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PRE-LITIGATION PRACTICE IN INSURANCE CASES

I. SCOPE

Insurance companies now enjoy a great sense of strength in dealing with their insured and third party beneficiaries in all aspects of insurance. Although the insurance companies’ exposure to liability has been greatly reduced, there has been no attendant reduction in premium costs.

With the present composition of the Supreme Court, all nine justices come from defense firms dealing in the defense of big business and the insurance industry, it is doubtful that there will be any change in the course set by the court to protect big business and insurance companies.1

To understand the political advantage the insurance companies have is necessary to any discussion of prelitigation practices in insurance cases.

Presently, because of the insurance companies “most favored nation” status at our highest court, they are becoming somewhat arrogant in their approach to their obligations under the insurance policies, Art. 21.21, the DTPA and Art. 21.55.

When insurance companies make decisions on an economic basis instead of their contractual and statutory duties under an insurance policy or a statute, the claims process itself is destroyed. The formula for economic success for insurance companies is to deny claims to get a reaction. For claims denied only a small percentage will go to an attorney of that small percentage only a few will bring suit and of that few, only a very small number will receive anything more than what they should have recovered under the contract anyway. What this means is that unwarranted denials are becoming more common place as are what insureds perceive to be a claims “run-around” before the denial. Also there is a significant problem with insurers offering less than the claim is worth.

It is a rare situation indeed that an insured goes to an attorney at the start of the claim process. If that occurs, the insurance companies may have that as one of their “red flags.”

II. THE BIG PICTURE

Pre litigation insurance work is complicated. The “law” is a mix of statutes, contract, and common law. There is overlap that may be confusing, at least the Supreme Court has found it so. Representing either an insurance company or an insured or third party beneficiary is a difficult task. All attorneys in this environment must have a sound knowledge of the present state of the following: 1. Statutes
a. Art. 21.21, Texas Insurance Code
   (1) policy misrepresentation
   (2) claims handling
b. Art. 21.55, Texas Insurance Code
   (1) claim time tables
   (2) claim limitations
c. DTPA
   (1) unconsonabiliy
   (2) misrepresentations
2. Common Law
a. Duty of good faith and fair dealing
b. Stower’s Doctrine
3. Contract - policy construction
a. Claim handling duties
b. Liability provisions
c. Exclusions
d. Limits of liability

Because each of these subjects requires extensive instruction and analysis far greater than that allowed by the scope of this article, it is limited

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1 In an interview that aired on PBS, two Justices of the Unites States Supreme Court openly criticized the Western States’ practice of electing judges. Their comments expressed concern that the judiciary was not suitable to be a political body and still render justice in any impartial way. Texas has received focused inquiry twice on 60 Minutes where the theme in both cases focused upon the Supreme court’s lack of even handedness and impartiality, first to the plaintiff’s position then to the defense position. The pendulum swings method of justice does not speak well of Texas.

2 Most insurance companies train and have procedures regarding handling claims. “Red Flag” is a term used by more than one insurance company to tag a suspicious or “fraudulent” claim.
to the claims evaluation process and discussions of what to expect from an insurance company.

III. THE CLAIM PROCESS

The claims process of any insurance claim follows a pattern, notification of the claim, evaluation of the claim, and outcome of the claim. Each of these steps can have significance to an insured. The insurance policy itself generally gives the basic parameters of the claim process with limitations imposed by common law and statute.

A. War Story Digression

1. Life Insurance
   The husband dies; the wife sends death certificates; six and a half months later insurance company is investigating cause of death? (Why? He died in a hospital with a brain tumor. What interest does a life insurance company have with what caused the tumor?)

2. Transport Insurance
   A Kit Car is significantly damaged in transit; the driver of truck cannot now be found; insurance company will not pay claim because transport company is not cooperating with investigation - won’t let them speak with the driver that can’t be found [may be dead] (What could driver say that would cause insurance company not to pay?)

3. Health Insurance (group)
   After having a group health policy six (6) years, patient complains of stomach cramps has ulcers, and emergency surgery - in “evaluating” the claims recorded statements discovers previous “undisclosed” stomach cramps with trips to emergency room - antacids and antibiotics prescribed Prior condition? How can that fact justify denial?

These war stories all involve delayed and legitimate payments. Look at questions directed to an insurance claims adjuster:

Q Did you receive any training prior to becoming a claim investigator?
A Yes

Q Was this training classroom training?
A Some. About four weeks in the classroom and six months on the job training.

