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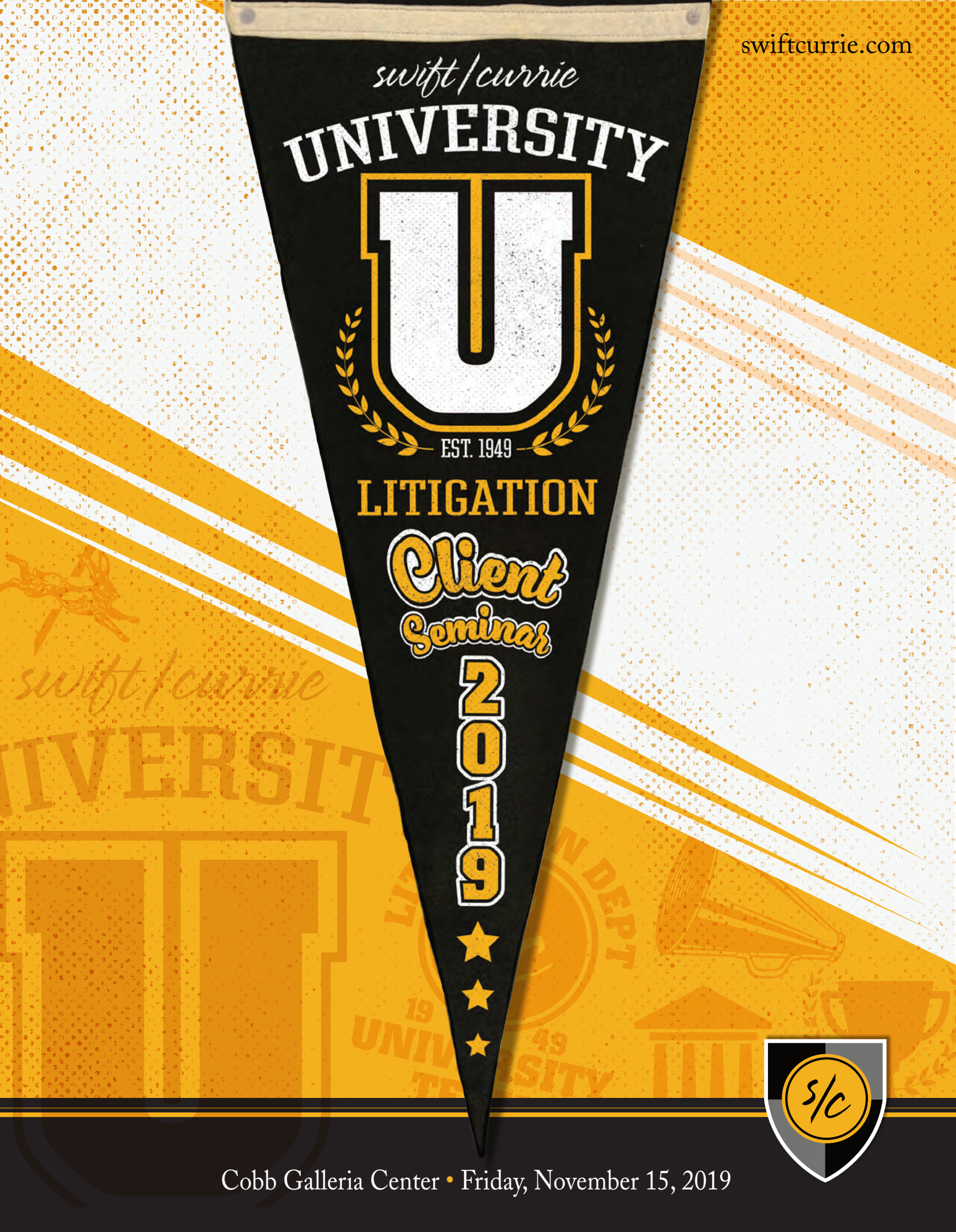

Cobb Galleria Center • Friday, November 15, 2019

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November 15, 2019

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Based on more than 50 years of representing clients in Georgia, Alabama and throughout the country, Swift, Currie, McGhee & Hiers, LLP, has evolved into a law firm capable of handling all areas of civil law and litigation. With approximately 150 attorneys, Swift Currie possesses the resources and abilities to tackle the most complex legal problems, while at the same time providing our clients with individualized, prompt and cost-effective service. Our law firm has a wealth of experience across numerous practice areas and our depth of legal talent allows us to tailor such strengths to individual cases. Our firm's philosophy is to provide our clients with creative, aggressive and professional representation of their interests. We also strive to conduct ourselves in a manner consistent with the legacy of our four founding partners. No matter the issue in dispute, Swift Currie has attorneys ready to assist you. We believe we have a well-deserved reputation for high-quality legal services and dedicated attorneys. Finding creative solutions to complex problems — that is our commitment to our clients.

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Maren R. Cave, Stephen M. Schatz, Bradley S. Wolff

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Avoiding the Infirmary: Medical Malpratice and Medical Causation

By Drew C. Timmons

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Drew Timmons counsels clients through various methods to efficiently resolve disputes, mitigate potential liability and defend claims related to medical malpractice, premises liability, insurance coverage, automobile liability, construction defects and trucking litigation. He represents a wide range of entities that include national retailers, medical professionals and facilities, public school systems, multifamily real estate owners and managers, transportation companies and contractors. He also represents insurance carriers in first-party coverage disputes and bad faith actions.

Drew works closely with clients from the beginning of a claim to evaluate realistic results, identify a successful outcome and cater his work toward the client's defined goal, whether that means negotiating an early settlement, engaging in discovery or motion practice or preparing the case for trial.

Based on his experience working with a diverse range of businesses, as well as his past work at both small and national firms, Drew's broad perspective allows him to be adaptable to the needs and unexpected challenges in his clients' matters. He is committed to developing a partnership with the client and communicating thoroughly and clearly to establish expectations and develop an effective legal strategy.

Drew is committed to serving his community and is a member of the firm's Community Relations Committee. He actively supports JDRF, a global type 1 diabetes research foundation, as well as Back on My Feet, an organization providing opportunities to the homeless through running-based incentive programs. Drew is also a member of the firm's Hiring Committee.

Avoiding the Infirmary: Medical Malpractice and Medical Causation

In some respects, a medical malpractice lawsuit is very similar to any other bodily injury tort claim. However, there are various unique rules and standards that specifically apply to claims for medical malpractice, which can affect the strategy and points of emphasis in discovery when defending a negligence claim against a physician, nurse or hospital. This paper does not touch on all of the peculiarities and distinctive defense strategies that should be implemented in the defense of these serious claims, but instead provides an overview of some important issues to remember.

EXPERT AFFIDAVIT

As defense lawyers and claims adjusters are well aware, a general negligence complaint may assert any number of duties and breaches by a defendant, many of which are not necessarily grounded in statute, regulation or any other legal standard. The notice pleading standard under Georgia law allows most of these claims to survive at least through the discovery period. However, medical malpractice claims (and other professional negligence claims) are treated differently from the start. In Georgia, a plaintiff who initiates a lawsuit for medical malpractice must attach to her complaint "an affidavit of an expert competent to testify, which affidavit shall set forth specifically at least one negligent act or omission claimed to exist and the factual basis for each such claim."[1] Meaning, rather than the plaintiff having at least six months[2] to search for a hired gun to support her professional negligence claim, she is required to have expert support for the allegations of her complaint up front. This requirement applies to professional negligence claims against almost any medical professional, including doctors, counselors, physical therapists, chiropractors, social workers, dieticians and physician's assistants.[3] It even applies if the specific allegations of the complaint avoid the express allegation of professional negligence. Regardless of nomenclature, any claim asserted that is predicated on allegations "that the defendant-professional . . . rendered negligent professional services" falls within the ambit of the statute.[4]

Not only does the expert affidavit requirement force a plaintiff alleging professional negligence to spend some time and money exploring her theories prior to filing suit, it also provides defense counsel and the defendant medical provider with an early look at the specific breaches of the standard of care that are likely to be the focus of the plaintiff's case. Moreover, the expert who signs the affidavit is usually the person the plaintiff will identify as a testifying expert, and the affidavit can allow for early research into the expert's background, specialty and prior testimony. There is only one exception permitting a plaintiff to avoid filing an expert affidavit contemporaneously with the complaint and its application is important to remember. The statute allows for a plaintiff who files her complaint within 10 days of the statute of limitations to supplement with an affidavit within 45 days of the filing of the complaint under certain, very specific circumstances.[5]

STATUTE OF LIMITATIONS

Due to the nature of medical malpractice claims, including the difficulty for lay plaintiffs to identify and associate certain medical conditions or injuries with the potential negligence of a medical professional, medical malpractice claims also have unique rules relating to the statute of limitations.

Malpractice claims are generally subject to the same two-year limitation period as other claims for bodily injury,[6] but unlike the accrual of other negligence claims, the statute of limitations for a medical malpractice

1 O.C.G.A. § 9-11-9.1(a).

2 By local rule, the discovery period in state court lasts for six months, unless otherwise shortened or extended by court order. Uni. Sup. Ct. R. 5.1.

3 The specific professionals to whom the statute applies are listed within the statute. O.C.G.A. § 9-11-9.1(d).

4 *Hobbs v. Great Expressions Dental Ctrs. of Ga., P.C.*, 337 Ga. App. 248, 249, 786 S.E.2d 897 (2016).

5 The attorney who filed the complaint must also swear by affidavit that his firm was not retained more than 90 days before the statute of limitations expired, and that there was not sufficient time to prepare an expert affidavit. O.C.G.A. § 9-11-9.1(b).

6 O.C.G.A. § 9-3-33.

claim focuses on the date of the injury, rather than the date of the negligent act or omission. "[A]n action for medical malpractice shall be brought within two years after the date on which an injury or death arising from a negligent or wrongful act or omission occurred."[7] The language of this statute was crafted to allow for claims in which the resulting injury and the medical treatment do not occur simultaneously, as you typically see in a trip-and-fall or automobile accident case. Georgia courts have expressly ruled the statute is not to be construed to allow for the tolling of the statute until the plaintiff discovers the relationship between her injury and the medical care. Rather, the period of limitation begins to run when the injury occurs and/or is discovered by the plaintiff, even if "plaintiff's lack of awareness of the causal relationship between the injury and defendant's breach of duty effectively precludes her from bringing suit at that time."[8]

Notwithstanding the above, medical malpractice actions are subject to a five-year statute of repose, beginning from the date of the negligent act or omission.[9]

APPLICABLE STANDARD OF CARE

A person professing to practice surgery or adminster medicine for compensation must bring to the exercise of her profession a "reasonable degree of care and skill," and any injury resulting from a want of such care and skill shall be recoverable.[10] The "degree of care and skill required is that which, under similar conditions and like surrounding circumstances is ordinarily employed by the profession generally."[11] As with other negligence cases, the burden of proof lies with the plaintiff. In a medical malpractice case, it is presumed the medical services were performed in an ordinarily skillful manner.[12] In order to rebut this presumption, a plaintiff may not use just any "arbitrary or artificial standard,"[13] but must rely on sworn testimony from a doctor or other expert that "the defendant-doctor failed to exercise that degree of care and skill which would ordinarily have been employed by the medical profession generally under the circumstances."[14] Without such testimony, a plaintiff's claims must fail.

Moreover, the Court of Appeals of Georgia and the Supreme Court have long held the standard of care for a physician may not be established "with evidence of an expert witness's personal practices, or evidence about the course of conduct the expert would have followed under similar circumstances."[15] Although a testifying expert may be examined on direct or cross regarding her personal practices, such testimony does not establish the standard of care on its own and may only be used to evaluate the credibility of the expert.[16]

In reviewing expert opinions regarding the standard of care, it is especially important to focus on the expert's background and prior testimony. Some key questions for cross-examination will relate to the expert's qualifications, personal practices, specific experience with the same procedure or illness and tendency to offer opinions that may exceed the scope of her experience, as well as frequency and subject matter of prior testimony.

EMERGENCY MEDICAL CARE

As discussed above, in nearly all medical malpractice cases, the plaintiff's burden of proof is the same as any other negligence case: the plaintiff must prove by a preponderance of the evidence that the physician or health care provider violated the standard of care, *i.e.*, committed "ordinary negligence."[17] However, for certain health care liability claims based on "emergency medical care," health care providers will be liable only if the plaintiff proves by "clear and convincing evidence" (rather than the usual preponderance of the evidence) that the "provider's actions showed gross negligence" (rather than the usual ordinary negligence).[18]

7 O.C.G.A. § 9-3-71(a).
8 *Jones v. Lamon*, 206 Ga. App. 842, 426 S.E.2d 657 (1992); *Luem v. Johnson*, 258 Ga. App. 530, 574 S.E.2d 835 (2002).
9 O.C.G.A. § 9-3-71(b).
10 O.C.G.A. § 51-1-27.
11 *Hayes v. Brown*, 108 Ga. App. 360, 363, 133 S.E.2d 102 (1963).
12 *Killingsworth v. Poon*, 167 Ga. App. 653, 654, 307 S.E.2d 123 (1983).
13 *Id*. at 655.
14 *Bowling v. Foster*, 254 Ga. App. 374, 377, 562 S.E.2d 776 (2002).
15 *Dendy v. Wells*, 312 Ga. App. 309, 314, 718 S.E.2d 140 (2011).
16 *Condra v. Atlanta Orthopaedic Group, P.C.*, 285 Ga. 667, 672, 681 S.E.2d 152 (2009); *Griffin v. Bankston*, 302 Ga. App. 647, 651-52, 269 S.E.2d 229 (2009).
17 *Johnson v. Omondi*, 294 Ga. 74, 76, 751 S.E.2d 288 (2013).
18 O.C.G.A. § 51-1-29.5(c); *Nguyen v. Sw. Emergency Physicians*, P.C., 298 Ga. 75, 77, 779 S.E.2d 334 (2015).

The ER statute provides a distinct advantage to medical providers when the medical care at issue fits within the definition of "emergency medical care." First, the statute raises the plaintiff's burden of proof to "clear and convincing evidence." "'Clear and convincing' is a more stringent standard than 'preponderating' and requires a greater quantum and a high quality of proof in plaintiff's favor."[19] Second, it heightens the standard from ordinary negligence to "gross negligence," which requires the absence of even slight diligence.[20]

The ER statute will only apply when (1) the care at issue was provided in a hospital emergency department, obstetrical unit or in a surgical suite immediately after treatment in the ER; and (2) the care provided qualified as "bona fide emergency services."[21] However, the case law is clear that the statute provides for an objective standard on whether the care provided was "emergency care." As such, where there is any factual dispute in the case as to whether the care qualified as "bona fide emergency services," the jury, not the court, must decide whether the ER statute should apply.[22] In a case where there is some evidence the patient did not have acute and severe symptoms and some evidence she did, the jury must assess "whether [O.C.G.A. § 51–1–29.5] applies and whether the defendants met whatever standard of negligence the jury determines to be applicable."[23]

The jury's role in this circumstance is generally believed to be advantageous for the defense in most cases. For example, if the jury believes the patient's condition was urgent and required immediate or prompt attention, then the higher standards imposed by the ER statute should apply. Alternatively, if the jury is forced to analyze the severity of the patient's symptoms and believes the patient's symptoms were not sufficiently acute or severe to apply the ER statute, the jury may be less inclined to be critical of the medical provider's care in general.

PROXIMATE CAUSE AND BURDEN SHIFTING

Under Georgia law, a plaintiff cannot recover for medical malpractice, even if there is evidence of negligence, unless the plaintiff establishes to a reasonable degree of medical probability the negligence either proximately caused or contributed to causing her harm.[24] Because of the scientific nature of medical malpractice actions, proof of proximate cause generally requires expert testimony and the burden is on the plaintiff to present same.[25]

In recent years, the plaintiffs' bar has attempted to shift this burden of proof to the defendant whenever the defense argues the plaintiff's injuries were caused by some other mechanism or illness other than the care provided by the defendant. In other words, the plaintiff argues that any opinion evidence provided by the defendant's experts as to the potential cause of the plaintiff's alleged injuries must also be expressed to a reasonable degree of medical probability or be excluded. The plaintiff argues the alternative theory of causation qualifies as an "affirmative defense." However, the applicable case law on this issue is in direct contrast to the plaintiff's arguments.

A defense to the plaintiff's causation theories in a medical malpractice action, even where alternative theories are offered by a defense expert, does not qualify as an affirmative defense and therefore does not require the defendants to meet the same evidentiary standard.[26] "It is only when a party admits the essential elements of a complaint against him and sets up other facts in justification or avoidance that that party has the burden of proving an affirmative defense."[27] In a medical malpractice action, the plaintiff bears the burden of proof in establishing causation. The same burden does not apply to the defendants, even when alternative theories are proposed.[28]

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19 *Johnson*, *supra* at 76.

20 O.C.G.A. § 51-1-4.

21 O.C.G.A. § 51-1-29.5(c).

22 *See Nguyen v. Sw. Emergency Physicians, P.C.*, 298 Ga. 75, 83 (2015) (finding that whether a patient received "emergency medical care" is "a determination to be made by a jury.").

23 *Hosp. Auth. of Valdosta/Lowndes Cnty. v. Brinson,* 330 Ga. App. 212, 221, 767 S.E.2d 811 (2014).

24 *Zwiren v. Thompson,* 276 Ga. 498, 500, 578 S.E.2d 862 (2003).

25 O.C.G.A.§ 24-14-1.

26 *See Evans v. DeKalb Cnty. Hosp. Auth.*, 154 Ga. App. 17, 19, 267 S.E.2d 379 (1980) (Defendants' burden of proof was satisfied in medical malpractice case where defense expert offered testimony that the cause of death ***could*** have been from other sources — no reasonable certainty necessary.).

27 *Id*.

28 *See Yang v. Smith*, 316 Ga. App. 458, 464, 728 S.E.2d 794 (2012).

CONCLUSION

Every medical malpractice claim is unique. The defense of such claims requires in-depth research into plaintiffs' claims, potential experts, the applicable standard of care, the medicine surrounding the treatment provided, theories of causation and the legal standards of proof that should apply, in addition to the general discovery and legal defenses necessary in other negligence claims. Understanding and navigating these and other key issues can make or break the case for a medical provider and have a significant effect on settlement value and potential exposure. While medical malpractice suits are very often resolved only after a jury trial, there are various legal obstacles to these claims that may allow for an earlier judgment favoring the provider.

Graduate Studies on Uninsured/Underinsured Coverage and Applicability

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Mike O. Crawford is an accomplished litigator with nearly 20 years of experience handling a variety of litigation, including trucking, automobile accidents, underinsured/uninsured motorist cases, premises liability, construction defect claims, bad faith, toxic torts and general liability defense.

Mike primarily represents insurance companies and their insureds. He has represented clients in nearly all of Georgia's 159 counties, litigated more than 2,000 matters and tried dozens of cases to verdict. Mike's negotiation skills are well honed, and insurance carriers seek his assistance for settlement and mediation resolutions on behalf of their insured individuals and companies.

Mike takes a "client-first" approach to litigation. A client's requirements, time and assets are sacred and should be treated as such. Mike understands controlling expenses is always a primary concern, and he is careful to remain cost effective, while still ensuring to achieve the best possible outcome.

Mike is co-leader of the coverage and commercial litigation practice team, a member of the Defense Research Institute (DRI) and former president of the North Fulton Bar Association.

Graduate Studies on Uninsured/Underinsured Coverage and Applicability

In many respects, the defense of an uninsured motorist (UM) or underinsured motorist (UIM) claim is no different than the defense of an ordinary motor vehicle liability claim. Similar issues are typically involved, e.g. negligence, proximate cause, plaintiff's damages, comparative negligence, etc. However, unique issues arise in the UM and UIM contexts that defense counsel must consider and manage throughout litigation. These issues can make the defense of a UM/UIM claim more complicated and difficult to manage than a typical car wreck case.

In garden variety automobile accident cases, the plaintiff's claimed damages do not exceed the policy limits available under the defendant's (tortfeasor's) motor vehicle liability insurance policy. If there is a settlement or judgment in such a case and the defendant has adequate liability insurance limits, the insurance carrier generally pays the settlement or judgment (assuming there is no appealable issue) and the case is essentially over (apart from the requisite settlement documents or the filing of a satisfaction of judgment).

UM and UIM actions arise when there is a shortfall in the amount of motor vehicle liability insurance coverage afforded to the defendant in an automobile accident case. This may occur for a number of reasons. For instance, the defendant may have no applicable motor vehicle liability insurance. Even when the defendant appears to have motor vehicle insurance, a carrier may deny coverage for a myriad of reasons, effectively rendering the defendant uninsured. In those cases, if the plaintiff has purchased UM/UIM coverage from his own motor vehicle insurance carrier, the UM/UIM coverage provisions are triggered and the plaintiff may seek recovery from his own UM/UIM policy.[1]

More commonly, defendants are not entirely without some amount of valid motor vehicle accident insurance, but may be "underinsured" when the policy limit of a defendant's motor vehicle liability insurance is too small to cover the plaintiff's damages from an accident. This situation may trigger a plaintiff's UIM coverage.[2]

If a pre-suit settlement cannot be reached with the defendant's liability carrier and the plaintiff's UIM insurance carrier, a plaintiff is permitted to serve a copy of the summons and complaint to his own automobile insurance carrier if he has purchased UM/UIM coverage. Although the carrier remains an "unnamed defendant" (unless the carrier chooses to become a named defendant), the carrier must retain counsel to represent its interests in the lawsuit.

Although perhaps obvious, "the purpose in providing for uninsured [and underinsured] motorist protection was to afford the public generally with the same protection that it would have had if the uninsured [or underinsured] motorist had carried the same amount of coverage under a public liability policy issued in his name."[3] To that end, Georgia enacted the uninsured motorist statute, which is currently O.C.G.A. § 33-7-11, but which has been around in one version or another since the mid-20th century.

REQUIREMENT OF UM/UIM COVERAGE

The uninsured motorist statute, O.C.G.A. § 33-7-11(a)(1), provides:

> No automobile liability policy or motor vehicle liability policy shall be issued or delivered in this state . . . unless it contains an endorsement or provisions undertaking to pay the insured damages for bodily injury, loss of consortium or death of an insured, or for injury to or destruction of property of an insured under the named insured's policy sustained from the owner or operator of an uninsured motor vehicle, within limits exclusive of interests and costs . . .

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1 If the plaintiff in an UM case is unable to settle his UM claim with his insurance carrier pre-suit, he must then proceed against the defendant tortfeasor in order to recover his damages from the UM carrier.

2 UM and UIM coverage is generally extended in the same section of an insurance policy, as there is little distinction between them insofar as the insurance carrier is concerned. There are some exceptions though, where additional policy provisions apply, for instance in hit-and-run cases, and additional analysis of the policy and applicable facts must be completed.

3 *Jones v. Cotton States Mut. Ins. Co.*, 185 Ga. App. 66, 67, 363 S.E.2d 303 (1987).

In other words, an insurance carrier must provide UM coverage to an insured if it provides motor vehicle liability coverage to the insured. The statute also defines uninsured motorist to include underinsured motorists.[4]

The insured has four options: (1) choose the minimum policy limits of $25,000 per person/$50,000 per accident for UM/UIM bodily injury coverage and $25,000 for UM/UIM property damage coverage;[5] (2) choose UM/UIM coverage in an amount equal to the amount of his liability insurance coverage;[6] (3) "affirmatively choose" UM/UIM coverage in an amount less than the liability policy limits; or (4) forego UM/UIM coverage altogether.[7] It is required to have written proof that an insured has chosen to reject UM/UIM coverage or accept lower UM/UIM limits; a separate signature line is typically included in the motor vehicle insurance application to make such an election. If an insured fails to specifically decline UM/UIM motorist coverage in the insurance application, then the insured may be deemed to have elected at least the statutory minimum UM/UIM policy limits of $25,000 per person/$50,000 per accident in UM/UIM coverage (even though the insured only paid the lower insurance premiums for a policy lacking UM/UIM benefits).

In practice, the requirement that an insured affirmatively elect the amount of UM/UIM coverage in his motor vehicle insurance policy tends to ensure many plaintiffs in automobile collision cases will have access to at least one UM/UIM policy.

WHO IS COVERED UNDER UM/UIM POLICIES?

O.C.G.A. § 33-7-11(b)(1)(B) defines "insured" to include:

> [T]he named insured and, while resident of the same household, the spouse of any such named insured and relatives of either, while in a motor vehicle or otherwise; any person who uses, with the expressed or implied consent of the named insured, the motor vehicle to which the policy applies; a guest in such motor vehicle to which the policy applies; or the personal representatives of any of the above.

Thus, UM/UIM coverage applies not only to the named insured, but also to his resident spouse, children, other relatives living in the household and permissive users of the insured vehicle. Likewise, passengers in the insured's vehicle are covered as well. Because UM/UIM coverage follows its insured(s), it may apply when an insured is a passenger in another person's vehicle or when the insured is struck while a pedestrian. As passengers are considered insureds and more than one UM/UIM policy may exist in a single household, situations frequently arise in which multiple UM/UIM policies provide coverage to a single injured individual. Such situations are discussed in the Order of Stacking of UM/UIM Policies section.

REDUCED-BY VERSUS ADD-ON UM/UIM POLICIES

UIM policies appear in two basic varieties in Georgia: "add-on" and "reduced-by." O.C.G.A. § 33-7-11(b)(1)(D) requires all UM/UIM policies be add-on policies, unless an insured specifically declines add-on UM/UIM coverage in favor of reduced-by UM/UIM coverage in writing.[8] Add-on UIM coverage is the simpler of the two as it extends the full policy limits under the UIM policy to the plaintiff once the applicable liability policy limits have been exhausted.[9]

Example:

- Where the defendant has a liability policy extending $50,000 in liability coverage; and
- The plaintiff's UIM policy has an additional $50,000 in add-on UIM coverage;
- A total of $100,000 in coverage would potentially be available to pay the plaintiff's damages claim.

4 O.C.G.A. § 33-7-11(b)(1)(D)(ii).
5 O.C.G.A. § 33-7-11(a)(1)(A).
6 O.C.G.A. § 33-7-11(a)(1)(B).
7 O.C.G.A. §§ 33-7-11(a)(1)(B) and 33-7-11(a)(3).
8 O.C.G.A. §§ 33-7-11(b)(1)(D)(ii)(I) and 33-7-11(b)(1)(D)(ii)(II). Generally, the insured's signature in the appropriate portion of the insurance application is sufficient to satisfy the requirement that the rejection be in writing.
9 O.C.G.A. § 33-7-11(b)(1)(D)(ii).

Insurance carriers appear unable to agree on the nomenclature for a reduced-by policy. Different insurance carriers refer to reduced-by UM/UIM policies as "difference in limits" policies, "off-set" policies or simply "reduced" policies. For purposes of determining the type of UM/UIM policy in play in a given case, the election of add-on or reduced-by UIM coverage typically appears on the declarations page of the policy. However, if the declarations page indicates that a plaintiff has elected reduced-by UM/UIM coverage, the declarations page alone should not be taken as proof that a plaintiff rejected add-on UM/UIM coverage. It is still necessary to review the policy application for the plaintiff's signature, showing that he specifically rejected add-on coverage and elected reduced-by UM/UIM coverage instead.

A reduced-by UM/UIM policy differs from an add-on UM/UIM policy in that the full UM/UIM policy limits may not be available to a plaintiff if a liability carrier pays its limits. In fact, the full limits of a reduced-by UM/UIM policy will only be available where there is no policy providing liability coverage on behalf of the tortfeasor defendant at all.

Example 1:

- The defendant has a liability policy with $50,000 in coverage; and
- The plaintiff has a reduced-by UIM policy with $100,000 in coverage;
- If the defendant's liability carrier tenders its $50,000 policy limit to the plaintiff, the plaintiff's available UIM policy limit would be "reduced-by" the $50,000 already paid by the liability carrier; thus
- A total of $100,000 would be available in coverage (rather than the $150,000 that would be available if the UIM policy were an "add-on" policy).

Example 2:

- The defendant has $50,000 in liability coverage;
- The plaintiff has $50,000 in reduced-by UIM coverage;
- If the defendant's liability carrier tenders its $50,000 policy limit to the plaintiff, the plaintiff's available UIM policy limit would be "reduced-by" the $50,000 already paid by the liability carrier; and
- The total coverage available to pay for the plaintiff's injuries would be $50,000 and the UIM would have no exposure at all.

Accordingly, the UIM carrier effectively has no exposure where there is motor vehicle accident liability coverage in an amount equal to or greater than the coverage extended by a reduced-by UIM policy.

ELECTION OF DEFENSE

As previously discussed, a plaintiff is permitted to serve a copy of the summons and complaint upon his own automobile insurance carrier if he purchased UM/UIM coverage.[10] Although the carrier is initially an unnamed defendant and not technically a party to the action, a UM/UIM carrier is permitted to elect how it wishes to handle its interests in the case. The UM/UIM carrier may proceed in its own name (thereby transforming into a named defendant) or in the name of the defendant.[11] Unless the UM/UIM carrier chooses to proceed in its own name, it need not file an answer. In practice, however, failing to respond at all is dangerous as the court will not know the UM/UIM carrier is represented, and may not provide any further notice of proceedings (or copies of pleadings) to the UM/UIM carrier's counsel.

When a UM/UIM carrier chooses to proceed in the name of the defendant, it may (1) not respond to the complaint (which again, is dangerous and not advised); (2) file a notice of appearance of additional counsel for the defendant; (3) file a responsive pleading specifically explaining it is choosing to proceed in the name of the defendant pursuant to O.C.G.A. § 33-7-11(d), though it does not specifically represent the defendant; or (4) file an answer in the name of the defendant. Importantly, the election to proceed in the name of the UM/UIM carrier or in the name of the defendant may be made at any time prior to trial.

10 O.C.G.A. § 33-7-11(d).

11 *Id.*

There are differing philosophies regarding which election an insurance carrier should make, but they may be broadly categorized into two camps. Some insurance carriers prefer to proceed in their own name and file a cross-claim against the defendant for indemnification/subrogation. This has the advantage of ensuring a subsequent subrogation suit need not be brought if the UM/UIM carrier is ultimately forced to pay plaintiff's damages. Of course, this also ensures a jury will be aware an insurance carrier exists that could potentially provide coverage for any damage award.

The other camp holds it is better to keep the insurance carrier's name out of the lawsuit if at all possible. Generally, insurers in this school of thought will only proceed in the name of the insurance carrier if there is a compelling reason to distance itself from a defendant (e.g., the defendant is not credible, excessively unlikeable or has an admissible criminal history outweighing the advantage of keeping the insurance carrier's name out of the lawsuit).

ROLES OF DEFENSE COUNSEL AND UM/UIM COUNSEL

Where the motor vehicle liability insurance carrier has not settled or otherwise tendered the limits of its policy on behalf of the defendant, the liability carrier provides a defense on behalf of its insured. While most motor vehicle insurance policies state the insurance carrier has no additional obligations to its insured once it has paid the liability insurance limits, most liability carriers will nevertheless provide a defense on behalf of the defendant, even if the liability policy limits are paid. Accordingly, UIM counsel must typically share the defense of the claim with the defendant's counsel.

Some benefits do arise from this situation. For instance, discovery costs are typically shared (to some extent) between defense counsel and UIM counsel. However, as the defendant did not hire (and is not paying for the legal services of) UIM counsel, UIM counsel does not have unfettered access to the defendant. This is obviously a problem for UIM counsel as much of the defense is often centered on the defendant himself. Moreover, the defendant's counsel often requests the UIM carrier waive its subrogation rights in order to obtain the cooperation of the defendant.

Where the defendant is entirely without means to pay a subrogation claim, a waiver of subrogation may be appropriate in order to obtain the advantage of access to the defendant. That decision need not be made early in the case, allowing an insurance carrier to engage in discovery to determine the extent of a defendant's assets prior to making that choice. Of course, other factors must be considered, such as the strength of the evidence for the defense, any comparative negligence on the part of the plaintiff and the overall exposure in the case. Ultimately though, the decision to waive (or not waive) subrogation belongs to the insurance carrier rather than its counsel.

ORDER OF STACKING OF UM/UIM POLICIES

Another frequently encountered problem in the UM/UIM context occurs when a plaintiff has multiple UM/UIM policies providing coverage to him for a single accident. While this scenario is certainly a benefit to the plaintiff, it raises the question of the order in which the multiple UM/UIM policies should provide coverage or "stack" (i.e., the insurance carrier paying first, the carrier paying second, etc.). Although not specifically addressed in the UM/UIM statute, Georgia courts have provided some guidance to assist in untangling this problem.

In general, an injured plaintiff who exhausted the limits of a defendant's available liability policy may stack UM/UIM coverage of all UM/UIM policies available to him and may recover to the extent of his damages and the available stacked policy limits. All policies containing UM coverage under which a plaintiff qualifies as an insured can be stacked.[12]

The initial test is the "receipt of premium" test. Under this analysis, the UM/UIM carrier receiving premiums from the plaintiff is primary and pays first. If the premium-receiving carrier exhausts its limits, then any other UM/UIM carriers will pay pursuant to their policy limits and terms. The "receipt of premium" test is applied before any other analysis and overrides all "other insurance" clauses among the various UM/UIM policies.[13]

[12] *Ford v. Ga. Farm Bur. Mut. Ins. Co.*, 191 Ga. App. 735, 382 S.E.2d 659 (1989).

[13] *Ga. Farm Bur. Mut. Ins. Co. v. State Farm Mut. Auto. Ins. Co.*, 255 Ga. 166, 366 S.E.2d 237 (1985); *Cont'l Ins. Co. v. S. Guar. Ins. Co.*, 193 Ga. App. 395, 388 S.E.2d 16 (1989).

Of course, UM/UIM cases arise where the insured did not pay an insurance premium (e.g. he has no UM/UIM coverage of his own, but is a permissive driver of vehicle insured by a UM/UIM carrier issuing a policy to the vehicle's owner). When that happens, the next applicable test employed is the "more closely identified with" test.[14] Here, the plaintiff's closeness to the policy is the determining factor. The relationship of the insured person to the policy is the significant fact, rather than the relationship between the circumstances of the injury and the policy. Thus, a UM/UIM policy extending coverage to a plaintiff by virtue of the fact he is a relative of the named insured will pay before a policy providing coverage solely because the plaintiff occupied a covered vehicle involved in a collision.

When both the "receipt of premium" and "more closely identified with" tests fail, the court will look to the "other coverage" clauses among the remaining insurers.[15] Typically, motor vehicle policies will state in the "other coverage" section of the UM/UIM coverage provisions they are not the primary policy if multiple UM/UIM policies are available to provide coverage.[16] However, if one UM/UIM policy states it is not primary and another applicable UM/UIM states it is primary (or is silent on the issue), then the courts will allow the policy language to control. If both "other coverage" clauses are substantially the same, then the exposure is prorated between the two UM/UIM policies.[17]

YARBOROUGH DISMISSALS

In actions where a UIM policy is available, but it does not appear from the evidence that the trial value of the case will meet or exceed the defendant's available liability coverage limits, plaintiff's attorneys still frequently serve the plaintiff's UIM carrier pursuant to O.C.G.A. § 33-7-11. This is typically done out of an abundance of caution in case the evidence changes through discovery and the plaintiff's damages ultimately result in being large enough to exceed the defendant's liability coverage limits or the defendant's liability carrier denies coverage or becomes insolvent.

In such cases, there is little reason for a UIM carrier to remain active within the suit, but the plaintiff may continue to desire retaining the coverage afforded under his UIM policy. A dismissal without prejudice pursuant to *Yarborough v. Dickinson*[18] may be appropriate.[19] *Yarborough* held once a plaintiff fulfills his obligation under O.C.G.A. § 33-7-11 to serve his UM/UIM carrier with a copy of the summons and complaint, and if the defendant is not an "uninsured" as defined in the statute, then the UIM carrier may not be a viable party. Moreover, after obtaining a dismissal, the UIM carrier could still be served pursuant to O.C.G.A. § 33-7-11 if the defendant later became "uninsured" by statutory definition, even if the statute of limitations had apparently expired as to the defendant. This is because the statute of limitations does not begin to run until a cause of action accrues. For a UIM carrier, that does not occur until the defendant becomes "uninsured."

