August 2014 Newsletter

RECENT DEVELOPMENTS IN ALABAMA AND THE ELEVENTH CIRCUIT
Selected Insurance Cases and Other Matters of Interest

In this Alabama Update, we have included a summary of numerous cases from the past several months. Included in the Update is the Alabama Supreme Courtôs opinion in *Owners Ins. Co. v. Jim Carr Homebuilder, LLC*, --- So.3d ----, 2014 WL 1270629 (Ala., Mar. 28, 2014) rendered after granting the homeownersô and contractorôs motion for re-hearing. This is the Courtôs second opinion rendered in this litigation, the first of which was summarized in the November 2013 Alabama Update. Owners Insurance filed an application for rehearing with the Court, but the Court denied the application. Therefore, the opinion referenced below is the Courtôs final pronouncement on the issue to date. Also, in *Nationwide Mutual Fire Insurance Co. v. Guster Law Firm, LLC*, --- Fed. Appx. ---, 2014 WL 2700187 (11th Cir. June 16, 2014). The Eleventh Circuit affirmed a lower courtôs grant of summary judgment in favor of the insurer based on the lack of insurable interest referenced in the January Alabama Update. In *Malone v. Allstate Indemnity Co.*, 2014 WL 2592352 (N.D. Ala. June 10, 2014), a federal court in the Northern District of Alabama addresses evidence sufficient to establish a debatable reason in the context of arson, misrepresentation, and advice of counsel defenses.

We hope you find this information useful. If you have any questions or would like to discuss, please do not hesitate to let us know.

Alabama State Law Update

Construction Defect

Owners Ins. Co. v. Jim Carr Homebuilder, LLC, --- So.3d ----, 2014 WL 1270629 (Ala., Mar. 28, 2014), *reh'g denied*, No.1120764 (Ala., June 27, 2014).

Facts: The insured general contractor sought coverage under a CGL policy for an arbitration award arising from construction defects in the construction of a house. The damage from the construction defects occurred after construction was completed on the home. The insurer filed a declaratory judgment action seeking a declaration that it had no duty to indemnify the insured. Following the arbitration award, the insured moved for summary judgment, and the trial court held that the arbitration award was covered by the CGL policy.

The insurer appealed the case, and, on September 20, 2013 the Alabama Supreme Court initially held that there was no occurrence under the policy. The insured and the underlying homeowner filed an application for rehearing with the Court, arguing that this opinion was inconsistent with the Courtôs prior opinion in *Town & Country*. The Court withdrew its September 20, 2013 opinion that we included in our December 2013 newsletter and substituted this opinion.

Issue: ***(1) Whether "occurrence," as it is defined in the CGL policy, excludes coverage***

from the homeowners' property damages. (2) Whether the "Your Work" exclusion in the CGL policy bars coverage from the homeowners' claims against the insured.

Holding: (1) No. The ñessential holdingò of the *Town & Country* opinion was that ñfaulty workmanship itself is not an occurrence.ò To provide clarification, the Alabama Supreme Court stated that ñfaulty workmanship itself is not óproperty damageô ócaused byô or ócarising out ofô an óoccurrence.ôò The purpose of a contractorôs CGL policy is not to cover the cost of repairing or replacing faulty workmanship. Therefore, ñoccurrenceò does not prevent coverage for the property damage alleged.

(2) No. According to the Court, the CGL policy insures a contractor from losses caused by the contractorôs negligence ñwhile engaged in the process of performing the construction work for which it was hired.ò Without supplemental coverage known as ñcompleted operations hazard,ò the CGL policy does not provide coverage for claims arising from exposure to harmful conditions caused by faulty workmanship once the ñongoing operationsò end at the construction site. This type of coverage is specifically excluded by the ñYour Workò exclusion. However, according to the Court, the insured purchased $4,000,000 in ñsupplemental insurance coverageò for completed operations. Therefore, according to the Court, the ñYour Workò exclusion is inapplicable in this action, as the damage occurred after the ñoperationsò were complete.

Uninsured Motorist/Phantom Vehicle Coverage When Contradicting Testimony is Present.
Hines v. Trinity Contractors, Inc., --- So.3d ----, 2014 WL 1258165 (Ala. Civ. App. Mar. 28, 2014).

