

HTML has links - PDF has Authentication**PDF WAC 284-30-330****Specific unfair claims settlement practices defined.**

The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices of the insurer in the business of insurance, specifically applicable to the settlement of claims:

- (1) Misrepresenting pertinent facts or insurance policy provisions.
- (2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.
- (3) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.
- (4) Refusing to pay claims without conducting a reasonable investigation.
- (5) Failing to affirm or deny coverage of claims within a reasonable time after fully completed proof of loss documentation has been submitted.
- (6) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. In particular, this includes an obligation to promptly pay property damage claims to innocent third parties in clear liability situations. If two or more insurers share liability, they should arrange to make appropriate payment, leaving to themselves the burden of apportioning liability.
- (7) Compelling a first party claimant to initiate or submit to litigation, arbitration, or appraisal to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in such actions or proceedings.
- (8) Attempting to settle a claim for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application.
- (9) Making a claim payment to a first party claimant or beneficiary not accompanied by a statement setting forth the coverage under which the payment is made.
- (10) Asserting to a first party claimant a policy of appealing arbitration awards in favor of insureds or first party claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.
- (11) Delaying the investigation or payment of claims by requiring a first party claimant or his or her physician to submit a preliminary claim report and then requiring subsequent submissions which contain substantially the same information.
- (12) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.
- (13) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.
- (14) Unfairly discriminating against claimants because they are represented by a public adjuster.
- (15) Failing to expeditiously honor drafts given in settlement of claims. A failure to honor a draft within three working days after notice of receipt by the payor bank will constitute a violation of this provision. Dishonor of a draft for valid reasons related to the settlement of the claim will not constitute a violation of this provision.
- (16) Failing to adopt and implement reasonable standards for the processing and payment of claims after the obligation to pay has been established. Except as to those instances where the time for payment is governed by statute or rule or is set forth in an applicable contract, procedures which are not designed to deliver payment, whether by check, draft, electronic funds transfer, prepaid card, or other method of electronic payment to the payee in payment of a settled claim within fifteen business days after receipt by the insurer or its attorney of properly executed releases or other settlement documents

are not acceptable. Where the insurer is obligated to furnish an appropriate release or settlement document to a claimant, it must do so within twenty working days after a settlement has been reached.

(17) Delaying appraisals or adding to their cost under insurance policy appraisal provisions through the use of appraisers from outside of the loss area. The use of appraisers from outside the loss area is appropriate only where the unique nature of the loss or a lack of competent local appraisers make the use of out-of-area appraisers necessary.

(18) Failing to make a good faith effort to settle a claim before exercising a contract right to an appraisal.

(19) Negotiating or settling a claim directly with any claimant known to be represented by an attorney without the attorney's knowledge and consent. This does not prohibit routine inquiries to a first party claimant to identify the claimant or to obtain details concerning the claim.

[Statutory Authority: RCW **48.02.060** and **48.30.010**. WSR 16-20-050 (Matter No. R 2016-12), § 284-30-330, filed 9/29/16, effective 10/30/16; WSR 09-11-129 (Matter No. R 2007-08), § 284-30-330, filed 5/20/09, effective 8/21/09. Statutory Authority: RCW **48.02.060**, **48.44.050** and **48.46.200**. WSR 87-09-071 (Order R 87-5), § 284-30-330, filed 4/21/87. Statutory Authority: RCW **48.02.060** and **48.30.010**. WSR 78-08-082 (Order R 78-3), § 284-30-330, filed 7/27/78, effective 9/1/78.]

RCW 48.30.015

Unreasonable denial of a claim for coverage or payment of benefits.

(1) Any first party claimant to a policy of insurance who is unreasonably denied a claim for coverage or payment of benefits by an insurer may bring an action in the superior court of this state to recover the actual damages sustained, together with the costs of the action, including reasonable attorneys' fees and litigation costs, as set forth in subsection (3) of this section.