In practice, parties agree to a *Yarborough* dismissal when appropriate. Once an agreement is reached, they file a motion to dismiss fewer than all defendants as required by O.C.G.A. § 9-11-21. The motion contains the terms of the agreement and typically spells out a waiver by the UIM carrier of any defenses as to the applicable statute of limitations, and any suit limitation period contained within the policy. The motion also typically requires that counsel for the UIM carrier agree to accept service on behalf of the UIM carrier should the liability limits be exhausted by tender, if the plaintiff's damages rise to a level to justify the inclusion of the UIM carrier as an unnamed defendant or if the defendant becomes uninsured as defined by O.C.G.A. § 33-7-11. The practical effect of a *Yarborough* dismissal alleviates the UIM carrier's need to defend the case, while still protecting the interests of the plaintiff.[20]

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14 *Travelers Indem. Co. v. Md. Cas. Co.*, 190 Ga. App. 455, 379 S.E.2d 183(1989).

15 *Id.*

16 Occasionally, a policy will state that it is the primary policy in the order of stacking. As these policies tend to carry higher premiums, they are rare.

17 *Travelers*, *supra*.

18 Ga. App. 489, 359 S.E.2d 235 (1987).

19 *See also Bohannon v. Futrell*, 189 Ga. App. 340, 375 S.E.2d 637(1988).

20 It has the added effect of reducing the number of defense attorneys (and thereby resources) available to the defendant, often becoming a principal reason that plaintiff's attorneys are willing to agree to *Yarborough* dismissals.

SETTLING THE UM/UIM CASE

When a liability carrier tenders its limits and UIM coverage is available, the carrier will obtain a limited liability release from the plaintiff. Such releases typically fully release the liability carrier from further obligation to the plaintiff. The defendant is usually released as well, except to the extent additional coverage (typically UIM coverage) is available to pay plaintiff's damages. UM/UIM counsel should obtain and review a copy of the limited liability release, if the liability carrier's policy limits have been tendered, to determine the extent of the exposure remaining to the UM/UIM carrier.

After any applicable liability policy limits have been exhausted, voluntary resolution of a UM/UIM action can become complicated. In addition to potential UIM stacking issues, the plaintiff will have received some amount of payment already and may be well funded to continue litigating the case with the UIM carrier. However, there is no contractual obligation for a UM/UIM carrier to pay any of its UM/UIM limits until all of the applicable liability policies have paid or tendered.

Example 1:

- Where a defendant holds a motor vehicle policy extending $50,000 in liability coverage; and
- The plaintiff has $100,000 in UIM coverage;
- If the defendant's motor vehicle liability carrier settles for $40,000; then
- The UIM carrier has no further obligation. Additionally, the dismissal with prejudice following such a settlement should be equally applicable to named and unnamed defendants alike, thereby ending the UIM carrier's exposure in the case.

Example 2:

- The defendant's liability carrier tenders its limits of $50,000;
- The UIM policy is triggered;
- The UIM carrier must analyze the evidence and determine whether the case has an expected trial value below the $50,000 already paid by the defendant's liability carrier, in which case a UIM carrier may decline to extend any settlement offer;
- If the value of the case exceeds the defendant's liability carrier's policy limits, then the UIM carrier would have some amount of exposure (up to its policy limits) and either need to settle the case or try it on its own.

Further complicating the issue, a plaintiff may make a demand pursuant to O.C.G.A. § 33-7-11(j) in order to position the case for a bad faith claim following a trial. The statute provides in part:

> If the insurer shall refuse to pay any insured any loss covered by this Code section within 60 days after a demand has been made by the insured and a finding has been made that such refusal was made in bad faith, the insurer shall be liable to the insured in addition to any recovery under this Code section for not more than 25 percent of the recovery and all reasonable attorney's fees for the prosecution of the case under this Code section.

While a bad faith UM/UIM demand does not possess the same "teeth" as the more dangerous bad faith liability demand created pursuant to *Southern General Insurance Co. v. Holt,*[21] its progeny and O.C.G.A. § 9-11-67.1, it is also not subject to the requirements imposed by O.C.G.A. § 9-11-67.1, which provide some protection to insurers. Instead, a UIM bad faith demand served pursuant to O.C.G.A. § 33-7-11(j) only requires the insured plaintiff provide the UIM carrier with 60 days to pay the demand before it is deemed rejected. If a UM/UIM carrier denies an O.C.G.A. § 33-7-11(j) UM/UIM bad faith demand (or allows the 60-day deadline to elapse), a plaintiff may bring a bad faith action against the UM/UIM carrier if a resulting jury award exceeds the combined amount of the liability policy's payment and the limits of the UM/UIM policy. Unlike a bad faith demand under *Holt*, where the sky is the limit, the penalty available pursuant to the statute for a UM/UIM bad faith demand is limited to the UM/UIM policy limits, plus 25 percent and plaintiff's attorneys fees for bringing the bad faith action.

[21] 262 Ga. 267, 416 S.E.2d. 274 (1992).

Trux, Lies and Videotape

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Richard "Richie" C. Foster represents insurers, trucking and transportation companies and their drivers in litigation matters related to motor carrier liability, commercial insurance coverage and general commercial insurance defense. He has served as lead counsel in more than 100 jury trials throughout his career, often defending clients involved in serious accidents that resulted in catastrophic injuries and death.

Richie also leads the firm's 24-hour emergency response team that leverages a broad network of investigators and accident reconstruction experts throughout Georgia and the Southeast to assess the details of an incident and assist with next steps.

In addition to advising clients on accident response, regulations issued by the Federal Motor Carrier Safety Administration (FMCSA) and the nuances of trucking and transportation law, Richie is an experienced litigator committed to client advocacy and their defense in the courtroom. He works to position clients for success and lessen liability when involved in an accident. In one case, he secured a defense verdict of zero dollars in a matter that posed $50 million in potential exposure for his client.

Richie works with some of the nation's largest trucking companies and the carriers insuring them, which enables him to stay abreast of the latest developments in the industry, such as new technologies and industry standards. His extensive familiarity with the transportation industry allows him to provide valuable perspective on business, safety and legal considerations when counseling his clients before, during and after a claim is litigated.

Trux, Lies and Videotape

DEBUNKING THE MYTHS SURROUNDING THE SAFETY OF THE TRUCKING INDUSTRY

The trucking industry has an image and public relations problem, especially in the world of litigation. Daytime television is littered with attorney advertisements demanding “the compensation you deserve” for anyone even remotely involved in an accident with a truck. In Georgia, there is a direct action statute allowing plaintiffs to name the insurer as a party defendant in cases against trucking companies. Almost every driver (meaning much of the population over the age of 16) has had a negative experience with a large truck, whether it involved a near-miss lane change, tailgating or an actual collision.

There certainly is a genuine basis for some of the public’s attitude toward the trucking industry. The reality is these trucks are typically more than 70 feet long and 13 feet feet high, weigh between 80,000 and 84,000 pounds, accelerate slower and require far more stopping distance than standard passenger vehicles. Tractor trailers are at least 10 times the size and weight of most passenger vehicles and generally have the most high-profile and noticeable presence on our highways. We all share the same roads, yet typically passenger vehicles (and their occupants) come out on the losing end when they are involved in wrecks with tractor trailers.

Add in the fact the minimum insurance limits for interstate motor carriers is $750,000 and almost every commercial auto policy carries at least $1 million in policy limits, and it is easy to see why truckers are a favorite target of the plaintiffs' bar.

So what does the public, and especially the plaintiffs' bar, take for granted about the trucking industry? Pretty much everything. Truckers are responsible for transporting fresh lettuce picked on Tuesday in California to a table at a New York City restaurant to be eaten in a salad on Thursday. In fact, truckers are the ones responsible for making “farm to table” happen for practically the entire country. It does not stop there. Truckers transport all the building materials and furniture for every home and office in America. This starts with hauling cut wood from South Georgia pine plantations to the mill, hauling processed wood from the mill to furniture manufacturing facilities, hauling the finished product to furniture showrooms and hauling the final retail product to our homes. Indeed, there is very little that we see, touch or use that was not brought to us by a truck driver. It is not an overstatement to say that our economy is dependent on the trucking and transportation industry. Meanwhile, truck drivers spend most of their time on the road. They spend very little time at home with friends and family, and very few truck drivers are particularly well paid. Of course, all of this goes ignored by the plaintiffs' bar.

Then there are the ongoing myths about the safety of the trucking industry, much of which is propagated by the plaintiffs' bar either in commercials or at trial. The reality is the overwhelming majority of crashes in the United States do not involve trucks at all. For example, in 2017, there were 29,769 fatal crashes involving passenger autos, but only 2,910 involving tractor trailers in that same year (or 9.7 percent of all such wrecks). In 2017, there was a total of 1,889,000 reported crashes resulting in some form of bodily injury in the U.S., but only 102,000 accidents resulting in injury involved large trucks (or 5.4 percent of all such wrecks).

While there are certainly more passenger vehicles on the road than commercial trucks, most individuals drive between 5,000 and 20,000 miles per year while the average over-the-road truck driver logs closer to 100,000 miles per year on average. To put this into context, there were 59 wrecks per 100 million miles driven by passenger vehicles in 2017. By comparison there were 34 wrecks per 100 million miles driven by truckers. All of this is true despite the realtiy truckers are required to operate significantly larger vehicles in comparatively tighter spaces. Indeed, this underscores the fact tractor trailers must be — and are — operated by trained professionals.

The safety of the trucking industry compared to the general public is no accident. Since the Federal Motor Carrier Safety Act was implemented in 1979, safety has become a priority both through government regulation and technological advancements. The safety standards range from ensuring drivers with poor driving histories are not hired in the first place to minimum training requirements to ensuring drivers are physically qualified to operate tractor trailers. Meanwhile driver fatigue has always been front and center in the industry and currently drivers are not allowed to drive more than 11 hours in one day or more than 70 hours in seven days.

The technological advances started in the 1980s with anti-lock braking systems that help decrease the risks of jackknifing and trailer swing during heavy braking events. Today, those advancements include forward-looking radar to recognize hazards in the road ahead and automatically cause the truck to brake or slow. There are lane departure warning systems alerting drivers when they drift out of their lanes. Many large trucking companies restrict the speeds of their trucks to less than 65 mph. Driver logs are now automated and drivers are alerted when they are approaching their maximum allowable hours of service. All of these advancements contribute to the overall safe operation of commercial motor vehicles. Additionally, these all require significant — and often voluntary — monetary investments by motor carriers that tend to go unrecognized by the general public.

USING SAFETY ENHANCEMENTS TO INVESTIGATE TRUCKING ACCIDENTS (OR RECONSTRUCTING AN ACCIDENT WITHOUT AN ACCIDENT)

Perhaps the greatest safety advancement from an accident investigation standpoint is the drive cam installed on the dashboard or windshield of a truck. From a safety standpoint, these cameras can look forward and backward. This allows the motor carrier to observe what drivers are doing while operating their vehicles and help prevent or deal with distracted driving issues as they may arise. Drive cams are also good driver coaching tools for helping understand how best to react when presented with an emergency situation. However, it is from an accident reconstruction standpoint that this technology is most useful (at least from a litigation and investigative point of view).

Drive cams are typically triggerred by a critical event, such as swerving or braking. As a general rule, they will capture between eight and 10 seconds of activity both before and after the critical event that triggered the camera to begin recording. Oftentimes, trying to reconstruct an accident based on physical evidence alone (including measuring vehicle deformation and angles of impact, downloading speeds from electronic control or air bag modules, locating and measuring tire and gouge marks in the roadway, etc.) results in there still being too many variables to conclusively prove exactly what happened and why. Drive cams, however, simply record in real time exactly what happened. For collisions occuring within the camera's view, there is rarely any room for interpretation. Of course, drive cams do not choose sides and will either reflect positively or negatively on the truck driver. However, if the drive cam conclusively shows the truck driver was at fault, the motor carrier or its insurer can save tens of thousands of dollars in investigative costs and expenses. On the other hand, drive cams often conclusively prove exactly who merged into whose lane on the interstate, which is rarely the type of impact that can be effectively reconstructed to determine fault. At least as often as not, the truck driver's version of events is corroborated or supported by the drive cam.

CREATIVELY IDENTIFYING AND USING OTHER MEDIA TO INVESTIGATE ACCIDENT

As a matter of course in almost every accident investigation, it is vital to secure all available police dash and body cam, 911 audio and computer-aided dispatch (CAD) records, and any available security video from surrounding businesses or posted cameras.

The police dash cam and body cam help establish the final resting points for all vehicles and often confirm the location of the area of impact. Just as importantly, such video and audio give a true indication of exactly how injured (or not) the claimant was at the scene. The same can be said of 911 audio, as the claimant usually makes the call to 911 and is asked to state their name and whether they are injured. An audible "no" response played at trial goes a long way in helping a jury truly understand whether or to what extent a claimant was genuinely injured in an accident. Meanwhile, the CAD records typically contain the contact information for all 911 callers, which regularly helps identify witnesses not listed on the accident report and may otherwise be unknown to one or both of the parties to a case.

THE TRUCK DRIVER'S ROLE IN ACCIDENT INVESTIGATION

Perhaps the best tool a truck driver has for accident reconstruction is his own cell phone, which allows the driver to take photos or video of all sides and corners of his truck, any other involved vehicles and the area of impact. It also allows the driver to photograph or video *uninjured* potential claimants as they casually mill about in the aftermath of the collision as police are taking information from the involved drivers. However, good judgment must be used under these circumstances because probably the worst thing a driver can do is take video depicting graphic injuries and suffering by a genuinely injured or deceased potential claimant. There is no better way to enhance the value of a damages claim than by placing a jury in the moment and showing genuine, real-time agony and anguish in the immediate aftermath of an accident.

CONCLUSION

As attorneys and claims professionals who handle accidents involving trucks, it is vital to understand the trucking industry in general and our clients/insureds specifically. Only then can we most effectively represent them throughout litigation and at trial. In so doing, we can debunk safety myths and effectively deal with the reptilian tactics that have become so popular with the plaintiffs' bar. From there, it is incumbent upon us to be aware of all of the investigative tools at our disposal to conclusively determine how and why an accident occurred, whose fault it really was and whether and to what extent any injuries arose from the accident.

Liens 101: Avoiding Double Payment and Penalty

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Lee represents clients in state and federal courts throughout Georgia and the Southeast, navigating clients through pre-suit consultations, negotiations, jury trials and appeals. He has secured numerous defense verdicts, as well as affirmed motions to dismiss and motions for summary judgment.

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Prior to joining Swift Currie, Lauren served as an attorney in the Staff Attorney's Office and as a chambers staff attorney to the Honorable Stanley Marcus, both in the the United States Court of Appeals for the Eleventh Circuit. This work helped her develop extensive legal research and writing skills, which she leverages to handle her cases today.

Liens 101: Avoiding Double Payment and Penalty

In Georgia, perfected medical provider liens[1] are "super liens" that survive settlement with an injured person, both against the at-fault party and their insurer. Failure to adequately consider and ensure the satisfaction of such liens can result in the at-fault party's insurance carrier paying money to a lienholder over and above money paid in settlement to the injured person, even where that payment exceeds applicable policy limits. This paper will discuss the pitfalls of settling cases involving medical liens and steps the insurance carrier should take to avoid them.

BACKGROUND ON GEORGIA MEDICAL LIENS

Under Georgia's medical lien statute, O.C.G.A. § 44-14-470, *et seq.*, the operators of hospitals, nursing homes, physician practices and providers of traumatic burn medical care have a lien for the reasonable charges incurred in the treatment of an injured person against all causes of action accruing to that person or his legal representative on account of the injuries.[2] If a medical lien is perfected, a release executed by the injured person or his representative is generally not valid against the lien.[3] A perfected medical lien is a "super lien" in that it can be enforced against the tortfeasor or the tortfeasor's insurer if not honored as part of the settlement.

Perfecting a Medical Lien

The holder of a medical lien perfects the lien by meeting two requirements. First, 15 days before filing a lien statement, the lienholder must give written notice to the injured person or his legal representative, the at-fault party and their insurers claimed to be liable for damages arising from the injuries.[4] However, insurers cannot rely solely on statutory notices to discover valid liens. Lienholders must only exercise "some degree of diligence in acquiring the information necessary to send the notice" to the claimed at-fault party and their insurers.[5] Even where the lienholder exercises such diligence, it may not discover all at-fault parties and insurers or obtain accurate information to effectively provide written notice to them.

Second, the lienholder must timely file a verified statement regarding the medical lien in the appropriate office of the clerk of the superior court.[6] The verified statement must include: (1) the name and address of the patient; (2) the name and location of the medical provider; (3) the dates of admission and discharge or treatment of the injured person; and (4) the amount claimed to be due for the medical care.[7] The statement must be filed in the superior court of the county in which the medical provider is located and in the county where the injured person resides if a Georgia resident.[8] Finally, the statement must be filed within 75 days of the patient's discharge from the facility (for hospitals, nursing homes or burn centers) or within 90 days after the patient first sought treatment (for physician practices).[9] A lienholder's failure to properly file a verified statement invalidates its medical lien.[10]

Enforcing a Perfected Lien

Once perfected, the holder of a medical lien can bring an action to foreclose on the lien against the tortfeasor or the tortfeasor's insurer.[11] The lien is against "any and all causes of action accruing to the person to whom

1 This paper's scope is limited to liens under Georgia's medical lien statute and does not discuss other possible liens, including Medicare liens, which should also be given adequate consideration in settlement.
2 O.C.G.A. § 44-14-470(b).
3 O.C.G.A. § 44-14-473(a).
4 O.C.G.A. § 44-14-471(a)(1).
5 *Allstate Fire & Cas. Ins. Co. v. Kennestone Hosp., Inc.*, 348 Ga. App. 335, 337, 822 S.E.2d 832, 834 (2019).
6 O.C.G.A. § 44-14-471(a)(2).
7 *Kennestone Hosp., Inc. v. Travelers Home & Marine Ins. Co.*, 330 Ga. App. 541, 542, 768 S.E.2d 519 (2015).
8 O.C.G.A. § 44-14-471(a)(2).
9 O.C.G.A. § 44-14-471(a)(2)(A)&(B).
10 An exception to this rule exists where a tortfeasor receives actual notice of the filed lien statement via hand delivery, certified mail or statutory overnight delivery prior to the date of settlement, but this exception does not apply to insurers. O.C.G.A. § 44-14-471(b); *Kennestone Hosp., Inc.*, 330 Ga. App. at 545, 768 S.E.2d at 523.
11 O.C.G.A. § 44-14-473(a).

the care was furnished" and is not a lien against the patient or his property.[12] Suit must be brought within one year "after the date the liability is finally determined by a settlement, by a release . . . or by the judgment of a court of competent jurisdiction," meaning one year from the date a release is executed.[13] In order to prevail, the lienholder need only show the treatment, the charges, the injured person's assertion of a claim and the settlement of the claim. No showing of fault is required.[14] The right created in favor of the lienholder is akin to the remedy provided by garnishment laws.[15] The lien statute allows the medical provider to step into the shoes of the insured for purposes of receiving payment from the tortfeasor's insurance company for economic damages represented by the medical bill.[16] Thus, the insurer's liability in a lien foreclosure action is capped by its policy limits without reduction for any amounts paid prior to the lien foreclosure action.

CONSIDERATION OF MEDICAL LIENS IN SETTLEMENT

Discovering Medical Liens

In order to avoid double payment of both a settlement and a medical lien, an insurer must first determine whether valid and enforceable medical liens exist. A lien search in the county where the medical provider is located and the county where the injured person resides can be used to identify any unknown liens. Traditionally, locating medical liens was done in person at the courthouse, but now they can be accessed online at the Georgia Superior Court Clerks' Cooperative Authority website (search.gsccca.org/Lien/namesearch.asp). Pay special attention to the effective date of any lien information, whether searching online or in person. If suit has been filed, lien information can be sought through basic written discovery.

Addressing Liens in Settlement Agreements and Releases

The plain language of the medical lien statute suggests a release is valid against the holder of a perfected medical lien if the lienholder joins in the release or executes its own release.[17] Despite the statute's specific recognition of this possibility, it rarely occurs in practice. In fact, a response to a demand seeking additional parties or releasees would be a counteroffer and would not result in a binding settlement. A more practical and feasible solution is the inclusion of a lien affidavit in a settlement agreement and release. If the patient or his representative executes an affidavit that all medical providers have been paid and sets forth the injured person's county of residence, there is no liability for a lien that was unperfected when settlement was consummated.[18] However, the statutory protection of O.C.G.A. § 44-14-473 is not always available. A lien affidavit does not invalidate a properly perfected lien. Additionally, the injured person may not be able to truthfully attest all medical providers have been paid.[19]

Where a lien affidavit cannot be obtained or will not protect the insurer against lien foreclosure liability, the settlement documents should address the procedure for outstanding liens. In particular, the release may require the injured party to attest that he will pay any outstanding liens from the settlement proceeds. The release may also include an indemnification clause in which the injured person and/or his attorney agree to hold the tortfeasor and his insurer harmless and defend them if any lienholders pursue them for satisfaction of liens. If an injured person or his representative refuse to accept such terms, the insurer should consider whether the facts of the case warrant payment directly to the lienholder.

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12 *Hosp. Auth. of City of Augusta v. Boyd*, 96 Ga. App. 705, 708, 101 S.E.2d 207, 209 (1957).

13 O.C.G.A. § 44-14-473(a); *Hosp. Auth. of Clarke Cnty. v. GEICO Gen. Ins. Co.*, 294 Ga. 477, 754 S.E.2d 358 (2014).

14 *Dawson v. Hosp. Auth. of Augusta*, 98 Ga. App. 792, 794, 106 S.E.2d 807, 809 (1958).

15 *Hosp. Auth. of City of Augusta*, 96 Ga. App. at 708, 101 S.E.2d at 210.

16 *Kight v. MCG Health, Inc.*, 296 Ga. 687, 689, 769 S.E.2d 923, 924 (2015).

17 O.C.G.A. § 44-14-473(a) ("No release of the cause . . . of action . . . shall be valid or effectual against the lien created by Code Section 44-14-470 unless the holder thereof shall join therein or execute a release of the lien. . . . ").

18 O.C.G.A. § 44-14-473(c).

19 An injured person could incur criminal liability for giving a false lien affidavit. O.C.G.A. § 44-14-477.

MEDICAL LIENS AND TIME-LIMITED DEMANDS: COMPETING INTERESTS AND COUNTEROFFERS

Consideration of medical liens in settlement is further complicated when a time-limited demand is made. When an insurer's response to a time-limited demand requires resolution of all liens where that was not included in the original demand, there is no binding settlement offer.[20] Where there are valid and enforceable medical liens, the insurer is called upon to "pick its poison" by either paying a demand when the injured party's counsel insists no lien assurances be given to avoid a potential bad faith claim or facing a medical lien claim from a medical provider that could result in payment above applicable limits.

Southern General v. WellStar: A "Safe Harbor"?

The Court of Appeals of Georgia addressed the situation faced by an insurer when it is presented with both a time-limited demand within policy limits and perfected medical lien in *Southern General Insurance Co. v. WellStar Health System*.[21] There, the Court of Appeals of Georgia noted:

> [I]t is possible for an insurance company to create a "safe harbor" from liability under *Holt* and its progeny when (1) the insurer promptly acts to settle a case involving clear liability and special damages in excess of the applicable policy limits, and (2) the sole reason for the parties' inability to reach a settlement is the plaintiff's unreasonable refusal to assure the satisfaction of any outstanding hospital liens.[22]

The court theorized there would be a "safe harbor" from bad faith liability if an insurer "tender[ed] its policy limits to the plaintiff, subject to a reasonably and narrowly tailored provision assuring that the plaintiff will satisfy any hospital liens from the proceeds of such settlement payment" and, upon refusal by the plaintiff, "verif[ied] the validity of any liens, ma[de] payments directly to the hospital, and then disburse[d] any remaining funds to the plaintiff."[23]

Unfortunately, the *WellStar* "safe harbor" was soon revealed to provide no real shelter from the storm. Although *WellStar* might protect the insurer from a "bad faith" claim because the failure to settle resulted from the plaintiff's refusal to satisfy the liens, a claim that the insurer negligently failed to obtain a settlement is still a viable cause of action.[24] Courts have also held that *WellStar* is not a complete defense to a bad faith claim unless the injured person's refusal to assure satisfaction of the liens is the sole reason why the claim had not settled.[25] In fact, there is not yet any published decision where a Georgia court has granted or affirmed an insurer's dispositive motion based on the "safe harbor" supposedly afforded by *WellStar*.

Legislative Relief in Pre-suit Motor Vehicle Demands

In 2013, the Georgia legislature provided automobile insurers with partial relief from the problems created by time-limited demands with its passage of O.C.G.A. § 9-11-67.1. This statute provides specific terms and conditions applicable to settlement demands made by an attorney prior to the filing of a lawsuit for personal injury or death arising out of the use of a motor vehicle.[26] Most importantly here, the statute provides that the recipient of a demand "shall have the right to seek clarification regarding terms, liens, subrogation claims, standing to release claims, medical bills, medical records, and other relevant facts" and "[a]n attempt to seek reasonable clarification shall not be deemed a counteroffer."[27] Accordingly, when confronted with an O.C.G.A. § 9-11-67.1 demand, an insurer can inquire about outstanding liens and their resolution without making a counteroffer. However, this statute does nothing to address the situation where an insurer is confronted with both a time-limited demand and perfected medical liens that the injured person refuses to address in a release.

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20 *McReynolds v. Krebs*, 290 Ga. 853, 854, 725 S.E.2d 584 (2012).
21 315 Ga. App. 26, 726 S.E.2d 488 (2012).
22 *Id*. at 31, 726 S.E.2d at 493 (emphasis added).
23 *Id*. at 32, 726 S.E.2d at 493.
24 *Patriot Gen. Ins. Co. v. Krebs*, 2012 U.S. Dist. LEXIS 101014 (N.D. Ga. July 20, 2012).
25 *Camacho v. Nationwide Mut. Ins. Co.*, 13 F. Supp. 3d 1343 (N.D. Ga. 2014).
26 O.C.G.A. § 9-11-67.1(a).
27 *Id*. or O.C.G.A. § 9-11-67.1(d).

Special Considerations in All Other Cases

Because O.C.G.A. § 9-11-67.1 only applies to demands made by an attorney prior to filing a lawsuit arising out of the use of a motor vehicle, insurers should tread lightly when addressing liens in response to time-limited demands outside of this category. Georgia courts have recognized the use of "mere precatory language seeking confirmation of an aspect of the agreement" does not convert an acceptance into a counteroffer,[28] but the question of whether language is precatory is fact-specific and could result in litigation to resolve that issue. Georgia courts have also held "the mere inclusion of a release form that is unacceptable to the plaintiff does not alter the fact that a meeting of the minds has occurred with regard to the terms of the settlement."[29] However, they have only so held when transmission of a draft release was accompanied by an invitation for revisions.[30] Thus, even if language addressing medical liens is provided in or added to a draft release, the insurer must make clear that the injured person is not required to retain the language. Ultimately, the unique facts of each demand outside of O.C.G.A. § 9-11-67.1 and the accompanying medical liens must be examined to determine whether resolution of the liens at issue warrants risking potential litigation regarding the enforceability of a settlement agreement and/or extracontractual liability for failure to unequivocally accept a time-limited demand.

[28] *Torres v. Elkin*, 317 Ga. App. 135, 141, 730 S.E.2d 518, 523 (2012).

[29] *Sherman v. Dickey*, 322 Ga. App. 228, 233, 744 S.E.2d 408, 412 (2013) (quotation and citation omitted).

[30] *Id*.; *Hansen v. Doan*, 320 Ga. App. 609, 613-14, 740 S.E.2d 338, 342 (2013).

The Medicare Effect: Can “an Apple a Day” Keep CMS Away?

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Ashley's diverse litigation background enables her to leverage experience and skillsets from a wide range of business disputes for a uniquely holistic perspective. Ashley serves her clients with innovative solutions for successful outcomes with an ability to move quickly, even in matters involving complex, voluminous medical records. Further, she is committed to swift and responsive client advocacy, whether negotiating for quick resolutions to business conflicts or aggressively defending her clients in the courtroom.

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The Medicare Effect: Can "an Apple a Day" Keep CMS Away?

Medicare — what was once simply the name of a government program for the elderly and disabled has become one of the most dreaded terms to arise in personal injury actions. Many insurance adjusters and attorneys make their best effort to avoid any entanglement with Medicare issues at all. However, the Centers for Medicare and Medicaid Services (CMS) continues to enact rules and procedures supporting and expanding its authority to seek recovery of conditional payments made on behalf of Medicare beneficiaries and assert Medicare's interests with regard to future treatment. These rules include penalties and fines for noncompliance against insurers, plaintiffs, defendants and their counsel. This paper provides updates on the Medicare Secondary Payer Act (MSP), reporting requirements to CMS and Medicare Set-Asides (MSAs) in liability cases, as well as recommendations on compliance with current CMS and Medicare guidelines with respect to conditional payments and Medicare recovery.

UPDATES ON CMS, MEDICARE LIENS AND THE SMART ACT

If ever Medicare and CMS had a mantra for the last few years, it would be: "Some things change, some stay the same." CMS has continued its efforts to better structure and organize its processes in order to maximize recovery of conditional payments and ensure parties are taking Medicare's interests into account with regard to future medical expenses. The passing of the Strengthening Medicare and Repaying Taxpayers Act (SMART Act) in 2013 forecasted the possibility of relief from the arduous and perplexing processes and guidelines currently in place that have resulted in difficulties for parties attempting to resolve claims fraught with competing interests and undue frustration. Since then, CMS has slowly, but surely, been working to promulgate the SMART Act provisions into applicable rules and policies expected to address the uncertainties and delays resulting from the MSP process.

For example, the SMART Act addressed the considerable mandatory fines and penalties of up to $1,000 per day for failing to comply with mandatory insurer reporting as set out in the Medicare, Medicaid, and SCHIP Extension Act (MMSEA). The assessment of fines are now to be discretionary based on guidelines set out by the Department of Health and Human Services to establish "safe harbors" for entities that report in good faith. After years of soliciting comments on the rule-making process, the Office of Management and Budget issued a notice that CMS has plans to release proposed rules around the imposition of civil money penalties. Industry insiders expect these proposed rules to be released sometime in late 2019.

In the last few years, a version of a "Medicare Secondary Payer and Workers' Compensation Agreements Act" has been introduced into Congress. In most versions, the bill establishes some interesting provisions, including setting thresholds for secondary payer provisions in certain workers' compensation settlements and providing a "safe harbor" for parties to satisfy secondary payer requirements through use of a "qualified Medicare Set-Aside." These bills have failed to gain widespread support and there has been hesitation to provide formal regulatory procedures for MSA review in place of the current administrative guidance provided by CMS. While this bill would primarily be limited to workers' compensation claims, the implication is it could eventually be amended to include review of liability MSAs if a program is ever implemented.

The legislation gaining more traction is the Provide Accurate Information Direct Act (PAID Act), which was introduced as H.R. 1375 in the U.S. House of Representatives in February 2019. The purpose of this bipartisan bill is to require CMS to return beneficiary enrollment information in Part C and Part D plans in addition to traditional Medicare Parts A and B information when queried. Part C plans include Medicare Advantage plans that may make payments for medical treatment related to an injury involved in a liability claim. Courts across the country, including the United States Court of Appeals for the Eleventh Circuit in Georgia, have held Medicare Advantage plans can seek recovery under MSP for conditional payments. Despite this right to asset recovery, many primary payers may be unaware such payments have been made related to the injury or even the claimant's enrollment in Part C or D programs. If payment information for Part C and D programs is provided by CMS, primary payers can take into account these conditional payments in the settlement and

ensure those liens are addressed. By doing so, primary payers can avoid private causes of action asserted by Medicare Advantage plans and possible "double damages." The House Subcommittee for Health is currently considering the bill. An identical version was introduced as Senate Bill 1989 on June 26, 2019, and referred to the Senate Committee on Finance.

LIABILITY MSAS: ARE WE ANY CLOSER TO CMS REVIEW?

With mandatory insurer reporting in liability and no-fault automobile cases, it is now easier for Medicare to follow up on such claims. This may be surprising, but there are no statutory or regulatory provisions *requiring* submission of a Medicare-Set Aside to CMS. There is also no formal review process in place for reviewing and approving liability MSAs as in the workers' compensation system. However, CMS has advised that the underlying statutory obligation to take Medicare's interests into account for future medical treatment is the same.[1]

Pursuant to 42 CFR 411.46(a):

> If a lump sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump sum payment.

Under current CMS procedures and guidelines, the easiest method of complying with this provision is to prepare an MSA and obtain approval from CMS confirming the amount set aside for future medicals is sufficient to consider Medicare's interests at the time of settlement. At present, CMS review is only available for Workers' Compensation Medicare Set-Asides (WCMSAs). However, CMS has made clear the law makes no distinction between the protections afforded to Medicare from payment for future services in workers' compensation or liability claims. As such, CMS continues to recognize the set-aside of funds for future medical expenses in settlements as the preferred "method of choice" to protect Medicare's interests.

In the years since CMS developed the program for review of MSAs in workers' compensation claims, CMS has indicated a similar process would eventually be put in place for liability cases. In late 2018, the Office of Information and Regulatory Affairs released a notice that CMS will be announcing plans to address future medicals in relation to liability and no-fault claims with a targeted release of September 2019. Notably, the notice did not specifically reference liability Medicare Set-Asides (LMSAs) but many believe the implication is there nonetheless.

Any LMSA review program is expected to roll out similarly to the one already in place for WCMSAs. As part of the program, there would be certain thresholds in place:

- Review of an LMSA would be triggered by a settlement being reached.
- A $250,000 workload review threshold would be established (without any "safe harbors"). A workload review threshold is an internal standard set by CMS to determine when CMS will review the MSA in light of the workloads presented by the amount of liability settlements with MSAs.
- The LMSA and administration of the money would be the responsibility of the plaintiff/beneficiary.
- Eligible individuals would be limited to Medicare beneficiaries or those who have reasonable expectation of Medicare enrollment within 30 months.

Obviously, these thresholds may or may not be those that CMS chooses to adopt if and when it decides to implement the program. Until then, parties are expected to protect Medicare's interests with regard to future Medicare-covered treatment with little to no direction from CMS. What are the best ways of doing so? There are a few key considerations in assessing whether an MSA may be appropriate if the plaintiff is a Medicare beneficiary:

1. Is future medical care addressed as a component of damages in the pleadings, award, judgment or release?
2. Is the released party, defendant or third party accepting responsibility for future medical costs for the subject injury(s)?
3. Are there funds available to pay specific, future Medicare reimbursable medical costs?

[1] Centers for Medicare and Medicaid Services, NGHP Transcript, *Town Hall Teleconference*, pg. 25 (Sept. 30, 2009).

If the answers to these questions are all "yes," an MSA is recommended to demonstrate Medicare's interests were taken into account. At the very least, it is prudent to consider preparation of an MSA where the plaintiff is a Medicare beneficiary and the settlement value exceeds $250,000 or involves a catastrophic injury. An LMSA can be submitted to CMS for review, although it will be likely be declined given the lack of resources available to conduct review of liability cases. In the absence of its express approval, CMS is not bound by an allocation stipulated by the parties even if a court has approved the arrangement. However, CMS will typically defer to allocations resulting from a jury verdict or hearing on the merits.

Alternatively, the parties can estimate future Medicare-covered expenses based on records from the treating physicians or a life care plan that documents the amount in the settlement agreement. The settlement agreement can include a provision by which the plaintiff agrees to treat that amount as if it were a formal MSA and use it only for future Medicare-covered expenses.

Medicare is most likely to find its interests have been protected where it has reviewed an MSA and agreed to its allocation. If Medicare determines otherwise, it may refuse to pay for the plaintiff's future medical expenses related to the injury until the entirety of the settlement is exhausted.

CONDITIONAL PAYMENTS: WHAT YOU NEED TO KNOW FOR SETTLEMENT

Under MSP, Medicare makes "conditional payments" for a beneficiary's medical expenses if a primary payer fails to issue payments within 120 days. Once a conditional payment is made, Medicare's right of recovery is triggered and the beneficiary, primary payer or other party must reimburse Medicare. If CMS determines Medicare's interests were not protected, the beneficiary's Medicare benefits may be terminated or CMS may seek recovery from the primary payer or other party through an independent cause of action.

To assist in this recovery, CMS has developed a process by which parties can obtain information regarding conditional payments made and any liens asserted by CMS arising out of the subject claim prior to and after a resolution is achieved.