Facts: The plaintiff, Hines, allegedly lost control of her automobile, crossed the median of the interstate, and struck Kelleyôs automobile, who in turn struck a Southern Haulers tractor-trailer truck driven by Cummings. Hines filed an action against Trinity Contractors, Inc. asserting that a vehicle owned by Trinity had caused her to initially lose control of her car. She also asserted claims against her UM/UIM motorist insurer. Then, Southern Haulers asserted negligence and wantonness claims against Hines and Kelley. At summary judgment, an issue arose as to whether one of Trinityôs trucks ran Hines off the road.

Issue: ***Whether a genuine issue of material fact existed whether a phantom truck owned by Trinity caused the accident.***

Holding: No. In an affidavit and later in a deposition, Hines gave differing accounts as to whether she could identify the phantom truck that ran her off the road. She said a ñrather large truckò ran her off the road, and later said that ñTrinity Contractorsò was written on the truck. Trinity testified that no truck with the description Hines gave was in that area at the time of the accident. The Alabama Supreme Court holds that a court may not consider testimony that contradicts an individualôs previous

testimony. The court found that Hinesô deposition testimony contradicted her affidavit testimony, and that Trinity provided a prima facie case showing that its trucks were not in the area at the time of the accident. Therefore, the Court affirmed summary judgment in favor of Trinity.

Insurance Coverage
Alfa Life Ins. Corp. v. Colza, --- So.3d ----, 2014 WL 1874703 (Ala. May 9, 2014).

Facts: The deceased, his wife, and an employee of the deceased met with an insurance agent and answered questions as the agent completed an application for life insurance. The deceasedôs wife was listed as the beneficiary. The application included a ñConditional Receiptò provision stating that the policy was not effective prior to delivery and acceptance unless certain conditions were met.

The deceased gave the agent a premium check, and the agent told him that he was covered. About six weeks later, the deceased submitted to a medical examination that had been ordered by the insurer. He revealed in the examination that he had a family history of heart disease and that he had received moving traffic violations over the past five years. His examination also revealed his cholesterol was above 255, all of which affected the initial rate that the agent had quoted the insured at application. The deceased was killed in an accident the day after the medical examination.

Upon receipt of the medical examination report two days after the insuredôs death, the insurer determined that it should have charged a higher premium based on the information from the medication examination. The insurer denied the widowôs claim, informing her that the conditions of coverage were not met.

The widow filed a complaint asserting claims for breach of contract and bad faith against the insurer, and a claim for negligent failure to procure insurance against the insurance agent. A jury found in favor of the plaintiff for all three claims and the court denied the defendantsômotion for judgment as a matter of law. The defendants appealed.

Issue: ***1) Whether the deceased fulfilled the conditions in the conditional receipt of the life insurance policy.***
2) Whether the agent had the actual or apparent authority to bind the insurer and create coverage for the deceased.
3) Whether the deceased and the insurer had an oral or written contract allowing the widow to successfully bring a bad-faith claim against the insurer.
4) Whether the deceased's contributory negligence prevented a claim against the agent for negligent failure to procure life insurance.

Holding: 1) No. Because the insurance policy had not been issued at the time of his death and because the deceased did not qualify for the conditional receipt coverage, there was

no coverage.

2) No. In finding that the agent did not have actual or apparent authority to bind the insurer, the Court noted that a clause in the conditional receipt document that specifically stated that: ñno agent . . . is authorized by the company to waive or modify in any way any of the conditions or provisions contained in this conditional receipt.ò Even though it was disputed whether the deceased actually received a copy of the conditional receipt document, the language in the application was sufficient to extinguish any issue of fact as to the insuredôs widowôs claim that the agent had the authority to bind the insurer.

3) No. It is not possible to have a bad-faith claim under Alabama law without a written or oral contract. Since no contract was in place, the insurer is entitled to judgment as a matter of law for the bad-faith claim.

4) Yes. Relying on previous Alabama case law that ñessentially held that it is almost never reasonable for an individual to ignore the contents of documents given him or her in association with a transaction,ò the Alabama Supreme Court held that the deceased was put on notice that he was not provided with immediate insurance coverage when he wrote the check and gave it to the agent. Further, the Court opined that ñ[w]e do not think it unreasonable to conclude as a matter of law that, in this day and age, any adult of sound mind capable of executing a contract necessarily has a conscious appreciation of the risk associated with ignoring documents containing essential terms and conditions related to the transaction that is the subject of the contract.ò The Court concluded that the deceased put himself in ñdangerôs wayò and had a ñconscious appreciation of the danger . . . of suffering a monetary lossò if he died before the conditions precedent to immediate coverage were achieved. Therefore, contributory negligence barred any recovery from the plaintiffôs negligent-procurement claim.

