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LEGAL UPDATE

May 2010

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A Brief History of Time-Limited Demands in Georgia and Implications of the Recent Fortner Decision

By Kristy Kramp and Elliot Tiller

Time-limited demands are quite common in personal injury claims. A claimant's attorney will make a settlement demand on the defendant for a certain amount of money, stating that the offer will remain open only for a set period of time, after which it will be stood considered rejected and forever withdrawn. When receiving such a demand, the insurance adjuster must give careful consideration to how he or she intends to respond based upon the information gathered about the claim and the requirements set forth in the demand. When deciding whether to settle the claim, an insurer must give equal consideration to its insured's financial interests as it does to its own economic interests, or it risks being liable for a bad faith claim.

In Georgia, an insurance company may be liable for an excess judgment entered against the insured if the insurer's bad faith refusal to settle a personal injury claim within the policy limits resulted in the excess judgment. Judged by the standard of the "ordinarily prudent insurer," the insurer is negligent in failing to settle if the ordinarily prudent insurer would have considered any attempt to try the case, rather than settling within the policy limits, to create an unreasonable risk.

Southern General Ins. Co. v. Holt is probably the case most relied upon by attorneys and the courts when discussing an insurer's duty to settle and when making time limited demands. In Holt, the injured party, Geneva Fortson initially made a demand on the Southern General Insurance Company for $30,000. The demand included medical bills and asserted claims for additional medical expenses and lost wages. Fortson's attorney withdrew the offer when Fortson entered the hospital for a ruptured disc.

LEGAL UPDATE is a review of recent judicial and legislative developments in areas affecting the insurance claims community. It is not the intention of LEGAL UPDATE to provide an exhaustive report on all cases relevant to insurance defense or to offer legal advice. Readers should not rely on cases cited in LEGAL UPDATE without checking the current status of the law. LEGAL UPDATE was created for clients of Goodman McGuffey Lindsey & Johnson, LLP and the possibility of circulation beyond the firm's clientele should not be construed as advertisement.

Several days later, Fortson's attorney requested information from Southern General regarding the limits of the policy. Southern General refused to reveal the policy limits, but requested information on the ruptured disc. After that, Fortson's attorney again offered to settle with Southern General for the policy limits, which were $15,000, and stated that Fortson's medical bills totaled more than $10,000 and her lost wages exceeded $5,000. With this offer, Fortson's attorney included doctor's notes showing that Fortson had a herniated disc and medical bills totaling $6,568. The demand stated that the offer would remain open for ten (10) days. Southern General did not respond within the allotted timeframe.

Fortson's attorney extended the time to respond to the demand for another five days and enclosed a certified copy of Fortson's complete medical records, but Southern General still did not respond. Two days after the offer was withdrawn, Southern General accepted the offer, but Fortson refused the late acceptance and the parties went to trial.

At trial, the jury awarded Fortson $82,000. The insured assigned his claim for bad faith against Southern General to Forston. The Supreme Court held that where there is clear liability and damages in excess of the policy limits, an insurance company may have a duty to settle the claim. If the insurance company fails or refuses to settle within the time allotted by the demand, an insurance company may be liable beyond its policy limits to pay an excess verdict if the failure to settle caused an excess verdict. The Court went on to state that, when deciding whether to settle a claim within the policy limits, the insurance company must give equal consideration to the interests of the insured.

The next important case after Holt was Cotton States Mutual Ins. Co. v. Brightman. In that case, the plaintiff, James Brightman, was injured in an automobile collision when he was struck by a vehicle owned by Lynn Martin and driven by Gregory Cumbo. Martin was insured by Cotton States Mutual Insurance Company, while Cumbo was insured by State Farm Mutual Automobile Insurance Company.

Brightman was cited for failure to yield the right of way and Cumbo was cited for speeding and causing a serious injury by vehicle. Police later charged Cumbo with driving under the influence based on a blood test that revealed the presence of marijuana metabolites in his blood. Brightman's attorney attempted to settle the case with Cotton States several times for $300,000, the limits of Martin's policy with Cotton States. Each offer stated that Brightman had sustained traumatic brain injuries and attached medical bills totaling $329,457.20. The last offer from Brightman's attorney stated:

> "We are willing to give Cotton States Mutual Insurance Company one last chance in which to settle this case for your policy limits of $300,000. **We will agree to accept your policy limits, contingent upon State Farm Mutual Insurance Company also tendering its limits of $100,000, for the next ten days.** If you have not accepted this offer within ten days from the date of this letter, then it is considered irrevocably withdrawn."

The ten day period expired without either Cotton States or State Farm offering to tender its policy limits. After the time had expired, Cotton States offered to pay its policy limits of $300,000 in exchange for a general release from Brightman and a dismissal of the complaint with prejudice. State Farm continued to deny coverage. Brightman declined to accept the offer by Cotton States.

At trial, the jury awarded Brightman nearly $1.8 million. Cotton States and State Farm each paid out their policy limits, leaving an excess judgment of over $1.3 million against Martin

and Cumbo. Martin assigned her bad faith claim against Cotton States to Brightman. Cotton States took the position that Brightman's demand was invalid or otherwise incapable of acceptance because the offer had conditions that were not under Cottons States' control.

The Court stated that if Cotton States had tendered its policy limits while the plaintiff's offer was pending, it would have done everything within its control to accept the plaintiff's offer, this protecting its policyholder from an excess verdict.

Brightman created a "safe harbor" for insurance companies in cases where multiple insurers are involved. In such cases, an insurance company can accept the portion of the settlement offer over which it has control in an effort to avoid liability for a potential bad faith claim.

In 2009, the Georgia Supreme Court further clarified its holding in Brightman. In Fortner v. Grange Mutual Insurance Company, the Supreme Court dealt with another bad faith claim against an insurance company for failing to accept an offer for its policy limits that was contingent upon another insurer paying a portion of the claim.

The facts in Fortner were slightly different from those in Brightman. In this case, the plaintiff, Cecil Fortner, was injured in an automobile accident by Alan Arnsdorff. Arnsdorff had a policy with Grange Mutual Casualty Insurance Company with a bodily injury liability limit of $50,000. At the time of the accident, Arnsdorff, a plumber, was driving a van owned by his plumbing company. The plumbing business had $1 million in liability coverage with Auto Owners Insurance Company .

Fortner offered to settle all claims against Arnsdorff for $50,000 from Grange contingent upon Auto Owners' payment of $75,000. Auto Owners did not respond within the time set forth by Fortner in his demand, but Grange responded that it would pay its policy limits of $50,000 contingent upon Fortner signing a full release with indemnification language and dismissing his claim against Arnsdorff with prejudice. Fortner considered this counter-offer a rejection of his offer and proceeded to trial.

