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## ARTICLE: The Policyholder's Duty to Cooperate

By: [John Travis; Insurance Practice Group Manager](#)

Policies typically require a policyholder to cooperate with the insurer. If the policyholder refuses to cooperate, the insurer may have to decide whether to pay the claim despite the lack of cooperation, or deny the claim. In making that decision, it is helpful to understand the purpose of the cooperation clause, the necessary elements of a failure to cooperate claim, the effect of a failure to cooperate, and consider examples in the case law where coverage has been denied based on a failure to cooperate. This article addresses those issues and also offers guidelines for dealing with an uncooperative policyholder.

### I. Purpose

“In order to protect themselves from false claims, insurers typically include provisions in their policies requiring the insured to cooperate with the insurer in its investigation of claims submitted by the insured. 8 Appelman, *Insurance Law and Practice* (1981), 211-215, Section 4771; 14 Couch, *Cyclopedia of Insurance Law* (1982), 604-607, Section 51:106”; *Northedge Laboratory, Inc. v. Tilden Financial Corp.*, No. CA 10090, 1987 Ohio App. LEXIS 6014 at \*8-9 (2d. Dist. Mar. 3, 1987). “These provisions obligate the insured to make a fair and frank disclosure in response to the insurer’s demands for information.” *Id.*

Compliance with a cooperation clause is “construed to be a condition precedent to liability under the contract.” *Moore v. State Farm Fire & Cas. Co.*, Nos. 9200, 9376, 1985 Ohio App. LEXIS 9595 at \*7 (2d Dist. Dec. 3, 1985). “Such provision is a material part of the policy and breach by the insured in a material respect constitutes a defense to liability.” *Id.*

### II. The Necessary Elements and Effect of Failure to Cooperate

Failure to cooperate may be used as a basis for denying a claim, and as an affirmative defense in an action by the policyholder against the insurer. *Sword v. Slaughter*, No. 92AP-69, 1992 Ohio App. LEXIS 3831 at \*5 (10th Dist. July 21, 1992). “A declaratory judgment is an appropriate remedy for an insurance company to pursue, where the conduct of its insured falls short of the standard that is required in cooperation clauses.” *State Farm Mut. Auto Ins. Co. v. Holcomb*, 9 Ohio App. 3d 79 (9th Dist. 1983).

“*The Insured’s Duty to Cooperate*” is continued on page 10.

## Supreme Court of Ohio

*Claims of defective construction or workmanship brought by a property owner are not claims for property damage caused by an occurrence under a commercial general liability policy.*



Younglove Construction entered into a contract with PSD Development to construct a feed-manufacturing plant in Ohio. PSD did not pay Younglove for its work, so Younglove sued PSD and three others in federal court for breach of contract and related causes of action. PSD answered and alleged damages as a result of a defective steel grain bin constructed by Custom Agri Systems, which was brought in on a third-party complaint. Custom, sued for defective construction and consequential damages from that defective construction, demanded coverage under the CGL policy issued by its insurer, Westfield. In response, Westfield intervened in the litigation and sought a declaration that there was no coverage because none of the claims against Custom were for property damage caused by an occurrence. Alternatively, Westfield argued that if there was property damage caused by an occurrence, coverage was excluded.

Eventually the Sixth Circuit Court of Appeals asked the Supreme Court of Ohio to answer two dispositive questions: (1) are claims of defective construction/workmanship brought by a property owner claims for property damage caused by an occurrence under a CGL policy; and (2) if such claims are considered property damage caused by an occurrence, does the contractual liability exclusion in the policy preclude coverage for claims for defective construction/workmanship?

Although the court observed that it is widely accepted that claims of defective workmanship are not covered by CGL policies, the court explained: “Specifically, we must decide whether Custom’s alleged defective construction of and workmanship on the steel grain bin constitute property damage caused by an occurrence.”

After noting an Ohio appellate decision that focused on whether the contractor controlled the process leading to the damages and whether the damages were anticipated, the Supreme Court concluded: “[C]laims for faulty workmanship, such as the one in the present case, are not fortuitous in the context of a CGL policy like the one here.” The court also cited with approval an Arkansas Supreme Court case where that court stated that the contractor’s obligation to repair or replace its subcontractor’s defective workmanship could not be deemed unexpected on the part of the contractor, and therefore, failed to constitute an ‘event’ for which coverage existed under the policy.

