

IN THE KNOW

When Is a Claim a Claim?

By Dan Kuczek, LUTCF

In general, it is a condition of every insurance policy that it is necessary to promptly notify the insuring company of a claim “as soon as practicable.” However, what defines when a claim is a claim and what is “prompt notice” has been an issue of evolving debate for a long time, and is different for each insurance carrier. To illustrate this in a very broad sense, with respect to certain liability coverage forms of yesteryear, prompt notice of a claim was generally adequate when you received a notice of a lawsuit and notified your insurance company that you were being sued when you received the notice. As most good risk managers know, the sooner you deal with a problem, the less likely it is to fester and grow in severity over time as claims experience would show. Since then, the policy language insurance companies used evolved to include “any written demand for damages” or “any demand.” Their original intent was to manage risk more efficiently, get a quick start on the claim, and broaden coverage. Today notification language includes phrases such as “potential claim,” or “notice of circumstance that could give rise to a claim” accompanied by an ever-expanding definition of terms that becomes part of the general terms and conditions.

At the heart of the matter is the condition precedent for prompt notice set forth in the language, how insurance companies interpret it, and whether or not they define claim and loss terms as a coverage trigger. “In contract law, a condition precedent is an event which must take place before a party to a contract must perform or do their part.” For example, a suit was brought by a hospital against a healthcare insurer for charges that originated over reimbursement disputes after the insurer left the state. While the healthcare insurer had tried to settle the reimbursement dispute on their own, charges were not made against the directors and officers until three years later. At that time, the health insurer notified their D&O carrier, but among other reasons for denial, notice wasn’t considered prompt enough for the contract to trigger coverage, according to the carrier. However, in the carrier’s denial they cited “...the insureds shall, as a condition precedent...give to the company... notice of any claim as soon as practicable, but in no event later than the earliest of the following dates...60 days after the effective date of expiration or termination, or the expiration date of the extended reporting period, if purchased;...” In this case, none of the conditional event dates were applicable. It appeared the basis of argument asserted by the carrier was the questionable and undefined phrase “as soon as practicable.” What that means may well yet be determined in court absent any existing case law precedent. While the healthcare insurer may not have suspected that their dispute would turn into a D&O claim, and they may arguably have given notice as soon as practicable when they received service of suit that D&O charges were filed, what could they have done to manage the risk better, avoid the carrier’s claim denial, and mitigate the circumstances?

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Communication - Internal communication with your company’s risk management staff about potential claims is very important, not only from a loss control aspect, but as a quality process. You don’t want the left hand not knowing what the right hand is doing. Ideally, you would like a parley between customer, insurance company

claims manager, and agent to come to a mutual understanding on how potential claims should be reported. The purpose should not be to box each other in by setting traps, but to create a process that has value for all parties. For example, we recently helped a financial services client come to a reporting agreement with their professional liability carrier. The client created an automated format for all complaints above an agreed threshold of retention, and reports monthly to the carrier. While most complaints will never amount to anything, on the off chance one does, reporting compliance has been achieved. One of the key challenges of this reporting technique is to convince underwriting not to punish the client for a claims frequency trend with respect to rating if it's not warranted. Over time, claim trends will reveal themselves and a track record will make itself clear.

Designated Person(s) for knowledge and reporting claims – If the carrier will agree, it may be a good idea to designate certain persons in the company (i.e., President, CFO, General Counsel and/or Risk Manager) as persons who are required to have knowledge of a claim/incident in order for this knowledge to be imputed to the company, and that these identified individuals are responsible for reporting these claims/incidents to the carrier. For example, this will avoid instances where a carrier denies coverage for an employee theft by invoking an exclusion that essentially claims that the rogue employee's knowledge of his own theft was prior knowledge imputed to the company, which should have been reported at the time of the employee's first knowledge.

Bottom line, each insurance carrier defines claim terms and conditions differently. It is important to reserve your rights under the policy and review the definitions with your agent and carrier. The last thing you want is a valid claim rescinded because you didn't report a claim in a timely fashion when you thought you did.

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Sources:

<http://legal-dictionary.thefreedictionary.com/condition+precedent>

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Dan Kuczek brings 20 years of experience to his clients. He has worked in multiple areas of the insurance industry, including both the agency and company side. He is a graduate of Western Michigan University. Dan has earned the designation of Life Underwriting Training Council Fellow.

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