At trial, a jury awarded Fortner $7 million for his injuries. Arnsdorff assigned to Fortner any cause of action he might have against Grange for bad faith in failing to settle. The Court agreed with Fortner that Grange's agreement to pay its policy limits for a general release was a rejection of the settlement offer and not an acceptance. These conditions would have required Fortner to forego any claim against Arnsdorff, thereby potentially forfeiting his access to the $1 million liability policy with Auto Owners. Thus, after taking into account Auto Owners $1 million in coverage, Grange incurred nearly $6 million in potential additional exposure *even though it had already tendered its policy limits within the time limitations of the claimant's demand.*

Plaintiffs' attorneys have not been slow to pick up on the potential implications of this decision. In our law practice, we have already seen at least one case involving an excess insurance policy where the plaintiff's attorney has successfully argued that an underlying carrier must tender its full policy limits *without receiving any release in return*. The plaintiff's attorney stated that requiring any type of release as a condition of a full tender of the primary carrier's policy limits – even a *limited* release, designed specifically (by statute) for precisely this type of situation – would be considered a *rejection* of plaintiff's demand and would subject the primary carrier to potential excess exposure under the Fortner decision. He reasoned that if plaintiff was forced to give the defendant even a limited release in exchange for the primary carrier's tender of its policy limits, the plaintiff would be precluded from pursuing a potential claim against the defendant's

excess carrier for bad faith failure to settle, since the defendant's own exposure to an excess verdict would have been eliminated by virtue of the limited release.

Although this is a crafty argument, we do not believe it is a proper interpretation or application of Fortner. The problem with Grange's tender of its policy limits in Fortner was that it conditioned its tender upon the plaintiff's execution of a *general* release and dismissal with prejudice of his claims against the defendant. Since there was additional insurance coverage available, insisting on a general release certainly would have foreclosed the plaintiff's access to the additional policy funds available to satisfy his claims. However, insisting on a *limited* release in such a situation would not create the same problem.

The limited release is a statutory vehicle for settling a claim with one insurer and limiting the exposure of the insured (and the settling carrier) in situations where there are multiple policies covering the same claim. A chief purpose of the statute is to encourage settlement by providing both parties with an incentive to settle *some portion* of the plaintiff's claims, even if settlement will not result in a dismissal of the lawsuit *or* a complete satisfaction of the plaintiff's claims.

If the Supreme Court intended its decision in Fortner to eliminate this statutory scheme for promoting settlement with one carrier where multiple carriers may provide coverage, it did not make any attempt to highlight what would be a major change in the law governing insurance settlements. A more rational explanation is that the Court never intended for its decision to be applied in this manner, since it is easily distinguishable on its facts from a limited release situation.

The application of Fortner to an *excess or additional carrier's* bad faith failure to settle is also tenuous. Remember, Fortner concerned the foreclosure of a plaintiff's right to pursue *his own* claim against another insurance carrier. When the primary carrier insisted on a condition that would have resulted in a foreclosure of this right, the Supreme Court said the plaintiff's attorney was correct to consider that a rejection. However, in the case of a bad faith failure to settle claim, the plaintiff has no such right – at least no *direct* right. Instead, any bad faith failure to settle claim must be *assigned* to him by the defendant, *if* there is an excess verdict and *if* there is a bad faith failure to settle. However, if you are an insurance adjuster handling claims in Georgia, be forewarned: a claimant's attorney may at some point demand all of your money and refuse to give you a release under the authority of the Fortner decision. Do not fall prey. As the law stands in Georgia, you are *always* entitled to some form of a written release in exchange for your payment of any money paid in settlement of a claim.

A full summary of the Fortner v. Grange case is included in the Case Notes section of this issue of Legal Update on page 16.

CASE NOTES

Georgia Liability

CIVIL PROCEDURE/RENEWAL ACTIONS: Renewal statute remains available where plaintiff voluntarily dismisses original action before trial court's ruling action should be dismissed for lack of diligence in perfecting service.

Boyd v. Robinson, 299 Ga. App. 795, 683 S.E.2d 862 (2009)

Plaintiff Allen Boyd, Jr. was involved in a motor vehicle collision on February 22, 2000. Boyd filed suit, pro se, on February 22, 2002, the date the applicable statute of limitations was set to expire. Boyd, however, made no attempt to serve defendants Gary W. Robinson and Eckerd Corporation until December 28, 2006, and service was not actually perfected until February of 2007, nearly five years after the statutory limitation period had expired.

Boyd subsequently voluntarily dismissed his original lawsuit within days of serving the defendants, and re-filed his action within the six-month renewal period provided for under Georgia's renewal statute, O.C.G.A. § 9-2-61(a). The defendants moved for summary judgment on the grounds that Boyd's claims were barred by judicial estoppel, spoliation of evidence, and his failure to exercise due diligence in perfecting service of process. The trial court agreed, and granted the defendants' motion.

On appeal, the Georgia Court of Appeals reversed the trial court, holding that under Georgia's renewal statute, "any delay in service in a valid first action is not available as an affirmative defense in the renewal action." Since Boyd voluntarily dismissed his first action before the trial court could issue any sort of ruling and then re-filed his renewal action within six-months of dismissal, Boyd's renewal was valid despite the fact it took him almost five years to perfect service in the initial action. Evidence was presented showing that, throughout this period of delay, the defendants were completely unaware that any lawsuit had ever been filed against them.

The Court of Appeals' decision was based on the much earlier Georgia Supreme Court decision of Hobbs v. Arthur, in which the Supreme Court held that the reasonableness of service in the original lawsuit cannot be attacked in the renewal action. Recognizing the absurdity (and potential injustice) of its holding in Boyd, the Court of Appeals remarked in its opinion that if ever there was a reason for the Supreme Court of Georgia to overturn Hobbs v. Arthur, "this is the case."

LIBEL AND SLANDER/EXCESSIVE DAMAGES: Proof of good reputation after defamatory statements made does not disprove injury. Damages awarded by jury are not excessive if consistent with evidence.

Barnes v. O'Connell, 300 Ga. App. 399, 685 S.E.2d 344 (2009)

Joe and Tammy Barnes hired Andrew O'Connell to appraise their coin collection. Andrew and his father, Joseph, cataloged and packaged the coins at O'Connell's Coins and Jewelry in Columbus, Georgia. Joseph had worked in the coin business since he was 14 years old and enjoyed an unblemished reputation in the Columbus area.