*Supreme Court of Ohio summary continued on Page 9.*

## Ohio State Appellate Decisions

*In order to no longer qualify as an insured resident relative, the relative must acquire a new residence with the intent to remain in that residence.*

Robert Schill was operating his own motor vehicle when he negligently struck and killed Dr. Miles M. Coburn, who was riding his bicycle. Coburn's estate filed suit for wrongful death and Schill sought liability coverage under his parents' automobile liability policy with Cincinnati Insurance Company. The Cincinnati policy defined an insured resident relative as: "A person related to 'you' by blood, marriage or adoption that is a resident of 'your household' and whose legal residence of domicile is the same as yours." The court reasoned that a domicile "is a person's 'pre-eminent headquarters'" and that "while a person may have multiple residences, he may have only one domicile at any one time." Although Schill's parents had moved from Ohio to live in Florida at the time of the accident, "a person is presumed to continue his old domicile until it is clearly shown that he has acquired a new one." In order to establish a new domicile, one must have both a residence and an intention to remain. Schill's parents established a residence in Florida but not an intention to remain there permanently. Rather, they maintained a residence in Ohio where their son, Robert Schill, resided. Therefore, the court found Robert qualified as an insured resident relatively under his parents' auto liability policy. [\*Spaeth v. State Auto Mut. Ins. Co., 8th Dist. No. 97715, 2012-Ohio-3813.\*](#)




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*An insured can have only one domicile.*

*A life insurer need not search death indexes; the policy beneficiaries must provide notice of death.*

Plaintiffs obtained life insurance policies from Nationwide payable upon "due" or "satisfactory" proof of the insured's death. They filed a class action alleging that Nationwide's policy language is ambiguous regarding who is required to provide "proof of death." Plaintiffs sought a declaration that Nationwide must annually search the Death Master File maintained by the Social Security Administration to determine whether any of its insureds had died, and that its failure to do so amount to bad faith. The court found that policy language requiring payment only "upon receiving proof that the Insured has died while this Policy is in force and before the Maturity Date" was clear and unambiguous. It required notice from the insured and did not place an obligation upon Nationwide to conduct an independent investigation. The court found plaintiffs' class action properly dismissed for failure to state a claim upon which relief can be granted. [\*Andrews v. Nationwide Mut. Ins. Co., 8th Dist. No. 9789, 2012-Ohio-4935.\*](#)

*Exception to definition of covered autos for vehicles owned by employees of the insured is valid.*

Ameritemps, Inc., was insured under a commercial auto liability policy issued by Crum & Forster. Several of Ameritemps' temporary employees negligently caused an accident while traveling in their own vehicle from the dispatch office to the place of their employment. The court found no coverage under the Crum & Forster policy because any "auto hired or borrowed from an employee" is "subject to the exception to the definition of 'covered autos' pertaining to vehicles borrowed from employees." [\*Crum & Forster Indem. Co. v. Ameritemps, Inc., 8th Dist. No. 97843, 2012-Ohio-4160.\*](#)

*Waiver of subrogation clause prohibits recovery for damages to work and non-work.*

MEROC was insured under a Westfield CGL policy which insured both the building structure and its contents. MEROC contracted with Affina to perform structural work on the building. MEROC did not purchase additional insurance for the construction project. During construction a fire caused damage to both the project and other contents of the building. Westfield, as subrogee of MEROC, sought recovery for the damage from Affina. The trial court awarded Affina summary judgment based on a “waiver of subrogation clause” in the construction contract, which stated: “the Owner and Contractor waive all rights against...each other...for damages caused by fire or other causes of loss to the extent covered by property insurance obtained pursuant to this Section 11.3 or other property insurance applicable to the Work.”

