Expert Bias Toolkit

Powerful Discovery Templates

Unveil the truth behind biased expert opinions with this comprehensive Expert Bias Toolkit. This invaluable resource is designed to equip you with the tools necessary to navigate the complexities of expert bias cases and expose hidden agendas and conflicts of interest. These requests implement the *Demer* paradigm and the four principal factors of bias. They are meticulously designed to compel the production of crucial evidence, including relational and decisional metrics, communication trails, and other materials that can expose bias. The comprehensive subpoena attachments ensure you leave no stone unturned in your pursuit of the truth.

The requests represent a best practice approach, distilled from countless cases addressing biased expert issues. They are an amalgamation of the most successful discovery requests, honed to perfection through years of experience and informed by highly successful recent cases, including *Chacko v. AT&T Umbrella Benefit Plan No. 3* (E.D. Cal., Apr. 27, 2020) 2020 WL 1984171 and *Franklin v. Hartford Life and Accident Ins. Co*. (D. Ariz., Dec. 7, 2023) 2023 WL 8481407. These cases — and others found in the E-Treatise: Biased Insurance Experts, Principles and Practice — exemplify the importance of thorough and targeted discovery in exposing expert bias. You're encouraged to explore them further and gain valuable insights into this critical practice area.

- **Requests for Admission (Expert Bias) (RFAs)**
- **Special Interrogatories (Expert Bias) (SROGs)**
- **Requests for Production (Expert Bias) (RFPs)**
- **Subpoena Attachments (Expert Bias) (Subpoena)**

Ensure Transparency and Impartiality with Complete and Honest Disclosures

Insurers are required to ensure that experts are impartial and reliable. Much like disclosures made in other proceedings determining the parties' rights and benefits, an insurance expert's disclosures are vital to ensuring a fair determination of benefits. This disclosure statement provides a minimum threshold for evaluating bias.

- **Expert Disclosure Statement (Expert Bias)**

Instruct the Jury with Easily Understood Legal Principles

The Judicial Council of California Civil Jury Instructions (CACI) offers informed law on insurer bad faith and unreasonable conduct, but the unique bias expert issues have never been addressed. The same is true in other jurisdictions. These instructions complement the CACI instructions of the Judicial Council of California Civil Jury Instructions (CACI). They adopt the same structure and

approach. Available for free download, this invaluable resource informs the court and jury on the *Demer* legal principles and exposes hidden agendas and conflicts of interest.

- **Jury Instructions (Expert Bias)**

Contribute and Collaborate

Stay tuned for more updates and resources, and don't hesitate to reach out with any questions or suggestions. This site is here to support you in your pursuit of justice. Do you have suggestions for improvements, additional cases, or samples to contribute? Your input is welcomed! Please share your comments or send us your materials here to help us continue enhancing our resources for the benefit of all claimants.

Appendix B-1

SAMPLE SPECIAL INTERROGATORIES

1. State the total compensation paid by YOU or on YOUR behalf to [*insert name of expert*] RELATING TO PLAINTIFF'S CLAIM. (For the purposes of these requests, the terms "YOU" or "YOUR" means and refers to [*insert name of insurer/benefit plan in dispute*], and its agents, attorneys, employees, representatives, accountants, and all other PERSONS representing or acting, or purporting to represent or act, on its behalf, including any third-party administrator, vendor, procuring agent, group, and other intermediary. For purposes of these requests, the terms "PERSON" or "PERSONS" means and refers to and includes any natural person, and any third-party administrator, vendor, procuring agent, group, or other intermediary, and any business entity, including but not limited to corporations, partnerships, limited partnerships, other types of limited liability entities, trusts, associations, unincorporated associations, firms, joint ventures, governmental bodies or entities, and their directors, officers, employees, agents, representatives, and attorneys acting on their behalf. For the purposes of these requests, the terms "RELATED TO" or "RELATING TO" or any grammatical variation of such words, refer to, with respect to a given subject, memorializing, identifying, describing, discussing, assessing, stating, referring, constituting, containing, embodying, and/or referring directly or indirectly, in any way, to the particular subject matter defined. For the purposes of these requests, the term "CLAIM" or "CLAIMS" means and refers to a claim made for benefits under a policy of insurance or benefit plan provided by YOU, including without limitation any appeal of a denial of a claim for benefits. For the purposes of these requests, the term "PLAINTIFF'S CLAIM" means and refers to that certain claim reported to YOU and assigned claim number [*insert claim number*].)

2. State the total compensation paid by YOU or on YOUR behalf to [*insert name of expert*] each year from [*insert year, e.g.,* 2019] to the present for services RELATING TO CLAIMS.

3. State the total compensation paid by YOU or on YOUR behalf to any PERSON (*e.g.*, a third-party administrator, vendor, procuring agent, group, or other intermediary) each year from [*insert year, e.g.,* 2019] to procure the services of [*insert name of expert*] RELATING TO CLAIMS.

4. Identify each CLAIM (by policy number, claim number, and date of claim) in which [*insert name of expert*] provided an opinion RELATING TO such CLAIM.[1]

[1] *In unique cases, add geographic and/or temporal constraint to the requests as necessary, such as:* "The term "RELEVANT TERRITORY" means and refers to the State of California", and "The term "RELEVANT TIME PERIOD" means and refers to January 1, 2019 through and including the date upon which this subpoena is answered."

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5. Identify each CLAIM (by policy number, claim number, and date of claim) in which [*insert name of expert*] provided an opinion that supported full payment of all benefits sought by the claimant under such CLAIM.

6. Identify each CLAIM (by policy number, claim number and date of claim) in which [*insert name of expert*] provided an opinion that supported full denial of such CLAIM.

7. Identify each CLAIM (by policy number, claim number and date of claim) in which [*insert name of expert*] provided an opinion that supported partial denial of such CLAIM.

8. Identify YOUR process for approving [*insert name of expert*] to perform services for YOU.

9. Identify YOUR process for monitoring the performance of [*insert name of expert*] RELATING TO CLAIMS.

10. Identify all measures YOU have taken to ensure the reliability of [*insert name of expert*]'s opinions RELATING TO CLAIMS.

11. Identify all measures YOU have taken to ensure the neutrality of [*insert name of expert*]'s opinions RELATING TO CLAIMS.

12. Identify YOUR process for retaining [*insert name of expert*] to perform services RELATING TO PLAINTIFF'S CLAIM.

13. Identify all PERSONS involved in retaining [*insert name of expert*] to provide an opinion RELATING TO PLAINTIFF'S CLAIM.

14. For each opinion of [*insert name of expert*] RELATING TO PLAINTIFF'S CLAIM that relies upon experiential knowledge of any matter and for which there is a range of opinions in the professional community concerning the matters subject to such experiential knowledge, please provide a summary of such range of views.

15. For each opinion of [*insert name of expert*] RELATING TO PLAINTIFF'S CLAIM that relies upon subjective interpretation of any matter, and for which there is a range of opinions in the professional community concerning the matters subject to such subjective interpretation, please provide a summary of such range of views.

Disclaimer: These sample discovery demands are for general informational purposes only. They are provided solely as a resource for California attorneys representing insureds and plan participants.