Q Is one of your responsibilities to protect the money of the people who have insurance with [insurance company]?
A Yes

Q In protecting the money [of the insurance company] do you make your evaluation of the amount of the claim so that your offer is a low offer?
A Yes. We try to make our evaluation of the claim . . . you know, so that we can pay the least amount of money . . . by saving money on the claims we lower the premiums charged . . . you know, they really need the money . . . they need the money now and I offer them fast money to make them happy.

Q Let me see if I get this right. You, as the claim adjuster, evaluate a claim and then offer something less to settle that claim fast.
A Well, yeah.

Q Do you discount the claim by 70%?
A No, not seventy percent . . . that’s too much.

Q Well, then what is it?
A 80-85% sometimes more

Q Is that what you learned in the training you received?
A Yes. We want to make insurance cheaper for everyone.

B. The “Law” of Insurance Claims

The rights of an insured and an insurer are set out in two places. The insurance contract itself and the provisions of Art. 21.21 and 21.55. One cannot discuss the “law” without a reading of “the law.” For your convenience it is set forth as follows:

Art. 21.55 - Relevant provisions of Art. 21.55 states:

Art. 21.55. Prompt Payment of Claims - Definitions

Sec. 1. In this article:
1. "Claimant" means a person making a claim.
2. "Business day" means a day other than a Saturday, Sunday, or holiday recognized by this state.

3. "Claim" means a first party claim made by an insured or a policyholder under an insurance policy or contract or by a beneficiary named in the policy or contract that must be paid by the insurer directly to the insured or beneficiary.

4. "Insurer" means any insurer authorized to do business as an insurance company or to provide insurance in this state, including:

5. "Notice of claim" means any notification in writing to an insurer, by a claimant, that reasonably apprizes the insurer of the facts relating to the claim.

Notice of Claim - Sec. 2.

(a) Except as provided by Subsection (d) of this section, an insurer shall, not later than the 15th day after receipt of notice of a claim or requested and required, as provided under Section 2 of this article, for a period exceeding eligible surplus lines insurer:

(1) acknowledge receipt of the claim;

(2) commence any investigation of the claim; and

(3) request from the claimant all items, statements, and forms that the insurer reasonably believes, at that time, will be required from the claimant. Additional requests may be made if during the investigation of the claim such additional requests are necessary.

(b) If the acknowledgment of the claim is not made in writing, the insurer shall make a record of the date, means, and content of the acknowledgment.

Acceptance or Rejection of Claims - Sec. 3.

(a) Except as provided by Subsections (b) and (d) of this section, an insurer shall notify a claimant in writing of the acceptance or rejection of the claim not later than the 15th business day after the insurer receives all items, statements, and forms required by the insurer, in order to secure final proof of loss.

(b) If the insurer has a reasonable basis to believe that the loss results from arson, the insurer shall notify the claimant in writing of the acceptance or rejection of the claim not later than the 30th day after the date the insurer receives all items, statements, and forms required by the insurer.

(c) If the insurer rejects the claim, the notice required by Subsections (a) and (b) of this section must state the reasons for the rejection.

(d) If the insurer is unable to accept or reject the claim within the period specified by Subsection (a) or (b) of this section, the insurer shall notify the claimant, not later than the date specified under Subsection (a) or (b), as applicable. The notice provided under this subsection must give the reasons the insurer needs additional time.

(e) Not later than the 45th day after the date an insurer notifies a claimant under Subsection (d) of this section, the insurer shall accept or reject the claim.

(f) Except as otherwise provided, if an insurer delays payment of a claim following its receipt of all items, statements, and forms reasonably requested and required, as provided under Section 2 of this article, for a period exceeding the period specified in other applicable statutes or, in the absence of any other specified period, for more than 60 days, the insurer shall pay damages and other items as provided for in Section 6 of this article.

(g) If it is determined as a result of arbitration or litigation that a claim received by an insurer is invalid and therefore should not be paid by the insurer, the requirements of Subsection (f) of this section shall not apply in such case.

Payment of Claims - Sec. 4.

If an insurer notifies a claimant that the insurer will pay a claim or part of a claim under Section 3 of this article, the insurer shall pay the claim not later than the fifth business day after the notice has been made. If payment of the claim or part of the claim is conditioned on the performance of an act by the claimant, the insurer shall pay the claim not later than the fifth business day after the date the act is performed. Surplus lines insurers shall pay the claim not later than the twentieth business day after the notice or date the act is performed.