(2) The superior court may, after finding that an insurer has acted unreasonably in denying a claim for coverage or payment of benefits or has violated a rule in subsection (5) of this section, increase the total award of damages to an amount not to exceed three times the actual damages.

(3) The superior court shall, after a finding of unreasonable denial of a claim for coverage or payment of benefits, or after a finding of a violation of a rule in subsection (5) of this section, award reasonable attorneys' fees and actual and statutory litigation costs, including expert witness fees, to the first party claimant of an insurance contract who is the prevailing party in such an action.

(4) "First party claimant" means an individual, corporation, association, partnership, or other legal entity asserting a right to payment as a covered person under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such a policy or contract.

(5) A violation of any of the following is a violation for the purposes of subsections (2) and (3) of this section:

(a) WAC 284-30-330, captioned "specific unfair claims settlement practices defined";

(b) WAC 284-30-350, captioned "misrepresentation of policy provisions";

(c) WAC 284-30-360, captioned "failure to acknowledge pertinent communications";

(d) WAC 284-30-370, captioned "standards for prompt investigation of claims";

(e) WAC 284-30-380, captioned "standards for prompt, fair and equitable settlements applicable to all insurers"; or

(f) An unfair claims settlement practice rule adopted under RCW 48.30.010 by the insurance commissioner intending to implement this section. The rule must be codified in chapter 284-30 of the Washington Administrative Code.

(6) This section does not limit a court's existing ability to make any other determination regarding an action for an unfair or deceptive practice of an insurer or provide for any other remedy that is available at law.

(7) This section does not apply to a health plan offered by a health carrier. "Health plan" has the same meaning as in RCW 48.43.005. "Health carrier" has the same meaning as in RCW 48.43.005.

(8)(a) Twenty days prior to filing an action based on this section, a first party claimant must provide written notice of the basis for the cause of action to the insurer and office of the insurance commissioner. Notice may be provided by regular mail, registered mail, or certified mail with return receipt requested. Proof of notice by mail may be made in the same manner as prescribed by court rule or statute for proof of service by mail. The insurer and insurance commissioner are deemed to have received notice three business days after the notice is mailed.

(b) If the insurer fails to resolve the basis for the action within the twenty-day period after the written notice by the first party claimant, the first party claimant may bring the action without any further notice.

(c) The first party claimant may bring an action after the required period of time in (a) of this subsection has elapsed.

(d) If a written notice of claim is served under (a) of this subsection within the time prescribed for the filing of an action under this section, the statute of limitations for the action is tolled during the twenty-day period of time in (a) of this subsection.

[2007 c 498 § 3 (Referendum Measure No. 67, approved November 6, 2007).]

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WAC 284-30-350**Misrepresentation of policy provisions.**

(1) No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

(2) No insurance producer or title insurance agent shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

(3) No insurer shall deny a claim for failure to exhibit the property without proof of demand and unfounded refusal by a claimant to do so.

(4) No insurer shall, except where there is a time limit specified in the policy, make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if such a time limit is not complied with unless the failure to comply with such time limit prejudices the insurer's rights.

(5) No insurer shall request a first party claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.

(6) No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage which contain language which release the insurer or its insured from its total liability.

(7) No insurer shall make a payment of benefits without clearly advising the payee, in writing, that it may require reimbursement, when such is the case.

[Statutory Authority: RCW **48.02.060** (3)(a) and **48.17.010**(5). WSR 11-01-159 (Matter No. R 2010-09), § 284-30-350, filed 12/22/10, effective 1/22/11. Statutory Authority: RCW **48.02.060**, **48.44.050** and **48.46.200**. WSR 87-09-071 (Order R 87-5), § 284-30-350, filed 4/21/87. Statutory Authority: RCW **48.02.060** and **48.30.010**. WSR 78-08-082 (Order R 78-3), § 284-30-350, filed 7/27/78, effective 9/1/78.]