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They should not be construed as legal advice on any specific matter. These samples are not intended to substitute for the advice of a licensed attorney in your state. You should consult with a qualified lawyer to discuss your situation and determine the appropriate course of action based on the laws in your jurisdiction. The samples may not be fully up-to-date or account for all possible legal scenarios. Laws and procedures can change over time and may be interpreted differently by courts and regulatory bodies. By accessing and using these samples, you agree that Exposing Expert Bias, LLC, and Chris Dion are not responsible for errors, omissions, or outdated information. We make no warranties or guarantees about the sample documents' accuracy, completeness, or adequacy. The samples are provided "as is" without any representations or warranties, express or implied. All warranties and conditions of any kind about the samples are hereby disclaimed. In no event shall Exposing Expert Bias, LLC, and Chris Dion or its attorneys be liable for any special, direct, indirect, consequential, or incidental damages or any damages resulting from the use of or reliance on the sample documents. The use of these samples does not create an attorney-client relationship. Please seek legal counsel for your specific situation. For additional information, please see *the Disclaimers and Privacy Policy on* ExposingExpertBias.com.

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Appendix B-2

SAMPLE REQUESTS FOR PRODUCTION OF DOCUMENTS

DEFINITIONS

For these requests, the following terms shall have the following meanings:

A. The terms "CLAIM" and "CLAIMS" refer to a claim made for benefits under a policy of insurance or benefit plan provided by YOU, including without limitation any appeal of a denial of a claim for benefits.

B. The terms "COMMUNICATION" and "COMMUNICATIONS" mean and refer to all forms of information exchange, whether written, oral, in person, by telephone, facsimile, computer, electronic mail, or other mode of transmission, and shall, concerning oral communications, include all DOCUMENTS which memorialize, in whole or in part, the contents of said oral communications, including correspondence, memoranda, agreements, handwritten notes, transcriptions, or e-mails.

C. The term "DOCUMENT(S)" includes any writing, including, but not limited to, handwriting, typewriting, printing, photostating, photographing, photocopying, transmitting by electronic mail or facsimile, and every other means of recording upon any tangible thing, any form of communication or representation, including letters, words, pictures, sounds, or symbols, or combinations thereof, and any record thereby created, regardless of how the record has been stored.

D. The term "ELECTRONIC" includes having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities.

E. The terms "PERSON" and "PERSONS" refer to any natural persons and legal entities, including corporations, companies, firms, associations, organizations, partnerships, joint ventures, proprietorships, businesses, trusts, limited liability companies, and public entities. Unless noted otherwise, references to any PERSON include their agents, attorneys, employees, employers, officers, directors, or others acting on or purporting to act on behalf of said PERSON.

F. The term "PLAINTIFF" means and refers to [*insert name of Plaintiff*] and their representatives and agents (*e.g.*, attorney).

G. The term "POLICY" refers to that policy of insurance or benefit plan provided by YOU, with reference number [*insert identification number of Policy*].

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H. The terms “RELATED TO” and “RELATING TO” or any grammatical variation of such words, mean and refer to, concerning a given subject, memorializing, identifying, describing, discussing, assessing, stating, referring, constituting, containing, embodying, and referring directly or indirectly, in any way, to the particular subject matter defined.

I. The term “RELEVANT TIME PERIOD” refers to [*insert relevant time period, such as* January 1, 2019, through and including the date upon which this request is answered].

J. The terms “YOU” and “YOUR” mean and refer to [*insert name of insurer/benefit plan in dispute*] and its agents, attorneys, employees, representatives, accountants, and all other persons or entities representing or acting, or purporting to represent or act, on its behalf, including any third-party administrator, vendor, procuring agent, group, and other intermediary.

K. The terms “and” and “or” shall be construed conjunctively and disjunctively to acquire the broadest meaning possible, and each shall include the other whenever such construction serves to bring within the scope of these requests any information that would not otherwise be brought within their scope. The term “any” includes and encompasses “all.” The singular shall always include the plural, and the present tense shall include the past tense.

INSTRUCTIONS

a) Any representation of YOUR inability to comply with any demand shall state, under oath, that a diligent search and reasonable inquiry has been made. In addition, YOU shall specify whether the inability to comply is because the particular DOCUMENTS never existed, have been destroyed, have been lost, misplaced, or stolen, or are no longer in the possession, custody, or control of YOU. This statement shall set forth the name and address of any natural person or organization known or believed by YOU to have possession, custody, or control of that item or category of items.

b) Concerning the production of emails or other electronic documents, each email or electronic document, or grouping of emails or electronic documents, shall be produced in such a fashion so that the identity of the PERSON from whose computer or email account the electronic document or email was taken can be identified or ascertained.

c) If YOU object to the production of any electronically stored information on the grounds that it is from a source that is not reasonably accessible because of undue burden or expense, identify in YOUR response: (a) the types or categories of sources of electronically stored information that YOU assert are not reasonably accessible; (b) the quantity or approximate quantity of electronically stored documents (including, if available, the number of emails) which are not being produced, on a type-by-type, or category-by-category basis; (c) the reasons, stated

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with particularity, as to why the electronically stored information is not reasonably accessible, stated on a type-by-type, or category-by-category basis; (d) the estimated number of hours of work, on a type-by-type, or category-by-category basis, that would be required to gain access to and produce the electronically stored information; and (e) the dollar cost, on a type-by-type, or category-by-category basis, that would be required to gain access to and produce the electronically stored information, including copies of any cost estimates or vendor estimates which YOU have obtained pertaining to, or corroborating, the cost of this work.

d) Where DOCUMENTS are produced that were in the possession of third parties who are agents of YOU (such as YOUR attorneys or accountants), the DOCUMENTS shall be produced in such a fashion so that it is ascertainable from which specific third party's files the DOCUMENT(S) was located.

e) These requests include all relevant DOCUMENTS within the possession, custody, or control of YOU, to the maximum extent permitted under applicable law.

f) DOCUMENTS from any single file should be produced in the same order found in such file. If copies of DOCUMENTS are produced instead of the originals, such copies should be legible and bound or stapled similarly. Labels or other file designations should be produced and copied.

g) To the extent that electronically stored information is responsive to any document requests, all such information shall be in their native file formats.

h) To the extent any of these requests for production calls for a DOCUMENT subject to privilege, produce all those DOCUMENTS called for in that request not subject to a claim of privilege and so much of each DOCUMENT subject to a claim of privilege that does not contain privileged information, with redactions if necessary to conceal the privileged information. With respect to any DOCUMENT or portion of any DOCUMENT withheld because of privilege, state in writing the basis for YOUR privilege claim as follows: (a) the date appearing on the DOCUMENT, or if no date appears, the date on which the DOCUMENT was prepared; (b) the title of the DOCUMENT; (c) the name and job title of the person(s) who signed the DOCUMENT, or if not signed, the name and job title of the person(s) who prepared it; (d) the name and job title of each person making any contribution to the authorship of the DOCUMENT; (e) the name and job title of the person(s) to whom the DOCUMENT was addressed; (f) the name and job title of each person, other than the addressee(s) identified in (e) above, to whom the DOCUMENT, or a copy thereof, was sent or with whom the DOCUMENT was discussed; (g) the name, job title, and address of each person who has custody of the DOCUMENT (or any copy thereof); (h) the general nature or description of the DOCUMENT and the number of pages; and (i) the specific ground(s) on which YOUR claim of privilege rests.