After Andrew's appraisal of the coin collection was completed, Joe and Tammy accused him of stealing or switching out several valuable coins. Based on this accusation, Andrew was arrested by the Columbus Police Department.

Joe and Tammy then went on local television to warn others that Andrew had stolen coins from them and advising other customers of O'Connell's Coins that they, too, may have been similarly victimized.

Other coin dealers and collectors learned of the accusations against the O'Connells through these television broadcasts and through internet message boards on the Professional Coin Grading Service website.

Andrew O'Connell and Joseph O'Connell subsequently filed suit against Joe and Tammy Barnes for slander and defamation. After trial, the jury awarded Andrew $6,000 and Joseph $175,000 against the Barneses.

On appeal, the Georgia Court of Appeals upheld the awards, finding the Barneses had slandered the O'Connells and that the jury verdict was appropriate, considering all of the evidence presented.

First, the Court of Appeals agreed that Joseph O'Connell had a good reputation that was injured directly as a result of the accusation of theft made against him. Under Georgia law, Mr. O'Connell did not have to prove that any actual injury to his reputation occurred; such damage is presumed when the plaintiff's business reputation is maligned.

Second, the appellate court found that the damages awarded were not excessive where there was evidence of malice, or intentional wrongdoing, on the parts of the defendants. In light of this evidence, as well as additional evidence of damage to the business reputation of both Joseph and Andrew O'Connell (e.g., Andrew was out of the coin business and only appraised coins every now and then after the accusations), the Court of Appeals upheld the jury's award on appeal.

INSURANCE LAW: Georgia statutory law does not authorize direct action by plaintiff against defendant's excess insurer.

Werner Enterprises, Inc. v. Stanton, 302 Ga. App. 25, 690 S.E.2d 623 (2010)

Plaintiffs sued for wrongful deaths arising out of an accident involving a freight truck owned by Werner Enterprises, Inc. Relying on Georgia's direct action statute, O.C.G.A. § 46-7-12.1, the plaintiffs included in their complaint a direct action against Liberty Mutual, which provided excess coverage over Werner Enterprises, Inc.'s self-insured coverage of $1 million.

The direct action statute provides that a plaintiff may file suit against a motor carrier's insurer before obtaining a judgment against the insured. The statute also permits a motor carrier to self-insure in lieu of indemnity insurance. Liberty Mutual moved for summary judgment, arguing that the statute does not authorize a direct action against an excess insurer. The trial court denied the motion,

taking the position that the statutory reference to "the insurance carrier" indicates no intention to limit the statute's application to the primary carrier. The Court of Appeals reversed, finding that the legislature's failure to specifically authorize suit against the excess insurer must be construed as the intent to exclude such an insurer from direct action, since excess coverage is not collectible until the underlying policy limits are exhausted.

PRODUCTS LIABILITY: Georgia law does not impose duty to recall product on manufacturer.

Ford Motor Company v. Reese, 300 Ga. App. 82, 684 S.E.2D 279 (2009)

Mary Reese's children brought a wrongful death and survival action against Ford Motor Company after their mother was killed when her 1994 Ford Tempo was rear-ended by a dump truck. Plaintiffs alleged that Reese's seatback collapsed upon impact, causing her to suffer more severe injuries than she otherwise would have.

At trial, the judge read an instruction to the jury on a manufacturer's duty to recall a product. In addition, the jury was permitted to hear evidence of other lawsuits involving a seatback that collapsed. Such evidence was entered in the form of complaints from the other lawsuits, as well as deposition testimony from plaintiffs in five other lawsuits concerning injuries sustained in similar incidents.

On appeal, Ford argued that it was reversible error to permit any instruction on a duty to recall as no such duty exists under Georgia law. Ford also argued that the evidence concerning other lawsuits should not have been admitted because the plaintiffs failed to establish that the other incidents were substantially similar to the incident in this case.

The Court of Appeals agreed that it was reversible error to charge the jury on a duty to recall. The court stated that, "absent special circumstances, no common law duty exists under Georgia law requiring a manufacturer to recall a product after the product has left the manufacturer's control." If a manufacturer chooses to recall a product voluntarily, Georgia law imposes a duty on the manufacturer to exercise ordinary care in conducting the recall. Special circumstances may also exist where a duty is imposed by federal or state statute or governmental agency.

Concerning other incidents, the Court of Appeals held that the evidence was admissible because it was offered for the limited purpose of proving Ford's knowledge or notice of the product defect. The court stated that "[i]n product liability actions, evidence of other incidents involving the product is admissible, and relevant to the issues of notice of defect…, provided there is a showing of substantial similarity."

In order to show substantial similarity, the plaintiff must come forward with evidence (1) that the products involved in the other incidents and the present incident shared a common design and manufacturing process; (2) that the products suffered from a common defect; and (3) that any common defects shared the same causation. The court found there was sufficient evidence to establish a substantial similarity between this incident and the other incidents involving a collapsed seatback.

The court noted that the rule in Georgia favors "admission of any relevant evidence, no matter how slight its probative value." Therefore, even evidence of doubtful relevancy should be admitted and its weight left to the jurors. Where evidence is offered and objected to, if it is competent for any purpose, it is not erroneous to admit it.

TORTS/STRICT LIABILITY: Under Georgia common law, common passenger carriers are not liable as insurers of passengers' safety.

Laidlaw Transit Services, Inc. v. Young, 299 Ga. App. 785, 683 S.E.2d 872 (2009)

Bus passenger Romona Young filed suit against Laidlaw Transit Services, Inc. and Calvin D. Williams, who was employed by Laidlaw as a bus driver, alleging that Williams assaulted Young in a church parking lot after transporting her on the bus. The trial court dismissed Young's claims against Laidlaw for negligent hiring, training, supervision, retention and respondeat superior, finding no evidence that any negligent conduct on the part of Laidlaw proximately caused any injury to Young. However, the trial court denied Laidlaw's motion for summary judgment on Young's strict or "absolute" liability claim under motor common carrier laws. Laidlaw appealed the ruling and the Court of Appeals reversed.

While Laidlaw was clearly a motor common carrier, under Georgia law, "a common carrier of passengers is not an absolute and unqualified insurer of the safety of its passengers." Instead, "[a] carrier of passengers must exercise extraordinary diligence to protect the lives and persons of his passengers but is not liable for injuries to them after having used such diligence." The Court of Appeals noted that, while a stricter standard than ordinary negligence, the "extraordinary diligence" standard is not as strict as the standard for common carriers of goods set forth under O.C.G.A. § 46-9-1, which provides that "in cases of loss[,] the presumption is against [the carrier], and no excuse avails [the carrier] unless the loss was occasioned by the act of God or the public enemies of the state."