Alabama Federal Law Update

Fraudulent Joinder/Amount in Controversy/Motion to Dismiss
Holderfield v. Allstate Ins. Co., 2014 WL 1600309 (N.D. Ala. Apr. 21, 2014).

Facts: The plaintiffs, residents of Alabama, brought a breach-of-contract, bad-faith, fraud, and suppression action against their insurer, whose principal place of business was in Illinois, and an insurance adjuster, who resided in Alabama. The defendants removed the action to federal court and the adjuster filed a motion to dismiss. In response, the plaintiffs moved to remand the action to state court.

Issue: ***(1) Whether the defendant insurance adjuster was fraudulently joined such that the plaintiff's motion to remand should be denied. (2) Whether the amount in controversy was met such that the plaintiff's motion to remand should be denied.***

(3) Whether the defendant insurance adjuster's motion to dismiss should be granted.

Holding: (1) Yes. The plaintiff cannot maintain breach-of-contract and bad-faith claims against the adjuster because the complaint fails to explain that the adjuster was a party to the insurance contract. There can be no breach-of-contract or bad-faith claims against the adjuster if the adjuster was not a party to the contract. Further, the fraud and suppression claims only contain allegations against the insurer and a fictitious party. Also, the adjuster submitted an affidavit stating that she had no involvement in selling insurance policies. Since the plaintiff did not assert any cause of action against the broker, the adjuster was fraudulently joined, and complete diversity exists.

(2) Yes. Although the plaintiff did not include a specific claim for damages in the complaint, the defendants submitted a Sworn Statement in Proof of Loss that claimed $332,377 in damages. Also, the policy limit was much greater than $75,000. By considering this evidence, the court maintained that the amount in controversy had been met.

(3) Yes. The court found that the complaint does not state a cause of action against the adjuster because the adjuster was fraudulently joined. Therefore, the court dismissed the claims against the adjuster.

Motion to Remand

Advantage Medical Electronics, LLC v. Mid-Continent Cas. Co., 2014 WL 1764483 (S.D. Ala. May 5, 2014).

Facts: The insured, an Alabama-based limited liability company, filed a declaratory judgment and breach-of-contract action against the insurer, which is incorporated in Ohio and has its principal place of business in Oklahoma, relating to an accident that occurred in South Carolina. The insured requested that the court require the insurer to defend and indemnify the insured in an action that will likely be filed against the insured relating to the accident. With regard to the breach-of-contract claim, the insured specifically requested damages less than $75,000. The plaintiff filed the action in state court, and the insurer removed the case to federal court more than ten months later after the plaintiff responded to the insurerôs request for admissions. The insurer removed the case because the insured admitted that the value of certain damaged equipment exceeded $75,000. The insured moved to remand the case to state court, although the insured did not challenge whether diversity exists or whether the removal notice was timely filed.

Issue: ***Whether the action should be remanded to state court, as the amount in controversy does not exceed $75,000 when applying the Lowery preponderance test.***

Holding: Yes. Applying the test set forth in *Lowery v. Alabama Power Co.*, 483 F.3d 1184 (11th Cir. 2007), the insurer is required to ñbear[] the burden of establishing the jurisdictional amount by a preponderance of evidenceò because the damages are unspecified in the complaint. In order to pass the preponderance test, the complaint or later documents and removal notice must unambiguously establish that the amount in controversy is met. Therefore, the court considered what information the insurer learned from the request for admission response that it did not already know, and whether this new information ñunambiguously establish[es] the amount in controversy.ò Although the insured admitted that the value of the damaged equipment was greater than $75,000, the insured argued that the insured thought the insurer meant the present day value of a equipment. Contrary to the insurerôs argument, the insured argued that it did not allege that the equipment was a total loss. Instead, the insured argued that the equipment retained substantial value after the accident. The court found that the response to the request for admission did not help clarify the amount in controversy, and the discovery response did not provide new information. Therefore, the action should be remanded to state court.

Insurable Interest

Nationwide Mut. Fire Ins. Co. v. Guster Law Firm, LLC, --- Fed. Appx. ----, 2014 WL 2700187 (11th Cir. June 16, 2014).