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DOCUMENTS REQUESTED FOR IDENTIFICATION AND PRODUCTION

1. All DOCUMENTS that describe your selection, approval, retention, and performance monitoring of [*insert name of expert*],

2. All DOCUMENTS between YOU and any vendor, procuring agent, group, and other intermediary that is involved in the procurement and provision of [*insert name of expert*]'s services RELATING TO CLAIMS, including without limitation contracts and agreements, memoranda of understanding, service agreements, and vendor agreements.[1]

3. All DOCUMENTS relating to the measures YOU have taken to ensure the reliability, accuracy, and impartiality of [*insert name of expert*]'s opinions, including the procedures YOU employ to oversee and monitor the performance of experts used for investigating claims and including all documents relating to YOUR performance monitoring of [*insert name of expert*].

4. All DOCUMENTS that identify any potential inaccuracy in [*insert name of expert*]'s opinions, including all complaints (formal and informal) received from insureds and plan participants, their representatives, and regulatory authorities (*e.g.*, California Department of Insurance and U.S. Department of Labor).

5. All DOCUMENTS that identify the amounts paid to [*insert name of expert*] for services related to claims for benefits made to YOU.[1] Please note that YOU may withhold tax forms (*e.g.*, IRS Form 1099) if YOU produce documents that identify the total payments made to [*insert name of expert*] for each year by YOU, and YOU identify such withheld tax forms on a detailed privilege log (including the identification of payee and payor).

6. All DOCUMENTS identifying the number of claims in which [*insert name of expert*] provided any opinions relating to claims made on policies issued by YOU.

7. All DOCUMENTS prepared by [*insert name of expert*] containing opinions relating to claims made on policies issued by YOU.

8. All COMMUNICATIONS between YOU and YOUR insureds that incorporate or

[1] *In unique cases, add geographic and/or temporal constraint to the requests as necessary, such as:* "The term "RELEVANT TERRITORY" means and refers to the State of California", and "The term "RELEVANT TIME PERIOD" means and refers to January 1, 2019 through and including the date upon which this subpoena is answered."

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reference an opinion provided by [*insert name of expert*].[2]

9. All COMMUNICATIONS between YOU and [*insert name of expert*]. Please note that all emails and a copy of YOUR claim management system's diary, log, notes, or other document reflecting the claim adjuster's notes on the CLAIMS in which [*insert name of expert*] communicated with YOU, if available, is sufficient for this request.

10. All DOCUMENTS that identity the persons, groups, or entities YOU have retained in the last five years to perform services RELATED TO a CLAIM [*in the State of California*][1] involving [*optional: limit by inserting policy type, nature of Plaintiff's claim, applicable exclusion, or expert's area of expertise*], together with all documents that identify the number of CLAIMS that such person, group or entity has evaluated for YOU.

11. All DOCUMENTS that identity persons, groups, or entities that claim adjusters may retain to investigate CLAIMS RELATING TO [*optional: limit by inserting policy type, nature of Plaintiff's claim, applicable exclusion, or expert's area of expertise*]. Please note that, if available, a list of the experts, vendors, procuring agents, groups, and other intermediaries (e.g., a preferred or approved vendor list) is sufficient for this request.

12. All DOCUMENTS that identify the fields in YOUR database(s) for monitoring claims, and the tools or methods available to perform a search on such database.

[2] Optional: If expert was retained for more than 50 claims, consider sampling and/or limiting to interim and final coverage decisions and emails.

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consequential, or incidental damages or any damages resulting from the use of or reliance on the sample documents. The use of these samples does not create an attorney-client relationship. Please seek legal counsel for your specific situation. For additional information, please see *the Disclaimers and Privacy Policy on* ExposingExpertBias.com.

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Appendix B-3

SAMPLE REQUEST FOR ADMISSIONS

1. Admit that in or about the month of [*insert month and year of Plaintiff's Claim*], PLAINTIFF reported PLAINTIFF'S CLAIM to YOU. (For these requests, the terms "YOU" or "YOUR" means and refers to [*insert name of insurer/benefit plan in dispute*] and its agents, attorneys, employees, representatives, accountants, and all other persons or entities representing or acting, or purporting to represent or act, on its behalf, including any third-party administrator, vendor, procuring agent, group, and other intermediary. For these requests, the term "PLAINTIFF" means and refers to [*insert Plaintiff's name*]. For these requests, "PLAINTIFF'S CLAIM" refers to a particular claim reported to YOU and the assigned claim number [*insert claim number*]. For these requests, the term "PLAINTIFF'S POLICY" means and refers to that policy of insurance or benefit plan provided by YOU, with reference number [*insert account number of policy/plan*].)

2. Admit that the damage PLAINTIFF suffered relating to PLAINTIFF'S CLAIM was caused by a covered peril under PLAINTIFF'S POLICY.

3. Admit that the damages PLAINTIFF suffered relating to PLAINTIFF'S CLAIM are not excluded from coverage under PLAINTIFF'S POLICY.

4. Admit that PLAINTIFF has reported PLAINTIFF'S CLAIM to YOU in a timely manner under PLAINTIFF'S POLICY.

5. Admit that PLAINTIFF has substantially complied with all relevant terms and conditions of PLAINTIFF'S POLICY pertaining to PLAINTIFF'S CLAIM.

6. Admit that YOU did not pay to PLAINTIFF all benefits due under PLAINTIFF'S POLICY pertaining to PLAINTIFF'S CLAIM.

7. Admit that YOU did not thoroughly investigate PLAINTIFF'S CLAIM.

8. Admit that YOU did not investigate PLAINTIFF'S CLAIM fairly.

9. Admit that YOU have a pattern and practice of minimizing CLAIM payments to insureds under policies issued by YOU based on [*insert applicable exclusion or specific reason*]. (For these requests, the term "CLAIM" or "CLAIMS" means and refers to a claim made for benefits under a policy of insurance or benefit plan provided by YOU, including without limitation any appeal of a denial of a claim for benefits.)

10. Admit that YOU frequently rely on opinions from [*name of expert*] in YOUR coverage decisions on CLAIMS.

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11. Admit that [*name of expert*] received substantial compensation for providing YOU opinions about CLAIMS.

12. Admit that the principles and methodologies used by [insert name of expert] in rendering their opinions on PLAINTIFF'S CLAIM are unreliable.

13. Admit that the test results utilized by [*insert name of expert*] in rendering their opinions on PLAINTIFF'S CLAIM are not independently verifiable.

14. Admit that [*insert name of expert*] did not reliably apply generally accepted principles and methodologies in rendering their opinions for PLAINTIFF'S CLAIM.

15. Admit that [*name of expert*] did not reliably apply the facts to the principles and methodologies they relied upon in reaching their opinions for PLAINTIFF'S CLAIM.

16. Admit that YOU did not take reasonable measures to ensure that [*insert name of expert*]'s opinions were impartial.

17. Admit that YOU did not take reasonable measures to ensure that [*insert name of expert*]'s opinions were reliable.

18. Admit that YOU did not take reasonable measures to ensure that [*insert name of expert*]'s opinions were accurate.

19. Admit that substantial evidence exists that [*insert name of expert*] performed a biased investigation of PLAINTIFF'S CLAIM.