Westfield appealed, arguing the clause waives Westfield’s right to sue for damages to “work” as defined by the policy, but does not waive the right to sue for damages to non-work property. The court of appeals affirmed, noted that it was a matter of first impression in Ohio and examined the minority and majority views in other jurisdictions. The court adopted the majority approach, finding the clause barred recovery because the damages to the building were covered by ‘other property insurance,’ namely the Westfield policy. Making a distinction between work and non-work was contrary to the plain language of the provision and would invite litigation as to whether the damages fall within the scope of the contract. [Westfield Ins. Group v. Affina Development, LLC., 5th Dist. No. 12-CA-2, 2012-Ohio-5348.](#)

*A misstatement by an insured is not a warranty that voids the insurance policy unless: 1) the misrepresentation is either in the policy or is incorporated into the policy; and 2) the policy plainly warns that a misstatement or misrepresentation renders the policy void from its inception.*

Attorney Goodman applied for legal malpractice insurance from Medmarc Insurance. He responded ‘no’ when asked whether he was aware of any possible claims, errors, or omissions. Several days after the policy was issued, Goodman received a letter threatening a malpractice suit based on his prior failure to timely appeal a judgment adverse to one of his clients. Medmarc denied coverage, claiming that the policy was *void ab initio* since it provided that: “the statements in the application and in all additional materials submitted by any ‘Insured’ for this Policy \* \* \* are made a part of this Policy, are personal representations, \* \* \* shall be deemed material and that this Policy is issued in reliance upon the truth of such representations.” The court held that the policy was not *void ab initio* because it did not plainly warn the insured that a misstatement or misrepresentation renders the policy void from its inception. [Goodman v. Medmarc Ins., 8th Dist. No. 97969, 2012-Ohio-4061.](#)



*The actions of an insurer may be imputed to its insured for purposes of determining personal jurisdiction.*

In 2008, plaintiff, an Ohio resident, was involved in an accident in Indiana with defendant's decedent Oeding, who was an Indiana resident. The decedent was operating his vehicle within the scope of employment for defendant J&R, an Indiana company. Defendants were insured under a policy issued by defendant Auto Owners Insurance Company. During the course of investigation, Auto Owners placed a hold on Plaintiff's trailer tractor for approximately 5 months.

After suit was filed in Ohio, all of the claims settled except for Plaintiff's claim for loss of use of his trailer. Defendants had filed a motion to dismiss for lack of personal jurisdiction. Plaintiff argued that since Auto Owners transacted business in Ohio, caused tortious injury in Ohio, and had a license to do business in Ohio, its conduct was imputed to its insured, J&R, for purposes of determining personal jurisdiction. In a case of first impression in Ohio, the court found that, "[u]nder the facts and circumstances of this case, we find that the actions of Auto Owners may be imputed to J&R and Oeding for the purposes of establishing personal jurisdiction." The court then went on to find that because the economic injury to Plaintiff occurred in Ohio and Auto Owners conducts business in Ohio, Auto Owners falls under the Ohio long-arm statute and, therefore, its insureds fall within the purview of Ohio's long arm statute. The court then determined that, under the facts of this case, Auto Owners had the necessary minimum contacts with Ohio to satisfy due process. By virtue of the conduct of Auto Owners, its insureds also "had sufficient minimum contacts with Ohio to comport with due process." Therefore, the court had personal jurisdiction over the defendants. [\*Fraley v. Estate of Timothy Oeding\*, 12th Dist. No. CA2011-09-180, 2012-Ohio-4770.](#)

*Father's vehicle was considered "furnished or available for regular use" by his minor child pursuant to a shared parenting plan.*

Minor plaintiff Justis Roos was injured in a single car accident while he was a passenger in a vehicle owned and operated by his father, Defendant Bryon Roos. Bryon was taking his son to a medical appointment when he lost control of his vehicle. At the time of the accident, Justis' parents were divorced and shared custody pursuant to a shared parenting plan. Under the plan, Bryon had parenting time during his days off work and was required to provide transportation to Justis during his parenting time. Bryon testified that he complied with the plan and always provided transportation in the same vehicle that was involved in the accident. After Bryon's insurance policy denied coverage for Justis, an uninsured motorist claim was filed under Plaintiff's mother's policy with American Family Insurance. The trial court granted the insurer's motion for summary judgment and "found that the mother's insurance policy did not cover Justis' injuries because Justis was a resident of mother's household and Bryon's vehicle was furnished for Justis' regular use." The trial court determined that the shared parenting plan required that Bryon provide Justis with transportation and "Justis 'used' the vehicle as a passenger because he benefitted from being transported to various activities." The appellate court agreed that Bryon's vehicle was "furnished or available for regular use" by Justis and affirmed the trial court's decision. [\*Roos v. Roos\*, 12th Dist. No. CA2012-02-033, 2012-Ohio-5243.](#)