At the outset of the claims process or litigation, it is important to confirm whether a plaintiff is Medicare eligible. If so, Medicare should be immediately notified regarding the claim either from a report by the Responsbile Reporting Entity (RRE) or notification by the beneficiary or her counsel to the Coordinator of Benefits Contractor (COBC). Subsequently, it is important to ascertain whether Medicare has made an initial determination of any amounts subject to a Medicare lien resulting from conditional payments for medical expenses related to the injuries associated with the underlying claim. These determination letters typically contain a list of charges and conditional payments made by Medicare purportedly related to the claim at issue. These letters should be closely scrutinized to confirm the injury or condition is related to the subject lawsuit and all of the conditional payments are related to the subject injuries. Notably, the scope of responsibility for payment of certain services is defined by the beneficiary's claim against the third party.[2] Any disputed payments should be submitted to Medicare who will review and if, in agreement, adjust the conditional payment demand.

Throughout the course of the claim, the parties may request an interim conditional payment letter, which lists the payments to date. However, the Medicare Secondary Payer Recovery Contractor (MSPRC) will not issue a formal demand recovery letter with a final conditional payment amount until a settlement, judgment or award occurs.

Once the parties have reached a settlement, they must notify the MSPRC by submitting the following:

1. the date of settlement, award or judgment;
2. the amount of the settlement, award or judgment;
3. the amount of attorney's fees;
4. the beneficiary's other procurement costs; and
5. a copy of the settlement documents.

[2] *See Weinstein v. Sebelius*, 2013 WL 1187052 (E.D. Pa. Feb. 13, 2013).

The MSPRC then issues a formal demand letter detailing the history of any conditional payments made by Medicare for medical treatment related to the subject claim. Payment of the amount demanded then becomes due within 60 days. If no payment is received within that time period, interest will be assessed beginning from the date of the demand letter. Under the current process, the parties may not receive the final conditional payment amount until after the claim settles. Conditional payments may be reduced or eliminated by Medicare if the Medicare lien is equal to or greater than the policy limits[3] or due to financial hardship.

Effective Jan. 1, 2018, the CMS threshold for liability insurance, no-fault insurance and workers' compensation settlements is $750. If a settlement is less than the threshold, the settlement does not need to be reported and the conditional payment does not need to be repaid as long as ongoing responsibility for medical expenses has not been reported to CMS.

Under the SMART Act, CMS may not file an action or seek penalties more than three years after it is given notice of a settlement, judgment, award or other payment.[4] The establishment of a statute of limitations provides parties with some certainty as to when CMS can recover conditional payments where CMS has received notification of the settlement, judgment or award.

MMSEA SECTION 11: PRACTICAL CONSIDERATIONS

In 2007, MMSEA was enacted as an amendment to the MSP. Section 111 of the MMSEA extended Medicare's authority to enforce the MSP by implementing mandatory reporting requirements for group health insurance plans, liability, no-fault and workers' compensation insurers. RREs are obligated to determine whether a claimant or plaintiff is eligible for Medicare and, if so, comply with the MMSEA by reporting information on any payment made pursuant to a settlement, award or judgment.

In liability cases, MMSEA mandates insurer reporting of a total payment obligation to the plaintiff (TPOC) reflecting any dollar amount paid toward a settlement or judgment. Importantly, this information must be reported *regardless* of whether there has been an admission of liability. Even if the claimant is not a Medicare beneficiary at the onset of a claim, an RRE is obligated to continue monitoring the claimant's Medicare status over the life of the claim. If the claimant becomes a Medicare beneficiary prior to payment of a settlement, award or judgment, the claim must be reported to CMS.

In order to determine the claimant's Medicare status, you should obtain the claimant's date of birth and social security number, if possible. If unable to obtain this information in the pre-suit stage, defense counsel can obtain that information through discovery procedures, including written discovery responses and/or deposition of claimant. Other sources that may have a date of birth include a motor vehicle accident report, medical records or medical bills.

To ensure compliance with these reporting requirements, the MMSEA imposes mandatory penalties of $1,000 per day, although the SMART Act altered this provision by making these fines discretionary based on guidelines and criteria set out by the Department of Health and Human Services.

By utilizing and enforcing these procedures, CMS and Medicare are now able to track conditional payments and review claim resolutions to confirm whether Medicare's interests were taken into account or if further steps must be taken to seek recovery for any past or future payments made on behalf of the beneficiary.

MEDICARE/CMS COMPLIANCE: ETHICAL PITFALLS, RISKS AND PENATLIES

There are a number of ways to take Medicare's interests into account at the time of settlement, including satisfaction of any conditional payment liens. The settlement agreement should include indemnification language and reference to the amount of the most current conditional payment lien. In cases where there is a Medicare lien, consider proposing that the Medicare lien amount is held in trust while plaintiff's counsel is negotiating the lien with Medicare. Once the final demand letter is received, you can issue payment directly

[3] 42 C.F.R. § 411.28.

[4] 42 U.S.C. § 1395y(b)(2)(B)(iii)(2013); *see also* Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012.

to Medicare and both parties can feel confident that Medicare's interests have been satisfied. Remember: if plaintiff or her counsel fails to satisfy the Medicare lien, the defendant or insurer is responsible to pay it within 60 days, regardless of whether payment of settlement has already been made to plaintiff. Document your file to demonstrate the steps taken to consider and protect Medicare's interests in the course of settlement.

There are many risks of failure to comply with Medicare and a potential bad faith claim in situations involving time-limited settlement demands. An insurer cannot force a plaintiff to agree to include Medicare on a check and many settlements have been thwarted by efforts to do so. As an alternative, the parties can agree that plaintiff's counsel will hold the total amount of the lien in trust until it is paid to Medicare. If the inclusion of Medicare is not a term of the settlement, an insurer tendering policy limits to avoid a bad faith claim may include correspondence with the settlement check to the plaintiff's attorney with a reminder regarding MSP obligations to demonstrate an intent by the insurer to comply with the MSP.

CONCLUSION

It is not easy and not fun to deal with Medicare recovery issues. However, parties must address the interests of Medicare in personal injury cases by taking every necessary step to ensure compliance with procedures for conditional payments and future Medicare-covered expenses. In doing so, you are not only taking into account Medicare's interests, but protecting your company's interests to avoid fines, penalties and future recovery efforts by Medicare as well. A good practice is to adapt the CMS procedures and guidelines to develop a step-by-step case analysis and procedure as part of your practice. If a case crosses your desk, one of the first questions you must ask is whether the plaintiff is a Medicare beneficiary. If so, you can then follow your process of ensuring you are informed, instructed and compliant with CMS guidelines.

Hall Pass: How Does a Visitor's Classification Result in Liability?

By Pamela N. Lee, Rachel W. Mathews and Kenneth C. Wilson

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Ken previously handled automobile and premises liability litigation as in-house counsel for a Fortune 500 company. Prior to that, he was an assistant district attorney in Fulton County's Major Case Division, where he was responsible for cases involving murder, homicide by vehicle and serious injury by vehicle cases that included allegations of driving under the influence.

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Hall Pass: How Does a Visitor's Classification Result in Liability?

In the world of premises liability, not all property visitors are created equal. In order to determine the liability of an owner or occupier of land for an injury occuring on the property, it is necessary to determine what classification the visitor falls into, as varying duties are owed to each type of visitor.

WHAT ARE THE DIFFERENT VISITOR CLASSIFICATIONS?

Before we can determine the duty owed to a property visitor, we must develop a working definition of the types of potential visitors. In Georgia, there are generally three types of visitors: invitees, licensees and trespassers. The specific facts as to how a person accesses the property in question determines that person's visitor classification. For instance, "generally, a person is an invitee when 'an owner or occupier of land, by express or implied invitation, induces or leads [him or her] to come upon his premises for any lawful purpose.'"[1] Simply put, an invitee is a person invited to the property for a specific, mutually beneficial purpose. For example, a landscaping company or general contractor hired for the purpose of performing maintenance or repairs on property would be considered an invitee. Similarly, a customer visiting a store or client visiting a business is considered an invitee under Georgia law.

On the other hand, a licensee: "(1) [i]s neither a customer, a servant, nor a trespasser; (2) [d]oes not stand in any contractual relation with the owner of the premises; and (3) [i]s permitted, expressly or impliedly, to go on the premises merely for his own interest, convenience, or gratification."[2] Thus, this class of visitors includes social guests, a person in a retail store solely for the purposes of using the restroom, an insurance salesman making a sales call or an employer entering upon property to offer an employee a job.[3] Lastly, a "trespasser is one who, though peacefully or by mistake, wrongfully enters upon property owned or occupied by another."[4]

Within the trespasser classification, courts have carved out a special rule as it pertains to children, bearing in mind that children are routinely drawn to certain man-made hazards. The rule is known as the attractive nuisance doctrine. The seminal case defining the doctrine is *Gregory v. Johnson*. In this case, the Supreme Court of Georgia adopted Section 339 of the Restatement (Second) of Torts to set out the criteria that must be met to prove an attractive nuisance.[5] Under Georgia law, this doctrine is applicable if there is evidence to show all five of the following conditions are met:

1. The place the condition exists is one in which the owner knows or has reason to know children are likely to trespass;
2. The owner knows or has reason to know and realizes or should realize the condition involves an unreasonable risk of death or serious bodily injury to such children;
3. The children, because of their youth, do not discover the condition or realize the risk involved in intermeddling with it or coming within the area made dangerous by it;
4. The utility to the owner of maintaining the condition and the burden of eliminating the danger are slight compared to the risk to children involved; and
5. The owner fails to exercise reasonable care to eliminate the danger or otherwise to protect the children.[6]

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1 O.C.G.A § 51-3-1; *see also Mcgarity v. Hart Elec. Membership Corp*., 307 Ga. App. 739, 706 S.E.2d 676 (2011).

2 O.C.G.A § 51-3-2 (a); *see also Harrison v. Legacy Hous., LP*, 324 F.Supp.3d 1288 (M.D. Ga. 2018).

3 *See generally Thompson v. Oursier*, 318 Ga. App. 377, 378, 733 S.E.2d 359 (2012) ("Georgia has adopted the rule that a social guest is not an invitee but is a licensee.").

4 *Id.*

5 *Craig v. Bailey Bros. Realty, Inc.,* 304 Ga. App. 794, 697 S.E.2d 888 (2010).

6 *Gregory v. Johnson*, 249 Ga. App. 151, 289 S.E.2d 232 (1982).

CAN A VISITOR'S STATUS CHANGE WHILE THEY ARE ON THE PROPERTY?

Although a person may initially enter the property as an invitee, that status can change if the visitor goes beyond the part of the property to which they were invited.[7] In this case, a person's classification can change to licensee or even trespasser. Similarly, an invitee's presence on the property can be time limited, so that if an invitee uses the premises at a time beyond that which is allowed by the merchant, the invitee becomes a mere licensee.[8] This is based on the theory that an invitee only remains an invitee for so long as they are on the property for a mutually beneficial purpose.[9]

For example, the Court of Appeals has held where a man entered a nightclub as a patron, he was initially considered an invitee to the property. However, once the man was rightfully ejected from the nightclub for intoxication and then attempted to reenter the establishment, he had turned into a trespasser on the property. The Court of Appeals described this as a "micro-adaption" or "mini-evolution" of his status from an invitee to a trespasser.[10]

WHAT ARE THE DUTIES OWED TO VARIOUS ENTRANTS ON PROPERTY?

The duties owed to each type of entrant are different. An invitee who comes onto the property for a mutually beneficial purpose is owed the highest duty of care of the three classifications. Under Georgia law, a premises owner or occupier owes an invitee the duty to exercise ordinary care to keep the premises and "approaches" in a reasonably safe condition.[11] This includes protecting the invitee against unreasonable risks of harm of which the owner has superior knowledge and inspecting the premises to discover possibly dangerous conditions.[12]

In contrast, a property owner owes a lesser duty to licensees to not willfully or wantonly injure them.[13] Willful behavior has been described as an actual intention to do harm or inflict injury, while wanton behavior is considered conduct "so reckless or so charged with indifference to the consequences as to be the equivalent in spirit to actual intent."[14] Additionally, a property owner can be considered to have acted willfully or wantonly where a property owner has superior knowledge of a condition on the property involving an unreasonable risk of harm to licensees and fails to exercise reasonable care to make the condition safe or warn the licensee of the risk involved.[15]

Similarly, a property owner owes no duty to a trespasser except to avoid willfully or wantonly injuring them.[16] This includes exercising ordinary care to protect anticipated trespassers from dangerous activities or hidden perils on the premises.[17]

HOW FAR DOES A PROPERTY OWNER'S DUTY EXTEND?

A property owner's duty is not limited to the actual premises; rather, a property owner must also keep the "approaches" to their property safe.[18] An approach is defined as property directly contiguous, adjacent to and touching those entryways to the premises under the control of an owner or occupier of land, through which the owner or occupier, by express or implied invitation, has induced or led others to come upon his premises for any lawful purpose, and through which such owner or occupier could foresee a reasonable invitee would

7 *Lenny's No. Two v. Echols*, 192 Ga. App. 371, 373, 384 S.E.2d 898, 900 (1989).
8 *Armstrong v. Sundance Entm't*, 179 Ga. App. 635, 635-36, 347 S.E.2d 292, 293 (1986).
9 *Lenny's No. Two v. Echols*, 192 Ga. App. 371, 373, 384 S.E.2d 898, 900 (1989).
10 *Ginn v. Renaldo*, 183 Ga. App. 618, 621, 359 S.E.2d 390, 393 (1987).
11 *Boyd v. Big Lots Stores*, 347 Ga. App. 140, 141, 817 S.E.2d 698 (2018); O.C.G.A. § 51-3-1.
12 *Robinson v. Kroger Co.*, 268 Ga. App. 735, 739, 493 S.E.2d 403, 408-09 (1997).
13 *Van v. Kong*, 344 Ga. App. 754, 755, 811 S.E.2d 474, 475 (2018).
14 *Ga. Dept. of Transp. v. Strickland*, 279 Ga. App. 753, 754, 632 S.E.2d 416, 418 (2006).
15 *Brown v. Dickerson*, 350 Ga. App. 137, 828 S.E.2d 376
16 *Handberry v. Stuckey Timberland, Inc.*, 345 Ga. App. 191, 195, 812 S.E.2d 547, 551 (2018).
17 *Gomez v. Julian LeCraw & Co.*, 269 Ga. App. 576, 578-79, 604 S.E.2d 532, 535 (2004).
18 O.C.G.A. § 51-3-1.

find it necessary or convenient to traverse while entering or exiting in the course of the business for which the invitation was extended.[19] While this does not include property traversed by "mere pedestrians," it may include noncontiguous property if the landowner extended the approach to their premises by some positive action on their part, such as constructing a sidewalk, ramp or other direct approach.[20]

CONCLUSION

In determining whether a property owner may be held liable for an injury on property, it is first necessary to determine whether the visitor is considered an invitee, a licensee or a trespasser to the property. Only then can we determine the standard of care owed to the injured party and whether there was a breach of that duty.

[19] *Motel Props. v. Miller*, 263 Ga. 484, 486, 436 S.E.2d 196, 198 (1993).

[20] *Id.*

Making a Statement! Use of Recorded Statements, EUOs and Depositions

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Mark is always up for a challenge on his clients' behalf, having tried more arson fraud cases than anyone else in Georgia. He focuses on the endgame of a matter at the beginning of the case in order to develop the best strategy to achieve the desired result. In addition, Mark understands a case is not just about an individual matter, but it may also impact his clients' overall business and sometimes an entire industry.

Mark regularly speaks to members of the arson investigator community to educate them on their legal responsibilities during an investigation. In addition, he keeps fire investigators abreast of new developments in the law and how they can be interpreted.

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Making a Statement! Use of Recorded Statements, EUOs and Depositions

In the context of first-party insurance claims, recorded statements, examinations under oath (EUOs) and depositions are generally similar processes. They consist of an insurance company representative (employee or retained attorney) asking an insured a number of "on the record" questions at some point after a loss. However, the general similarities are far outweighed by the differences in details between these three statements, which include the basis for authority to take the statement, the formalities that apply within the statement, the purpose for taking the statement and the statement's admissibility in court.

The recorded statement is the first statement an insured gives after a loss. This statement is traditionally taken by an insurance company employee during one of the first meetings between the insured and the insurance company after the loss in question. Usually, the process is handled via telephone and the insured is not under oath. The insurance company employee asks general questions to the insured about her background, the loss and other varying topics depending on the type of loss. The insured's questioning is usually somewhat limited at this time because the statement is taken at the beginning of the investigation process and many of the key issues and facts have not yet developed. Rarely is the insured provided with a copy of the recording or transcript. The insured never signs it.

Next, if further investigation of the claim is warranted based on the information gleaned by the insurance company, whether it be through the recorded statement or some other method of investigation (e.g. cause and origin investigation, information request related to the insured, etc.), the insurance company consults with its attorney and requests an EUO be scheduled. The EUO is more formal than the recorded statement, includes a court reporter and is away from the loss location. At the EUO, the attorney goes into greater depth with the insured about the loss and focuses specifically on the issues related to the coverage question(s). The insured is usually asked to produce a number of documents that relate to the coverage issue(s). Afterward, the attorney reviews all available information and provides a legal analysis and recommendation regarding the future handling of the claim. The EUO is the most important statement with regard to making a decision on the insured's claim.

The decision regarding the claim after the EUO may be the end of the process. If it is determined the claim is covered and payable, the insurance company moves forward with payment, effectively ending the claim process. The insurance company denies the claim if it is determined the claim is not covered. If the insured accepts the denial, the claim process is complete. However, a deposition may be necessary if the insured does not accept the denial or carrier's settlement offer and files suit. As there is no longer any potential benefit in attempting to remain non-adversarial with the insured, the insurer can take a more aggressive approach at the deposition. While a deposition is very similar in appearance to an EUO, the two are very different in practice. The deposition is the final sworn statement in this process before trial, thus it is the least utilized process. Because of this, the deposition is of least concern to the typical first-party insurance claim representative. This paper will focus primarily on the recorded statement and EUO.

All in all, the statements discussed in this paper give the insurance company three separate and distinct occasions to speak on the record with the insured. Note that neither the law nor the policy limits the insurer to a single recorded statement or EUO. Utilized properly, these statements give the insurer the opportunity to solidify an applicable defense, prove relevant exclusions, properly deny the claim and succeed at trial. Failure to utilize these statements properly can lead to payment of a claim despite unknown facts showing the loss was not covered by the insurance policy. Therefore, these statements are critical to the claims handling process.

Initially, an insurance company is completely in the dark with regard to a loss. In nearly all instances, it does not even know a loss occurred until the insured provides notice. Thereafter, the insured is the party responsible for gathering much of the relative information and providing it to the insurance company so it can assess the claim. This gives the insured responsibility, power and control over the claim. As we all know, many an insured has used their control and power to make a fraudulent claim, inflate a claim or attempt to pull the wool over the insurance company's eyes in some other way. In fact, fraud *is* a multibillion dollar a year industry.

The recorded statement, EUO and deposition are means to keep the insured's control and power in check. Being detailed and thorough at all three statements will ensure all of the information needed to make an educated, correct decision on the claim has been obtained and will support the insurer's decision on the claim if the case goes into litigation.

Mark Twain once wrote, "If you tell the truth, you don't have to remember anything." Applied to the case of a potentially fraudulent claim, insureds who tell the truth have nothing to worry about throughout this process because their story will not change regardless of how many times they are asked about the loss. Furthermore, their story should not conflict with the statements of other witnesses or documents showing their whereabouts, phone calls or financial situation. Of course, the inverse of the Twain quote is, "If you don't tell the truth, you have a lot to remember." Therefore, being detailed and thorough during all three statements can highlight variations in the insured's story and provide clues as to possible falsehoods from the insured. Understanding how to properly utilize these statements is extremely important for all individuals who use recorded statements, EUOs or depositions in their work.

RECORDED STATEMENTS

The story the insured provides to her insurer starts with the recorded statement. The more quickly the insurance company meets the insured and takes her statement, the better. This way, the loss is fresh in the insured's mind and the insured should be able to provide an accurate account of the important information. Therefore, the recorded statement should be taken as soon after the loss as possible.

The authority to take a recorded statement is provided in the insurance policy itself. Usually, authority is provided in the section that details the insured's duties after a loss. The authority to take an EUO requesting a proof of loss, inventory or other documentation is also contained in these provisions.

A typical policy provides:

2. Your Duties After Loss: In case of a loss to covered property, we have no duty to provide coverage under this policy if there is a failure to comply with the following duties. These duties must be performed either by you, an insured seeking coverage, or a representative of either:
    e. Cooperate with us in the investigation of the claim;
    f. Prepare an inventory of damaged personal property showing the quantity, description, actual cash value, and amount of loss. Attach all bills, receipts, and related documents that justify the figures and inventory;
    g. As often as we reasonably require:
        (2) Provide us with records and documents we request and permit us to make copies; and
        (3) Submit to examination under oath while not in the presence of another insured, and sign the same;
    h. Send to us, within 60 days after our request, your signed, sworn proof of loss which sets forth to the best of your knowledge and belief:
        (1) The time and cause of loss;
        (2) Your interest and that of all others in the property involved and all liens on the property;
        (3) Other insurance which may cover the loss;
        (4) Changes in title or occupancy of the property during the term of the policy;
        (5) Specifications of damaged buildings and detailed repair estimates;
        (6) The inventory of damaged personal property described in 1c;
    j. Receipts for additional living expenses incurred and records that support the fair rental value loss.

The authority to take the recorded statement is derived from the insured's duty to cooperate with the insurer in its investigation of the claim.

GENERAL CONSIDERATIONS

Recorded statement transcripts that are incomplete or contain multiple parties not clearly identified or numerous inaudible statements due to poor sound quality or rushed questioning are difficult to use as investigation tools. Further, they are unpersuasive evidence at trial and, ultimately, ineffective tools for the claim representative or counsel. Therefore, the representative taking the recorded statement should ensure the recording device is in good working order, the insured is speaking clearly and background noise is minimized to create a complete transcript of the insured's statement. If there are multiple individuals in the area while the recorded statement is conducted, the interviewer should clearly identify each person speaking or take statements separately to create a clear record. Also, the interviewer should allow the insured to complete her response to a question prior to asking another question or for clarification to an answer. If due care is taken in the recorded statement process, the result will be an effective source of information and admissible evidence should the claim result in litigation.

Insurance companies have developed their own standards with regard to taking effective recorded statements. Taking an effective recorded statement is often fact sensitive and it is difficult to identify certain questions that will apply to all claims. The claim representative should be observant as to the circumstances surrounding the loss and ask as many specific questions regarding the loss as possible, including the identities of any witnesses for follow-up investigation, times, dates and locations.

There are certain procedures to observe every time an insurance company takes a recorded statement. For example, the claim representative may consider having on record that the insured is giving her statement voluntarily. This will assist in satisfying the foundation requirement should the recording enter into evidence at trial. Furthermore, for ease of use and in order to establish a chronology for the investigation, the claim representative may consider stating the date, time and location of the recording at the beginning of the statement. Finally, the interviewer should make clear that if the insured does not understand a particular question, the insured should ask for clarification or ask the interviewer to rephrase the question. This precaution minimizes the chance an insured can effectively recant a response based on not understanding the question.

AUTHENTICATION

Unlike the EUO or deposition, a recorded statement is unsworn. It is still admissible in court to impeach the insured in the event that her testimony is contradictory or conflicts with some other evidence. In that regard, the recorded statement can be an important piece of evidence at trial. However, there are several legal considerations to keep in mind to effectively use the recorded statement at trial.

First, the recorded statement must be authenticated. In the case of audio-only recordings, such as recorded statements, there are a number of steps required to show the proper foundation to submit the recorded statement as evidence at trial. Showing proper foundation requires providing the following evidence:

1. The recording was made on a capable machine;
2. The operator was competent;
3. The recording is a fair and accurate representation of what was said and heard;
4. No changes have been made to the tape;
5. The tape was properly preserved;
6. The speakers are all identified; and
7. The statements were not elicited under duress.

When there are no witnesses available to authenticate the recording from personal knowledge, O.C.G.A. § 24-4-48 provides an alternative method of authentication "based on competent evidence presented to the court, that such items tend to show reliably the fact or facts for which the items are offered."

The simplest way to authenticate a recording is to have the adjuster or investigator who took the statement testify the recording is a fair, accurate representation of the statements made. Although this is enough to authenticate the recording, some jurors harbor excessive suspicions about such evidence and believe it is easily altered or fabricated. Therefore, it is important the recording is as clear as possible, the individual making the recording on behalf of the company is available to lay a foundation for the use of the statement at trial and to authenticate the recording for use as evidence.

USE AT TRIAL

Unclear recorded statements are problematic for use as evidence at trial. When the sound quality of a recording is poor, any party may prepare a written transcript of the recording and request to provide it to the jurors while they are listening to the recording in court. The trial judge decides what, if anything, to show the jury and may excise portions of a transcript that attempt to translate statements the court finds too inaudible or ambiguous to be accurately transcribed. Furthermore, the jury is instructed that any transcript of a recorded statement is merely an aid, not evidence, and they should make their own independent determination of what was actually said. The recorded statement transcript does not exit the courtroom with the jury.

EUO

Georgia courts have been quite clear that a recorded statement is not an EUO, and recorded statements should be as thorough as possible. Like the recorded statement, the EUO is a process provided for by the insurance policy. Sometimes, the policy refers to the process as a sworn statement. The insurance contract defines the rights and duties of the insurer and insured. The right to take an EUO must be found within the four corners of the policy.

Outside of those who routinely handle first-party insurance claims, the rules for EUOs are much less understood than those for a deposition. There are no judicial procedures or statutes defining the process. The typical EUO clause says the insured must submit to an EUO as often as the insurer reasonably requests. Another notable part of the typical provision states an insured must submit to a separate EUO conducted outside the presence of any other insured. In potential fraud cases, this provision is important because it prevents an insured from being able to modify their story based on what another insured says in her EUO. To further this objective, it is also beneficial to schedule multiple EUOs on the same day, one after the other, so insureds do not have time to coordinate their testimony with each other.

Procedurally, the EUO is normally not demanded until a proof of loss is filed by the insured. As one of the purposes of the EUO is to inquire about damages, a complete EUO cannot be accomplished unless the insured has formally presented a claim. It is also beneficial to have an inventory prior to the EUO in cases involving personal property losses. A number of cases uphold the insurer's right to demand documents and take the EUO of its insured.

WAIVER OF RIGHT TO EUO

An insurer's right to examine its insured is a privilege it may waive. For example, a waiver of the right to examine the insured may occur if the insurer accepts or denies liability for a claim prior to demanding an EUO. Thus, rights under the policy may be lost by either waiver or estoppel. The authorities are unanimous that an insurer breaching the policy by denying the claim cannot later demand that its insured comply with the terms of the policy.

It is a basic principle of contract law that once a party to a contract breaches the agreement, the other party is no longer obligated to continue performing her own contractual obligation. As a result, once the carrier has denied coverage, an insured is no longer bound by the insurance policy's provisions governing cooperation, proof of loss statement, access to books and records and submission to examination.

INSURED'S FIFTH AMENDMENT RIGHTS

The insured is obligated to submit to an EUO, even when the insured claims Fifth Amendment protection. In *Pervis v. State Farm Fire & Casualty Co.*, the United States Court of Appeals for the Eleventh Circuit held the insured, who filed an action to recover fire insurance proceeds, was required to submit to an EUO before he could initiate an action to recover under the policy pursuant to the terms of his policy.[1] As he was facing criminal arson charges, the insured took the position that submitting to an EUO would violate his constitutional rights against self-incrimination. The court held the insured had a contractual duty to submit to the EUO as a condition precedent to filing his action and his constitutional right did not excuse

[1] 901 F.2d 944 (1990).

him from complying with the insurance contract he wished to enforce. The court further held, despite the constitutional questions raised by the insured, the insured lost his rights under the insurance contract by failing to submit to the EUO. Additionally, Georgia law indicates insureds cannot refuse document requests on the basis of self-incrimination.

CONTENT

The EUO can also be used to gather background information regarding the insured, such as the insured's financial condition at the time of the loss, if there are indications of fraud in the claim. For example, in *Halcome v. Cincinnati Insurance Co.,* the insureds took a trip to Disney World with their son during which their car containing valuable jewelry was allegedly stolen. The insureds filed a claim with their insurer for a total property loss of $128,495. Based on information the insureds had submitted prior questionable claims with other carriers and their state of unemployment at the time of the loss, the carrier requested information relating to the insured's income, prior claims and criminal history. The insureds refused to provide the information and filed suit. The district court entered summary judgment in the insurance company's favor. The Eleventh Circuit affirmed the district court's grant of summary judgment to the insurance company, holding the insureds' claim raised questions of fraud, thus making their income relevant to the insurance company's investigation. The insureds breached their contract of insurance by failing to provide the information the insurer requested during the EUO process.[2]

A more recent federal case applying Georgia law further substantiates the *Halcome* holding. In *Hall v. Liberty Mutual Fire Insurance Co.,* the insureds failed to submit to an EUO and did not produce documents requested by Liberty Mutual, including a proof of loss, before filing suit. The court held the insureds' failure to produce the requested documents warranted the grant of summary judgment to the insurer, regardless of whether the insured had a valid reason for failing to submit to an EUO.[3]

REQUESTING AN EUO

A request for an EUO must meet certain guidelines to be enforceable. A carrier cannot casually ask for an exam. The demand must be clear and unequivocal and designate who will take the EUO. The insurer must also name a specific time, date and location for the EUO. Some states hold that the insured has no duty to appear for an EUO outside of the area where they live or the site of loss. A demand for an EUO in a different county may be invalid.

When scheduling an EUO, it is important to include in the letter sent to the insured the policy language referencing the insured's duties after a loss. The policy language helps identify the specific coverage issues raised that will be investigated in the EUO and provides a blueprint as to how the loss may be adjusted, if necessary, following the conclusion of the investigation. Furthermore, the demand for the EUO must be timely. In *Appleby v. Merastar Insurance Co.*, the court held an insurer may waive the contractual suit limitation period when the insurer demands an EUO of its insured after the suit limitation period has expired.[4]

REQUESTING THE PRODUCTION OF DOCUMENTS

A key case discussing the EUO process, as well as other conditions precedent to coverage under a policy of insurance, is *Farmer v. Allstate Insurance Co.* In *Farmer*, Allstate suspected a fire loss resulted from arson committed by or on behalf of the insured. Allstate requested documents regarding the insured's financial status at the time of the loss, such as bank records and income tax returns, as part of its demand for the insured's EUO. The insured submitted to the EUO but refused to provide the requested documents, arguing the documents were not relevant to the fire loss. Allstate subsequently denied the insured's claim. Shortly after, the insured brought suit against Allstate for proceeds under the policy following the fire loss. Allstate filed a motion for summary judgment arguing the insured was barred from recovering under the policy because she failed to comply with conditions precedent to coverage. [5]

2 *Halcome v. Cincinnati Ins. Co.*, 254 Ga. 742, 334 S.E.2d 155 (1985).
3 *Hall v. Liberty Mut. Fire Ins. Co.*, 2009 U.S. App LEXIS 2075.
4 223 Ga. App. 463 (1996).
5 396 F. Supp. 2d 1379 (2006).

In granting Allstate's motion for summary judgment, the U.S. District Court for the Northern District of Georgia cited approvingly of legal principles that apply to the questions of fraud, an insured's obligations under the policy and relevant material an insurance company may rely on in evaluating a claim. Relying on *Pervis v. State Farm Fire & Casualty Co.,* the court held when questions exist as to the cause of a fire for which a claim is made, the insurer has the right to thoroughly investigate before reaching a decision about paying the claim.[6] Moreover, relying on *Diamonds & Denims, Inc. v. First of Georgia Insurance Co.,* the court held "[a]n insurer is entitled to require its insured to abide by the policy terms, and the insured is required to cooperate with the insurer in its investigation and resolution of the claim."[7]

Pursuant to the policy language, which was substantially similar to the provisions referenced in this paper, the *Farmer* court held the requirement that requested documentation be provided was a condition precedent to the insured's filing of any action against Allstate because such conditions were binding against the insured. Furthermore, the court was not persuaded by the insured's contention that the information Allstate requested was not relevant to the claim under investigation and unnecessarily intrusive. In fact, the court held, "[w]here an insurer suspects that a claim might be fraudulent, information relating to the insured's recent income and sources of income is material and relevant to the suspicion of fraud and to the insured's possible financial motive."[8]

Georgia and federal law uphold the enforceability of the conditions to coverage provisions contained in most insurance policies. Especially where fraud or arson are suspected, the insurance company has a number of tools to develop information necessary to make the proper decision with regard to its obligations under the insurance policy to the insured following its initial receipt of the claim.

CONTENT

The broad scope of subjects available for discussion is one advantage of an EUO. While it is not advisable to ask questions that do not relate in some way to the claim or could not be explained to a judge, evidentiary rules applying in depositions do not apply to EUOs. Therefore, no one can object to questions and the individual taking the statement is provided with some latitude.

In some instances, as seen with respect to document requests, insureds argue the questions posed are outside the scope of what is allowed in their EUOs. However, any topic that might contain information the insurance company will consider or use to make a decision on the claim is fair game.

The case of *Meyers v. State Farm Fire & Casualty Co.* provides an excellent illustration of the types of questions and issues that can be explored in an effective EUO. In *Meyers*, the insureds' house and certain contents in the house were destroyed by fire. The fire loss was reported to a State Farm representative as suspicious in nature, which led the representative to request a cause and origin investigation. It was the cause and origin expert's opinion that the fire had been intentionally set.

Due to both the suspicious nature of the fire and the cause and origin findings, State Farm determined it was necessary to conduct a full investigation into the circumstances and events surrounding the fire. Pursuant to the terms of the policy, the insureds were required to submit to EUOs and provide information, records and documents regarding their financial condition. State Farm notified the insureds of its suspicions regarding the nature of the fire loss and requested they appear for their EUOs and provide certain financial information, as provided by the policy. Meanwhile, the insureds submitted to State Farm a partial sworn statement in proof of loss making a claim for payment under the policy.[9]

Pursuant to the terms of the policy, State Farm's counsel conducted the EUO of the insureds. The attorney reminded the husband of his duty under the policy. The *Meyers* court cited the following exchange approvingly:

> "I do want to warn you that your policy states that if you misrepresent or conceal any material facts, the insurance contract is void. Therefore, it is important that you be completely truthful and honest in responding to my questions. Do you understand that?"[10]

6 *Id.*
7 203 Ga. App. 681, 683 (1992).
8 396 F. Supp. 2d 1379, 1382 (2005).
9 801 F. Supp. 709 (1992).
10 *Id.* at 712.

The court also approved of a similar warning given to the insured wife:

> "I do want to warn you that the policy provides that if you misrepresent or conceal any material facts, the policy is void. That means that it's important that you be completely truthful in responding to my questions and don't try to hide information or play word games. If I ask a question and there's an answer to it, give me the full answer and that will save both of us some time and some problems. Okay?"[11]

The *Meyers* court also acknowledged the procedure employed by State Farm to demand signatures on the transcripts to verify the testimony's accuracy. Both insureds reviewed their respective transcripts, signed the errata sheets before a notary public and returned them without substantial change to State Farm.

Despite these admonitions, the facts cited by the court in *Meyers* revealed both insureds made numerous intentional misrepresentations concerning their financial condition during their examinations. When the insureds attempted to diminish the importance of the examinations or their misrepresentations, the court referred to the explicit instructions they received about their responsibilities and the possible effects of any misrepresentations. As a result, the court in *Meyers* upheld State Farm's denial of the claim and granted State Farm's motion for summary judgment.[12]

Meyers illustrates some important procedural elements of an EUO and how the examination fits into the overall claim process. In *Meyers*, State Farm conducted a thorough initial investigation and identified certain material circumstances warranting careful examination of the insureds. The EUOs were used to evaluate the initial investigation, obtain from the insureds an explanation of any discrepancies and identify follow-up investigation necessary to conclude the claim. During the examinations, specific instructions about the policy, their duties and the possible effects of violating the policy negated any contention by the insureds that they did not understand what was expected or what the effect of their conduct would be. In short, a thorough investigation, coupled with properly conducted examinations, enabled State Farm to prevail as a matter of law on a defense — misrepresentation — that is often reserved for a jury to decide.