20. Admit that [*name of expert*] has a pattern and practice of offering opinions disfavorable to YOUR insureds.

21. Admit that [*insert name of expert*] has a pattern and practice of performing biased investigations of CLAIMS for YOU.

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Appendix B-4

SUBPOENA FOR THIRD-PARTY EXPERT
ATTACHMENTS "3" AND "4"
DEFINITIONS

A. The terms "CLAIM" and "CLAIMS" refer to a claim made for benefits under a policy of insurance or benefit plan provided by YOU, including without limitation any appeal of a denial of a claim for benefits.

B. The term "DOCUMENT(S)" includes any writing, including, but not limited to, handwriting, typewriting, printing, photostating, photographing, photocopying, transmitting by electronic mail or facsimile, and every other means of recording upon any tangible thing, any form of communication or representation, including letters, words, pictures, sounds, or symbols, or combinations thereof, and any record thereby created, regardless of how the record has been stored.

C. The terms "and" and "or" shall be construed conjunctively and disjunctively to acquire the broadest meaning possible, and each shall include the other whenever such construction serves to bring within the scope of these requests any information that would not otherwise be brought within their scope. The term "any" includes and encompasses "all." The singular shall always include the plural, and the present tense shall include the past tense.

REQUEST FOR PRODUCTION OF DOCUMENTS

1. All DOCUMENTS reflecting any income you received for your services performed for or on behalf of [*insert name of insurer/benefit plan in dispute*]. Please identify the amounts by year, and please identify separately the amounts you received for services related to: (1) employee benefit plans, (2) worker's compensation benefits, and (3) social security benefits.[1]

2. All DOCUMENTS reflecting any income you received for services you performed for or on behalf of insurers and benefit plans other than [*insert name of insurer/benefit plan in dispute*].

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[1] *In unique cases, add geographic and/or temporal constraint to the requests as necessary, such as:* "The term "RELEVANT TERRITORY" means and refers to the State of California", and "The term "RELEVANT TIME PERIOD" means and refers to January 1, 2019 through and including the date upon which this subpoena is answered."

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3. All DOCUMENTS reflecting any income you received for your services from claimants and their representatives relating to their insurance and benefit plan CLAIMS.

4. All DOCUMENTS reflecting the number of CLAIMS you were retained by or on behalf of [*insert name of insurer/benefit plan in dispute*].

5. All DOCUMENTS reflecting the number of CLAIMS in which you were retained by or on behalf of insurers and benefit plans other than [*insert name of insurer/benefit plan in dispute*].

6. All DOCUMENTS reflecting the number of CLAIMS claimants retained you.

7. All DOCUMENTS reflecting opinions you offered to or on behalf of [*insert name of insurer/benefit plan in dispute*].

8. All communications between you and [*insert name of insurer/benefit plan in dispute*]. Please note that copies of all emails between you and [insert name of insurer/benefit plan in dispute] in electronic format are sufficient for this request.

DEPOSITION TOPICS

1. Principles and theories that you relied upon in evaluating [*insert name of Plaintiff*]'s claim.

2. Methodologies used in evaluating [*insert name of Plaintiff*]'s claim.

3. Nature and type of services you perform for or on behalf of [*insert name of insurer/benefit plan in dispute*].

4. Measures you have taken to ensure the reliability and accuracy of your opinions for insurers and benefit plans.

5. Measures you have taken to ensure the impartiality of your opinions for insurers and benefit plans.

6. Communications between you and [*insert name of insurer/benefit plan in dispute*].

7. Compensation you receive for services you perform for or on behalf of [*insert name of insurer/benefit plan at issue in the dispute*], including the total amount broken down annually.

8. Compensation you receive for services you perform for or on behalf of insurers and

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benefit plans other than [*insert name of insurer/benefit plan at issue in the dispute*], including the total amount broken down annually.

9. Compensation from claimants and their representatives for services you perform on CLAIMS, including the total amount broken down annually. If you performed any work for claimants, please separately identify the amounts you received for services relating to: (1) employee benefit plans, (2) worker's compensation benefits, and (3) social security benefits.

10. Number of CLAIMS in which you performed services for or on behalf of [*insert name of insurer/benefit plan at issue in the dispute*], including the number of CLAIMS broken down annually.

11. Number of CLAIMS in which you performed services for or on behalf of insurers and benefit plans other than [*insert name of insurer/benefit plan at issue in the dispute*], including the number of CLAIMS broken down annually.

12. Number of CLAIMS in which claimants retained you, including the number of CLAIMS broken down annually.

13. The percentage of CLAIMS in which you perform services for or on behalf of insurers and benefit plans versus the percentage of CLAIMS in which you perform services for claimants is broken down annually.

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Appendix B-6

SAMPLE EXPERT DISCLOSURE STATEMENT

A. Qualifications

1. Provide a copy of your most recent curriculum vitae, including:

   (a) a description of your professional employment and experience (including the name of the employer, firm, or other group, and start and end date).

   (b) list of professional licenses (including license number, issuing entity, and date of issuance).

   (c) list of published works (including publisher, title, and date publication).

B. Insurance Related Work

1. For each of the past seven years, identify each insurance company, benefit plan, and third-party administrator for which you performed services on claims.[1] State for each year the total number of claims for which you performed services for each such entity.

2. For each of the past seven years, state the total compensation you received for performing work relating to claims. Of this total compensation, state:

   (a) the amount you received (directly or indirectly) from or on behalf of insurance companies, benefits plans, third-party administrators, and their representatives (*e.g.*, attorneys, vendors, procuring agents, groups, and other intermediaries).

   (b) the amount you received from claimants and their representatives (*e.g.*, their attorneys).

3. For each of the past seven years, state the percentage of your total income derived from performing work relating to claims under insurance policies and benefit plans. Of this percentage, state:

   (a) the percentage attributable to services performed by or on behalf of an insurance company, benefits plan, third-party administrator, and their representatives.

   (b) the percentage attributable to services for which the claimant and their representatives retained you.

4. For the past seven years, identify each vendor, procuring agent, group, or other intermediary involved in retaining you to perform claims-related services. State the number

[1] As used herein, the term "claims" means a claim made for benefits under an insurance policy and/or a benefit plan, including without limitation any appeal of a denial of a claim for benefits.

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of claims you performed services for each vendor, procuring agent, group, or other intermediary for each year.

5. For each of the past seven years, identify the number of claims for benefits under insurance policies and benefit plans for which you provided an opinion. Of these claims, state:
    (a) the percentage in which you provided an opinion that supported full payment of all benefits sought by the claimant of such claim.
    (b) the percentage in which you provided an opinion that supported complete denial of such a claim.
    (c) the percentage in which you provided an opinion that supported partial denial of such a claim.
6. Identify all matters you provided (*e.g.*, live testimony, deposition, declaration, or affidavit), including the jurisdiction, case title, case no., and the party retaining you.

