Some Signs Of Bad Faith Insurance Claims Settlement Practices

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The following are some examples and indicators of **bad faith insuranc**e claims settlement practices and a few of the signs that may be indicative to make you aware that you are or may be **dealing with a bad faith insurer**. The following have been identified and compiled as some of the potential signs of bad faith insurance claim settlement practices. These signs are not meant to be offered as legal advice nor should be construed as legal advice. FBIC is a **consumer advocacy** as well as an educational non-commercial media that specializes in identifying and ranking good and bad insurers based on their good faith and bad faith insurance claims settlement practices. FBIC is neither a court of law nor legal counsel, so accordingly nothing indicated herein should be taken or construed as legal advice. In order to establish whether an insurer is in violation of "**Bad Faith**" insurance laws, "**Unfair or Deceptive Insurance Claim Practices**" laws and/or is not acting in good faith, must be decided and is determinable **only by a court of law** according to the specifics of the case, the court's applicable interpretation of statutes and case laws which may vary by state. When questioning or in doubt consult your state's bad faith insurance claims settlement practices and other pertinent statutes, case laws and key applicable court interpretations ... and most importantly, if you feel your **insurer may be guilty of bad faith**, **unfair claims settlement practices and/or other pertinent illegal insurance practices** and you feel you require legal advice, you should seek legal counsel from a licensed attorney admitted to the BAR and in good standing in your state or jurisdiction who is knowledgeable and familiar with the issues raised. (click here to read FBIC's Legal Disclaimer and Copyright.) As indicated and referenced, although subject to a court's specific bad faith findings in each case and state, the following are a few referenced "**Signs Of Bad Faith Insurance Claims Settlement Practices**" which have been identified and

compiled as being **potentially indicative** if not common and/or **contributory signs of bad faith insurance claims practices**.

1. An insurer may be acting in bad faith if the insurer delays, discounts or denies payment without a reasonable basis for its delay, discounting or denial.
2. Failure of insurer to acknowledge and reply promptly upon notification of a covered claim.
3. Failure of Insurer to pay a covered claim as a result of failing to do a proper, prompt and thorough investigation as to reasonable liability and damages based upon all available information. (*did not respond to my initial letters asking for information)*
4. Failure of insurer to affirm or deny coverage of claims within a reasonable time upon receipt of claim and/or proofs of loss.
5. Failure to offer or attempt to effectuate prompt, fair and reasonable evaluation of damages and equitable settlements of claims to insured within a reasonable time where liability is reasonably clear.
6. Insurer attempts to settle a claim for less than the amount to which a reasonable person would have believed was entitled or attempts to substantially diminish a claim requiring an insured to initiate litigation.
7. Attempting to settle claims on the basis of an application and/or policy which was altered without notice, knowledge or consent of the Insured.
8. Making payment(s) for claims without accompanying statement indicating the coverage for which payment(s) are being made. *(Overriding the system, to pay for some patients, patient D.G.)*
9. Insurer failure to make known any arbitration award appeals policy in an attempt to settle a claim for less than the arbitration amount awarded.
10. Insurer requiring claimant or physician to submit both a preliminary claim report and formal proof of loss forms which contain substantially the same information.
11. Failure of insurer to promptly settle claims, where

liability and coverage is reasonably clear under one portion of the insurance policy in order to influence settlements of coverage for another portion(s) of the policy.

12. Failure of insurer to promptly provide reasonable explanation and basis when denying or making a compromise offer of claim settlement.

13. Failure of insurer, when making a cash payout to settle a first party auto insured claim, to pay the same amount which the insurer would pay if repairs were made.

14. Requesting over burdensome documentation demands not required by the policy. *(and not for other practices)*

15. Reference or focusing on recovering on the uninsured portion of the loss.

16. Using illegal and fraudulent investigative methods and procedures. *(Initial [redacted] person coming in without notice)*

17. Using harassing, intrusive or demeaning investigative methods and procedures which victimize the insured.

18. Failure of an insurer to settle a claim directly, when and where settlement is required, and instead requiring the insured to pursue a claim against another party first *(directing towards APA)* before offering settlement.

19. Failure of Insurer to make full and satisfactory payment of a first party claim prior to requiring settlement or exhausting the limits of a third-party insurer (i.e. in uninsured motorist cases).

20. Failure of Insurer to unreasonably refuse to waive subrogation thus hindering or preventing a claimant from reaching settlement with the party at fault (i.e. in uninsured motorist cases).

21. Unjustified contention and/or "lowballing" regarding the value of a loss.

22. Intentionally withhold, misinterpret or misconstrue claims information and/or failure to not inform insured of provisions and covered benefits under the policy pertinent to a claim.

23. Attempts to use indiscriminate measures, reference and/or procedures that diminish or reduce the top line amount or value representing full payment of the claim.