FINAL CONSIDERATIONS

Although policies and applicable laws do not mandate that EUOs should be taken by an attorney, most companies hire outside counsel to conduct EUOs, and for good reason. First, the attorney is often more familiar and comfortable with questioning witnesses and utilizing documents in a manner that would be admissible in a court proceeding, should the matter end up in litigation. Also, having an outside attorney conduct the examination gives the insurance company an outsider's point of view on important issues, such as credibility and legal sufficiency of the evidence to support a defense.

After the EUO, the attorney can provide a legal analysis containing (1) an assessment of the credibility of the witness; (2) a summary of the facts learned; (3) an analysis of the sufficiency of the testimony and the evidence to support the defenses investigated by the company; (4) a statement about what follow-up investigation should be taken; and (5) any legal analysis regarding the interpretation of the policy provisions as they apply to the facts of the case. The report prepared by the attorney is privileged and protected as work product should the claim be denied and result in litigation.

If used effectively, the EUO is the most important tool to further the claim investigation and reach the correct decision regarding a claim in the shortest period of time.

DEPOSITIONS

Depositions are similar to EUOs except they occur only after a lawsuit is filed and are subject to a number of evidentiary rules and procedures. Depositions are part of a case's discovery process and subject to the rules of the court in which the lawsuit is filed. As depositions only take place after a lawsuit is filed, in a first-party insurance claim context, they most often occur after a claim is denied. In these instances, the lawsuit is the insured's final chance at recovering under her policy.

11 *Id.*

12 *Id*.

When a deposition is taken in a first-party loss context, the insured is now an adversary of the insurer. Therefore, any benefit of the doubt or deference given to the insured during the recorded statement and EUO is now inapplicable. In other words, the gloves are off. However, the insured does have new layers of protection that were likely not available at the previous statements.

First, the insured will likely have an attorney present. If the attorney is competent, she will know the applicable evidentiary rules, which differ from state to state and in federal court and govern her client accordingly. The evidentiary rules can be used as protection because they often allow an attorney to object to certain questions based on the manner in which the question was asked, the information the question seeks or the information referenced in the question itself.

An attorney who takes a good EUO may have very little to ask at the deposition. The deposition is likely the attorney's second chance to question the insured and, because a lawsuit was filed, it is likely the claim was denied. In this regard, the information needed to deny the claim was likely already elicited. Nevertheless, the deposition has a number of beneficial uses even when information sufficient to deny the claim already developed in the EUO.

First, the deposition can be used to further illustrate the insured's changing story when the denial was based on misrepresentations or fraud. For instance, when an insured gives different stories at her recorded statement and EUO, she will often try to tie those two stories together during her deposition, as she will now have had the chance to read both of her previous statements. This can work in the carrier's favor because it presents a new third story that does not coincide with either previous story.

Additionally, new information is often obtained between the time of the EUO and deposition. For instance, the insurer's counsel will often make document requests to third parties in discovery. The documents obtained may contradict the insured's EUO testimony and those issues can be raised at the deposition. Finally, the deposition gives an inside look at how the insured will present her case at trial. At the time of the deposition, the insured has likely identified why her claim was denied and strategized with her counsel about the same. Therefore, their deposition testimony will more closely coincide with her trial testimony, thereby giving the opportunity to prepare for and combat the insured's explanation of the events.

The deposition is an insurer's chance to tie its case together in preparation for trial. By the time of the deposition, the insurer should have all of the pertinent information, giving its attorney a chance to confront the insured with pointed questions, providing critical evidence supporting the insurer's case in a way that can be used effectively at trial. Keep in mind, at the time of the EUO, the insurer and its attorney were still gathering the facts and determining what issues caused coverage questions. Those coverage questions have been researched and applied to the facts prior to the deposition, thus making a simple and understandable transcript a much more manageable task. In this regard, the deposition transcript is often an easier way to present the insurer's case to a jury in an easily understandable way.

The most critical difference between the EUO and deposition is its evidentiary impact on a case. Nearly all policies contain a concealment or fraud provision, which either voids the policy or provides the insurer a basis to deny the claim if the insured intentionally conceals or misrepresents material facts during the presentation of the claim. This defense is available if the insured has intentionally concealed or misrepresented material facts during the recorded statement or the EUO process. In other words, a significant lie by the insured during the investigative stages of the claim will provide a basis for the denial of the entire claim.

However, if the insured provides contradictory statements during the deposition process, the deposition transcript may only be used to impeach the credibility of the insured, not deny the claim. Therefore, the significance of inaccurate or false testimony varies greatly depending upon the format in which the testimony is provided. Once the parties are in litigation, the significance of the false statement is governed by procedural rules, not necessarily the provisions of the insurance contract.

CONCLUSION

The use of recorded statements, EUOs and depositions is critical in any disputed insurance claim. Each of these techniques is governed by specific rules and requirements. The manner in which they are conducted, the formalities required and the evidentiary significance of the information obtained varies with the nature of the sworn statement. However, all have their place in the effective investigation of a claim and its subsequent litigation.

The Cooperative Gator: The Duty to Cooperate in Georgia

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Kelly Chartash represents clients in matters related to insurance coverage and commercial litigation. She focuses her practice on third-party insurance coverage disputes, automobile litigation and premises liability, having successfully defended clients in dispositive motions and in jury trials.

Kelly provides clients with effective legal counsel with a highly communicative approach that ensures clients are on the same page during every step of a claim, lawsuit, negotiation or trial. Noting time constraints, Kelly brings a focus on efficiency when determining the best legal strategy for her clients.

Prior to joining Swift Currie, Kelly represented clients as a certified legal intern at the Virgil D. Hawkins Full Representation Civil Clinic during law school at the University of Florida Levin College of Law. She also served as a summer judicial extern for Magistrate Judge Andrea M. Simonton in the Southern District of Florida.

The Cooperative Gator: The Duty to Cooperate in Georgia

It is well-established Georgia law that insurance is a matter of contract and therefore the rules governing contract construction also apply to insurance contracts.[1] The insurance contract, similar to other contracts, usually contains conditions precedent to coverage. "A condition precedent is one which must be performed before any right to be created thereby accrues. It requires performance by one party before performance by the other."[2] As such, when the right to recover is dependent on a condition precedent, the party must allege performance of the condition precedent or a sufficient legal excuse for nonperformance.[3]

Insurance policies often include provisions that no action can be brought against the carrier "unless there has been compliance with the policy provisions." Georgia courts are clear that such conditions precedent are permitted and binding against the insured.[4] That being said, the duty to cooperate is a condition precedent in lawsuits against the insurer for breach of contract. Insureds are required to cooperate in the investigation and resolution of the claim.[5] Yet, the duty to comply with a condition precedent to coverage may be excused in some circumstances, such as an insured's death or physical or mental disability.[6]

AN INSURED'S "DUTIES AFTER LOSS"

The cooperation clause is typically found in the "duties after loss" section of the insurance policy and usually separated by duties for first- and third-party claims. However, prompt notice is a duty required in both types of claims.

In first-party property claims, an insured's duties generally include the following:

- Notify the police in the case of a loss by theft;
- Protect the property from further damage, including making reasonable and necessary repairs;
- Prepare an inventory of the damaged personal property;
- Submit for an examination under oath;
- Permit inspection and testing; and
- Submit a signed, sworn proof of loss within a specified time period.

An insured's duties in third party liability claims often include the following:

- Forward all written material received to the insurer;
- Make witnesses available;
- Attend hearings and trials; and
- Assist in securing and giving evidence.

NONCOMPLIANCE AS A MATTER OF LAW

When an insured fails to cooperate, summary judgment in favor of an insurer is generally only granted as a matter of law when there has been a complete lack of cooperation.[7]

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1 *Wilson v. S. Gen. Ins. Co.*, 180 Ga. App. 589, 349 S.E.2d 544, 545 (1986) (*quoting Nationwide Mut. Ins. Co. v. Ware*, 140 Ga. App. 660, 231 S.E.2d 556, 559 (1976)).

2 *Wolverine Ins. Co. v. Sorrough*, 122 Ga. App. 556, 560, 177 S.E.2d 819 (1970) (citations omitted).

3 *Id.*

4 *Townley v. Patterson*, 139 Ga. App. 249, 228 S.E.2d 164 (1976).

5 *Diamonds & Denims, Inc. v. First of Ga. Ins. Co.*, 203 Ga. App. 681, 683, 417 S.E.2d 440, 441 (1992).

6 *Blackburn v. State Farm Fire & Cas. Co.*, 174 Ga. App. 157, 158, 329 S.E.2d 284 (1985).

7 *See Halcome v. Cincinnati Ins. Co.*, 254 Ga. 742, 334 S.E.2d 155 (1985).

Courts have explained as follows:

> A total failure to comply with policy provisions made a prerequisite to suit under the policy may constitute a breach precluding recovery from the insurer as a matter of law. If, however, the insured cooperates to some degree or provides an explanation for its noncompliance, a fact question is presented for resolution by a jury.[8]

In order to deny a claim for noncooperation, an insurer is required to prove it acted with "diligence and good faith" in securing the necessary information.[9] Courts look carefully to how clearly the insurer specified the exact information requested, as well as the insured's duties under the policy and possible penalties for noncompliance.[10]

EUOS AND PRODUCTION OF MATERIAL INFORMATION

The contractual requirements to "submit to an examination under oath (EUO)" and "produce material information" are two of the common requirements under a policy's duties to cooperate and are conditions precedent to coverage, particularly in first-party claims.

The contractual provision requiring an insured to submit to an EUO has been repeatedly upheld.[11] An insurer must fulfill certain requirements to rely on this affirmative defense. For example, the demand for EUO must clearly designate a specific time and place.[12] An insured's refusal to submit to a requested EUO constitutes a breach of insurance contract.[13] Even if the insured still technically appears for the examination, the insured's refusal to answer substantive questions at an EUO still constitutes a material breach of the policy.[14] Furthermore, an insured is not excused from appearing and responding to an EUO based on the Fifth Amendment privilege against self-incrimination.[15]

In addition, an insured has a duty to cooperate by providing material information to the insurer.[16] Insurance policies often include language that an insured must permit the insurer to examine their records. Georgia courts have held the failure to provide material information by way of documents is a material breach of the insurance contract.[17] In insurance fraud investigations, requests for documents containing information regarding the insured's income and financial situation are considered material and relevant to possible fraud and financial motive.[18]

Importantly, Georgia courts treat an insured's duty to submit to an EUO separately from the duty to provide requested documents. Insurance policies often include separate duties to "submit to an examination under oath" and "produce requested records and documents." For instance, while the Court of Appeals of Georgia would not grant summary judgment for lack of cooperation when an insured provided some, but not all, of the requested documents, the Court of Appeals did grant summary judgment when the insured refused to submit to the requested EUO.[19] This was true even though the insured requested to reschedule his EUO two days before the two-year suit limitation period expired.[20]

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8 *Diamonds*, 203 Ga. App. at 683.

9 *Allstate Ins. Co. v. Hamler*, 247 Ga. App. 574, 577, 545 S.E.2d 12, 14 (2001).

10 *See Wages v. Atlanta City Metrocab*, 193 Ga. App. 601, 388 S.E.2d 733 (1989).

11 *Pervis v. State Farm Fire and Cas. Co.*, 901 F.2d 944, 947 (11th Cir. 1990).

12 *See Saft Am., Inc. v. Ins. Co.*, 155 Ga. App. 500, 271 S.E.2d 641 (1980) (finding no breach of policy because the insurer failed to designate time and place for examinations).

13 *Pervis*, 901 F.2d at 947.

14 *Hutchinson v. Allstate Ins.Co.*, 2018 U.S. Dist. LEXIS 43819, at *7 (N.D. Ga. Jan. 4, 2018) (carrier had the obligation to seek or schedule a second examination under oath after insured failed to answer substantive questions at first examination).

15 *Pervis*, 901 F.2d at 947.

16 *Hines v. State Farm Fire & Cas. Co.*, 815 F.2d 648, 651 (11th Cir. 1987).

17 *Halcome*, 254 Ga. at 744.

18 *Meyers v. State Farm Fire & Cas. Co.*, 801 F. Supp. 709, 716 (N.D. Ga. 1992).

19 *Lucas v. State Farm Fire & Cas. Co.*, 864 F. Supp. 2d 1346 (N.D. Ga. 2012).

20 *Id.*

DUTY TO COOPERATE IN THIRD-PARTY LIABILITY CLAIMS

Insurance contracts will often include a duty to cooperate in third-party liability claims and an insured "is obligated to assist in good faith in making every legitimate defense to a suit for damages."[21] The insured must make "full, fair, complete, and truthful disclosures of the facts known . . . ."[22] An insured also has a duty to reply to communications addressed to him regarding the lawsuit.[23] The U.S. District Court for the Northern District of Georgia recently held the insured did not cooperate when he failed to have any "substantive" communications with defense counsel and just being available to communicate was insufficient.[24] Specifically, the insurer never received a substantive response or any of the information it requested from the insured, including the insured's "version of what happened" with respect to the allegations.[25] If the "insured refuses to give the information which the insurer needs in establishing the defense, or absents himself so that his testimony at the trial cannot be obtained, recovery on the policy should be denied, if the insurer acts with good faith and diligence."[26] The failure to cooperate must be material.[27]

In order to justify the denial of coverage for an insured's noncooperation, the insurer must establish (1) it reasonably requested the insured's cooperation in defending against the claim; (2) the insured willfully and intentionally failed to cooperate; and (3) the insured's failure to cooperate prejudiced the insurer's defense of the claim.[28] For instance, courts presume prejudice to the insurer due to the insured's complete absence at trial.[29] The burden of proof rests on the insurer to prove it diligently sought to obtain the insured's cooperation.[30] Insurers have demonstrated good faith and diligence by making multiple attempts to communicate in person and by telephone, correspondence and e-mail to secure the cooperation and assistance of the insured — being rebuffed in each instance.[31] Once the insurer meets its burden of diligence and good faith, the burden then shifts to the insured to show failure to cooperate was justified or excused.[32]

CONCLUSION

In sum, it is important for insurers to document requests for the insured's cooperation in their files to the extent a noncooperation defense later becomes applicable and a condition precedent to coverage.

21 *H.Y. Akers & Sons, Inc. v. St. Louis Fire & Marine Ins. Co.*, 120 Ga. App. 800, 172 S.E.2d 355, 359 (1969).

22 *St. Paul Fire & Marine Ins. Co. v. Gordon*, 116 Ga. App. 658, 158 S.E.2d 278, 279 (1967).

23 *H.Y. Akers & Sons, Inc.*, 120 Ga. App. at 803.

24 *State Farm & Cas. Co. v. King Sports, Inc.*, 489 Fed. Appx. 306 (11th Cir. 2012).

25 *Id.* at 308.

26 *H.Y. Akers & Sons, Inc.*, 120 Ga. App. 800.

27 *H.Y. Akers & Sons, Inc.*, 120 Ga. App. 800. *See also S. Mut. Ins. Co. v. Mason*, 213 Ga. App. 584, 445 S.E.2d 569, 572 (1994) ("It is well established that the insured has a duty to cooperate with his insurer in all aspects of a lawsuit and to make a full, fair, complete, and truthful disclosure of all facts relating to the [incident].") (internal citations omitted); *Sorrough*, 122 Ga. App. 556 ("The cooperation clause in a liability insurance policy is a material condition of liability, and a breach of it by one who is insured . . . relieves the insurer of any obligation to defend a damage action against the insured."); *Gordon*, 116 Ga. App. 658 ("[I]nsured does have an obligation to co-operate with his insurer in the investigation of accidents, the securing of evidence, giving notice of the accident and of claims or suits brought against him arising out of it, in attending court, assisting as he can at the trial, and in making full, fair, complete and truthful disclosures of the facts known to him relative to the accident when called upon to do so.").

28 *Travelers Home & Marine Ins. Co. v. Castellanos*, 297 Ga. 174, 177, 773 S.E.2d 184, 186 (2015).

29 *H.Y. Akers & Sons, Inc.*, 120 Ga. App. at 803.

30 *Hamler*, 247 Ga. App. 574.

31 *King Sports, Inc.*, 489 Fed. Appx. 306.

32 *H.Y. Akers & Sons, Inc.*, 120 Ga. App. at 803.

First Party-ology: Lessons From 2018

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Thirty-year veteran attorney Thomas D. Martin is a Swift Currie partner whose clients include some of the largest insurance companies in the United States. He focuses on first- and third-party insurance coverage cases, as well as arson and insurance fraud defense, where he has extensive experience defending carriers in claims involving commercial, homeowners and automobile insurance.

Tom handles between 70 and 100 matters every year, assisting clients in making thoughtful and appropriate decisions about coverage. In the vast majority, litigation does not become necessary, but where it ensues, Tom is prepared to assist his clients in efficiently and effectively defending their decisions based upon the pre-litigation assistance he offered during the claims investigation.

Tom's experience trying cases in state and federal courts, as well as before the Georgia Office of Insurance and Safety Fire Commissioner, has shaped the way he handles matters for his clients, communicates with them about their cases and works to advance their interests.

Tom has an intimate understanding of how insurance companies work, which helps him to effectively meet their legal needs. His experience with insurance company auditors has refined his approach to client service and efficiency. In addition, he shared his knowledge with insurance professionals by teaching Chartered Property Casual Underwriter (CPCU) and Associate in Claims (AIC) courses, as well as instructing at industry seminars sponsored by the Insurance Committee for Arson Control (ICAC), the Property & Liability Resource Bureau (PLRB), and numerous regional and local organizations. This experience not only helps insurance professionals understand the law, but it also helps Tom deepen his knowledge of insurance industry concerns and trends, which he, in turn, uses in his practice.

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Kori Eskridge is a litigation associate practicing in the areas of property liability, premises liability, automobile liability and fraud for corporate and insurance clients, as well as insured individuals. Kori handles matters related to automobile litigation with a focus on fraud, slip-and-fall accidents and water loss for national insurance carriers.

Before joining Swift Currie in 2015, Kori worked in sales and customer relations for a national distribution company and a Southeast-based national manufacturer and distributor. Kori's experience working in high-volume business industries gives her a keen understanding of her clients' business concerns.

Kori won a defense verdict in her first jury trial and has continued to obtain favorable verdicts and court rulings throughout her career.

Kori keeps clients updated and involved in their cases. She helps clients see all sides of an issue, understand the strengths and weaknesses of a strategy and fully evaluate how to proceed. This collaborative relationship helps her clients achieve the best results.

Kori has published various articles on trends and updates in the industry and presented property liability topics to a multitude of industry groups, including the Southern Loss Association and the Georgia Chapter of the International Association of Special Investigation Units (GA IASIU), as well as client training seminars.

First Party-ology: Lessons From 2018

A few cases in 2018 addressed first-party cases in Georgia. The following is a recap of what took place.

OFFER TO SIT FOR AN EUO DOES NOT CURE A BREACH

The United States Court of Appeals for the Eleventh Circuit rejected an insured's offer to cure his breach of the policy's duties after loss. In *Hutchinson v. Allstate Insurance Co.*,[1] Hutchinson suffered a fire loss on March 15, 2015. During Allstate's investigation, questions arose concerning Hutchinson's residency in the home. In order to evaluate these potential coverage issues, Allstate demanded Hutchinson's examination under oath (EUO).[2] During the EUO, Hutchinson disputed statements in previous letters from Allstate's attorney regarding his responsiveness to Allstate's requests.[3] Hutchinson said he would cooperate but only if Allstate recanted the statements in the letters.[4] Allstate refused.[5] Allstate's attorney explained Hutchinson's refusal to answer questions could result in a denial of the claim.[6] Allstate then began questioning Hutchinson about his residency in the home.[7] Hutchinson sat silently, refusing to answer the questions.[8] Nine days later, Allstate denied his claim on the grounds that Hutchinson breached the policy by refusing to answer questions during his EUO.[9]

Over a year after the denial, Hutchinson's attorney sent a bad faith letter to Allstate, simultaneously offering for Hutchinson to submit to the EUO.[10] Allstate replied it would reconvene the EUO subject to a reservation of all rights and defenses by Allstate.[11] The EUO never occurred.[12] Hutchinson filed suit against Allstate, alleging breach of contract and bad faith.[13] The district court granted summary judgment to Allstate and Hutchinson appealed.[14]

On appeal, Hutchinson agreed he was not legally excused from complying with the policy conditions[15] and a refusal to submit to the EUO was a breach of the policy.[16] However, Hutchinson argued his offer to submit to the EUO created a question of fact regarding his compliance with the policy.[17] The Eleventh Circuit disagreed.[18] Relying upon its previous decision in *Pervis v. State Farm,*[19] the court concluded a belated offer to submit to the EUO did not cure the breach.[20]

JUDICIAL ESTOPPEL: REVISITING THE EFFECT OF PRIOR INCONSISTENT BANKRUPTCY DISCLOSURES

The U.S. District Court for the Northern District of Georgia addressed the doctrine of judicial estoppel — whether a party is estopped from taking an inconsistent position in an insurance claim concerning the value of personal property lost in a fire when that same party assigned a different value for the personal property in a bankruptcy proceeding. In *Squires v. State Farm*,[21] plaintiffs Kevin and Aleta Squires had a fire loss at their home in Canton on July 14, 2015.[22] During the pendency of the claim, the Squires submitted five different

1 741 F. Appx 680 (11th Cir. 2018).
2 *Id.* at 681.
3 *Id.*
4 *Id.*
5 *Id.*
6 *Id.*
7 *Id.*
8 *Hutchinson*, 741 F. Appx at 681-82.
9 *Id.* at 682.
10 *Id.*
11 *Id.*
12 *Id.*
13 *Id.*
14 *Hutchinson*, 741 F. Appx at 682.
15 *Id.*
16 *Id.*
17 *Id.*
18 *Id.*
19 901 F.2d 944, 947 (11th Cir. 1990).
20 *Hutchinson*, 741 F. Appx at 682.
21 2019 U.S. Dist. LEXIS 31954 (2019).
22 *Id.* at *2.

inventories and proofs of loss for their personal property, with values ranging from $91,815 to $144,881.81.[23] Two of the inventories were submitted while the Squires had a Chapter 13 bankruptcy proceeding pending.[24] The Squires valued their personal property in the bankruptcy petition at only $2,925.[25] State Farm alleged photos taken after the fire did not substantiate the large quantity of items claimed[26] and denied the Squires' claim on the grounds they misrepresented and concealed material information.[27] The Squires filed suit against State Farm for breach of contract and bad faith.[28]

The district court held the Squires were judicially estopped from asserting a claim for more than the amount disclosed in their bankruptcy proceedings.[29] The court determined the inconsistency "made a mockery of the judicial system" because it was calculated to obtain unfair advantage.[30] State Farm was therefore granted summary judgment.[31] Importantly, the district court applied the higher level of scrutiny required by the Eleventh Circuit in *Slater v. U.S. Steel*.[32] This was important because some may have inferred from *Slater* that summary judgment on judicial estoppel would be unlikely, as a jury would have to decide whether the plaintiffs " . . . intended to make a mockery of the judicial system."[33] This was not the case. The district court simply analyzed the "totality of circumstances" required by the court in *Slater*, detailing how the Squires' inconsistent disclosures were indisputably "calculated to make a mockery of the judicial system."[34]

The court first noted the Squires made inconsistent statements regarding the reasons for discrepancy between the bankruptcy and insurance claim disclosures. During her EUO, Ms. Squires said the sworn disclosures in the bankruptcy petition were made based upon the advice of counsel.[35] Later at her deposition, she said the bankruptcy disclosures only included her business personal property, as the bankruptcy was for her business (the court noting the bankruptcy was a Chapter 13 personal bankruptcy).[36] Finally, in response to State Farm's motion for summary judgment, Ms. Squires argued that amounts asserted in the bankruptcy petition were simply "thrift store values" for the same items claimed in the fire.[37] The court seemed unpersuaded by these remarks because the bankruptcy values were less than 2 percent of the retail value claimed against State Farm.[38] Under these circumstances, the court concluded the Squires made inconsistent sworn statements in the bankruptcy and the insurance claim.[39]

The court went on to analyze whether the inconsistencies were calculated to make a mockery of the judicial system.[40] The court considered the following factors:

- The Squires were discharged for approximately $34,000 in unsecured debt, but never informed the bankruptcy court they expected to receive over $140,000 from their personal property claim with State Farm.[41]
- The Squires never amended their bankruptcy petition to disclose their fire claim despite numerous other amendments to open personal lines of credit, incur debt to purchase a new car and identify a personal injury claim. [42]
- The Squires had motive to conceal the personal property assets.[43]
- Despite ample notice, the Squires never corrected the inconsistency between their insurance claim and their bankruptcy disclosures.[44]

23 *Id.*
24 *Id.* at *2.
25 *Id.*
26 *Id.* at *7.
27 *Id.* at *2-3.
28 *Id.*
29 *Id.* at *4-6.
30 *Id.* at *9-10.
31 *Id.* at *10.
32 *Id.* at *9, citing *Slater,* 871 F.3d 1174, 1185-88 (11th Cir. 2017).
33 *Slater,* 871 F.3d at 1176.
34 *Id.*
35 *Id.* at *8.
36 *Id.*
37 *Id.*
38 *Id.*
39 *Id.* at *9.
40 *Id.*
41 *Id.*
42 *Id.* at *7
43 *Id.* at *10.
44 *Id.*

- The Squires were educated, sophisticated parties.[45]
- The Squires took inconsistent positions despite ample access to legal counsel.[46]

Based upon these circumstances, the court concluded the Squires were estopped from claiming more than $2,925 in their claim against State Farm.[47] Because State Farm paid $4,000 before litigation ensued, it had satisfied its obligations under the policy.[48] Further, because State Farm had reasonable grounds for contesting the Squires' claim, there could be no bad faith as a matter of law.[49]

POLICY DECLARATIONS DO NOT CREATE AMBIGUITY

The Court of Appeals of Georgia considered whether lights not installed as part of a building were "fixtures" under an insurance contract and whether those lights, purchased prior to insured's tenancy, were covered under a policy that insured business personal property. In *Goldeagle Ventures, LLC v. Covington Specialty Insurance Co.*,[50] a lightning storm damaged 103 halide lights attached to a building owned by Goldeagle Ventures, LLC (Goldeagle). The lights were attached to, but not permanently installed in, the building.[51] Additionally, the lights were purchased prior to Goldeagle's tenancy and had not been paid for by Goldeagle.[52]

Goldeagle filed an insurance claim with Covington Specialty Insurance Company (Covington), which was subsequently denied.[53] Goldeagle then filed suit against Covington and sought summary judgment, asserting the lights were covered under Goldeagle's insurance.[54] Covington argued that lights were not covered. Covington prevailed.[55] Goldeagle appealed.[56]

The principal argument asserted by Goldeagle was that Covington's policy was ambiguous.[57] The policy stated Covington would pay for loss or damage to "Covered Property" at the premises described in the "Declarations."[58] Under the policy, "Covered Property" could include the "Building," "Your Personal Property" and "Personal Property of Others," "if a Limit of Insurance is shown in the Declarations for that type of property."[59] The Declarations also stated "insurance at the described premises applies only for coverage for which a limit of insurance is shown."[60] The only limit of insurance shown in the Goldeagle Declarations was for Business Personal Property.[61] Goldeagle did not purchase or pay a premium for the "Building" or for "Personal Property of Others."[62]

Nevertheless, because the policy contained these other coverages, Goldeagle attempted to argue the Declarations and the policy created an ambiguity. The court rejected the argument, noting insurers are "allowed to issue standard form policies, containing multiple coverage provisions, even though not all coverages have been purchased by an insured."[63] Quoting at length from a previous decision dealing with a similar contention, the court noted the Declarations provide a roadmap for the coverages purchased by the insured and should be read together with, rather than separate from, the rest of the policy:

45 *Id.*
46 *Id.*
47 *Id.*
48 *Id.*
49 *Squires,* 2019 U.S. Dist. LEXIS 31954 at *10-11.
50 349 Ga. App. 446, 825 S.E.2d 881 (2019).
51 *Id.* at 447, 825 S.E.2d at 883.
52 *Id.* at 447, 825 S.E.2d at 883.
53 *Id.* at 448, 825 S.E.2d at 884.
54 *Id.* at 446, 825 S.E.2d at 883.
55 *Goldeagle*, 349 Ga. App at 446, 448, 825 S.E.2d at 883-84.
56 *Id.* at 447-48, 825 S.E.2d at 883-84.
57 *Id.* at 450, 825 S.E.2d at 885.
58 *Id.* at 447, 825 S.E.2d at 883.
59 *Id.* at 447, 825 S.E.2d at 883.
60 *Id.* at 450, 825 S.E.2d at 885.
61 *Id.*
62 *Id.*
63 *Id.* at 449, 825 S.E.2d at 884, *quoting, Simalton v. AIU Ins. Co.,* 284 Ga. App. 152, 154, 643 S.E.2d 553, 555 (2007).

> The Declarations Page represents the means by which an insurer tailors its standard form policy to allow insureds to purchase only the types of coverage, and the amount of such coverage, that they desire. It "is the one part of the policy likely to be read by the insured, and contains the terms most likely to have been requested by the insured." 16 Richard A. Lord, *Williston on Contracts*, § 49:25 (4th ed.); see also *Zacarias v. Allstate Ins. Co.*, 168 N.J. 590, 775 A2d 1262, 1270 (2001) (Because the declarations page is the "one page most likely to be read and understood by the insured," insurers should "incorporate thereon as much information as may reasonably be included."). For that reason, the form policy must be read together with the Declarations Page to determine exactly which coverages, and in what amounts, an insured has purchased.[64]

Accordingly, the Court of Appeals concluded the policy was not ambiguous.[65]

Because Goldeagle only purchased coverage for Business Personal Property, the court analyzed coverage despite the fact that Goldeagle did not " articulately set forth the argument that the lights were covered" under this provision.[66] To be covered, the lights had to be "fixtures . . . (a) [m]ade a part of the building or structure . . . and (b) . . . acquired or made at your expense."[67] The court used an ordinary dictionary meaning of the term "fixture" and concluded the lights were not permanently installed as part of the building, and thus did not meet the definition of "fixture."[68] The court also determined that even if the lights could be considered fixtures, the lights were not "'acquired or made at [Goldeagle's] expense.'"[69]

The court also rejected Goldeagle's argument that the lights were Business Personal Property because the lights were "leased personal property . . . which [Goldeagle had] a contractual responsibility to insure."[70] The court noted Goldeagle's lease agreement for the building required Goldeagle to keep the premises in good repair but did not explicitly require Goldeagle to insure the lights.[71] With respect to insurance, the lease only required Goldeagle to purchase adequate coverage for Goldeagle's "merchandise, trade fixtures, furnishing, wall covering, floor covering, carpeting, drapes, equipment and all items of personal property of Tenant located on or within the Premises." Because the lease specifically included "lighting" in the list of items Goldeagle was required to maintain but excluded "lighting" from the list of assets Goldeagle was required to insure, the lease demonstrated that a duty to maintain was not equivalent to a duty to insure.[72] For these reasons, the court affirmed the trial court's judgment in Covington's favor.[73]

ZILLOW AND QPUBLIC.NET NOT RELIABLE SOURCES FOR VALUED POLICY DISPUTE

In *Hollingsworth v. LM Insurance Co.*,[74] the U.S. District Court for the Middle District of Georgia rejected a pro se plaintiff's attempt to use online estimates of home values to establish her fire-damaged home had been "wholly destroyed" under the Valued Policy Act. Hollingsworth's home sustained some damage from a fire on Sept. 6, 2017, but did not burn to the ground.[75] Adjusters from her insurance company, LM Insurance Company (LM), several repair contractors hired and fired by the plaintiff and an engineer all examined the premises but none concluded the home was wholly destroyed.[76] Repair estimates included LM's estimate of about $232,000, an informal verbal estimate from Paul Davis Restoration (PDR) of about $325,000 and a written estimate from Sentry Construction Company (Sentry) for about $366,000.[77] The policy limit for the structure was $502,600.[78] None of the estimates concluded the house was a total loss.[79]

64 *Id.*
65 *Id.* at 450, 825 S.E.2d at 885.
66 *Id.*
67 *Id.*
68 *Id.* at 447-48, 450-51, 825 S.E.2d at 883-85.
69 *Id.* at 451, 825 S.E.2d at 886.
70 *Id.* at 451, 825 S.E.2d at 886.
71 *Goldeagle*, 349 Ga. App at 451-52, 825 S.E.2d at 886.
72 *Id.*
73 *Id.*
74 2019 U.S. Dist. LEXIS 37419 (2019).
75 *Id.* at *2.
76 *Id.* at *8 and *15 at n.12.
77 *Id.* at *5-6.
78 *Id.* at *12.
79 *Id.*

Hollingsworth sought the policy limits under Georgia's Valued Policy Act.[80] Under *Georgia Farm Bureau Mutual Insurance Co. v. Brown*,[81] Hollingsworth asserted "it would cost more to repair her house than to replace it and [that] photographs and other evidence show[ed] that her home ha[d] been substantially gutted by the fire due to the damage of structural components of the foundation."[82] In making these assertions, the plaintiff relied upon her own "prior experience with remodeling historic homes in the area," "a diploma in Carpentry . . . which include[d] a certification in framing," real estate estimates from Zillow.com and Realtor.com, a tax appraisal from qPublic.net, estimates of building costs from an unnamed person from the Home Builders Association of Middle Georgia and photographs showing fire damage to her home.[83]

The court rejected Hollingsworth's arguments because she failed to submit any admissible evidence that the cost of repairing the home exceeded the cost of replacement.[84] The details are as follows:

- Hollingsworth's experience in remodeling and her certification in framing lacked sufficient foundation and methodology to qualify her as an expert under the Federal Rules of Evidence.[85] Her remarks, if admissible at all, would only be admissible as lay opinion testimony.[86] In addition, as a property owner, she would only be permitted to provide her lay opinion regarding the value of her property.[87] "Value" was irrelevant as, under *Brown*, proof of the cost of new construction was needed.[88]
- Hollingsworth could not rely upon valuations from Zillow.com, Realtor.com and qPublic.net to establish replacement values (that were less than the repair estimates) as the valuations were not authenticated and were therefore unreliable hearsay.[89] The court noted sites like Zillow.com and Realtor.com are "'inherently unreliable' because they are 'participatory site[s]' which allow homeowners 'to input or change specific entries,' much like Wikipedia allows the general public to edit its entries."[90] In addition, the information was irrelevant under the Fed. R. Evid. 401 because the values included the land ("the dirt on which her house sits") "baked into" the prices given.[91] Such estimates displayed a purchase price including the value of the house and the land, not the value of replacement construction as required by *Brown*.[92]
- Hollingsworth also could not rely upon statements allegedly made by an unknown "secretary" at the Home Builders Association of Middle Georgia for the cost of new construction.[93] Such remarks were inadmissible hearsay and excluded because Hollingsworth made no discernable argument that the unknown secretary was qualified to provide replacement estimates.[94]
- Hollingsworth's photographs did not indicate the home was substantially gutted by fire because many of the photos depicted rooms in the home "undergoing" a "cosmetic remodel" with no fire damage while only some showed "extensive fire damage" to a single area (the "dining room area").[95] Further, despite the clearly visible char throughout some areas of the home, no one — aside from Hollingsworth — took the position that the photographs showed "substantial gut."[96] The court noted the home was still standing and supported by all pre-existing walls. As the fire damage was largely interior, no reasonable jury could find the home was wholly destroyed.[97]

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80 *Id.* at *9.
81 192 Ga. App. 504, 385 S.E.2d 87, 90 (1989).
82 2019 U.S. Dist. LEXIS 37419 at *15-16.
83 *Id.* at *16.
84 *Id.* at *22.
85 *Id.* at *16 at n. 13.
86 *Id.*
87 *Id., citing U.S. ex rel. Tenn. Valley Auth. v. An Easement and Right-of-Way Over 6.09 Acres of Land,* 140 F. Supp. 3d 1218, 1236-44 (N.D. Ala. 2015).
88 *Id.*
89 *Id.* at *17.
90 *Id. citing In re DaRosa,* 442 B.R. 173, 177 (Bankr. D. Mass. Nov. 17, 2010).
91 2019 U.S. Dist. LEXIS 37419 at *19.
92 *Id.*
93 *Id.* at *20-21.
94 *Id.* at *20-21.
95 *Id.* at *21.
96 *Id.*
97 *Id.* at *22 *citing Scott v. Harris*, 550 U.S. 372, 380, 127 S. Ct. 1769, 167 L. Ed. 2d 686 (2007) ("When opposing parties tell two different stories, one of which is blatantly contradicted by the record, so that no reasonable jury could believe it, a court should not adopt that version of the facts for purposes of ruling on a motion for summary judgment.").