C. Knowledge/Expertise

1. Please provide a general description of your area(s) of expertise. For each area of knowledge, provide the following:
    (a) Describe the fundamental principles and theories you apply to evaluate claims.
    (b) Provide a list of source materials (including any peer-reviewed articles and studies) you rely upon to reach your opinions.
    (c) Describe the methodologies you use to evaluate claims.
    (d) Describe the tests you use to evaluate claims.
        (i) Are the tests generally accepted in the expert community?
        (ii) Are the test results independently verifiable?
        (iii) Do the test results involve subjective interpretation?
2. Please provide three samples of your reports where you have been requested to provide your professional opinions (*e.g.*, a claim investigation report or an independent medical examination). For each report, identify:
    (a) each of your opinions relies upon experiential knowledge.
    (b) each of your opinions is based on a subjective interpretation of principles, theories, tests, or facts.
    (c) for each of your opinions, where there is a range of views in the scientific and professional community concerning matters subject to experiential knowledge or subjective interpretation of principles, theories, tests, or facts, summarize the

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range of opinions.

3. Have you ever been subject to adverse action relating to your professional experience (*e.g.*, your license was suspended or revoked)? If so, please describe the matter in detail (including the governing body that took such action and the date of such action).
4. Identify all matters in which you were a defendant and the subject matter of the case related to your professional experience.

D. Other

1. Describe all matters that could cause a person aware of the facts to reasonably entertain a doubt that you would be able to be impartial, including without limitation if you have a current arrangement concerning prospective employment or other compensated service to evaluate claims for benefits under insurance policies and benefit plans.

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Appendix B-7

The following instructions are complements to CACI Nos. 2300, 2303, 2304, 2306, 2330, 2331, 2332, and 2337. These instructions were drafted for use in most claim types. Instruction No. 1 is intended solely for homeowner policy claims.

POLICYHOLDER'S SPECIAL JURY INSTRUCTION NO. 1
[*insert name of insurer*]'s Homeowners Insurance Policy
is an All-Risk Policy with Specified Exclusions

[*insert name of insurer*]'s homeowners insurance policy is an "all-risk" policy. Under an "all-risk" homeowners insurance policy, all risks are covered except loss caused by those specifically excluded by the policy.

Authority: See [*insert name of insurer*]'s Homeowner's Insurance Policy, [*p. 3 (Section I – PROPERTY), and pp. 4-7 (exclusions)*]; *Freedman v. State Farm Ins. Co.* (2009) 173 Cal. App. 4th 957, 965 fn. 1; *State Farm Fire & Casualty Co. v. Von Der Lieth* (1991) 54 Cal.3d 1123, 1131; *Garvey v. State Farm Fire & Casualty Co.* (1989) 48 Cal.3d 395, 406-407; *Strubble v. United States Auto. Assn.* (1973) 35 Cal.App.3d 498, 504.

Notes: This instruction is a prefatory instruction to CACI Nos. 2300 and 2306 and entirely explanatory in nature. It is a simple, informative statement of the law generally endorsed by both parties.

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POLICYHOLDER'S SPECIAL JURY INSTRUCTION NO. 2
Purpose of Insurance

The nature of an insurance contract is unique. An insured does not enter into an insurance contract seeking profit but seeks security and peace of mind through protection against misfortune and accidental loss. Insureds pay premiums in advance for this protection. Thus, insurance companies have a "special relationship" with their insureds. Insurers are held to a higher standard in contract performance than other contracting parties, and the law imposes duties on insurers not found in other contracts. Above all, an insurer has a duty to treat the insured with fairness, decency, and honesty.

Authority: *Wilson v. 21st Century Ins. Co.* (2007) 42 Cal.4th 713, 720-721; *Love v. Fire Ins. Exch.* (1990) 221 Cal.App.3d 1136, 1151; *Egan v. Mutual of Omaha* (1979) 24 Cal.3d 809, 819; *Mariscal v. Old Republic Life Insurance* (1996) 42 Cal.App.4th 1617, 1623; *Major v. Western Home Ins. Co.* (2009) 169 Cal.App.4th 1197, 1209.

Notes: This instruction is a prefatory instruction to CACI Nos. 2330, 2331, and 2332, and is fundamental to understanding insurance policies and the reason for the insurer's duty of good faith and fair dealing, as well as setting up the insured's general duty of good faith and fair dealing and the more specific duties in the instructions that follow.

"An insured does not enter into an insurance contract seeking profit, but instead seeks security and peace of mind through protection against calamity." (*Love, supra,* at 1151; see also *Egan, supra,* at p. 819; *Mariscal, supra,* at p. 1623.) Insureds pay premiums in advance for an intangible right: protection against misfortune. Even those insured who never suffer a loss receive the benefit of having peace of mind and security in the event misfortune occurs. The duty of good faith and fair dealing is predicated on this intangible, along with the perceived disparate bargaining power and the nature of insurance policies (which potentially allow predatory or unscrupulous insurers to exploit their insureds' misfortune when resolving claims). This instruction succinctly captures the unique nature of the insurance policy. The following is a similar instruction adopted in the Nevada Civil Jury Instructions that captures the foregoing:

> "The relationship of an insured to an insurer is one of special confidence and akin to that of a fiduciary. A fiduciary relationship exists when one has the right to expect trust and confidence in the integrity and fidelity of another. This special relationship exists in part because consumers contract for insurance to gain protection, peace of mind, and security against calamity. To fulfill its implied obligation of good faith and fair dealing, an insurance company must give at least as much consideration to the interests of the insured as it gives to its own interests."

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POLICYHOLDER'S SPECIAL JURY INSTRUCTION NO. 3
Insurance Company's Duties Once a Claim is Made

[*insert name of insurer*] has a duty under the law to promptly commence and diligently conduct a thorough, fair, objective, and unbiased investigation of a claim. When investigating [*insert name of Plaintiff*]' claim, it was essential for [*insert name of insurer*] to fully and fairly inquire into possible bases that might support [*insert name of Plaintiff*]'s claim, not just those facts, claims, or coverage theories advanced by [*insert name of Plaintiff*]. In determining whether [*insert name of insurer*] acted unreasonably, you may consider whether [*insert name of insurer*] failed to fully and fairly inquire into possible bases that might support [*insert name of Plaintiff*]'s claim.

Authority: *Wilson v. 21st Century Ins. Co.* (2007) 42 Cal.4th 713, 720; *Frommoethelydo v. Fire Ins. Exchange* (1986) 42 Cal.3d 208, 215-220; *Egan v. Mutual of Omaha* (1979) 24 Cal.3d 809, 817-19; *Mariscal v. Old Republic Life Insurance* (1996) 42 Cal.App.4th 1617, 1623; *Jordan v. Allstate Ins. Co.* (2007) 148 Cal.App.4th 1062, 1072; Cal. Admin. Code tit. 10, § 2695.7, subs. (d); Cal. Ins. Code § 790.03(h)(3).

Notes: As an example of the disparate treatment in the enumerated duties of the insurer and policyholder, the industry-standard homeowner's insurance policy (*e.g.*, the ISO HO-3 form) describes the insured's duties after loss in detail. These duties are also found in the statutory form of California Insurance Code § 2071, and every California homeowner policy must incorporate terms that are no less favorable than those found in § 2071. The insured's duties include:

(1) giving notice to [*insert name of insurer*] without unreasonable delay;

(2) protecting the property covered by the policy from further damage;

(3) not destroying the property covered by the policy;

(3) maintaining accurate records of repair costs;

(4) making a list of all damaged personal property (with specific details on quantity, cash value, replacement cost and amount of loss);

(5) showing the property upon request;

(6) providing upon request all records and documents relating to the damaged property;

(7) providing testimony at an examination under oath; and

(8) submitting a proof of loss upon request.