The Court of Appeals took exception to the trial court's willingness to impose a strict liability standard on Laidlaw despite Georgia law's imposition of a standard of "extraordinary diligence" for common carriers of passengers under O.C.G.A. § 46-9-132. The trial court found that a common carrier could be found strictly liable to its passenger, without regard to its diligence, based on a prior Court of Appeals decision concerning the theft of a diamond ring. Besides being distinguishable on its facts, the earlier decision was not binding precedent since only two of the three panel judges joined in the decision.

Because Georgia law provides that a common carrier of passengers is not liable as an insurer of its passengers' safety, the trial court erred in finding that Laidlaw could be found liable on a claim of "strict or absolute liability" for the injuries allegedly sustained by Ms. Young. Accordingly, it was error for the trial court to deny Laidlaw's motion for summary judgment on Young's strict liability claim.

Georgia Workers' Compensation

SUBROGATION/CHOICE OF LAWS: Limitations exist on employer's right to sue third-party tortfeasor as substitute for claimant/plaintiff.

Butts v. Thomas, 300 Ga. App. 639, 686 S.E.2d 262 (2009)

Bobby Wayne Butts was injured in a work-related motor vehicle wreck while working for Coca-Cola on August 18, 2005. Another driver, Janet Rosser Thomas, was at fault in the accident. Coca-Cola accepted Butts's accident as compensable and paid him workers' compensation benefits pursuant to Tennessee law. The wreck actually occurred in Georgia, but Butts's employment was principally located in Tennessee.

Although Thomas was at fault, Butts elected not to sue her in tort. Coca-Cola therefore proceeded to file suit against Thomas in Georgia pursuant to a Tennessee law that allows an employer to directly sue a third-party tortfeasor if the employee does not file suit within one year from the date of the accident. Pursuant to the same law, the employer has six months after the expiration of one year to actually file suit. Coca-Cola filed suit on February 13, 2008.

Thomas moved for summary judgment and argued that the case was barred by the Georgia statute of limitations. Thomas argued that the two-year statute of limitations for personal injury claims applied and since Coca-Cola did not file suit within two years from the date of the accident, their claim was time-barred. Coca-Cola argued that Tennessee law provided that since the cause of action arose in Georgia, the Georgia statute of limitations should apply, but that they should be given the extra six months to file suit following the expiration of the statute of limitations, as provided by Tennessee law. The trial court granted Thomas's motion for summary judgment. Coca-Cola appealed.

The Court of Appeals affirmed the trial court's award of summary judgment. In so ruling, the court noted that the general rule in Georgia is that the statute of limitations from the forum state (in this case Georgia) should apply, as statutes of limitation are procedural in nature. The court further cited the principle that the statute of limitations in Georgia cannot be extended by a foreign state's law.

SUBROGATION RECOVERY/ NON-RESIDENT EMPLOYEE: Employer does not have right to subrogation for claims that arise in Georgia but are paid under foreign law.

Performance Food Group, Inc. v. Williams, 300 Ga. App. 831, 686 S.E.2d 437 (2009)

Jesse Gunn, a Tennessee resident, was driving a tractor-trailer in the course of his employment with Performance Food when he was involved in a motor vehicle wreck in Gwinnett County, Georgia. Gunn's truck collided with a vehicle owned by Jonathon Mikul and driven by Charles Williams. Performance Food paid medical and indemnity benefits to Gunn under the workers' compensation law of Tennessee.

Performance Food brought a subrogation claim against Williams and Mikul in Georgia, but under Tennessee law, to recover for

the medical and indemnity benefits paid to Gunn. The trial court granted Williams and Mikul's motion for summary judgment. Performance Food appealed the decision.

Georgia law states that where a non-resident employee is hired by a foreign corporation and is injured in Georgia, it will apply its own substantive law whether or not Georgia's workers' compensation law is invoked to pay.

The Court of Appeals affirmed the grant of summary judgment for Williams and Mikul because Performance Food's claim to enforce subrogation rights under Tennessee law is precluded by controlling authority providing that Performance Food's subrogation rights are governed by Georgia law.

O.C.G.A. § 34-9-11.1(b) states that the employer and insurer's right of subrogation is limited to benefits that are paid under the Georgia Workers' Compensation Act. As a result, Performance Food could not pursue a subrogation claim for benefits because (1) benefits were paid under the Tennessee workers' compensation law, and (2) Georgia law is the controlling authority. Although the decision seems harsh, the court has previously held that an employer has no constitutionally protected interest in money its employee receives from a third-party tortfeasor.

CHANGE IN CONDITION OR NEW INJURY: There can be no change in condition unless employee has previously received income benefits; subsequent disability is not new injury unless there is actual worsening of employee's condition due to continuing work activities.

Trucks, Inc. v. Trowell, No. A09A1624, 2010 WL 424910 (Ga. App. Feb. 8, 2010)

Claimant Marion Trowell is a truck driver. While working for Trucks, Inc., she drove a tractor- trailer. Her job duties included hooking and unhooking the trailers, which required her to use a hand crank to roll down the landing gear.

On April 18, 2006, Trowell injured her right shoulder while rolling down the landing gear. Her claim was accepted as medical only, and medical treatment was provided, but she continued to work her regular job. An orthopedic surgeon treated her with an injection, medication, and therapy.

In October of 2006, Trowell resigned from Trucks because of a work slowdown. She went to work for Trans Systems, Inc., driving a dump truck. She did not have to hook and unhook trailers, but she did have to shift a manual transmission with her right arm. She quit the job at Trans Systems in December again due to lack of work. In January 2007, the orthopedic surgeon recommended surgery and took Trowell out of work.

The issue to be resolved in this case was which employer should be responsible for the surgery and disability benefits. The Court of Appeals addressed three possible findings: a change in condition (for which Trucks would be responsible); a new injury (for which Trans Systems would be responsible); and disability due to the original injury (for which Trucks would also be responsible).

The superior court ruled that Trucks was responsible because Ms. Trowell had had a change in condition. The Court of Appeals, however, found that ruling to be incorrect because income benefits had not been previously paid to Trowell and it ruled that there can be no change in condition unless the employee has previously been paid income benefits, either voluntarily or by award of the State Board.

The State Board ruled that Trowell's disability was attributable to her original injury while employed at Trucks. The Court of Appeals agreed with that ruling.