As Hollingsworth failed to submit any admissible evidence that the cost of repairing the home exceeded the cost of replacing it entirely and the photographs did not indicate the house was substantially gutted by fire, summary judgment was granted in LM's favor.[98] The court also rejected Hollingsworth's bad faith claim as it was reasonable for LM to withhold payment of the policy limit pending a decision under the Valued Policy Act.[99]

A CONTRACTOR'S EXPERIENCE MAY QUALIFY HIM TO TESTIFY ON DIMINISHED VALUE

The Court of Appeals of Georgia considered whether excluding a witness was an abuse of discretion where that witness was offered as an expert or, alternatively, as a lay witness. In *Woodrum v. Georgia Farm Bureau Mutual Insurance Co.*,[100] William and Kathy Woodrum's home was damaged by a falling tree during a thunderstorm on July 5, 2012.[101] Months later, when the Woodrums and their insurer, Georgia Farm Bureau Mutual Insurance Company (Farm Bureau), could not reach an agreement on the amount of the loss, the Woodrums demanded appraisal.[102] Farm Bureau paid the award.[103]

Still, the Woodrums filed suit against Farm Bureau, alleging the house had diminished value (DV) because of the tree impact, that such DV was not included in the appraisal award and Farm Bureau failed to pay DV.[104] In support of their claims, the Woodrums introduced an affidavit from a contractor, George Hall, who repaired the Woodrums' house and opined the value of the house was diminished due to a cracked foundation. In his deposition, Hall said the house lost 25 percent of its value due to the foundation damage.[105] Farm Bureau filed a motion to exclude Hall's testimony as both an expert and a lay witness and moved for summary judgment as Hall's testimony was the only basis for the DV claim.[106] The trial court granted both motions.[107]

The Court of Appeals agreed Hall could be excluded as an expert on DV because the Woodrums failed to show the methodology underlying Hall's testimony.[108] Hall's affidavit did not describe a methodology by which he reached his conclusions and, at his deposition, the only basis he provided for his valuation was his experience.[109] Accordingly, the Court of Appeals affirmed that part of the trial court's order.[110]

However, the Court of Appeals reversed the trial court's exclusion of Hall as a lay witness.[111] Under the lay witness opinion rule,[112] a lay witness can give opinion testimony as to market value "if he or she has had an opportunity to form a reasoned opinion."[113] The Court of Appeals found the evidence "amply"[114] demonstrated that Hall could form a reasoned opinion as to the diminished value of the house based upon his experience and familiarity with the Woodrum's home.[115] Accordingly, the Court of Appeals concluded Hall was qualified to give lay opinion testimony as to the effect of the foundation damage on the value of the home[116] and the trial court erred in excluding Hall's testimony as a lay witness.[117]

Notably, two judges on the panel concurred in the judgment only, rendering the case physical precedent only under Court of Appeals Rule 33.2(a).[118]

98 *Id.* at *23.
99 *Id.* at *26.
100 347 Ga. App. 89, 815 S.E.2d 650 (2018).
101 *Id.* at 89, 815 S.E.2d at 651.
102 *Id.* at 89, 815 S.E.2d at 651.
103 *Id.* at 89, 815 S.E.2d at 651.
104 *Id.* at 90, 815 S.E.2d at 652.
105 *Woodrum,* 347 Ga. App at 90, 815 S.E.2d at 652.
106 *Id.*
107 *Id.* at 90, 815 S.E.2d at 652.
108 *Id.* at 91, 815 S.E.2d at 652.
109 *Id.*
110 *Id.* at 91-92, 815 S.E.2d at 652-53.
111 *Id.* at 94, 815 S.E.2d at 653.
112 OCGA § 24-7-701(b)
113 *Woodrum,* 347 Ga. App at 92, 815 S.E.2d at 653.
114 *Id.*
115 *Id.* at 92-93, 815 S.E.2d at 653-54 *relying on Vitello v. Stott,* 222 Ga. App. 134, 136, 473 S.E.2d 504 (1996).
116 *Id.* at 93, 815 S.E.2d at 654.
117 *Id.* at 94, 815 S.E.2d at 654.
118 *Id.* at 95, 815 S.E.2d at 655.

Stealing the "T"echnology: An Introductory Course in Cyber Risk and Policies

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Rebecca Strickland defends insurance carriers, as well as insured businesses and individuals, in coverage disputes, commercial litigation, premises liability and commercial transactions that involve nuances or special complexities.

Rebecca has defended insurers in coverage disputes from examination under oath through jury trial. She is a zealous advocate for her clients, particularly when handling cases involving potentially fraudulent claims. In addition, Rebecca has tried multiple liability cases, including personal injury cases and business disputes, to verdict. Rebecca has handled business disputes valued at more than $1 million and matters involving claims ranging from $60,000 to more than $2 million.

Rebecca focuses her practice on first-party property claims, bad faith claims and defense of insureds. That practice includes experience in complex commercial litigation, including contractual, royalty and franchisor/franchisee disputes. She has represented clients in matters involving the Computer Fraud and Abuse Act (CFAA), Telephone Consumer Protection Act (TPCA) and Fair Business Practices Act. Her practice also includes prosecuting trademark applications and defending clients in copyright, trademark, trade secret and complex commercial litigation matters. Rebecca is a registered patent attorney.

Before beginning her law practice, Rebecca was a consultant and manager at Accenture. She has programmed in Fortran, COBOL and SQL. Rebecca also worked on Y2K compliance and designed payroll, human resources, hotel billing, banking and cash management, and other financial systems for U.S. and Canadian companies. In addition, she managed a software support team that was based in the U.S. and the Philippines.

Rebecca brings a varied and comprehensive background to her practice, which gives her a broad perspective and enables her to resolve the most complex questions and challenges that arise during a claim. She earned her undergraduate degree in chemical engineering.

Her unique technical background allows her to address nontraditional claims. She has more than 20 years of experience solving problems in a creative and organized manner.

Stealing the "T"echnology: An Introductory Course in Cyber Risk and Policies

"There's definitely a feeling in InfoSec that the attackers are outpacing us."[1]

As the use of technology grows, so too does the risk of cyberattacks. Cyberattacks are expensive; the average cost of a data breach is $3.86 million. Mega-breaches, defined as breaches of 1 million to 50 million records, may cost $40 million to $350 million.[2] However, in 2018, 43 percent of breaches involved small businesses. For those businesses, the average cost of a cyberattack was $35,967.[3,4]

Where there is risk, there is a market for insurance. The cyber insurance market is growing. In 2012, premiums for cyber coverage were less than $1 billion. By 2020, some experts estimate the U.S. cyber insurance market will grow to $7.5 billion, with others projecting $20 billion by 2025.[5] Claims professionals are on the front lines of these matters.

OVERVIEW OF CYBER THREAT TYPES

Brief explanations of some cyber threat types are as follows:

- A data breach occurs when sensitive, protected or confidential data is accessed and perhaps stolen or copied without authorization. In 2018, 69 percent of breaches involved external actors and 34 percent of breaches involved internal actors.[6]
- Hacking can involve using stolen credentials to access a system and using a backdoor (illicit entry).[7] In 2019, 52 percent of breaches involved hacking.[8]
- A denial of service attack occurs when a server is shut down without authorization, often by being overloaded with unauthorized requests such that authorized users cannot access the system.
- Malware is software that damages or disables computers or computer systems.
- Ransomware is malicious software that encrypts the victim's data. The perpetrators then demand the payment of a ransom, often in virtual currency such as Bitcoin, in order to obtain a decryption key. Ransomware is often delivered through a phishing email.[9]
- Cryptomining, which comprised 90 percent of all remote code execution attacks in 2018 and is a new and growing threat, occurs when the bad actor infects computers with Bitcoin-mining software.[10]
- Social tactics involve methods, such as phishing, in which the cyber-attacker tries to obtain information like usernames, passwords, or personal financial or educational information by sending an email that looks legitimate, or pretexting, thereby obtaining information through a fictional situation, e.g. a fake marketing survey.[11] In 2018, 33 percent of all breaches involved social tactics and nearly all of those involved phishing.[12]

In 2018, 10 percent of all breaches occurred in the financial and insurance industries. Denial-of-service attacks were the most common type of attack, and ransomware was the top type of malware.[13]

1 Verizon, 2019 Data Breach Investigations Report. Available at https://enterprise.verizon.com/resources/reports/dbir/2019/data-breaches/.
2 Takahashi D. "IBM Security Study: Mega Data Breaches Cost $40 Million to $350 Million." Available at https://venturebeat.com/2018/07/10/ibm-security-study-mega-data-breaches-cost-40-million-to-350-million/.
3 Verizon, 2019 Data Breach Investigations Report.
4 Lynch, J. "Protecting against #cyberfail; Small Business and Cyber Insurance," Insurance Information Institute.
5 Romanosky S., Ablon, L., Kuehn , A., Jones, T., "Content analysis of cyber insurance policies: how do carriers price cyber risk?," Journal of Cybersecurity, Volume 5, Issue 1, 2019. Available at https://doi.org/10.1093/cybsec/tyz002.
6 Verizon, 2019 Data Breach Investigations Report.
7 Verizon, 2018 Data Breach Investigations Report, 11th ed.
8 Verizon, 2019 Data Breach Investigations Report.
9 "Cybersecurity Considerations for K-12 Schools and School Districts." Available at https://rems.ed.gov/docs/Cybersecurity_K-12_Fact_Sheet_508C.pdf.
10 Fruhlinger, J., "Top cybersecurity facts, figures and statistics for 2018." Available at https://www.csoonline.com/article/3153707/top-cybersecurity-facts-figures-and-statistics.html.
11 Bisson, David. "5 Social Engineering Attacks to Watch Out For." March 23, 2015. Available at https://www.tripwire.com/state-of-security/security-awareness/5-social-engineering-attacks-to-watch-out-for/.
12 Verizon, 2019 Data Breach Investigations Report.
13 Verizon, 2018 Data Breach Investigations Report, 11th ed.

CYBER INSURANCE POLICIES

As an introduction, the general types of coverage that may be available in a cyber policy include the following:

- Data breach response and liability coverage for expenses arising from a data breach;
- Computer attack coverage for damage to data and systems caused by an attack, such as malware or denial-of-service attempt;
- Network security liability coverage or liability coverage applicable when a third party asserts it was damaged because of an insured's failure to secure data on the insured's systems;
- Media liability coverage for claims asserting copyright infringement and negligent publication of media while publishing content online and via social media channels;
- Funds transfer fraud for losses from the transfer of funds as a result of fraudulent instructions; and
- Cyber extortion coverage for "settlement" of an extortion threat against a company's network.[14]

While the language used to describe the cause of loss in a cyber loss may be unfamiliar, cyber insurance, at a high level, is the same as other policies — first-party coverage insures losses incurred by the insured and third-party coverage insures against claims brought by third parties against the insured.[15]

When an insured faces an attack, they must first determine the cause of the attack and remedy the breach. This can involve hiring a specialized consulting firm to help assess, contain and resolve the breach. Ransomware attacks may require the insured to pay ransom to the bad actor to regain access to its computer systems. While the system is down, the insured may incur a loss of business income. Once the cyber threat is contained, the insured may incur costs to restore its business systems. In addition, the victim of a data breach often must comply with notification laws. For instance, O.C.G.A. § 10-1-912 requires data collectors to provide notice, in the most expedient way possible, of the breach to any Georgia resident whose unencrypted personal information was, or is reasonably believed to have been, acquired by an unauthorized person. In some instances, providing credit monitoring services to affected individuals is recommended or required. At a higher level, data breaches can create a public relations nightmare, necessitating public relations services. Finally, it often makes sense to engage cyber breach counsel to coordinate the response effort and provide privileged legal advice to the insured.[16] These are all examples of direct losses by the insured and may be first-party coverages.

Third-party coverage is triggered by claims against the insured. In other words, a claim is made against the insured as a result of some cyber event. Some types of claims that may give rise to third-party coverage include claims for breach of privacy, misuse of personal data, defamation/slander or the transmission of malicious content. In addition, third-party coverage may include paying regulatory fines and penalties.[17] Notably, the most commonly covered type of loss under cyber policies is for paying costs associated with penalties and defense and settlement costs.[18]

THE EVOLUTION OF POLICY LANGUAGE

Cyber policies are not standard, and policy language has evolved in response to coverage decisions.

CGL Policies

Not every insured has a cyber policy, so when an insured is faced with a cyber attack but does not have a cyber policy, the insured may look for coverage under other coverage parts. For instance, some insureds have argued a commercial general liability (CGL) policy provided coverage, with mixed (and increasingly less

14 Lynch, J. "Protecting against #cyberfail; Small Business and Cyber Insurance," Insurance Information Institute.

15 Romanosky S., Ablon, L., Kuehn , A., Jones, T., "Content analysis of cyber insurance policies: how do carriers price cyber risk?," *Journal of Cybersecurity*, Volume 5, Issue 1, 2019.

16 *Id*.

17 Selby, J. "Removing the Mystery from Cyber Insurance." American Bar Association, Jan.1, 2019. Available at https://www.americanbar.org/groups/law_practice/publications/law_practice_magazine/2019/january-february/JF2019Selby/.

18 Romanosky S., Ablon, L., Kuehn , A., Jones, T., "Content analysis of cyber insurance policies: how do carriers price cyber risk?," Journal of Cybersecurity, Volume 5, Issue 1, 2019.

successful) results. In *Travelers Indemnity Co. of America v. Portal Healthcare Solutions, LLC*,[19] the insured stored confidential medical records. The Travelers CGL policies in force at the time of the loss obligated Travelers to pay sums that Portal was "legally obligated to pay as damages because of injury arising from (1) the 'electronic publication of material that . . . gives unreasonable publicity to a person's private life.'" A class action lawsuit asserted records were available to anyone who searched on the internet. Travelers filed a declaratory judgment to determine whether it was obligated to provide a defense to Portal in the underlying class action lawsuit. Based upon the language of the specific CGL policies, the U.S. Court of Appeals for the Fourth Circuit found Travelers was obligated to provide coverage.

However, a more recent case reached a different result. In *St. Paul Fire & Marine Insurance Co. v. Rosen Millennium, Inc.*,[20] Rosen Millennium provided data security services for RHR. RHR became aware of a potential credit card breach at one of its hotels. A forensic investigator found malware installed on the payment network and determined that customers' cards used between September 2014 and February 2016 may have been affected. Millennium filed a notice of claim and sought coverage under the personal injury provision of CGL policies in force during the relevant time period. The policies defined "personal injury" as "an 'injury, other than bodily injury or advertising injury, that's caused by a personal injury offense.'"[21] The court held a "personal injury," as defined by the policy, was an injury resulting from the insured's business activities, rather than the actions of a third party, and the malware was installed by a third party. Thus, the court held the CGL policies did not provide coverage.

Although these are relatively recent decisions, the policy language involved may be obsolete. In order to avoid these coverage disputes, many insurers are specifically excluding cyber liability coverage in their CGL policies.

Specificity of Policy Language

In *P.F. Chang's China Bistro, Inc. v. Federal Insurance Co.*,[22] a Chubb subsidiary issued a policy to P.F. Chang's parent company, which provided coverage for "direct loss, legal liability, and consequential loss resulting from cybersecurity breaches." P.F. Chang's had a data breach, resulting in approximately 60,000 of its customer credit card numbers being posted on the internet. There was no dispute that Chubb provided coverage to P.F. Chang's for $1.7 million for claims brought by injured customers and credit card issuers. However, Mastercard sent Bank of America Merchant Services (BAMS), P.F. Chang's credit card processor, three assessments: a fraud recovery assessment of $1,716,798.85, an operational reimbursement assessment of $163,122.72 and a case management fee of $50,000. P.F. Chang's paid BAMS and sought coverage from Chubb. Chubb's policy excluded coverage for any loss "based upon, arising from or in consequence of any . . . liability assumed by any Insured under any contract or agreement" and "for. . . any costs or expenses incurred to perform any obligation assumed by, on behalf of, or with the consent of any Insured." Losses insured did "not include 'any costs or expenses incurred to perform any obligation assumed by, on behalf of, or with the consent of any Insured.'"[23] Because the amounts paid to BAMS were the result of a contractual obligation, the court found that Chubb properly denied coverage.[24] After *P.F. Chang's* was decided, many insurers have revised their policies to more specifically define which fees and costs are covered.

STANDING IN LIABILITY CASES

Cyber liability claims can involve constitutional issues involving whether the plaintiff has "standing" to bring a lawsuit. To show standing, a plaintiff must show he "suffered an injury in fact traceable to the defendant's conduct and redressable by a favorable judicial decision."[25] The U.S. Supreme Court addressed standing of a plaintiff in a data breach case in *Spokeo, Inc. v. Robins*.[26] Spokeo is a website that searches databases to provide information

19 35 F. Supp. 3d 765, 767 (E.D. Va. 2014).
20 337 F. Supp. 3d 1176, 1180-81 (M.D. Fla. 2018).
21 *Id.* at 1185.
22 No. CV-15-01322-PHX-SMM, 2016 U.S. Dist. LEXIS 70749 (D. Ariz. May 26, 2016).
23 *P.F. Chang's China Bistro, Inc. v. Fed. Ins. Co.*, No. CV-15-01322-PHX-SMM, 2016 U.S. Dist. LEXIS 70749, at *21-22 (D. Ariz. May 26, 2016).
24 Other cases decided similar coverage issues. *See, e.g., Spec's Family Partners, Ltd. v. Hanover Ins. Co.*, 739 F. App'x 233 (5th Cir. 2018).
25 *Muransky v. Godiva Chocolatier, Inc.*, 922 F.3d 1175, 1184, 27 Fla. L. Weekly Fed. C 1885 (11th Cir. 2019).
26 136 S. Ct. 1540, 194 L.Ed.2d 635 (2016).

about a person. Thomas Robins found his profile had inaccurate information. He contended Spokeo was subject to the Fair Credit Reporting Act (FCRA), which requires credit reporting agencies to provide a fair and accurate history of a consumer's credit history, and had violated the FCRA. Robins filed a class action complaint against Spokeo for failure to comply with the FCRA.[27] The Supreme Court held that in order to establish an injury in fact sufficient to show Article III standing, "a plaintiff must show that he or she suffered 'an invasion of a legally protected interest' that is 'concrete and particularized' and 'actual or imminent, not conjectural or hypothetical.'"[28] The Supreme Court held the U.S. Court of Appeals for the Ninth Circuit needed to evaluate both whether (1) Robins had pled an actual, concrete injury; and (2) the injury was particularized to him. While a violation of FCRA and a risk of possible harm *might* constitute an actual injury, a mere procedural violation *might not*. Thus, the case was remanded to the Ninth Circuit to further consider the standing argument. Some think *Spokeo* was intended to prevent would-be plaintiffs whose data has been compromised from suing on the possibility of a potential, vaguely defined harm.

More recently, the Eleventh Circuit addressed the standing issue. In *Muransky v. Godiva Chocolatier, Inc.*, Dr. Muransky filed a class action against Godiva for allegedly violating the Fair and Accurate Credit Transactions Act (FACTA), which prohibits merchants from printing "more than the last 5 digits of the card number or the expiration date upon any receipt provided to the cardholder at the point of the sale or transaction."[29,30] Dr. Muransky alleged he suffered a heightened risk of identity theft because Godiva printed more digits of his credit card number than the law allows. The Eleventh Circuit found that under the facts of the case, Dr. Muransky had standing because the injury was actual, not conjectural, and particular to him. In so holding, the Eleventh Circuit held *Spokeo* did not change the requirements for standing, but rather reaffirmed a concrete injury must exist, a concrete injury could be an intangible injury and the injury need not be a substantial injury. The Eleventh Circuit observed the *Spokeo* decision did not determine whether Robins had suffered a concrete injury, but rather instructed the Ninth Circuit to further evaluate the concreteness of Robins' alleged injury. Thus, *Muransky* suggests the intangible injuries suffered by consumers whose data is breached may have standing to pursue claims, opening the door to liability cases to which the door might otherwise have been closed.

27 *Id.*

28 *Id.* at 1548.

29 922 F.3d 1175, 1181, 27 Fla. L. Weekly Fed. C 1885 (11th Cir. 2019).

30 15 U.S.C. § 1681c(g)(1).

Recent Developments in Third-Party Liability Coverage: A Survey Course

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Christy M. Maple practices in the areas of insurance coverage and commercial litigation with an emphasis on third-party liability insurance coverage matters, including bad faith litigation. Christy also practices in the areas of first-party property insurance and fidelity insurance.

Christy currently represents businesses in a range of liability insurance coverage issues, including construction defect claims and long-tail losses under commercial general liability policies. Her clients include premier, multinational insurance and claims management companies.

Representing insurance companies in disputes with corporate policyholders concerning the breadth of policy coverages, Christy helps insurers determine whether an insured corporation or company is entitled to legal defense and indemnification in both pre-suit disputes and litigation with third parties.

Protecting clients' best interests, Christy concentrates on shielding them from costly suits and litigation. Her careful and prudent analysis of all matters, coupled with the long-term view, provide risk reduction and successful, cost-saving outcomes for her clients.

A world traveler, Christy studied abroad in Germany during college and lived there for a year following law school, teaching English at German university Universität Erfurt as part of the Robert Bosch Foundation Fellowship Program. Christy was awarded a Fulbright Scholarship, which she declined in favor of the Bosch Fellowship opportunity. Recent travel destinations include the Amalfi Coast and northern Arizona. Reading takes her on adventures, too. She is a member of two book clubs.

Christy graduated from Vanderbilt University in 2004 with *summa cum laude* and Phi Beta Kappa honors and from the University of North Carolina School of Law with honors in 2008.

Recent Developments in Third-Party Liability Coverage: A Survey Course

Recent developments in Georgia law address issues that are impactful to liability insurers, including:

- effective reservation of rights;
- bad faith failure to settle;
- an insurer's options for determining coverage; and
- choice of law.

RESERVATION OF RIGHTS

It is a well-settled principle of Georgia law that when a liability insurer is unsure of its obligation to its insured, the insurer may provide a defense to the insured under a reservation of rights and seek a declaratory judgment.[1] Insurers must be exceedingly careful when reserving their rights. A federal court in Georgia recently ruled an insurer that had sent three separate reservation of rights letters failed to properly reserve its rights and was therefore estopped from denying coverage.[2]

In *Auto-Owners Insurance Co. v. Cribb*, Auto-Owners issued a general liability policy to "Insured: Brian Thurman & Richard Davis DBA BR Mountain Homes, LLC." The claimant, an employee of another subcontractor, was injured on the job site and initially only filed suit against BR Mountain Homes. After receiving notice of the underlying lawsuit, Auto-Owners issued a reservation of rights letter to BR Mountain Homes to the attention of Mr. Brian Thurman and retained counsel to defend BR Mountain Homes. Subsequently, the claimant amended his complaint in the underlying action to add claims against James Brian Thurman and Richard Scott Davis, officers and employees of BR Mountain Homes. The same counsel retained to defend BR Mountain Homes filed answers on behalf of Thurman and Davis. Almost three months after those answers were filed, Auto-Owners issued two more reservation of rights letters. The second reservation of rights letter was sent to "Mr. James Brian Thurman, c/o BR Mountain Homes." The third reservation of rights letter was sent to "Mr. Richard Scott Davis, c/o BR Mountain Homes."

Thurman and Davis argued Auto-Owners was estopped from denying coverage to them because Auto-Owners failed to reserve its rights before providing them with a defense. The court agreed, explaining an insurer defending an insured in the absence of an express and specific reservation of rights to deny coverage is estopped from later denying coverage.[3] Noting the policy was issued to "Insured: Brian Thurman & Richard Davis DBA BR Mountain Homes, LLC," the court further explained each insured is treated separately for the purposes of coverage, by way of the policy's "separation of insureds" provision, which provided:

> 7. Separation of Insureds
>
> Except with respect to the Limits of Insurance, and any rights or duties specifically assigned in this Coverage Part to the first Named Insured, this insurance applies:
>
> a. As if each Named Insured were the only Named Insured; and
>
> b. Separately to each insured against who claim is made or "suit" is brought.

The first reservation of rights letter was addressed to "BR Mountain Homes, LLC, Attn: Mr. Brian Thurman" and sent before Thurman and Davis were named as defendants in the underlying lawsuit. This letter was insufficient for Auto-Owners to reserve its rights as to Thurman and Davis. The second and third reservation of rights letters, sent to Thurman and Davis, respectively, "c/o BR Mountain Homes, LLC," were delivered almost three months after defense counsel retained by Auto-Owners filed answers on behalf of Thurman and Davis.

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1 *Richmond v. Ga. Farm Bur. Mut. Ins. Co.*, 140 Ga. App. 215, 217, 231 S.E.2d 245, 247 (1976) ("A proper and safe course of action for an insurer in this position is to enter upon a defense under a reservation of rights and then proceed to seek a declaratory judgment in its favor.").

2 No. 2:17-CV-106-RWS, 2019 U.S. Dist. LEXIS 17785 (Feb. 5, 2019).

3 *Id.* at *12 (citing *World Harvest Church, Inc. v. GuideOne Mut. Ins. Co.*, 287 Ga. 149, 695 S.E.2d 6, 9-10 (Ga. 2010)).

Under these circumstances, the court found Auto-Owners was estopped from denying coverage to Thurman and Davis. The court did not address that Thurman and Davis may have had actual notice of Auto-Owners' coverage position by way of the first reservation of rights letter addressed to "BR Mountain Homes, LLC, Attn: Mr. Brian Thurman." *Cribb* is a good reminder an insurer cannot be too careful when it comes to reserving rights and needs to ensure all affected insureds are sent the reservation of rights in a timely fashion.

BAD FAITH FAILURE TO SETTLE

Perhaps the single issue causing the most concern to every insurer is the possibility of being found to have acted in bad faith toward its insured, particularly with respect to the insurer's duty to settle a third-party claim against its insured. After the recent ruling in *First Acceptance Insurance Co. of Georgia v. Hughes*,[4] insurers have a clearer guideline of when they must respond to a demand for policy limits. In that case, the Supreme Court of Georgia, for the first time, clearly articulated the rule that an insurer's duty to settle arises only when the injured party presents a valid offer to settle within the insured's policy limits.

Hughes involved a multiparty vehicle accident in which the at-fault driver, First Acceptance's insured, was killed and several other parties, including the two claimants at issue, were seriously injured. First Acceptance determined the accident was covered by its policy, its insured was at fault and the exposure would exceed available policy limits.

First Acceptance then retained counsel to attempt to reach a global settlement of all the claims. Counsel for two of the claimants sent letters to First Acceptance stating the claimants' interest in attending a settlement conference and, in the alternative, offered to settle their claims for the available policy limits. Notably, the claimants' offer to settle within policy limits did not contain a time-limited demand.

First Acceptance did not respond to the letters and the claimants filed suit. Shortly thereafter, claimants sent a letter to First Acceptance revoking the pre-suit offer to settle. First Acceptance responded by inviting claimants to attend a global settlement conference, which they declined to do. Several months later, First Acceptance offered to settle the claimants' claims for the policy limit of $50,000. The claimants rejected the offer, and the jury ultimately returned a verdict in favor of the claimants for $5.3 million.

The insured's estate filed suit against First Acceptance alleging negligence and bad faith for First Acceptance's failure to settle the claimants' claims within policy limits and sought to recover the $5.3 million judgment. The Supreme Court of Georgia framed the issue as follows:

> To the extent that this Court's decisions have been deemed to be unclear, we take this opportunity to clarify that an insurer's duty to settle arises when the injured party presents a valid offer to settle within the insured's policy limits. Accordingly, the question is whether [claimants] made a valid offer that First Acceptance failed to accept negligently or in bad faith.

Applying basic contract principles of offer and acceptance, the court found the claimants' pre-suit letters to First Acceptance were not clear and unequivocal time-limited settlement demands. The court further explained, given that the claimants' letters communicated an unequivocal desire by the claimants to attend the proposed settlement conference, First Acceptance could not have reasonably known it needed to respond within a certain time or risk that its insured would be subject to a judgment in excess of the policy limits. First Acceptance's failure to promptly accept the claimants' pre-suit offer was reasonable, as an ordinarily prudent insurer could not be expected to anticipate that, having specified no deadline for the acceptance of their offer, the claimants would abruptly withdraw their offer and refuse to participate in the settlement conference. Therefore, First Acceptance was entitled to summary judgment.

Hughes makes it clear that in order to trigger an insurer's duty to settle, there must first be a clear and unequivocal offer to settle within policy limits.

[4] 305 Ga. 489, 826 S.E.2d 71 (2019).

OPTIONS FOR DETERMINING COVERAGE

Historically, a liability insurer defending its insured under a reservation of rights typically had three options for determining whether coverage is owed. First, the insurer could monitor the underlying lawsuit for developed facts that would support any coverage defenses. Second, the insurer could file a declaratory judgment against all parties to the underlying action. Third, the insurer could file a motion to intervene in the underlying lawsuit for the purpose of seeking a special jury verdict form that would allocate the verdict between covered and noncovered damages.

Based on the Court of Appeals of Georgia's recent decision in *O'Brien v. Builders Insurance*,[5] the third option may no longer be viable. In *O'Brien*, the claimant filed suit against the insured seeking to recover damages for alleged defective construction of property. Approximately three years after the lawsuit was filed, the insurer filed a motion to intervene, seeking to participate in discovery and propose a special verdict form in order to determine whether it was obligated to provide coverage for the damages claimed against its insured. The trial court granted the motion.

The Court of Appeals explained a party may not intervene where he has a remedy that may be asserted in a proper proceeding.[6] "[I]f the one who seeks to intervene will still be left with his right to pursue his own independent remedy against the parties, regardless of the outcome of the pending case, then he has no interest that needs protecting by intervention and should not be allowed to intervene over objection."[7]

The insurer acknowledged it could bring a declaratory judgment action to determine coverage after the underlying action was completed. In fact, as the court explained, it is well-settled that a declaratory judgment action is a proper proceeding for determination of insurance coverage issues. As the insurer had the right to pursue its own independent declaratory judgment action, intervention was improper.

The *O'Brien* opinion does not address the limitations of the declaratory judgment remedy. For example, in an underlying construction defect case, a verdict against an insured contractor is unlikely to be apportioned between damages to the insured's own work that are not covered and resulting damages to other property that may be covered. The insured's defense counsel, provided by its insurer, would be ethically constrained from requesting such a jury verdict form, as the insured would benefit from lumping the damages together and preventing the insurer from differentiating between covered and noncovered damages. A declaratory judgment action is not necessarily the most efficient method for making such a differentiation. Nonetheless, it may be the only option after *O'Brien*.

CHOICE OF LAW

As set forth in any number of insurance cases, when determining what law applies to an insurance policy, Georgia courts have traditionally followed the rule of *lex loci contractus*.[8] That is, the applicable law is the law of the place where the policy was made, which is the place where the policy was delivered.[9] Typically, a policy is delivered to the insured's address (or the address of its broker) listed on the policy's declarations page. However, recent case law indicates a more nuanced approach to the choice of law analysis is necessary.

In *Coon v. The Medical Center, Inc.*, the Supreme Court of Georgia addressed choice of law in a tort case that turned on whether Georgia or Alabama law applied.[10] The court explained under *lex loci delicti* — the place where the tort was committed — Alabama law would apply. However, the choice of law inquiry did not end there. The next step was determining what Alabama law was. Applying the "presumption of identity" doctrine, the court explained that as a matter of comity, a Georgia court will defer to another state's statutes. However, if there is no statute and the foreign state was one of the 13 original colonies or formed therefrom, a Georgia court will presume the foreign state's law is the same as Georgia law — regardless of what the foreign state's law actually is — and apply Georgia law.

5 No. A19A0686, 2019 Ga. App. LEXIS 243 (May 3, 2019).

6 *See Potter's Props., LLC v. VNS Corp.*, 306 Ga. App. 621, 623, 703 S.E.2d 79, 81 (2010).

7 *Gregory v. Tench*, 138 Ga. App. 219, 220, 225 S.E.2d 753, 754 (1976).

8 *See, e.g., Lima Delta Co. v. Glob. Aero., Inc.*, 338 Ga. App. 40, 45-46, 789 S.E.2d 230, 234-35 (2016).

9 *Id.*

10 *Coon v. The Med. Ctr., Inc.*, 300 Ga. 722, 797 S.E.2d 828 (Ga. 2017).

On its face, the 2017 *Coon* decision does not appear to have much to do with choice of law with respect to insurance policies. However, in *Coon*, the Supreme Court of Georgia specifically stated the choice of law principles enunciated therein applied to contract, as well as tort claims.[11] Moreover, the U.S. District Court for the Middle District of Georgia, citing *Coon*, subsequently applied the presumption of identity doctrine to an insurance coverage case.[12] In that case, the doctrine worked to the insurer's advantage when the court held Georgia law, rather than Maryland law, applied, and the insurer was therefore entitled to summary judgment.

In light of the Supreme Court of Georgia's application of the presumption of identity doctrine in a tort case and the Middle District of Georgia's application of the doctrine in an insurance case, carriers should be sure to consider the doctrine when evaluating choice of law and which state's law will apply in interpreting policy language.

11 *Id.* at 733, 797 S.E.2d 828.

12 *See, Mass. Bay Ins. Co. v. Fort Benning Family Cmtys.*, LLC, No. 4:15-CV-75-CDL, 2017 U.S. Dist. LEXIS 76913, at *1 (M.D. Ga. May 15, 2017).

Code of Conduct: Bad Faith and Time-Limited Demands

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Code of Conduct: Bad Faith and Time-Limited Demands

Like most states, Georgia allows an insured to make a claim against an insurer for its bad faith failure to settle a tort claim within policy limits.[1] Such a claim is a separate cause of action from a bad faith claim for the statutory penalties allowed under O.C.G.A. §§ 33-4-6 and 33-4-7. The claim for failure to settle allows compensatory damages (the excess verdict), while the statutory bad faith claim permits the insured to recover a penalty and attorney fees based on the insurer's bad faith refusal to pay the covered claim. Unlike a claim for statutory penalties, which cannot be assigned by the insured to another party, a cause of action for compensatory damages based on the insurer's failure to settle may be (and often is) assigned.[2]

Although Georgia law recognized a cause of action against an insurer for bad faith failure as early as a 1962 decision in *Smoot v. State Farm Mutual Automobile Insurance Co.*,[3] such claims are typically referred to as "*Holt* claims," based on the 1992 decision by the Supreme Court of Georgia in *Southern General Insurance Co. v. Holt*.[4] As *Holt* involved a situation in which the insurer failed to tender policy limits by a deadline imposed by the claimant's attorney, *Holt* is most often cited in this context. *Holt* led to the common practice of sending time-limited demands to settle personal injury cases ("*Holt* demands"), accompanied by the assertion that the insurer will be liable for any verdict in excess of policy limits if it fails to tender limits by the deadline. While the *Holt* court specifically noted the decision was not intended to "lay down a rule of law that would mean a plaintiff's attorney under similar circumstances could 'set up' an insurer for an excess judgment merely by offering to settle within the policy limits and by imposing an unreasonably short time within which the offer would remain open,"[5] attempts to "set up" an insurer and create liability for "bad faith" failure to settle have become increasingly prevalent.

In 2013, the Georgia General Assembly passed O.C.G.A. § 9-11-67.1, which was intended to resolve some of the uncertainty *Holt* and subsequent decisions have created for insurers when responding to time-limited demands and provide guidance to attorneys making such demands. The statute imposes requirements for pre-suit settlement demands in personal injury claims arising out of motor vehicle accidents.[6] O.C.G.A. § 9-11-67.1 failed to curb many of the abuses under *Holt*, leading to increasing efforts by plaintiff's attorneys to set up insurers under the statute.

This paper will discuss the current state of the law in Georgia regarding time-limited demands, particularly demands in auto claims governed by O.C.G.A. § 9-11-67.1, as well as requirements of the statute, some of the tactics employed by plaintiff's attorneys and some suggestions for how insurers might respond.

SOUTHERN GENERAL INSURANCE CO. V. HOLT

In some cases, it is clear the insurance company has not acted reasonably in responding to a settlement demand. The facts in *Holt* provide a good example. There was evidence the insurer, Southern General, knew almost immediately it had a "policy limits case." Liability was clear and it was apparent the plaintiff's medical bills would exceed the limits of coverage under the policy. The plaintiff's attorney tendered a settlement demand for the policy limits, sent Southern General copies of the medical bills and gave the insurer 10 days to respond. Southern General failed to respond to the demand within the deadline. On the tenth day, the

1 *E.g., S. Gen. Ins. Co. v. Holt*, 262 Ga. 267, 268-269, 416 S.E.2d 274 (1992).