Exemption - Sec. 5.

(a) This article does not apply to:

(1) workers' compensation insurance;

(2) mortgage guaranty insurance;

(3) title insurance;

(4) fidelity, surety, or guaranty bonds;
(5) marine insurance other than inland marine insurance governed by Article 5.53 of this code; or
(6) a guaranty association created and operating under Article 9.48 of this code.

(b) A guaranty association created and operating under Article 21.28-C or 21.28-D of this code shall not be subject to the damage provisions contained in Section 6 of this article. A guaranty association may receive an extension of the time periods under this article from a court of competent jurisdiction upon good cause shown and after reasonable notice to policyholders.

c) This article does not apply to Chapter 20A of this code except as provided in Section 9 of that chapter.

d) In the event of a weather-related catastrophe or major natural disaster, as defined by the State Board of Insurance, the claim-handling deadlines imposed under this article are extended for an additional 15 days.

Damages - Sec. 6.

In all cases where a claim is made pursuant to a policy of insurance and the insurer liable therefor is not in compliance with the requirements of this article, such insurer shall be liable to pay the holder of the policy, or the beneficiary making a claim under the policy, in addition to the amount of the claim, 18 percent per annum of the amount of such claim as damages, together with reasonable attorney fees as may be determined by the trier of fact. Such attorney fees shall be taxed as part of the costs in the case.

Cumulative Remedies - Sec. 7.

The provisions of this article are not exclusive. The remedies provided herein are in addition to any other remedy or procedure provided by any other law or at common law.

Liberal Construction - Sec. 8.

This article shall be liberally construed to promote its underlying purpose which is to obtain prompt payment of claims made pursuant to policies of insurance.

The provisions of the standard Texas homeowners insurance policies having to do with the respective duties of the insured and insurer are as follows:

C. Excerpts of Typical Homeowner’s Insurance Policy.

“You” and “your” refer to the “named insured.”(preamble)

“We” “us” and “our” refer to the Company providing this insurance. (preamble)

Section I - Conditions

3. Duties After Loss.
a) Your Duties After Loss. In case of a loss to covered property caused by a peril insured against, you must:
   A. give prompt written notice to us of the facts relating to the claim.
   B. Notify the police in case of loss by theft.
   (3) (a) protect the property from further damage.
   (b) make reasonable and necessary repairs to protect the property.
   (c) keep an accurate record of repair expenses.
   (4) furnish a complete inventory of damaged personal property showing the quantity, description and amount of loss. Attach all bills, receipts and related documents which you have that justify the figures in the inventory.
   (5) as often as we reasonably require:
      (a) provide us access to the damaged property.
      (b) provide us with pertinent records and documents we request and permit us to make copies.
      (c) Submit to examination under oath and sign and swear to it.
   (6) send to us if we request, your signed sworn proof of loss within 91 days of our request on a standard form supplied by us. We must request a signed sworn proof of loss within 15 days after we receive your written notice or we waive our right to require a proof of loss. Such waivers will not waive our other rights under this policy.
      (a) This proof of loss shall state, to the best of your knowledge and belief:
         (i) the time and cause of loss;
         (ii) the interest of the insured and all others in the property involved including all liens on the property.
(iii) other insurance which may cover the loss.
(iv) the actual cash value of each item of property and the amount of loss of each item.

(b) If you elect to make claim under the Replacement Cost Coverage of this policy, this proof of loss shall also state, to the best of your knowledge and belief:

(i) the replacement cost of the described dwelling.
(ii) the replacement cost of any other building on which loss is claimed.
(iii) the full cost of repair or replacement of loss without deduction for depreciation.

b. Our Duties After Loss.

(1) Within 15 days after we receive your written notice of claim, we must:

(a) acknowledge receipt of the claim.

If our acknowledgment of the claim is not in writing, we will keep a record of the date, method and content of our acknowledgment.

(b) begin any investigation of the claim.

(c) specify the information you must provide in accordance with “Your Duties After Loss”

We may request more information, if during the investigation of the claim such additional information is necessary.

(2) After we receive the information we request, we must notify you in writing whether the claim will be paid or has been denied or whether more information is needed:

(a) within 15 business days; or

(b) believe the loss resulted from arson.