*An insurer who engages in settlement negotiations with a third-party may be sued independent of the insurance contract by that third-party for breach of any agreements reached as to the claim.*

Whitacre was involved in a motorcycle accident caused by an insured of Nationwide Insurance Company. Nationwide engaged in verbal settlement negotiations and entered into a verbal contract to pay all of Whitacre's medical expenses, which Nationwide then refused to pay. Whitacre sued Nationwide (on the verbal settlement contract) and its insured (for the accident). Whitacre's claims against the insured were settled and dismissed but his claim against Nationwide proceeded to discovery. Whitacre sought discovery of Nationwide's claim file and the depositions of the claims adjusters. Nationwide argued privilege, but the trial court issued an order compelling Nationwide to make the requested production. Nationwide appealed, claiming privilege and arguing that Whitacre, as a non-party to the insurance contract, could not obtain discovery of the claims file. The court of appeals disagreed and affirmed the trial court's order compelling production, reasoning that Whitacre's "claims are based on the premise that he is not a third party, but instead, has formed his own contract with [Nationwide] to pay his claim." The court further found the claim file not to be privileged because "documents produced by a company in the course of business do not become privileged merely because they are given to an attorney, and they are certainly not subject to privilege where there is no indication that they were ever transmitted to an attorney or referenced when seeking representation." [Whitacre v. Nationwide Ins. Co., 7th Dist. No. 11 BE 5, 2012-Ohio-4557.](#)

*A two and one-half year delay in providing notice of a claim is presumed prejudicial to the insurer and, absent evidence rebutting the presumed prejudice, bars coverage as a matter of law.*

Kelley was insured for uninsured motorist coverage under an automobile policy issued by State Farm. She was injured while walking to her car in a parking lot by another car backing out of a parking space. She sued State Farm for uninsured motorist coverage and alleged a bad faith denial of her claim. However, she had "waited over two-and-one half years to report the incident and then filed suit within 60 days of the late reporting in violation of the policy's prompt notice requirement." State Farm moved for summary judgment based on late notice. The trial court and court of appeals agreed that the two and one-half year delay in providing notice "is presumed prejudicial to the insurer absent evidence to the contrary." Kelley failed to rebut the presumption of prejudice and because "an insured's duty to give \* \* \* proper and timely notice of an occurrence is a condition precedent to coverage," coverage was not available. [Kelley v. State Farm Mut. Auto. Ins. Co., 8th Dist. No. 98749, 2013-Ohio-585.](#)

*Policy requiring action to be “started” within one year bars insured from refiling outside limitations period after voluntarily dismissing a timely claim.*

Plaintiff filed a breach of contract action against State Farm on January 14, 2005 for failure to pay for property damage arising in part from an incident occurring on January 14, 2004. Plaintiff then voluntarily dismissed the complaint, and refiled her action in March of 2011. The trial court granted judgment on the pleadings to State Farm, finding that the claim was barred by the one-year limitations period in the Plaintiff’s insurance policy that required any action to “be started within one year after the date of loss or damage.” On appeal, the Plaintiff argued in part that she had filed her initial lawsuit against State Farm within one year of the loss, and had therefore timely “started” her action against State Farm in accordance with the policy provision. The Second District disagreed and affirmed the trial court’s decision. Relying on *Dominish v. Nationwide Ins. Co.*, 129 Ohio St.3d 466, 2011-Ohio-4102, which found the language of the limitations provision to be unambiguous, the court held that a plaintiff could not avoid the one year limitations period by simply filing a suit, voluntarily dismissing the suit, and then refiling with the normal 15-year statute of limitations. [\*Offill v. State Farm Fire & Cas. Co.\*, 2nd Dist. No. 25079, 2012-Ohio-6225.](#)