2 *Jefferson Ins. Co. of N.Y. v. Dunn*, 224 Ga. App. 732, 741, 482 S.E.2d 303 (1997), *rev'd. on other grounds*, 269 Ga. 213, 496 S.E. 2d 696 (1998).

3 299 F.2d 525 (5th Cir. 1962).

4 The cause of action was first discussed in a 1947 decision, *Francis v. Newton*, 75 Ga. App. 341, 343-44, 43 S.E.2d 282 (1947) (stating that it would be possible to hold an insurance company liable for damages to its insured for "failing to adjust or compromise a claim covered by its policy of insurance, where the insurer is guilty of negligence or of fraud or bad faith in failing to adjust or compromise the claim to the injury of the insured."). The Georgia Court of Appeals later recognized a similar cause of action in *U.S. Fid. & Guar. Co. v. Evans*, 116 Ga. App. 93, 94, 156 S.E.2d 809 (1967), *aff'd.*, 223 Ga. 789, 158 S.E.2d 243 (1967). In 1984, the Georgia Supreme Court decided *McCall v. Allstate Ins. Co.*, and held that an insurer may be liable to the insured for failure to settle a claim within policy limits "where the insurer is guilty of negligence or of fraud or bad faith in failing to adjust or compromise the claim to the injury of the insured." 251 Ga. 869, 870, 310 S.E.2d 513 (1984) (other citations omitted).

5 *Holt*, 262 Ga. at 269 (quoting *Grumbling v. Medallion Ins. Co.*, 392 F.Supp. 717, 721 (D. Or. 1975)).

6 O.C.G.A. § 9-11-67.1(a).

plaintiff's attorney sent copies of the medical records to the insurer and extended the settlement offer another five days. Southern General did not communicate with the plaintiff's attorney until two days after the deadline expired, at which time it offered policy limits to settle the case. The plaintiff refused to accept the offer, stating his demand expired. When the case went to trial, the jury awarded the plaintiff more than five times the limit of liability under the policy.[7]

Holt then assigned her claim against Southern General for negligent or bad faith refusal to settle within policy limits to the tort plaintiff. A jury awarded the full amount of the verdict to the tort plaintiff, as well as compensatory and punitive damages to Holt, who sued Southern General for intentional infliction of emotional distress and punitive damages.[8] The Court of Appeals affirmed the award of compensatory damages to the plaintiff and punitive damages to Holt, but reversed the award of emotional distress damages to Holt.[9] After granting *certiorari*, the Supreme Court of Georgia affirmed the verdict in favor of the plaintiff, but reversed the verdict in favor of Holt.[10] Citing its 1984 decision in *McCall v. Allstate Insurance Co.,* the court held: "An insurance company may be liable for damages to its insured for failing to settle the claim of an injured person where the insurer is guilty of negligence, fraud or bad faith in failing to compromise the claim."[11]

THE INSURER'S DUTY OF CARE

Holt is sometimes cited in demand letters for the proposition that an insurer may be held liable for no other reason than its failure to pay policy limits within a particular deadline. Yet that was not the Supreme Court of Georgia's holding. As the *Holt* court explained, the insurer may not be held liable solely because it fails to accept the settlement offer within the deadline set by the plaintiff's attorney.[12] Rather, the insurer is liable if it acted unreasonably in declining to accept the settlement offer.[13]

The focus of a bad faith (or negligent) failure to settle claim is on the insurer's conduct in responding to a settlement offer. The insurance company "must give equal consideration to the interests of the insured" in deciding whether to settle a claim within policy limits.[14] The issue is whether the insurer, in view of the existing circumstances, has given the interest of the insured "the same faithful consideration it gives its own interest."[15] The interests of the insurer and insured diverge when a plaintiff offers to settle a claim for the limits of the insurance policy. "The insured is interested in protecting itself against an excess judgment; the insurer has less incentive to settle because litigation may result in a verdict below the policy limits or a defense verdict."[16] The insurer may be held liable when it places its interests above the interests of its insured. The insurer's actions are judged by the standard of the "ordinarily prudent insurer."[17] "[T]he insurer is negligent in failing to settle if the ordinarily prudent insurer would consider choosing to try the case created an unreasonable risk."[18] The insurer's potential liability for bad faith thus "depends on whether the insurance company acted reasonably in responding to a settlement offer."[19]

7 *Id*. at 275.
8 *Id*.
9 *S. Gen. Ins. Co. v. Holt*, 200 Ga. App. 759, 409 S.E.2d 852 (1991); *rev'd in part on other* grounds, 262 Ga. 267, 416 S.E.2d 274 (1992).
10 262 Ga. at 269-70.
11 *Id*. at 268 (citing *McCall*, 251 Ga. at 870).
12 262 Ga. at 269.
13 *Id*.
14 *Id*. (citing *Great Am. Ins. Co. v. Exum*, 123 Ga. App. 515, 519, 181 S.E.2d 704 (1971)).
15 *Id*. (citing *Exum*, *U.S. Fid. & Guar. Co. v. Evans*, 116 Ga. App. 93, 156 S.E.2d 809, *aff'd*. 223 Ga. 789, 158 S.E.2d 243 (1967)).
16 *Id*. (citation omitted).
17 *Cotton States Mut. Ins. Co. v. Brightman*, 276 Ga. 683, 685, 580 S.E.2d 519 (2003).
18 *Id*. (citation omitted).
19 *Id*. *See also Fortner v. Grange Mut. Ins. Co.,* 286 Ga. 189, 190, 686 S.E.2d 93 (2009) "Whether an insurance company acts in bad faith in refusing to settle depends on whether the insurance company acted reasonably in responding to a settlement offer, bearing in mind that, in deciding whether to settle, the insurer must give the insured's interests the same consideration that it gives its own." (citations and punctuation omitted).

"NEGLIGENT" FAILURE TO SETTLE?

The Georgia courts have referred to both negligence and bad faith when evaluating claims against insurers for failure to settle and failed to clarify whether "negligence" and "bad faith" have separate meanings in this context.[20] This issue was discussed by a federal district court in *Butler v. First Acceptance Insurance Co.,* which ultimately concluded there was little distinction between a bad faith and negligence cause of action for failure to settle.[21] More recently, a district court distinguished between "bad faith" and "negligent failure to settle" claims in *Patriot General Insurance Co. v. Krebs*, granting a motion to dismiss the bad faith claim while refusing to dismiss the negligence claim.[22] However, the court later granted a motion for reconsideration and reinstated the bad faith claim, rendering the issue moot.[23] While the *Krebs* court's characterization of bad faith and negligence as separate causes of action has not been adopted by Georgia's appellate courts, policyholders and their assigns continue to assert claims against insurers for "negligent failure to settle," recognizing that it is easier to establish negligence and create a jury question than it is to prove bad faith.

There is an argument the negligence standard should not apply to a failure to settle claim and "bad faith" requires something more than mere negligence. At this point, however, it is unlikely the Supreme Court of Georgia will address whether the negligence standard is proper. Instead, the Supreme Court and Court of Appeals continue to repeat the phrase that the insurer may be held liable for its "bad faith or negligent refusal to settle a personal claim within the policy limits."[24] Until this issue is resolved by the Supreme Court, which has never explicitly recognized "negligent failure to settle" as a cause of action, we will continue to see claims against an insurance company for "negligent failure to settle" within policy limits.

DOES *HOLT* APPLY TO EVERY SETTLEMENT DEMAND?

In *Holt*, it is important to remember there was no question that the insured was liable for causing the accident or the value of the plaintiff's claim exceeded the available policy limits. The Supreme Court stated it was rejecting Southern General's argument "that an insurer has no duty to its insured to respond to a deadline to settle a claim within policy limits *when the company has knowledge of clear liability and special damages exceeding the policy limits*."[25] This language suggests the insurer might be justified in rejecting a time-limited demand — or at least requesting an extension — if it has legitimate questions regarding liability or damages. There are conflicting *dicta* in two different opinions by the Court of Appeals of Georgia as to whether *Holt* only applies when liability is clear and damages clearly exceed the policy limits.[26] Given the number of failure-to-settle claims arising out of situations where damages were less than policy limits when the demand was made, this is another area where the Supreme Court could perhaps clarify the law. At the moment, however, insurers should recognize the possibility that a *Holt* claim could be made any time they reject a demand for policy limits.

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20 *See Delancy v. St. Paul Fire & Marine Ins. Co.,* 947 F. 2d 1536, 1547-48 (11th Cir. 1991) ("Georgia law is ambiguous . . . as to whether an insured may recover for the insurer's negligence, as well as bad faith failure to settle. Some Georgia cases imply that only bad faith is actionable . . . . Other cases are ambiguous on the issue or blend the negligence and bad faith standards . . . . Still other Georgia cases explicitly recognize a claim for negligent failure to settle.") (citations omitted). *See also Benton Express v. Royal Ins. Co. of Am.*, 217 Ga. App. 331, 334, 457 S.E.2d 566 (1995)("Although earlier cases support [the insurer's] argument that an insured has no cause of action against its insurer for negligent failure to settle claims, recent cases seem to suggest the contrary, at least in excess judgment cases.") (citations omitted).

21 652 F. Supp. 2d 1264, 1275-1276 (N.D. Ga. 2009).

22 2012 U.S. Dist. LEXIS 101014 (N.D. Ga. July 20, 2012) at **17-18.

23 *Patriot Gen. Ins. Co. v. Krebs*, 2013 U.S. Dist. LEXIS 31994 (N.D. Ga. March 7, 2013).

24 *First Acceptance Ins. Co. of Ga. v. Hughes*, 305 Ga. 489, 492, 826 S.E.2d 71, 74 (2019) (quoting *Brightman*, 276 Ga. at 684. Notably, however, *First Acceptance* then goes on to discuss "bad faith" without ever discussing whether "bad faith" means something other than negligence in the context of failure to settle claims. *See Id*.

25 262 Ga. at 269 (emphasis in original).

26 Notably, in *Baker v. Huff* the Georgia Court of Appeals held that *Holt* "cannot be construed as holding that it is always reasonable for an insurer not to respond to a time-limited offer to settle within the policy limits when special damages do not exceed policy limits." 323 Ga. App. 357, 364-365, 747 S.E.2d 1(2013). But *see S. Gen. Ins. Co. v. WellStar Health Sys. Inc.,* 315 Ga. App. 26, 31, 726 S.E.2d 488 (2012) (suggesting that *Holt* might not apply given, *inter alia*, "a lack of documentation to show that special damages actually *exceeded* Southern General's policy limits")(emphasis in original).

MAY A COVERAGE ISSUE INFLUENCE THE INSURER'S DECISION?

The insurance company cannot be held liable for bad faith if there is no coverage under the policy.[27] In some situations, the insurer may legitimately believe there is no coverage for the claims presented against the insured. In that case, the question arises as to whether the insurer may refuse to tender limits (and pay what may be an uncovered claim) until it is determined whether there is coverage under the policy. If it is later determined the policy provides coverage for the claim, can the insurer be held liable for an excess verdict?

The Supreme Court has yet to rule on whether a reasonable coverage defense provides a legitimate basis for an insurer to reject a time-limited demand in the context of a *Holt* claim. When considering claims brought under O.C.G.A. § 33-4-6, Georgia's bad faith statute, Georgia courts hold reasonable coverage defenses will bar such claims as a matter of law.[28] Likewise, statutory bad faith claims are not appropriate if an insurer's coverage defense was based on a policy interpretation that is the subject of disagreement between appellate courts.[29]

The standard applied against the insurer in statutory bad faith cases is whether it has "reasonable and probable cause for making a defense to the claim."[30] If the insurer has reasonable cause to question coverage, there should be no basis for a bad faith claim even if it is later determined that the policy does provide coverage. The Supreme Court has stated: "Not every defense bars a finding of bad faith. It is a defense which raises a reasonable question of law or a reasonable issue of fact though not accepted by the trial court or jury."[31] Given this standard, it is arguable that the insurance company could reasonably refuse to accept a time-limited settlement demand because of a legitimate concern the claim might not be covered under the policy. Yet, there is at least one Court of Appeals decision that suggests otherwise.

In *Cotton State Mutual Insurance Co. v. Brightman*, the Supreme Court of Georgia stated: "Our holding in *Holt* was consistent with the general rule that the issue of an insurer's bad faith depends on whether the insurance company acted reasonably in responding to a settlement offer."[32] However, the prior decision by the Court of Appeals of Georgia contains the following statement: "An insurer who fails to accept a reasonable settlement offer within the policy limits because it believes the policy does not provide coverage assumes the risk that it will be held liable for all damages resulting from such refusal."[33] This statement was not addressed by the Supreme Court in its opinion, nor has the issue been addressed in any subsequent reported decision by a Georgia appellate court.[34] Absent any clarification from the courts, the Court of Appeals' opinion in *Brightman* will support the argument that the insurer "assumes the risk" of an excess verdict if it rejects a demand based on a good faith belief that there is no coverage for the claim in the event a court later rules there is coverage.

The safest course of action for the insurer in this situation is to file a declaratory judgment action as soon as it becomes aware of a potential coverage issue. When confronted with a time-limited demand, the insurer can respond by identifying the coverage issue, citing the declaratory judgment action and explaining it will respond to the demand once coverage issues are determined. If it is later determined there is coverage for the claim, the insurer can cite this response as evidence of its effort to act reasonably under the circumstances.

A similar issue was addressed by a federal district court in *Hulsey v. The Travelers Indemnity Co. of America*, where the insurer claimed it could not respond to a time-limited demand because it needed more time to investigate coverage.[35] *Hulsey* involved a situation in which there was clear liability and damages exceeding

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27 *See Moon v. The Cincinnati Ins. Co.,* 975 F. Supp. 2d 1326, 1332 (N.D. Ga. 2013) (Because the policy did not provide coverage for the underlying claims against the plaintiffs, they could not assert common law claims for bad faith failure to settle or statutory claims for penalties pursuant to O.C.G.A. § 33-4-6.). *Accord New Appleman Ins. Bad Faith Litigation*, § 2.03 (there in no obligation to settle claims not covered by the policy).

28 *See*, *e.g.*, *Int'l. Indem. Co. v. Collins*, 258 Ga. 236, 238, 367 S.E.2d 786 (1988) ("[W]hen there is no evidence of unfounded reason for nonpayment, or if the issue of liability is close, the court should disallow the imposition of bad faith penalties . . . . Good faith is determined by the reasonableness of nonpayment of a claim.") (citations omitted).

29 *See Id*. ("When the Court of Appeals is divided on an issue, and certiorari is granted to resolve the issue, the insurer is legally justified in litigating the issue and cannot be held liable for a statutory bad faith penalty as a matter of law.").

30 *Colonial Life & Accident Ins. Co. v. McClain*, 243 Ga. 263, 253 S.E.2d 745 (1979).

31 *Id*.

32 276 Ga. at 685.

33 *Cotton States Mut. Ins. Co. v. Brightman*, 256 Ga. App. 451, 453, 568 S.E.2d 498 (2002) (quoting 444 Am. Jur. 2d 331-33, Insurance § 1399 (1982)), *aff'd.*, 276 Ga. 683, 580 S.E.2d 519 (2003).

34 Many courts around the country have reached a similar result in addressing whether an insurance company can refuse to tender policy limits based on a coverage defense. *See Appleman on Insurance*, § 23.02 [6][c][ii]. A majority of courts have held that "an insurer that allows coverage doubts to affect its settlement decision does so at its peril." *Id*. There is some question whether this is *currently* the majority rule.

35 460 F. Supp. 2d 1332 (2006).

the available policy limits. However, Travelers argued it did not accept the settlement demand within the deadline because it needed more time to investigate whether the at-fault driver was an insured under the policy.[36] The court denied Travelers' motion for summary judgment, concluding there was sufficient evidence in the record to permit a reasonable jury to find Travelers "either knew or through the exercise of ordinary care should have known" the driver was an insured prior to the expiration of the settlement demand.[37] The opinion focused on Travelers' delay in investigating coverage. Although Travelers eventually requested an extension of the deadline to investigate coverage, the evidence suggested Travelers could have completed its investigation within the original deadline "had it handled the matter more diligently."[38] As the court concluded: "A reasonable jury could find that Travelers either knew or should have known that [the driver was insured] prior to the expiration of the thirty-day period and did not act reasonably in failing to settle this case within the policy limits."[39] Although *Hulsey* is not a decision by a Georgia appellate court, the opinion explains why an insurer should promptly investigate coverage so it will be prepared in the event of a time-limited demand.

MAY QUESTIONS REGARDING LIABILITY INFLUENCE THE INSURER'S DECISION?

Unlike *Holt* and most of the other reported decisions, there will be times when the insured's liability is far from clear. Presumably, the insurer could argue it acted reasonably under the circumstances if it refused to tender limits due to a legitimate question regarding liability. This remains an open question under Georgia law, but it will likely be a jury issue as to whether the insurer reasonably refused to tender limits based on its belief that the insured was not liable. In hindsight, however, it will be difficult to justify the claims decision when the insured has been found liable in excess of the policy limits.

SETTLEMENT DEMANDS WITH UNREASONABLE CONDITIONS

Although most of the reported cases have focused on whether the insurer acted reasonably in responding to settlement demands, some consideration should be given to whether the demand itself was reasonable. It has become common practice for settlement demands to include a list of conditions, along with the statement that the insurer's refusal to accept all conditions will be deemed a rejection of the offer. Georgia law has provided little guidance as to what actions on the part of the insurer in response to such a demand might be considered unreasonable.

In some instances, the demand will not include an agreement to release all insureds under the policy. This issue arose in a 2014 case decided by the U.S. District Court for the Southern District of Georgia, *McKeel v. State Farm Mutual Automobile Insurance Co.*[40] The case arose out of a car accident in which Coung Nguyen injured plaintiff Erica McKeel, resulting in the death of her unborn child. Nguyen was insured under a policy issued by State Farm, which tendered its policy limits of $100,000 to McKeel. As part of the offer, State Farm insisted the plaintiffs sign a limited release for Nguyen's employer, which also qualified as an insured under the policy. McKeel refused to sign the release and ultimately obtained a verdict against Nguyen in excess of $3 million. In a subsequent lawsuit to collect the excess verdict, McKeel alleged State Farm acted in bad faith by insisting Nguyen's employer be included on the release.[41] The district court granted State Farm's motion for summary judgment, concluding State Farm's insistence that McKeel execute a limited release that included the employer, an additional insured under the policy, "was wholly reasonable and precisely what one would expect from a reasonably prudent insurer."[42]

The insurer may be justified in refusing to tender limits in response to a demand that does not fully settle a claim. In *Baker v. Huff*, the Court of Appeals of Georgia held the insurer, Liberty Mutual, did not act in bad faith when the plaintiff's demand stated he was willing to accept policy limits "to compensate him for his pain and suffering only," and further stated the release should indicate the sum was to partially compensate the plaintiff

36 460 F. Supp. 2d at 1335.
37 *Id*.
38 *Id*. at 1336.
39 *Id*. at 1337 (citing *Brightman*, 276 Ga. at 685.).
40 2014 U.S. Dist. LEXIS 137170 (S.D. Ga., Sept. 26, 2014).
41 *Id*. at **2-5.
42 *Id*. at *8.

for his pain and suffering.[43] The court held that a partial settlement for only pain and suffering damages "was not an offer to fully settle a claim within the policy limits to which Liberty Mutual had a duty to respond under *Holt*."[44] Instead, the court concluded the offer to settle only pain and suffering damages for policy limits in effect invited Liberty Mutual to engage in negotiations to fully settle the claim, which included additional damages for medical expenses and lost wages, for an amount in excess of the policy limits.[45] Because Liberty Mutual had no duty "to engage in negotiations concerning a settlement demand that was in excess of the insurance policy's limits," it did not act in bad faith as a matter of law.[46]

Baker also includes a discussion of the insurer's duty to respond to a settlement demand that failed to include current medical records, information about current treatment or medical condition, a and statement of special or other damages.[47] Prior to sending the "pain and suffering only" demand, the plaintiff sent a policy limits demand with a 10-day deadline, but failed to include any current information. Liberty Mutual responded within the deadline and asked for current information, but did not receive any. In response, Liberty Mutual informed the plaintiff it could not tender policy limits under the circumstances.[48] The court concluded Liberty Mutual acted reasonably under the circumstances by informing the plaintiff's attorney it was not prepared to tender its policy limits to settle the claim without more information and granted Liberty Mutual's motion for summary judgment.[49] The *Baker* court noted that although the insurer's liability for failing to accept a time-limited offer is usually a jury question, it "[found] under these circumstances that no reasonable trier of fact could conclude that Liberty Mutual acted unreasonably when it failed to tender the $100,000 policy limits within the 10-day time limit imposed in [plaintiff's] settlement offer."[50]

There will also be situations in which settlement offers include conditions beyond the insurer's control. *Cotton States Mututal Insurance Co. v. Brightman* involved a situation where two insurance companies provided coverage for the plaintiff's claims.[51] One insurer was presented with a policy-limits demand for a settlement contingent on the other insurer also tendering its limits. The Supreme Court of Georgia held that a jury question existed as to whether the insurer had an adequate opportunity to settle and therefore acted unreasonably when it refused to tender policy limits in response to the demand.[52] As the court concluded, "an insurance company faced with a demand involving multiple insurers can create a safe harbor from liability for an insured's bad faith claim under *Holt* by meeting the portion of the demand over which it has control, thus doing what it can to effectuate the settlement of the claims against its insured."[53] The *Brightman* court did place some limitations on the insurance company's duty to negotiate. The court held an insurance company does not have an affirmative duty to engage in negotiations concerning a settlement demand in excess of the policy limits.[54] The court was also unwilling to "ascribe a duty to insurers to make a counteroffer to every settlement demand that involves a condition beyond their control."[55]

Liens for medical treatment are also an issue the insurer must consider. It has become a common practice for demand letters to state that any requirement for the claimant to satisfy liens or provide indemnity for medical liens (common language in most settlement agreements) will be deemed a rejection of the offer. This puts the insurer in a difficult position given its statutory obligation to satisfy hospital liens.[56] In *Southern General Insurance Co. v. WellStar Health Systems*, the Court of Appeals of Georgia held an insurer would not be liable under *Holt* when it refuses to tender limits solely because the plaintiff unreasonably refused to

43 323 Ga. App. 357, 365, 747 S.E.2d 1 (2013).
44 *Id*.
45 *Id*.
46 *Id*. (citing *Brightman*, 276 Ga. at 687).
47 *Id*. at 366-67.
48 *Id*. at 366.
49 *Id*. at 367.
50 *Id*. at 367-68. *Baker* was later followed by the Eleventh Circuit in an unpublished decision, *Linthicum v. Mendakota Ins. Co.,* 2017 U.S. App. LEXIS 7840 (11th Cir. May 3, 2017), which affirmed a grant of summary judgment to an insurer which failed to respond to time limited demand within the deadline. Because the demand only included the wrongful death claim and the plaintiffs also had a potential estate claim, the *Linthicum* court held that there was no bad faith as a matter of law. *Id*.
51 276 Ga. 683, 580 S.E.2d 519 (2003).
52 276 Ga. at 686.
53 276 Ga. at 687.
54 *Id*. (citing *Cotton States Mut. Ins. Co. v. Fields*, 106 Ga. App. 740, 742, 128 S.E.2d 358 (1962)).
55 *Id*. at 687.
56 O.C.G.A. § 44-14-470.

assure the satisfaction of any hospital liens.[57] Instead, the insurer may tender limits "subject to a reasonably and narrowly tailored provision assuring that the claimant will satisfy any liens from the proceeds of the settlement payment."[58]

These cases show not all demands must be accepted unconditionally to protect the insurer from liability for an excess verdict. If the test of bad faith or negligent failure to settle is whether the insurer acted reasonably, then it should not be unreasonable to request satisfaction of liens, release of all parties insured under policy or even basic documentation of the claim before tendering limits. Yet, time-limited demand letters continue to include such conditions and insurers are left to speculate as to what response will trigger potential liability for an excess verdict under *Holt*.

AN ATTEMPT AT STATUTORY REFORM

As previously mentioned, O.C.G.A. § 9-11-67.1 was passed in 2013 to resolve some of the uncertainty *Holt* and subsequent decisions insurers have when responding to time-limited demands, as well as guide attorneys making such demands. The statute sets requirements for settlement demands in personal injury claims from motor vehicle accidents.[59] The settlement demand must be made in writing and delivered via certified mail or statutory overnight delivery (FedEx). Additionally, it must contain the following material terms:

1. Time period the offer will remain open, which must be at least 30 days;
2. Amount of the demand;
3. Party or parties to be released if the offer is accepted;
4. Type of release that the claimant will execute; and
5. Specific claims to be released.[60]

The statute was intended to curb some abuses that previously existed, such as vague settlement demands with unreasonable terms.[61] The statute provides that the recipient of a demand "shall have the right to seek clarification regarding terms, liens, subrogation claims, standing to release claims, medical bills, medical records, and other relevant facts" and "[a]n attempt to seek reasonable clarification shall not be deemed a counter offer."[62]

The statute, while a step in the right direction, arguably does not go far enough. First, the statute applies only to demands in motor vehicle claims.[63] While there are certainly many personal injury claims that arise out of motor vehicle accidents, *Holt* demands are made in many types of tort cases. Second, the statute applies only to pre-suit demands and fails to provide any guidance regarding settlement demands made after suit has been filed.[64] More important, the statute has not brought any reduction in the type of "set-up" letters routinely sent in every auto accident case.

While the legislature may have intended to curb abuses and bring certainty to the law, the statute has instead led to even more attempts to set up the insurance company, as plaintiff's lawyers think of creative ways to impose conditions and create liability. For example, some plaintiff's lawyers file suit, delay serving the insured so the insurer will not know about the lawsuit and then send a demand that obviously does not comply with the statute, hoping the insurer will treat the demand as invalid and either ignore it or respond within the time prescribed by O.C.G.A. § 9-11-67.1. While the Supreme Court of Georgia may be called upon to address this practice and others discussed below, the one decision by the court interpreting O.C.G.A. § 9-11-67.1 is not encouraging.

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57 315 Ga. App. 26, 32-33, 726 S.E.2d 488 (2012).

58 *Id*. *WellStar* is often described as a "safe harbor" for insurers confronted with unreasonable demands.

59 O.C.G.A. § 9-11-67.1(a).

60 *Id*.

61 For example, a common practice in many demand letters was to include language that any response other than unconditional acceptance would be deemed a rejection, therefore triggering potential liability for an excess verdict. Given the uncertainty in some appellate decisions as to what constituted rejection of settlement demands, many insurers were reluctant to request clarification or even inquire about the status of liens.

62 O.C.G.A. § 9-11-67.1(d).

63 O.C.G.A. § 9-11-67.1(a).

64 *Id*.

The statute provides that the insurer shall have at least 10 days after written acceptance of the offer to deliver payment to the attorney.[65] In *Grange Mutual Casualty Co. v. Woodard*, the Supreme Court of Georgia answered a certified question from the Eleventh Circuit and held that a claimant's attorney could require the settlement funds be delivered within the statutory 10-day period as a condition of settlement, even though the insurer had already accepted the offer and the settlement funds were late because of an administrative error.[66] While the Supreme Court did not address whether the insurer could be held liable for an excess judgment, the case was ultimately settled by the insurer in return for a payment well in excess of the policy limits. Most demand letters now state there is no settlement unless the settlement funds are received within 10 days of the written acceptance.[67]

There are a number of other common tactics and issues under the statute that have yet to be addressed by the Georgia appellate courts.

Affidavit of No Additional Insurance

Many demand letters impose additional conditions beyond the insurer's control, such as a requirement that the insured sign an affidavit she does not have additional insurance. The insurer has no control over what its insured does or the timing of compliance if the insured does provide an affidavit. In that situation, the insurer should address the affidavit issue in the acceptance letter, explain this is a condition beyond its control and then offer to request an affidavit.

Language in the Limited Liability Release

Demand letters will often include a proposed limited liability release and state the insurer may not suggest alternate language or the offer will be deemed rejected. At times, the release will fail to cover all elements of the settlement, such as liens. The statute allows the insurer to request clarification, so it is recommended to send a letter asking if the claimant will agree to sign a release that addresses liens, consistent with the *WellStar* decision. If the demand fails to include a proposed release, the insurer may send its release, but it is important to state it is simply a proposed release.

If the insurer is going to request clarification, it is important to do so before the deadline to accept the demand. In a recent decision, *Yim v. Carr*, the Court of Appeals of Georgia held that an insurer made a counteroffer when it sent a letter requesting whether the claimant would agree to include the named insureds on the release, even though the letter specifically stated it was a request for clarification under the statute.[68] A petition for certiorari to the Supreme Court of Georgia is pending, and it is possible that the Supreme Court will take the case.

Acceptance Letters Referring to All Claims

Some companies use form letters stating the insurer is tendering limits to settle "any and all claims" arising out of the accident. If the demand was to settle only a bodily injury claim, the claimant could take the position that the acceptance letter is a counteroffer. Again, care must be taken to state the insurer is accepting the demand presented in the letter, subject to any clarification.

Ultimately, the appellate courts or the legislature will have to address the shortcomings in the statute as attorneys inevitably try to exploit these weaknesses and create liability in excess of policy limits.

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65 O.C.G.A. § 9-11-67.1(g) ("Nothing in this Code section shall prohibit a party making an offer to settle from requiring payment within a specified period; provided, however, that such period shall be not less than ten days after the written acceptance of the offer to settle.").

66 300 Ga. 848, 858-59, 797 S.E.2d 814 (2017).

67 *Woodard* also illustrates the problem with allowing "negligent failure to settle" as opposed to bad faith. Grange Mutual accepted the offer and did everything it could to protect the interests of its insured, but mistakenly sent the settlement check to the wrong address. While this may have been negligent, it was certainly not bad faith.

68 *Yim v. Carr*, 349 Ga. App. 892, 903-908, 827 S.E.2d 685 (2019). Notably, the plaintiff then sued the named insureds under a theory of vicarious liability.

DAMAGES

The failure to tender policy limits in response to a time-limited demand does not automatically render the insurer liable for any judgment entered against the insured in excess of policy limits. As aforementioned, there must be evidence the insurer acted unreasonably in responding to the demand before it can be held liable for the excess judgment. If the jury finds liability, it is then authorized to award damages against the insurer.

A cause of action for bad faith or negligent refusal to settle sounds in tort.[69] It is founded on the breach of a duty owed by the insurer to the insured in response to a settlement demand. If the insurer breaches that duty, the insured would be entitled to recover compensatory damages — the amount of the excess judgment — and, if warranted by the evidence, punitive damages.[70]

Unlike a claim for statutory bad faith penalties under O.C.G.A. § 33-4-6, a common law claim for bad faith refusal to settle may be assigned by the insured.[71] In the typical situation, the insured will negotiate an agreement with the plaintiff following an excess verdict in which the insured assigns the bad faith cause of action to the plaintiff in return for the plaintiff's agreement not to seek recovery of the judgment from the insured's personal assets. Because a claim for punitive damages cannot be assigned under Georgia law, the plaintiff, as assignee, may only seek to recover compensatory damages from the insurer.[72] Although a claim for failure to settle within policy limits may be based on the insurer's negligence, the insured may not sue the insurer for "negligent claims handling" or any other cause of action arising out of the manner in which the insurer handled the claim.[73]

THE FUTURE OF BAD FAITH

Go to a meeting of insurance adjusters, bring up time-limited demands and you will hear about unreasonable demand letters and efforts to create a "bad faith set-up" in cases where they have legitimate defenses to liability and/or damages. Similarly, plaintiffs' lawyers tell war stories about hard-nosed adjusters who refuse to make reasonable offers in cases of clear liability, hoping to "save a little off the policy" and failing to protect their insureds. The reality probably lies somewhere in between. Not every time-limited demand is a "bad faith set-up" and not every response that is anything other than unqualified acceptance represents "bad faith." The rules will remain unclear as long as courts focus almost exclusively on whether the conduct of the insurer is reasonable, give little consideration to the content of the demand and view all but the most extreme cases as questions of fact.[74] O.C.G.A. § 9-11-67.1 is a step in the right direction as it sets clear rules that must be followed when making time-limited demands. If similar standards are applied to other types of claims, as well as cases that are already in suit, then the "bad faith set-up" may become a thing of the past and insurers will have clear guidance as to when they can be held liable if they reject time-limited demands.

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69 *S. Gen. Ins. Co. v. Ross*, 227 Ga. App. 191, 196, 489 S.E.2d 53 (1997)(citation omitted).

70 *Thomas v. Atlanta Cas. Co.,* 253 Ga. App. 199, 205, 558 S.E.2d 432 (2001)

71 *Cotton States Mut. Ins. Co. v. Brightman*, 256 Ga. App. 451, 455, 568 S.E.2d 498 (2002), *aff'd*, 276 Ga. 683, 580 S.E.2d 519 (2003).

72 *See Holt*, 262 Ga. at 270. In *Holt*, the insured was barred from seeking punitive damages from the insurer after she assigned her claim for compensatory damages to the tort plaintiff. *See also Empire Fire & Marine Ins. Co. v. Driskell*, 262 Ga. App. 646, 649, 592 S.E.2d 80 (2003) (punitive damages may not be assigned under Georgia law) (citations omitted).

73 *Camacho v. Nationwide Mut. Ins. Co.,* 13 F.Supp.3d 1343, 1363 (N.D. Ga. 2014) (citing *Tate v. Aetna Cas. & Sur. Co.,* 149 Ga. App. 123, 253 S.E.2d 775, 776 (1979)) (no basis under Georgia law to sue insurer for tortious claim handling other than claim for negligent failure to settle).

74 What insurer wants to try a "bad faith" claim to a jury after an excess verdict against its policyholder? Almost all conduct will appear unreasonable in hindsight.

Attorney Bios

Michael H. Schroder

Partner

Michael "Mike" H. Schroder is a highly experienced Swift Currie partner with a passion for trying cases. He focuses his practice on insurance defense, including matters of defense litigation and insurance coverage disputes. A fifth generation Atlantan, he has served Swift Currie clients for the entire duration of his over four decade legal career.

Mike handles automobile defense for a multinational insurer, as well as coverage work for first- and third-party insurers, including a property insurer with multiple properties and apartment complexes throughout Georgia.

Mike integrates a conscientious and diligent approach to his practice, inspiring trusted relationships with clients, colleagues and the attorneys he mentors. He is deeply vested in the pursuit of his clients' best interests and is always available to provide counsel and guidance on all matters. His motivation reflects the firm's strongest and most transparent values, the ideals he embraced early in his career while working alongside the founding partners.

Mike handles matters throughout the Southeast and has argued before the United States Court of Appeals for the Eleventh Circuit and the Supreme Court of Georgia. He is consistently named a Georgia Super Lawyer, a ranking that designates him among the most prominent attorneys in his field.

Mike is a member of the Federation of Defense and Corporate Counsel, the Atlanta Bar Association and the Defense Research Institute. He participates as a speaker, a discussion leader and a panelist for litigation seminars on numerous subjects, and he served as the dean of the Litigation Management College At Emory University for more than 10 years.

Stephen L. Cotter

Partner

With several decades of experience representing clients in thousands of matters, Stephen "Steve" L. Cotter promptly and efficiently handles complex litigation through all stages of conflict. He has successfully represented insurance carriers and businesses in a broad range of disputes, including automobile and marine accidents, wrongful death, products liability and catastrophic injury claims, as well as especially challenging matters related to toxic torts.

Steve is an avid advocate for his clients and will try cases to conclusion to secure a favorable outcome in the face of complex, high-stakes litigation. He has defended businesses through hundreds of jury trials and appeals in state and federal courts.

Steve began his legal career as an assistant attorney general in Georgia handling constitutional and public policy "impact" actions, which include class and mass actions. In private practice, he served as an administrative law judge (ALJ) by appointment by the governor to hear disputes related to several state departments.

He served as an adjunct professor at Emory Law School in the field of litigation, taught at the Georgia Defense Lawyers Trial Academy and has presented to various professional and industry groups on a variety of contemporary legal topics. Steve has also been extensively published, most especially in the insurance field.