Facts: A building owned by Guster Properties, LLP was destroyed in a fire, and the insured, Guster Law Firm, LLC, sought coverage from its insurer. The insurer filed a declaratory judgment action, seeking a declaration that the law firm, which was the named insured under a property policy, did not have an insurable interest in the building, owned by a separate (albeit related) legal entity. The district court awarded summary judgment to the insurer and the law firm appealed. (**We included the district court's opinion in our January 2014 Newsletter.)**

Issue: ***Whether the district court properly awarded summary judgment to the insurer, as the named insured law firm did not have an insurable interest in the damaged property owned by the principal's other entity.***

Holding: Yes. The Eleventh Circuit adopted the district courtôs reasoning that the insured law firm did not have an insurable interest in the property. Moreover, the court refused to consider arguments raised for the first time on appeal.

The law firm also argued that the insurance contract should be reformed to add the owner of the building as a named insured. However, the court noted that the law firm failed to demonstrate that the insurer and insured agreed that the owner of the property should be the named insured or that the insurer did not care who owned the property. Because ñ[r]eformation is not available to make a new agreement,ò summary judgment was due to be affirmed.

Bad Faith/Debatable Reason in the Arson Context
Malone v. Allstate Indemn. Co., 2014 WL 2592352 (N.D. Ala. June 10, 2014).

Facts: The insuredôs house was destroyed by fire. The insuredôs homeownerôs insurer investigated the loss and determined that the fire was a result of ñarson by someone.ò The insurer also discovered evidence of misrepresentations by the insured in that the insured claimed substantially more in the fire loss (over $82,000 for personal property) than she had in a recently-filed bankruptcy (approximately $1,100 in personal property). When the insurer questioned the insured about the discrepancy, the insured said the personal property number listed in the bankruptcy was not correct, but she never amended her bankruptcy petition. In addition, the insurer hired a private attorney to render a coverage opinion and relied on that opinion in denying the claim. The insurer moved for summary judgment on the insuredôs claims for bad faith claim and negligent, reckless, and/or wanton denial of insurance benefits.

Issue: ***Whether the insurer had a debatable reason to deny homeowners insurance coverage when the insured had financial problems, "arson by someone" was the suspected cause of the fire, and the insurer relied on legal counsel before denying the claim.***

Holding: Yes. The Northern District of Alabama held that the insurer had multiple debatable reasons for denying the claim: (1) evidence of arson; (2) evidence of a misrepresentation by the insured; and (3) advice of counsel. The court noted that ñ[i]f any one reason for denial of coverage is at least arguable, this court need not look any further, and a claim for bad faith refusal to pay will not lie.ò

With regard to the evidence of arson, the court noted that the insurer had the following facts were sufficient to create at least a debatable reason as related to the arson defense:

* evidence of gasoline in an area where no gasoline was stored establishing ñarson by someone;ò

* financial motive in that the plaintiff had filed bankruptcy and planned to move out of state immediately;

* the insured had purchased the insurance policy just days after receiving a job offer that would take her out of the state and several weeks before the fire;

* the insured and her alibi witness gave conflicting accounts of the insuredôs trip to the emergency room around the time of the fire; and

* an informant had contacted the insurer and told the insurer that the insured

intended to recoup $60,000 insurance proceeds, which corresponded with the policy limit.

The court did not determine whether these facts actually established arson, but determined that they ñclearly providedò the insurer with a debatable reason to conclude that the insured had started the fire.

ó

With regard to the misrepresentation defense, the court noted that the insurer had established the following facts:

* the insured had submitted a claim for damaged personal property of $82,000 but, fifteen months earlier, had filed a sworn bankruptcy petition identifying only $1,132.00 in personal property;

* the insured had not shown a sufficient increase in income to explain the increase in personal property;

* when the insured was made aware of the discrepancy, stated that she had not read the sworn bankruptcy petition; and

* the insured never sought to amend the bankruptcy petition.

The court determined that these facts were also sufficient to give the insurer at least a debatable reason to deny the claim based on the insuredôs misrepresentation.

The court also held that the fact the insurer hired a private attorney who rendered an informed coverage opinion that was not against evidence to the contrary, upon which the insurer appropriately relied, was also sufficient to establish a debatable reason for denial of the claim.

For all of these reasons, the court granted summary judgment to the insurer with regard to the insuredôs claims for bad faith.