*The location where the injury takes place, not the location of the insured’s acts, determines if the event occurred within the policy’s coverage territory.*

Numerous plaintiffs filed claims against Chiquita International, Inc. alleging that it had illegally financed terrorist groups in Columbia, resulting in damages to the plaintiffs. Chiquita and one of its insurers, National Union, each filed declaratory judgment actions as to National Union’s obligation to defend and indemnify. The trial court denied competing motions for summary judgment, and National Union was found liable for defense costs and losses at trial. On appeal, National Union argued that it owed no defense because (1) there was no “occurrence” under the policy as the underlying complaints alleged intentional conduct, and (2) all injuries for which Chiquita faced liability occurred in Columbia, outside the policy’s coverage territory. The appellate court agreed and reversed. The applicable policy defined a covered “occurrence” as “an accident,” and while the underlying complaints alleged some counts sounding in negligence, those counts were all based on Chiquita’s alleged intentional conduct (*i.e.* vicarious liability for deaths, aiding and abetting, and conspiracy). Furthermore, the policy defined the applicable “coverage territory” as the U.S., Puerto Rico and Canada. While the trial court found that the alleged negligent acts took place in the U.S., the appellate court held that “it is the location of the injury – not some precipitating cause – that determines the location of the event for purposes of insurance coverage.” As there was no occurrence, and the injuries occurred outside the coverage territory, no duty to defend existed. [\*Chiquita Brands Int’l, Inc. v. Nat’l Union Fire Ins. Co.\*, 1st Dist. No. C-120019, 2013-Ohio-759.](#)



*Gallagher Sharp celebrated its 100 year anniversary in 2012.*

## Sixth Circuit and District Opinions

*Expenses incurred by insured advising of and protecting its customers from a security breach caused by an outside computer hacker were a covered loss under a "blanket crime policy."*

DSW Shoe Stores sought coverage from its insurer under a "blanket crime policy" for costs incurred in defending lawsuits and administrative investigations, improving its computer systems, public relations, and associated fees resulting from a hacker's theft of consumer information. Claiming the commercial crime policy was akin to a fidelity bond, National Union denied coverage under a computer fraud rider on the grounds that the claim arose from indirect losses created by third party theft of proprietary information. The court rejected the argument, holding that the policy language losses "resulting directly from" computer fraud was ambiguous and did not limit coverage to solely first party losses. The court determined that a proximate cause standard was the best method for determining whether coverage existed. Lastly, an exclusion for losses of proprietary information, trade secrets, confidential processing methods, or other "confidential information" did not apply. The stolen consumer credit card and checking account information – the largest component of the \$6.8 million loss – was not "proprietary" information as it was not owned by DSW and, under the doctrine of *ejusdem generis*, the term "confidential information" was limited to the insured's secret information involving the manner in which their business was operated. [\*Retail Ventures, Inc. v. Nat'l Union Fire Ins. Co.\*, Nos. 10-4576/4608, 2012 U.S. App. LEXIS 17850, 2012 Fed. App. 0279P \(6th Cir. Aug. 23, 2012\).](#)

*An insurer's acceptance of premiums on a homeowner's policy with knowledge that the named insured has passed away may create an implied contract with the decedent's heir.*

The plaintiff's house, which he inherited when his father passed away, was destroyed by fire. While the father was alive, he maintained a homeowner's insurance policy on the house provided by Allstate; Bank of America had a mortgage on the property and paid the premiums from the father's account. After the father passed away, Bank of America continued to pay the insurance premiums, but now did so from the plaintiff's account. Allstate continued to renew the coverage but never named the plaintiff on the policy. Allstate denied coverage for the loss because the policy was not in the plaintiff's name at the time of the fire. While the court agreed that there was no express contract between the plaintiff and Allstate, it determined that an implied in fact contract might exist. The evidence established that Allstate cancelled the father's *automobile* policy after his death, so their continual acceptance of the premium payments on the *homeowner's* policy could constitute a contract implied in fact with the plaintiff. [\*Ramsey v. Allstate Ins. Co.\*, No. 11-4347, 2013 U.S. App. LEXIS 2776 \(6th Cir. Feb. 8, 2013\).](#)