K. Marc Barré, Jr.

Partner

Marc Barré draws on 36 years of legal experience as he defends clients in matters involving automobile litigation, premises liability, extracontractual insurance issues, insurance coverage, construction litigation and business owners' liability issues. He has resolved thousands of cases through the years, including at trial, from small matters to those alleging tens of millions of dollars in damages. His clients include large retailers, insurance carriers, restaurant chains, construction companies and transportation entities.

An experienced trial attorney, Marc has advocated for clients before both federal and state courts. He also has served as appellate counsel in numerous matters.

Over his years of experience, Marc has cultivated an ability to develop creative solutions for clients in nuanced matters that require thinking outside of the box. He is committed to providing attentive and responsive service to his clients.

C. Bradford Marsh

Partner

C. Bradford Marsh focuses on the defense of catastrophic injury, property damage and commercial cases. His practice is diverse and includes products, premises, professional malpractice and general liability cases. Brad represents automobile, electrical and heavy equipment product manufacturers, along with individual and corporate clients in Georgia and across the United States.

Brad is equipped to handle every conceivable matter that his clients have based on over three decades of litigation experience. He has handled more than 50 jury trials, as well as numerous appeals. Although he has extensive trial experience, his strong negotiating skills have led to favorable resolutions in high exposure matters, saving his clients significant amounts of time and resources.

Brad is a regular speaker in the many industry organizations he is a part of. He has also provided testimony at the Committee on Rules of Practice and Procedure of the Judicial Conference of the United States regarding changes to the Federal Rules of Civil Procedure.

Brad is a strong believer in his obligation to mentor young lawyers and serve on committees that better the legal profession. Since 2001, he has served on the Review Panel for the State Bar of Georgia's Disciplinary Board where he served as chair in 2004. He has also served on Formal Advisory Opinion Board of the State Bar of Georgia for many years and was elected chair in 2014.

M. Diane Owens

Of Counsel

M. Diane Owens specializes in products liability, employment discrimination, premises liability, environmental and toxic torts. Diane has also handled a significant number of matters involving catastrophic injury and wrongful death litigation. She practices in all state and federal courts in Georgia and is admitted to practice before the Supreme Court of the United States.

Diane graduated from Mercer University with an A.B. degree, *summa cum laude*, in 1977, and her J.D. degree, *magna cum laude*, in 1980. A member of Phi Delta Phi, Sigma Mu and Brainerd Currie Honor Society, she also served on the Mercer Law Review as associate editor. In 2011 and 2006, Diane received Mercer University's prestigious Meritorious Service Award. She has served as a member of the board of trustees for Mercer University and is currently serving as chair of the board.

Diane is a member of the Atlanta and American Bar Associations, the State Bar of Georgia, the Georgia Defense Lawyers Association and the Lawyers Club of Atlanta. She is also a member of PLAC, the International Association of Defense Counsel and Defense Research Institute, where she serves on the Products Liability Committee and the Environmental and Toxic Tort Committee. Diane has been named a Georgia Super Lawyer by Atlanta Magazine since 2005.

Diane has presented legal seminars for PLAC, Georgia State University, Insurance Law Institute, the Georgia Defense Lawyers Association (Trial Academy) and the Georgia Association of Trial Lawyers. Additionally, she was selected as a Best Lawyer in America for 2013, 2014 and 2017 to present. M. Diane Owens specializes in products liability, employment discrimination, premises liability, environmental and toxic torts. Diane has also handled a significant number of matters involving catastrophic injury and wrongful death litigation. She practices in all state and federal courts in Georgia and is admitted to practice before the Supreme Court of the United States.

Bradley S. Wolff

Partner

Bradley "Brad" Wolff defends businesses and individuals in litigation connected to products liability, premises liability and personal injury. He represents national and Georgia-based clients from a broad range of industries, including automobile manufacturers, vaccine and other medical manufacturers, school systems, professional sports teams and venues, large and small insurers and more.

Brad's diverse background includes handling matters ranging from small auto accident claims to multimillion dollar cases. He handles litigation and appellate cases in jurisdictions across the United States and is admitted to practice before the U.S. Supreme Court.

Brad spent more than 10 years as part of a team representing a national vaccine manufacturer in hundreds of claims alleging a connection to childhood autism. During this litigation, Brad helped secure victory for the manufacturers in trial and appellate courts around the country, including by participating in a briefing to the U.S. Supreme Court.

At Swift Currie, Brad is often brought into matters by other lawyers in the firm to assist with complex motions and as appellate counsel.

Brad has a demonstrated history of addressing the unique and complex challenges facing a client's business and litigation needs. Understanding that businesses rarely want to be involved in litigation, he works closely with the client to determine the best legal strategy to resolve a claim, either through settlement, trial or appeal.

At Swift Currie, Brad is a member of the firm's Executive Committee and chair of the Technology Committee. He is also a co-author of the annual insurance law summary update that is published in the *Mercer Law Review*.

Federick O. Ferrand

Partner

Frederick "Fred" Ferrand defends clients in complex, high-stakes litigation matters related to insurance claims, products liability, contract issues and other commercial disputes.

Fred handles matters across the United States, the U.S. Virgin Islands and overseas on behalf of his clients, including major insurance carriers and large multinational corporations in the hospitality, products manufacturing and risk management and insurance industries.

In addition to his litigation practice, Fred counsels businesses in matters related to establishing and maintaining subsidiaries in the U.S. for foreign corporations. Fred handles international arbitration and has litigated in the French Commercial Court in Paris.

Fred has successfully tried, mediated and arbitrated numerous cases over his decades-long career, consistently obtaining judgments in favor of his clients, as evidenced by his volume of favorable rulings and reported major cases.

Indeed, Fred helped create an insurer favorable bad faith standard in the U.S. Virgin Islands, has successfully handled multimillion-dollar claims and was named a Georgia Super Lawyer.

With more than 30 years of experience handling high-dollar litigation matters, Fred works with his clients to provide informed, effective legal solutions to their most significant business challenges. He began his career in St. Croix where he counseled a client to victory in an appellate matter that established precedent to reduce then-existing high jury rewards in the U.S. Virgin Islands. He also served as the treasurer of the U.S. Virgin Islands Bar Association.

In addition to and in support of his extensive international legal work, Fred is fluent in Spanish and French, and he is an active member of the Atlanta branch of the Italian cuisine organization, Accademia della Cucina Italiana.

Fred is highly involved in the metro Atlanta community. He was the president of the Sandy Springs Rotary Club and is an assistant governor, a role in which he helps organize initiatives to address childhood literacy, opioid abuse prevention, mentorship for underprivileged children and social enrichment for senior citizens.

Stephen M. Schatz

Partner

Stephen "Steve" M. Schatz is a skilled litigator with more than 30 years of experience handling an array of litigation matters that include first- and third-party coverage, construction defects, arson and fraud, bad faith, environmental law, property insurance disputes, products liability, toxic torts and general liability defense

Throughout his career, Steve has handled a multitude of complex coverage issues under commercial general liability, excess and umbrella, reinsurance, auto, specialty lines, D&O, disability, pollution, professional liability and personal lines insurance policies. He often represents third-party insurers in coverage matters where a case is brought by or against an insured or another insurer, and Steve has successfully pursued nearly a thousand of these cases in state and federal courts.

Steve primarily represents insurance companies who underwrite large exposure policies for commercial entities or individuals in the general liability, property and professional liability arenas. He also represents insurance companies faced with claims of bad faith in connection to claims handling and decisions, as well as time-limited demands for policy limits.

Another of his areas of practice is pursuing and defending against tenders for defense, indemnification and additional insured coverage.

Steve understands that a business' reputation is often the most valuable asset they have. He looks at the big picture and makes sure the end result of a case lines up with the overall goals of his clients' businesses. Whether he is handling a mediation, settlement or trial, Steve finesses a plan of attack to ensure the best possible outcome is achieved. He treats all cases with the same vigilance, regardless of "how many zeroes" are involved.

Steve is a dedicated, hard-working and "high motor" litigator who recognizes that with active pursuance comes favorable results. If his clients are on a tight deadline, he works tirelessly to achieve the results they desire. He values his client relationships and makes himself available whenever they need him.

Steve is a member of the Defense Research Institute, the Claims and Litigation Management Alliance, the Georgia Fire Investigators Association and the Southern Loss Association. He co-leads the coverage and commercial litigation practice team, co-chairs the Expansion Committee and is a former managing partner.

Anandhi S. Rajan

Partner

Anandhi S. Rajan counsels businesses and individuals in matters of potential liability arising from their business operations or actions and handles litigation when disputes arise.

Anandhi primarily represents management in employment matters, although she has more than 25 years of experience handling litigation in a wide variety of matters.

Anandhi has litigated claims related to products liability, premises liability, automobile liability, breach of contract, mass torts, civil rights, agency actions brought by the Equal Employment Opportunity Commission (EEOC) and Occupational Safety and Health Administration (OSHA) and other general liability cases. Anandhi also is a trained mediator, registered with the State Bar of Georgia, and provides mediation and arbitration services through BAY Mediation & Arbitration Services.

Her clients include a wide range of business entities, including large national retailers, religious organizations, manufacturing entities, staffing agencies, recruiting companies and automobile dealerships.

Anandhi works to efficiently resolve disputes with practical solutions in line with her clients' needs and goals. In addition to her extensive experience litigating cases and negotiating settlements in state and federal courts on behalf of businesses and individuals, Anandhi counsels her clients on compliance issues to avoid litigation.

Prior to entering private practice, Anandhi clerked for the Honorable Gail Tusan of the Fulton County Judicial Circuit for two years. She has also served as an adjunct faculty member at Emory University School of Law, teaching Advanced Trial Techniques to 2L and 3L students.

Terry O. Brantley

Managing Partner

Terry Brantley is licensed to practice in Georgia and South Carolina, and his civil litigation practice focuses on defending clients facing a broad range of disputes. He serves as a valued business partner and litigation counsel for corporate entities, individuals and insurers. His clients include international auto manufacturers, Fortune 500 retailers, national insurance providers, preeminent consumer and commercial product manufacturers, national restaurant and hospitality companies, and trucking and logistics services companies.

Terry's clients entrust him with their high-exposure cases, and he has served as lead trial counsel in some of Georgia's most significant matters. Leveraging his diverse trial background, along with experience from his colleagues across the firm, he provides effective counsel and ensures businesses succeed when legal challenges arise.

Terry serves as the firm's managing partner, leading its operations in Georgia and Alabama. He is also a member of several industry organizations including the PLAC (formerly the Product Liability Advisory Council), Network of Trial Law Firms, Defense Research Institute (DRI), Lawyers Club of Atlanta and Georgia Defense Lawyers Association (GDLA).

Maren R. Cave
Partner

Maren Cave is a skilled litigator who represents and defends clients in a variety of matters in state and federal court, including personal injury, premises liability, products liability, insurance coverage matters, insurance bad faith claims and general tort litigation throughout all of Georgia. She has extensive experience defending companies in significant or catastrophic injury claims.

Since beginning her career at Swift Currie 20 years ago, Maren has represented many types of insurance companies, including one of the largest insurers in the country, and she commits herself to their success by serving as a trusted adviser and business partner. Maren is an experienced insurance litigator and is co-author of the Annual Survey of Georgia Law – Insurance for the *Mercer Law Review* each year.

Maren has handled over a dozen jury trials in both state and federal court, as well as a number of cases at the appellate level, including as first chair. She has achieved successful outcomes on behalf of her clients utilizing her pragmatic approach to accomplish her clients' goals, whether obtaining summary judgment, trying a case to a favorable conclusion before a jury or reaching a resolution.

Steven J. DeFrank
Partner

Steven J. DeFrank is a Swift Currie partner with a diverse practice that includes matters related to insurance coverage, personal injury, tort liability, bad faith, arson, breach of contract, fraud and premises liability. He represents both companies and individuals.

Steven is a strong communicator who strives to give all of his clients the personal attention they deserve. He has experience with difficult negotiations where liability is clear and exposure is particularly high.

Because minimizing the likelihood of injuries is more important now than ever before, Steven also encourages and works with his clients to develop comprehensive risk management programs, code compliance resources and other preventative measures that can bring to light potential hazards. This enables his clients to address and eliminate possible safety risks up front at minimal expense, significantly reducing the potential for accidents that can lead to costly litigation.

Steven brings to his practice a strong medical background. His master's degree in biomechanics and previous work at a hospital rehabilitation center allow him to analyze claims involving injuries with greater efficiency, and provide him with an understanding of what treatments affecting overall exposure are — and are not — necessary. He also depends on this background when deposing medical professionals.

Roger E. Harris
Partner

With two decades of experience and more than 40 cases tried to verdict, Roger E. Harris is a skilled attorney and problem solver who aggressively advocates on behalf of his clients in catastrophic injury and wrongful death, commercial litigation, medical malpractice, nursing home and long-term care litigation, products and premises liability, professional liability and trucking litigation matters.

Roger has experience representing insurance carriers, their insureds and corporations. He also defends physicians before state medical boards. Whether he is negotiating a favorable settlement, going to trial or making arguments on the appellate level, he handles cases in a cost-effective and efficient manner and keeps clients fully informed throughout every stage of the process. He is a fierce advocate for his clients and does everything in his power to achieve their legal goals.

Throughout his career, Roger has held various leadership positions including finance partner, information technology partner and member of the firm expansion committee, and he is currently serving as the co-team leader for the litigation group.

Before pursuing a legal career, Roger worked as a marketing consultant in the consumer goods industry and a strategic planner in the medical device industry, which helped him develop the strategic thinking and detail orientation that he brings to his practice today. With this background, he understands every aspect of each case he works on so he can provide the guidance clients need to make informed decisions.

Ashley C. Webber
Partner

Ashley C. Webber is a partner in the firm's civil litigation section. Ashley has a diverse practice that includes products liability, premises liability, professional malpractice, environmental liability, automobile/trucking litigation and mass tort defense. She has significant experience in litigating catastrophic injury and wrongful death cases in both state and federal courts and has handled several matters at the appellate level. Ashley defends some of the world's largest heavy equipment manufacturers, lift truck manufacturers, automobile manufacturers, automotive parts suppliers and power management companies. She also defends one of the nation's largest pharmaceutical companies in a wide variety of matters. In addition to practicing in Georgia, Ashley has litigated and resolved cases in Alabama, Massachusetts, North Carolina, South Carolina, Texas and Virginia.

Ashley is a member of the American Bar Association, where she is actively involved in the Women in Products Liability (WIPL) subcommittee. She is also a member of several additional industry organizations including PLAC, Network of Trial Law Firms, Georgia Defense Lawyers Association (GDLA) and Defense Research Institute (DRI).

F. Lane Finch, Jr.

Partner

F. Lane Finch, Jr., has more than 30 years of experience counseling insurance carriers on a broad range of claims and coverage disputes, including small claims, nine-figure class action litigation and everything in between. He advises insurers on first- and third-party claims in Alabama related to construction, personal injury, products and professional liability, property and casualty claims, catastrophic injury, death, bad faith and extra-contractual disputes.

Lane's clients benefit from his role and experience as a leader in the insurance industry, including his service as the chair of the Defense Research Institute's (DRI) Insurance Law Committee. Through his connections within this 3,000-member committee and his role planning educational programming for events, Lane is uniquely positioned to stay abreast of the latest trends in insurance issues, including how courts are behaving and in what direction decisions are trending

Leveraging his vast amount of experience and extensive understanding of the insurance industry, Lane works with clients to reduce their liability through summary judgments, mediations and, if necessary, trials. In one recent case his client was granted summary judgment on the insured's claim that the defendant insurer owed defense and indemnity expenses well in excess of one million dollars.

Lane has a broad network of fellow leaders in the national insurance bar and continues to advance the discussion on the key developments affecting his clients. Lane provides unique client services, such as using his network to develop a specialized coverage training program covering all 50 states for a large national auto insurer.

Joseph J. Angersola

Partner

Joseph Angersola defends clients in a variety of disputes, with an emphasis on product liability, personal injury and commercial litigation. In addition to representing clients in Georgia, Joe has defended clients as regional and national counsel in Arizona, Florida, Kentucky, Mississippi, Nevada, North Carolina, Oklahoma and Tennessee.

Joe understands that each client, whether it is a large corporation, local business or an individual, has specific objectives and challenges in litigation. His experience in a variety of cases and jurisdictions allows him to tailor his approach to address those considerations.

Originally from Iowa, Joe practiced in Chicago for five years before moving to Georgia. He is active in various professional organizations, along with his children's youth activities.

William T. Casey
Partner

William “Bill” T. Casey, Jr., is a Swift Currie partner with over 35 years of experience defending serious injury cases. He primarily works with large insurance companies and national retailers — many of which he has nurtured long-term relationships spanning decades — on claims related to premises liability, construction defect, transportation and automobile accidents and products liability.

Bill has tried more than 100 cases to verdict, many of which involved wrongful death and catastrophic injuries. Additionally, he has served as counsel in high-profile appellate cases before the Court of Appeals of Georgia, Supreme Court of Georgia and the U.S. Court of Appeals for the Eleventh Circuit, including one of the leading cases on landowner liability for the criminal acts of third parties.

While in law school, Bill worked in the claims department of a national insurance company, which gave him unique insight that he now uses in his practice. He has a deep understanding of what insurance companies and risk managers need to know about a case. Bill also ran his own law firm for 30 years, which helped him further hone his efficiency and effectiveness as an attorney.

Bill dedicates a great deal of time sharing his knowledge through articles and lectures. As a board member of the Georgia Defense Lawyers Association (GDLA) and faculty member of its Trial & Mediation Academy, he helps young attorneys sharpen their courtroom skills. In addition, he has spoken at trial tactics seminars held by the Defense Research Institute (DRI), where he has provided demonstrations of winning closing arguments. Bill also shares his knowledge with his clients by educating them on how juries reach verdicts and what drives awards up or holds them down.

Erica L. Morton
Partner

Erica Morton has more than 15 years of experience defending insurance companies and policyholders in personal injury matters. She also handles a variety of general liability matters for corporate and retail clients who are self-insured or have high deductibles. She has handled a broad array of actions, from slip-and-fall cases and car accidents to negligent security cases involving allegations of sexual assault, as well as wrongful death and catastrophic injury cases. Erica has been instrumental in creating case law at the appellate level addressing the recovery of hospital and medical liens.

Erica brings a well-rounded perspective to her work. After being a personal injury claimant herself and then beginning her career in a plaintiffs' firm, she depends on the understanding and experience she has gained from being on the "other side of the table" as she tenaciously defends her clients.

Erica has a passion for helping her clients work through the challenges that arise in the litigation process and a willingness to explore all options, from mediation to taking a case all the way through trial or appeals. At the same time, she listens to her clients' goals and concerns and tailors legal strategies for each one based on the challenges they may experience throughout litigation or because of the specific circumstances of their cases.

Jessica M. Phillips
Partner

Jessica Phillips has over nine years of experience defending first-party property claims and third-party liability claims. She represents some of the nation's largest insurance carriers as well as third-party administrators in damage disputes and fraud matters involving roofing, arson, theft and contractor claims, among others. Jessica frequently litigates in state and federal courts and handles cases ranging from roofing disputes involving single-family homes to multimillion-dollar fraud claims.

Jessica's work primarily involves first-party property disputes, and she has developed significant skill in this area. Further, her experience in federal court exceeds that of most of her peers, enabling her to aggressively, effectively and confidently cross-examine arsonists, investigators, water mitigation contractors, roofing contractors and other witnesses.

Jessica has significant experience defending insureds in tort litigation, including slip-and-falls, intentional act cases and dog bite cases, among others.

Jessica makes a substantial effort to understand the position of each of her clients. She also brings to her work a technical and scientific background that helps her understand the complex issues in a claim. She has developed a detailed understanding of mitigation guidelines, protocols, roofing provisions, building codes, engineering papers, publications and other sources that inform her cross-examinations.

During law school, Jessica participated in two national moot court competitions, including one focused on highly technical federal insurance statutes, which continues to be important in her work today. She also was an active member of the *Mercer Law Review*, in which she was published twice, and participated in the university's nationally recognized legal writing program.

Calvin P. Yaeger
Partner

Calvin P. Yaeger practices in a variety of automobile litigation, construction law, trucking litigation, premises liability, catastrophic injury and wrongful death matters. He primarily handles slip-and-fall, trucking and automobile accidents, while also working on environmental and construction cases.

Some of Calvin's clients include insurance companies, retailers, individuals and trucking companies, and he has worked with large national organizations in the insurance, theater, restaurant, and hotel and lodging industries.

Calvin prides himself on being a thoughtful and meticulous advocate who sets mutual objectives with his clients based on realistic goals and expectations. He is an excellent communicator and is skilled at advising clients on best-case scenarios given the immutable facts and circumstances in their case. His commitment to excellence, accountability, responsiveness and transparency has culminated in proven results for his clients.

As a member of a military family, Calvin has always known the importance of being a service-oriented member of the community who makes a difference by giving back. He is an active member of the State Bar of Georgia's Young Lawyers Division and Georgia Defense Lawyers Association, as well as St. Thomas More Church.

Melissa K. Kahren

Senior Attorney

Melissa Kahren is a senior attorney with more than 20 years of experience handling matters in the firm's construction law, insurance coverage and property insurance practice areas. She primarily focuses on first- and third-party coverage litigation and liability defense with a concentration on property liability. Her practice also includes defending insureds who have been sued, such as contractors and homeowners' associations. Melissa's clients include prominent multinational insurers with offices around the globe.

Melissa joined the firm in 1999 and continues to achieve highly successful outcomes in complex, multimillion-dollar matters that have contributed to the firm's acumen, agility and preeminent reputation in the field of property insurance litigation.

Addressing the needs of clients with fast, informative and efficient solutions is Melissa's top priority. She is always available for conversations and meetings with clients to discuss thoughtful and prudent strategies that best serve and expedite clients' goals in a timely and cost-effective manner.

S. DeAnn Bomar

Senior Attorney

DeAnn Bomar has more than 20 years of experience practicing general civil tort litigation with an emphasis on products and premises liability. She also represents clients in cases involving claims of asbestos exposure and related illness.

DeAnn is experienced in handling all aspects of litigated claims and has a substantial record for obtaining favorable results for her clients, which include manufacturers of a variety of products including automobiles, elevators and medical devices. She also handles premises liability litigation on behalf of industrial and commercial owners, contractors and other occupiers, ranging from retail stores and sports and entertainment venues to individual homeowners.

DeAnn also serves on Swift Currie's Hiring Committee, in which she is involved in both the hiring and mentoring of new associates.

DeAnn is a member of the Mississippi Bar, as well as the State Bar of Georgia, having represented clients in workers' compensation matters at a firm in Jackson, Mississippi, before moving back to her home state of Georgia.

DeAnn's attention to detail, timely communication and respectful relationships with both opposing and co-counsel have allowed her to obtain dismissals based on merit and by successfully negotiating resolutions through settlements.

Alicia A. Timm

Senior Attorney

Alicia A. Timm is a senior attorney with Swift Currie who practices general civil litigation, focusing primarily on complex automotive injury, mass torts, products liability and premises liability cases.

Alicia has defended manufacturers of products and equipment from a variety of industries including automotive, industrial, pharmaceutical, trucking and consumer goods. She has also defended multiple large insurance companies, supermarket chains and individuals in litigation. Her clients include multiple automotive manufacturers, an international vaccine manufacturer and a manufacturer of industrial electrical equipment. Alicia has represented her clients in multiple state and federal courts, including those in Georgia, North Carolina and South Carolina.

Alicia has defended the manufacturers and suppliers of motor vehicles in alleged catastrophic injury and wrongful death cases relating to rollovers, airbags, seat belts, unintended movement, seat backs, interior knob and switch placement, push-button start and fire.

Alicia has handled all aspects of claim and case management from inception through trial and resolution and recently was part of the trial team in a multimillion-dollar products liability lawsuit. Additionally, she has extensive experience taking and defending depositions, and writing a wide array of motions, including dispositive motions, pretrial motions and appellate briefs.

In all cases, Alicia works to help clients reduce legal expenses, avoid litigation and favorably resolve cases short of trial. She has helped her clients achieve favorable settlements in many complex cases with disputed liability and damages. In addition, Alicia counsels to her clients on defense strategies and resolving pre-suit claims.

Tracy A. Gilmore

Senior Attorney

Tracy A. Gilmore practices in the areas of automobile litigation, insurance coverage and property insurance and is most active in premises liability and sexual abuse/assault matters.

Multinational insurance corporations are among her prominent clients, and some of her most recent cases involved premises liability, a trucking accident, a construction defect, mold litigation defense, landlord-tenant disputes and contract litigation.

Tracy's litigation experience and insurance claims background uniquely position her to understand how to best approach a case and the preparation required for successful litigation or resolution. Those experiences highlight the urgency of expediting prompt reporting and comprehensive advice and guidance, the processes that instruct claims' committees in properly evaluating and setting reserves in a timely manner.

Tracy formerly served as the deputy state's attorney in Carroll County, Maryland. In that role, she handled investigations before grand juries for more than 15 years. She also lobbied local, state and federal officials for victims' rights and laws spherically addressing children, as well as supervised and managed numerous prosecution and investigative teams, including violent crimes, gang, narcotics, domestic violence, child abuse and sexual assault units. She also served on numerous state and local commissions and task forces.

With nearly 30 years practicing law and handling high profile cases as the first chair, Tracy manages her practice through the lens of a diverse portfolio of experiences as prosecutor and litigator. In every matter, she puts great emphasis on personal relationships, building trust and developing client confidence that leads to successful resolutions.

Monica L. Wingler

Senior Attorney

Monica L. Wingler is a Swift Currie senior attorney who practices in the areas of general liability and civil litigation. She focuses her practice on premises liability, catastrophic injury and wrongful death, automobile litigation and trucking litigation matters.

Monica primarily represents insurance and retail companies. Her experience focuses on the interrelated strategies tied to the various stages of litigation, including depositions, discovery and evaluation of matters for dispositive and other pretrial motions.

Monica has worked on five jury trials in recent years, as well as numerous magistrate court trials. She also has experience with appeals and alternative dispute resolutions.

Roberta Ann Henderson

Senior Attorney

Roberta Ann “Bobbie-Ann” Henderson is a senior attorney with more than 20 years of experience focusing on commercial and civil disputes, including first- and third-party insurance coverage, surety and construction matters, business transactions and creditor rights.

Bobbie-Ann represents insurance, surety and construction companies in claims arising out of commercial general liability, personal and commercial auto, property and casualty and homeowners’ insurance policies. She also represents clients in claims and disputes arising out of construction, probate and miscellaneous surety bonds. Drawing on her experience as both outside counsel and in-house counsel, Bobbie-Ann counsels underwriters, management and adjusters in policy formation, risk transfer and claims resolution.

In addition to her insurance and surety practice, Bobbie-Ann represents a variety of large and small businesses. She handles corporate governance, commercial transactions and disputes, creditor rights and secured transactions. She has significant experience in representing businesses and individuals in bankruptcy and collection matters.

Bobbie-Ann is involved from the initial stages of a claim through final resolution, helping to examine coverage issues, identifying policy exclusions and sources of loss. She has substantial litigation experience involving bodily and personal injury, property damage, general liability, extra-contractual, construction and surety claims. She successfully positions matters for effective resolution, including interpleader, mediation, declaratory judgment and summary judgment.

Bobbie-Ann is a great listener and serves as a trusted partner and advocate for her clients. She applies creative thinking and crafts solutions that meet her clients’ needs to achieve their desired outcomes.

Prior to joining Swift Currie, Bobbie-Ann served as corporate claims counsel for Berkley Southeast Insurance Company. Her in-house experience has helped her see the claims side from the insurer and adjuster perspective and develop an understanding of the inner workings and financial considerations of insurance matters.

Janie E. Hagood

Senior Attorney

Janie Hagood is a senior attorney serving in Swift Currie's litigation section. Focusing on defending trucking and transportation companies, drivers and insurance companies, she lends more than 13 years of litigation experience to her clients in matters related to motor carrier liability and commercial insurance coverage. Additionally, her practice includes resolving automobile litigation, catastrophic injury and wrongful death, commercial litigation, construction law and professional liability claims. Janie is a member of both the State Bar of Georgia and the Florida Bar and practices in Georgia state and federal courts, as well as alternative dispute resolution forums.

Throughout her career, Janie has successfully defended her clients in high-dollar negligence claims ranging from $100,000 to $30 million and actively leverages this experience to provide effective counsel to her clients. Whether proactively avoiding claims, drafting and filing dispositive motions, or defending her clients' interests in litigation or other forms of dispute resolution, Janie works diligently to achieve the results her clients deserve.

Janie's depth of experience also includes the defense of catastrophic claims. In one case, she represented a professional architecture company sued for negligence in the unfortunate death of a minor. The case had limited liability yet vast exposure, however Janie settled the case under policy limits with a claim of damages of $50 million. This is just one example of the many cases for which Janie has obtained favorable results over the years.

Janie protects her clients' interests by guiding them in taking preemptive measures to avoid litigation and advising them of the importance of risk management. Accessibility is paramount in Janie's practice, as she encourages her clients to discuss their cases, concerns and strategies for defense.

Janie earned her J.D. from Stetson University College of Law. Prior she received her B.S. in Public Relations from the University of Florida.

Myrece R. Johnson

Associate

Myrece R. Johnson has more than 10 years of experience handling matters in the area of civil litigation and general liability, representing businesses and individuals sued in Georgia. Myrece defends premises liability suits, product liability actions, professional liability actions, catastrophic injury and wrongful death claims and general tort litigation in state and federal court throughout Georgia and the Southeast.

Myrece has experience working in all stages of the litigation process, including appeals. In addition, she has worked on toxic exposure cases involving Diacetyl and popcorn lung litigation. Her clients include auto manufacturers and nationally recognized insurance companies, to name a few.

Myrece has also obtained summary judgments for her clients in a variety of cases throughout Georgia, in both state and federal court.

Myrece joined Swift Currie in 2009. She received her B.A. in political science from Michigan State University in 2005 and her J.D., *summa cum laude*, from Georgia State University College of Law in 2009.

Myrece has defended clients in several multimillion-dollar claims, including a legal malpractice suit and a bad faith claim. She also successfully defended a client in a multimillion-dollar software dispute.

Daniel J. Kingsley

Associate

Dan Kingsley's practice includes general liability counsel and civil litigation with an emphasis on transportation law, premises liability and products liability. Specifically, he defends motor carriers, their drivers and insurers in all aspects of litigation stemming from motor vehicle collisions.

Dan is regularly involved in the defense of companies for trucking accidents, accidents in industrial settings and wrongful death suits. He also defends product manufacturers in products liability actions and warranty issues with a specific focus on defending automobile manufacturers.

Dan meticulously assesses risk in his clients' cases to develop a strategy and game plan to mitigate risk to a company and its employees. In addition to handling complex litigation matters, he navigates clients through key actions that must be taken prior to a suit being filed, including full investigation of a claim, preservation of evidence and properly addressing pre-suit demands. With this level of preparation, he also has a track record of favorably resolving cases through negotiation and mediation.

Dan ensures his accessibility to clients and is substantively involved in all aspects of his cases, including the handling of depositions, oral arguments and jury trials. While Dan can appreciate the immediate needs of a client, he is always focused on the bigger picture with a long-term strategy in play.

Marcus L. Dean

Associate

Marcus Dean represents clients in matters relating to insurance coverage, commercial litigation, automobile litigation and premises liability, including providing counsel in multimillion-dollar lawsuits. He advises clients in the resolution of claims involving arson, fraud, breach of contract, negligence and many other insurance-related and commercial disputes.

Marcus represents national and regional insurance companies, hotels, trucking companies, building owners and managers and business owners. He also conducts depositions for high-level insurance executives and business professionals.

Marcus has successfully tried cases, obtained summary judgment and argued motions for his clients in state and federal courts. He is also experienced in handling cases in magistrate courts.

Marcus also serves on Swift Currie's Hiring and Diversity Committees and has served as the chairperson for the Associate Liaison Committee for multiple years.

Marcus always aims to provide high-quality service with client-focused results, understanding that each case is different and provides a new challenge.

Marcus' flexible nature when approaching unexpected deadlines, court dates, depositions and motions and his ability to multitask under pressure help his clients achieve the very best results for their businesses.

Before joining Swift Currie, Marcus served as a judicial intern for the Honorable Kimberly Best-Staton of the Mecklenburg County District Court in Charlotte, North Carolina.

Christopher S. Antoci

Associate

Christopher “Chris” S. Antoci is a civil litigator focusing primarily in automobile litigation, premises liability, commercial litigation and subrogation. He handles a diverse scope of litigation matters on behalf of Fortune 500 corporations, small businesses and individuals. His insurance defense practice involves advising domestic and international home, auto, personal and commercial insurers.

Chris is an aggressive advocate for his clients, seeking early dismissal, dispositive motions and favorable settlement opportunities. He has extensive trial experience, including receiving defense verdicts — one of which he achieved in a clear liability case. In addition, he has resolved numerous high-value cases by way of summary judgment.

Chris leverages his previous professional background to provide clients with a unique perspective in developing effective legal solutions. Before practicing law, Chris handled extensive negotiations as a sports marketing executive responsible for closing deals with some of the largest companies in the world. He has also handled matters from the opposition’s perspective, having begun his legal career representing plaintiffs and pursuing claims similar to those he currently defends.

Jennifer L. Nichols

Associate

Jennifer Nichols practices with the firm’s litigation team and handles various general liability matters with a primary focus on premises liability cases. She has extensive legal experience representing businesses and insurance companies, as well as the corporations and individuals they insure, in litigation relating to personal injury claims, including those involving catastrophic injury and wrongful death. She routinely defends clients in cases involving injuries that occur on commercial and residential properties, such as slip-and-falls, dog bites and matters involving negligent supervision or security.

Jennifer prides herself on her professionalism, hard work and dedication as an advocate for her clients at all stages of the litigation process. She values the relationships she has with her clients and makes it a priority to be available to them when needed.

Jennifer has obtained summary judgment for her clients in numerous cases and has served as lead and co-counsel at trials in both the state and federal courts of Georgia. She has also successfully defended cases on appeal.

Brian C. Richardson

Associate

Brian C. Richardson has a diverse practice that includes work in the firm's arson and fraud, automobile litigation, bad faith litigation, commercial litigation, construction law, insurance coverage, property insurance and trucking litigation practice areas. His clients, which include large insurance companies, benefit from his extensive expertise and the open dialogue he provides related to their cases.

Brian also works with businesses and individuals on matters related to employment, wrongful death, transportation and products liability.

Brian has experience with federal Section 1983 class action lawsuits, including one matter with plaintiff demands of over $500 million, which were dismissed with prejudice during the dispositive motion phase.

Brian assisted when Swift Currie opened its Alabama office, which gave him the opportunity to work on numerous cases related to bad faith litigation involving the applicability of policy exclusions, as well as products liability, Special Investigation Unit, trucking, property and Section 1983 claims. This experience showcased his dedication to providing strong legal strategies for his clients, coupled with timely communication that keeps them informed on all the issues involving their case.

Brian brings extensive knowledge of the construction industry to his practice, which he cultivated while working as an estimator and project manager for a large, regional general contractor prior to becoming an attorney. As a result of this experience, he understands the inner workings of how the construction business operates, from the bidding process to the construction of multimillion dollar health care facilities, schools, banks and wastewater treatment plants.

R. Brady Herman

Associate

Robert Brady Herman is an attorney in the firm's coverage and commercial litigation practice group. Brady is dedicated to zealous advocacy, hard work and attention to detail on behalf of his clients.

During his final semester of law school before graduating, *cum laude*, he gained valuable experience working as a judicial extern for the Honorable Chief Justice Hugh P. Thompson of the Supreme Court of Georgia.

While in law school, Brady served as a member on the *Mercer Law Review*. He also served on the Mercer Advocacy Council as the student writing editor for Moot Court and competed in the John J. Gibbons National Moot Court competition in Newark, New Jersey. In addition, he was class representative and the chair of community service on the Student Bar Association.

Brandon J. Clapp
Associate

Brandon J. Clapp is as an associate for the firm's insurance and commercial litigation practice areas where he represents clients in matters related to insurance coverage, professional liability and commercial disputes. Brandon provides litigation services for clients at every level of court throughout Alabama and counsels clients for out-of-court resolutions.

In addition to Brandon's experience representing both businesses and individuals on insurance law matters, he has a diverse litigation background handling construction, employment, products liability and transportation cases.

