3-19

IN THE SUPREME COURT OF FLORIDA

CASE NO. 77,089

FILED
SID J. WHITE
FEB 22 1991
CLERK, SUPREME COURT
By _____ Deputy Clerk

ROBERT McLEOD, ETC.,

Petitioner,

vs.

CONTINENTAL INSURANCE CO.,

Respondent.

On Discretionary Review of Certified Question from the Florida Second District Court of Appeals (Case No. 89-02586).

INITIAL BRIEF OF ROBERT McLEOD

HUGH N. SMITH, ESQUIRE
DAVID S. NELSON, ESQUIRE
SMITH & FULLER, P.A.
P. O. Box 3288
Tampa, FL 33601
(813) 221-7171

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases — Page(s)

Other Authorities

STATEMENT OF THE CASE AND FACTS

On or about June 17, 1985, MCLEOD visited the offices of Charles Jennings and Jennings & Associates (hereinafter collectively referred to as "Jennings") in Brandon, Florida. (ROA VII, 1141, paragraph 3).[1] At all times material hereto, Jennings was an authorized agent of CONTINENTAL. (ROA VII, 1140-41, paragraph 2).

The purpose of MCLEOD's visit to Jennings was to obtain information and a premium quotation on personal insurance coverage for himself, his wife, his daughter, and his three automobiles and home. (ROA VII, 1141, paragraph 3). At the time of his visit to Jennings on June 17, 1985, MCLEOD was covered under a policy of insurance with Iowa National Mutual Insurance Company (hereinafter "Iowa National"). (ROA VII, 1141, paragraph 4). MCLEOD's Iowa National policy provided, in relevant part, for uninsured/underinsured (hereinafter "UM") insurance in the amount of $50,000.00 per person with a $100,000.00 maximum benefit per covered accident. Written in 1984, MCLEOD's Iowa National policy was set to expire at midnight on July 17, 1985. (ROA VII, 1141, paragraph 5).

---

[1]Appellant ROBERT McLEOD, as Personal Representative of the Estate of Monzelle K. McLeod, deceased, and ROBERT McLEOD, personally, Plaintiffs and Appellants in the actions below, are collectively referred to as "McLEOD." CONTINENTAL INSURANCE COMPANY, Defendant and Appellee below, is referred to as "CONTINENTAL." References to the record on appeal are indicated by a parenthetical and prefix "ROA" with the volume and page number(s) indicated respectively. References to the "Stipulated Statement" (ROA VII, 1140-53), are similarly indicated but with an additional reference to the appropriate paragraph number.

During their meeting on June 17, 1985, MCLEOD described the Iowa National policy and further explained that it was set to expire in one month. (ROA V, 706-07). With that information, and with other information provided by MCLEOD, Jennings prepared a premium quotation which he then provided MCLEOD. (Id.) The premium quotation of $1,779.00 was for insurance with CONTINENTAL, and MCLEOD was so advised. (ROA V, 707-08). Jennings assured MCLEOD that the policy with CONTINENTAL would be similar to that MCLEOD had with Iowa National. (Id.) MCLEOD left with the quotation but without a policy or other literature describing the coverages or exclusions. (ROA V, 709).

MCLEOD next visited Jennings on July 8, 1985. (ROA V, 709). Based upon the premium quotation of $1,779.00, MCLEOD returned to Jennings for the purposes of applying for coverage with CONTINENTAL. (ROA V, 710). During the course of the visit on July 8, 1985, MCLEOD indicated a desire to increase his UM coverage to $100,000.00 per accident. (ROA VII, 1141-42, paragraph 9).

It was during the same meeting that MCLEOD first expressed concern that delay in obtaining new insurance might leave him uninsured when the Iowa National policy expired on July 17, 1985. (ROA V, 714-15). Accordingly, MCLEOD expressed a desire to purchase insurance which would become effective July 10, 1985. Jennings assured MCLEOD that such a new policy with CONTINENTAL could be written (ROA V, 716), and a CONTINENTAL application form as filled out accordingly. (ROA IV, 485-86; ROA V, 713-714).

In the application, Jennings listed the Iowa National policy and documented its impending expiration date. Nonetheless, the portion of the form marked "credit for existing insurance" was left blank. (Id.). This was not surprising inasmuch as Jennings and MCLEOD had not even discussed a "credit for existing insurance" provision during the earlier June 17, 1985, meeting, or during the July 8, 1985, office visit. (ROA V, 710-13, 719).

Similarly left blank was the portion of the application marked "umbrella." This too was not surprising inasmuch as MCLEOD and Jennings had not discussed the creation of an umbrella or excess policy for the week of July 10-17, 1985. (Id.) In fact, Jennings believed he had no authority to write excess or umbrella policies for $100,000.00. (ROA V, 753-54). What Jennings believed he could provide, and what Jennings believed he was providing, was duplicate primary coverage. (ROA IV, 494; ROA V, 726). Accordingly, by the end of their discussion on July 8, 1985, Jennings had "issued," and MCLEOD had agreed to pay for, an oral binder providing UM coverage in the amount of $100,000.00 per accident effective July 10, 1985. (ROA V, 722-23).

On July 16, 1985, MCLEOD's wife, Monzelle Kay McLeod, was the victim of a tragic automobile accident on her way to work. Mrs. McLeod was struck broadside by a dump truck owned by CEN-COM ASSOCIATES, INC. (hereinafter "CEN-COM") and driven by ROBERT VERNON SIMMONS (hereinafter "SIMMONS"), a CEN-COM employee. SIMMONS was driving between 45 and 50 miles per hour through a red light at the time of the accident. No comparative negligence on

the part of Mrs. McLeod was ever suggested or shown. The impact sent both vehicles into oncoming traffic before the dump truck came to rest on its side. SIMMONS was relatively unhurt, but Mrs. McLeod was taken to Tampa General Hospital where she died that same day from the injuries sustained. (ROA VII, 1142, paragraphs 12-15).

MCLEOD reported his wife's accident and resulting death to Jennings on the afternoon of July 16, 1985. (ROA V, 719-20). Subsequently, Jennings prepared an amended application for insurance. (ROA IV, 487-92). While the amended application identified MCLEOD's existing Iowa National policy, it, like the original application, made no reference to, or concession for, a credit for existing insurance. (ROA V, 719).

On July 16, 1985, Jennings also wrote to CONTINENTAL to describe the "unusual circumstances" surrounding MCLEOD's tragic loss and subsequent claim (ROA IV, 493-94). In pertinent part, the letter explained that:

> The insured is a cousin to an existing PCP client. He was a referral to our agency.
>
> When we first met insured, we planned to put all coverages in effect on 7/17/85 at 12:01 a.m. when present coverage expired.
>
> Then, at that time, he advised he would prefer we put all coverages in effect on 7/10/85, one week earlier, as he was afraid he might have some lapse of coverage, and he just did not want to take any chances. Since he was insistent on this, and we sort of felt he had had some bad experience in the past because of his insistence, we complied with his request and made all coverage effective 7/10/85.
>
> . . .

> The bottom line is that there has been a very serious accident, and it appears that we will have some duplicate coverage.