*A policyholder is deemed to have notice of an exclusion added to a renewal policy when the insurer sends a separately attached letter.*

The policyholder was sued for violating the Junk Fax Act, and sought coverage for the claim from its insurer. North River denied the claim under an exclusion for unsolicited communications that was added when the policy was last renewed. The policyholder asserted that it was not provided with adequate notice of the exclusion because of the multitude of documents insurer sent with the updated policy. The court held that “notice is sufficient if it is provided in ‘a separately attached and clearly worded letter describing the modifications.’” Further, notice does not need to be addressed to a specific individual at the insured company to satisfy notice requirements. [\*MDC Acquisition Co. v. North River Ins. Co., et al., Northern District of Ohio Case No. 5:10 CV 2855 \(Sept. 27, 2012\).\*](#)



### ***Supreme Court of Ohio summary continued from page 2:***

The Arkansas Supreme Court held that defective workmanship standing alone resulting in damages only to the work product itself is not an occurrence under a CGL policy. That court also observed that to protect itself from faulty performance by a subcontractor, a contractor can require a subcontractor to purchase a performance bond.

Therefore the Supreme Court answered the first certified question only and held in its syllabus that claims of defective construction or workmanship brought by a property owner are not claims for property damage caused by an occurrence under a commercial general liability policy.

The opinion was written by Chief Justice Maureen O’Connor; Justices Lundberg Stratton, Lanzinger, Cupp, and McGee Brown concurred in that opinion. Justice O’Donnell concurred in judgment only. Justice Pfeiffer, the sole dissenter, raised a variety of procedural and substantive objections. Substantively, he stated that the question should be whether the defective workmanship was intentionally caused, and if coverage is not owed, it is by operation of the policy’s exclusion. He asserted that a deliberate act such as performing construction work can have accidental consequences. [\*Westfield Ins. Co. v. Custom Agri Sys., Inc., 133 Ohio St.3d 476, 2012-Ohio-4712.\*](#)



**Article: Policyholder's Duty to Cooperate continued from page 1:**

Ohio follows the weight of authority which requires that a policyholder's lack of cooperation results in material and substantial prejudice to the insurer to constitute a defense to liability. *Holcomb, supra*. The courts recognize that "[a]lthough the concept of prejudice is not susceptible to a bright-line analysis, prejudice has been described as seriously impairing the insurer's ability to investigate a claim." *Johnson v. Allstate Ins. Co.*, 11th Dist. No. 2001-T-0127, 2002-Ohio-7165 at ¶ 31. In general, "whether an insured has cooperated with an insurer as required by a liability insurance policy is a question to be determined in each case in light of the particular facts and circumstances." *Moore, supra* at \*7. However, "[w]hen the facts presented are undisputed, whether they constitute a performance or breach of a written contract, is a question of law for the court." *Luntz v. Stern*, 135 Ohio St. 225, 228 (1939).

If the insurer claims a lack of cooperation, "the insurance company must establish [its] diligence in soliciting the assistance and cooperation of [its] insured and must establish that the particular circumstances of the case did not justify the insured's [alleged failure to act or comply with the insurer's request]." *Sword, supra* at \*9. Moreover, like most defenses, an insurer may waive its defense of failure to cooperate. *Harless v. Sprague*, 9th Dist. No. 23546, 2007-Ohio-3236 at ¶ 27.

### III. Examples of Failure to Cooperate

Ohio courts have little tolerance for a policyholder failing to cooperate in the investigation of a claim. In *Marcum Transport & Rigging, Inc., supra* at \*7, the court held that "[a]n insured's failure to cooperate by virtue of misrepresentations is material and prejudicial."