Brandon brings a comprehensive perspective to litigating cases because of his multifaceted experience, from acting to resolve cases pre-suit to assisting with post-trial appellate work. Brandon also routinely advises insurance companies on matters regarding insurance coverage in Alabama.

Brandon's litigation successes include arguing a motion for summary judgment in a building products liability case in Alabama, obtaining a summary judgment for an insurer in a bad faith claim, additional insured disputes in federal court, and obtaining judgment on pleadings for an insurer in a declaratory judgment action.

Brandon's philosophy as a lawyer is to develop a strong relationship with his clients, understand their businesses and create a long-lasting partnership, ensuring successful legal results in individual cases for years to come.

Yamisi T. James
Associate

Yamisi T. James is an associate in Swift Currie's general civil litigation practice. Yamisi's practice focuses primarily in the areas of premises liability, products liability and automobile litigation where she represents insurance companies in the automobile, trucking, manufacturing and commercial business industries.

While in law school at the University of Georgia School of Law, Yamisi was a notes editor of the *Journal of Intellectual Property Law*, as well as a member of the Black Law Students Association. She also took part in the Family Violence Clinic, where she gained firsthand experience assisting victims of domestic abuse. Additionally, Yamisi was an intern for the Georgia Lawyers for the Arts, a nonprofit organization that provides legal assistance and educational programming to artists and arts organizations.

Prior to joining Swift Currie, she was an attorney for an insurance defense firm in Sandy Springs, Georgia, where she defended businesses and municipalities in a variety of matters. Before moving into private practice, she served as a judicial law clerk in Floyd County, Georgia.

David A. Smith
Associate

David A. Smith is a trial attorney who focuses on civil litigation defense, including tort claims and insurance coverage disputes. He routinely handles matters involving automobile liability, premises liability and environmental torts and has experience in all stages of litigation, including trial and appellate work.

Favorable results come from persistent investigation, compelling storytelling and a keen understanding of the law. David is known for his cogent communication style and the attention to detail he brings to each case.

Nelofar Agharahimi
Associate

Nelofar Agharahimi is an attorney with extensive experience handling automobile litigation, commercial litigation and insurance coverage matters. She primarily represents insureds and uninsured motorist carriers in personal injury, third-party automobile and premises liability cases.

Nelofar has tried approximately 40 jury trials and more than 200 bench trials including misdemeanor traffic, driving under the influence (DUI), marijuana possession and battery as well as first degree felonies, including attempted murder.

In addition to trying cases, she has drafted appellate briefs and presented oral arguments while working as a prosecutor in Miami-Dade County, as well as presenting appellate arguments before the Georgia Board of Workers' Compensation. Further, Nelofar had an opportunity to expand her writing abilities in drafting trial briefs when representing insurers and employers in workers' compensation trials.

Prior to joining Swift Currie, Nelofar worked at a mid-size firm in Atlanta where she represented employers, insurers and third-party administrators in workers' compensation matters, expanding her legal knowledge in insurance coverage issues.

While working as in-house counsel for an automobile insurance company in south Florida, Nelofar was also ranked second in closing cases among the 40 attorneys she worked with.

Nelofar was born and raised in the Midwest, growing up in Holland, Michigan. She attended the University of Michigan and received her B.A. in English literature in 2005 and her J.D. from the University of Toledo in 2008. During law school, she participated in Moot Court and represented Toledo in the Herbert Wechsler National Criminal Moot Court Competition. She spent a summer clerking in Washington, D.C., and stayed through the fall semester to attend American University Washington College of Law, where she was recruited by the Miami-Dade State Attorney's Office. Additionally, Nelofar is fluent in Farsi and has a working knowledge of Spanish.

Gillian S. Crowl
Associate

Gillian S. Crowl is an associate with Swift Currie who practices in the areas of commercial litigation, trucking litigation, catastrophic injury, wrongful death, insurance coverage, premises liability and bad faith litigation. Gillian represents corporations, insurance companies and trucking companies, as well as self-insured and small business clients. She handles matters in Georgia and North Carolina.

Gillian's practice focuses primarily on complex personal injury, insurance and business disputes. She also has experience with matters related to life, health and disability law, as well as ERISA.

Gillian has in-depth knowledge and experience handling matters involving a number of relevant laws and regulatory agencies, including the Federal Motor Carrier Safety Administration (FMCSA), the Employee Retirement Income Security Act (ERISA), the Federal Employers Liability Act (FELA), and the Georgia Department of Early Care and Learning (DECAL).

Gillian pairs her knowledge of the law with a calm and focused demeanor, which allows her to effectively represent her clients while providing the responsive service needed to keep them informed. She knows the high stakes her clients face with every case and she understands no two cases are the same, especially because the injuries, manner of injuries and causes of action are unique.

Gillian is highly active within the legal community. She currently serves as the deputy director of Region XI of the National Bar Association and serves as the Auction chair and Judicial Review Committee co-chair for the Georgia Association of Black Women Attorneys.

Clayton O. Knowles
Associate

Clayton “Clay” O. Knowles represents clients in matters related to insurance coverage, commercial litigation, property insurance, automobile liability, arson and fraud and premises liability. He has defended some of Georgia’s most prominent insurance companies and their insureds in litigation involving automobile policies, homeowners’ policies and commercial general liability policies. He has effectively litigated complex matters through trial and defended coverage disputes around Georgia.

Clay is experienced in handling depositions, hearings and trials related to first- and third-party insurance litigation. He also drafts and argues dispositive motions, evaluates coverage issues and defenses, and negotiates settlements across all areas of his practice. Clay achieves success in the courtroom by combining his skill in evaluating claims with an aggressive approach to defending his clients.

Clay is responsive, detail oriented, honest and straightforward with his clients. He always puts the client's interests first and tirelessly works toward achieving successful outcomes in an expedient and efficient manner.

Brycen D. Maenza
Associate

Brycen D. Maenza is a member of the firm’s coverage and commercial litigation practice group where she handles matters related to automobile defects, bad faith claims, uninsured and underinsured drivers involved in automobile accidents with resulting deaths and injuries.

Brycen frequently works with insurance companies, insureds and self-insureds to defend a broad range of clients, including hotels, convenience stores, general contractors and subcontractors, corporations, retailers and individuals.

Brycen is very personable and utilizes her client-relation skills to determine the primary objectives of her clients in order to craft a strategy that achieves their individual desired case outcomes in the most economical and efficient manner possible. This investment into her clients’ goals helps Brycen to creatively and proactively negotiate and resolve cases.

Brycen finds great value in effectively communicating with her clients to keep them abreast of all developments in their case — even setbacks and issues that have a negative impact on the matter. She provides comprehensive explanations related to the cases she handles so her clients feel confident their needs are always taken care of.

Anna K. Beaton
Associate

Anna Beaton is an associate in the firm’s general litigation section. Her practice focuses on trucking, premises and coverage litigation.

Before joining Swift Currie, Anna practiced insurance defense at another Atlanta law firm focusing on a range of matters from automobile accidents to medical malpractice.

Anna graduated from Emory School of Law, where she was an active participant in its moot court program and ranked in the top 10 percent as an oralist at the Legal Writing, Research and Advocacy Program – Spring 2013 Competition. She received her B.S. in government from Georgetown University in Washington D.C.

Elizabeth L. Bentley

Associate

Elizabeth "Beth" Bentley has more than five years of litigation experience and focuses her practice on assisting businesses in civil liability matters, including transportation and trucking defense and other general liability cases. She devotes a significant portion of her practice to representing insurers in coverage disputes.

Beth also has experience with litigation proceedings and appellate matters at the state and federal level and has tried cases before the Supreme Court of Georgia and the United States Court of Appeals for the Eleventh Circuit.

Lawyers can be overly aggressive and unnecessarily adversarial, which can prevent or delay a client result, but Beth takes a different approach. Her prior experience has taught her to be mindful and level-headed in litigation.

At Georgia State University School of Law, Beth was chosen as a top student in her litigation course and was honored for preparing the best brief in support of a motion for a summary judgment. Beth was also awarded third place in a closing argument competition sponsored by a local Atlanta law firm and volunteered as a court-appointed special advocate in her spare time.

Beth takes pride in working hard, working smart and recognizing priorities to achieve the best results for her clients.

Marvis L. Jenkins

Associate

Marvis L. Jenkins is an attorney with Swift Currie and focuses his practice primarily on general liability, commercial litigation and transportation law. Marvis has represented a wide variety of clients in the transportation industry, including commercial motor vehicle companies and motor carriers, their drivers, specialty haulers, bus lines and motor coaches, automobile dealerships, emergency and nonemergency transportation providers and their insurers.

Prior to joining Swift Currie, Marvis worked at another well-respected insurance defense firm in the Atlanta area. He began his legal career in Birmingham, Alabama, and remains licensed to practice law in all state and federal courts in Alabama.

Smita Gautam
Associate

Smita Gautam is a member of the firm's coverage and commercial litigation team, handling a variety of issues related to arson, property damage, fraudulent claims and general liability. Her clients include high-profile multinational insurers and automobile owners.

Smita represents clients in the full scope of insurance issues and claims, from the complex analysis of coverage to applying the principles of contract interpretation through the lens of Georgia law. Every step of the way, she meticulously manages each process to the full conclusion of litigation, including defending the coverage decisions of clients.

Smita is passionate about ensuring clients' success and meeting their obligations under Georgia law and the insurance contract in a way that best serves the client and their customers. She understands the costly potential of risk and accesses the firm's cutting-edge resources and technologies to always provide the long-range view in her counsel, carefully guiding clients to protect and position them against future conflict.

Before joining Swift Currie, Smita practiced consumer financial services litigation at a metro Atlanta firm. Her experience spans trial and appellate levels, including preparing and successfully litigating multiple dispositive motions.

Marc Hood
Associate

Marc Hood is an attorney with Swift Currie who handles matters related to insurance coverage and liability defense. He works primarily with insurance companies and high-profile restaurants in the Atlanta area.

Marc focuses his practice on diverse and complex liability issues such as premises liability, trucking and transportation, toxic torts and Americans with Disabilities Act (ADA) accommodation claims. He also has experience with matters related to negligent security and fire loss. Marc is a trusted and knowledgeable adviser who is comfortable dealing with challenging property and liability coverage questions, such as the distinct issues that arose along Georgia's coast in the wake of Hurricane Irma.

Before pursuing a legal career, Marc spent years working as an educator. This experience helped him hone his litigation and communication skills, as it gave him the ability to tailor his messages to different audiences and personalities.

As a result of his unique experience, Marc has been able to protect and defend business owners from various lawsuits and legal claims by handling coverage and liability matters exceeding $1 million, as well as complex coverage matters involving multiple lawsuits.

Marc prides himself on being an empathetic advocate who truly understands his clients' concerns and treats them with the respect and attentiveness they deserve. In addition to providing advice on their cases, he gives them guidance to help them run their businesses efficiently.

Marc has represented clients in matters related to coverage and liability claims exceeding $1 million. He has also advised clients on multimillion-dollar cases related to wrongful death, such as a significant dram shop case involving the death of a teenager.

Negin K. Portivent
Associate

Negin Portivent practices in the firm's general liability and civil litigation section, with a focus on defending clients in premises liability actions and automobile litigation. The matters she focuses on include complex product liability, personal injury, contractual dispute and simple car accident cases.

Negin primarily represents product manufacturers, retailers and individuals. She has strong communication skills that allow her to masterfully litigate on her clients' behalf, as well as help them cope with the anxiety they may feel during their cases.

Sabrina L. Atkins
Associate

Sabrina L. Atkins is a litigation associate practicing in the areas of appellate law, insurance coverage, commercial litigation, financial services litigation and insurance defense. Sabrina's practice is built from her years of experience defending bad faith claims arising out of third-party administrator services.

Sabrina has developed a successful litigation practice which includes her involvement on a national coordinating counsel team for one of the world's largest claims servicing companies, utilizing her skills to defend errors and omissions claims that may arise out of third-party administrator services and counseling clients from pre-suit coverage issues through trial.

By staying at the forefront of developing case law, Sabrina eases the burdens that may face her clients, keeping them informed and up-to-date on any potential claims that may arise.

A. Warren Adegunle
Associate

A. Warren Adegunle counsels clients in matters related to insurance coverage and other general commercial litigation disputes. He is experienced at all stages of courtroom litigation proceedings, and his exposure to a large swath of liability claims makes him uniquely positioned to handle a wide variety of claims and cases.

Warren brings a unique perspective from his past work as in-house staff counsel for a national insurance company, in which role he litigated many first- and third-party automobile insurance liability claims to successful conclusions.

Warren was also previously an attorney with the largest criminal defense firm in Georgia, where he represented hundreds of indigent clients and served as first or second chair for more than 30 jury trials.

Warren advocates on behalf of his clients to identify the most effective solution to their legal disputes, including handling every aspect of litigation from complaint to jury trial to post-trial motions. He also previously served as an intern with the White House. At the White House, he interned on the Justice and Regulatory Policy Team, where he helped vet stakeholders, organized events and performed research on assets forfeiture statutes.

In 2014, Warren received his law degree from the University of Georgia School of Law. During his time in law school, he won the DeKalb Lawyers Association Donald Lee Hollowell Legacy Award for his essay on the Second Amendment. He later won the Center for Alcohol Policy Essay Contest.

Alexander McDonald
Associate

Alex McDonald has practiced exclusively in the area of civil litigation since 2014 with an emphasis on the defense of individuals, businesses and insurance carriers in personal injury, automobile accident, construction, premises liability and insurance coverage litigation. He also advises clients on pre-suit demands, claims management, internal investigations and bad faith exposure.

Alex has served as lead counsel in nine civil jury trials across the Metro Atlanta area and dozens of bench trials and has handled multiple appellate matters.

Alex received his J.D., *cum laude*, from the University of Georgia School of Law in 2014. While in law school he was awarded the CALI Excellence for the Future Award in Civil Procedure, the Julian McDonnell Award for Excellence in the Study of Commercial Law and the 2013-2014 Outstanding Articles Editor Award for the *Georgia Journal of International and Comparative Law*. Alex graduated from the University of Georgia in 2010 with B.A. degrees in music and political science.

Kevan G. Dorsey
Associate

Kevan G. Dorsey is an attorney on Swift Currie's litigation team and represents clients in an array of matters including transportation and automobile liability, premises liability and product liability.

Kevan and his colleagues in the practice handle all aspects of dispute resolution and litigation for corporations, organizations and individuals. He also has experience representing medical and dental professionals, hospitals and nursing homes.

Through Kevan's litigation career and collegiate sports, he has learned to fervently face adversity and utilize teamwork to accomplish common goals, which gives him a competitive advantage. These characteristics provide a solid foundation as he continues to fight for his clients and work with his legal team to accomplish their objectives.

Kevan's foremost goal is to understand each client's issues so he can effectively and efficiently resolve their case. As a result, Kevan's clients receive exceptional service and cost-effective results that build mutually prosperous and lasting client relationships.

Kevan has worked on a wide array of cases, ranging from multimillion-dollar wrongful death actions to minor soft tissue injury cases. Each case presents a unique opportunity to represent the client. No matter the monetary value, each case is closely dissected and analyzed to ensure the client's desired outcome is achieved. Kevan has an open line of communication with his clients and keeps them informed throughout the entirety of their case.

Jordan M. Mahoney
Associate

Jordan M. Mahoney is a skilled attorney who handles matters in the areas of premises liability, catastrophic injury and wrongful death and automobile litigation. He is a zealous client advocate who works with large retailers, property owners and motor carriers — as well as their drivers and insurers — on a broad range of litigation issues.

Jordan's unique experiences throughout his career have helped shape his professionalism and efficiency. Before working in civil defense, he spent four years as a plaintiff's attorney, which gives him a unique perspective on strategy and the calculus that informs how decisions are made throughout the course of a case. In addition, Jordan has experience representing large corporations and small businesses so he understands the challenges they face and the long-term ramifications litigation can have on their operations.

Sean P. Farrell
Associate

Sean P. Farrell represents insurers, businesses and individuals in commercial and insurance coverage litigation matters. He defends clients in a variety of legal matters, including arson and fraud cases, commercial litigation, premises liability and insurance coverage disputes.

Sean handled a high-volume plaintiff caseload for a large insurance company that included subrogation and personal injury matters, lending him extensive familiarity with the perspective of opposing plaintiff attorneys and how the insurance industry handles claims and suits.

This knowledge helped Sean to successfully litigate approximately 12 jury trials to verdict in the past three years, as well as numerous mandated arbitrations. He also assisted in the defense of diacetyl litigation on behalf of a national chemical company.

As an aggressive advocate for his clients, Sean's goal is to make their experience during litigation as painless as possible. To achieve this, Sean extends knowledgeable, trustworthy and collaborative service to not only his clients but also his colleagues in the practice.

Prior to joining the firm, Sean practiced at a law firm in Chicago where he focused primarily on subrogation and insurance defense matters through every stage of litigation for large insurance institutions.

Brianna S. Tucker
Associate

Brianna Spann Tucker practices in the firm's civil litigation section defending businesses in premises liability matters, car accidents and uninsured motorists claims. Her clients primarily include retailers and insurance companies.

Brianna's foremost priority is to protect clients' legal interests in all matters. Her strategic planning and balanced, disciplined approach lead to successful outcomes.

Before joining Swift Currie Brianna was the staff attorney for the Honorable Philip C. Smith in the Superior Court of Forsyth County. Brianna lived in Spain and taught English there for a brief period. She loves traveling, particularly to Spain, and is an avid runner.

Murray S. Flint
Associate

Murray S. Flint is an associate in the firm's coverage and commercial litigation practice area. He handles arson and fraud claims, advises insurance carriers on coverage issues and defends companies both before and during civil litigation.

Additionally, Murray represents businesses and individuals in the areas of construction defects, premises liability, product liability, personal injury and appellate advocacy.

Murray has tried multiple high-exposure cases to verdict and prepared successful briefs in both state and federal appellate courts. He has defended companies in a variety of complex disputes, including one matter where the plaintiff claimed approximately $20 million in damages.

Murray's top priority is protecting his clients' legal interests, and he strives to make their lives easier by doing so. He understands that whether his clients' legal matters are personal or professional, there is always something at stake. He seeks to provide his clients with the best solution to every legal matter they face.

Murray credits his father for teaching him the meaning of hard work and overcoming adversity, which has shaped his perspective on helping clients and winning cases.

Jenna B. Rubin
Associate

Jenna B. Rubin is an associate in the firm's general litigation section, focusing on the areas of insurance coverage and trucking litigation. Her practice concentrates on matters related to motor vehicle accidents that have caused bodily injury, as well as cases that involve property damage and insurance coverage issues.

Jenna represents insurance companies and self-insured trucking companies and their drivers. She leverages her expertise and knowledge on the Federal Motor Carrier Safety Act and related regulations to help achieve her clients' legal objectives.

Prior to joining Swift Currie, Jenna worked as a staff attorney and appellate jurisdiction specialist at the Eleventh Circuit Court of Appeals where she assisted with the disposition of criminal and civil appellate cases.

Kristen M. Vigilant
Associate

Kristen M. Vigilant practices in the areas of commercial litigation and insurance coverage, counseling clients in matters related to arson, fraud and premises liability, in addition to her work with subrogation claims.

Almost from the start of her career, Kristen's clients have appreciated that she is approachable and personable. She also makes it a high priority to be responsive to and available for her clients.

During law school, Kristen served as a judicial extern for the Honorable L. Scott Coogler in the United States District Court for the Northern District of Alabama, and she was a law clerk in the Alabama governor's legal department. She was also the editor in chief of the *Law & Psychology Review.*

Kristen further cultivated her mediation skills by working at her law school's mediation clinic. In addition, she completed more than 140 hours of community service — 50 of which were pro bono work — and was honored with the Order of Samaritan award as a result of these efforts.

Avery G. Carter
Associate

Avery G. Carter focuses his practice primarily on the areas of commercial litigation, automobile litigation and premises liability. Avery typically handles matters for a variety of insurance companies.

Avery prides himself on building a strong relationship with clients and works to help guide them through various challenges, such as when an insurer and insured do not agree on the defense strategy.

Prior to joining Swift Currie, Avery interned for the Honorable Wilford Taylor of the Eighth Judicial Circuit of Virginia. In addition, he achieved the highest pro bono award during law school.

Avery graduated, *cum laude*, from the University of Florida Frederic G. Levin College of Law in 2018. While there, he served as an executive board member of the Florida Moot Court Team. He was also a teaching assistant for Trial Practice Spring 2018. Prior to law school, Avery graduated, *magna cum laude*, from North Carolina State University in 2015 with a Bachelor of Arts in political science and international relations.

Leah F. Parker

Associate

Leah F. Parker practices in Swift Currie's premises liability, trucking litigation and automobile litigation practice areas. She handles slip and fall cases as well as automobile accident matters, including car and trucking accidents and uninsured motorist claims. She also has experience working on cases related to dog bites, employment discrimination and wage and hour disputes, and nursing home and long-term care matters. In the past, Leah has also handled workers' compensation matters.

Leah represents major insurance companies, as well as the individuals and businesses they insure. She also has experience working with many retail stores and restaurants, including large chains and small family-owned businesses.

Leah has handled a wide range of issues and her extensive experience gives her insight into her cases and allows her to use creativity in resolving them with favorable settlements, effective depositions and with strategic motions and legal arguments.

Leah understands the personal, and often traumatic, nature of the cases she works on, therefore she makes an effort to help clients deal with both the legal and emotional ramifications of the case. As a result, she is able to ensure her clients can make the best decisions as they navigate their way through the issues that arise during the process.

Rebecca M. Beane

Associate

Rebecca Miller Beane practices in the areas of general liability and civil litigation with an emphasis in products liability, construction law, premises liability and commercial litigation.

The scope and breadth of Rebecca's practice informs her acumen and capabilities to serve clients. Drawing from a deep well of experience, her versatility is the strength that leads to success representing a large roster of clients that includes billion-dollar companies, such as global insurers, a media conglomerate, a designer and manufacturer of electrical transporters, wealth management companies and more. She has also represented design professionals, general contractors and a host of subcontractors in the industries of roofing, waterproofing, stucco, landscape and irrigation, among others.

Rebecca practices in both state and federal courts and she has handled several matters at the appellate level.

Rebecca adheres to the timeless values of responsiveness, open communication and progressive solutions. She endeavors always to provide integrated solutions that protect clients' legal interests, taking into account a constellation of factors affecting business operations and risk exposure.

In her first three years of practice, she served as the associate to the school board attorney for four county school boards. Before joining Swift Currie, Rebecca practiced in the construction group of the largest civil defense law firm in Florida.

Sara Alexandre
Associate

Sara Alexandre is an associate with the firm's civil litigation section. Her practice includes defending clients in the areas of catastrophic injury and wrongful death, products liability, automobile and trucking litigation, premises liability, medical malpractice and professional liability. Sara also has experience handling healthcare law litigation and ERISA matters. She is a client-focused attorney who primarily works with insurance companies.

During law school, Sara was a judicial intern with Supreme Court of the State of New York and was an intern with the Supreme Court Library of the State of New York.

Lauren P. Kamensky
Associate

Lauren P. Kamensky practices general civil litigation, with an emphasis on automobile, trucking, premises liability and construction litigation defense. She has experience working with claims at every stage, from pre-suit investigations through all aspects of litigation.

When facing challenging situations in her clients' matters, Lauren develops creative and innovative approaches to resolve issues efficiently.

During law school, Lauren interned with the U.S. Bankruptcy Courts for the Middle District of Florida and Northern District of Georgia. She also served as the executive managing editor of the *Emory Corporate Governance and Accountability Review.*

Hannah Beth Reynolds
Associate

Hannah Beth Reynolds is a Swift Currie attorney who handles matters in the firm's commercial litigation and insurance coverage practice areas. She represents business owners and insurance companies on diverse coverage and litigation cases.

Hannah Beth has experience with matters related to contract disputes, construction defect claims, insurance fraud, simple automobile accidents, general liability and personal injury. She also gained appellate experience when she was a judicial extern for Judge Stephen Louis A. Dillard at the Court of Appeals of Georgia.

Raqketa D. Williams

Associate

Raqketa D. Williams is a general civil litigator handling personal injury claims arising from automobile accidents, as well as slip-and-fall and other premises liability incidents, products liability matters and insurance contract issues. She represents both corporations and individuals, including a well-known transportation and logistics provider, some of the largest insurance carriers in the nation and a global hospitality company, among others.

Over the course of her practice, Raqketa has tried both jury and bench trials throughout Georgia and taken or defended more than 100 depositions. She also has experience briefing, arguing and winning motions for summary judgment and has resolved cases favorably through alternative dispute resolution.

Raqketa brings to her practice not only a zeal for advocacy, but also an ability to conceptualize solid plans and enact concrete steps to bring those plans to fruition. Further, as a female attorney of color, her ability to draw on diverse experiences benefits her clients and those around her.

Prior to joining Swift Currie, Raqketa served as in-house counsel for one of the largest property and casualty insurers in the U.S.

While in law school, Raqketa clerked for the Equal Employment Opportunity Commission. She also assisted in authoring a textbook on alternative assessment methods in legal education.

Christine H. Lee

Associate

Christine H. Lee is an attorney in the firm's coverage and commercial litigation section with a practice divided between providing coverage opinions for fraud cases and serving as defense counsel in insurance coverage, arson, premises liability, automobile and commercial litigation. Her experience representing both insurers and businesses in all forms of commercial disputes, as well as plaintiffs in personal injury litigation, allows her to have a particularly practical approach to defending those facing a threat of commercial liability.

Christine strives to provide each of her clients with practical and user-friendly advice, while caring deeply about providing quality work and results with a combination of approachability and understanding. Zealous and efficient both inside and outside of the courtroom, she has counseled clients through legally and emotionally fraught claims involving large monetary losses as well as physical injuries.

Christine truly believes Swift Currie's commitment to community shows that people-focused legal services result in better advice, counseling and outcomes. During her time in law school, she was awarded the ALI CLE Scholarship and Leadership Award, the highest pro bono and public service distinction, and the opportunity to be a pupil in Bleckley Inn of Courts.

Christine also served as a symposium editor on Georgia State University's Law Review board. She also served as vice president of the Student Trial Lawyers Association and chairwoman of the Public Interest Law Association's annual fundraiser, and competed in national mock trial competitions.

Lauren E. Meadows

Associate

Lauren E. Meadows is an attorney in Swift Currie's commercial litigation and insurance coverage practice areas, who represents insurance companies and their insureds.

Lauren's diverse litigation background enables her to handle any type of matter related to insurance issues. In addition, she has worked on several lawsuits that garnered media coverage for her clients, so she is able to counsel organizations on the specific issues related to their cases as well as how to handle the press.

Lauren has experience with various aspects of insurance coverage and commercial litigation in both state and federal courts, which has helped her develop a unique approach to her cases.

A detail-oriented multitasker, Lauren always tries to make a difficult litigation process less stressful for the client.

Riley W. Snider

Associate

Riley W. Snider represents insurance carriers in a broad range of commercial litigation and premises liability matters, as well as wrongful death claims. Prior to joining Swift Currie, Riley represented individuals and businesses as both plaintiffs and defendants in complex commercial litigation involving breach of contract, fraud, accounting and fraudulent transfer, as well as employment cases involving wage and hour discrimination. His experience includes jury trials in Georgia Superior Court.

In addition to his law degree, Riley has a financial background and received a joint MBA while in law school. This enables him to understand the business side of his clients' needs and legal concerns and has led to experience handling delicate and sensitive matters. For example, he represented individuals in a highly contentious, multimillion dollar "business divorce" in which family members accused one another of engaging in fraudulent transactions, breach of fiduciary duties and self-dealing. Riley helped all parties walk the fine line of keeping family and business separate so he could assist his clients with making deliberate business decisions.

Riley understands the importance of teamwork, strategic thinking and efficiency in order to provide the highest quality service to his clients while reining in costs. His clients appreciate that he is dedicated and hard-working, yet personable.

While in law school, Riley served on the *Mercer Law Review* and was an academic success mentor.

Alexander A. Mikhalevsky

Associate

Alexander “Alex” A. Mikhalevsky represents some of the largest property and casualty insurers in the United States in first-party coverage matters and bad faith litigation. He has significant experience handling claims related to suspected arson, fraudulent theft of property and vehicles, disputes over scope of loss and other coverage issues, both prior to and throughout litigation. His work has included investigating and defending insurers in seven-figure personal and commercial claims involving total losses, deaths and significant injuries.

Over the course of his career, Alex has handled more than 100 claims with multimillion-dollar exposures and tried over 20 cases.

Prior to joining Swift Currie, Alex worked as a claim manager at an insurance company where he handled commercial claims involving large losses, catastrophic injuries, deaths and coverage issues. This inside experience has given him a unique understanding of his clients' needs that he applies as he investigates and litigates their claims.

While in law school, Alex interned with the Supreme Court of Georgia. He also tried dozens of misdemeanor criminal cases during an internship at the Gwinnett County Solicitor's Office.

Kathryn B. Robertson

Associate

Kathryn “Katy” B. Robertson is an insurance defense attorney who handles trucking, automobile, medical malpractice, and premises liability claims and litigation.

During a hiatus from the legal field, Katy worked as a public relations associate where she honed writing and editing skills that are invaluable in her litigation practice. She also gained an ability to make a more personal connection with her clients through this experience. Combined with her commitment to accessibility and willingness to spend the time her clients need from her, she has helped her clients become comfortable working with her and confident in her commitment to their success.

Katy has given back to her community by providing pro bono legal services to the homeless through the Christian Legal Society, as well as volunteering with Junior League.

Brendan S. Thompson

Associate

Brendan S. Thompson has exclusively dedicated his career as an attorney to insurance defense matters. He focuses his efforts on defending his clients in cases related to personal injury, premises liability, coverage disputes and automobile accidents.

Over the years, Brendan has developed his practice through his successful representation of well-known companies, which include national insurers where he handled automobile, homeowners and commercial general liability claims. Additionally, Brendan has defended a major airline in personal injury and baggage claim matters.

Brendan understands that handling insurance claims properly on the front end is key to resolving claims in a cost-effective manner and he provides his clients with the tools to do so. As the insurance industry is ever changing, he guides his clients to stay in the know of the latest rules and developments to come out of the jurisdictions in which they operate.

As an avid traveler, Brendan has met people from around the world with diverse backgrounds and varied experiences. His travels have helped shaped his perspective and given him the ability to work efficiently with an array of clients. Brendan is steadfast in getting to know his clients on an individual basis in order to adjust his approach to their needs and believes communication is essential to a productive relationship.

While earning his J.D. at the University of Arkansas, Brendan clerked for a circuit judge and at a personal injury firm. Prior, he graduated from the University of Central Florida with a B.A. in history.

Lauren R. Smith

Associate

Lauren R. Smith is an attorney practicing in the firm's coverage and commercial litigation section with a concentration on automobile litigation, insurance coverage, premises liability and property insurance.

Lauren has made more than 200 appearances in court, conducting both bench and jury trials. She also has extensive experience with complex mediations and has aided in more than 20 appellate cases.

Throughout her years of practice, Lauren has come to recognize the immediate impact the legal system can have on her clients' lives. This understanding drives her to build personal relationships with her clients in order to provide them with effective, individualized service through her zealous representation. She views problems from a pragmatic perspective and focuses on creating solutions tailored to her client's circumstances, needs and goals.

While earning her J.D. at the Georgia State University College of Law, Lauren stayed active as a coach and participant of Moot Court, president of legal fraternity Phi Alpha Delta, national finalist of the Student Trial Lawyers Association and a member of the Public Interest Law Association. Prior to law school, she received her B.S. in English from Auburn University.

Amy D. Katz
Associate

Amy D. Katz is an attorney practicing in Swift Currie's coverage and commercial litigation section, with an emphasis on commercial litigation, construction law and insurance coverage. An adept written and oral communicator, Amy employs her approachable character and negotiation skills to firmly advocate for her clients.

Engaged in all aspects of litigation, Amy has worked closely with national clients and other outside counsel on an array of cases. She has defended architects, engineers and other design professionals in construction litigation, professional malpractice, general liability and insurance coverage claims. A former e-discovery attorney and legal researcher and writer, Amy is highly analytical and well-versed in technical research methodology.

Amy's top priority is providing her clients with excellent representation and in-depth legal knowledge. She continually advances her skills and stays involved in the legal community by remaining an active member of the Claims and Litigation Management Alliance, the Construction Law Section of the State Bar of Georgia and the Georgia Association for Women Lawyers.

While attending the University of North Carolina School of Law, Amy was a member of UNC Law Moot Court's environmental negotiation team and a research assistant at the UNC Center for Civil Rights. Prior, she earned her B.A. in English and Spanish, magna cum laude, from Salem College.

Anelise R. Codrington
Associate

Anelise R. Codrington concentrates her practice on the defense of insurance companies and government entities in matters related to automobile litigation, premises liability, insurance coverage and governmental liability.

Prior to joining Swift Currie, Anelise served as a judicial law clerk in the Clayton County State Court where she gained significant insight into civil cases from the view of the bench. She extends this knowledge to her clients in her current practice as she effectively counsels them throughout their cases.

Anelise is highly involved in the legal community, participating in the Clayton County Bar Association, Gate City Bar Association, Georgia Association for Women Lawyers and Mercer University School of Law Black Law Student Association Alumni Council. As a member of the Young Lawyers Division Intrastate Moot Court Competition Committee of the State Bar of Georgia, Anelise drafted the bench brief for the 2019 competition.

Anelise underwent a life-changing experience that shaped her into the person she is today when she immigrated to Atlanta from England at the age of 17. She gained perseverance and strength through leaving her home and family behind at a young age and now applies her determined mentality when resolving issues for her clients by strictly adhering to deadlines while reviewing matters with a careful eye.

While earning her J.D. at Mercer University School of Law, Anelise authored "Bitter Fruit, Lynching and the Legislative Reform to End It: A Timeline of Lynching and its Transformation into the Contemporary Era" for the Southern Journal of Policy and Justice, a publication that promotes legal scholarship examining the intersection of race, ethnicity, socioeconomic condition and the law. Additionally, she was awarded Georgia Defense Lawyers Association's Rusty Gunn Award, which recognizes a student who quietly leads with strength, intelligence and good humor.

Justin E. Jorgensen
Associate

Justin E. Jorgensen is a civil litigation attorney focusing his practice on the defense of matters related to commercial litigation, insurance coverage and premises liability.

As a judicial law clerk personally assisting Judge Leah K. Seaton in the Circuit Court for Wicomico County, Maryland, on more than 1,000 cases and nearly 50 jury trials, Justin gained experience successfully handling a high case load involving criminal matters and civil cases ranging from attorneys' fee issues to boating contract disputes.

Justin also interned for the City Attorney of Richmond where he helped defend the city against claims made under the Americans with Disabilities Act (ADA). During his internship, Justin prepared a 20-page memo regarding an employee's claim against the city. His memo facilitated the settlement of the claim for far less than the city's maximum settlement goal before a federal magistrate judge, who agreed with his legal analysis.

Justin is diligent on the front end of litigation preparation to help his clients avoid jury trial. In the event a trial is necessary, Justin's tireless work ethic and open communication style ensure he provides the work product necessary to achieve optimal results for his clients.

While earning his J.D. from the University of Richmond School of Law, Justin was consistently recognized as one of the top intellectual property students in his class. In addition to winning the Virginia State Bar Intellectual Property Law Student Writing Competition, Justin received the CALI Excellence for the Future Award in trademarks and unfair competition and the Auzville Jackson Jr. Award for Excellence in Intellectual Property, an award given at graduation to only one student.

Shannon P. Auvil
Associate

Shannon P. Auvil practices in Swift Currie's civil litigation section with a focus on providing defense counsel to companies involved in premises and products liability matters, as well as insurance coverage issues.

Before joining Swift Currie, Shannon served as a law clerk to the Honorable Michele J. Kim in the U.S. Bankruptcy Court for the Southern District of Georgia. The sensitive nature of her work in this position demanded a great deal of integrity and precision, which she continues to apply in her current efforts to deliver favorable results for clients. During law school, Shannon worked as a legal intern for the U.S. District Court for the Northern District of Alabama and the U.S. Army Legal Services Agency.

As she earned her J.D., Shannon stayed active as the executive editor of the Alabama Civil Rights & Civil Liberties Law Review. Shannon also won several awards, including first place in the Louis Jackson National Student Memorial Writing Competition in Employment and Labor Law, Order of the Samaritan Award for pro bono and volunteer work, and the Best Mediator award from the University of Alabama School of Law Mediation Clinic.

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