(ROA V, 493-94). The letter continued to explain the facts and circumstances surrounding Mrs. McLeod's death. (Id.) Jennings sent the letter, together with the amended application, original application, a copy of the loss report, a photo of MCLEOD's home (MCLEOD had applied for personal comprehensive insurance covering three automobiles as well as his house), a copy of the declaration of automobile coverage being replaced (MCLEOD's Iowa National policy), a copy of MCLEOD's homeowner's policy being replaced, and the original agency worksheet used in preparing the application. (ROA V, 729).

As of July 16, 1985, Jennings believed that MCLEOD had contracted for, and CONTINENTAL was obligated to provide, duplicate coverage. (ROA V, 725-26). While aware of the existence of the credit for existing insurance provision in the underwriting rules, Jennings did not deem it applicable to MCLEOD's situation. (ROA V, 732-33). Not surprisingly, then, Jennings still had not informed MCLEOD of the potential applicability of a credit for existing insurance provision to his coverage with CONTINENTAL. (ROA V, 719).

CONTINENTAL's underwriting file reflects that Jennings' letter and MCLEOD's applications were received in Jacksonville on or about July 19, 1985. On or about the same day, Jennings had a telephone conversation with Eloise Slaughter, a supervisor in CONTINENTAL's Jacksonville office. (ROA V, 730-31). During the course of that

conversation, Ms. Slaughter informed Jennings of underwriting guidelines which provide for a credit for existing insurance provision on a policy of the type MCLEOD purchased. (ROA V, 732). The underwriting file reflects that Jennings first became angry at the suggestion that CONTINENTAL would seek to interject such an exclusionary provision into MCLEOD's policy. (ROA IV 556). Based upon his experience and understanding of the underwriting rules, Jennings simply did not believe the provision was applicable. (ROA V, 732-33). Hence, Jennings still did not contact MCLEOD to tell him that his CONTINENTAL coverage may be subject to a limitation under a credit for pre-existing insurance provision. (ROA V, 734).

After speaking with Ms. Slaughter, Jennings spoke with Jerry Freeland, Vice President of Underwriting at CONTINENTAL's Jacksonville office. Mr. Freeland advised Jennings that, because of the Iowa National UM policy, CONTINENTAL's coverage would be excess pursuant to the credit for existing insurance provision contained in the written policy booklet and on the declaration page CONTINENTAL would soon send to MCLEOD. (ROA IV, 567). That provision provides:

> "We will pay the amount of your loss that is left after you have been paid the full amount available under other policies."

(Id.). Mr. Freeland's subsequent handwritten note to Ms. Slaughter, however, reflects that if all was as indicated on the insurance applications, "then due to the circumstances, we should issue policy." (Id.)

Jennings continued to disagree as to the applicability of the credit for existing insurance provision even after the telephone conversations with Ms. Slaughter and Mr. Freeland. (ROA V, 732-33). By July 26, 1985, however, Jennings wrote Ms. Slaughter to express humble agreement with CONTINENTAL's position that the policy as written should have been denominated excess for the week of July 10-17, 1985, and that Jennings should have so informed MCLEOD at the time of application. (ROA IV, 496). Even at this point, though, Jennings never informed MCLEOD that the CONTINENTAL policy would be subject to a credit for existing insurance clause or any other limitation. (ROA V, 749-50).[2]

On August 12, 1985--a full 27 days after his wife's death, and a full 35 days after Jennings assured MCLEOD he would have the duplicate coverage--MCLEOD was sent a copy of the policy booklet. (ROA VII, 1145, paragraph 25). Included in the booklet was a declaration sheet describing the various amendments to the general policy provisions. (ROA IV, 497). Also included were specific amendments, including one designed to conform the policy provisions to Florida law. The coverage data page indicated that the policy would become effective at 12:01 a.m. on July 10, 1985. As agreed, it further provided primary liability coverage in the amount of $100,000.00 and UM coverage in the amount of $100,000.00 for each accident. Conspicuously absent on the coverage data page was any

---

[2] CONTINENTAL's records reflect that on July 23 and 24, 1984, UAC and Jennings consciously agreed <u>not</u> to contact MCLEOD regarding the credit for existing insurance provision (ROA IV, 556).

indication that any CONTINENTAL coverage would be deemed excess or umbrella in nature. (Id.).

Attached to the coverage data sheet was a supplemental listing of the various amendments allegedly modifying the general policy provisions. Listed was the "credit for existing insurance amendment," which was attached. (Id.). The "credit for existing insurance amendment" listed the Iowa National policies MCLEOD had disclosed to Jennings and Jennings had then disclosed to CONTINENTAL. It was upon receipt of the policy booklet that MCLEOD could have been first apprised of the credit for existing insurance "amendment." (ROA VII, 1145, paragraph 26).

Prior to receiving the policy booklet from CONTINENTAL, McLeod engaged the services of Attorney Larry Gramovot to pursue a wrongful death action against CEN-COM and SIMMONS, the tortfeasors. (ROA VII, 1145, paragraph 27). At the time of the accident, CEN-COM carried $250,000.00 in liability insurance with The Insurance Company of North America (hereinafter "INA"). (ROA VII, 1145, paragraph 28). Additionally, CEN-COM carried an umbrella policy of insurance with Iowa National for $1 million per accident (ROA VII, 1145, paragraph 29). In due course, Mr. Gramovot filed claims for benefits with both INA and Iowa National under CEN-COM's policies. (ROA VII, 1145, paragraph 30). When INA and Iowa National balked at payment, Mr. Gramovot filed a wrongful death action against CEN-COM and SIMMONS on September 27, 1985. (ROA VII, 1145, paragraph 32). At or about the same time, Mr. Gramovot filed claims for

benefits with Iowa National under MCLEOD's own policy. (ROA VII, 1145, paragraph 31).

Unfortunately, on October 11, 1985, Iowa National was declared insolvent pursuant to Chapter 631, Fla. Statutes (1985). (ROA VII, 1146, paragraph 33). Under the provisions of Chapter 631, the Florida Insurance Guaranty Association (hereinafter "FIGA") was appointed ancillary receiver for Iowa National and assumed the responsibilities of Iowa National under CEN-COM's $1 million umbrella policy and under MCLEOD's own $200,000.00 UM policy. (ROA VII, 1146, paragraphs 34-36). The effect of FIGA's involvement was to reduce CEN-COM's umbrella policy to $300,000.00. See, §631.57, Fla. Stat. The involvement of FIGA did not affect the $200,000.00 ($50,000.00 coverage on four automobiles was "stacked") available under MCLEOD's own UM policy.

On October 29, 1985, CONTINENTAL's claim-adjusting subsidiary, Underwriter's Adjusting Company (hereinafter "UAC"), wrote to Mr. Gramovot to advise that CONTINENTAL's coverage would be excess over the coverage provided by MCLEOD's UM policy with Iowa National. (ROA IV, 576-78). Nonetheless, on November 20, 1985, Mr. Gramovot wrote to UAC to advise that in light of Iowa National's insolvency, MCLEOD would be looking to CONTINENTAL for UM benefits totalling $300,000.00 ($100,000.00 coverage on three automobiles was "stacked"). (ROA IV, 579). In the letter, Mr. Gramovot demanded arbitration of MCLEOD's UM claim pursuant to the policy provisions of the written insurance policy. (Id.).