24. Intentional or irresponsible non-disclosure and withholding of information, misinterpretation of file documents and/or policy provisions, that would be in favour *(another practice)* of the claimant.*(non-compliant to* [redacted] *or Physio rules)*
25. Unsubstantiated and unwarranted accusations of arson.
26. Wrongful threats not to pay claims. *(HCCC)*
27. Utilization and/or development of deceptive insurer schemes or use of outside company services set up or conducted to carry out the same false pretense schemes (i.e. "Independent Medical Examiner Paper Reviews") for the purpose to be able to wrongfully deny or reduce payment of claims.
28. Insurer advice to claimant not to hire a lawyer.
29. Treatment of insureds represented by attorneys as insurer adversaries.
30. Treatment of insureds and claimants as adversaries.
31. Significant increase in amount of premium as a result of making a claim where insured was not at fault and in conflict with industry standards.
32. Cancellation of a policy as a result of making a claim or result of an accident where insured was not at fault and in conflict with industry standards.
33. Failure to live up to, conform or comply to industry standards.
34. Using inaccurate or wrongful information of a factual or legal nature to diminish, deny or delay payment of a claim. *(wrote to the ombudsman stating they replied to my contacts points. They did not at all initially)*
35. Not being forthcoming with facts regarding coverage to deny, delay or reduce the amount of the claim.
36. Using extreme undue persecution, wrongful and victimizing tactics and actions, meant to crush, threaten, thwart, intimidate, oppress, in order to scare away and get the claimant not to make or pursue a claim.
37. Failure to convey to insureds settlement offers and demands of adversaries in accident and liability cases.

38. Changing or altering policy coverage without informing or receiving the consent of insured.
39. Representation by an insurer that an investigation "of fact" is taking place, knowing that no investigation is being done*(I would really like to get an authority to check if an investigation ever got done on the practice P.C.)*, in order to intentionally stop and dismiss an inquiry by a plaintiff, plaintiff's attorney or DOI examiner.
40. Biased investigation of that which is supposed to be neutral and unbiased.
41. Utilization of internal one-sided or outside companies biased schemes, such as in so-called "IME" bias (independent medical examiner bias), which are supposed to be objective and neutral *(PHIO),* in order to wrongfully enable, facilitate and support insurer's position to fraudulently deny, reduce or discontinue payments of claims.
42. Repeated and constant reference and intentional miscommunication *(no response to initial letters)* and misrepresentation by insurer *(P.C.)* downplaying the size of a claim to insured's attorney.
43. The same claims person of an insurer handling conflicting and both *sides (uneven treatment compared with* [redacted] *and P.C.)* of the same or related claims.
44. Deviating from standard procedures *(P.C. was the only practice in Australia to claim classes.* [redacted] *claim they did an audit on P.C., however this practice did 3 assessments in 8 years and had up to 24 people in a session)* called for in an insurer's claims manuals.
45. Attempting to prevent the court or an insured's attorney with due exception from securing a copy of an insurer's claims manual.
46. Abusing and/or misusing the judicial court system in order to delay or settle in good faith payment of a claim where liability to the claim is clear and amount of the claim is reasonable in order to delay insurer's having to make payment of a claim.
47. Fraudulently misrepresenting and revealing various

conflicting financial information that mischaracterizes the true financial information and status of an insurer.

48. Attempting to shift *blame* *(saying the APA should have communicated with me)* and responsibility of investigation to insured and away from the insurer.

49. Threatening to harm *(harming my practice)* insured and/or take legal action against *(repayments)* an insured to recover amounts paid by insurer as in a short-term workmen's compensation or short-term disability claim in order for insurer to discontinue having to make payment on a longer or long-term basis.

50. Insurer refusal to settle a third party claim against an insured within the limits of the insured's policy thereby exposing the insured to additional liability.

51. Intentionally misinterpreting or misconstruing *(the physio rules)* the law to the disadvantage of the insured and benefit of the insurer.

52. Deny treatment for a covered health benefit because of its expensive cost and instead misrepresenting and suggesting a less costly procedure in its place to be just as effective when it is not.

53. Unreasonable denial of a covered health benefit because of its high cost.

54. Unreasonable misinterpretation of policy language.

55. Taking undue excessive advantage of unlimited *time* *(2 ½ years and still unresolved)* when knowing there may be no time limitations established on alleged investigations of such matters or matters of fact.

56. Making health insured patients pay their standard copay when the cost of both the drug and the pharmacy's fee for dispensing the managed care prescription is lower than the copay amount.

57. Causing health insureds to pay a copay that is higher than what the cost of the prescription is to the insurer because of common secretive rebate deals between insurers and drug manufacturers which subsequently are not disclosed and therefore do not accurately represent the true cost of the drug.

58. ********Health insurers not acting in the best interests of the patient and/or acting for their own self-enrichment at the health expense and disadvantage of the patient. *(suddenly stopped claiming, no notice or time for patients to adjust to change)*

59. ****Some health insurer secretive deals (P.C.) are alleged to result in the health insurer selection of a more expensive drug to be on their list of acceptable drugs ("Formulary list"), services or procedures deceptively generating greater insurer profits, excessive higher costs to patients and illegally billing federal Medicare or state Medicaid programs.

60. Good faith insurers look for and find ways to accept and pay claims properly and promptly ... Bad faith insurers unlawfully look for and find ways to not pay, delay, diminish, disapprove and deny payment of claims.