(3) If we do not approve payment of your claim or require more time for processing your claim, we must:

(a) give the reason for denying your claim; or

(b) give the reasons we require more time to process your claim. But, we must either approve or deny your claim within 45 days after requesting more time.

11. Suit Against Us. No suit or action can be brought unless the policy provisions have been complied with. Action brought against us must be started within two years and one day after the cause of action accrues.

Art. 21.21 now has the blueprint on how to evaluate and “settle” an insurance claim:

(10) Unfair Settlement Practices.

(a) Engaging in any of the following unfair settlement practices with respect to a claim by an insured or beneficiary:

(i) misrepresenting to a claimant a material fact or policy provision relating to coverage at issue;

(ii) failing to attempt in good faith to effectuate a prompt, fair, and equitable settlement of a claim with respect to which the insurer's liability has become reasonably clear;

(iii) failing to attempt, in good faith, to effectuate a prompt, fair, and equitable settlement under one portion of a policy of a claim with respect to which the insurer's liability has become reasonably clear in order to influence the claimant to settle an additional claim under another portion of the coverage, provided that this prohibition does not apply if payment under one portion of the coverage constitutes evidence of liability under another portion of the policy;

(iv) failing to provide promptly to a policyholder a reasonable explanation of the basis in the policy, in relation to the facts or applicable law, for the insurer's denial of a claim or for the offer of a compromise settlement of a claim;

(v) failing within a reasonable time to:

(A) affirm or deny coverage of a claim to a policyholder; or

(B) submit a reservation of rights to a policyholder;

(vi) refusing, failing, or unreasonably delaying an offer of settlement under applicable first-party coverage on the basis that other coverage may be available or that third parties
are responsible for the damages suffered, except as may be specifically provided in the policy;

(vii) undertaking to enforce a full and final release of a claim from a policyholder when only a partial payment has been made, provided that this prohibition does not apply to a compromise settlement of a doubtful or disputed claim;

(viii) refusing to pay a claim without conducting a reasonable investigation with respect to the claim;

(ix) with respect to a Texas personal auto policy, delaying or refusing settlement of a claim solely because there is other insurance of a different type available to satisfy all or any part of the loss forming the basis of that claim; or

(x) requiring a claimant, as a condition of settling a claim, to produce the claimant's federal income tax returns for examination or investigation by the person unless:

(A) the claimant is ordered to produce those tax returns by a court;

(B) the claim involves a fire loss; or

(C) the claim involves lost profits or income.

(b) Paragraph (a) of this clause does not provide a cause of action to a third party asserting one or more claims against an insured covered under a liability insurance policy.

Even a cursory reading of both statutes and the policy language shows the inconsistencies and the gaps of both as it applies to both claims.

The Art. 21.55 timetable is important. Failure to abide by the time able will warrant litigation and can be presumed even if the rest of the claim is settled. Northwestern National County Mutual Ins. Co. v. Rodriguez, ___ S.W.2d ____ (Tex App. – San Antonio Feb. 9, 2000).

The majority of Art. 21.55 relates to a timetable. Which is discussed separately in another article? There are two commands related to the claim investigation itself. They are:

1. “...request from the claimant all items, statements, and forms that the insurer reasonably believes, at that time, will be required from the claimant.”

2. “Additional requests may be made if during the investigation of the claim such additional requests are necessary.”

The two commands are simple, within 15 days request all statements, items and forms and an insurance company can only make a further request after that fifteen-day period only “...if during the investigation of the claim such additional requests are necessary.” [emphasis added]

The insurance policy’s contract language in the standard Homeowner’s Insurance Policy paragraph 3 a. (5) seems to vary the provisions of Art 21.55 when it states “as often as we reasonably require: (a) provide us access to the damaged property. (b) provide us with pertinent records and documents we request and permit us to make copies. (c) submit to examination under oath and sign and swear to it.” The contract provisions found in an insurer’s duties “Section 13b provides, Our Duties After Loss. (1) Within 15 days after we receive your written notice of claim, we must . . . (c)specify the information you must provide in accordance with ‘Your Duties After Loss’. We may request more information, if during the investigation of the claim such additional information is necessary.”

The only way to read the insurance policy to conform with the statute is to insure that the “required” demands for statements, forms and items to be made within fifteen days or require a showing that the “required” information requested is really “necessary” and there is a showing that something in the investigation necessitated the new request. That is consistent with the “our duties” portion of the policy.