In *Williams v. Permanent General Assurance Corp.*, 8th Dist. No. 80536, 2002-Ohio-4445, the court affirmed the trial court's grant of summary judgment to the insurer because the policyholder refused to submit to an examination under oath ("EUO"). The court stated that "[t]he insurer must have access to information held by the insured when making coverage decisions," and concluded that "[t]he refusal to provide a statement under oath constitutes a substantial and material breach of the insurance agreement." *Id.* at ¶ 28. Further, the court held that "[b]y including the words 'when and as often as "we" reasonably require' in the clause, [the insurer] placed its insured on notice that multiple statements and/or multiple types of statements might be required." *Id.* at ¶ 36.

Even if the policyholder submits to an EUO, refusing to answer questions may be deemed a failure to cooperate. Ohio case law "supports complete avoidance of an insurance policy where an insured fails to submit to oral examination or answer specific questions pertaining to financial status, and income tax returns." *Moore, supra* at \*13. "In these situations courts have determined, without knowledge of what the oral examination or answers to specific questions would have revealed, that the insurer is substantially and materially prejudiced and entitled to completely avoid its obligation under an insurance policy." *Id.* at \*14.

Although an insured has a constitutional right not to incriminate herself, if she pursues a claim she still must cooperate. In *FT Mortgage Cos. v. Williams*, 12th Dist. No. 2000-09-023, 2001-Ohio-8694, the court explained that an insured could not use the invocation of her Fifth Amendment right against self-incrimination to relieve her of the duty to answer under oath questions posed by the insurer.

*Continued on page next page.*

A policyholder's financial condition is often at issue. In *Northedge Laboratory, Inc., supra*, the insured refused to sign an authorization for the insurer to investigate the insured's financial condition in an arson case. The court affirmed summary judgment in favor of the insurer because the policyholder could not rebut the insurer's claim "that the standard bank confirmation inquiry was essential to a complete investigation." *Id.* at \*14. Similarly, in *Moore, supra*, the court found that "income tax returns are clearly material and admissible where the insurer raises arson as an affirmative defense to liability, in order to clarify the policyholder's financial situation and shed light on possible motive for arson" and "that it is only logical to preclude an insured's recovery where arson is suspected, when he refuses to provide a copy of his income tax return." *Id.* at \*10-11 & 14.

Cell phone records may also be relevant. In *Doerr v. Allstate Ins. Co.*, 121 Fed. Appx. 638, 641-42 (6th Cir. 2005), the court found that the policyholder's cellular phone records were "arguably relevant to determining [the insured's] whereabouts and contacts around the time of the fire," that "[d]ue to [the insured's] continued refusal [to produce relevant records], [the insurer] was unable to determine motive, alibi, or other aspects of [the insured's] involvement (or non-involvement) in the fire," and "[a]ccordingly, [the insured's] refusal to produce the requested records was a breach of his duty to cooperate and materially prejudiced [the insurer's] investigation."

#### IV. Guidelines

Insurers faced with an uncooperative policyholder may consider the following guidelines:

1. Set forth in writing, ideally at the outset, the policyholder's duties under the policy.
2. Make reasonable requests that are relevant to the investigation.
3. If necessary, set reasonable deadlines. If appropriate, afford the policyholder more time to comply with the requests.
4. Consider any reasonable concerns or objections the policyholder may have as well as any legitimate difficulties the policyholder may encounter. Thus, the *insurer* should cooperate with any good faith efforts of the policyholder to cooperate.
5. Before denying a claim, advise the policyholder in writing that the failure to cooperate may have that result. Setting a final deadline may be advisable.
6. If the failure to cooperate continues, *and* the insurer is satisfied that it can show that the information sought is relevant *and* the policyholder's failure to provide that information is prejudicial, consider denying the claim.

Insurers should be alert to claims where a policyholder fails to cooperate. By properly invoking a failure to cooperate defense, an insurer can discriminate between legitimate claims that should be paid and illegitimate claims that should be denied.

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## Gallagher Sharp Insurance Practice Group Profile:

The insurance practice group has a long history of defending insurers and insureds in all types of litigation, including coverage actions, ERISA claims, bad faith suits, fire losses, uninsured/underinsured motorist claims, and other first and third-party complex litigation. John Travis is the Insurance Practice Group Manager.

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