unfair Claims Settlement Practices statutes make it much easier for the consumer to get a fair shake from insurance companies and, if the consumer does have to take an insurance company to court, these statutes make it much easier for the consumer to win.

These Unfair Claims Settlement Practices statutes set out a laundry list of specific claims practices which are forbidden by law.

One of the forbidden practices is that an insurance company may not compel the insured to instigate litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insured. In other words, if an insured is forced to go to court because of a lowball offer and obtain the verdict "substantially" more than the pre-trial offer made by the insurance company, the insurance company has violated the law.

Another statutory violation would arise when an insurance company attempts to settle a claim for less than the amount to which a reasonable person would have believed he was entitled. Although this prohibition is somewhat subjective, if a jury were to find that an insurance company attempted to get the claimant to settle for less than a jury felt the claimant should recover, that is a violation of law.

It is a violation of statute for an insurance company to make

known to the claimant that it is their policy to appeal from arbitration awards in favor of the claimants, for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration. In other words, insurance companies may not use the threat of appeal to get a favorable settlement from the insurance company.

Another statutory violation would arise when an insurance company fails to properly settle claims for which liability has become reasonably clear under one portion of the insurance policy coverage, in order to influence settlement under another portion of the insurance policy coverage. This was the practice committed by the insurance company in the case referred to above involving the failure of the insurance company to pay a medical payments claim properly.

The statute also forbids misrepresenting pertinent facts or insurance policy provisions relating to coverage. In other words, insurance companies must not misstate or lie about the facts of the claim or the provisions of the insurance policy.

These statutes also make it a violation for an insurance company to fail to acknowledge and act reasonably promptly upon communications with respect to claims arising under the policies. In other words, an insurance company must not unreasonably delay working on the claim and must engage in reasonable communications with its insured.

These statutes require an insurance company to conduct a reasonable investigation based upon "all available information" before it refuses to pay a claim. This law puts an affirmative burden upon the insurance company to investigate the claim. It is not the insured's responsibility to investigate the claim. That burden rests with the insurance company.

These statutes also make it a violation for an insurance company to fail to either admit or deny coverage after a claim has been made. In other words, an insurance company may not legally string a policyholder along without stating its position on the claim.

Perhaps the most comprehensive and all-encompassing regulation is the one which makes it a violation for an insurance company to fail to attempt in good faith to effectuate prompt, fair and equitable settlements of claims for which liability has become reasonably clear. In other words, an insurance company must promptly investigate claims and must promptly make a good faith offer to settle the claim for the amount of the claim, not a compromised amount.

These illustrations above are not a complete list of the statutory violations under the Unfair Claims Settlement Practices Act of the various states. However, it is a good representative sample.

If you are having trouble collecting for a claim arising under your insurance policy, chances are the insurance has violated one or more of the statutory requirements set out above.

In North Carolina and in most other states, a violation of even one of the requirements and prohibitions of the Unfair Claims Settlement Practices Act is also an unfair and deceptive trade practice. North Carolina and most other states have enacted for the benefit of consumers a statute commonly referred to as the Unfair and Deceptive Trade Practices Act.

Under these laws, if a defendant has committed an unfair or deceptive trade practice, the victim of such conduct may recover three times those compensatory damages plus attorney's fees.

If a consumer has been a victim of unfair and deceptive trade practices by an insurance company, the consumer would bring two (2) causes of action in one lawsuit. One part of the lawsuit would arise from the failure of the insurance company to treat its insured fairly and act in good faith with respect to the claim. This is what lawyers call a "common law" claim. That is, the claim arose from a long history of court decisions by the appellate courts. If the bad faith conduct of the insurance company gives rise to punitive damages, the consumer can recover both compensatory damages and punitive damages.

The second part of the lawsuit will be based upon the Unfair Claims Settlement Practices Act. Under this Act, the consumer will be able to recover three (3) times the compensatory damages as well as attorney's fees. The attorney's fees will be set in the discretion of the court. This means that the judge may or may not award attorney's fees depending upon how the judge sees the case.

The law does not, however, allow the consumer to recover under both theories. The consumers must choose which remedy he or she would like. Fortunately, the law allows the consumer to make this election of remedies after the trial. Therefore, the consumer will know which theory will require the insurance company to pay the most money. Of course, the consumer will choose that theory which allows the highest reward.

These laws which allows consumers to sue and recover more than merely the amount due under the insurance policy are very beneficial. The effect of these laws is that insurance companies are more likely to treat their insured more fairly than they otherwise would, if these laws did not exist.

ABOUT BRENT

North Carolina lawyer Brenton D. Adams, Esq., has been representing individuals against insurance companies since 1973.

He is board certified by the National Board of Trial Advocacy and is a member of the Million Dollar Advocacy Forum. He has been selected as one of the top 100 trial lawyers in North Carolina by the American Trial Lawyers Association.

Mr. Adams has given lectures to trial lawyers at numerous seminars dealing with trial advocacy and trial practice issues. Among the trial lawyer organizations at which Mr. Adams has lectured are the North Carolina Academy of Trial Lawyers, The North Carolina Bar Association, American Association for Justice (formerly the Association of Trial Lawyers of America), Wake Forest University School of Law, ATLAS Lawyers Group and the prestigious Melvin M. Belli Seminar.

He has written articles for legal publications and institutions including Wake Forest Law Review, North Carolina Bar Association and American Association for Justice (formerly the Association of Trial Lawyers of America). In addition, he has authored books for consumers dealing with motor vehicle injury claims, workers' compensation law and medical malpractice.

Mr. Adams has a passion for representing injured and disabled people. His practice is concentrated in medical malpractice, motor vehicle collisions, product liability, disability insurance (including social security disability as well as private disability insurance policies), workers' compensation, and bad faith insurance practices.

Currently, Mr. Adams serves on the Board of Directors of the Southern Trial Lawyers Association.

He is past vice president of the North Carolina Academy of Trial Lawyers and past State Delegate to the American Association for Justice (formerly the Association of Trial Lawyers of America).

Mr. Adams is a graduate of Wake Forest University and the Wake Forest University School of Law.