Because CONTINENTAL would not arbitrate (ROA VI, 863)(CONTINENTAL does not arbitrate coverage issues), Mr. Gramovot filed a motion for leave to amend MCLEOD's complaint to add CONTINENTAL as a defendant. (ROA VII, 1147, paragraph 41). That motion was granted, and on March 12, 1986, MCLEOD's first amended complaint was filed. (ROA VII, 1147, paragraph 42).

On March 31, 1986, UAC wrote Mr. Gramovot to indicate that CONTINENTAL's coverage would be excess over MCLEOD's UM policy with Iowa National by virtue of the "credit for existing insurance" provision included in the written insurance policy forwarded to MCLEOD after his wife's death. (ROA VII, 1147, paragraph 43). However, on April 1, 1986, CONTINENTAL's counsel, Bradley Powers, wrote Mr. Gramovot to indicate that:

> Continental Insurance Company is willing to pay its pro rata share with the Iowa National coverage within its policy limits, should a jury return a verdict in excess of the liability coverage carried by the tortfeasor.

(ROA IV, 603-04). On the same day, Mr. Powers wrote Camille Lyle of UAC to indicate that:

> It is my understanding that the tortfeasor has a $250,000.00 policy with AETNA [sic] and excess coverage with Iowa National of $1 million. As FIGA is now handling Iowa National's policy, the excess policy is reduced to $300,000.00. As a result, the tortfeasor has $550,000.00 in coverage available. In addition to the the [sic] 100/300 UM coverage on three cars Mr. McLeod carried with Continental, he also carried UM coverage with Iowa National in the amount of 50/100 UM coverage on four cars. As a result, it appears that we would prorate any verdict in excess of the tortfeasor's policy limits with the $200,000.00 UM coverage provided by Iowa National. It is my opinion that the

> course of action outlined above is as favorable as proceeding with arbitration. Please contact me immediately if you do not agree. (ROA VII, 1147-48, paragraph 45) (emphasis added).

The "immediate" response came in an April 24, 1986, letter from Camille Lyle of UAC to Mr. Powers. That letter informed Mr. Powers that, pursuant to the credit for existing insurance provision contained in the written policy of insurance forwarded to MCLEOD on August 12, 1985, CONTINENTAL would be excess over the coverage provided by FIGA under MCLEOD's UM policy with Iowa National. (ROA VII, 1147-49, paragraphs 46 and 48). The letter went on to state:

> We do not know exactly what FIGA will pay at maximum under their policies. You advised you were under the impression that they would pay a total of $300,000.00 under the PIP and UM coverages afforded to Mr. McLeod and $300,00.00 total on the excess policy of the tortfeasor. We are of the understanding that FIGA intended to pay only $300,000.00 total under all policies for this one occurrence (Id.)(emphasis in original).

Subsequent to April 1, 1986, MCLEOD filed an independent action against FIGA to enforce the arbitration provisions under MCLEOD's UM policy with Iowa National. (ROA VII, 1149, paragraph 50). In or about July, 1986, MCLEOD's action against SIMMONS, CEN-COM and CONTINENTAL was consolidated with the independent action against FIGA and trial in the consolidated action was scheduled to begin on August 4, 1986. (ROA VII, 1149, paragraph 51).

With trial approaching, Mr. Powers drafted a detailed analysis letter of the accident and the unique circumstances surrounding MCLEOD's claim. (ROA IV, 605-610). Mr. Powers' July 14, 1986,

letter described how MCLEOD was partially disabled as the result of advanced arthritis and how Mrs. McLeod had been the family's sole means of support. (Id.). The letter further described how Mrs. McLeod donated 25 percent of her income to her church where she was active in various activities. (Id.). The letter concluded with Mr. Powers evaluating MCLEOD's claim at $1.15 million--an amount described as "conservative" under the circumstances. (Id.).

It was also during July, 1986, that Mr. Gramovot communicated to counsel for all parties, including CONTINENTAL, an offer to settle MCLEOD's claims for a total of $850,000.00. (ROA VII, 1149, paragraph 52). INA, as the primary insurer for CEN-COM, agreed to contribute its $250,000.00 policy limits to the settlement of MCLEOD's claims. (ROA VII, 1149, paragraph 53). FIGA agreed to contribute its $300,000.00 policy limits under CEN-COM's excess policy with Iowa National. (ROA VII, 1149, paragraph 54). In a show of generosity, CEN-COM's owner even agreed to contribute $75,000.00 to the settlement pool. (ROA VII, 1150, paragraph 55).

In spite of the willingness of the other carriers to settle, CONTINENTAL refused to contribute anything to the settlement of MCLEOD's claims until FIGA paid $200,000.00 under MCLEOD's UM policy with Iowa National. (ROA VII, 1150, paragraph 56). CONTINENTAL's refusal to contribute was predicated on its concern that any payment made to MCLEOD before FIGA had paid $200,000.00 under MCLEOD's UM policy with Iowa National would be considered "voluntary" and would, therefore, extinguish CONTINENTAL's right to subrogation from CEN-COM. (ROA VI, 851). As CONTINENTAL would

later discover, however, §631.54(3) precluded subrogation against CEN-COM, since CEN-COM's insurer became insolvent. Unfortunately, neither Mr. Powers nor CONTINENTAL's own legal department[3] ever advised CONTINENTAL that, pursuant to the statute, no subrogation rights existed. (ROA VII, 1150, paragraph 58).

When the settlement discussions broke down due to CONTINENTAL's recalcitrance, MCLEOD moved for leave to file a second amended complaint to add allegations against CONTINENTAL for failing to negotiate and settle his claims in good faith as required by §624.155(1)(b)1. (ROA VII, 1150, paragraph 60). On August 29, 1986, the motion was granted, and MCLEOD's second amended complaint was accepted as filed. (ROA I, 1-7).

On or about October 6, 1986, CONTINENTAL filed a motion to dismiss the second amended complaint alleging that MCLEOD had failed to set forth the proper elements for recovery under §624.155 (ROA VII, 1150, paragraph 63). CONTINENTAL's motion to dismiss was heard on November 14, 1986. Instead of dismissing the complaint, the trial court gave MCLEOD twenty (20) days to amend to include specific reference to ultimate facts supporting the claims that CONTINENTAL failed to negotiate and settle MCLEOD's claims in good faith. (ROA VII, 1151, paragraph 64). In response to the trial court's mandate, MCLEOD filed an amended Count III to the second amended complaint on November 21, 1986. (ROA I, 8-10). A

---

[3] The extent to which CONTINENTAL's own legal department was consulted or even participated in connection with MCLEOD's claim is unclear. (ROA VI, 823).

subsequent motion to dismiss MCLEOD's amended Count III to the second amended complaint (ROA VII, 1151, paragraph 66), was denied. (ROA VII, 1153, paragraph 75).