Practically the insurance companies focus on the timetable and not the limitations of their power to investigate. Because of the timetable mandated in Art 21.55 the insurance companies seem to be timing their requests for information so as to at least delay payment. The insured complains that they feel like the proverbial jackass following the carrot tied to the string dangling from the pole and held so that no matter what he does, the carrot will always remain inches away. That is because the time for their
obligation to pay is started by “... the date the insurer receives all items, statements, and forms required by
the insurer, in order to secure final proof of loss.” Art. 21.55 (3) By asking for the additional
information and metering out the requests for statements and items, the insurance companies
routinely defeat the fast pat timetable of Art. 21.55.

Not included in the items, statements, and forms
that the contract allows are the following:

a. Recorded Statements
b. Medical Release of Information Authorizations
c. General Release of Information Authorizations
d. Credit Check Release of Information Authorizations
e. Conferences with employers

These are, however, practical investigative tools
of the insurance company and are typically not
onerous. The information the insurance company
receives by releases, credit checks, and recorded
statements should be demanded before an EUO is
taken.

What is contemplated by the contract language
is that the insurance company can require “pertinent
records and documents we request and permit us to
make copies,” “access to the damaged property” and
“examination under oath and sign and swear to it.”
They can ask for anything else and generally do.
When one gives access to the documents that the
insurance company copies then one knows what they
have. If one gives carte blanch to the insurance
company two things happen – first one does not know
what you have given to them and second the insurance
demand for the EUO is a contractual demand. In an
company now has the ability to go well past the
normal bounds of fair play and discover much more
about the insured.

Each insurance company has its standard form
for the release of information. It works equally well
for OB-GYN health claims as it does for an auto
accident as it does for a fire investigation. Probably
too broad is an overstatement.

If an insured does not sign the release, a Red
Flag is signaled. If the insured tries to limit the scope
of the release or limit the use another Red Flag is
raised. A Red Flag will delay the claim.

The investigation process gives the insurance
company the ability to investigate the claim. It also is
given a head start on any upcoming litigation
discovery with a “claims evaluation process” that
does not have the safeguards of the discovery rules.

Because the insurance companies share their
information and conclusions in a secret data bank one
should be weary of what information is freely given
to them.

IV. THE EUO – ITS USES AND ABUSES

The EUO is specifically specified in the
insurance contract. The present provision that
authorizes an insurance company to require an EUO
states “submit to examination under oath and sign
and swear to it.” That is one interview with the
insured. The insurance companies take the term
“submit” to heart and do much more than take a
sworn oral statement. Typically the insurance
companies ask an attorney to take the EUO. The
attorney writes a letter which has a great propensity
to overstate the insured’s obligations under the policy
or otherwise misrepresented an insured’s right.

The policy language has changed over time.
The previous language specifically authorized an
attorney or any person to take the EUO. “It is
significant that in the paragraph of the policy in suit
next succeeding that relating to proof of loss, the
insured bound himself to ‘submit to examination
under oath by any person named by this company,
and subscribe the same.’” Provident Fire Insurance
Co. v. Ashy, 139 Tex. 334; 162 S.W.2d 684, 685
(1942).

What is the person taking the EUO? The
demand for the EUO is a contractual demand. In an
engineering loss perhaps an engineer can be the EUO
examiner. Who is better trained to ask questions?

Why make an attorney the EUO examiner? The
answer is relatively simple – the insurance companies
seek to cloak the EUO portion of its claim
investigation in secrecy and secondarily to intimidate
the insured. Can the attorney client and work product
privileges be asserted to an insurance company’s
advantage? To answer that question the Court of
appeals said simply “no.” In the matter of In Re
Texas Farmers Insurance Exchange, 990 S.W.2d
337 (Tex App. – Texarkana 1999) a writ ref’d, see
dissent of Supreme Court in failing to grant writs at
PUNITIVE/ADDITIONAL DAMAGES?

12 S.W.3d 807 the appellate court framed the issue as follows:

In June 1996, Farmers hired an attorney, . . . to conduct Examinations Under Oath (EUO) of the Chappells. The EUOs were conducted on July 30, 1996. A letter from Farmers dated September 17, 1996 informed the Chappells that their claim was denied . . .