(*see e.g.,* ISO HO-3 form, Section entitled "Conditions", subsection "2. Duties After Loss", pp. 8-9

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of the policy form; *see also* Cal. Ins. Code § 2071)

A violation of these duties gives rise to forfeiture of benefits and the right to sue under the policy. On the other hand, the policy is silent as to the insurer's duties, and thus statutes, regulations, and judicial decisions have filled in the missing duties. The duty to conduct a *thorough, fair, objective, and unbiased investigation* of a claim is one of the preeminent duties of an insurer and the most critical to evaluating expert bias.

While breach of this duty has generally been found to constitute unreasonable conduct and bad faith as a matter of law (*see e.g.*, *Wilson, supra,* at p. 729); *Frommoethelydo, supra,* at pp. 215-220; *Egan, supra,* at pp. 817-19; *Mariscal, supra,* at p. 1623; and *Jordan, supra,* at p. 1072), the last sentence of this instruction is modeled after CACI No. 2337, acknowledging that the breach is a factor for the factfinder to consider in evaluating unreasonable conduct.

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POLICYHOLDER'S SPECIAL JURY INSTRUCTION NO. 4
Insurance Company's Duty to Interview Percipient Witnesses

[*insert name of insurer*] has a duty under the law to diligently search for evidence that favors coverage under the insurance policy and evidence that disfavors coverage under the insurance policy. Once [*insert name of insurer*] was advised of the existence of witnesses who had knowledge of disputed facts that were material to [*insert name of Plaintiff*]'s claim, [*insert name of insurer*] had a duty to investigate those witnesses.

In determining whether [*insert name of insurer*] acted unreasonably, you may consider whether [*insert name of insurer*] failed to investigate witnesses who had knowledge of disputed facts material to [*insert name of Plaintiff*]'s claim.

Authority: *Frommoethelydo v. Fire Ins. Exchange* (1986) 42 Cal.3d 208, 219-220; *Mariscal v. Old Republic Life Insurance* (1996) 42 Cal.App.4th 1617, 1624; *Hughes v. Blue Cross of Northern California* (1989) 215 Cal.App.3d 832, 846

Notes: Please refer to instruction No. 3 for support for this instruction.

While a breach of the duty to interview the percipient witnesses has generally been found to constitute unreasonable conduct and bad faith as a matter of law (*see e.g.*, *Frommoethelydo, supra,* at pp. 219-220; *Mariscal, supra,* at p. 1624; and *Hughes, supra,* at p. 846), the last sentence of this instruction is modeled after CACI No. 2337, thus eliminating any suggestion that the breach is bad faith as a matter of law. Rather, it is a factor for the factfinder to consider in evaluating unreasonable conduct.

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POLICYHOLDER'S SPECIAL JURY INSTRUCTION NO. 5
Insurer's Duty Not to Mislead or Conceal Material Information

[*insert name of insurer*] has a duty under the law not to mislead or conceal material information from [*insert name of Plaintiff*].

Authority: Cal. Ins. Code § 790.03(h)(1). *See also generally*, Cal. Ins. Code §§ 330, 332 (West's 2023); Cal. Admin. Code, Tit. 10, § 2695.7(b)(1) ; CACI No. 2308.

Notes: Please refer to instruction No. 3 for support for this instruction. The failure to communicate that which a party knows and ought to communicate is concealment. Insurers often successfully invoke this duty against insureds to rescind a policy — often after a claim is made — based on a material misrepresentation in the application process. *See e.g., Nieto v. Blue Shield of California Life & Health Ins. Co.* (2010) 181 Cal.App.4th 60, 75; *TIG Ins. Co. of Michigan v. Homestore, Inc.* (2006) 137 Cal.App.4th 749, 755-756. While the statute is reciprocal, and insurers have routinely used the statute to rescind policies, very few insureds have successfully used the statute against insurers, and never against an insurer based on the material misrepresentation or concealment concerning its claim handling practices (*e.g.*, the systemic use of biased experts).

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POLICYHOLDER'S SPECIAL JURY INSTRUCTION NO. 6
Insurer's Duty to Give Equal Consideration to the Interests of the Insured

To fulfill its implied obligation of good faith and fair dealing, an insurance company must give at least as much consideration to the interests of the insured as it gives to its own interests. When evaluating valid claims that are potentially covered by the insurance policy, an insurer may not consider the interests of its other policyholders or shareholders, its profitability, or the impact of the claim on its financial condition. When evaluating invalid claims not covered by the insurance policy, an insurer is not required to disregard the interests of its shareholders and other policyholders.

Authority: *Love v. Fire Ins. Exchange* (1990) 221 Cal.App.3d 1136, 1148-1149

Notes: Please refer to instruction No. 3 for support for this instruction. This instruction should be offered only if an insurer puts forth a jury instruction that it may consider the interests of its own shareholders. It's generally unnecessary and already covered in CACI No. 2330, which recites:

> "To fulfill its implied obligation of good faith and fair dealing, an insurance company must give at least as much consideration to the interests of the insured as it gives to its own interests."

The CACI instruction captures the import of the California Supreme Court in *Wilson v. 21st Century Ins. Co.* (2007) 42 Cal.4th 713, 720–723, which recites in relevant part:

> "The law implies in every contract, including insurance policies, a covenant of good faith and fair dealing. "The implied promise requires each contracting party to refrain from doing anything to injure the right of the other to receive the agreement's benefits. To fulfill its implied obligation, ***an insurer must give at least as much consideration to the interests of the insured as it gives to its own interests***. When the insurer unreasonably and in bad faith withholds payment of the claim of its insured, it is subject to liability in tort." " (*Id.,* at p. 720, citing *Frommoethelydo v. Fire Ins. Exchange* (1986) 42 Cal.3d 208, 214–215, [emphasis added].)

Yet, insurers attempt to mislead the courts over this instruction by mis-citing *Love v. Fire Ins. Exchange,* which opined as follows:

> "Unique obligations are imposed upon true fiduciaries which are not found in the insurance relationship. For example, a true fiduciary must first consider and always act in the best interests of its trust and not allow self-interest to overpower its duty to act in the trust's best interests. An insurer, however, may give its own interests consideration equal to that it gives the interests of its insured; it is not required to

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> disregard the interests of its shareholders and other policyholders when evaluating claims; and ***it is not required to pay noncovered claims, even though payment would be in the best interests of its insured***." (*Love, supra,* at p. 1148–1149 [citations omitted, emphasis added.].)

An insurer's shareholders have no interest in a claim, except as it relates to the company's profitability.

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POLICYHOLDER'S SPECIAL JURY INSTRUCTION NO. 7
Insurance Company's Duty to Provide the Claim-Related Documents to a Policyholder Upon Request

[*insert name of insurer*] has a duty under the law to notify [*insert name of Plaintiff*] that they may obtain, upon request, copies of all claim-related documents. [*insert name of insurer*] has a further duty to provide all claim-related documents to [*insert name of Plaintiff*] within 15 calendar days after receiving a request. The "claim-related documents" are all documents that relate to the evaluation of damages. They include [*insert name of insurer*]'s [*insert specific documents withheld from production upon request*].

In determining whether [*insert name of insurer*] acted unreasonably, you may consider whether [*insert name of insurer*] failed to timely provide the claim-related documents to [*insert name of Plaintiff*] upon request.