The Court of Appeals said that, in order for there to be a new injury for which the second employer will be liable (if there has not been an actual new accident or injury), the former employer must show that the employee's inability to work is due to a worsening of the employee's condition due to having continued to

work after the initial injury. If the employee's condition does not worsen, or if the worsening of the employee's condition is not due to her activities in continuing to work, then the disability will be attributed to the initial injury and the first employer is responsible. If the employee's condition does change due to her activities in continuing to work, then the new employer is liable.

The determination of whether, and for what reason, an employee's condition has worsened is a factual determination to be made by the State Board. The State Board's finding will be upheld unless there is no evidence to support it. In Trowell's case, the State Board resolved the conflicting evidence by finding that her condition had not changed due to her continued work activities; her symptoms simply did not improve with conservative treatment. Because there was some evidence that supported that finding, including Trowell's own testimony and the doctor's opinion, the Court of Appeals upheld it.

IDIOPATHIC INJURIES: Employee must prove injury arose out of employment by showing injury was related to or caused by peculiar nature of condition of employment.

St. Joseph's Hosp. v. Ward, 300 Ga. App. 845, 686 S.E.2d 443 (2009)

Sandra Ward worked as a nurse for St. Joseph's Hospital. On June 23, 2005, she injured herself when she turned to get a patient some water, twisted her right knee, and felt a sudden pop. After an unsuccessful attempt to return to her regular duty job, she was offered a light duty "sit and greet" position. However, on September 16, 2005, she went out of work for total knee replacement. Ward then filed for workers' compensation benefits, alleging multiple accident dates involving both of her knees.

At trial, Ward alleged that her knee condition gradually worsened due to on-the-job walking and her return to work following the June 23, 2005 accident. As such, the Administrative Law Judge felt Ward established a fictional new injury date of September 16, 2005. However, based upon medical evidence of Ward's pre-existing, progressive arthritis, the Appellate Division reversed.

The Appellate Division also concluded that Ward's idiopathic knee injury was simply not compensable. Ultimately, that determination was appealed up to the Georgia Court of Appeals, which upheld the decision, relying on the oft-cited Chaparral Boats case.

In ruling against Ward, the court opined that she failed to carry her burden of proving by a preponderance of the evidence that her accidental injury arose out of her employment. O.C.G.A. § 34-9-1(4). As the Appellate Division had stated, Ward "was not exposed to any risk unique to her employment by standing and turning, and that, in turning, she did not come into contact with any object or hazard of employment." In this case, Ward's injury "was caused by a risk to which she would have been equally exposed apart from the employment . . . the injury was not related to or caused by the peculiar nature of a condition of the employment." Thus, her claim was not compensable.

The decision in this case will clearly be useful to employers and insurers seeking to justify controversion of idiopathic claims. It also underscores the authority of the Appellate Division in making such factual determinations. The court distinguished Harris v. Peach County Board of Commissioners, a 2009 appellate case frequently cited by employees/claimants to support claims that an idiopathic injury is compensable. In Harris, a janitorial employee injured herself while bending over to pick up an object on the floor, pointed out by her supervisor. There too, the Court of Appeals upheld the Appellate Division's Award, this time finding that Ward's injury was compensable.

ATTORNEY FEES/FINDINGS OF FACT BY APPELLATE DIVISION: Appellate Division can substitute its own findings for those of ALJ if it finds ALJ's findings of fact are not supported by preponderance of credible evidence.

Flores v. Keener, No. A10A0583, 2010 WL 446979 (Ga. App. Feb. 10, 2010)

In Martin Garcia's claim for workers' compensation benefits, Garcia was represented first by attorney Keener and then by attorney Flores. After Garcia and his employer reached a settlement, Flores filed a motion seeking the entire amount allotted in the settlement for attorney fees. After a hearing, an administrative law judge largely rejected Flores's motion and ruled that Flores should receive only 1.2 percent of the attorney fee allotment while Keener should receive the remaining 98.8 percent.

On appeal to the Board's Appellate Division, the Appellate Division vacated the ALJ's decision, determined that the ALJ did not properly determine the relative values of the attorneys' services, and ruled that Flores was entitled to 30 percent of the total attorney fees, while Keener was entitled to 70 percent. On appeal to the superior court, the court vacated the Appellate Division's ruling based on its conclusion that the Appellate Division failed to apply the correct legal standard, and remanded. The Court of Appeals granted Flores's application for a discretionary appeal.

After 20 months of litigation that included two mediations, a rehabilitation conference, and creation of a life care plan, Garcia's employer offered to settle his claim for a lump sum payment of $650,000. Garcia rejected the offer and, on June 14, 2007, dismissed Keener. Keener filed a lien for his legal fee in the amount of $162,500 (25 percent of the settlement offer of $650,000) plus accrued expenses.

The same day that Garcia dismissed Keener he hired Flores. Eight days after hiring Flores, Garcia accepted his employer's modified settlement offer of $657,500. The parties stipulated that the correct amount for attorney fees was 25% of the settlement, or $162,875, and agreed to hold the attorney fee in escrow until the attorney fee lien was resolved. Then the litigation between Flores and Keener ensued.

O.C.G.A. § 34-9-108(a) provides for awards of attorney fees that are "reasonable" in light of evidence of the value of the services rendered but does not otherwise dictate the manner in which the amount of an award of attorney fees is determined. The Board is vested with the discretion to determine whether the amount of fees claimed by an attorney under an engagement contract is reasonable in light of evidence of the value of services rendered in the particular case.

The Appellate Division is authorized to weigh the evidence in the trial record and to assess the credibility of the witnesses who testified before the ALJ, to substitute its own findings for those of the ALJ and enter an award thereon, if it finds that the ALJ's findings of fact are not supported by a preponderance of the credible evidence.

Because the Board was limited to distributing a total of $162,875 in fees (25% of the settlement), the Board was required to exercise its discretion to determine the relative value of the attorneys' services to Garcia. The record showed that the Appellate Division considered evidence regarding Keener's typical hourly rate, the amount of time he spent pursuing Garcia's claim, and the result of his efforts, as well as the amount of time Flores spent pursuing Garcia's claim, and the result of his efforts. As a result, the Court of Appeals concluded that the superior court erred in ruling that the Appellate Division committed a legal error in the manner in which it exercised its discretion in distributing the allotted legal fees between Garcia's attorneys.

Georgia Coverage

POLICY TERRITORIAL RESTRICTIONS: Policy provision limiting coverage to use of named vehicles within particular territorial restriction is enforceable.