The Chappells filed suit claiming that Farmers unjustifiably denied liability under the homeowners’ policy and had acted in bad faith. On May 27, 1998, the Chappells noticed the deposition of Gregory Scott and included a subpoena duces tecum for the following items:

1. Any and all files maintained by or in your possession concerning this matter, including the adjuster’s file, investigation reports etc., including the report of the fire investigator.

2. All documents in your possession or control relating to any aspect of this lawsuit, including all claims against the Chappells.

On June 17, 1998, Farmers filed a motion to quash, contending that Scott's knowledge of and involvement with the claim fit within the attorney-client privilege, attorney work product, party communication, and witnesses’ statement exemptions. Farmers claimed that the documentation and information sought by the subpoena was compiled in anticipation of litigation as defined by the Texas Supreme Court in National Tank Co. v. Brotherton.

The trial court held a hearing on the motion to quash on August 8, 1998. [The attorney] testified at the hearing. Following the hearing, at the trial court's request, Farmers filed the EUO transcripts of Paul and Treva Chappell, transcripts of the Chappells' recorded statements, a letter dated June 28, 1996 from [the attorney] to the Chappells requesting their submission to EUOs, and the May 31, 1996 fire cause and origin report . . . [t]he trial court found that Farmers had failed to present sufficient evidence in opposition to the deposition with subpoena duces tecum to support its claimed party communications, witness statement, and attorney work product exemptions, and attorney-client privilege. The court further held that Farmers was conducting a routine investigation of a fire of suspicious origin, that Gregory Scott was acting as an investigator, not an attorney, until suit was filed by the Chappells, and Farmers had no reasonable basis to anticipate litigation. The court held that all documents responsive to the subpoena duces tecum are discoverable if such documents existed prior to the time the Chappells filed suit. The motion to quash was overruled.

The Supreme Court recognized the importance of this decision and the dissent of Justices Hecht and Owen points on the High Court’s failure to grant a writ. “The rule the court of appeals has adopted affects not only every lawyer retained to take an EUO, but every plaintiff’s lawyer who investigates a client's claims, and every attorney retained to investigate the internal affairs of a corporation or other group, as in Upjohn. The court's holding that the attorney-client privilege ‘would not apply to . . . communications [from an attorney to a client] concerning bare facts’ is startling in the breadth of its incursion into the protection of the attorney-client privilege.” In Re Texas Farmers Insurance Exchange, 12 S.W.3d 807, 808 (Tex 2000). Seven of the justices got it right – when an attorney takes an EUO he wears the hat of an insurance adjuster and not an attorney. There is no privilege.

A. Practical Considerations for EUO’s.

1. It is clear that the EUO is a writing in that it must be sworn to. When the EUO examiner demands TV cameras and bright lights to add to the inquisition appearance, it should be resisted.

2. Offer the EUO on nurtural ground like the home of the insured or that of a friend. Offer the EUO at a time that will minimize the time available to take it. After 12 an EUO will tend to be shorter and after 3 p.m. even shorter.

3. Demand all documents received pursuant to releases given by the insured as well as both the recorded and transcribed statements made by each. The documents should be presented several days before the EUO to give you and your client an opportunity to prepare.

4. If you know others that gave written or recorded statements have them request them as well. That way one can reduce the blind siding effect of the questions.
5. If you attend the EUO, help your client with the answers. The insurance companies take the position that the rules of civil procedure do not apply. Before the EUO starts the attorney will confirm that. When he does, you are free to help privately or openly.

B. Waiver of an EUO.

The insurer can waive its contractual right to have an insured submit to the EUO by its conduct. Consider that the reason for the EUO is contractual. The Examiner then must be an agent, employee or authorized representative. By refusing to stipulate to that fact or agree that all matters pertaining to the EUO will not be protected by privilege or by requiring things like video cameras or by failing to agree on the record that the examiner is an agent, employee, or authorized representative the insurance company runs the risk of waiving its right to an EUO.

As used in the policy, the terms “we,” “us,” and “our” refer to the Company providing insurance. An insured agrees to submit to be examination under oath by the insurance company and not an independent contractor attorney attempting to shroud the process in secrecy.