Authority: California Insurance Code § 2071

Notes: Please refer to instruction No. 3 for support for this instruction.

This instruction reflects the lone statutory duty imposed on insurers. The duty is found in Cal. Ins. Code § 2071, section entitled "Requirements in case loss occurs," which also describes the policyholder's duties. Yet, while all of the policyholder's duties identified in this provision were incorporated into the standard homeowner's policy, the insurer's only duty was omitted.

The last sentence of this instruction is modeled after CACI No. 2337, thus eliminating any suggestion that the breach is bad faith as a matter of law. Rather, it is a factor for the factfinder to consider in evaluating unreasonable conduct.

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POLICYHOLDER'S SPECIAL JURY INSTRUCTION NO. 8
Insurance Company's Duty to Respond Completely
to a Policyholder's Request for Information

After receiving a request for information from a policyholder about a claim, [*insert name of insurer*] has a duty under the law to furnish the policyholder a complete response based on the facts as then known by [*insert name of insurer*]. [*insert name of insurer*] must furnish the response no later than 15 days after receiving the request.

In determining whether [*insert name of insurer*] acted unreasonably, you may consider whether [*insert name of insurer*] failed to furnish [*insert name of Plaintiff*] with complete responses to their requests based on the facts as then known by [*insert name of insurer*].

Authority: Cal. Admin. Code tit. 10, § 2695.5, subs. (b); [*insert name of insurer*]'s Claims Manual (which incorporates and recites Cal. Admin. Code tit. 10, § 2695.5, subs. (b) verbatim)

Notes: Please refer to instruction No. 3 for support for this instruction.

This instruction is used when Plaintiffs make inquiries from their insurer for information and the insurer withholds that information. An insurer's failure to respond within 15 days fully and completely based on the facts then known is a violation of Cal. Admin. Code tit. 10, § 2695.5, subs. (b).

The last sentence of this instruction is modeled after CACI No. 2337, thus eliminating any suggestion that the breach is bad faith as a matter of law. Rather, it is a factor for the factfinder to consider in evaluating unreasonable conduct.

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POLICYHOLDER'S SPECIAL JURY INSTRUCTION NO. 9
Insurance Company's Duty to Use Impartial Experts

In determining whether [*insert name of insurer*] acted unreasonably by failing to perform a full and fair investigation, you may also consider whether [*insert name of insurer*]'s use of experts was unreasonable. You may conclude [*insert name of insurer*] acted unreasonably from any of the following:

(a) [*insert name of insurer*] failed to conduct a thorough and unbiased investigation;

(b) [*insert name of insurer*] dishonestly selected its experts;

(c) [*insert name of insurer*]'s experts were unreasonable;

(d) [*insert name of insurer*] was guilty of misrepresenting the purpose and nature of its investigation; and

(e) [*insert name of insurer*] misrepresented to or concealed material information about its investigation from [insert name of Plaintiff].

This list is not intended to be an exhaustive or exclusive list of unreasonable conduct, and you may conclude [*name of insurer*] acted unreasonably based on other conduct.

Authority: *Fadeeff v. State Farm Gen. Ins. Co.* (2020) 50 Cal.App.5th 94, 101-104; *Brehm v. 21st Century Ins. Co.* (2008) 166 Cal.App.4th 1225, 1237-1240; *Chateau Chamberay Homeowners Assn. v. Associated Internat. Ins. Co.* (2001) 90 Cal.App.4th 335, 348-349, n. 8; *Hangarter v. Provident Life and Acc. Ins. Co.* (9th Cir. 2004) 373 F.3d 998, 1010-1011.

Notes: Please refer to instruction No. 3 for support for this instruction.

The cornerstone of a "fair" investigation is the *lack of bias*. (See *Fadeeff, supra,* at pp. 101-104; *Brehm, supra,* at pp. 1237-1240; *Chateau Chamberay, supra,* at pp. 348-349; *Hangarter, supra,* at pp. 1010-1011.) Guidance is generally lacking on what constitutes bias in the claims-handling arena. The above instruction is the only direct guidance the courts have issued to date. Hence, the instruction is critical to the juror's evaluation of [*insert name of insurer*]'s bad faith conduct.

While it could be argued that the use of biased experts constitutes bad faith as a matter of law, this instruction is modeled after CACI No. 2337, thus eliminating any suggestion that the breach is bad faith as a matter of law. Rather, it is a factor for the factfinder to consider in evaluating unreasonable conduct.

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POLICYHOLDER'S SPECIAL JURY INSTRUCTION NO. 10
Definition of Bias and Factors to Consider

"Bias" means a strong feeling in favor of or against one side in an argument, often not based on fair judgment. You may conclude that [*insert name of expert*] has a substantial likelihood of bias in favor of [*insert name of insurer*] based on any circumstance concerning the [*insert name of expert*]'s relationship with [*insert name of insurer*] or otherwise, including one or more of the following:

(a) whether [*insert name of expert*] receives substantial compensation for their work on [*insert name of insurer*]'s claims, and whether [insert name of expert] works on a substantial number of [*insert name of insurer*]'s claims;

(b) whether [*insert name of expert*] has a pattern and practice of offering favorable opinions that support [*insert name of insurer*] denying some or all of a claim;

(c) whether [*insert name of expert*] failed to use reliable principles, theories, and methodologies in reaching their opinions, or whether [*insert name of expert*] failed to properly apply the facts of this case to those principles and theories; or

(d) whether [*insert name of insurer*] failed to take reasonable measures to ensure [*insert name of expert*]'s impartiality and the accuracy of the [*insert name of expert*]'s opinions.

You may not consider facts that show only a social acquaintance, such as common membership in the same social club, without any substantial business relationship.

Authority: *Demer v. IBM Corp. LTD Plan* (9th Cir. 2016) 835 F.3d 893 *Haworth v. Superior Court* (2010) 50 Cal.4th 372; *Natarajan v. Dignity Health* (2021) 11 Cal.5th 1095); *Haas Haas v. County of San Bernardino* (2002) 27 Cal.4th 1017, 1025; *Michael v. Aetna Life & Casualty Ins. Co.* (2001) 88 Cal.App.4th 925, 938-940;
https://www.oxfordlearnersdictionaries.com/us/definition/english/bias_1?q=bias

Notes: The duty of good faith and fair dealing requires the insurance company to conduct a full, fair, and thorough investigation of a claim. The cornerstone of a "fair" investigation is the *lack of bias*. This instruction is critical to introducing the *Demer* factors and the conduct that may give rise to a rebuttable presumption of bias.

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POLICYHOLDER'S SPECIAL JURY INSTRUCTION NO. 11
Obligation to Prove – Inference of Expert Bias

In the context of an insurer's use of biased experts, [*name of Plaintiff*] has the initial burden to show a weak inference of bias, which may be implied from facts indicating a likelihood of bias. Once [*name of Plaintiff*] shows a weak inference of bias on the part of [*insert name of expert*], the burden then shifts to [*name of insurer*] to show by a preponderance of evidence that [*name of expert*] is unbiased.

Authority: *Demer v. IBM Corp. LTD Plan* (9th Cir. 2016) 835 F.3d 893, 902-903; Evidence Code § 500; *see also* CACI Nos. 200, 2304.