On January 21, 1987, MCLEOD settled as to CEN-COM's excess liability policy, accepting the $300,000.00 limit of coverage provided by FIGA as ancillary receiver for Iowa National. (ROA VII, 1151-52, paragraph 67). At or about the same time, Mr. Powers was recommending that CONTINENTAL make an offer to avoid bad faith liability. (ROA III, 470-71). In fact, CONTINENTAL's underwriting file reflects a telephone conversation with Mr. Powers on February 6, 1987, wherein Mr. Powers recommended CONTINENTAL make a "substantial offer." (ROA IV, 564). However, no offer was forthcoming.

On February 13, 1987, CONTINENTAL did authorize $75,000.00 to its local adjuster to attempt settlement of MCLEOD's claim. (ROA IV, 565; ROA VI, 849-50). The authorization was contingent, however, upon FIGA tendering policy limits of $200,000.00 to MCLEOD for UM coverage under the Iowa National policy. (Id.) The contingency was based upon CONTINENTAL's continued fear that its non-existent subrogation rights would be prejudiced. Mr. Powers' subsequent requests for authority to settle were rejected and, hence, no settlement offers were extended to MCLEOD.

On February 16, 1987, the trial court granted CONTINENTAL's motion to sever the bad-faith action from the trial of the wrongful death action, which was then scheduled to commence in early March. (ROA VII, 1150, paragraph 61). Trial was later continued until

April 6, 1987. (ROA VII, 1152, paragraph 71). In the meantime, however, MCLEOD settled with FIGA for $179,900.00 on MCLEOD's UM policy with Iowa National and with INA for $250,000.00 under CEN-COM's primary liability policy. (ROA VII, 1152, paragraph 72 and 73). CONTINENTAL was made aware of, and approved, the settlements all the while feeling that its non-existent subrogation rights would be protected. (ROA II, 179, paragraph 59 and ROA II, 217, paragraph 59; ROA VII, 1152, paragraph 74).

As trial approached, CONTINENTAL again asked Mr. Powers to evaluate the value of MCLEOD's wrongful death claim. (ROA IV, 598). In this evaluation, he was assisted by Bob Banker, a senior attorney with the firm of Fowler, White, Gillen, Boggs, Villareal and Banker, P.A. CONTINENTAL's underwriting files reflect a February 26, 1987, telephone conversation between Mr. Banker and UAC in which the value of MCLEOD's claim was evaluated at an amount in excess of all available insurance other than that of CONTINENTAL by as much as $150,000.00 to $175,000.00. (ROA IV, 565, 599).

Subsequently, another evaluation letter was prepared by Mr. Powers with advice and input from Mr. Banker. (ROA IV, 613-15). As before, the letter concluded with an evaluation of the file. Unlike the previous letter, however, the evaluation had been reduced to $900,000.00 in apparent response to Mr. Banker's input. (Id.). Nonetheless, the evaluation was still in excess of all of the benefits available from all other insurers.

On April 6, 1987, trial of MCLEOD's wrongful death action began. By April 13, 1987, the jury returned a verdict against

SIMMONS, CEN-COM and CONTINENTAL for $1.25 million. A judgment reflecting the jury's verdict was executed on April 14, 1987, and was filed on April 15, 1987. (ROA I, 15). Subsequent motions for new trial and remittitur were denied. (ROA I, 16-18, 35). No appeal was taken.

With the resolution of his wrongful death action, MCLEOD renewed his action against CONTINENTAL for failing to negotiate in good faith in violation of §624.155(1)(b)1. CONTINENTAL continued to deny liability claiming its refusal to negotiate was based on the belief that as an excess carrier, it was not required to negotiate until MCLEOD exhausted all other available coverages. (ROA I, 21). Nonetheless, on May 11, 1987, CONTINENTAL tendered MCLEOD $300,000.00 in UM benefits in satisfaction of the claims under the CONTINENTAL policy. (ROA I, 32; ROA VI, 852). It was expressly understood that the tender and acceptance would not effect MCLEOD's claims under §624.155. (ROA I, 42).

On April 12, 1988, MCLEOD filed a motion for partial summary judgment as to CONTINENTAL's fourth and fifth affirmative defenses to the bad-faith allegations. (ROA I, 68). CONTINENTAL's fourth and fifth affirmative defenses merely restated the self-serving view that no cause of action could lie for bad-faith refusal, because CONTINENTAL was an excess insurer. (ROA I, 20-22; 68). On June 7, 1988, CONTINENTAL took the offensive and restated its fourth and fifth affirmative defenses as a basis for asking for summary judgment as to MCLEOD's claim for bad faith. (ROA I, 72-74).

Prior to the hearing on August 29, 1988, both MCLEOD and CONTINENTAL filed extensive memoranda of law in support of the respective motions for summary judgment. (ROA I, 113-135, and 78-112, respectively). At the August 29, 1988, hearing, the Court considered the arguments and memoranda and took the matters presented under advisement.

On September 12, 1988, the trial court prepared a letter to counsel for both parties reflecting a decision as to the respective motions for summary judgment. (ROA I, 146-148). In that letter, the trial court officially denied the cross-motions for summary judgment. (Id.) The trial court did hold that, notwithstanding its position to the contrary, that CONTINENTAL's coverage was "viable," even if deemed excess. The trial court noted that under the authority of Miller v. Safety Mutual Casualty Corp., 497 So.2d 1273 (Fla. 2d DCA 1986), MCLEOD's settlement with FIGA for less than the limits of his own UM policy did not absolve CONTINENTAL of responsibility to deal in good faith. (Id.).

The trial court specifically declined to rule on the existence of an oral contract for insurance. (Id.). While recognizing that oral binders are "a way of life in the insurance industry," the trial court recognized that what, if anything, constituted the July 8, 1985, agreement between MCLEOD and Jennings would be for the jury to decide. (Id.).

A formal Order reflecting the trial court's September 12, 1988, memorandum opinion was entered on September 20, 1988. (ROA I, 150-151). On October 3, 1988, CONTINENTAL moved for a rehearing

or, in the alternative, for relief from the September 20, 1988, Order, arguing that the trial court was ambiguous as to the existence or non-existence of an oral contract. (ROA I, 152-153). After a hearing, the trial court entered an amended Order clarifying the holding as to the existence or non-existence of an oral contract. (ROA I, 164-165).

After the filing of two amended complaints (ROA I, 136-43, 168-74), trial of MCLEOD's bad-faith action against CONTINENTAL began on August 21, 1989. At the close of the presentation of the evidence, MCLEOD moved for a directed verdict as to the issue of liability. (ROA VII, 984). MCLEOD argued that the evidence showed CONTINENTAL's handling of MCLEOD's claim was unjustified under the law or the facts. (Id.). On this, the trial court reserved ruling. (ROA VII, 986).