It is clear in Texas that all information leading to the denial of a claim is discoverable in an insurance bad faith case. See, Jackson v. Downey, 817 S.W.2d 858 (Tex. App.-- Houston [1st Dist.] 1991); Eckermann v. Williams, 740 S.W.2d 23 (Tex. App.-- Austin 1987); Victoria Lloyds Ins. Co. v. Gayle, 717 S.W.2d 166 (Tex. App.-- Houston [1st Dist.] 1986). In an insurance bad faith action or an Art. 21.21 action, the primary issue is the reasonableness of the insurer’s conduct. Plaintiff is entitled to full discovery of all information regarding the insurer’s investigation, the advice the insurer received from experts, and every factor that went into the insurance company’s determination. The examination under oath is part of the insurer’s investigation of the claim. Therefore, the insurer should not be allowed to try to shield its internal communications from discovery by involving lawyers in the claim settlement process.

Federal courts addressing this issue are in accord. In Pete Rinaldi’s Fast Foods, Inc. v. Great American Insurance Co., 123 F.R.D. 198, 202 (M.D.N.C. 1988) the court stated:

Because an insurance company has a duty in the ordinary course of business to investigate and evaluate claims made by its insureds, the claims file containing such documents cannot be entitled to work product protection. Normally, only after the insurance company makes a decision with respect to the claim, will it be possible for there to arise a reasonable threat of litigation so that information gathered thereafter might be said to be acquired in anticipation of litigation.

The attorney-client privilege does not protect communications with an attorney acting in the role of a claims investigator of facts related to the claim. National Farmer’s Union Prop. & Casualty Co. v. District Court, 718 P. 2d 1044, 1049 (Col. 1986). The reasoning of the court’s who has found that claims files are not protected by work product and attorney-client privileges are sound: to prevent insurers from shrouding the facts of the case from discovery by having attorneys conduct the claims investigation which is the ordinary course of the insurer’s business.

C. Is The Claim Denied by The Assertion of The Work Product Privilege?

In their effort to shield the EUO process from scrutiny the insurance company will assert the work product privilege. E.g., see In Re Texas Farmers Exchange above. Rule 192.5 of the “new and less than improved” discovery rules define the parameters of the work product privilege as: “(1) material prepared or mental impressions developed in anticipation of litigation or for trial by or for a party or a party's representatives, including the party's attorneys, consultants, sureties, indemnitors, insurers, or agents; or (2) a communication made in anticipation of litigation or for trial between a party and the party's representatives or among a party's representatives.”

Can an EUO be used as a litigation tool? No, is the simple answer. If litigation is anticipated at the time the EUO is taken then the claim has been effectively denied and the taking of the EUO is in and of itself a bad faith act. The claims investigation receives information to pay or deny the claim and not to prepare for litigation. Litigation can be anticipated only in those cases where there has been a threat of prosecution of a claim or that the insurance company agrees that their conduct was sooooo bad that a reasonable insured would sue.
The assertion of the work-product privilege necessarily implies that the claim has been denied. To qualify for the attorney work product privilege, the materials must be prepared and assembled in actual anticipation of litigation. *Humphreys v. Caldwell*; *National Tank v. Brotherton*. The work product doctrine protects against disclosure of materials prepared and assembled by a lawyer or at his direction in the actual anticipation of litigation or subsequent to the occurrence or transaction. *Owens-Corning Fiberglass Corp. v. Caldwell*. In insurance cases the date of the occurrence or transaction on which suit is based cannot predate the communication of the denial of coverage to the plaintiff. *See Jackson v. Downey*. This rule is to prevent insurance company’s from choosing “a decision date” far in advance of its notifying it’s insured of the denial decision and shielding its internal communications from discovery. *Id.* The assertion of the work product privilege in this case necessarily presumes that the insurer anticipates litigation and that the internal decision to deny this claim has already been made. The “examination under oath,” therefore, is actually a subterfuge to unreasonably obtain pretrial discovery, to antagonize its insured and to try to gains some unfair trial advantage. It is totally improper and is further evidence of the insurer’s bad faith.

**D. Offensive Use of The Attorney-Client Privilege.**

When an insured seeks to keep form scrutiny the part of the claim settlement process which is, according to insurance companies, so very important it would seem that the insurance company is making a prohibited offensive use of the attorney-client privilege. The privilege cannot be used offensively to shield information relevant to issues raised by the party claiming the privilege. *Republic Insurance Co. v. Davis*, 856 S.W.2d 163 (Tex. 1994). The factors to determine whether the privilege is being used offensively are: 1) if the party asserting the privilege seeks affirmative relief; 2) the information being withheld would be outcome determinative; and 3) disclosure is the only means to obtain the information.