Sapp v. Canal Insurance Co., 301 Ga. App. 596, 688 S.E.2d 375 (2009)

Pamela and Floyd Sapp sued David Lamb and his employer, Entra Demond Blackmon, for injuries occurring in a collision between Ms. Sapp and a dump truck driven by Lamb while working for Blackmon. Canal Insurance Company, the insurer for Lamb and Blackmon, filed a declaratory judgment action to resolve insurance coverage and to obtain a court declaration of its rights and obligations. The trial court granted summary judgment to Canal and the Court of Appeals affirmed.

Canal's action in the trial court sought enforcement of a provision that limited coverage to a 50-mile radius from Blackmon's garage. The provision specifically read: "No vehicle is covered if operated beyond its radius … It is expressly understood and agreed that occasional trips beyond the radius specified are not permitted." The collision between Sapp and Lamb occurred well outside the 50-mile radius from Blackmon's garage. The Court of Appeals found that, based on the clear language of the exclusion, the Canal policy did not cover this incident.

In an attempt to avoid the exclusion, the Sapps and Blackmon argued that the radius restriction was unenforceable because Blackmon was a "motor carrier" and that the Canal policy was a "motor carrier policy" subject to minimum liability limits. The evidence showed, however, that Blackmon, was never certified or permitted as a motor carrier. Under Georgia law, a "carrier" is defined as one who undertakes the transporting of goods or passengers for compensation. Additionally, the policy did not contain a "Form F" endorsement so as to bring it under the motor carrier statutory provisions.

Blackmon also argued that the exclusion should not apply because he did not know about it. Rejecting this argument, the court noted that "[o]ne who can read, must read, for [they] are bound by their contracts … [c]ompetent parties are free to choose, insert, and agree to whatever provisions they desire in a contract, including insurance contracts, unless prohibited by statute or public policy." The court also found that no public policy prohibited territorial exclusions and that such exclusions have been upheld under Georgia law.

POLICY NOTICE PROVISION/OCCURRENCE: Insurer's denial of claim does not result in waiver of insured's requirement to comply with notice provisions in policy; negligent work admitted by default constitutes occurrence under policy.

Hathaway Development Company, Inc. v. American Empire Surplus Lines Insurance Company, 301 Ga. App. 65, 686 S.E.2d 855 (2009)

General contractor Hathaway Development Company hired Whisnant Contracting Company to install plumbing on three separate construction projects. American Empire Surplus Lines Insurance Company (AESLIC) issued a commercial general liability (CGL) policy to Whisnant. Plumbing problems arose at all three projects. Hathaway sued

Whisnant alleging negligent construction which resulted in the plumbing problems and other damage at the projects. Whisnant did not answer Hathaway's complaint and Hathaway obtained a default judgment in the amount of $188K. Hathaway then filed suit against AESLIC to recover the judgment. Hathaway did not claim it was an additional insured under Whisnant's policy.

In defense of Hathaway's suit, AESLIC contended there was no coverage for the claim for the following reasons reasons: (1) Whisnant failed to give AESLIC proper notice; (2) there was no "occurrence" under the policy; and (3) the "business risk" exclusions eliminated coverage. The trial court granted summary judgment in favor of AESLIC. Hathaway appealed and the Georgia Court of Appeals reversed.

On appeal, Hathaway argued that granting summary judgment to AESLIC based on a "late notice" defense was erroneous, contending that (a) compliance with conditions precedent to coverage (such as a notice provision) is waived by the insurer when coverage is denied; (b) AESLIC had sufficient notice of the suit against Whisnant in any event; and (c) AESLIC produced no evidence that Whisnant had failed to cooperate.

The Court of Appeals held that, although an insurer's denial of a claim will not waive its right to demand compliance with policy notice requirements or other conditions precedent, AESLIC nevertheless had received sufficient notice of the claims against Whisnant. The initial claims were forwarded within a month of their occurrence and notice of the lawsuit was forwarded to AESLIC by Hathaway before the matter went into default. The court refused to require that notice come directly from the insured, finding instead that the notice provision was satisfied as long as someone gave the insurer reasonable and timely notice of the suit.

The Court of Appeals also found that a covered "occurrence" was alleged in the underlying action. Because the claims against Whisnant asserted negligence (an act of negligence generally constitutes an "occurrence") and because those allegations were admitted by operation of the default, AESLIC could not later argue that the claim was actually a claim for breach of contract (which generally is not a covered "occurrence" under a CGL policy).

POLICY INTERPRETATION: Misnomer on declarations page is not ambiguity when determining who is insured.

Banks v. Brotherhood Mutual Insurance Co., 301 Ga. App. 101, 686 S.E.2d 872 (2009)

Pastor Banks was both the pastor of the Hollywood Church of God and a meter reader for the City of Toccoa. On August 24, 2004, Pastor Banks was involved in an automobile accident while working for the City of Toccoa and driving a City of Toccoa vehicle. Brotherhood Mutual issued a business auto policy to the "Hollywood Church of God, Inc." that insured the church's only vehicle, a church van; however, the church was an unincorporated association. Even though Pastor Banks was not operating the church van at the time of the accident, he claimed that because the Hollywood Church of God was unincorporated, the named insured was therefore ambiguous and the policy should be interpreted as if Pastor Banks was the named insured, rather than the church. The trial court granted summary judgment to Brotherhood Mutual and Pastor Banks appealed.

The issue before the Georgia Court of Appeals was whether the inclusion of "Inc." in the church's name on the Declarations Page was an ambiguity or misnomer. The Court of Appeals reviewed the entire record to determine the intention of the parties.

Other then the inclusion of "Inc." in the name on the Declarations Page, the name of the church was correct, the address on the policy for the church was correct, an underwriter for Brotherhood Mutual attested he intended to insure the church, not an individual, and the policy was a "business auto policy" rather than a personal lines policy. The Court of Appeals held

the inclusion of "Inc." was a misnomer and that the intention of the parties was to insure the church and not the church's pastor. Because the policy covered the organization and not the individual, the policy did not afford coverage to Pastor Banks since he was operating a vehicle other than the church van at the time of the accident.

GOODMAN McGUFFEY LINDSEY & JOHNSON successfully handled this case on behalf of Brotherhood Mutual Insurance Company.

EXCESS COVERAGE: Where policy provides that coverage for additional insured is excess, such coverage may become primary where policy's endorsement allows additional insured to have primary coverage under certain conditions and those conditions are met.