With regard to the issue of damages, MCLEOD took the position that if the jury found CONTINENTAL acted in bad faith, the appropriate award would be the "verdict shortfall," or $200,000.00. (ROA VII, 986-87). The "verdict shortfall" in this case represented the amount of the jury's verdict in the wrongful death action ($1.25 million), minus the amount collected from all insurance ($1,029,900.00), minus the extent to which FIGA was forgiven under MCLEOD's UM policy ($20,000.00), and minus the $100 deductible required under §631.57(1)(a). (Id.). MCLEOD argued this "verdict shortfall" was recoverable as a matter of law and, accordingly, asked for a directed verdict. (ROA VII, 987). MCLEOD also submitted a proposed jury instruction to the same effect.

(Id.). CONTINENTAL countered by arguing that the measure of damages should be left to the jury's discretion. (ROA VII, 988). The trial court subsequently denied MCLEOD's motion for directed verdict as to damages and rejected MCLEOD's proposed jury instruction to the same effect. (ROA VII, 991).

On August 23, 1989, the jury returned a verdict against CONTINENTAL on the issue of bad faith. (ROA III, 436). Pursuant to an agreement between the parties,[4] the jury was asked to decide the date on which CONTINENTAL first acted in bad faith towards MCLEOD. (Id.; ROA VII, 1024). The jury specifically determined that CONTINENTAL first acted in bad faith on April 1, 1986 (the date of Mr. Powers' letter describing CONTINENTAL's coverage as pro-rata), and awarded MCLEOD $100,000.00 in compensatory damages. (ROA III, 436-37). A final judgment to that effect was entered by the trial court on August 29, 1989. (ROA III, 440).

On September 15, 1989, MCLEOD filed a notice of appeal. (ROA III, 441). On December 7, 1989, MCLEOD filed an amended statement of judicial acts to be reviewed, adding to the assignments of error the trial court's failure to grant the motion for directed verdict as to the issue of damages. (ROA VII, 1138-39). CONTINENTAL then

---

[4] The agreement was reached for the purposes of determining when, if at all, MCLEOD became entitled to interest on wrongfully withheld policy benefits. See, Ray v. Traveler's Insurance Co., 477 So.2d 634 (Fla. 5th DCA 1985); See also, Argonaut Insurance Co. v. May Plumbing Co., et al., 474 So.2d 212 (Fla. 1985); Vigilant Insurance Co. v. Humana of Florida, Inc., 518 So.2d 989 (Fla. 4th DCA 1988).

filed a notice of cross appeal, questioning the trial court's so-called "Miller" instruction.

Briefs were timely submitted by both parties and the appeal moved to oral argument on July 16, 1990. On November 14, 1990 the Second District Court of Appeal filed its written opinion. See, McLeod v. Continental Insurance Co., 15 FLW D2785 (November 14, 1990). The District Court's opinion accepted CONTINENTAL's argument that the trial court's "Miller" instruction preordained a finding of bad faith. Finding that without the instruction the jury could have found either way on the issue CONTINENTAL's bad faith, the District Court remanded for a new trial. Id.

As to the issue of damages, the District Court rejected MCLEOD's argument that the appropriate measure of damages in a first-party bad faith action can, and should, include the amount of the excess judgment. The District Court further rejected MCLEOD's argument that the legislature intended the measure of damages in a first-party bad faith action mirror that awarded in third-party bad faith actions. Id. at D2786. Nonetheless, the District Court certified the question to this Court as being one of great public importance. Id. at D2785. A timely motion for rehearing and/or for clarification was filed and, with the exception of effecting a change in a footnote, was subsequently denied.

SUMMARY OF ARGUMENT

Prior to 1982, Florida courts prohibited first-party bad faith actions against insurers while allowing third-party actions where the insurer's bad faith failure to settle caused damages. In 1982, the Florida legislature enacted §624.155 to curb insurers' bad faith by providing for a statutory cause of action in both first and third-party situations. The legislature intended that the measure of damages be the same in either action, to wit: the excess judgment. The weight of authority and public policy all support this construction of §624.155. Nonetheless, the District Court's opinion in the instant case ignored the legislative history, weight of authority, and compelling public policy choosing instead to rely on a common law causation analysis. The District Court's analysis is misplaced and should be rejected. In sum, this Court should answer the certified question by holding that the excess judgment is a recoverable item of damage in a first-party bad faith action brought under §624.155 against an insurer.

ARGUMENT

IN VIEW OF LEGISLATIVE INTENT, PUBLIC POLICY, AND THE WEIGHT OF APPLICABLE AUTHORITY, "DAMAGES" AS USED IN §624.155 SHOULD INCLUDE THE EXCESS JUDGMENT

From the foregoing complicated factual background evolved a simple legal issue. As the Second District Court of Appeal's certified question to this Court succinctly states:

> WHAT IS THE APPROPRIATE MEASURE OF DAMAGES IN A FIRST-PARTY ACTION FOR BAD FAITH FAILURE TO SETTLE AN UNINSURED MOTORIST INSURANCE CLAIM?

The issue before the Court necessarily involves an interpretation of §624.155, Fla. Stat. (1989). Enacted in 1982, §624.155 states that :

> (1) Any person may bring a civil action against an insurer when such person is damaged:
>
> (a) By a violation of any of the following provisions by the insurer:
>
> 1. §626.9541(1)(i), (o), or (x);...
> [or]
>
> (b) By the commission of any of the following acts by the insurer:
>
> 1. Not attempting in good faith to settle claims when, under all the circumstances, it could and should have done so, had it acted fairly and honestly towards its insured and with due regard for his interests;
>
> ...
>
> Notwithstanding the provisions of the above to the contrary, a person pursuing a remedy under

> this Section need not prove that such act was committed or performed with such frequency as to indicate a general business practice.

Section 624.155(3) further provides that:

> Upon adverse adjudication at trial or upon appeal, the insurer shall be liable for damages, together with court costs and reasonable attorney's fees incurred by the Plaintiff.

From its enactment, §624.155 has been the subject of judicial interpretation. The early cases turned on the question of whether §624.155 created a first-party cause of action. In Rowland v. Safeco Insurance Co. of America, 634 F.Supp 613 (M.D. Fla. 1986), for instance, the court denied a motion to dismiss a bad faith action brought by an insured against an insurer pursuant to §624.155. Relying on decisions predating the statute, the defendant insurer argued that the plaintiff's complaint failed to state a cause of action for an independent tort. In denying the motion to dismiss, the Rowland court noted that the enactment of §624.155 "created an independent cause of action for bad faith refusal to pay." Id. at 614-15, citing, Industrial Fire & Casualty Insurance Co. v. Romer, 432 So.2d 66, 69, n.5 (Fla. 4th DCA)(Hurley, J., concurring), rev. denied, 441 So.2d 633 (Fla. 1983). Citing legislative history, the Rowland court noted that §624.155:

> [R]equires insurers to deal in good faith to settle claims. Current case law requires the standard in liability [third party] claims, but not in [first party] uninsured motorist coverage; the sanction is that a company is

> subject to a judgment in excess of policy limits. This section would apply to all insurance policies.

Id., citing, Staff Report, 1982, Insurance Code Sunset Revision (H.B. 4F; as amended H.B. 10G)(June 3, 1982).