Information related to communications to and from the attorney involved in the claims settlement process would be outcome determinative since those discussions result in the denial of a claim. In other words, the Examination under Oath is outcome determinative and the assertion of attorney-client privilege in connection with the examination under oath is offensive.

There is simply no other way to obtain the communications to and from the EUO questioner who was by chance, happenstance or design an attorney.

**E. A Question of Privity.**

The policy is between “we” and “you,” the insurance company and its insured. The attorney’s name is not contained in the contractual words of the policy. The attorney is then not in privity with the insurance policy or the insured, and has no rights to compel attendance, orchestrate the EUO setting, to ask question or even be present unless he is, in fact, the agent, employee or authorized representative of the insurance company.

**F. EUO May Be Time Barred by Statute.**

In 1991 the Texas legislature, fed up with insurance companies’ delays in evaluating claims imposed a statutory timetable by enacting Tex. Ins. Code § 21.55.

By the 15th day after a loss is reported, an insurance company must inform its insured claimant of all items, statements and forms that will be required from the claimant. Tex. Ins. Code §21.55(2)(a)(3) [emphasis added]. While there is a provision which allows for the request of additional information, it can only be necessary information. *Id.* The obvious purpose of § 21.55 is to stop the past insurance practice of prolonging the “investigation” (which delays payment) by timing its requests for information bit by bit.

When an insurance company fails to request an EUO within 15 days, the clear import of Art. 21.55 is that there should not be an EUO allowed unless it can show that it is “necessary” to an investigation that found the need for the EUO. Consider the scope of the EUO. Only necessary things can be asked! What will the courts do? Remembering the openly politically aligned Supreme Court, the insurance companies should be confident of a favorable decision, whatever the issue. This is so even though the insurance company knew its EUO would be done because their procedures require an EUO in fire, theft, and personal injury cases and they knew it was required when the investigation was started.
G. EUO May Not Be Not “Necessary”

The insurance companies have a reputation of taking more than one statement. There have been cases where the insurance company’s trial strategy was to actually track the identical questions and the differences in the answers. The stated purpose of the tracking of changed answers is to expose the untruthfulness of the statement which would then allow the insurance company to deny the claim on the basis of making a false statement. How many statements from an insured does it take to make the EUO unnecessary? A trial court refused to disallow the EUO when eight previous recorded statements had already been taken but required the insurance company not to duplicate the questions in light of the information it had already received.

H. Abatement Is the Remedy

When a lawsuit is started and an EUO has not been taken the insurance company will most likely ask for an abatement citing to State Farm Gen. Ins. Co. v. Lawlis, 773 S.W.2d 948 (Tex. App.--Beaumont 1989, orig. proceeding), and the cases cited therein as authority that it is entitled to abatement in order to obtain the EUO.

Since Lawlis was decided in June 1989 two important events have occurred. First, the Texas legislature enacted Tex. Ins. Code § 21.55 in 1991, imposing time limits on the insured for settling claims. As previously stated, State Farm has failed to comply with § 21.55. Second, the language of Texas Standard Homeowners Policy at issue in Lawlis is different from the language presently used. No longer does an insurer have a “right” to take an EUO. Instead there is a reasonableness requirement. Compare the language. The language of the policy at issue in Lawlis was:

If loss occurs . . . the Insured shall . . . if requested by the Company, submit to examination under oath and subscribe the same.

The language in the present policy states:

...As often as we reasonably require: . . . (c) submit to examination under oath and sign and swear to it. (Emphasis added)

The trial court will probably grant an abatement after the lawsuit is filed as a Pavlovian response to the EUO request. If that does occur, then request that there be only one deposition in the case – their EUO – and that since the proceeding is in court that the EUO be conducted according to the rules of Civil Procedure. The insurance company’s response to those requests is sure to raise the eyebrows of the Judge and focus more clearly the court’s attention on the lack of fairness.

V. CONCLUSION

Insurance companies are the big men on campus. Some, but by no means all, have become bullies. The High Court condones almost everything they do. When the billion dollar insurance companies make sound business decisions on the risk of successful litigation, policyholders get hurt - especially those with small and medium sized claims. Because punitive damages are now so hard to preserve on appeal, even in cases of intentional conduct and because the present Supreme Court does not understand real mental anguish, insurance companies have virtually no incentive to be fair or do their statutory duties.

Texans are hurting.