3060 Corp. v. Crescent One Buckhead Plaza, L.P., 300 Ga. App. 749, 686 S.E.2d 367 (2009)

Crescent One Buckhead Plaza, L.P. ("Crescent One") and Nava Restaurant ("Nava") entered into a landlord-tenant lease agreement. Pursuant to the lease, the tenant Nava was required to have liability insurance that listed the landlord Crescent One as a named insured. Nava obtained a policy through Transcontinental Insurance Company, Inc. ("TIC"). However, the TIC policy named Crescent One only as an "additional insured" under the policy's Noncontractor's Endorsement. With respect to "additional insureds," the endorsement stated that the policy would provide excess coverage over any other policy *unless a written agreement specifically required the TIC coverage to be primary.*

When a server at Nava slipped and fell on some stairs at work and injured his hand, he sued Crescent One for its alleged negligent maintenance of the stairs. Crescent One in turn sent the suit to Nava and Nava's insurer TIC. As Crescent One had other coverage through Great Northern Insurance Company ("Great Northern"), TIC denied coverage to Crescent One because, under the Noncontractor's Endorsement, it considered its policy excess to the Great Northern policy. After notice of TIC's denial of coverage, Crescent One sought and received permission from the court to file a third-party claim against Nava and TIC for contribution and indemnification.

On cross-motions for summary judgment from the third parties, the trial court ruled in favor of Crescent One against TIC. The court found that the TIC policy provided primary coverage to Crescent One under the Noncontractor's Endorsement would be primary for Crescent One because Nava was contractually obligated to procure primary liability coverage for Crescent One. Accordingly, the court held that TIC had a primary duty to defend and indemnify Crescent One under the policy.

The issue on appeal was whether or not TIC, which listed Crescent One as an "additional insured" pursuant to the lease, had the sole duty to defend and indemnify the additional insured, or whether Great Northern had a duty to share in that obligation. Looking to the language of each policy and the facts before it, the Court of Appeals found that by its very terms, the TIC policy provided that coverage for Crescent One was primary where the lease agreement demanded it to be primary. On the other hand, the Great Northern policy, which provided that it was excess over another party's insurance policy to which the named insured was an "additional insured," was excess over the TIC policy because Crescent One was an "additional insured" under the TIC policy.

TIC countered that Crescent One could not both claim that it had primary coverage under the TIC policy and that it should be considered an "additional insured." The Court of Appeals did not find this argument persuasive. Since TIC drafted the Noncontractor's Endorsement allowing for an "additional insured" to have primary coverage under certain conditions, TIC could not thereafter complain when the conditions it chose and imposed had been met. As a result, the Court of Appeals affirmed the trial court's judgment.

BAD FAITH: Insurer may not utilize "safe harbor" provision to prevent bad faith liability when it places conditions on settlement offer that are within its control.

Fortner v. Grange Mutual Insurance Company, 286 Ga. 189, 686 S.E. 2d 93 (2009)

Cecil Fortner was injured in a car accident caused by Alan Arnsdorff. Arnsdorff had a policy with Grange with bodily injury liability limits of $50,000 and his plumbing business had $1,000,000 in liability coverage with Auto Owners. Fortner offered to settle all claims for $50,000 from Grange "contingent upon" Auto Owners' payment of $750,000. Auto Owners did not respond to the demand. Grange responded that it would pay $50,000 contingent upon Fortner "signing a full release with indemnification language" and dismissing his claim against Arnsdorff with prejudice.

Fortner considered Grange's response a rejection of his offer and proceeded to trial. The jury awarded Fortner a $7 million verdict against Arnsdorff. Arnsdorff then assigned to Fortner any cause of action he might have against Grange based on its alleged bad faith in refusing to settle Fortner's claim within its policy limits. In the suit that followed, the jury returned a verdict in favor of Grange on Fortner's bad faith claim.

Fortner appealed the verdict contending that the trial court erred in giving the following jury charge: "In responding to a settlement demand, which demand is conditional upon the response of another insurance company, an insurance company can offer its policy limits in response to the demand and then let the plaintiff negotiate with the remaining insurers. In that situation, the insurance company would have given equal consideration to its insured's financial interest and fulfilled its duty to him."

The Court of Appeals found this charge was consistent with the "safe harbor" provision explained in Cotton States Mut. Ins. Co. v. Brightman. This "safe harbor" protects an insurer from bad faith liability when the plaintiff makes a settlement offer containing a condition that is beyond the control of the insurer. The Supreme Court granted certiorari to consider whether the Court of Appeals properly interpreted the "safe harbor" provision.

The Supreme Court reversed the Court of Appeals. In its analysis, the Supreme Court focused on Grange conditioning its acceptance of Fortner's offer to settle on his signing a *general release* of Arnsdorff with indemnification language and dismissing his claim against Arnsdorff with prejudice. It should be noted that a *limited release* is generally used in situations where one insurer wishes to pay its limits but additional coverage may available under a separate policy with a different insurer. Effectively, the conditions Grange placed on its offer would have required Fortner to forego any claim against Arnsdorff and potentially forfeit his access to the Auto Owners policy. As these conditions were clearly *within* Grange's control, the Supreme Court found that the jury should be allowed to consider these circumstances in determining bad faith and the "safe harbor" provision therefore was inapplicable.

Georgia
Underinsured/Uninsured Motorist

STACKING: Insured is not entitled to stack UM coverage from employer's insurance policies covering vehicles that were not involved in the car accident.

State Farm Mutual Automobile Insurance Company v. Staton, et al., 286 Ga. 23, 685 S.E.2d 263 (2009)

Cecil Staton, an officer, majority shareholder and employee of Smyth & Helwys Publishing, Inc., was severely injured in an automobile collision while driving a vehicle owned by Smyth & Helwys. The State Farm policy insuring the vehicle identified the "named insured" as the "first person named" on the declarations page. Smyth & Helwys was the first and only name listed on that page.

Smyth & Helwys owned two other vehicles which were insured separately by State Farm, but which were not involved in the collision. These policies for the non-involved vehicles also identified Smyth & Helwys, and only Smyth & Helwys, as the named insured on the declarations pages. The uninsured motorist coverage for each separate policy was $100,000. Staton sought to stack the coverage provided under the three separate policies to provide UM coverage totaling $300,000.

State Farm moved for summary judgment, claiming that Staton was not the named insured on any of the policies and therefore could seek UM coverage only under the policy covering the vehicle he was driving at the time of the collision. The trial court granted State Farm's motion and Staton appealed.

The Court of Appeals reversed. In spite of the fact that the policy named only Smyth & Helwys as the insured, the Court of Appeals determined that the identity of the named insured was ambiguous because the policy defined a person as a "human being," and Smyth & Helwys, a corporation, was not a human being.

The issue before the Supreme Court was whether the employee was a beneficiary of *only* the UM policy covering the vehicle involved in the accident or *each* policy covering his employer's other vehicles.