Notes: A defendant bears the burden of proving affirmative defenses.

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POLICYHOLDER'S SPECIAL JURY INSTRUCTION NO. 12
Insurance Company's Continuing Duty of Good Faith and Fair Dealing

An insurance company's duty of good faith and fair dealing to the insured is a contractual duty that does not cease when litigation begins. The duty is a continuing obligation that persists throughout litigation until the claim is fully and finally resolved. Thus, any investigation of the claim performed by [*insert name of insurer*] during the litigation must be full, fair, thorough, and unbiased.

In determining whether [*insert name of insurer*] acted unreasonably, you may consider whether [*insert name of insurer*]'s investigation of the claim after the litigation commenced was full, fair, thorough, and unbiased.

Authority: *White v. Western Title Ins. Co.* (1985) 40 Cal.3d 870; see also Insurance Code § 790.03(h)(6); *Jordan v. Allstate Ins. Co.* (2007) 148 Cal.App.4th 1062, 1072, n.7; *Tomaselli v. Transamerica Ins. Co.* (1994) 25 Cal.App.4th 1269; Insurance Code § 790.03(h)(6); Croskey et al., *Cal. Practice Guide: Insurance Litigation* (TRG 2022) ¶¶ 12:985-12:987

Notes: It's axiomatic that an insurance company's duty of good faith and fair dealing to the policyholder is a contractual duty that does not cease when litigation begins. The duty is a continuing obligation that persists throughout. (See *White, supra*; *Jordan, supra,* at p. 1072, n.7; *Tomaselli v. Transamerica Ins. Co.*, *supra*, at p. 1281 (insurer may violate the duty of good faith and fair dealing by employees lying during deposition); see also Insurance Code § 790.03(h)(6) (insurance company prohibited from forcing insureds to institute litigation to recover benefits due). In literature, the insurance company's duty is frequently referred to as the "doctrine of continuing duty of good faith and fair dealing" or "continuing bad faith." (See *e.g.*, Croskey et al., *Cal. Practice Guide: Insurance Litigation* (TRG 2022) ¶¶ 12:985-12:987.)

Thus, while an insurer arguably may not be held liable for much of its litigation conduct, it may not act in contravention of its pre-litigation duties, including the duty to investigate with unbiased experts fairly. Hence, any expert the insurer uses post-claim denial may be evaluated using the same standards as pre-claim denial experts.

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POLICYHOLDER'S SPECIAL JURY INSTRUCTION NO. 13
Policyholder's Duties End Once a Claim is Denied

Under the [*insert name of insurer*] homeowners insurance policy, after the appearance of observable physical damage to property covered by the policy, an insured is required to perform certain duties, including giving notice without unreasonable delay, not destroying the property, and protecting it from further damage, and showing the property. A policyholder's unreasonable failure to comply with their duties after loss is grounds for denying a claim, and the policyholder may lose their right to sue the insurer for their benefits.

After [*insert name of insurer*] denied the claim, [*insert name of Plaintiff*] was not required to comply any further with their duties and they were not required to show the property to [*insert name of insurer*] or its experts. In determining whether [*insert name of insurer*] acted unreasonably, you may consider whether [*insert name of insurer*] required [*insert name of Plaintiff*] to show the property after the claim was denied, or whether [*insert name of insurer*] informed [*insert name of Plaintiff*] that they were not in compliance with the policy because they failed to show the property.

Authority: [*insert name of insurer*]'s Homeowners Insurance Policy, Section entitled "Conditions", subsections "2. Duties After Loss" and "13. Suit Against Us" (pp. 8-10 of the policy); Insurance Code § 2071; *Prudential-LMI Commercial Ins. v. Superior Court* (1990) 51 Cal.3d 674, 684 (*Prudential-LMI*); *Kapsimallis v. Allstate Ins. Co.* (2002) 104 Cal.App.4th 667, 672-673; *Vu v. Prudential Property & Casualty Ins. Co.* (2001) 26 Cal.4th 1142, 1147-1149; *Marselis v. Allstate Ins. Co.* (2004) 121 Cal.App.4th 122, 125; *Aliberti v. Allstate Ins. Co.* (1999) 74 Cal.App.4th 138, 142-148; *Prieto v. State Farm Fire & Casualty Co.* (1990) 225 Cal.App.3d 1188, 1192-1997; *Campbell v. Allstate Ins. Co.* (1963) 60 Cal.2d 303, 305-307; *Brizuela v. CalFarm Ins. Co.* (2004) 116 Cal.App.4th 578, 587-91; see also *Henderson v. Farmers Group, Inc.* (2012) 210 Cal.App.4th 459, 471-474; *Abdelhamid v. Fire Ins. Exchange* (2010) 182 Cal.App.4th 990, 999-1001; *Robinson v. National Auto. Etc. Ins. Co.* (1955) 132 Cal.App.2d 709, 714-716; *Hickman v. London Assurance Corp.* (1920) 184 Cal. 524, 532-535; *Shell Oil Co. v. Winterthur Swiss Ins. Co.* (1993) 12 Cal.App.4th 715, 759-764; *Xebec Development Partners, Ltd. v. National Union Fire Ins. Co.* (1993) 12 Cal.App.4th 501, 532-534; *Downey Savings & Loan Assn. v. Ohio Casualty Ins. Co.* (1987) 189 Cal.App.3d 1072, 1089; *Martinez v. Infinity Ins. Co.* (C.D.Cal. 2010) 714 F.Supp.2d 1057, 1063.

Notes: This instruction is essential when an insurer attempts to force the insured to permit a reinspection post-denial. Unlike the insurer, the insured's duties cease after the claim is denied. This instruction is derived from the ISO HO-3 form, Section entitled "Conditions", subsections "2. Duties After Loss" and "13. Suit Against Us" (pp. 8-10 of the policy.

These policy provisions – required by statute – are valid as a matter of law. "When a clause in an insurance policy is authorized by statute, it is deemed consistent with public policy established by the Legislature … In addition, the statute must be construed to implement the intent of the

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Legislature and should not be construed strictly against the insurance company (unlike ambiguous or uncertain policy language)." (*Prudential-LMI, supra,* at p. 699; see also *Home Ins. Co., supra,* at p. 1392; *Doheny Park, supra,* at p. 1089 fn. 10; *Blue Shield, supra,* at pp. 735-736 (policy provisions more favorable to the insured are valid).)

The courts have also uniformly upheld the limitations and compliance provision of Insurance Code 2071 for suits on claims, albeit often with due consideration of other legal principles and caselaw, such as the delayed discovery rule, estoppel, and equitable tolling. (See *Kapsimallis, supra,* at pp. 672-673; *Vu, supra,* at pp. 1147-1149; *Marselis, supra,* at p. 125; *Aliberti, supra,* at pp. 142-148; *Prieto, supra*., at pp. 1192-1997)

Similarly, the courts have also upheld the forfeiture of the insured's rights for failing to comply with the duties after loss provision in the policy. (See *Abdelhamid, supra,* at pp. 999-1001; *Brizuela, supra*; *Robinson, supra,* at pp. 587-91; and *Hickman, supra,* at pp. 532-535.) But in each instance, the Court upheld the forfeiture because the insurance company was prejudiced *pre-denial* in their "full, fair and thorough" investigation.

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