Since Rowland, courts have uniformly held that §624.155 creates a first-party cause of action for the bad faith refusal to settle uninsured motorist claims. See, United Guaranty Residential Insurance Co. of Iowa v. Alliance Mortgage Co., 644 F.Supp 339 (M.D. Fla. 1986); Kujawa v. Manhattan National Life Insurance Co., 541 So.2d 1168, 1169 (Fla. 1989); Allstate Insurance Co. v. Melendez, 550 So.2d 156, 157 (Fla. 5th DCA 1989); Cardenas v. Miami-Dade Yellow Cab, 538 So.2d 491, 495 (Fla. 3d DCA), rev. dismissed, 549 So.2d 1013 (Fla. 1989).

The issue of the appropriate measure of damages in a first-party action has not been so often addressed. In fact, the issue appears to have been first addressed in Jones v. Continental Insurance Co., 670 F.Supp. 937 (S.D. Fla. 1987)(Jones I). In Jones I, the court dealt with a motion to dismiss in a case factually analogous to the instant action. The lawsuit arose from an automobile accident in which Karen Jones, a covered insured, was fatally injured. Karen's parents made a claim for the $600,000 limits for the uninsured motorist coverage with CONTINENTAL. CONTINENTAL rejected the claim and proceeded to arbitration. Id. at 938-39.

On the eve of arbitration, CONTINENTAL offered the Joneses $500,000.00 to settle. The offer was rejected and the arbitration

panel ultimately awarded $1 million to Karen's parents. A state court later entered judgment in their favor for $600,000.00 representing the limits of CONTINENTAL's uninsured motorist coverage. Id. at 939.

In Jones I, the Joneses discovered that CONTINENTAL knew that their damages were far in excess of policy limits yet failed to conduct a proper investigation before refusing the claim for policy limits. Id. at 939. They then filed a complaint under §624.155 seeking the difference between the arbitration award ($1 million) and the state court judgement ($600,000.00). The complaint in Jones I argued that this difference, excess judgment or shortfall, was the appropriate measure of damages in a first party bad faith action. Id. at 942.

In Jones I, the court was only concerned with CONTINENTAL's motion to dismiss. The motion was denied. Citing Rowland, the Jones I court held that by enacting §624.155 the Florida legislature created a statutory cause of action for bad faith where only a common law cause of action had previously existed.

It was not until Opperman v. Nationwide Mutual Insurance Co., 515 So.2d 263 (Fla. 5th DCA 1987), rev. denied, 523 So.2d 578 (Fla. 1988), that a Florida appellate court first addressed the contours of §624.155. In Opperman, the insureds had a UM policy with Nationwide for $75,000.00. While that policy was in effect, the insureds were injured in an automobile accident. The tortfeasor was underinsured, and the Oppermans sought relief from Nationwide under their own UM policy. Id. at 264.

Notwithstanding its complete knowledge of the seriousness of the Oppermans's injuries and that, by its own evaluation, the value of the Oppermans' claims far exceeded the amount of available coverage, Nationwide offered only $22,500.00 to settle. As the negotiations progressed, the Oppermans offered to settle for policy limits, but Nationwide never offered more than $40,000.00. Id. at 267. The matter was finally referred to arbitration where the Oppermans were awarded $165,000.00. Subsequently, the Oppermans filed an action against Nationwide under §624.155 for the entire arbitration award. The trial court dismissed the bad faith action and the Oppermans appealed. Id.

The Fifth District Court of Appeal reversed, holding that the Oppermans' complaint stated a cause of action against Nationwide for bad faith refusal to settle. Citing legislative history, the Opperman court held that §624.155 created a new cause of action against an insurer for acting in bad faith in the handling of first-party claims the sanction for which is the same as that imposed in the third-party context. Id. at 266. While not directly answering the damage question, the Fifth District implicitly held that an excess award was an appropriate element of damage in a first-party bad faith action.[5]

The specific question of the appropriate measure of damages in a first-party bad faith action has been addressed by only a handful

---

[5]Similarly in Fidelity & Casualty Insurance Co. of New York v. Taylor, 525 So.2d 908 (Fla. 3d DCA 1987), rev. denied, 528 So.2d 1181 (Fla. 1988), the court allowed an insured to maintain a counterclaim for bad faith against her insured for the amount of an excess arbitration award.

of courts including, obviously, the Second District Court of Appeal in the instant case. The question of the appropriate measure of damages in a first-party bad faith action appears to have been first expressly decided by the circuit court in Fidelity & Casualty Insurance Co. v. Taylor, No. 84-1884 (11th Fla. Cir. Ct., November 4, 1988). In Taylor, the circuit court held that, as a matter of law, the appropriate measure of damages in a first party bad faith action was the excess award:

> [T]he statute [§624.155] is not clear or unambiguous. However, the court rules that the cases heretofore decided which concern F.S. §624.155, [citations omitted], imply that first-party, bad faith claims should be considered in conformity with the law of third-party bad faith claims. Since an element of damage in the third-party context is the amount a judgment exceeds the underlying insurance limits, the court determines that a proper element of damage in a first-party claim such as that presented by Mrs. Taylor includes the amount of the excess arbitration award.

The damage issue was next addressed by a circuit court in Wahl v. Insurance Co. of North America, Case No. CL-87-1187 CA-17 (Fla. 19th Cir. Ct. June 6, 1989). In Wahl, the insured was involved in an automobile accident with an underinsured driver. The accident left the insured, Mr. Wahl, in a coma for approximately two weeks. Subsequent to the accident, Mr. Wahl put INA on notice that he would be seeking benefits up to policy limits. Subsequently, Mr. Wahl's attorneys made similar demands. While it evaluated the case in an amount in excess of those policy limits, INA never responded with an offer to settle.

Predictably, INA's recalcitrance became the subject of a §624.155 action. Only after the §624.155 action was filed, did INA make an offer. However, it was made on the eve of arbitration and amounted to less than policy limits. Again, the offer was made notwithstanding the fact that INA had evaluated Mr. Wahl's claim for an amount in excess of policy limits. At the arbitration hearing, Mr. Wahl was awarded $662,468.20. His wife was awarded $125,000.00 on her loss of consortium claim.

In the first-party bad faith action brought under §624.155, Mr. Wahl argued that the appropriate measure of damages was the difference between the arbitration award and policy limits. The trial court agreed and ruled that the unsatisfied excess judgment was a recoverable element of damage as a matter of law.

The first reported decision dealing specifically with the issue involved here, is Jones v. Continental Insurance Co., 716 F.Supp. 1456 (S.D. Fla. 1989)(Jones II). In Jones II, the parents of Karen Jones were again before the court. Their bad faith action, brought pursuant to §624.155 had gone to trial. The jury found against CONTINENTAL on the issue of bad faith but found that the Joneses had suffered no damages. The Joneses filed motions for judgment notwithstanding the verdict and for a new trial. The focus of both motions was the argument they had previously and unsuccessfully asserted in connection with a motion for summary judgment, to wit: The appropriate measure of damages in a first party bad faith action was the difference between the prior award and the policy limits which had been tendered. Id. at 1457-58.