Reversing the Court of Appeals, the Supreme Court held that the term "named insured" was unambiguous, as the policy clearly defined it as the "first person named in the declarations." The only entity named in the declarations was Smyth & Helwys, a corporation. No other person was named as an insured. To the extent the pre-printed portion of the insurance policies – which defined a "person" as a "human being" – were in conflict with the written portion (i.e., the name appearing on the declarations), the written portion would prevail. Thus, the corporation, rather than Staton, was the insured and Staton could not stack the policies covering his employer's other two vehicles that were not involved in the accident.

Florida
Liability

PREJUDGMENT INTEREST: Once verdict is reached and value of damages is established, prejudgment interest is due as matter of law on all damages awarded in order to make plaintiff whole.

Capitol Environmental Services, Inc. v. Earth Tech, Inc., 25 So.3d 593 (Fla. 1st DCA 2009)

Earth Tech, Inc. (ETI) contracted with the Florida Department of Environmental Protection to clean up hazardous waste from a site. ETI then subcontracted this work out to Capital Environmental Services, Inc. (CES). CES, in turn, subcontracted the transportation of waste material to an offsite disposal location to Freehold Cartage, Inc.

As part of the contract between ETI and CES, CES agreed to obtain insurance to protect ETI from liability for any claims that may arise from CES's performance of the contract. The contract specified that CES would list ETI as an additional insured. CES obtained a commercial automobile insurance policy through United States Fire Insurance Company (U.S. Fire), but failed to include ETI as an additional insured.

A motor vehicle accident occurred involving a vehicle driven by a Freehold employee, seriously injuring another driver. The injured driver filed suit against ETI, Freehold and Freehold's driver. ETI submitted the claim to U.S. Fire, which denied coverage and refused to defend ETI. ETI filed a declaratory judgment action in federal court and ultimately lost due to the fact that ETI was not listed on the policy as an insured. The underlying claim ultimately settled for $500K, with ETI paying $250K of this sum.

ETI then sued CES for breach of contract and contractual indemnity. Judgment was entered in favor of ETI in the amount of $630K, consisting of the damages awarded by the jury and prejudgment interest on the $250K settlement, from the date the claim was settled.

Several issues were raised on appeal: (1) whether it was proper for the trial court to allow the jury to award attorney fees and costs incurred by ETI in the declaratory judgment action; (2) whether the trial court erred by not awarding prejudgment interest on all of the damages awarded; and (3) whether prejudgment interest on the declaratory judgment should be fixed on the same date as interest on the underlying claim.

The court affirmed the award of attorney fees and costs relating to the declaratory action. These items were properly included in the award of damages because they were causally related to the breach, were reasonably foreseeable at the time the parties entered into the contract and the award of same was necessary in order to put ETI in the same position it would have occupied had CES not breached its contract.

With respect to the issue of prejudgment interest, the court stated that the purpose of prejudgment interest is to make the plaintiff whole from the date of loss. Such interest is due as a matter of law, once a verdict, establishing liability and setting the amount of damages to be awarded is rendered. Because the attorney fees and costs for handling the declaratory action were included in the award of damages, it was improper for the trial court to limit prejudgment interest to only a portion of the settlement.

Finally, the court determined that it would be proper to fix the prejudgment interest relating to the declaratory action on a different date than the prejudgment interest relating to the underlying claim. The court held that the proper date to fix interest for the declaratory action was the date that the federal court determined that ETI was not covered by the insurance policy, whereas the proper date to fix interest for the underlying claim was the date the claim was settled.

Florida Coverage

EXHAUSTION OF REMEDIES: Administrative remedies must be exhausted before insured homeowner may sue insurer for failure to provide statutorily mandated premium discount.

Serchay v. State Farm Florida Ins. Co., 25 So.3d 652 (Fla. 4th DCA 2010)

Alan Serchay sued State Farm under his homeowner's policy, alleging that State Farm violated Florida Statutes §§ 627.0629 and 627.71 relating to mandatory premium discounts for consumers who implement windstorm damage measures to their properties. Serchay alleged that his home had a windstorm-mitigating hip roof that entitled him to a premium discount. Serchay further alleged that State Farm failed to provide him with the mandatory discount and had also failed to notify him of his right to receive the discount. Serchay sought to recover the discount and to enjoin State Farm from committing further alleged violations of these statutes.

State Farm moved to dismiss the action, contending Serchay had failed to exhaust his administrative remedies under Florida Statute § 627.371 prior to filing suit. Section 627.371 provides that "any person aggrieved by any rate charged … by an insurer … may … make written request of the insurer … to review the manner in which the rate … has been applied with respect to insurance afforded her or him. If the request is not granted within 30 days … the requester may treat it as rejected. Any person aggrieved by the refusal of an insurer … to grant the review requested … may file a written complaint with the Office of Insurance Regulation (OIR) specifying the grounds relied upon."

In addition, Florida Statute § 627.371(2) provides the "if the OIR had good cause to believe that the insurer … did not comply with the requirements and standards of this part applicable to it, [the OIR] shall … give notice in writing to such insurer … stating therein in what manner and to what extent noncompliance is alleged to exist and specifying therein a reasonable time, not less than 10 days thereafter, in which the noncompliance may be corrected, including premium adjustment."

Florida Statute § 627.371(3) further provides that, "if … within the period prescribed by the [OIR] in the notice required by subsection (2), the insurer … does not make such changes … to correct the non-compliance … then the [OIR] is required to proceed to further determine the matter."

Based on § 627.371, State Farm asserted that if the complainant did not obtain the relief requested, then he could obtain judicial review of the OIR's action pursuant to § 120.68 of the Florida Statutes. That section provides, in pertinent part, that (1) a party who is adversely affected by final agency action is entitled to judicial review and (2) judicial review shall be sought in the appellate district where the agency maintains its headquarters or where a party resides or as otherwise provided by law.

The Circuit Court granted State Farm's motion and dismissed the suit on the ground that Serchay failed to exhaust his administrative remedies under § 627.371. Serchay appealed the order, arguing that § 627.371 did not apply because the case did not involve "rate-making" and the current action did not challenge the rates charged by State Farm. Rather, Serchay asserted that the action concerned State Farm's failure to provide the statutorily mandated premium discount.

While the appellate court acknowledged the distinction between insurance rates and the premium discounts at issue in Serchay's lawsuit, it nevertheless held that premium discounts are inextricably linked to the rate charged. Consequently, § 627.371 did apply and the trial court's order was affirmed in its entirety.