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WAC 284-30-360**Standards for the insurer to acknowledge pertinent communications.**

(1) Within ten working days after receiving notification of a claim under an individual insurance policy, or within fifteen working days with respect to claims arising under group insurance contracts, the insurer must acknowledge its receipt of the notice of claim.

(a) If payment is made within that period of time, acknowledgment by payment constitutes a satisfactory response.

(b) If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment must be made in the claim file of the insurer describing how, when, and to whom the notice was made.

(c) Notification given to an agent of the insurer is notification to the insurer.

(2) Upon receipt of any inquiry from the commissioner concerning a complaint, every insurer must furnish the commissioner with an adequate response to the inquiry within fifteen working days after receipt of the commissioner's inquiry using the commissioner's electronic company complaint system.

(3) For all other pertinent communications from a claimant reasonably suggesting that a response is expected, an appropriate reply must be provided within ten working days for individual insurance policies, or fifteen working days with respect to communications arising under group insurance contracts.

(4) Upon receiving notification of a claim, every insurer must promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this paragraph within the time limits specified in subsection (1) of this section constitutes compliance with that subsection.

[Statutory Authority: RCW **48.02.060**, **48.44.050**, **48.46.200**, and **48.30.010**. WSR 13-12-079 (Matter No. R 2013-05), § 284-30-360, filed 6/5/13, effective 1/1/14. Statutory Authority: RCW **48.02.060** and **48.30.010**. WSR 09-11-129 (Matter No. R 2007-08), § 284-30-360, filed 5/20/09, effective 8/21/09; WSR 78-08-082 (Order R 78-3), § 284-30-360, filed 7/27/78, effective 9/1/78.]

HTML has links - PDF has Authentication**PDF****WAC 284-30-370****Standards for prompt investigation of a claim.**

Every insurer must complete its investigation of a claim within thirty days after notification of claim, unless the investigation cannot reasonably be completed within that time. All persons involved in the investigation of a claim must provide reasonable assistance to the insurer in order to facilitate compliance with this provision.

[Statutory Authority: RCW **48.02.060** and **48.30.010**. WSR 09-11-129 (Matter No. R 2007-08), § 284-30-370, filed 5/20/09, effective 8/21/09; WSR 78-08-082 (Order R 78-3), § 284-30-370, filed 7/27/78, effective 9/1/78.]

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WAC 284-30-380**Settlement standards applicable to all insurers.**

(1) Within fifteen working days after receipt by the insurer of fully completed and executed proofs of loss, the insurer must notify the first party claimant whether the claim has been accepted or denied. The insurer must not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the specific provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer must contain a copy of the denial.

(2) If a claim is denied for reasons other than those described in subsection (1) and is made by any other means than in writing, an appropriate notation must be made in the claim file of the insurer describing how, when, and to whom the notice was made.

(3) If the insurer needs more time to determine whether a first party claim should be accepted or denied, it must notify the first party claimant within fifteen working days after receipt of the proofs of loss giving the reasons more time is needed. If after that time the investigation remains incomplete, the insurer must notify the first party claimant in writing stating the reason or reasons additional time is needed for investigation. This notification must be sent within forty-five days after the date of the initial notification and, if needed, additional notice must be provided every thirty days after that date explaining why the claim remains unresolved.

(4) Insurers must not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

(5) Insurers must not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant's rights may be affected by a statute of limitations or a policy or contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the claimant's rights. This notice must be given to first party claimants thirty days and to third party claimants sixty days before the date on which any time limit may expire.

(6) The insurer must not make statements which indicate that the rights of a third party claimant may be impaired if a form or release is not completed within a specified period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations.

(7) Insurers are responsible for the accuracy of evaluations to determine actual cash value.

[Statutory Authority: RCW 48.02.060 and 48.30.010. WSR 09-11-129 (Matter No. R 2007-08), § 284-30-380, filed 5/20/09, effective 8/21/09; WSR 78-08-082 (Order R 78-3), § 284-30-380, filed 7/27/78, effective 9/1/78.]