In resolving the post trial motions, the Jones II court again surveyed the history of first party bad faith actions in Florida and the legislative history surrounding §624.155. That review convinced the Jones II court to hold:

> [T]he statute's purpose is to provide the same remedy in both first-party and third-party bad faith claims--the excess award. In fact, Florida courts which have construed the statute have looked at third-party bad faith law as the basis for their decisions. (citations omitted). Moreover, some Florida courts have ruled specifically that an excess arbitration award may be recovered as damages under the statute in a first party bad faith suit. Wahl v. Insurance Company of North America, No. 87-1187-CA-17 (19th Fla. Cir. Ct., June 6, 1989); Fidelity & Casualty Insurance Co. v. Taylor, No. 84-1884, (11th Fla. Cir. Ct., November 4, 1988).

Id. at 1460. Based upon its review of the statute, legislative history, and relevant case law, the Jones II court concluded that the appropriate measure of damages in that first-party bad faith action was the difference between the prior arbitration award and the policy limits. The court further held that this was the measure of damages as a matter of law. Id. The court concluded by setting aside the jury's verdict and entered judgment in favor of the insureds in the amount of the excess award minus appropriate set-offs. Id.

The court's opinion in Jones II subsequently served as the basis for the decision in Prudential Property & Casualty Insurance Co. v. Cook, Case No. CA89-2345, Division H, formerly pending in the Circuit Court for the Sixth Judicial Circuit in and for Pasco County. In Cook, the insurer sought to vacate, modify or correct

an arbitration award entered in favor of its insured, Patricia Cook. Ms. Cook filed a counterclaim alleging that the insured acted in bad faith and, as damages, sought the entire arbitration award.

After a bench trial, the Honorable Lawrence Keough entered an order finding the insurer acted in bad faith in negotiating Ms. Cook's underinsured motorist claim. Judge Keough found that Ms. Cook's damages should be determined in accordance with Jones II and entered judgment accordingly.

In the instant case, the trial court and the appellate court were presented, and considered, the foregoing discussion of relevant case law.[6] The trial court simply rejected the authority submitted by MCLEOD. The Second Court of Appeal failed to address some of MCLEOD's authority, attempted to harmonize others, and expressly noted that Jones II is in conflict with the opinion rendered in this case. 15 F.L.W. at D2787

The District Court's opinion in the instant case also appears to be in conflict with Hollar v. International Bankers Insurance Co., 15 FLW D2888 (Fla. 3d DCA, November 27, 1990). See, Jones v. Continental Insurance Co., 920 F.2d 847, 851 n. 7 (11th Cir. 1991)(discussing apparent conflict and certifying identical

---

[6] At the time of trial, MCLEOD was unaware of the opinion in Jones II. The opinion was first published on August 11, 1989--only ten days before the commencement of trial. Neither MCLEOD or CONTINENTAL brought Jones II to the trial court's attention. It was, however, incorporated into MCLEOD's briefs on appeal. Similarly, while not considered by the trial court, Cook was presented to the District Court as supplemental authority for MCLEOD's position.

question to this Court). In Hollar, the issue was whether §624.155 limits the measure of damages for failure to settle a claim in good faith. The insurer in Hollar argued that the payment of policy limits within the 60-day grace period provided under §624.155(2)(d), absolved it from additional liability for bad faith. 15 F.L.W. at D2888.

In Hollar, the insureds furnished their insurers with a notice of a claim of bad faith. The insureds sought recovery alleging that while it knew of their liability for the injury of third-party, and that damages exceeded policy limits, the insurer still failed to accept an offer to settle within policy limits. The insured was subsequently exposed to liability for a judgment which exceeded policy limits. Id.

While arising in the context of a first-party bad faith action for failure to settle a third-party's claim, Hollar turns on §624.155's definition of damages. As the Hollar court noted:

> Section 624.155 changes neither the case law obligation of good faith nor the measure of the damages due an insured once bad faith is proved. Rather than changing that decisional law, §624.155 simply expands the cause of action to first-party claims, [citations omitted], and adds a procedural first step that requires insureds to notify the insurer of a bad faith claim. See, §624.155(2)(a), Fla. Stat. (1989). Thus, it provides a cumulative and supplemental remedy.
>
> Statutes should be construed to harmonize with existing law. Statutes intending to alter the established case law must show that intention in unequivocal terms. [citations omitted]. The legislature is presumed to know the existing law at the time it enacts a statute. [citations omitted]. We agree with the Fifth District's observation in Opperman that there

> is nothing in section 624.155 which indicates an intent to limit a remedy existing under the decisions of the Supreme Court. [citation omitted]. On the contrary, the statute clearly indicates the legislature's intent to expand that remedy.
>
> ...
>
> In the instant case, insurers' self-serving reading of the term "damages" as being confined to policy limits is an illogical interpretation, a radical departure from the decisional law and, further, an explanation in no way consistent with the legislature's stated desire for insurers to act in good faith towards their insureds. The function of the bad faith claim is to provide the insured with an extra contractual remedy. [citations omitted] ... Damages, as both the clear wording of the statute and past Florida case law establish, must be all damages resulting from an insurer's bad faith actions.
>
> Following the analysis as stated above, we conclude that when the legislature employed the term "damages" in section 624.155(2)(d) [the 60-day notice provision], it necessarily contemplated the same elements of damages that are viable and extant under the decisional law of the Supreme Court.

Id. at D2888-89. (emphasis added).

The considerations underlying the Court's opinion in Hollar apply with equal force and validity to the instant action. The enactment of §624.155 did not change bad faith law, it simply added an additional class of plaintiffs, i.e., the insureds themselves. It must be remembered that the purpose of §624.155 was to guarantee that insurers would act in good faith towards their insureds. While the cases might arise in somewhat different factual situations, the underlying policy of deterrence is best realized if the penalty is the same. See, Helmbolt v. LeMars Mutual Insurance

Co., Inc., 404 N.W.2d 55 (S.D. 1987).[7] Without an identifiable and expected sanction such as the threat of exposure to the excess award (common in third-party bad faith actions), a UM carrier could force every insured into court first hoping that a jury finds no bad faith and, second, even if bad faith is found, that the jury finds that the insured has recovered enough. The result would not be only the multiplication of legal proceedings, but the emasculation of the intended deterrent effect of §624.155.

---

[7] In Helmbolt, the insured sought and recovered the excess judgment in a first-party bad faith action. The insurer appealed arguing that irrespective of any bad faith, the insured did not prove damages. The South Dakota Supreme Court rejected the insurer's argument and held:

> "In [previous cases], this court approved damages awards equal to the amount the judgment taken against the insured exceeded policy limits. In [those cases], however, the insured was the tortfeasor who either sued his insurance company or assigned his cause of actions to do so to the injured party. The justification for imposing liability upon the insurance company equal to the amount in which the judgment exceeded policy limits was that the company's bad faith failure to settle resulted in its insured being subject to liability for this excess amount. (citations omitted). In the present case, it is the tort victims who are suing their own insurance company. The same justification for assessing damages equal to the excess liability does not exist because the insured plaintiffs are not subject to a judgment in that amount. However, this court also stated in [a previous decision] that <u>if an insurance company were not required to pay the excess liability, its "responsiveness to its well-established duty to give equal consideration to an...insured's interests would tend to become meaningless." [citation omitted]. This concept applies with equal force to an insurer's duty to the purchaser of underinsurance.</u> 404 N.W.2d at 60. (emphasis added).

If the measure of damages is not the excess judgment, then just what does §624.155 provide? According to the District Court, §624.155 merely provides insureds with an vehicle for the recovery of interest on the unpaid benefits, attorney's fees, and costs of pursuing the action. However, these items are recoverable anyway. Interest on wrongfully withheld benefits has long been recoverable. See, The Equitable Life Assurance Society v. Nichols, 84 So.2d 500 (Fla. 1954). Attorney's fees are recoverable under §624.155(3) as a separate item of damage or under §627.428. Inacio v. State Farm Fire & Casualty Co., 550 So.2d 926 (Fla. 1st DCA 1989). The "costs of pursuing the action" are similarly a separate item of damage under §624.155(3) and are traditionally awarded the prevailing party even without specific statutory authorization.

In short, under the District Court's analysis, the enactment of the statute changed nothing. It cannot be gainsaid that the legislature intended to enact an unnecessary statute. See, Johnson v. Feder, 485 So.2d 409, 411 (Fla. 1986)(Court should not assume that legislature acted pointlessly). Yet to accept the District Court's analysis leads to this absurd result. Accordingly, this Court must reject the District Court's analysis. Drury v. Harding, 461 So.2d 104 (Fla. 1984)(courts must avoid interpretations which cause unreasonable or absurd results).

The District Court in the instant case, and the minority of courts in other cases, base their conclusions that the excess judgment is not a recoverable element of damage under §624.155 on a common law causation analysis. See, Cocuzzi v. Allstate Insurance

Co., Case No. 89-613-Civ-Orl-19 (M.D.Fla. 1990). Indeed, the District Court in the instant case, borrowed heavily from Baxter v. Royal Indemnity Co., 285 So.2d 652 (Fla. 1st DCA 1973), cert. discharged, 317 So.2d 725 (Fla. 1975). See, McLeod, 15 FLW at D2786. In Baxter, the court discussed the differences between a third-party and a first-party bad faith cause of action. That discussion, however, is presented in the context of common law and bears no applicability to the statutory scheme created by the legislature when enacting §624.155. Hence the District Court's discussion of common law distinctions is simply inapposite.

In its opinion, the District Court attempts to differentiate between first and third-party actions by claiming that the damages accruing in the former are not caused by the insurer, while the damages accruing in the latter are directly related to the insurer's conduct. This is really a false distinction. In both first and third-party bad faith actions the initial damage is caused by a tortfeasor. Whether it is an uninsured motorist in the context of a first-party bad faith action, or the insured himself in the context of a third-party bad faith action, it is the tortfeasor and not the insurance company that literally causes the damage. However, it is the insurer that "causes" the excess judgment. In the third-party context, the insurer becomes liable to **its** insured for its failure to settle with a third party. That liability arises even where the insured is not, or never can be, exposed to additional liability. See, Shook v. Allstate Insurance Co., 498 So.2d 498 (Fla. 4th DCA 1986), rev. denied, 508 So.2d 13

(Fla. 1987). The insurer can be called to atone for its bad faith by paying damages caused by another.

There is no logical or legal reason to apply a different analysis in a first-party action. While it is true that CONTINENTAL did not kill Mrs. Mcleod, it is equally true that CONTINENTAL could be called on to pay UM benefits to MCLEOD.[8] It is further true that CONTINENTAL, and CONTINENTAL alone, caused MCLEOD to go to trial where he obtained the excess judgment.

CONTINENTAL was given the opportunity to contribute to a settlement which would have involved less than policy limits. When CONTINENTAL failed to contribute, it "caused" the excess judgment to be rendered in the same way that an insurer's recalcitrance in a third-party action "causes" an excess judgment to be entered against its insured. In a very real sense, the insurer causes the excess judgment in both cases and should be equally sanctioned. To hold otherwise would allow insurers like CONTINENTAL, in cases such as this, to incredulously withhold paying benefits content in knowing that in a worst case scenario, its exposure is capped at policy limits plus relatively minimal expenses.

Finally, it is worth noting that §624.155 also provides for a third-party action, separate and apart from any cause of action arising under common law. The statute "<u>any person</u>" may bring a civil action against an insurer for the bad faith refusal to

---

[8]In this regard, UM benefits are actually a form of third-party coverage that are paid for, and inure to the benefit of, the insured. <u>See</u>, <u>Allstate Insurance Co. v. Boynton</u>, 486 So.2d 552, 557 (Fla. 1986).

settle. See, §624.155(1). Nowhere in the statute did the legislature attempt to differentiate between first and third-party causes of action in the manner suggested by the District Court's opinion in this case.[9] The legislature did not define "damages" differently based upon the nature of the action brought under the statute. It certainly could have made such a distinction; but it did not. In the absence of legislative direction, this Court should not create a judicial distinction.

CONCLUSION

The key to interpretation of any statute is consideration of the act as a whole, the evil to be corrected, the language of the act, history of the enactment, and the state of the law already in existence bearing on the subject. Byrd v. Richardson-Greenshields Securities, Inc., 552 So.2d 1099, 1102 (Fla. 1989). All courts are obligated to honor the obvious legislative intent and policy behind the enactment even when that intent requires interpretation that exceeds the literal language of the statute. Id. In the instant case, the District Court ignored the teachings of Byrd and interpreted §624.155 in such a way as to emasculate its intended

---

[9]Indeed the only attempt to distinguish first-party (underinsured) and third-party (liability) claims appears in §624.155(1)(b)(3) relating to acts of bad faith. The fact that the legislature made this distinction in only one provision of the statute is certainly suggestive that the legislature did not intend to make the same distinction in other provisions such as those dealing with damages recoverable upon a showing of bad faith. See, Russello v. U.S., 464 U.S. 16, 23 (1983)(explaining the rule expressio unius est exclusio alterius).

deterrent effect. The District Court ignored that intended effect and based its holding upon an interpretation of insurance law predating §624.155. The enactment of §624.155, however, changed insurance law. The enactment was accompanied by legislative history which talked of sanctions being the same in first and third-party actions. To hold otherwise would be to reject legislative intent.

For the foregoing reasons, MCLEOD respectfully requests this Court quash the District Court's opinion in the instant case as it relates to damages and answer the Certified Question by holding that the appropriate measure of damages in a first-party action for bad faith failure to settle an uninsured motorist claim includes the excess judgment.

HUGH D. SMITH, ESQUIRE
DAVID S. NELSON, ESQUIRE
P. O. Box 3288
Tampa, FL 33601
(813) 221-7171
Fla. Bar Nos. 120166 and 705780

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by U.S. Mail to Michael Bell, Esquire, Hannah, Marsee, Beik & Voght, P. O. Box 536487, Orlando, FL 32853 and to Roy D. Wasson, Esquire, Suite 402, Courthouse Tower, 44 W. Flagler Street, Miami, FL 33130, this 22d day of February, 1991.

Attorney